

**PARENTAL ALCOHOLISM AND ITS INFLUENCE ON PSYCHOSOCIAL
DEVELOPMENT AMONG PUBLIC PRIMARY SCHOOL PUPILS IN
BUNGOMA COUNTY, KENYA**

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**A Thesis Submitted in Partial Fulfillment of the Requirements for the Conferment
of the Degree of Doctor of Philosophy in Disaster Management and Humanitarian
Assistance of Masinde Muliro University of Science and Technology**

SEPTEMBER, 2020

DECLARATION

This thesis is my original work prepared with no other than the indicated sources and support and has not been presented elsewhere for a degree or any other award.

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CERTIFICATION

The undersigned certify that they have read and hereby recommend for acceptance of Masinde Muliro University of Science and Technology a thesis entitled “**Parental Alcoholism and its influence on Psychosocial Development of Primary School Pupils in Bungoma County, Kenya**”.

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DEDICATION

I dedicate this work to my husband Alan Libusi, our sons Charles, Moses, Joel and Stephen who were patient, supportive and eager to see me through with the development of this thesis.

It is also dedicated to my mother Esther Tete and my late father Jason Wandati for their invaluable contribution to my academic foundation.

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ABSTRACT

Alcoholism is a global problem that causes many problems including deaths. Many studies have been done on drugs and substance abuse in Kenya. Few studies have singled out alcohol and the harm to family members. The motivation of this study was on the basis of establishing the influence that parental alcoholism has on psychosocial development of public primary school children in Bungoma County with a purpose of improving their welfare. The general objective of this study was to examine Parental Alcoholism and its influence on Psychosocial Development of Primary School Pupils in Bungoma County, Kenya. The specific objectives of the study were to; determine the magnitude of alcoholism among parents in Bungoma County, examine the nexus between parental alcoholism and psychosocial development of primary school pupils, and evaluate strategies to enhance children's psychosocial development among alcoholic parents of Bungoma County. The study was guided by the Social Learning Theory by Albert Bandura, Erik Erickson's Theory of Psychosocial Development and Maturational Theory by Gesell. The study used descriptive survey, correlation and evaluation research designs. Simple random sampling was used to select the sub-counties; purposive random sampling was used to select the schools; then stratified simple random sampling to pick pupils from each class in standard seven from the randomly selected schools. The sample comprised 400 pupils, 72 Class Teachers, 72 Guidance & Counseling Teachers, 72 Senior Teachers, 72 Parent-Teacher Committee members, 3 Sub County Administration Officers, 3 Sub County Education Officers, 3 Sub County Children Officers and parents. Questionnaires, interview schedules and focus group discussions were used to collect primary data. Secondary data was also used. The data was analyzed using descriptive statistics that included frequencies, percentages and means; and inferential statistics such as Pearson correlation and chi square. The study found that 55.4% of the parents drank alcohol every day, Pupils gender and parental alcoholism were insignificant with $\chi^2 = 54.453$ at $p = 0.675$. Further the results show that churches, schools and the local administration are central in strategizing on mitigating the effects of parental alcoholism on psychosocial development of pupils. The study concluded that parental alcoholism has a negative influence on psychosocial development of pupils regardless of gender. The study recommends that there should be increased Community Education on the adverse effects of alcohol consumption at individual, family and community levels; Pupils should be taught skills of coping with alcoholic parents and Governments to develop more and better strategies to reduce the availability of alcohol to children and grownups. Future studies should be carried out in other parts of the country and compare the findings.

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LIST OF ABBREVIATIONS AND ACRONYMS

ADCA	Alcoholic Drinks Control Act
ADHD	Attention Deficit Hyperactivity Disorder
AIHW	Australian Institute of Health and Welfare
ALSWH	Australian Longitudinal Study on Women's Health
ANROWS	Australia's National Research Organization for Women's Safety
ASPD	Antisocial Personality Disorder
ATP	Adolescent Transition Program
BPD	Borderline Personality Disorder
CASA	Centre on Addiction and Substance Abuse
CAST	Children of Alcoholics Screening Test
CAPR	Center for Alcohol Policy Research
COA	Children of Alcoholic Parents
COALES	Children of Alcoholics Life Events Schedule
EMCDDA	European Monitoring Centre for Drug and Drug Addiction
ESPAD	European Schools Survey Project on Alcohol and Other Drugs
FAS	Fetal Alcohol Syndrome

FES	Family Environmental Scale
FBCIDP	First Bungoma County Integrated Development Plan
GSRAH	Global Status Report on Alcohol & Health
HTO	Harm to Others
ICAP	International Center for AIDs Care and Treatment Program
KARF	Korean Alcohol Research Foundation
KI	Key Informants
KII	Key Informants Interview
KNBS	Kenya National Bureau of Statistics
MICS	Marital Interaction Coding System
MLDA	Minimum Legal Drinking Age
NACADA	National Campaign Against Drug Abuse
NATA	National Authority on Tobacco and Alcohol
NATSISI	National Aboriginal and Torres Strait Islander Social Survey
NCS	National Comorbidity Survey
NDDCB	National Dangerous Drugs Control Board
NDSHS	National Drug Strategy Household Survey

NIAAA	National Institute on Abuse and Alcoholism
NICE	National Institute for Health and Clinical Excellent
NSMHWB	Australian National Survey on Mental Health and Well being
NSDUH	National Survey on Drug Use and Health
NSW	New South Wales
OCPD	Officer Commanding Police Division
PTA	Parents/Teachers Association
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SAMHSA	Substance Abuse and Mental Health Services Administration
SDN	Standard Daily Nation
SRS	Simple Random Sampling
STRS	Stratified Random Sampling
UK	United Kingdom
UNICEF	United Nations Children’s Fund
US	United States
WHO	World Health Organization

DEFINITION OF OPERATIONAL TERMS

Alcoholism	Refers to the inability of a person to control how much he or she drinks due to the physical and emotional dependence on alcohol
Bodaboda	Refers to local means of transport in Kenya
Busaa	Refers to a local brew that is not intoxicating
Chang'aa	Refers to Illicit brew locally made and drunk in brewers' homes that intoxicates
Carers	Refers to people who are responsible for children but not living with them
Disaster	Refers to an action that causes significant damage to people
Disaster management	Refers to addressing of a situation that is likely to cause a lot of damage
Harmful use	Refers to a pattern of drinking that causes or contributes to physical or psychological harm including impaired judgement or dysfunctional behavior which may lead to disability or have adverse consequences for interpersonal relationships.
Humanitarian assistance	Refers to efforts to help people who live in difficult circumstances or conditions
Kumi kumi	Refers to some poisonous liquor made locally with formalin

Matatu	Refers to a local means of vehicle transport for about 14 passengers
Mitigation	Refers to reducing the effects of a disaster
Parent	Refers to the head of a household, can be male or female or grandparent
Preparedness	Refers to planning the response
Prevention	Refers to activities aimed at trying to prevent future harm occurring
Private Schools	Refers to schools under private management that hire their own teachers
Public Schools	Refers to schools run by the Government that is responsible for hiring teachers and disbursement of funds
Pupils	Refers to school going children below the age of 18 years.
Psychosocial development	Refers to development in areas such as social, psychological, mental, and physiological
Resilience	Refers to the ability to regain balance after exposure to a difficult situation
Response	Refers to activities aimed at understanding needs and responding to them
Tout	Refers to a Matatu conductor to whom fares are paid
Vulnerability	Refers to being in a position to be easily harmed

CHAPTER ONE

INTRODUCTION

1.1 Background to the Study

Alcohol is the world's fifth biggest cause of death. The growth of alcohol consumption in developing countries is a potential result of the resulting increase in drinking-related issues (WHO, 2004). The harmful use of alcohol constitutes 5.9 percent of the deaths worldwide, and may also contribute to significant social and economic effects for non-drinkers and for society at large (WHO, 2014; Sacks, et al., 2013). In most countries, alcohol drinks are an integral component of adult culture. The majority of societies have culturally determined moderate and responsible beverages as part of natural, regular life (Giannetti *et al.*, 2002; Freeman & Parry, 2006; Willis, 2006).

Most societies have lost the control of the sale and consumption of alcoholic drinks, contributing to the growth of alcoholic issues, especially amongst children, including chronic alcohol. Due to the waning standards alcohol consumption, irrespective of age, is typically available to the general population (Osail & Pereverzev, 2010).

Alcohol is the disorder in which a person, despite repeated problems related to alcohol, tends to long for alcohol. There are similar symptoms of alcoholism and substance dependence and they are mostly only a matter of degree or severity. The drunken person is usually the last to be aware of serious drink issues because they deny them. Some signs and symptoms of alcoholic and alcoholic addiction include a drink alone, unable to minimize the amount of alcohol consumed, dropping hobbies

and activities used by or losing interest in alcohol, experiencing a urge to drink, having trouble with the law, having financial issues, and consuming a significant amount of alcohol to experience its effects (Videbeck, 2007).

Alcohol is generally a coveted product, which means that drinking generally requires resources that would otherwise be usable for other purposes. In cases where earnings are low, heavy drinking can further deplete drinkers, the family of the drinker and the entire society, rising either socially or healthily (Schmidt *et al.*, 2010; De Silva *et al.*, 2011). The addiction, dependency and withdrawal of alcohol can lead to bad performance in major social roles-in working, parental relations and in friendly roles. The effects, for example, job or loss of productivity, divorce and instability in the family, including domestic violence, can affect both drinkers and others. This in turn can lead to physical or mental health damage caused by the function of the disorder, other injury reactions or both (Schmidt *et al.*, 2010).

Parental alcoholism can have serious impact on all aspects of children's lives and to differing extents. Clinical and research evidence worldwide shows that children of alcohol abusing parents are an at-risk population for diminished intellectual capacity and development, increased emotional problems and a wide range of psychological and behavioral disorders (McNamee & Offord, 1994). As well as being at risk, these children are also likely to experience long-term adverse consequences. Parental alcoholism can significantly affect relationships within the family and the quality of parenting. Child rearing practices of alcoholic fathers have been found to be rejecting, harsh and neglecting (Basangwa, *et al.*, 1994). The Global Status Report on Alcohol (WHO, 2004) found that in homes where the male parent drinks, there is

violence. Studies show that the prevalence of alcohol among individuals with alcoholic parents is two and a half times that of the general population. Some of the predisposing factors are lack of parental monitoring, severe and recurrent family conflict and poor child-parent relationship (Haynes, *et al.*, 2004).

Globally, there are up to 1.3 million (one in eleven) children in the UK living with parents who misuse alcohol (Alcohol Harm Reduction Strategy for England, 2004). Findings from Gallup's Annual Consumption Habits Poll in 2012 indicate that 44% of Americans are regular drinkers consuming at least one alcoholic beverage in a week, with 14% of the adults admitting that they sometimes drank too much (Saad, 2012). The following are global statistics of total adult per capita consumption 15+ years in litres of pure alcohol: United Kingdom 13.37, Sweden 10.30, United States 9.44 and Spain 11.62. In Africa, Rwanda 9.80, South Africa 9.46, Zimbabwe 5.80, United Republic of Tanzania 6.75, Uganda 11.93 and Kenya 4.149 (GSRAH, 2011).

In Kenya, a study by NACADA in 2012 reported that 30% of the respondents aged 15-65 years had used an alcoholic drink (NACADA, 2012) and that the current use of alcohol stands at 13.6% in the country. A study in Bungoma County found that some of the children do not complete school because they assist their parents in brewing and selling illicit brews like chang'aa and busaa (Simiyu, 2010). Another study in the same County found that 22% of children in primary schools take alcohol, and that the youth abuse drugs because they modeled what their parents did (Omutsani & Owiye, 2013).

Children of alcoholics make up a large number of the population and are at risk for numerous psychological and developmental problems throughout their lives. The present study sought to find out the psychosocial harm that alcohol drinking parents pose to their primary school going children.

1.2 Statement of the Problem

According to the National Association for Children of Alcoholics, around 30 million children are born to alcoholic parents. Children of alcoholic parents are at risk for a variety of cognitive, emotional and behavioral problems when compared to peers who were not raised by alcoholic parents. The drinking parent may spend all his earnings and time on alcohol thereby causing the child to live in a home full of instability and suffering, with a pattern of lack of basic needs, in shame, without friends and having many responsibilities (Atieno, 2020). A recent survey by NACADA on primary school pupils focused on their involvement with drugs and substance abuse (Musau, 2019). Parental alcoholism can be a predictor of later adult drinking for the child. Mitigation and prevention measures have focused on harm to the drinkers' health and have placed limited emphasis on the harm of family members around the drinker, especially the children (GSRAH, 2014). In view of this, there was need for a research to establish the association between parents' alcohol consumption and their children's psychosocial development. This study sought to find out the influence parental alcoholism has on psychosocial development of primary school pupils in Bungoma County, Kenya.

1.3 Research Objectives

The overall objective of this study was to examine the impact of Parental Alcoholism and its Influence on Psychosocial Development among Public Primary School Pupils in Bungoma, Kenya.

The specific objectives were:

- i. Determine the magnitude of alcoholism among parents in Bungoma County, Kenya.
- ii. Examine the nexus between parental alcoholism and psychosocial development of primary school pupils in Bungoma County, Kenya.
- iii. Evaluate strategic options to enhance children's psychosocial development among alcoholic parents in Bungoma County, Kenya.

1.4 Research questions

The research questions were as follows:

- i. What is the magnitude of parental alcoholism in Bungoma County, Kenya?
- ii. What is the nexus between parental alcoholism and psychosocial development of primary school pupils in Bungoma County, Kenya?
- iii. Which strategic options can be generated to enhance children's Psycho-Social development among alcoholic parents in Bungoma County, Kenya?

1.5 Justification

Bungoma County is the third largest County in Kenya with a population of 1,378,224 as per 2009 Census (Bungoma District development Plan, 2002-2008). As a result,

the poverty levels are high with a lot of intra and outer migration. Hazardous alcohol brewing and consumption is done on a large scale.

The results of this study should be able to empower stakeholders in Education with knowledge of the influence that parental alcoholism has on the psychosocial development of young children in primary schools and hence empower them in making policies that may benefit school going children.

The communities in Bungoma County may benefit from this study, as it will bring awareness of the harmful effects of parental alcoholism on their children presently and through adulthood. The Ministry of Special Programs may use the results of this study to create other forms of income generating ventures that may enable parents to be with their children most of the time and hence reduce the negative impact parental alcohol use has on children and the family as a whole. Children may be assisted by Guidance and Counseling teachers and their parents to develop their own capacities and be in a position to grow through childhood in a way that prepares them for independent and integrated living during adulthood. The study may generate more current knowledge on the state of psychosocial development of young children living with alcohol abusing parents. Disaster Management specialists will benefit from this study as it will help them plan and direct programs and procedures for responding to children of alcoholic parents. The National Policy for Disaster Management will use the results to strengthen the resilience of vulnerable children to cope with potential disasters.

1.6 Scope of the Study

The study covered only parental alcoholism and psychosocial development in Bungoma County, Kenya. The study limited itself to alcohol consumption by parents and the influence it has on the psychosocial development of their primary school going children in public schools. Only pupils from standard seven in the school took part in the study because they were deemed able to read, understand English and express their opinion and views about issues in their lives. The Class one to six pupils were excluded from participating in this study because of the trauma they would experience from answering questions on their parents' drinking. Pupils from the lower classes may have required an interpreter in order to fill the questionnaires. Standard 8 pupils were left out because they were preparing for national examinations at the time of the study. Other stakeholders involved in this study included Education Officers, Children Officers, teachers and parents. Private schools and other relevant parts of development such as moral, language, and aesthetic were left out as all these could not be handled in one study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reviews literature on magnitude of alcoholism, parental alcoholism and psychological development, parental alcoholism and social development, strategies for enhancing children's psychosocial development and theories explaining stages in psychosocial development of children.

2.2 Alcohol Behavior

Poverty in underdeveloped and developing countries is both the cause and the result of disasters. In most countries, alcohol drinks are an integral component of adult culture. In most cultures, moderate and responsible drinking is considered a natural and healthy part of life, and drinking habits are defined culturally. Both adults and young people decide to drink on the basis of a number of factors: pleasure, lifestyle, transit rites, parental pressures and cultural acceptability (WHO, 2013). Drinking is generally viewed as normative activity and an integral part of everyday life in many countries. Children are frequently exposed to alcohol in the early days of the family and are involved in other events in the general area (WHO, 2013).

Drug abuse is a major global problem as evidenced by the many studies that have been done. Alcohol is particularly abused by adults and school going children. In a study in Netherlands by Zundert *et al.*, 2006) using longitudinal survey, 428 families

with at least 2 children aged 12-17 years in regular education were interviewed in their homes and also filled an extensive questionnaire in the presence of a trained interviewer. The parents had to be living together or married and the children and their parents had to be biologically related. Families with twins or off-spring who had mental or physical disabilities were excluded from the study. Respondents were asked about the frequency and intensity of each parent's drinking habits separately, alcohol availability, rules about alcohol; parental emotional support, behavioral control and adolescent alcohol use (Zundert *et al.*, 2006).

Ritson (2011) in his study compared the drinking culture of the youth in the UK who he said top the rest in the world thus making UK a 'drinking nation'. He further averted that the high number of adult drinkers had a direct causal effect to their children as it led to dangerous drinking habits within that social group. Ritson (2011) continued to describe how alcohol had become cheap and therefore readily available for children and further suggested that for children to be protected from these deadly drinking habits, parents had to become more responsible. He described the many negative effects of hazardous alcohol consumption that included both physical and psychological consequences (Ritson, 2011).

Cochrane and Bal (1990) undertook a study to identify patterns of alcohol consumption. It involved randomly selected participants from English, Sikh, Muslim and Hindu in Wolverhampton and Birmingham all at ages between 17 – 69 years concluded that; Muslim men drank the least amount of alcohol, followed by Hindu. The Sikh and white men were not only reported to be at the same level of alcohol

intake but were also regular alcohol consumers. This best explains why there was a continuous variation in alcohol consumption by youth from different ethnic backgrounds (Cochrane and Bal, 1990).

In 2013, Fuller and Hawkins (2014) published an investigation in England on the trends of smoking, drinking and substance use by young people. The data was obtained through a paper questionnaire, distributed in 174 colleges in England to 5,187 pupils. This research provides details on the use of alcohol by young people in England between 11 and 15 years old as a point of reference for alcoholic and misused health problems. The survey's main findings were: at least once, 39% of young people reported to have consumed alcohol. The number of boys and girls who have drunk alcohol was similar. At least once in age there was an rise in the number of students drinking alcohol (from 6% of 11 to 72% of those 15). Over the past 10 years, research suggests a declining trend in the rate of young people drinking in the week prior to data collection. The study showed that the proportion of young people who had consumed alcohol in the past week rose from 1% of 11-year-olds to 22% of 15-year-olds, and for those students who had consumed alcohol in the past week, the total number of units was 8.2. Rising rates indicate that despite steps taken to educate young people about the harmful effects of alcohol consumption, they continue to drink (Fuller & Hawkins, 2014).

Henderson *et al.* (2013) also suggested that male pupils were more likely to drink beer, lager or cider, whereas girls were more likely to drink spirits, alcopops or wine. Younger students typically drank with family members, while older students usually

drunk with colleagues. There has been a rise since 2006 in the proportion of students who typically drink at home or at other people's homes or parties with friends, and a decrease in students who drink outside. 50 per cent of students who had used alcohol in the previous month indicated that they had 'gotten drunk at least once' during that period, and 61 per cent had 'deliberately attempted to get drunk' while 39 per cent had not (Henderson *et al.*, 2013).

The Henderson *et al.* (2013) study found that, in terms of the reasons of consuming alcohol, students suggested that the actions and attitudes of their families had a significant impact on consuming. Students preferred to drink if they were staying with someone who was drinking. Students who came from homes where alcohol was not consumed indicated that they did not drink alcohol themselves. On the other side, students who lived with 'three or more drinkers' drank alcohol themselves. Similarly, students who felt their families didn't like drinking were less likely to drink alcohol than students who felt their families wouldn't mind drinking. These results indicate the effect of the family on the drinking activity of their children (Henderson *et al.*, 2013). According to students' assumption in why young people of their age consume alcohol, students who have never used alcohol believed that young people drink alcohol because of social pressure. They're trying to 'look nice in front of their peers,' and they also felt their peers were placing pressure on them to drink alcohol. Students who drink alcohol have said that people drink to be sociable with friends and that alcohol gives them a high or buzz (Henderson *et al.*, 2013).

The most popular strategies used by young people to procure alcohol were to 'give it to parents or guardians' and 'give it to friends.' The most popular source of alcohol for younger students was to be supplied to them by parents or guardians. Older students, on the other hand, usually get it from friends followed by parents. With respect to drinking place, younger students were more likely to drink at home than older students, while older students were more likely to drink at someone else's home. Students who currently drink alcohol indicated that they typically drank with their parents or friends of both sexes (Henderson *et al.*, 2013).

Studies on drinking motivations have looked at whether a person chooses to consume or not alcoholic drinks actively or unconsciously, based on the assumption that the effects of drinking will be beneficial or not. Various factors, such as previous drinking experiences and current life circumstances, enable people to develop expectations for an emotional improvement from drinking (Cox & Klinger, 1988). Plant & Plant (2001) found out that the reason young people drink alcohol is that teenagers enjoy the taste and effects of alcoholic drinks. Individuals usually drink alcohol because they enjoy it and get refreshment from the effects of alcoholic beverages. However, situation-specific variables have an effect on young people's drinking behaviour, and may therefore be able to drink differently in different circumstances. For example, when young people were with their families, they may have a sip of alcoholic beverage, but they might drink a lot at a party or with their friends, or before watching a football match. They can also drink heavily during study / examination times. In addition, peer pressure and interest is one aspect that leads young people to drink alcohol (Plant & Plant, 2001).

Kuntsche *et al.* (2005) examined the data of young people and young adults and their drinking motivations through a computer-assisted search for appropriate posts. The findings showed that most young people between the ages of 10 and 25 suggested that drinking was due to social motives; some claimed that they were drinking for reasons of change, and only a few identified drinking for reasons of coping. In general, most young people drink for a social purpose or a sense of pleasure. Between 14 and 16 years in the UK, they drink to make the party more fun (Kuntsche *et al.*, 2005). A year later, Kuntsche *et al.* (2006) analyzed the observational study of young people aged 10 to 25 years who had clear reasons for drinking. In their paper there were two variables which were believed to be the drivers of drinking among youth: firstly social-demographic factors like age, sex, and patterns over time. Secondly, personalities such as emotions, inhibition control, sociability and anxiety sensitivity.

A cross-sectional sample study of students aged 6 and 12 in Mississippi United States by McDermott *et al.* (2013) in a rural and ethnically diverse population has shown that drinking prevalences range from 32.2 percent to 72 percent. Australian study uses a sample of 12 to 17 years of age and has found that 33.1 percent in 16 years of age is the prevalence of alcohol in teenagers. Studies that have been checked have shown that, with a rising age, alcohol consumption in all countries becomes more frequent and the figures in each country are very different (McDermott *et al.*, 2013).

Two major factors that impact on youth drinking behaviour, namely internal and external factors, were examined by Ahlström & Österberg (2005). Internal factors include features such as gender, personality and biological characteristics. Age and gender were big drinking behavioral problems. In young adults, girls can drink more frequently than boys because they mature more quickly than boys and have no family or obligations. Yet young men appeared to drink more alcohol and more often than young women as they reached a young adulthood (Ahlström and Österberg 2005). With regard to external influences, social expectations or society, physical availability and price of alcohol: social norms make drinking your friends and siblings the most accurate indicator for young people. In addition, the relationship between parents and children, communication and behaviors often affect alcohol consumption among young people. How much teenagers drank affected society. For example, in Mediterranean cultures teenagers are more likely than in other regions to consume alcohol (International Center for Alcohol Policies, 2014).

According to research in Europe, men drink twice as much as women and there is a substantially higher prevalence of alcohol in men than in women. Alcoholism is far more prevalent in middle ages, lower incomes and lower education. On the educational level, there was a wide gap between rural and urban areas: in urban areas, alcoholism was more prevalent among people with higher education levels, while in rural areas it was correlated with those with lower education (Moinuddin et al . , 2016).

The perception of drinking has changed all over the world – with a rising number of women and younger people drinking. A research in the United States of America sought to investigate the association between inappropriate parental drinking and depression in adult alcoholics 'children and non-adult alcoholics' children in help-seeking college students. In addition, the study investigated whether or not inappropriate parental drinking was related to students' own use of alcohol. In a sample of 4,679 clients who participated in the 1997-1998 survey, 24 per cent reported having a drinking problem parent, 71.2 per cent reported not having a drinking problem parent, and 4.2 per cent reported that they did not know whether or not a parent had a drinking problem (Shankar *et al.*, 2000).

Western countries are typically correlated with higher levels of alcohol consumption and lower rates of abstinence. According to the World Health Organization, alcohol-related mortality and disease and injury burdens are higher in many low-and middle-income countries that are known as 'non-western' due to drinking habits and the type of products consumed, especially illegally produced alcohol (WHO; 2006, 2014). Countries like Sri Lanka have experienced the alcohol consumption as the country has grown economically (Siriwardhana *et al.*, 2012).

The World Health Organization recognized that the harmful use of alcohol is the third leading risk factor for premature death and disability in the world. It accounts for approximately 3 million deaths and 5 percent of the global burden of disease and injuries as measured in disability-adjusted life years worldwide every year. Early

initiation of alcohol use, before 14 years of age, is associated with increased risk of alcohol dependence and abuse at a later age (WHO, 2014).

Alcohol is associated with many serious physical, social and mental related issues, including deterioration of relationships with family, friends and co-workers. It has been widely used in many cultures for centuries and there are a variety of examples from around the world of environmental factors and historical trends in alcohol consumption and harm (WHO, 2014). Those environmental factors include economic development, culture, availability of alcohol, and the level and the effectiveness of alcohol policies. A wide range of global, regional and national policies and strategies have attempted to mitigate the effects excessive alcohol use. A quarter (24.8%) of world alcohol consumption was unrecorded, homemade alcohol, illegally produced or sold outside normal government control (WHO, 2014).

According to the NIH Senior Health, alcohol affects men and women differently. In general, older men are more likely to drink alcohol compared with older women. But women of all ages are often more sensitive than men to the effects of alcohol. Women's bodies tend to break alcohol down more slowly. Also, women have less water in their bodies than men, so alcohol becomes more concentrated. As a result, women may become more impaired than men after drinking the same amount. That is why the recommended drinking limit for women is lower than for men. Drinking for a long time is more likely to damage a woman's health than a man's health (Shankar *et al.*, 2000). Research suggests that as little as one drink per day can slightly raise the risk of breast cancers in some women, especially those who have

been through menopause or have a family history of cancer. But it is not possible to predict how alcohol will affect the risk for cancer in any one woman. Many people enjoy a drink without any problems, but binge drinking or drinking heavily over longer periods of time can have very serious consequences. Alcohol misuse not only harms the individual, but damages relationships and society in general in terms of violence and crime, accidents and drink driving. In Northern Ireland, the number of alcohol-related deaths has more than doubled since 1994. The most recent figures show: there were 270 deaths recorded as alcohol-related in 2012. There were more than 11,500 alcohol-related admissions to hospitals in 2009/10(Shankar *et al.*, 2000).

A study conducted by Jaisoorya *et al.* (2016) in Kerala state, India noted that the prevalence of lifetime alcohol among adolescents aged between 12-19 boys 23.2% and girls 6.5% showing a prevalence increasing with age. A study from a developing country, Italy, reported that the widely used substance in Italy is alcohol among the adolescents and sample age range were 15 to 21 and the prevalence of participants alcohol drinking was 9% (wine) up to 28% (beer). The prevalence of adolescents alcohol use in developing countries varied from low to a higher level (Jaisoorya *et al.*, 2016).

A global school-based student health survey was conducted using data from twelve developing countries. Botswana, Grenada, Indonesia, Kenya, Myanmar, the Philippines, Saint Lucia, Saint Vincent, and the Grenadines, the Seychelles, Thailand, Trinidad and Tobago and Uganda. The prevalence of alcohol use was varied widely across countries. It was ranged from a low of 1.6% in Myanmar to a

high of 60.1% in the Seychelles. The current drinking rate of junior high schools boys was 20.5% and senior high school boys was 36.2 in 2004. The prevalence of junior and senior girls was 20% and 34.1 respectively (Osaki *et al.*, 2009). A systematic review of the literature was conducted in Brazil to recognize the prevalence of adolescents alcohol use. According to the review, the prevalence of adolescents aged 10-19 alcohol use was 23% to 67.7% (Barbosa Filho, Campos, & Lopes, 2012).

Vantamay (2009) conducted a cross-sectional survey of 1,200 students in six universities about alcohol consumption among university students aged 18-24 years in Bangkok, Thailand. The researcher found that adolescents are sometimes likely to ask their parents or peers for information regarding health and alcohol use. Here the students see how parents can act as sources of information and models for educating their children with regards to the use of alcohol. However the parents' advice and education will of course depend on their own attitudes towards alcohol consumption. A study found that Thai parents do not often provide the best education or advice surrounding alcohol use, do not often act as good role models for their children, and often are the root cause of their children's drinking patterns (Assanangkornchai *et al.*, 2002; Chaveepojnkamjorn & Pichainarong, 2007).

According to World Health Organization, in Africa, local brews are cheap and readily available and 30% of females and 55% of males are drinkers; 2.2 % of all deaths in Africa are attributable to alcohol; more than fifty percent of mental hospital admissions in Lesotho, Mauritius and Swaziland are due to alcohol dependence and

delirium tremors while twenty to thirty percent of general hospital admissions are alcohol related; about 42 % of Zambian young people aged 13-15 years consume alcohol and 42.8 % have been drunk; while in Namibia about 33% of the same age group has consumed alcohol and 32 % have been drunk and Uganda has the second highest per capita consumption of alcohol in the world (WHO, 2013). Adolescents were more likely to use alcohol when they reported that they had seen either their father or mother drunk or both according to a sample drawn from 704 adolescents aged 16 to 18 years from high schools in Emawaleni District of KwaZulu-Natal (Hoque & Ghuman, 2010).

Alcohol is the leading risk factor in developing countries with low rates of child and adult mortality and in Sub-Saharan Africa 2.2% of all deaths and 2.5% of all adjusted life years (DALYs) are related to alcohol (WHO 2011; Obot & Jos, 2006). Consumption of commercial beverages is expected to rise in the next years as economic conditions continue to improve in some African countries and as a result of increasing alcohol marketing and promotion activities by the global alcohol industry (Obot & Jos 2006; Casswell & Thamarangsi 2009). The youth population, which constitutes the largest demographic group in African countries, has increased in size and is expected to further increase their alcohol consumption. Several authors have noted that adolescents and young adults have become the specific target audience for alcohol marketers (Jernigan 2001; Odejide & Ibadan 2006).

In what constitutes present-day Nigeria, locally-produced alcoholic beverages such as *burukutu*, *pito* (fermented beverages from maize or Sorghum) and palm wine (sap

from palm tree) served different purposes before any contact with the European traders (Heap, 2005). Because alcohol had strong symbolic value, different communities used locally-produced alcoholic beverages for diverse purposes such as oath taking and the pouring of libations during ancestral worship and child naming celebrations. This is a moderate level compared to some other African countries like Zimbabwe (5.08 litres) Tanzania (5.29 litres) and Botswana (5.38 litres). On the other hand, based on unrecorded alcohol the per capita consumption (15+) from 1995 was 5.0 litres, which compares with levels found in the high range African countries such as Swaziland (4.1 litres), Rwanda (4.3 litres), Burundi (4.7 litres), Seychelles (5.2 litres), Zimbabwe (9.0 litres) and Uganda (10.7 litres) annually (WHO, 2014).

The most recent Global Status Report on Alcohol and Health of 2014 gave the average annual per capita alcohol consumption in Uganda to be 23.7 liters, with 3.4% of the population being heavy episodic drinkers (drinking six or more standard drinks of alcohol in the past 30 days). This is equivalent to approximately 6.4 standard drinks of alcohol per day per person. 9.8% of participants in its survey had an alcohol-use-related disorder. It was evident therefore, that, among alcohol users, some were heavy consumers, a factor that increased overall per capita alcohol consumption (WHO, 2014).

Other countries in the sub-Saharan Africa region that have similar levels of current alcohol use include Tanzania 29.3% (32), while higher levels have been shown in Zimbabwe 58% (33) and Ethiopia 45.7% (34). Lower levels have been shown in Botswana 18.7% (35) and Zambia 20.8% (36). However, findings from the survey

were in contrast with previous reports in the local media and other reports that had ranked Ugandans as being the highest consumers of alcohol in sub-Saharan Africa (Kiyanga, 2013).

Community studies show significant alcohol consumption in Kenya where only 15% of alcohol consumption is recorded and based on this measure, Kenyans aged 15 years and above on average consume 1.74 litres of pure alcohol annually (WHO, 2004). A countrywide survey by NACADA indicated a current usage of alcohol (consumption in the last 30 days) among persons aged 15-65 years (n = 3,356) to be 14.2% with male consumption being 22.9% and female consumption being 5.9%. Other rates of consumption were: rural - 13.0%, urban - 17.7%; legal/packaged alcohol – 9.1%, traditional liquor – 5.5% and *chang'aa* – 3.8%. Disaggregating by province, the lowest use was found in North Eastern (0 %) and Western provinces (6.8%) while the other six provinces were comparable with a range of 13% - 19% (Rift Valley - 12.5%, Eastern – 14.8%, Nyanza – 17.0%, Central – 17.7%, Coast – 18.6%, Nairobi – 18.6%) (NACADA, 2010).

In Kenya, 70% of families are affected by alcohol. Statistics indicate that 16.6 per cent of the urban population consumes an alcoholic beverage of some sort, compared to 11.4 per cent in the rural areas (Njung'e, 2014; NACADA, 2010). Alcohol is bought alongside bread in retail outlets and ten shillings is enough to get someone intoxicated. Over 100 people from Kiambu, Muranga, Embu, Trans Nzoia and Laikipia Counties died in a span of less than a week because of consuming illegal brew laced with methanol while others were admitted to hospitals in critical

condition and others are blind up to today (Wanyoro & Ngunjiri, 2014). Most of these people were parents who had woken up very early to look for alcoholic drinks. Studies in Central Province found that children of alcoholics are more likely than the general population to develop alcohol problems such as lifetime violence and violence where the male is an intolerable drinker of alcohol (Mahugu, 2010; NACADA, 2010).

From the NACADA survey of 2007, of the 188 patients evaluated after a motor vehicle crash in all hospitals located in Eldoret, 23.4% were blood alcohol concentration positive (5 mg%) and 12.2% were intoxicated (50 mg%). Greater proportions of night-time and weekend crashes involved intoxicated subjects. In November 2000, at least 140 Kenyans died, many went blind and hundreds others were hospitalized after consuming an illegally brewed and poisonous liquor called *kumi kumi* in the poor neighborhoods of Mukuru Kwa Njenga and Mukuru Kaiyaba. Made from sorghum, maize or millet, the alcoholic drink is common among Kenyans living in the country's low-income urban and rural areas, who are too poor to afford conventional legal beer. Poverty has been referred to as the springboard of many disasters in Kenya (NACADA, 2007).

At a NACADA workshop (2004), it was revealed that in the then central province, now comprising Kiambu, Meru, Taaraka- Nithi, and Murang'a Counties, 16.3% adults drank bottled beer, 17.7% second generation beer and around 20% take illicit brews - those brews brewed at home and other areas not licensed by the government as fit for human consumption. At this workshop, youth were said to be most affected,

and engaged in alcohol abuse due to unemployment, idleness, poverty and changes in social systems (NACADA, 2004).

Many Kenyans use every excuse to indulge in alcohol, like celebrating a wedding or the birth of a child or to cope with tragic news such as death and divorce. A survey by NACADA in 2012 revealed that 13.3% of Kenyans are current users of alcohol and in Western Province, which includes Bungoma County, 7.1% of the population use the local brew *chang'aa* (NACADA, 2012). In the year 2011, 15 people in Banana, Kiambu died as a result of taking the illicit brew, *kumi kumi*. Recently in Kenya, over 61 people died and a larger number were hospitalized, their fate unknown after consuming illicit brew from Muranga, Embu, Kiambu and Kitui (SDN, 2014). According to NACADA boss John Mututho, access to alcohol was the main reason turning Kenyans into alcoholics and the fact that they have no idea to how to use their leisure time (SDN, 2014). Reports from one of the Kenyan newspapers show that Nairobi and Western Regions have the highest number of alcohol abusers (Gatoche, 2011).

The following table shows the current rates of alcohol consumption by type and by Region in Kenya.

Table 2. 1: Current rates of alcohol consumption by type and by Region in Kenya

	Mainstream alcohol %	Chang’aa %	Traditional liquor %	Illicit brew %
Nairobi	15.7	7.2	2.3	1.3
N-Eastern	4.3			1.1
Coast	7.5	1.3	4.4	0.9
Central	9.2	0.5	1.4	1.1
Eastern	9.0	2.1	4.6	1.0
Rift Valley	8.7	5.5	6.0	2.0
Nyanza	6.2	6.2	5.1	1.0
Western	3.8	7.1	3.8	

Source: NACADA, (2014)

A study by Ngesu *et al.* (2008) revealed that alcohol was the most abused drug because it was acceptable in society compared to other types of drugs. Furthermore, commercials and the media portray those who take alcohol as being very happy and enjoying their drinks. Alcohol was the most commonly abused drug largely because it is sold legally and has attained a commodity status. Most alcohol adverts target men and tend to portray a picture that alcohol drinking is masculine. Those who escape the allure of alcohol advertisements are captured by the fact that moderate alcohol drinking is good for one’s health (Ngesu *et al.*, 2008).

In a study in Kisii County investigating the prevalence of drug abuse among female and male adolescent adolescents found that a great number of boys (84%), who are the upcoming fathers, abused alcohol. In addition, the students who stayed with drug users also abused drugs. The study used 120 form four students aged 16-24 years as participants. Questionnaires, interview schedules, direct observation and document

analysis were the data collection instruments. The research design used was causal comparative (Ondieki & Ondieki, 2012).

Kabuka & Ochola (2013) in their study in Kisumu Municipality on the prevalence of substance abuse adopted a descriptive survey design, using peer counselors and guidance and counseling teachers found that alcohol was the most abused drug. A study by Otieno (2009) using a cross-section survey design with secondary school students in Kisumu and Western Province found that the onset of alcohol abuse was as early as below 15 years. Furthermore, most of the students who abused alcohol came from families where alcohol was easily available and acceptable and family members, especially parents abused alcohol. A majority of these families were from low economic classes (Otieno, 2009).

Another study of alcoholics in alcohol and drug rehabilitation centers in Nairobi city revealed that most of the alcoholics seeking treatment in drug and alcohol rehabilitation centers were between the ages of 30 and 49 years and that a majority of fathers, sixty six percent of alcoholics used alcohol while only twenty six percent of the mothers used alcohol. Most of the alcoholics started drinking between 11 and 17 years, when according to the Kenyan system of education, they were in primary school (Mahugu, 2009).

Many of these studies have explored the extent of consumption of alcohol using secondary school students, college students and alcoholics from drug rehabilitation centers, with cross-sectional survey and casual comparative designs. The purpose of

this study was to find out the magnitude of parental alcohol consumption in Bungoma County, Kenya, using descriptive survey design with primary school pupils as respondents.

2.3 Parental Alcoholism and Psychological Development of Children

Development of a child starts when the genetic materials from the sperm and ovum unite. It entails the biological, psychological and emotional changes that occur in human beings between birth and the conclusion of adolescence, as the individual progresses from dependency to increasing autonomy. Emotional development tends to go in cycles throughout childhood; hence, a positive concept is needed for good emotional and social development. Exposure to good social development results in an adult whose behavior conforms to the expectations and norms of the society he lives in (Mwangi & Njuguna 2006; Waller 2009; Patterson, 2008).

A woman who consumes alcohol during her pregnancy is likely to give birth to a child with Fetal Alcohol Syndrome (FAS), which is one of the three leading causes of birth defects in children. Babies born with FAS are shorter and underweight compared to normal children. They have deformities of the skull and brain and abnormal facial features such as small eye openings, thin upper lips, long flat faces, and a long groove in the middle of their upper lips. The children's nervous systems are also damaged. As a result, children with FAS are impulsive, poorly coordinated, and have impaired speech and hearing. FAS and its effects are often permanent and irreversible and may lead to mental retardation (Hoffman *et al.*, 2001).

Children exhibit intense concern about physical growth and maturity as profound physical changes occur that influence their self-esteem. Adolescents display a wide range of intellectual development. The skills they learnt earlier as children become coordinated and they are able to apply them generally. This is because they are in transition from concrete to abstract thinking. This enables the adolescent to see the world and all that is in it from a different perspective. They are intensely curious and determined in a wide range of pursuits, few of which are sustained. They think in terms of what might be instead of what is. They get to understand scientific reasoning, the principles and gain better understanding of the society (Hoffman *et al.*, 2001)

Adolescence represents a vulnerable and essential period for normal and maladaptive development patterns. It has been portrayed as the period of transition from concrete operational thinking to abstract thinking, as well as the forming of reason and judgment. Recent research supports the idea that adolescent thinking represents a “function of social, emotional, and cognitive processes” (Steinberg, 2005). Research also supports the idea that the brain continues to develop during adolescence and in the early period of adulthood. During this period, the behavioural and cognitive systems, as well as the brain, develop in different proportions causing the adolescent to be in a continuous state of vulnerability and adaptation (Gogtay *et al.*, 2004). In order for teenagers to develop into socially integrated individuals with the capacity to make appropriate decisions that have long-term consequences, it is important for them to have a healthy emotional development right from conception phase. Adolescents who do not manage to control their emotions risk making poor decisions

that might generate an increased risk of substance abuse, delinquent behavior or relationship challenges (Gogtay *et al.*, 2004).

A study in the United States found that growing up in a household of alcoholic parents was likely to produce low self-esteem, great dysphoria and more anxiety in adulthood. A similar study in Hawaii cited more parent-child conflict, less parent-child interaction, more deviant behavior and belonging to deviant peer groups by children in homes where parental alcoholism was evident. Furthermore, parents who abuse alcohol may be inconsistent in expressing warmth and affection towards their children (Burke, *et al.*, 2006).

The 2008 Harm to Others (HTO) Survey reported in *The Range and Magnitude of Alcohol's Harm to Others* showed that the majority of Australians had been affected by others' drinking in the last year and many had been seriously affected (Laslett *et al.*, 2012). Amongst those more seriously affected were family members, including children. Families where one or both parents abuse alcohol are more likely than others to include yelling, insults and serious arguments between family members, making the home an unstable environment for children (Kumpfer & DeMarsh, 1985; Sher, 1991). As part of the 2002 NSDUH, data were collected from 68,126 respondents on the number of children in the US living with substance-abusing or substance-dependent parents. Results indicated that parents who were dependent on or abusing alcohol in the past year were significantly more likely to report household turbulence than parents who did not have an alcohol use disorder (SAMHSA, 2004). This household turbulence was defined as frequent insults, yelling, serious arguments

and threats of physical violence. In Scotland, 2.5 per cent of children (N = 24,302) are estimated to live in households where violence had occurred after the perpetrator had been drinking, and 1.2 per cent of children (N = 11,665) witnessed these acts of violence (Manning *et al.*, 2009). Studies have also shown that children as young as six expect more verbal and physical aggression by an adult towards his/her spouse when the adult is thought to be intoxicated versus sober (El-Sheikh & Elmore-Staton, 2007). Exposure to family violence has been shown to have a range of effects on children's development, with both age and gender of the child being important; outcomes may include poor sleep and health, externalising and aggressive behaviours, and internalising behaviours and depression (Dawe *et al.*, 2007).

Reviews of family violence in Australia in Indigenous communities have shown that the incidence of violence is disproportionately high when compared with non-Indigenous communities, and that rates of violence are both escalating in frequency and becoming more serious in nature (Memmott *et al.*, 2001). In 2002, the National Aboriginal and Torres Strait Islander Social Survey (NATSISS, N = 9,359) found that 21 per cent of Indigenous Australians aged 15 years and over reported that they felt family violence was a particular problem in their community; family violence was seen as more of a problem in remote areas and in overcrowded dwellings (ABS, 2004). Another study used the same dataset to reveal that within the Indigenous population, high-risk alcohol consumption doubles the rate of victimization more than any other single factor, from 10.1 per cent to 20 per cent (Snowball & Weatherburn, 2008).

In their meta-analyses of the literature on family violence in Indigenous communities, (Blagg, 1999; Memmott, 2001) both identified multi-causal models in which alcohol was one of numerous situational factors underlying family violence. It was suggested that the link between alcohol misuse and violence in Indigenous communities was related to the concepts of disinhibition, behavioral expectancies and ‘allowing’ violence to occur by providing a socially accepted excuse for it, rather than being a direct causal mechanism (Hennessy & Williams, 2001). For example, an individual may try to explain away antisocial behavior by using phrases such as: “I was drunk, I couldn’t help it”, “I didn’t know what I was doing”, or “I don’t remember” (Bolger, 1991; Memmott *et al.*, 2001). In support, Australian research indicates that Indigenous offenders are significantly more likely to attribute their offending to alcohol than non-Indigenous peers (Putt, Payne & Milner, 2005). Whilst family violence and problem alcohol use appear to be particular problems in Australian Indigenous communities, one is not a sufficient or necessary cause of the other. This is evident by the fact that not all Indigenous people who use alcohol become violent; while violence continues to occur in many alcohol-free Indigenous communities (Memmott *et al.*, 2001).

A number of longitudinal studies conducted internationally have examined the relationship of alcohol use specifically to separation and divorce. Wilsnack *et al.* (1991) compared 143 problem drinkers and 157 non-problem drinkers in a female sample over a five-year period. Results indicated that the relationship between alcohol use and divorce or separation was moderated by problem drinking status at baseline. Among non-problem drinkers, higher average consumption and frequency

of intoxication at baseline were related to separation and divorce across time. Divorce or separation was found to predict lower levels of subsequent alcohol dependence among problem drinkers. These results suggest that separation and divorce were more likely to follow, than pre-cede, heavier drinking in women. This in part would impact on children's psychological development (Wilsnack *et al.*, 1991)

Power & Estauth (1990) examined a large (N = 9,337) representative cohort of young people in Great Britain and found that partnerships among heavy drinkers were relatively unstable. Examination of drinking levels at ages 16 and 23 indicated that relationship breakdown was common in young men and women who had been heavy drinkers at both time points and among those increasing consumption between adolescence and early adulthood. The direction of effect could not be established because the temporal sequencing of partnership breakdown and heavy drinking was not clear over the seven-year period, for example, difficult emotional relationships and excessive drinking may occur simultaneously. However, relationship breakdown was confounded by other factors including economic status, housing tenure, and having children. In a later follow-up of the cohort, Power, *et al.* (1999) examined the relationship between heavy alcohol consumption and marital status at age 23 and 33 (N = 11,405). The study found that 23-year-old heavy drinkers were not significantly more likely to divorce than those who did not drink heavily. However, marital separation was accompanied by short-term increases in heavy drinking, suggesting that alcohol may be used as a temporary means of coping with relationship breakdown and its concomitants (Power *et al.*, 1999).

Locke & Newcomb (2003) conducted a 16-year prospective study of women (N = 305) using a community sample in which alcohol use was identified as a significant predictor of marital dissatisfaction. The study found that comorbid alcohol involvement and dysphoria during young adulthood was a stronger predictor of relationship maladjustment in adulthood than either alcohol involvement or dysphoria alone. Other evidence suggests that the predictive relationship between marital dissatisfaction and problem drinking may be bi-directional. In several prospective studies, marital functioning has been shown to predict the likelihood of relapse and time to relapse among people in treatment for alcohol dependence (Maisto, McKay & O'Farrell, 1998; O'Farrell *et al.*, 1998). Moreover, in a community study of 1,675 married couples in the US, baseline marital dissatisfaction was prospectively associated with a diagnosis of alcohol abuse or dependence at the 12-month follow-up (Whisman, Uebelacker & Bruce, 2006). Both male and female spouses who were dissatisfied with their marriage at baseline were 3.4 times more likely to have a diagnosis of alcohol use disorder at follow-up than satisfied spouses, after controlling for demographic variables and history of alcohol use disorders. However, the generalization of the findings was limited because only 14 people met criteria for current alcohol use disorder at follow-up (Whisman, Uebelacker & Bruce, 2006).

Homish & Leonard (2007) followed up a sample of 634 couples at their first- and second year anniversaries using prospective time-lagged analyses and found that decreased marital satisfaction was associated with discrepant heavy drinking. This

refers to reported differences between marital partners in their frequency of drinking to intoxication and in the frequency of heavy drinking (six or more drinks). These authors reported that greater levels of marital satisfaction usually occurred when partners drank together at similar quantities and frequencies (Homish & Leonard, 2005). A later follow-up of this cohort revealed that among those with high marital satisfaction, marriage is associated with a decline in drinking behaviors and reduced risk for alcohol problems. For those who continued to display heavy drinking and alcohol use problems up to four years after marriage, the identified predictive factors were pre-existing alcohol problems and heavy drinking prior to marriage, antisocial characteristics, and family history of alcohol abuse, negative effect, and alcohol expectancies. Such antisocial activities affect the children these parents stay with (Leonard & Homish, 2008).

Data also suggest that congruence between partners in drinking behaviors may positively influence marital satisfaction. Floyd *et al.*, (2006) studied individually rated positive and negative marital behaviors in 132 couples, comparing alcohol-dependent and nondependent combinations of husbands and wives. They also examined the influence of antisocial behavior in the husband, noting that the comorbid prevalence of alcohol use disorders in those with antisocial personality disorder was 74 per cent (Floyd *et al.*, 2006). They found that irrespective of the alcohol dependence status of the wife, more hostile behaviors occurred in relationships where the husband had antisocial behaviors and was alcohol dependent. However, there were a greater proportion of positive behaviors when alcohol dependence was congruent, i.e. where either both of the spouses or neither of the

spouses had a diagnosis related to alcohol use. Supporting the notion of the relevance of matched drinking behaviors, a large and representative longitudinal study (N = 4,589) conducted in the US between 1992 and 2000 found that discrepant drinking levels (rather than actual drinking levels) in partners were predictive of marital dissolution. This study also found that history of problem drinking by either spouse was not associated with an increased risk of divorce (Ostermann *et al.*, 2005).

A large body of research has been dedicated to understanding the relationship between alcohol use disorders and intimate partner or marital violence. A strong relationship has consistently been identified between male-perpetrated intimate partner violence and alcohol problems (Finney, 2004; Heyman, O’Leary & Jouriles, 1995; Holtzworth-Munroe *et al.*, 1997; Leonard & Jacob, 1988; Leonard & Senchak, 1993; Quigley & Leonard, 2000). Maritally violent men are significantly more likely than a wide variety of comparison groups to abuse alcohol (Holtzworth-Munroe *et al.*, 1997). Physically aggressive episodes have been shown to be four times as likely as verbally aggressive episodes to involve the husband’s drinking (Quigley & Leonard, 2000; Testa *et al.*, 2003). These episodes were also more likely to result in injury to the victim and consequent reporting to the police if the partner was drinking at the time of the incident (Thompson & Kingree, 2006). In Australia, alcohol is involved in around 50 per cent of domestic and sexual violence cases (English *et al.*, 1995). The Australian component of the International Violence Against Women Survey found that some 35 per cent of women recalled their partners being under the influence of alcohol on the last occasion of partner violence. The survey also found that women whose husbands got “drunk a couple of times a month or more” were

three times more likely to experience domestic violence than women whose partners drank less. Such domestic violence was seen by the children (Mouzos & Makkai, 2004).

Murphy *et al.* (2005) examined the relationship between proximal alcohol consumption and intimate partner violence in a clinical sample of alcohol-dependent men. Results indicated that alcohol consumption was present prior to both psychological and physical aggression, yet the quantity of alcohol consumed by the husband was significantly higher prior to violent conflicts. Not only was alcohol present during the vast majority of conflicts for this sample, but alcohol was also a very common topic of conflicts, reported by over half of the respondents for both violent and non-violent conflict event (Murphy *et al.*, 2005).

There is some evidence that female victims of male-perpetrated violence are more likely to be dependent on alcohol than non-victims (Miller *et al.*, 2000). Women who report regular alcohol use or abuse have been shown to be between 2.2 and 3.4 times more likely to be physically abused by their intimate partners than non-drinkers (Grisso *et al.*, 1999; El-Bassel *et al.*, 2000). An Australian study of 267 substance-dependent women found that 59 per cent (138 women) had experienced any physical or sexual assault as an adult, and 81 of these women had been sexually or physically assaulted by their partners. Of those women who were assaulted by a partner, 24 per cent reported they were intoxicated at the time of the assault and 59 per cent reported their partner was under the influence of alcohol or other drugs (Swift, Copeland & Hall, 1996). Leonard (1993) identified associations between wives' excessive

alcohol consumption and their husbands' violence; however, after controlling for husbands' alcohol consumption, the relationship was no longer significant. In another study of newlywed couples, wives' heavy drinking did not emerge as a significant predictor of husband aggression. Taken together, there is mixed evidence for a relationship between female heavy drinking and male-perpetrated physical violence (Leonard, 1993).

Assanangkornchai *et al.* (2002) researched the effects of paternal drinking, conduct disorder and childhood home environment on the development of alcohol use disorders in the Thai population (n=312 aged 18 and over). The findings showed that there was a significant relationship between having a father who enjoyed drinking and the occurrence of drinking-related problems in children. It was more likely that if fathers consumed lots of alcohol, then their children would do the same. Mulvihill *et al.* (2005) explored spirituality in families and its role in the prevention of drug abuse among adolescents, and concluded that the belief and behavior of parents and other family members shaped the behavior of young people.

Kumpfer (1998) noted that young people, who came from high stress families and dysfunctional families, had a big risk of alcohol problems. Young people who defined their family as somewhat authoritative tended to drink less than young people who described their family as having neglecting parents (Adalbjarnardottir & Hafsteinsson, 2001). Furthermore, the young people who came from a single-parent family were more intense alcohol users than those who had both a mother and father in the family (Kask, *et al.*, 2013).

Family bonding provides strength to the relationship between children and their parents. Ideally, young people should abide by the norms and culture of the family, and obey their parents on grounds of the hierarchy of the family structure (Jones *et al.*, 2006). At this age, the impact of the family is most prominent as, according to the model proposed by Erikson, young people are at the time when they are faced with the 'psycho-social crises', trying to find their identity (Crain, 2011). The appeal role model is very important at this point, and it is likely to shape the young people's attitude towards drinking.

Adolescence is a period of great stress and anxiety for both the young person and their families (Kumpfer & Alvado, 2003). Additionally, other researchers argue that young people passing through adolescence may exhibit nonsocial, unethical behavior during this phase in life for instance; deviant behavior may involve drinking, violent activities with friends, theft, sexual assaults, rash driving and substance abuse. These types of behavior may be reduced by means of family influence, which accounts for the important role that parents play (Velleman, 2009; Berk, 2013).

In the United States of America, 0.05- 2.0 per 1000 births have FAS while in South Africa, one of the highest incidences of FAS globally the figures are 19-23 per 1000 births (WHO, 2013), with the greatest prevalence reported in the Western Cape (Hoque & Ghuman, 2010). It is believed that one and two-thirds of all children with special education needs were affected by their mother's alcohol intake during pregnancy. FARR estimates that there are about 6 million people who are mentally

physically disabled by the effects of alcohol. Adult sons of alcoholic parents see doctors more often while the daughters have reproductive problems and have high rates of an eating disorder, bulimia (Hoque & Ghuman, 2010).

Furthermore, a study carried out by Kumpfer & Alvarado (2003) exploring the impact of the family on young people's attitude towards drinking has revealed that parents are the most influential factors in alcohol and drug prevention and healthcare interventions. Discussing in detail the implications of binge drinking across the UK population, together with the possible ways to mitigate its negative consequences, several studies have shown that the role of parents can be further strengthened by skill training, communication development, parental monitoring and parental involvement in prevention programs. The effectiveness of the family structure, family members and parents play a part in shaping the young people's development into adulthood (Kumpfer & Alvarado, 2003; Ary *et al.*, 1999; Center for Substance Abuse Prevention, 2000).

Physical problems can continue into childhood and beyond, with children from a very early age experiencing tremors, seizures and epilepsy. There is also an increased risk of a younger child being harmed because of poor hygiene, lack of safety precautions or being left for long periods of time unsupervised, in the care of an older sibling, or with someone outside of the family who may not be appropriate (Horgan, 2011). Children living in families with a heavy-drinking parent are reported to have been affected, including by disruptions to family rituals such as birthdays, by changes in and reversal of parent-child roles, by disturbed school attendance, eating

and bedtime routines, by limited or more aggressive communication, by diminished social connectedness, and by lack of finances and worsening relationships (Velleman & Templeton, 2007).

Research suggests that parental drinking patterns, of both mothers and fathers, can contribute to increased problematic drinking patterns for their children (Raitasalo, 2011; Smith *et al.*, 1999; Wilks *et al.*, 2006; Yu 2003). Parents may also find it difficult to maintain routines and, for instance, be unable to take children to organized early morning sports matches because they have a ‘hang over’ (Velleman & Templeton 2007). At the other extreme, parental drinking may play a role in accidental child deaths, infanticide, assault, and extreme cases of neglect and child abuse (Victorian Child Death Review Committee 2009). Problems associated with a parent’s drinking may be limited (e.g. affecting supervision at one-off social functions) or ongoing, such as potentially affecting a child’s development over many years if the child is inadequately fed, clothed and looked after (Laslett *et al.*, 2010).

An Australian mixed methods action research study of parents in treatment for drug or alcohol dependencies and their children showed that intoxication and withdrawal could impair parents’ ability to prepare meals, maintain household cleaning, keep school routines, respond to children’s emotional needs, and supervise and manage risk of injury, including neglect or harm of their children by others (Gruenert *et al.*, 2004). Parents in this study reported that during times of active alcohol or other drug use they themselves were more irritable, intolerant or impatient toward their children, used harsher discipline, were less responsive to their children’s needs,

yelled more and let go of routines, including getting their children to school. They also reported that they let their children take on adult roles, including caring for younger siblings (Gruenert *et al.*, 2004).

Other studies have shown a range of negative effects on children of problem drinkers, including depression and reduced intellectual development (Barber & Crisp 1994; Dawe *et al.*, 2007; Straussner 1994). Dawe *et al.* (2007) reviewed and summarized case-control studies comparing children of alcohol-dependent parents with children of non-alcohol-dependent parents, and reported that these provide some evidence that higher levels of internalizing disorders such as anxiety and depression and externalizing disorders such as conduct disorder and aggression were more common in children of alcohol-dependent parents than non-alcohol-dependent parents. Only a minority of children of alcohol-dependent parents were negatively affected (West & Prinz 1987 cited in Dawe *et al.*, 2007). Dawe *et al.* (2007) had also summarized the international literature on the impact of a family member's drug use including alcohol on children between the ages of two and 12 years. They discuss neglect, harm or abuse (which in severe cases are the potential triggers for intervention by child protection agencies), exposure to hostility and conflict, the impact of alcohol on family functioning, and the associated child behavioral problems (Dawe *et al.*, 2007).

Studies have provided the perspective of affected children themselves on the harms experienced from a parent's or carer's drinking. In an Australian survey of children who called the telephone help service 'Childline', parental alcohol misuse was

identified by children as connected to a broad range of problems, including the child running away, violence in the home, physical abuse, sexual abuse, neglect and poor family relationships (Tomison 1996). In the UK and Finland, focus groups with children and reviews of the literature revealed that children of substance-using parents felt ashamed, that they had missed out on their childhood, had normalized negative situations that a child should not have to deal with, and had felt anxious about their own safety. In addition, children reported being concerned for their parents in relation to the effects of their drinking. They were upset by their parents' quarrelling and violence when they drank, and felt that their families did not function as they should. They felt they were not prioritized in their parents' lives and that they were neglected and physically hurt (Adamson & Templeton 2012; Raitasalo 2011). It was noted that in Finland many of these children had developed methods for coping with some of these problems and had suggestions about what might help other children in the same situations (Raitasalo, 2011).

In the 2008 HTO Survey among the 446 respondents, the most commonly reported harm from the problematic family drinker was being involved in a "serious argument that did not involve physical violence" (63 per cent). Almost three quarters (74 per cent) of those who lived with the problematic family drinker reported a serious argument. This harm was also common amongst those affected by the dividing of non-household problematic family drinkers. The majority (66 per cent) of the 446 respondents also reported that that they had been "emotionally hurt or neglected" because of their family member's or intimate partner's drinking, and that that person's drinking "had negatively affected a social occasion" (65 per cent) (Laslett *et*

al., 2010). A larger percentage of female (56 per cent) than male respondents (43 per cent) reported that the problematic family drinker had “failed to do something they were being counted on to do” because of their drinking, regardless of whether they lived with this family member (57 per cent for females compared to 39 per cent for males) or not (51 per cent for females compared to 41 per cent for males). More than two in five respondents (43 per cent) not living with the problematic family drinker reported that they “stopped seeing” the drinker (suggesting that it was easier for respondents to stop seeing the drinker if they did not live with them, although a proportion of this group may have previously lived with the respondent and be describing a permanent change). Twenty-seven per cent of respondents reported “feeling threatened” as a result of the family member’s drinking, but only small percentages reported being physically hurt, being put at risk in a car or being forced or pressured into sex (Laslett *et al.*, 2010).

In 2008, an estimated 2,791,964 Australians (17 per cent of the adult population) were negatively affected “a lot” or “a little” by a family member or intimate partner’s drinking. This number includes an estimated 1,300,727 Australians who were substantially negatively affected (“a lot”) by that person’s drinking. Of the 446 respondents in the 2008 HTO Survey (Laslett *et al.*, 2010) who reported that a family member’s or intimate partner’s drinking had affected them most; 28 per cent named a named a current or ex-spouse/partner, 14 per cent a parent, 19 per cent a child, 20 per cent a sibling, 17 per cent another relative, and three per cent indicated a boyfriend or girlfriend was responsible, 34 per cent lived in the same household as the drinker, women (41 per cent) were more likely to report that they had been

negatively affected “a lot” by the family member’s drinking than men (21 per cent) and ninety two per cent reported experiencing one or more incidents of specific harm: being emotionally hurt or neglected (66 per cent), having a social occasion negatively affected (65 per cent) and being involved in a serious argument (63 per cent) because of a family member’s drinking were the three most common specified harms reported (Laslett *et al.*, 2010).

In the 2010 HTO Report, the harms to children reported were, initially based on key markers from response agencies for which statistics were available – Fetal Alcohol Syndrome (FAS), child abuse, child deaths and hospitalizations (Laslett *et al.*, 2010). The study also used survey responses to measure the prevalence of more widespread harms to children as a result of others’ drinking. Respondents who reported either that they lived in a household with children (under 18 years) or that they had responsibility for children but did not live with them (e.g. a father or mother not currently living with the child or children) are termed ‘carers’. In response to specific questions about harms children in their families experienced, carers most commonly reported that in the previous 12 months children were yelled at, criticized or verbally abused (8 per cent) because of others’ drinking. Smaller percentages reported witnessing serious violence in the home (3 per cent), that children were left unsupervised or in unsafe situations because of others’ drinking (3 per cent) or that children were physically hurt because of others’ drinking (1 per cent). In response to a more general question in the 2008 HTO Survey, 17 per cent of carers reported that the drinking of other people had negatively affected their child or children “a little” (14 per cent) or “a lot” (3 per cent) in the past year (Laslett *et al.*, 2010).

Findings from the 2008 HTO Survey indicate that, carers with children in the household were not significantly more or less likely to report that their children had been affected by others' drinking than those whose children were not in the household. However, carers with children both in and out of the household were more likely to report that their children had been affected by one or more specific types of harm. This group of carers was more likely to report that their children had been verbally abused because of others' drinking than those carers with children in the household only (21 per cent versus 7 per cent). Somewhat counter-intuitively, carers with children outside the household were more likely to report that their children witnessed violence in the home because of others' drinking than those with children in the household (10 per cent versus 2 per cent). From the findings, which relationships were reported to be responsible for harms to children, as described by the 135 carers who reported that their child or children had been negatively affected in one of the specified ways. Almost half (46 per cent) of the carers who reported that their child had been negatively affected by others' drinking identified that the drinker's relationship to the child was a parent (n = 58), step-parent or the carer's partner or ex-partner (n = 8), or the child's guardian (n = 2). As carers could report more than one type of harm, the total number of alcohol-related harms due to the drinking of someone in a parental or quasi-parental relationship with the child reported in the year prior to survey completion was 101(Laslett *et al.*, 2010).

In regard to distress associated with parental alcohol abuse, it was found that among college students who had sought counseling, those who were raised in a home in

which a parent had problematic drinking behavior reported more overall distress than those who were not raised in such an environment. In addition, participants who had parents with problematic drinking behavior were found to have high levels of problematic alcohol use themselves. Data in this study were collected by use of questionnaires (Shankar *et al.*, 2000).

Of the studies reviewed, some used mixed methods research, longitudinal survey, national survey, cross-sectional, case-control studies comparing children of alcohol dependent parents and non-alcohol dependent parents. The respondents were parents in treatment for drug dependencies, women only, children under carers and college students who sought counseling, and those of age 18 and above. Many of the studies used large samples such as 68,126 respondents and over, few had small samples such as 305. Findings included results of children getting harmed, physical and emotionally hurt, neglected and distressed. The current study sought to find out the influence parental alcoholism has on psychological development of children using descriptive survey with a small sample of 400 drawn from public primary pupils as respondents. This study sought to find out whether the psychosocial developmental problems encountered by children of alcoholic parents from other countries were similar to those of children from Bungoma County, Kenya.

2.4 Parental alcoholism and Social Development of Children

Development of a child starts when the genetic materials from the sperm and ovum unite. It entails the biological, psychological and emotional changes that occur in human beings between birth and the conclusion of adolescence, as the individual progresses from dependency to increasing autonomy. Emotional development tends

to go in cycles throughout childhood; hence, a positive concept is needed for good emotional and social development. Exposure to good social development results in an adult whose behavior conforms to the expectations and norms of the society he lives in (Mwangi & Njuguna 2006; Waller 2009; Patterson, 2008).

Families with an alcohol abusing parent have poorer organization compared to families unaffected by alcohol abuse and this may be due to the fact that with increasing patterns of abuse, substance dependence becomes the central organizing principle of the family at the expense of regular rituals and routines (Dawe *et al*, 2007, Tubman, 1993). Family systems theories identify organization and regular activities, such as routines and rituals, as the cornerstone of structure, predictability and stability for healthy families (Haugland, 2005). As a result, it is likely that the maintenance of organization, rituals and routine may serve as a protective factor for families affected by parental problem drinking.

Empirical studies have indicated that problem drinking is commonly associated with disruptions to everyday family routines. In one Australian longitudinal study (N = 260 male adolescents and their parents), fathers' heavy drinking was associated with rarely or never eating dinner at home together (Cumes-Rayner *et al.*, 1992). Furthermore, 89 per cent of these sons reported that their families rarely or never spent evenings together, and 66 per cent reported that their families never or rarely spent weekends together. Cumes-Rayner *et al.* (1992) also found that families with heavy drinking fathers were more likely to have heavy drinking sons and more

difficulty settling disagreements at home, and surmised that it was the sons who absented themselves from home activities rather than the fathers.

In a Norwegian study of 23 families, Haugland (2005) found that paternal problem drinking was associated with disruptions to the structure of many every day events. These events included family routines and rituals associated with mornings, meal times, bedtimes, discipline, leisure activities and children's social contact with their peers. Empirical studies of parental problem drinking and family rituals and routines have been limited by their exploratory nature, small sample sizes, lack of a control comparison group and their focus on paternal drinking (Haugland, 2005). Considering the central role of the mother in family organization, it is plausible that studies of maternal problem drinking, or families in which both parents abuse alcohol, may find stronger associations between parental problem drinking and disruptions to family organization and routine. The extent to which these disruptions impact on both family life and children is also likely to vary depending on the presence of other risk factors such as marital conflict, family violence, separation or divorce, and ambivalent and unpredictable parenting (Haugland, 2005).

Research suggests that unpredictability and instability associated with a lack of routines and rituals may contribute to maladjustment in children of problem drinkers, specifically, it may contribute to children's problem drinking in adult life, and an increase in anxiety-related health disorders. A cross-sectional study (N = 68 couples) showed that family ritual disruption is significantly associated with an increased risk of alcohol problems in adult offspring of problem drinkers (Bennett *et al.*, 1987).

Bennett and colleagues found that maintaining family rituals during periods of parental problem drinking appeared to protect children from developing problems with alcohol later in life (Bennett *et al.*, 1987). However, in another study, Fiese (1993) found little evidence for an association between family rituals and alcohol problems in adult offspring of problem drinkers. Rather, a strong association was found between disruption of family rituals and an increased prevalence of anxiety related health disorders in these children later in life. It is important to note that families dealing with problem drinking who are able to maintain routines and rituals may also be distinguishable from those who are not by other characteristics, such as lower levels of conflict, divorce or family violence (Fiese, 1993). These protective characteristics are also likely to contribute to child adjustment, and to mediate or moderate the relationship between child adjustment and a lack of routines and rituals associated with parental problem drinking.

Teesson *et al.* (2010) examined the prevalence of comorbidity between alcohol use disorders and anxiety disorders using the 2007 NSMHWB data. Australians with an alcohol use disorder were found to be almost three times more likely to be diagnosed with an anxiety disorder than those without an alcohol use disorder and 3.5 per cent of the sample met criteria for combined affective, anxiety and substance use disorder (Teesson *et al.*, 2010). The odds of agoraphobia and obsessive-compulsive disorder were both significantly increased in respondents with an alcohol use disorder. Teesson *et al.* (2010) reported that the co-occurrence of alcohol dependence and anxiety-related disorders (such as posttraumatic stress disorder, panic disorder and

social phobia) was related to both increased severity of alcohol dependence symptoms and increased treatment seeking.

An Australian private hospital drug and alcohol treatment sample (N = 104) revealed that comorbid disorders were not significantly related to treatment attendance or self-report measures of substance use (Dingle & King, 2009), where 92 per cent of the sample met diagnoses for at least one other mental disorder, including major depression, generalized anxiety, and borderline personality disorder (BPD). Further evidence indicates that it was the severity of depression symptoms at the nine-month follow-up which significantly predicted fewer days abstinent from substance use in the past 30 days (Dingle & King, 2009). Conversely, substance use has also been shown to increase the risk of affective disorders. A meta-analysis of 17 published studies, revealed that substance-using women reported significantly higher rates of postpartum depression than control subjects, indicating that prenatal substance use predicted postpartum depression symptoms (Ross & Dennis, 2009).

Anecdotal evidence suggests that money spent on alcohol is often not available for other purposes like housing, rent or school fees (Tunnard, 2002). Children living with parental problem drinking have spoken of the shortage of finances for clothes, food and bills, and of their own money being borrowed in times of financial need (Tunnard, 2002). Living conditions can also be poor, with large amounts of household financial resources directed towards the procurement of drugs and alcohol (Tunnard, 2002). Health complications commonly associated with alcohol abuse and dependence can also lead to medical costs which have the potential to further

increase the financial strains on families dealing with such problems (Butterworth, 2003). To further compound these difficulties, alcohol problems are more common in low-income single parent families, meaning that additional financial pressures are commonly placed on families that have fewer economic resources to draw on (CASA, 2005).

Australian data from the 1997 NSMHWB suggest that lone mothers who receive financial assistance from the government are almost four times more likely than other mothers to report alcohol and other substance use disorders (Butterworth, 2003). Women on welfare who are dependent on alcohol or other drugs also report more barriers to employment than women on welfare that do not have a substance use disorder. Barriers to employability include domestic violence, mental health problems, legal problems, child welfare investigations and fewer job skills (Morgenstern *et al.*, 2003). These barriers decrease the chances of alcohol- and substance-dependent women achieving the financial security often associated with stable employment. However, financial strains can also impact on the involvement of families in treatment because reduced or limited income often means that these families cannot afford to receive treatment in private or specialized facilities. Families where one or both parents have an alcohol-related problem may have reduced access to treatment, or access to treatment that is inadequate to deal with the cluster of problems that such individuals and their families typically experience (Mitchell *et al.*, 2001). This can be a source of anxiety on the part of the children.

Epidemiological data from the US such as the National Comorbidity Survey (NCS) a nationally representative household survey conducted in the US (N = 8,098), show that personality disorders also commonly co-occur with alcohol use disorders (Grant *et al.*, 2008; Helzer & Pryzbeck, 1988; Kessler *et al.*, 1997). The findings from the research data indicate that for those who met lifetime criteria for BPD, 58.3 per cent also met a lifetime diagnosis of an alcohol use disorder (Gianoli *et al.*, 2012). While the causal links or factors associated with these comorbid disorders is not well known, BPD traits are predictive of future problems with alcohol use, and poor prognosis is observed for those with comorbid and alcohol use disorder compared to those with only one disorder (Gianoli *et al.*, 2012). Past 12-month alcohol dependence was reported in 18 per cent of cases and 50.7 per cent reported substance use in the past 12 months, with greater prevalence amongst men with BPD compared to women. When comorbidity was controlled for, alcohol dependence remained significant but any association with alcohol abuse disappeared, suggesting that these associations may be accounted for by factors common to both disorders (Grant *et al.*, 2008).

Similarly, parental antisocial personality disorder (ASPD) and trait characteristics also appear to be important in the relationship between parental alcohol dependence and family functioning. Zucker *et al.* (1996) conducted a study in which alcohol-dependent fathers (N = 311) were subtyped according to whether they had a high-level history of antisocial behavior during both childhood and adolescence or no sustained history of antisocial behavior. The researchers hypothesized that family risk would be greatest when the parents' psychopathological risk structure had been

in place across the lifespan. Results revealed that antisocial alcohol-dependent fathers have denser family histories of alcohol use disorders, lower intellectual functioning, and significantly higher levels of non-alcohol-related psychopathology compared to non-antisocial alcohol-dependent fathers. Antisocial alcohol-dependent parents were also shown to display more aggressive behavior and conflict, and were lower in socioeconomic status than were the non-antisocial alcohol dependent parents and the control group (Zucker *et al.*, 2009).

Moss *et al.* (2001) compared mother-reported psychiatric disorders and problem behavior scores in pre-adolescent children with antisocial alcohol-dependent fathers, non-antisocial alcohol-dependent fathers, and children whose fathers were without either disorder (N = 639). Children from the antisocial alcohol-dependent group showed elevated rates of major depression, conduct disorder, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder and separation anxiety disorder when compared to both other groups of children. These children also had higher internalizing and externalizing problem behavior scores than the other two groups of children; there were no significant differences between children with non-antisocial alcohol-dependent parents and controls (Moss *et al.*, 2001).

Hussong *et al.* (2007) integrated the analyses of two independent longitudinal studies (N = 1,050 adolescents and at least one or both of their parents), which used a high risk design to assess children with subtypes of alcohol-dependent parents (alcoholism only, alcoholism and depression, and alcoholism and ASPD) and compared them with depressed parent-only controls on their externalizing behaviors, measured by

the aggressive and delinquent behavior sub-scales on the Child Behavior Checklist and Youth Self Report. Consistent with the aforementioned findings, children whose parents were both diagnosed with alcohol disorders and those whose parents had comorbid alcohol use disorder and depression were found to exhibit greater externalizing symptoms than children whose parents were only diagnosed with depression. This was evidence for an intergenerational susceptibility for developing antisocial characteristics with a risk of later development of adult alcoholism (Hussong *et al.*, 2007).

Alcohol-related problems can also impede job performance, leading to reduced earnings or loss of employment (Booth & Feng, 2002). In one Australian study of children of parents who were engaged in a drug or alcohol treatment program in Victoria, it was found that 97.9 per cent of substance misusing parents were unemployed. Only 17 per cent of those unemployed were actively seeking work, and the 2.1 per cent who were employed were all employed on a part-time basis (Gruenert *et al.*, 2004). Of those families in the study, 92.8 per cent also reported an annual household income of less than \$20,000 (\$384 weekly) which primarily came from government social benefits payments (Gruenert *et al.*, 2004). This was low compared to the median Australian household income of \$40,664 (\$782 per week) from the 2001 Census data (ABS, 2006). Although the numbers in this clinical sample were small (N = 118, comprising 48 children and 70 members of their extended families) only 27.1 per cent were seeking treatment primarily for alcohol. Another 48.9 per cent sought primary illicit drug treatment and had a secondary problem with alcohol. The sample also most likely represented the more severe range of drug and alcohol problems, with most of the adult participants having long

histories of substance dependency. A high proportion of the sample reported poly-substance use (79.2 per cent), multiple rehabilitation attempts (70.3 per cent had accessed a detoxification service at least once), previous criminal offences (70 per cent), and low educational attainment (82.2 per cent had not completed Year 12) (Gruenert *et al.*, 2004).

Problem drinking has been shown to have a major impact on the social life of families. Where a parent suffers alcohol dependence or problem drinking, spouses and children may be isolated and less able to obtain support from social and health care support systems. The value of community connectedness and social support for children is now recognised as a protective factor against the development of future problems (Gruenert *et al.*, 2004). Community connectedness and social support can assist in the development of children's pro-social skills, enhance supervision, and promote positive self-esteem (Gilliga & Kypri, 2013). Social isolation may therefore act as a risk factor for the maladjustment of children dealing with parental alcohol misuse.

Tunnard (2002) suggests that children of problem drinkers have little time for social activities because of the increased care giving responsibilities and household duties they often take on. Children of problem drinkers may also experience a feeling of shame about their home circumstances (Boyd & Mackey, 2000), causing them to distance themselves from other children and from adults such as teachers, who otherwise may be able to offer social support (Tunnard, 2002). Children of problem drinkers also report more difficulties with peer relationships including fewer friends

to socialize with, lower confidence in making friends, and avoidance by both their peers, and the parents of peers who discourage friendships with such children (Tunnard, 2002). Additionally, house, school and neighborhood moves are often common for families of problem drinkers, making it difficult for children to establish and maintain social connections and to engage with their communities. In one study it was found that children of parents with severe drug and alcohol problems had attended approximately two different schools, and moved house over five times by the average age of 7.4 years (Gruenert *et al.*, 2004). Extracurricular sporting and recreation activities can be a good source of social support for children; however, due to the financial strains often experienced by families dealing with parental problem drinking there may not be enough money to afford participation in these kinds of activities (Gruenert *et al.*, 2004).

Psychosocial wellbeing is an important area of functioning that can be affected both positively and negatively by alcohol use. With regard to social/leisure functioning, there is fairly consistent evidence that older or elderly problem drinkers both in and out of treatment tend to have social/leisure problems in the form of loneliness and low social support (Schonfeld & Dupree, 1991), fewer social resources (Brennan & Moos, 1990), lower social integration (Hanson, 1994), lower satisfaction with social relationships (Meyers *et al.*, 1982), social isolation, and fewer satisfying leisure activities (Graham *et al.*, 1995). This in turn impacts negatively on the social aspects of their children.

A longitudinal study of 8,271 adolescents provided supporting evidence that drinking predicted lower socio-emotional and academic functioning (Crosnoe *et al.*, 2012). However, the authors emphasized that the social context of drinking is significant in the socio-emotional functioning of adolescents, whereby teen drinkers felt marginalized within schools with dense networks of low-rate drinking. However, the inverse relationship has also been found, where high socialization has found to be associated with increased drinking for male adolescents (Cumes-Rayner *et al.*, 1992). This finding is also relevant for adults, where expectations of social effects of alcohol and peer-network heavy drinking were significant predictors of both husbands' and wives' own heavy drinking (Leonard & Homish, 2008). Thus, it appears that the social context and expectancies of drinking rather than alcohol were associated with negative impacts on individuals and families.

Parental alcohol misuse is at the center of a web of problems including violence and neglect. Children experience considerable lack in a parent's capacity to provide practical and emotional care. Parental absences for long periods of time are common, sometimes because of imprisonment. The parents are unable to show consistent interest in their children's work. The children face emotional blackmail, often in the form of suicide threats from their parents. Children from an early age often have a higher level of knowledge about parental alcohol and drug misuse than parents may assume although they may not fully understand (Kyalo, 2010). Younger children may be more likely to witness parents taking alcohol due to parental perceptions that they are too young to understand. Lack of understanding of what is happening leads to frustration, confusion, fright, anxiety and anger on the part of the child. Drunken

declarations of love and caring are resented as meaningless and instead the children develop feelings of anger and sorrow (Bancroft & Wilson, 2004). Feelings of guilt may develop, with the child seeing himself as the cause of the parents' drinking problem. The child may be anxious as he or she worries constantly about the situation at home. He or she may fear the alcoholic parent will become sick or injured and may also fear fights and violence between parents (Bancroft & Wilson, 2004).

Drinking parents may give the child the message that there is a terrible secret at home leading to embarrassment on the part of the child; the child may feel ashamed to invite friends at home and may fear asking for help. There is evidence of high levels of distress in COA (Shankar, *et al.*, 2000). A study by Merky (1993) postulates that when children are feeling bad about themselves, or they are feeling unworthy, unloved or rejected, they turn to drugs and substance abuse. Findings from a study among college students in the U.S, in regard to distress associated with parental alcohol abuse, it was found that among 3,214 college students who sought counseling, those who were raised in a home in which a parent had problematic drinking behavior reported more overall distress than those who were not raised in such an environment. In addition, participants who had parents with problematic drinking behavior were found to have higher levels of problematic drinking themselves. Participants who were unsure about problematic parental drinking reported high levels of distress also, leading to the possibility that the unsure participants either had no knowledge of or were unwilling or unable to confront a possible reality of parental alcoholism (Shankar *et al.*, 2000).

A cross-sectional study by Wu, Chong, Cheng, and Chen (2007) in Taiwan investigated family relationships, deviant peer influence and adolescent alcohol use in a sample of 780 grade nine students. Measures of family characteristics, school factors and peer influence were used, with peer influence including peer relationships, deviant peer behavior and alcohol use. The study reported that substance use was predicted by perceptions of poor family relationships and deviant peer relationships. There were two major limitations in the study: that cross-sectional research did not allow causal inference and all family, school and peers measures were self-reported (Wu *et al.*, 2007).

A study in the Netherlands used multiple data sources to examine whether the association between friends' drinking norms and male adolescent alcohol use was moderated by peer influence. Using a sample of 73 male adolescents with the average age of 17 years, the study comprised three parts: a baseline class-room questionnaire assessment, a chat room experience and a multiple time diary assessments to measure alcohol use. Peer influence susceptibility was defined as the change in adolescent responses before and after exposure to peer norms (Teunissen *et al.*, 2016).

A cross-sectional study conducted in Illinois (USA) was part of a larger research project on adolescents. The sample comprised 259 students aged 14-18 with the study seeking adolescents' self-reported perceptions of four types of parental messages that may influence alcohol use intentions. Those four messages were

parents' references to the negative consequences of alcohol use, parents' references to their own past experiences with alcohol use, parents' conditional permissive messages and parents' views on drinking alcohol responsibly (Kam *et al.*, 2017). This study examined how parent-child alcohol-specific verbal messages indirectly related to adolescents' alcohol use intentions, focusing on parents' own experiences to create a 'teachable moment' to discuss alcohol with their children. Adolescents perceived their parents' conversations regarding parents' own experiences as a sign of honesty and trust. This study noted that adolescents learning behavior from parents may be an important model (Kam *et al.*, 2017).

Fraga *et al.* (2011) conducted a mixed method cross-sectional study in Portugal to understand alcohol use among 13 year old school students. This study had both quantitative and qualitative components: a self-administered questionnaire to a sample of 2036 students, and a semi structured interview (N=30). This study intended to assess the reason for and consequences of drinking as perceived by adolescents and discover their views on prevention strategies. The results of this study demonstrated that more than 50% of 13 year olds had drunk alcoholic beverages at least once in their lifetime. There were likely cultural reasons for the high proportion of adolescents who had experienced alcohol by 13 years, probably due to the tradition of home consumption with meals. Results indicated that adolescents only identified minor and temporary consequences of drinking alcohol but most recognized that the drinking can be harmful and lead to addiction that is difficult to treat. However, participants only perceived the consequences for the person who drinks and not how this could affect others (Fraga *et al.*, 2011). Despite

the strengths of the mixed-method model which allowed both objective measures of behavior and in-depth analysis of several features of this behavior, researchers noted that a limitation of the study was related to not having enough information about parents' behaviour and parental roles (Fraga *et al.*, 2011).

Children of alcohol abusers are at greater risk of attention and conduct problems at school, repeating a grade, low academic performance, skipping school days and dropping out of school and low school bonding (Serec *et al.*, 2012, Mylant *et al.*, 2002). Poor academic performance may be linked in some way to prenatal exposure to alcohol due to maternal drinking. Fathers' drinking may have similar effects on children's school and educational outcomes. Farrell *et al.* (1995) found that a father's problem drinking can be a chronic stressor and this environmental influence could account for poorer outcomes in children. In particular, having a father with a reputation as a problem drinker may place additional stress on the child, particularly when they reach adolescence, a period of increased sensitivity and anxiety. Alcoholic parents may be less encouraging of academic success in their children and may not place as much emphasis on academic achievement or provide supportive environments for their children's academic success. They may not monitor children's activities at home regarding their schoolwork, homework and exam preparation because of their drinking patterns and associated behaviors (Bond *et al.*, 2005).

Furthermore, poor school performance may lead to school failure and affect future progression to higher education and subsequent employment opportunities. Young people's connectedness with school has proven to be a protective factor; a strong

social bond with school is associated with diminished involvement in a range of adolescent health-risk behaviours (Bond *et al.*, 2005). Other school attributes including extracurricular activities and teachers have all been found to modify school connectedness (McNeely *et al.*, 2002). Where some elements of parenting skills may be deficient, teachers have been shown to help compensate for lack of parental warmth and support at home particularly for those families on a low income; positive relationships with teachers have been shown to be beneficial in motivating low SES students and can have positive effects for students at risk (Wehlage, 1989). Overall stabilizing activities such as school, clubs, sports and religion can be beneficial in helping a young person to develop a sense of self and self-esteem (Velleman & Templeton, 2007).

Engaging with stabilizing people outside the family can be a positive factor in the development of resilience. Parental alcohol misuse may impair a child's ability to go places since the parent cannot drive if drunk or make friends since the child will be unable to invite friends home (ISPCC, 2010; Velleman & Templeton, 2007). The ability to seek external support may also be hampered due to finances, parents' permission or location (Velleman & Templeton, 2007). Individual disposition appears to be more important for females whereas external support is more important for males (Werner, 1993). In addition, while the support of friends appears to be an important protective factor for young people, others suggest that many young children may find it hard to make friends (Werner, 1993). While strategies of detachment, avoidance and withdrawal in dealing with a parent can be very effective,

they can result in attachment and relationship difficulties later in life (Harwin *et al.*, 2010; Werner & Johnson, 1999).

Serec *et al.* (2012) found that children of alcoholics (aged 12-18 years) reported spending more time in sedentary activities (such as watching television, internet, listening to music) and less time in physical activities. Reported heavier use of technology (text messaging, emails, and watching television) among adolescents with an alcoholic parent was also associated with earlier and heavier substance use during adolescence (McCauley Ohannessian, 2009)

In a study by Mclaughlin *et al.* (2016), children of problem drinkers demonstrated resilience through engagement in activities and relationships outside the family environment. At 14 years of age, the greater the parents' alcohol use, the greater the number of evenings their children spent outside the home, particularly when the father was the drinker. By 15 years of age, there was an association between increased number of evenings spent at a friend's house and mothers' drinking, for boys. The likelihood of spending time with members of the opposite sex was greater for girls whose parents drank more. In their study, there was no association between parental drinking and child reports of peer problems such as difficulties in making friends and spending time alone (Mclaughlin *et al.*, 2016). The greater the parents' levels of alcohol use, the more likely their children spent time on the following activities: hanging around on the streets, going to a café/shopping with friends, going to discos/ parties and baby-sitting for their family. Children whose parents drank at higher levels were less likely to go to a youth club, afterschool/homework club or

attend a place of worship. A number of activities were associated with parental drinking for girls: listening to Compact Discs, going to the park/playground, going to a sports club/team or leisure centre. Parental drinking was not associated with spending time watching Television, reading books/magazines or playing computer/game consoles or doing homework (McLaughlin *et al.*, 2016).

Hoque and Ghuman (2012) conducted a cross-sectional study in South Africa with a total of 704 16-18 year old adolescents, to understand their perception of parental practices relating to adolescent alcohol use. The researchers examined adolescents' perceptions of their own alcohol use, parental alcohol use and the associated behavior and family rules regarding alcohol use. They reported that 54% of participant adolescents had consumed alcohol at some time in their life. The study noted that a large number of mother/female guardians and father/male guardians do not allow drinking at home. Adolescents were more likely to use alcohol in households where parents drank. Hoque & Ghuman (2012) found a significant association between parental alcohol use and adolescent alcohol use, and parents' views on their adolescents' alcohol drinking.

The qualitative research from Portugal from Fraga *et al.* (2011) discussed alcohol consumption at home, perhaps reflecting cultural norms where drinking was acceptable at family meals. Adolescents who reported that they drank at home may reflect their parents' approval of their drinking and easy access to alcohol at home. However, researchers noted that parents may acquiesce to their adolescents drinking

alcohol at home and their knowledge of their children's drinking may reflect efforts to protect adolescents from heavy drinking outside the home (Fraga *et al.*, 2011).

A study by Pathirana (2016) on child-parent relationships in Sri Lanka found that majority of participants reported a happy, pleasant relationship, close bond and non-conflictive parent-child relationship. Further, the researchers indicated that adolescents who are engaged in a supportive and attentive relationship with their parents are very positive about their parents, but those with uncaring and distant relationships have negative attitudes towards their parents (Pathirana, 2016). Another study highlighted that since the parent-child connectedness is one of the major factors in adolescent health and risk-taking behavior in Sri Lanka, addressing this is an immediate research need (Agampodi *et al.*, 2008).

Studies from Israel indicate that alcoholic fathers display lower warmth and higher negative affect during interactions with their infants than fathers without alcohol abusing problems. A destructive consequence of men's addiction to alcohol is that they are literally absent from their families' lives (Horgan, 2011).

According to Bronfenbrenner (1994), adolescent behavior is significantly influenced by the micro-system of the family, with parents playing an important part. Adolescence is a time of transition for both parents and adolescents. As much as adolescents should be given room by parents to explore, develop and grow, they are still not fully mature; therefore parents are very important providing guiding and monitoring (Steinberg, 2001). Some studies recognized that adolescents model their

alcohol behavior on their parents' patterns, context, and attitudes (Kam *et al.*, 2017; Loke & Mak, 2013; Mares *et al.*, 2011). Parent-child relationships such as parental engagement and parental attachment have been linked to adolescents' alcohol use in various studies, with attention paid to the individual elements of parental engagement such as monitoring, controlling and communication (Bourdeau *et al.*, 2012; Ryan *et al.*, 2011). Fraga *et al.* (2011) noted that as adolescence is a key period for developing patterns of substance use and abuse that can continue into adulthood, it is the appropriate moment for prevention.

In a longitudinal study in Upper New York State, with a sample of 2573 high school students, Nash *et al.*, (2005) examined the relationships among family environment, peer influence, stress, self-efficacy and adolescents' alcohol use. The study found that as adolescents begin spending more time with their friends and less time under parental supervision, influence shifts from parents to peers. Adolescents with more positive family environments demonstrated greater self-efficacy in refusing alcohol use and were less susceptible to peer influence enticing them to drink. Peer influence and stress were positively related to subsequent alcohol use whereas self-efficacy was negatively related to it (Nash *et al.*, 2005).

A longitudinal study by Mares *et al.* (2011), examined the role of parents' alcohol use, parents' alcohol-related problems, and attitudes towards youth alcohol use in alcohol-specific communication. This study consisted of 428 Dutch families, both parents and adolescents, with adolescents aged 13-15. They have surveyed annually for five years. Parents' alcohol consumption, parents' alcohol related problems,

parents' alcohol-specific attitudes, alcohol specific communication, adolescents' excessive drinking and adolescents' alcohol-specific problems areas were included in the questionnaire (Mares *et al.*, 2011). The results of this study recognized the different impact of paternal and maternal factors on adolescent drinking. When fathers express strict alcohol-specific attitudes both parents talk more often about alcohol with their children but the attitudes of mothers did not show this effect. However, the research indicated that paternal strict alcohol-specific attitudes about alcohol were associated with lower adolescent alcohol use. The researchers emphasized that both parents' alcohol use and the alcohol related problems were associated with excessive drinking by adolescents (Mares *et al.*, 2011).

A cross-sectional study conducted by Loke & Mak (2013) examined the family process, parenting style and the influence of friends' substance use on risk behavior of adolescents. The questionnaire used in this study included questions on students' perceptions of family process, substance use (smoking, drinking and alcohol and using drugs), their parents' and friends' smoking behavior, their acceptance of smoking, the demographic characteristics of the adolescents and their family structure. The researchers reported that most of the questions had been used in previous research and they adopted and modified questions to suit their context, with content validity assessed by a panel of three experts (Loke & Mak, 2013). A sample of 805 adolescents completed the questionnaires. Sample participants were categorised into two age groups: 11-15 and 16-18, with more boys (73%) than girls (27%) in the study. Loke & Mak (2013) found that more participants had fathers than mothers who smoke or use alcohol. About one quarter of students had friends who

smoked or drank alcohol. They noted that more of the adolescents were satisfied with role fulfillment by their mothers than by their fathers (Loke & Mak, 2013). As children looked up to their parents as role models, adolescents saw parents' smoking or drinking as acceptable behavior which they could emulate. The findings confirmed that the smoking or drinking habits of parents were associated with adolescent smoking and drinking (Loke & Mak, 2013).

Loke & Mak (2013) concluded that familial influences were important factors in the development of adolescents. As parents are role models, parents provide support and control to guide their adolescents in their development. The quality of the parent-child relationship was another factor influencing the development of risk behavior. A poor child-parent relationship, as reflected by less time spent in activities together and increased conflict between adolescents and with parents, was a factor associated with risky behavior. On the other hand, parents with warmth, love, care, acceptance, respect, and appropriate level of monitoring could encourage positive psychosocial development in adolescents (Loke & Mak, 2013).

It is recognized that there is a broad differentiation between western and non-western cultures in relation to alcohol. Culture includes knowledge, belief, art, morals, law, custom and other capabilities and habits that people acquire as members of society. Therefore to understand alcohol behavior, it is important to recognize the differing cultural perspectives of people in different societies (Kase *et al.*, 2011).

Western countries are generally associated with higher levels of alcohol consumption and lower abstinence rates. However, alcohol-attributable mortality and burden of disease and injury are greater in many low and middle-income countries that are recognized as 'non-western' due to patterns of drinking and the type of products consumed, particularly illegally produced alcohol (WHO, 2014; 2006). Countries like Sri Lanka experienced rising alcohol consumption as the country developed economically (Siriwardhana *et al.*, 2012).

According to the data provided by WHO (2014), the prevalence of alcohol use in South African, Asia and middle east countries are lower than the developed countries. But, the report also emphasized that these countries have unrecorded alcohol consumption and South East Asian region has over 50% unrecorded alcohol. Registered data were largely unavailable in some countries in Asia, Latin America, North Africa, and Middle East countries (WHO, 2014).

Drinking is not a socially approved custom among Sinhalese, Tamils and Muslims. Frequent drinkers could be found among Roman Catholic and other Christian population and this community is more westernized. Most of the time heavy drinkers were found among Tamil estate workers who drank cheap illicit brews. It was also noted that drinking among Muslims was low compared to other ethnic groups. Drinking of Sinhalese/Buddhist was lower than Tamil/ Hindu people in the country and drinking was high among Sinhala and Tamil Roman Catholic group (Hettige & Paranagama, 2005).

In the United States it has been estimated that one in four children is exposed to the effects of alcohol abuse or dependence of a family member (Grant, 2000). In the United Kingdom an estimated 30% of children (or 3.3-3.5 million children) live with at least one “binge drinking” parent (the United Kingdom the definition of binge drinking is greater than 6 standard drinks (Manning *et al.*, 2009). Indeed the estimates of the proportion of children living with problematic drinkers vary widely between countries: in 2006 in Lithuania a reported 3% of children aged 0-18 years grew up with a parent who misused alcohol, whereas in Finland and Poland the corresponding figures were around 10% and 19% respectively (Harwin *et al.*, 2010).

The United Nations Children’s Fund (UNICEF) states that it is the fundamental right of children to develop and be safe within their family, protected from harm and supported to reach their full potential (UNICEF, 2015). Effects of heavy drinking upon families can include arguments, disharmony, divorce, domestic violence and inadequate role performance by various family members. People who are seeking treatment for their own alcohol problems are often dealing with financial problems, separations and divorces, stress, and poor health (Keenan *et al.*, 2013; Orford *et al.*, 2010; Rodriguez *et al.* 2001; Room *et al.*, 1991) which often have flow-on effects within their families (Orford *et al.*, 2005). Families in which both parents drink heavily have been found to be at even greater risk of harm (Haugland, 2005), yet in contrast, the lack of a protective adult in single-parent families is often noted by child protection workers as a feature of child maltreatment (Department of Human Services, 1999).

Alcohol is involved in a significant proportion of cases of violence against intimate partners both in and outside the household. In assessing intimate partner violence in population surveys in the United States (US), Leonard (2001) estimated that 25-50 per cent of domestic violence incidents involved alcohol. The Australian component of the International Violence Against Women study found that one in three (35 per cent of) recent domestic violence incidents were alcohol-related, with 32 per cent of women reporting that their partner was drinking at the time of the most recent violent act (Mouzos & Makkai 2004). In analyses based on victimization data from the 2005 Australian Personal Safety Survey, it was estimated that alcohol contributed to 50 per cent of all partner violence and 73 per cent of physical assaults by a partner (Laslett *et al.*, 2010).

Alcohol is widely used in Australia (Bittman & Wajcman 2000). Although most adults consider it inappropriate for an intoxicated adult to be in charge of young children (Dawe *et al.*, 2007; Maloney *et al.*, 2010; NSW Department of Community Services 2006), a recent poll of Australians found that 79 per cent of drinkers with children under 18 years living in their home reported consuming alcohol around their children. The vast majority of Australian children and families are exposed to drinking situations, and it is likely that in these situations alcohol is not always responsibly consumed (FARE 2013).

Both norms and behaviors concerning drinking by carers were important in understanding the risks for children and other family members in different contexts. There are situations where drinking by adult carers appears to be more acceptable;

for example, if only one or two drinks are consumed. A survey of adults' attitudes to parents drinking around small children in Victoria, Australia, found that most respondents felt no drinking (49 per cent) or consumption of only one or two drinks (45 per cent) was considered acceptable (Matthews, 2012). Only six per cent thought it was okay to drink "enough to feel the effects." While children may not be at risk because of their parents' moderate drinking, there is evidence that children are exposed to a range of different drinking patterns of their parents and others at social occasions (Adamson & Templeton 2012; Allan *et al.*, 2012; Cook 2005; Jayne *et al.*, 2011; Velleman & Templeton 2007).

In a Finnish study, drinking to intoxication while responsible for small children was unanimously disapproved of. However, 40 per cent of respondents regarded such drinking as acceptable if someone else was in charge of the children. For example, if the mother was in charge, while the father drank. Respondents in this study reported that children were present at 12 per cent of their drinking occasions, and that 24 per cent of all drinking occasions were heavy-drinking occasions estimated to be at a blood alcohol concentration level of .05% or greater, suggesting that while respondents may disapprove of drinking around children, many still do so (Raitasalo, 2011). Women's attitudes and drinking behaviours were significantly correlated with each other in this study, whereas men's were not, suggesting that men were more likely to drink around children regardless of their reported general disapproval of drinking to intoxication around children. The lack of correlation may also mean that some men were not drinking around children although approving of it (Raitasalo, 2011).

Estimates of the proportion of children living with or exposed to heavy drinking of a family member are available from various countries, though the criterion of 'problematic drinking' varies in its designation and meaning. Indeed the estimates of the proportion of children living with problematic drinkers vary widely between countries: in 2006 in Lithuania a reported three per cent of children aged 0-18 years grew up with a parent who misused alcohol, whereas in Finland and Poland the corresponding figures were around ten per cent and 19 per cent respectively (Harwin *et al.*, 2010). In the US it has been estimated that one in four children is exposed to the effects of alcohol abuse or alcohol dependence of a family member and in the UK an estimated 30 per cent of children about 3.3-3.5 million, live with at least one binge drinking parent (Grant, 2000; Manning *et al.*, 2009).

While Australians do not approve of drinking too much when parenting, in other countries, those of child-bearing and child-raising age often drink at risky levels. Dawe *et al.*, (2007) estimated that 13 per cent of children are at risk of exposure to short-term risky drinking in Australian households by at least one adult. Further analysis suggested that around 25 per cent of fathers and ten per cent of mothers in couple-plus-children families had drunk at short-term risky levels (greater than 5/7 drinks for women/men on an occasion respectively) two or more times a month in the past year (Dawe *et al.*, 2007). Maloney *et al.* (2010) reported that Australian mothers and fathers are less likely to binge-drink than others in their age group, and that fathers were more likely than mothers to report problematic drinking patterns. However, these parents may choose only to drink at risky levels when their children

are not with them, and whether parents' drinking occasions were in the presence or absence of their children was not specified in the studies (Dawe *et al.*, 2007; Maloney *et al.*, 2010).

Family life can be difficult for both those who drink heavily and others who are affected by their drinking. Holmila *et al.* (2013) describe the outcomes for mothers in Finland who misused alcohol. These mothers were more likely to die, have concomitant mental health problems and have their children removed from their care than other women. The disadvantage apparent in the lives of these mothers was extensive; they were much more likely than those who do not misuse substances to be single parents without support, and to have less education and lower incomes (Holmila *et al.*, 2013).

Approximately 100 000 children in Finland are living in substance abusing families and numerous adults have experienced excessive consumption of alcohol in their childhood homes. This causes insecurity, anxiety and other emotional harm in childhood as well as in adulthood (Peltoniemi, 2005.) The whole family suffers from the misuse but especially the child's emotional development is in danger (Nyman, 2004). The understanding of the children living in substance abusing families should not be underestimated as the first memory of their childhood often concerns the parental substance misuse (Itäpuisto, 2003).

The United Nations Convention on the Rights of the Child (1989) states that all public or private social welfare institutions should secure the child's position.

Moreover, the Finnish legislation directs that the care and upbringing of the children in the parents' custody have to be taken into consideration, when the parent is offered substance abuse services. The child's well-being and support must be safeguarded if the adult is not capable. For this reason, the child's visibility in the treatment cycle of the hospital was examined as the services often took an adult perspective (Child Welfare Act, 2007).

In Finland, Child Welfare Act (417/2007) and Child Custody and Right to Access Act (361/1983) both define child's best interest in order to secure the child's position. The Child Custody and Right to Access Act (2007) emphasizes that children should be brought up in a safe environment with understanding, security and tenderness. Nevertheless, the parents have the right to parental guidance, support and counseling but if the parents are not capable of ensuring the well-being of their child despite all of this, the state must safeguard the care of the child (United Nations Convention on the Rights of the Child, 1989).

Substance abusing families are a very common phenomenon in Finland but its effects on children's emotional development and life choices are not fully comprehended (Peltoniemi,2005). Itäpuisto (2008) stated that the parents should provide sufficient physical, psychological and developmental conditions for their child. Parental substance abuse creates conflict and violence as well as a decrease in cohesion and parenting within a family. These factors threaten the child and the negative impact may be seen in forms of different illnesses and symptoms. For this reason, the

children of substance abusing parents have weaker relationships with their parents than other children on average (Itäpuisto, 2008).

The qualitative research from Portugal of Fraga *et al.* (2011) discussed alcohol consumption at home, perhaps reflecting cultural norms where drinking was acceptable at family meals. Adolescents who reported that they drink at home may reflect their parents' approval of their drinking and easy access to alcohol at home. On the other hand, researchers noted that parents may acquiesce to their adolescents drinking alcohol at home and their knowledge of their children's drinking may reflect efforts to protect adolescents from heavy drinking outside the home (Fraga *et al.*, 2011).

A cross-sectional study conducted in Illinois (USA) was part of a larger research project on adolescents. The sample comprised 259 students aged 14-18 with the study seeking adolescents' self-reported perceptions of four types of parental messages that may influence alcohol use intentions. Those four messages were parents' references to the negative consequences of alcohol use, parents' references to their own past experiences with alcohol use, parents' conditional permissive messages and parents' views on drinking alcohol responsibly (Kam *et al.*, 2017). This study examined how parent-child alcohol-specific verbal messages indirectly related to adolescents' alcohol use intentions, focusing on parents' own experiences to create a 'teachable moment' to discuss alcohol with their children. Adolescents perceived their parents' conversations regarding parents' own experiences as a sign

of honesty and trust. This study noted that adolescents learning behavior from parents may be an important model (Kam *et al.*, 2017).

Alcohol misuse can lead parents to spend significant amounts time away from their children, when drinking or recovering from a binge- drinking episode. This can mean that the Children of Alcoholics (COA) have to fend for themselves and this can lead to high risk situations, such as children cooking for themselves or looking after younger brothers and sisters or drunken parents. In part, the young people experience a fore shortened childhood with early responsibilities for their own and other's care. Parental alcohol misuse may be a source of vulnerability for drug problems in their children (Escandon & Galvez, 2005).

Children of alcoholic parents often have conduct problems such as lying, stealing, fighting and truancy; they tell lies in order to protect their parents (Leadership, 2007). Many times they face acute embarrassment and in some cases, shame at their parent's behavior. Because of the lack of love in the family, the children become vulnerable to alcohol misuse. Since the child is disappointed many times by the drinking parent, he or she may not trust others and hence be unable to form close relationships. Feelings of confusion develop as the alcoholic parent changes suddenly from loving to being angry, regardless of the child's behavior. There are no regular daily routines such as sleeping or meal times. The child feels angry with the alcoholic parent for drinking and may be angry with the non-alcoholic parent for lack of support and protection. The loneliness and the helplessness in the child arise out of the inability to change the situation at home (Leadership, 2007).

Children who live with parents who misuse alcohol report feeling socially excluded, isolated, frequently being left alone, not being loved and have feelings of low self-worth (Burke, Schmied & Montrose, 2006). The children may adopt a range of behaviors to cope with their situation, including detachment, avoiding the drinking parent, keeping the problem a secret, switching off, blaming oneself or feeling guilty. In a study in the U.S, (Gilvary, 2005), respondents, who were children, talked about violence and parental disappearances from the home to drinking dens and bars. Because of stigma, due to the parent's inability to support the family financially, the children made efforts to concealment and silence. For some children, basic needs may not be met and there is a heightened risk of abuse and maltreatment. Alcohol has the effect of producing indifference and distance in the parent, more evasive, either in a violent or maudlin way and is associated with parents angrily flaring up verbally or physically. Another study found that some COA experienced high levels of external locus of control, feeling less responsible for, and having less control over the events that shape their lives (Kroll & Taylor, 2003).

A study in Netherlands among Dutch students in regular education and education for adolescents with behavioral problems found that higher levels of parental drinking to be associated with more alcohol availability at home. In turn, this increased availability was associated with higher levels of adolescent alcohol use. The study also found that parents who drank more heavily tended to be less strict in their enforcement of alcohol specific rules, which in turn increased the likelihood of adolescents reporting high levels of drinking (Zundert, *et al*, 2006).

Clinical and research evidence worldwide shows that children of alcoholic parents are at-risk population of diminished intellectual capacity and development (McNamee & Offord, 1994). Research suggests that consumption of small doses of alcohol, less than 3 to 6 ounces daily have been associated with retarded intellectual growth (Brooks, 2004). They are at a high risk of academic difficulties such as inability to concentrate and poor grades, resulting in their taking too long to complete studies or dropping out of school completely. Problems of parents drinking at home are also exhibited in the following behaviors by their children; failure in school; truancy, school dropout, lack of friends; withdrawal from classmates, delinquent behaviors such as stealing or violence, frequent physical complaints such as stomachaches or headaches, abuse of alcohol, aggression towards other children, risk taking behaviors, depression or suicidal thoughts or behavior. Some children become controlled, successive overachievers throughout school and at the same time emotionally isolated from other children and teachers (Burke, Schmied & Montrose, 2006; Sue & Sue, 2006; Gilvary, 2005).

The communication problems of families affected by parental problem drinking have been documented in a number of studies using the Marital Interaction Coding System (MICS) (Jacob *et al.*, 2001). Investigators videotaped discussions amongst family members, and then coded these discussions using the MICS. The MICS allows trained observers to classify verbal and non-verbal communication into four summary categories: positive, negative, problem-solving, and congeniality. The positive category consists of positive evaluations of the speaker in regard to other

family members, that is, agreement and approval. The negative category includes instances of negative evaluation, disagreement and criticism. The problem-solving category consists of efforts made towards discussing and resolving problems. Finally, the congeniality category reflects smiles, laughter and unrelated talking (Jacob *et al.*, 2007).

Results from studies that have used the MICS show that families affected by parental problem drinking exhibit more negative communication, less positive communication, less congeniality, and impaired problem-solving capabilities when compared with unaffected controls (Haber & Jacob, 1997; Jacob *et al.*, 1991; Jacob *et al.*, 2001; Moser and Jacob, 1997). These patterns have been documented in parent-child interactions, as well as in interactions between spouses (Jacob *et al.*, 1991; Moser & Jacob, 1997).

Problems in communication also appear to differ as a function of parental characteristics other than drinking per se. For example, two studies examining the differential effects of parent gender found that families affected by maternal alcohol misuse exhibited higher levels of negative communication and lower levels of positive communication compared to both: families affected by paternal problem drinking alone; and controls (Haber & Jacob, 1997; Moser & Jacob, 1997). In another study, families affected by marital distress in conjunction with maternal alcohol misuse were shown to exhibit higher levels of negative communication compared to families independently managing maternal problem drinking or marital distress but not both (Kelly *et al.*, 2000). Studies have also found that in families

where paternal drinking with no concomitant maternal alcohol misuse is accompanied by antisocial personality or aggression, communication is particularly impaired. Taken together, these results suggest that factors such as parent gender, marital distress, and both paternal antisocial personality and aggression might interact with parental alcohol misuse to compound impairments in family communication (Jacob *et al.*, 2001; Leonard & Roberts, 1998). However, no causal associations between these constructs have been established since none of the reported studies used longitudinal data, and there was insufficient control for a range of possible confounding variables. It remains possible that other factors associated with both alcohol and communication problems such as comorbid psychopathology, socioeconomic status, or education level explain these findings (Jacob *et al.*, 2001).

Some important methodological limitations hindered the interpretation of the findings described above. Sample sizes were often too small to achieve adequate power range of experimental group, $N = 15-50$ and response rates were low. Furthermore, very strict inclusion criteria were often necessary, such as the need for families to be intact, and the screening of problem drinkers with any evidence of comorbid psychological problems. These limitations preclude the generalization of these findings to the total population of alcohol misusing parents (Jacob *et al.*, 2001).

Several other studies have examined the cohesion of families affected by parental alcohol misuse using the Family Environment Scale (FES). The FES is a self-report measure that consists of 10 scales, including the Family Cohesion Scale, which measures the feeling of support and togetherness within a family. Studies have

administered the FES to caregivers and children in examining the impact of parental alcohol problems on family cohesion and organization (Jester *et al.*, 2000; Bijttebier *et al.*, 2006). Both studies reported lower levels of family cohesion and organization among families characterized by parental alcohol use problems (Jester *et al.*, 2000; Bijttebier *et al.*, 2006). The cross-sectional studies were unable to determine causality, providing two possible explanations; that low cohesion families experience less support and vulnerable parents may be more likely to use alcohol as a maladaptive coping mechanism or that alcohol misuse creates additional stressors which interfere with maintaining trust, forgiveness and family cohesion (Scherer *et al.*, 2012).

A study using the FES with Indigenous Australians (N = 99) found that despite alcohol predicting high family conflict and aggression, there was no association between family cohesion and alcohol misuse (Kelly & Kowalyszyn, 2003). Inconsistent findings between these studies may be the result of methodological limitations, including low sample sizes in the alcohol-affected groups, disparate cultural subgroups (i.e. Dutch families, African American women and Indigenous Australians), and the low reported internal consistency of the FES sub-scales in some studies (Bijttebier *et al.*, 2006).

The African continent has the smallest consumption rates of alcohol in the world. In South Africa, statistics show that teenagers who imitate their drinking parents remember 10% less of what they have studied, absent themselves from school and are likely to drop out of school completely (Li, 2003). Hoque & Ghuman (2012)

conducted a cross-sectional study in South Africa with a total of 704 16-18 year old adolescents, to understand their perception of parental practices relating to adolescent alcohol use. The researchers examined adolescents' perceptions of their own alcohol use, parental alcohol use and the associated behavior and family rules regarding alcohol use. They reported that 54% of participant adolescents have consumed alcohol at some time in their life. The study noted that a large number of mother/female guardians and father/male guardians do not allow drinking at home. Adolescents were more likely to use alcohol in households where parents drank. A study in South Africa with 13-19 year-old adolescents found that adolescents with positive family communication, good health practices and future aspirations were one and a half times less likely to use alcohol than others. However, the study also found that when parents used alcohol frequently, their adolescents had an increased likelihood of exposure to alcohol-related risk behaviors (Hoque & Ghuman, 2012).

A study in Kenya by NACADA (2010) found that the psychological consequences of an absent father are adverse; boys who grow up without a male role model can become emotionally stunted. Similarly, girls who never experience a caring father figure or whose father is not emotionally available to them are known to become rebellious teenagers (Doyle, 2011). Alcohol abuse is one of the reasons why fathers are unavailable for their children. Having seen alcoholism in their own homes, many of these children grow up replicating the behavior patterns of their parents: the boys grow up to be alcoholics while the girls tend to marry alcoholics. Due to their coming from dysfunctional families where their needs were not met, they are attracted to situations that are emotionally painful or chaotic (Barrows, 1991).

Another study among secondary school students in Kisii County revealed that of the students who abused alcohol, 63% had parents who also consumed alcohol but a majority 62% whose parents did not consume alcohol also did not (Ondieki & Ondieki, 2012).

The studies above majored on alcohol related behaviors in children of alcohol abusing parents.

This study investigated whether there were similar or more social effects other than taking alcohol that COA experience. The review of literature had studies using national surveys, longitudinal research designs, cross-sectional designs and large samples. This study intended to investigate whether similar results can be obtained with primary school children of alcoholic parents in Bungoma County, Kenya, using a smaller sample of 400 respondents.

2.5. Disaster Management Strategies to enhance children's Psychosocial

Development among alcoholic parents

Disasters can be sudden or gradual. The misuse of alcohol which can be said to be a gradual disaster has increased continuously over the last decade and is a major family, organizational, social and policy concern (Advisory Council on the Misuse of Drugs, 2006).

2.5.1 Family Strategies

Poverty is both cause and consequence of disasters in under-developed or developing countries. Family-level prevention strategies for drug and alcohol abuse are very effective. This implies that theories emphasizing an ecological approach and the influence of peers and family members, about the behavior of individuals, are empirically supported (Valleman, 2009).

The role of family and community participation is also very crucial for the enhancement and the sustainability of disaster education. When it comes to Disaster Risk Reduction at the community level, it is usually addressed by forming community-based disaster organizations and training individuals in disaster management courses. Many types of associations can be found in the community, but some do not play a direct role in disaster prevention and management. However, these associations have strong human relationships and much local knowledge. As an example, family members traditionally take care of children and old and handicapped people (WHO, 2011). Presently, lifestyles and social systems have changed such as long-distance commuting, husband and wife working, weak family relationships, fewer children, aging, and unstable economies, among others. It is therefore necessary to carry out disaster prevention education aimed at building local capacity for disaster prevention, after determining the situation in the community and family and the roles people in the community play (WHO, 2011).

Disaster preparedness that ensures interventions tailored to the current socio-cultural state of the population is needed. For more effective disaster preparation education

and to maintain and manage disaster preparedness at home, it is important to form networks for sharing the latest disaster-related information both inside and outside the family (Takeuchi *et al.*, 2011). Therefore, efforts are increasingly being made globally to link families, schools, and communities to better prepare for disasters.

The review of literature also suggests that prevention programs of alcohol misuse, especially family-based interventions such as the Family-Strengthening Approaches showed long-term results (Kumpfer & Alvarado, 2003). The family-strengthening approach is focused on developing and promoting activities, services and programs that are designed to consolidate the interpersonal relationships among the family members, with a focus on contributing to the healthy development of adolescents. In the review of family-level prevention strategies that included: Family Therapy, Family Education, Behavioral Parental training, Family Skills training and In-home Family Support, it was concluded that family-level interventions were two to nine times more effective than those solely focused on children. These included school-based, individual-based and peer-based strategies (Kumpfer *et al.*, 2003).

It has been suggested that the core components of Family Level prevention programs should be incorporated and integrated into other substance abuse prevention and intervention programs. The core attributes of family-level strategies include enhanced interaction, the ability to build resilience among young people towards alcohol and substance abuse, and engaging families who are otherwise hard to reach (Small, 2010).

2.5.2 Parent interventions

Parents are the most important people who have an influence on young people's attitudes towards alcohol (Kask, Markina & Podana, 2013; Donovan, 2004). Moreover, Sondhi & Turner (2011) stated that parents effectively succeed in conveying the social pleasures and risks of alcohol use at home. Young people also learn and copy messages and behaviour from parents or family members. However, young people are not taught to recognize the health consequences of drinking. Parents should apply these implications to talk to children about alcohol, on learning to drink safely at home, other drinking practices and environments, and the consequences (Valentine *et al.*, 2010).

A study conducted on the effect of family based intervention programmes, showed that the effects of the prevention programmes increase considerably when both parents participate in the intervention (Valleman, 2009). It is important for parents to be consistent when children are younger but in adolescence parental consistency is less important than having at least one parent who is authoritative (Steinberg, 2001). Since adolescents are not fully mature, providing parental guidance is still very important. Parents may need to renegotiate their parenting roles and modify their parenting behavior to accommodate adolescent development at this time (Steinberg & Silk, 2002). During adolescence, the role of parental control becomes less clear and sometimes too much parental control can inhibit adolescents developing in healthy ways. Another view was that parental control remained crucial for adolescents and stricter parental controlling generated negative emotions in adolescents (Bourdeau *et al.*, 2012; Harris-McKoy & Cui, 2012; Chong *et al.*, 2014).

Many studies have demonstrated the association between parental control and adolescent alcohol use. Parents can exert consistent and strong influence on their children's alcohol use throughout the adolescence, in particular by setting alcohol-specific rules (Harris-McKoy & Cui, 2012; Koning, van den Eijnden, Verdurmen, Engels, & Vollebergh, 2012; McKay, 2015; van der Vorst *et al.*, 2007).

2.5.3 Community interventions

Kieft & Nur (2001) claimed that during disasters, the community's vulnerabilities are more pronounced than their capacities. Community has a great deal of local experience and local knowledge of disasters. Historical local disaster prevention methods were passed on to other family/community members through daily activity (Takeuchi *et al.*, 2011). However, the characteristics of disasters have changed due to climate change, thus necessitating that people now need to prepare for disasters of which they have no experience and about which they have difficulty in obtaining information. It is thus necessary for communities and families to know different scenarios of disaster (Takeuchi *et al.*, 2011). Bongo (2010) stressed the gaps in the integration and linking of disaster-related information with the community level participation.

The role of family and community participation is also very crucial for the enhancement and the sustainability of disaster education. When it comes to Disaster Risk Reduction at the community level, it is usually addressed by forming community-based disaster organizations and training individuals in disaster management courses (Haddow & Bullock, 2003).

The community based promotion of disaster and climate change education; the community based disaster risk management (CBDRM) would be the most effective strategy in building community resilience because CBDRM approach is a people oriented approach with community members being the main actors (Takeuchi *et al.*, 2011). Contrary to this, imposing new disaster coping mechanism and ignoring the community based traditional knowledge would be less productive. Community is a wider level compared to family and school levels, therefore, strategies at community level should engage the family, school settings, peer elements and other ecological factors, such as the intrapersonal, the interpersonal, or the organizational level, which all influence the behavior of adolescents towards drug abuse. Stead *et al.*, (2006) stated that some community-level strategies showed a smaller reduction in substance misuse especially alcohol. Examples of successful multi-component prevention strategies included:

Project SMART (Standardizing Measurement of Alcohol Related Troubles) funded by the European Union that aimed at developing a standardized comparative surveys methodology on drinking and all its facets as well as assessing the economic impact of existing alcohol policies in the EU (Hansen *et al.*, 1988). Project SMART focused on the personal skill development of 7th grade students in enhancing resistance towards alcohol and other drugs. It also trained students to resist peer pressure.

The Adolescent Transition Program (ATP) was another example of a community level strategy. It focused on parental training for effective communication with young people and early adolescents who were at risk of alcohol abuse. It was also a

multifaceted strategy involving school, family, parental group meetings and peers (Stead *et al.*, 2006).

Other community intervention programmes had significant effects on substance use. Biglan *et al.* (2000) studied a community programme that included media advocacy, youth anti-tobacco activities, family communications about tobacco use, and reduction of young people's access to tobacco and other substances. Project Northland (Stigler *et al.*, 2006) is an intervention project which included classroom curricula, peer leadership, extra-curricular activities, parent programs, and community activism in order to prevent and reduce alcohol use among students.

2.5.4 School based interventions

Children look to significant adults in times of a disaster. Schools can play an important part in providing a familiar and stable environment with the support of caring adults to bring normalcy. Schools have an important role in knowledge development for building community resilience and it is also important to continuously provide disaster education in school (Haddow & Bullock, 2003).

Relationship between education and knowledge, perceptions or preparedness of pupils/students for responding to natural disasters has been dealt by many researchers (Adem, 2011; Becker *et al.*, 2012; Dufty, 2009). The research results show that school contributes to formation of basic knowledge related to natural disasters, however, as authors Shiwaku & Shaw (2008) suggest, school is not very effective in disseminating this kind of knowledge.

School plays a key role in disseminating disaster and climate change education in the community (Takeuchi *et al.*, 2011; Shaw *et al.*, 2008). It has been found that the significance of disaster and climate change education is increasing, because children are the most vulnerable group in a society and it is these children who transfer disaster knowledge to community and family (Shiwaku, 2009).

Literature has also shown the significance of school as a DRR hub that connects school with the community through DRR education and other activities (Ronan and Johnston 2005; Petal & Izadkhah 2008; Takeuchi *et al.*, 2011). The integration of DRR education through schools is one way to ensure that messages reach into every home and community and that learning is sustained into future generations (Petal & Izadkhah, 2008).

Thus, the disaster education in schools increased disaster knowledge among the children. The literature has also shown the significance of school as a DRR hub that connects school with the community through DRR education and other activities (Ronan & Johnston 2005; Petal & Izadkhah 2008; Takeuchi *et al.*, 2011). Thus, the integration of DRR education through schools is one way to ensure that messages reach into every home and community and that learning is sustained into future generations (Petal & Izadkhah 2008). According to Jones *et al.* (2007), school-based interventions were the most commonly applied interventions. The Life Skills Training (LST) was a school-based prevention strategy. It has often been explored and evaluated by researchers. There were less, but positive results in minimizing the

indicators of alcohol or other drug abuse. Life Skills Training was created in the attempt to prevent the use of drugs, alcohol and tobacco among young people. The methods used involve developing social and self-management skills, as well as skills for resisting peer pressure. This represents an example of an approach that addresses the cause of the problem. Extracurricular activities and sports are also reported to reduce problems associated with alcohol abuse among adolescents. Jones *et al.*, (2007) stated that school-based prevention strategies were most widely used to develop and implement universal drug prevention programs. This is similar to the National Institute for Health and Clinical Excellence guidelines on interventions in schools to prevent and reduce alcohol use among young people (NICE, 2007).

Stothard and Ashton (2000) claimed that the LST was a competency development strategy because it focused entirely on key psychological and social factors that promoted substance abuse. Another study, carried out by Fletcher, Bonell and Hargreaves (2008) carried out a systematic review on the influence of a school's setting with regards to the misuse of drugs and substances by young people. The review showed that a supportive, inclusive, engaging and interactive culture at school, and extracurricular activities, were likely to have a positive impact on non-normative alcohol consumption, and disengagement and poor teacher-student relationships were associated with drug use and other risky health behavior (Fletcher, Bonell and Hargreaves, 2008). It is claimed that the Healthy School and Drugs project as implemented in Holland may have some effect on drug use in the children exposed to it (Cuijpers *et al.*, 2002).

A longitudinal study conducted by Tomczyk *et al.* (2015) in Germany analyzed the school climate and the association between peers and adolescents' alcohol use. A sample of 2490 children participated in the final stage of the study. At baseline, the participants' mean age was 10.8 years and 13.3 years at 36 months follow up. The measures were assessed by a self-reported questionnaire. School climate contained two dimensions, class climate and school organization. School organization referred to the structural components of school life: size of staff, student-to-teacher ratio, and location of alcohol. Class climate referred to more personal connections such as student-teacher relationships, the atmosphere in class, perceived interaction and friendliness within the class. Outcomes were adolescents drinking, lifetime alcohol use, frequency and amount of drinking and binge drinking and peer alcohol use was also included as a variable (Tomczyk *et al.*, 2015).

The findings of this study indicated the significant moderating and mediating effects of school climate. Class climate mediates the association between peers and adolescent alcohol use. A positive class climate was associated with lower alcohol-related outcomes among students and peers. School organization variables have a significant moderating influence on the association between peer and adolescent alcohol use. Teacher-student ratios were associated with adolescents' alcohol use, when teacher-student ratios were higher; the greater was the adolescents' problem behavior (Tomczyk *et al.*, 2015).

A study investigated the cross-sectional association between alcohol outlets density and adolescent alcohol use. A total of 2,721 adolescents from 10-16 years of age

were sampled as part of a large longitudinal study of middle school students in California. There were five waves of investigation over 30 months, with only those living in California for the full period selected for the final wave. Three types of alcohol outlets were identified: off-premises alcohol outlets which included grocery and convenience stores, all on-premises alcohol outlets including restaurants, bars, clubs and hotels, and on-premises alcohol outlets where minors were not allowed. They used two indicators of alcohol use by adolescents: any lifetime use but not in past month and any heavy use in the past month. Findings showed higher levels of on- and off-premise outlets within 0.10, 0.25 and 0.50 miles around respondents' homes were associated with higher odds of being a heavy drinker. Findings also suggested that youth who are exposed to higher densities of on-premises alcohol outlets were at risk for both lifetime use and heavy drinking. The researchers suggested that it was important to reduce the number of alcohol outlets in neighborhoods where minors reside and increase enforcement to limit distribution to minors (Shih *et al.*, 2015).

2.5.5 Policy Interventions

In Kenya, the Ministry of State for Special Programmes is in charge of Disaster Management policies, and, therefore, coordinates implementation of these policies. It coordinates all the disaster efforts of sectoral ministries, including Disaster Risk Reduction, and ensures that the policy is mainstreamed in their 37 planning, development and budgeting. It develops appropriate guidelines together with the private sector and Civil Society Organizations as well as other stakeholders on relevant matters pertaining to Disaster Management. The Ministry of State for

Special Programmes is the custodian of Disaster Management policy formulation processes within Government and, through the Minister, advises Cabinet on all matters pertaining to Disaster Management Cycle. The Disaster Management Cycle has 4 phases: Mitigation, which is minimizing the effects of a disaster; Preparedness, which is planning for a response; Response, which are efforts to minimize hazards created by a disaster; Recovery, which involves returning the community to normal (National Policy for Disaster Management in Kenya, 2009).

The mandate of the Ministry of State for Special Programmes is to fund-raise for Disaster Management from other stakeholders other than the Government. It also conducts and supports public awareness, sensitization and education on Disaster Management (National Policy for Disaster Management in Kenya, 2009).

WHO aims to reduce the health problems which are caused by harmful alcohol consumption. Moreover, it needs to save lives, reduce disease and prevent injuries from alcohol use. In this case, the ‘Alcohol Policy’ has been developed as an organized set of values, principles and objectives to reduce the harmful burden of alcohol in a population. It explains the global alcohol policy and hopes that the data will mitigate the global problems associated with alcohol use (WHO, 2011).

WHO defines “Alcohol policy” as:

A collective noun referring to the set of measures in a jurisdiction or society aimed at minimizing the health and social harms from alcohol consumption. These measures may be in any governmental or societal sector, and may include measures,

which are not directly aimed at alcohol consumption; for instance, the promotion of alternatives to drinking, where such a measure has the aim of minimizing alcohol-related harms. A national alcohol policy will be made up of a set of individual policies, strategies, and implementing actions. There are also a variety of other policies which impinge on alcohol-related problems, increasing or reducing them, but which are neither normally described as alcohol policies nor normally included within an overall alcohol policy, since the policies are not adopted or implemented with the minimization of alcohol problems as a primary aim (WHO, 2011).

Other policies include such policies as ‘Availability of alcohol’, which is one of the most effective policies, restricting sales and consumption by people below a legal drinking age; ‘Prices and taxes’ is an effective strategy for reducing alcohol consumption by increasing alcohol prices, usually accomplished by raising alcohol taxes; ‘Drinking and driving’ is one of the most effective policies whereby maximum blood alcohol concentrations for drivers are set and then enforced through checkpoints and random breath testing, which can reduce the risk of traffic accidents; ‘Alcohol advertising and marketing’ is a policy to control alcohol advertising and marketing where the primary responsibility for regulating alcohol marketing lies within the alcoholic beverage industry itself (WHO, 2011).

At policy level, prevention strategies include age restrictions on the availability and purchase of alcohol in different places. For some countries, it is illegal for young people under 18 years of age to purchase alcohol for their own use (ICAP, 2013). Lawmakers have implemented policy strategies that focused on: reducing alcohol

availability for young people, restricting commercial access, regulating the content of alcohol advertisements and its exposure to young people, reducing economic and social access and raising the Minimum Legal Drinking Age (MLDA). Moreover, laws about blood alcohol concentration limits and drinking and driving have been developed to ensure that the risk for harm is minimized for young people who drink (ICAP, 2013). The literature shows that policy level strategies have proved ineffective. The results of a survey by Harrington carried out between 1998 and 1999, revealed that more than 60% of young people aged 16-17 years old, and 10% of young people aged between 12 and 15 years old, purchased alcohol; retailers refused only one third of under-18s from buying alcohol; bars, pubs and nightclubs were identified as popular outlets where under-18s tried to buy alcohol (Harrington, 2000).

In 2010, the Scottish Schools Adolescent Lifestyle and Substance Use (SALSUS) reported that 12% of young people aged 13 compared with 22% of those aged 15 illegally purchased alcohol from shops. 1% of young people aged 13 and 2-3% of young people aged 15 bought alcohol from pubs, bars or clubs (Black *et al.*, 2010). This trend had declined in 2013: the findings of the SALSUS showed that few young people purchased alcohol from pubs, clubs, shops or supermarkets (Dodds *et al.*, 2014).

Cuijpers (2005) and Foxcroft *et al.* (2003) have questioned the effectiveness and implementation of policy level strategies. They are of the view that the strategies have no impact on the use of alcohol by young adults because they address in the

first place institutions and organizations, with policies that do not reach the core issues that make young people consume alcohol. Policies are aimed at helping these structures find solutions for young people, so that they tackle the issue from a social point of view.

In this section it can be stated that prevention strategies at the family-level are the most effective for achieving long-term behavioral change towards alcohol, and other substance abuse. Testing prevention strategies was one of the aims of the present study. Policy level strategies have not been effective due to the lack of implementation of regulations such as the Minimum Legal Drinking Age (MLDA). The present review suggests that school-level prevention strategies involving sports, and other extracurricular activities, reduced alcohol-related problems among young people. Alternatively, community-level prevention strategies show a positive influence on the misuse of alcohol (Kok *et al.*, 2008).

These and other interrelated strategies have not been implemented fully in Bungoma County and are hence examined in this study.

2.6 Conceptual Framework

It is a system of concepts, assumptions, expectations and theories that support a study. The theories used drew attention to aspects in the psychosocial development of children that can be linked to parental alcoholism. The study employed the Psychosocial Theory of Development by Erik Erikson; the Social Learning Theory by Bandura and Walters and Maturation theory by Gesell (Kabiru and Njenga, 2009).

2.6.1 Erik Erikson's Theory of Psychosocial Development

Erikson (1958, 1963) maintained that personality develops in a predetermined order through eight stages of psychosocial development, from infancy to adulthood. During each stage, the person experiences a psychosocial crisis which could have a positive or negative outcome for personality development. These crises according to Erikson are of a psychosocial nature because they involve psychological needs of the individual conflicting with the needs of society (Macleod, 2018). If the individual resolves the crisis successfully, development is healthy, but if he does not, his development is impaired. At each stage, the individual acquires attitudes and skills that make him an active and productive member of society.

Stage one – Trust versus mistrust

Development of trust is based on social attachment. A strong emotional and physical relationship between the infant and caregiver makes the child learn to trust his mother and later, other people. Infants whose basic needs are not met in a warm, loving and consistent manner develop mistrust and hence become insecure, are anxious and easily become angered. They are likely to be antisocial, unable to make friends and unable to cooperate with others.

Stage two- Autonomy versus shame

The child develops a sense of independence as he gains motor and language abilities. If the child is not encouraged to gain independence, he develops feelings of shame and doubt. This hinders him from developing independence.

Stage three -Initiative versus guilt

During this period children learn to initiate their own plans during their play and other activities. When encouraged, they feel able and engage in more initiatives. If the child is discouraged from initiating his plans, he develops a feeling of guilt.

Stage four- Industry versus inferiority

Child feels competent when he achieves success. A child who is academically and socially competent is happier than other children. A child who does not have opportunities to experience success and mastery develops a feeling of inferiority, may lose interest and motivation to want to achieve in academic and social life.

Stage five-Identity versus confusion

This is the adolescent stage where the child develops a sense of identity by developing own set of values and social behavior. She/he feels guilty for actions that go beyond limits set by parents. A child who fails to develop a clear sense of identity, to know who she/he is, ends up experiencing role confusion. She/he does not know who she/he is and what she/he is capable of doing.

This theory highlights the developmental deficits that can be faced by a child whose parents, due their absence from home deny their child necessary opportunities and encouragement to cause him to fully develop in psychosocial aspects. The study adopted this theory in order to find out which aspects of psychosocial development are impaired or missing in children of alcoholic parents in answer to objective ii. However, this theory did not take into consideration the aspect that children also copy the behavior of significant people in their lives, who are parents. Therefore, a second theory was paramount.

2.6.2 Social Learning Theory

The Social Learning Theory also referred to as ‘modeling’ or ‘observational learning’ or ‘imitation learning’ was by Bandura and Walters (1977). According to this theory, a child learns in his environment as he interacts and observes others. An assumption is made that people learn social behaviors mainly through observation, mental processing of information and modeling what they observe. Behavior learning is ongoing and continuous, and adult behavior which has the potential of being modeled is picked consciously and unconsciously. Bandura and Walters

believed that children acquire most of their social concepts and behavior by observing models in their daily lives. They copy or 'model' the behavior of these models. In society, children are surrounded by influential models such as parents from the family, characters on television, friends within the peer group and teachers at school (Macleod, 2010). These models provide examples of masculine and feminine behavior to observe and imitate.

As Bandura posits:

The baby who claps her hands after her mother does so, the child who angrily hits a playmate in the same way that he has been punished at home, and the teenager who wears the same clothes and hairstyle as her friends at school are all displaying observational learning (Berk, 2013).

Other researches investigating the development of children and their evolution through all stages into adulthood have also argued that children imitate everything in the beginning but then gradually become selective in the process (Coleman and Hendry, 1999; Goswami, 2008; Slater and Bremner, 2003; Slater and Muir, 1999). Furthermore, as posited by Seigal (2008), and Smith, Cowie and Blades (2003), children construct their own sense of efficacy and personal standards for behavior. That is, based on the behavior they witness, they build a model and try to internalize it, guiding their decisions based upon it. Self-efficacy is defined as the belief that their personal attributes and abilities will make them successful (Bandura, 1977). This prefaces the early adolescence stage when authority is being questioned and personal views begin to be expressed by the teenager. It is also a stage where

children need to be encouraged in order to maintain this sense of efficacy as it aids confidence in adolescence when they are confronted with the influence of peers (Seigal, 2008; Smith, Cowie and Blades, 2003). Social learning theories are important for the analysis of the young people's attitudes towards alcohol consumption, as they provide insight into the youths' behavior, and their tendency to imitate adults sometimes taking up their drinking habits (Seigal, 2008; Smith *et al.*, 2003).

According to the theories on social learning, young people acquire behavioral norms and norms of social conduct in both a direct and an indirect way. The attitude towards drinking is made explicit to the adolescents by means of rules of conduct, social expectations as well as the overall consequences they are likely to have for the entire family and household. As Windle (2000) argues, in order for these rules to be assimilated, it is necessary that children are presented with them at a very young age, even before entering the adolescent stage, before they start relying to a greater extent on their peers than on their parents. Consequently, parents should discuss directly with their children about acceptable conduct, including as regards the consumption of alcohol. Otherwise, the desired behaviour can be presented indirectly to the youth, by the power of models. As posited by Peterson *et al.*, (1994) a permissive alcohol behavior witnessed at home by the child, or by the adolescent is perceived as adequate conduct, as accepted behavior, and may subsequently lead to a similar behavior from the latter. Furthermore, Andrews *et al.*, (1993) argue that failure to discuss with the children in an open manner about matters regarding alcohol consumption may constitute a predictive element of adolescent alcohol consumption.

This study singled out drinking parents in the family that children can copy and model drinking behavior. This theory was used to answer objectives i and ii; how much the parent drinks and the influence that parental alcoholism has on psychosocial development of children.

2.6.3 Maturation Theory

This study was also based on Maturation Theory of development which was developed beginning in 1925 by Arnold Gesell, an American educator and a child psychologist whose studies in child psychology is primarily concerned with biological maturation and how it is related to overall development of children. Gesell and his colleagues constructed a set of behavioral norms that illustrate sequential and predictable patterns of growth and development. He asserted that all children go through similar stages, although each child may move through these stages at their own rate which depends on how they were born. Maturation theory believed that a child's growth, development and learning readiness is influenced by the environment (which can be conditions of the mother during pregnancy, health status and even nutritional factors) and heredity, but he largely investigated the children's physiological development. He called this process maturation, that is, the process by which development is governed by intrinsic factors, principally the genes. According to Gesell, the rate at which children develop primarily depends on the growth of their nervous system, consisting of the complicated web of nerve fibers, spinal cord, and brain which is not fully developed in preterm children. As the nervous system grows, their minds develop and their behaviors change accordingly. This theory also observed that children language development depends on the intrinsic factors

governed by their birth term. Babies first gain control over their lips and tongues, then their eye movements which generally depends on how the child perceives information at a tender age and whether children's language is fully developed depending on the birth term hence can communicate back making learning readiness easy.

Concerning retarded development, Gesell (1991) came to the conclusion that an understanding of normal infant and child development was indispensable to understanding childhood abnormality. He then began his studies of the mental growth of babies, and by 1919 he was addressing himself chiefly to the development of normal infant mentality. He found new methods for observing and measuring behavior by using controlled environments and precise stimuli. Children born of various ages and levels of development were filmed candidly through a one-way mirror, and eventually records of children from the stage of birth through their late childhood were compiled. From these observations Gesell concluded that children must reach specific maturational stages in development before their learning influences their behavior; there appeared to be retarded scheme for development in preterm children in the four areas of motor skills, adaptive behavior, language development, and personal and social skills.

Gesell noted children psychomotor development that as they grow, they learn to sit up properly, play, stand, walk, and run. These capacities develop in a specific order with the growth of the nervous system, even though the rate of development may vary from child to child according to their birth term. Gesell believed that individual

differences in growth rates are a result of the internal genetic mechanisms which can fail to develop in preterm because they are born earlier and therefore should be assisted because it affects their learning readiness.

He opposed efforts to teach children things ahead of their developmental schedule, asserting that a child's social and cultural environments also play a role in their development, these socializing once the nervous system had matured adequately which is only evident in full term children, a child would begin interacting with others freely in class and during play hence they share and socialize without fear. However preterm children tend to withdraw from play activities and most of the time would like to do their work independently without involving others.

Critics often point out that when summarizing his findings, Gesell gave the impression that all children behave in exactly the same way at each age. However, his position was that the developmental sequences are common to all children, but they vary in their individual rates of growth which supports this study by the fact that preterm births affects children's learning readiness since their brain size is not fully developed establish the cognitive, emotional and social foundation upon which they can build their futures. He suggested that these growth rates are possibly related to differences in personality depending on the age one is born. For example, he speculated that a preterm child would grow slowly and might not be cautious, high-tempered, and impatient, where as a full term child develops more quickly might be more outgoing, happy, and quick to react. Gesell believed that a child's environment

should be adjusted to his or her temperament and growth style. These developmental patterns are affected by the child's birth term which can be preterm or full term.

This theory believes that children's care givers should familiarize themselves with all children, become more patient and understanding during times of disequilibrium and instability, knowing that they can only disappear eventually when their needs are taken into consideration. It therefore aims at understanding the psychosocial developmental concepts of children. The theory was relevant to the current study because it guided the psychological and social aspects of development of a child.

2.6.4 Pressure and Release Model of Disaster Management

Pressure and Release Model sets out a series of steps that come together to produce the progression of vulnerability. The progression of vulnerability begins with a variety of what are termed root or underlying causes. These include poverty, limited access to resources and general pre-conditioning factors. Progressing from these, the model sets out a range of more specific dynamic pressures in the society of a country that include lack of institutions, education, training and skills. Finally, the progression leads to what are termed unsafe conditions; these include fragile local income levels and livelihoods at risk. A disaster occurs as a result of not only the potential hazards, but with them acting in combination with these vulnerabilities (Wisner, *et al.*, 2004).

The Pressure and Release Model shows how the risk of disasters can be reduced by applying preventive and mitigation actions. It begins by addressing the underlying

causes, and analyzing the nature of hazards. This leads to safer conditions which help in order to prepare the community to deal with disasters (Blaikie *et al.*, 1994).

2.7 Conceptual Framework Model

Based on the theories above, the indicators of parental alcoholism were based on poverty in the home, neglect of parental roles, domestic violence directed to the children, nature of the alcohol drug, time spent out drinking, frequency of the drinking and the money spent on alcohol. The indicators for psychosocial development of children included delinquency(missing school), academic difficulties(finding difficulty keeping mind on studies), low self esteem(not able to do things like others), attachment (closeness to parents), distrust(inability to trust parent, having been betrayed before), isolation (wanting to keep to self), relationships(the ability to make friends easily), fear and shame (inability to invite friends, not sure how the parent will come back home, violent, abusive or sober). The intervening variables were to lessen the impact of parental alcoholism on children's psychosocial development; they included strategies such as: Government policies concerning alcohol, counseling, school involvement, community and church. Figure 2.1 gives the interactions and relations between independent, intervening and dependent variables.

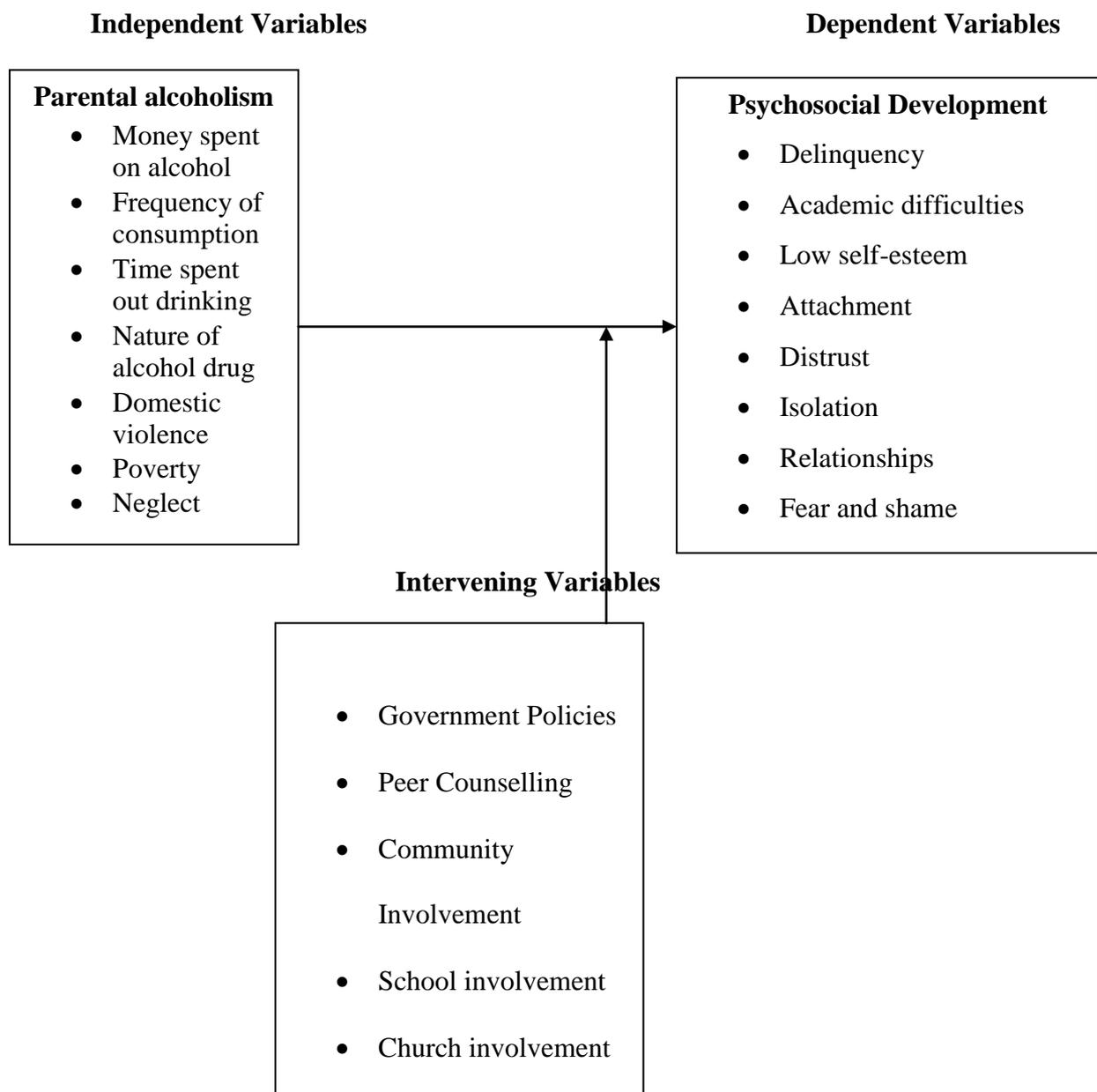


Figure 1.1: Conceptual Framework Model of Variable Interaction

Source: Researcher's own Conceptualization, 2015

2.8 Summary

The literature review showed that the problem of alcohol and substance abuse has attracted the attention of a number of scholars in Kenya and elsewhere. However, not many studies have singled out alcohol abuse on its own for study (Masinde, 2014;

Simiyu, 2010). Furthermore, most of the studies on drugs and substance abuse in Kenya have used secondary school students as their subjects (Kabuka & Ochola, 2010; Ondieki & Ondieki, 2012; Kin'gendo, 2010; Ngesu, Ndiku & Masese, 2008; Otieno & Ofulla, 2009). A few of the local studies have singled out primary school children as respondents and their parental alcohol abuse.

The goal of the current study was to fill the gaps by examining the influence parental alcoholism has on the psychosocial development of primary school children in Bungoma County, Kenya. The specific objectives of the study were i) to determine the magnitude of alcoholism among parents, ii) examine the nexus between parental alcoholism and psychosocial development of primary school pupils and iii) evaluate strategic options to enhance children's psychosocial development among alcoholic parents. The sections covered in the literature review included alcohol behavior, parental alcoholism and psychological and social development, disaster management strategies and the theories governing the study.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter covers research design, study site, study population, sampling strategy, data collection instruments, data analysis, limitations and summary of the chapter. They are discussed in the following sub sections.

3.2 Research Design

The study utilized both quantitative and qualitative research methods. Descriptive survey design addressed objective i: to determine the magnitude of alcoholism among parents of primary school pupils. Descriptive survey designs are used in preliminary and explorative studies to allow researchers to gather information, summarize, present and interpret for the purpose of clarification (Bordens & Abbott, 2011). For objective ii, correlation research design was applied to examine the nexus between parental alcoholism and psychosocial development of pupils. Correlation research method involves observing two variables in order to establish a statistically corresponding relationship between them. Objective iii was addressed by evaluation research design to assess strategies to enhance children's psychosocial development among alcoholic parents. Evaluation is a practice research design that provides a means to judge actions, activities in terms of values, criteria and standards in order to enhance effectiveness (Kothari, 2004).

Table 3.1 gives a summary of the specific objectives and research designs.

Table 3.1: Summary of specific objectives and research designs

Specific objectives	Research design
i. Determine the magnitude of alcoholism among parents in Bungoma County.	Descriptive survey
ii. Examine the nexus between parental alcoholism on psychosocial development of primary school pupils in Bungoma County.	Correlation
ii. Evaluate strategic options to enhance children’s psychosocial development among alcoholic parents in Bungoma County	Evaluation

Source: Researcher, 2015

3.3 Study Site

The study was carried out in Bungoma County, one of the 47 counties in Kenya. The County lies between latitudes $00^{\circ} 28'$ and $10^{\circ} 30'$ North of the Equator, and longitudes $34^{\circ} 20'$ and $35^{\circ} 15'$ East of the Greenwich Meridian. It covers an area of 3,032.4 square kilometers, borders the republic of Uganda to the North West, Trans Nzoia County to the North East, Kakamega County to the East and South East and Busia County to the West and South West (FBCIDP, 2014). The major physical features include the extinct volcanic Mt Elgon 4,321 metres high, Mt Elgon Forest Reserve, waterfalls such as Nabuyole and Teremi. The altitude of the County ranges from over 4,321 metres (Mt Elgon) to 1200 metres above sea level. It experiences

two rainy seasons, the long March to July and short rains August to October with annual rainfall varying from 400 to 1800 milliliters. The temperatures are from 00⁰ C to 32⁰ C (FBCIDP, 2014).

The County comprises nine Sub-Counties Bumula, Bungoma East, Bungoma Central, Bungoma North, Bungoma West, Kimilili, Bungoma South, Mt Elgon, and Cheptais. It has a population of approximately 1,630,934 people according to the 2009 Population and Census Report (KNBS, 2009). The population is concentrated in major towns, urban centers and markets because of availability of various social or economic opportunities and social infrastructural amenities and facilities. Land uses in the County include agriculture, forestry, mining, construction of human settlements, and business, social and public amenities. It has two underdeveloped and underutilized airstrips in Webuye and Bungoma towns. Factories and industries are agriculture based; relying on raw materials produced locally such as sugarcane, coffee, beans, logs and tobacco leaves. They include Nzoia Sugar Company, Malakisi Leaf Centre, and Webuye Heavy Chemicals Industry and Coffee factory at Makhanga in Bungoma North Sub County.

Absolute poverty is widespread in the County and currently stands at 52 percent, the rural poor are about 53 percent while food poor are estimated to be about 42 percent. The mean monthly income is Kenya shillings 5,528. Human induced hazards include drugs, substance abuse and alcohol abuse. The County is prone to disasters such as landslides, flooding, fires, lightning, oil spillage, human/ livestock epidemics, collapsing buildings/bridges, disease and destructive winds (FBCIDP, 2014).

3.3.1 Map of Study Area

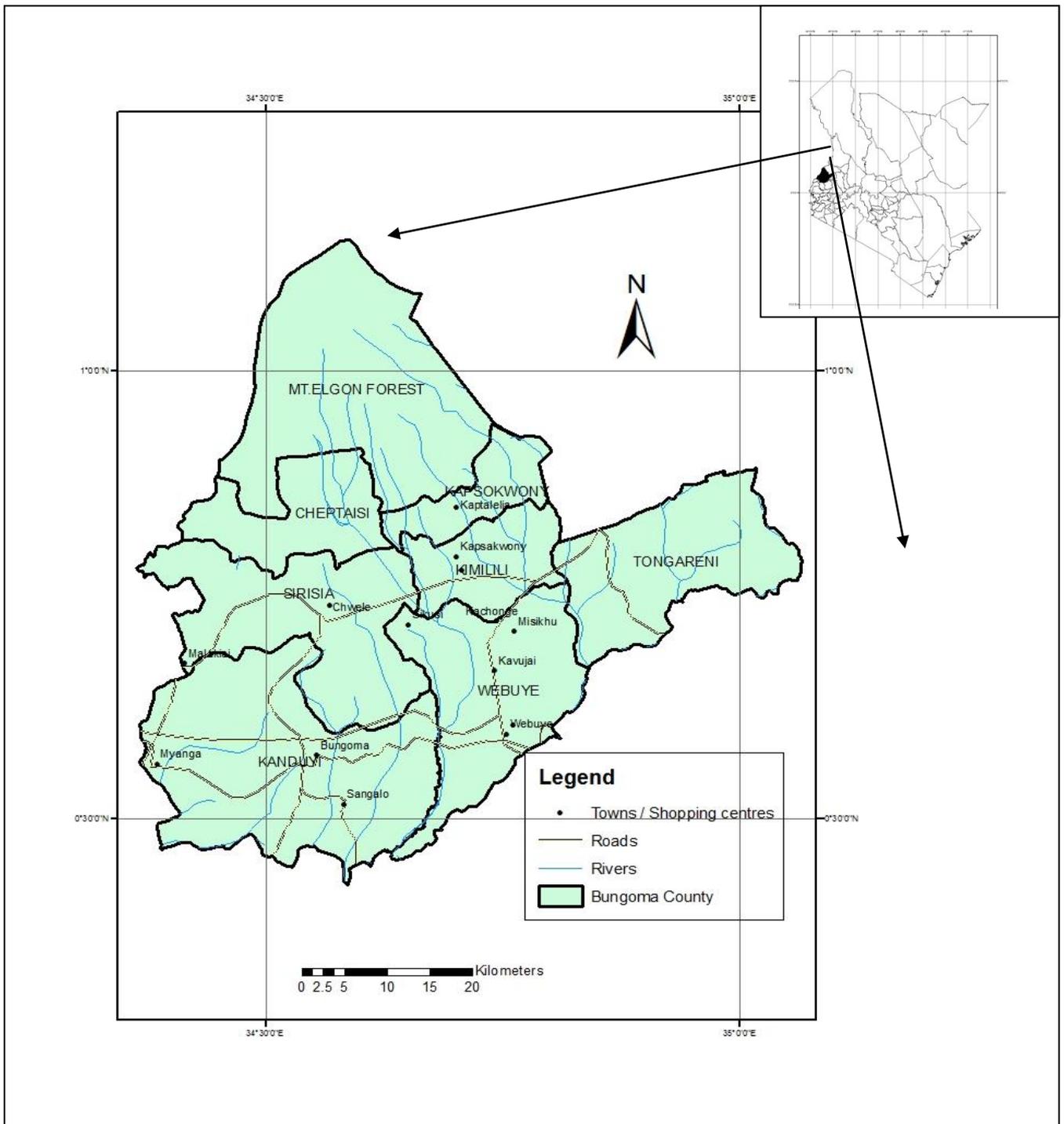


Figure 3.1: Map of Bungoma County, Kenya

Source: Survey of Kenya, (2004)

3.4 Study Population

A population refers to all items or people under consideration in any field of inquiry (Sekaran, 2013). Population of a study can be considered as an entire group of people; events or things of interest that a researcher wishes to study. The unit of analysis of this study was public primary schools in Bungoma County. The target population comprised public primary school pupils, Guidance and Counseling Teachers, Class Teachers, Senior Teachers, Parents/Teachers Executive Committee, Parents, Key Informants, Children Officers and Education Officers.

Table 3. 2: Summary of Target Population

Sub-County	No. of Public Primary Schools	No. of Boys	No. of Girls	Total
SOUTH	87	30,862	31,174	61,436
WEST	76	20,847	18,730	39,217
BUMULA	91	29,330	29,782	59,112
EAST	123	37,791	36,027	75,818
NORTH	80	18,295	18,966	37,261
CENTRAL	60	23,100	21,206	44,306
CHEPTAIS	83	19,318	19,176	38,494
MT ELGON	81	14,779	14,675	29,454
KIMILILI	43	18,822	19,381	38,203
TOTAL	724	213,144	209,177	422,261

Source: Bungoma County Education Office, (2014)

3.5 Sampling Procedure

A sample is a section of a large populace which is used for research study or investigation. The sample size is a representative of the large population (Bryman, 2012). The sampling involved a combination of various methods: purposive, stratified and simple random sampling methods (Table 3.3). Multistage sampling approach of thirty percent was used to select 3 Sub-Counties from the 9. The ten percent rule by

was used to select 72 schools from 724 the schools to take part in the study (Mugenda & Mugenda, 2003). Pupils in the sampled schools were stratified in classes of standard 1-8 then purposively targeted standard 7 pupils. Simple random sampling was applied to get the required number of pupils according to Fischer's formula. From each of the sampled school, members of the Parents Teachers Committee were selected using simple random sampling. From each of the sampled schools, standard 7 class teachers and Guidance & Counseling teachers were purposively sampled. Education Officers, Administration Officers and Children Officers from each of the sampled Sub-Counties were sampled purposively. The Guidance & Counseling teachers, class teachers and senior teachers were purposively sampled from each of the schools selected.

3.6 Sample Size

The study was carried out in Bungoma County, which was purposively chosen. The County comprises 9 Sub-Counties, 724 primary schools with enrollment of about 430,000 pupils (BCEO, 2014). Based on Gupta (2008), a sample size of 30 % of the population is studied to be a representative of the population. The sample comprised both male and female pupils from standard 7.

According to Mugenda & Mugenda (2003), when the population is over 10,000, then Fischer's formula is used to determine sample size:

$$n = \frac{Z^2 pq}{d^2}$$

$$d^2$$

Where:

n= the minimum desired sample size

z = the standard normal deviate at 95% confidence interval = 1.96

p = the proportion of the population which has characters under study = 0.5

$q = 1 - p = 0.5$

d = the statistical level of significance set at 5% for precision of estimate

Hence,

$$n = (1.96)^2(0.5)(0.5)$$

$$= 384.16$$

$$= 384$$

In order to avoid reduction of expected sample size as a result of spoilage, losses and non-response of questionnaires, the sample size of the pupils was adjusted from 384 to 400 to take care of the questionnaires that might not be returned or lost or spoiled during the study.

Bungoma County has 9 Sub-Counties. Using simple random sampling technique for the 30 percent, 3 sub-counties were selected to take part in the study (Mugenda and Mugenda, 2003, Kombo and Tromp 2006). 3 Education Officers, 3 Administration Officers and 3 Children Officers each from the sampled sub-counties formed part of the sample. Using the rule of 10 percent, because of the large number of primary schools in the study area, 72 schools were selected, 24 from each sub-county, 72 Head teachers, 72 Guidance & Counseling teachers, 72 the Class teachers, 72 Senior teachers and 72 Parent/ Teacher Association Committee members, each from the selected schools responded to the interview schedule. The summary of sample sizes is shown in Table 3.3.

Table 3.3: Summary of population units, Total population, sampling procedure

Study population units	Total population	Sample size	Sampling procedure
Pupils	422,261	400	STRS, Simple random
Class Teachers	724	72	Purposive
G & C Teachers	724	72	Purposive
Senior Teachers	724	72	Purposive
PTA Committee	724	72	Purposive
Sub-County Admin	9	3	Purposive
Education Officers	9	3	Purposive
Children Officers	9	3	Purposive
TOTAL	439,439	697	

Source: Researcher, 2015

3.7 Data Collection Instruments

The data collection instruments used in this study were both primary and secondary as discussed in the following subsections.

3.7.1 Questionnaires

Questionnaires are commonly used as a primary data collection instrument to obtain important information about the population (Mugenda & Mugenda, 2003). In this study, questionnaires were used to gather information on socio-demographic characteristics and knowledge about parents' drinking problem from pupils. CAST, (Jones, 1993), a most frequently used child self-completed questionnaire was used on all the pupils so as to confirm children of alcoholics and issues on psychosocial development. A self-esteem test developed by Sorensen was used to rate the respondents' self-esteem individually (Sorensen, 2014). Questionnaires were used since the study dealt with variables that could not be directly observed such as views,

opinions, perceptions and feelings of respondents. The study population being literate was unlikely to have difficulties responding to questionnaire items. The questionnaire was used to collect quantitative data.

3.7.2 Interview Schedules

According to (Orodho, 2005), key informants are individuals targeted for data collection because they have key information that is vital for the research study. In-depth semi-structured interviews were used to collect qualitative data from Guidance and Counseling Teachers, Class Teachers, Senior Teachers, Parent/Teacher Committee members, Sub-County Children Officers, Education and Administration Officers about the state of drinking parents and COA in their respective Sub-Counties. The tool was ideal for this group because it generated reliable results, was flexible and quick to execute (Kombo & Tromp, 2006).

3.7.3 Focus Group Discussions

The focus group discussion (FGD) guide was used by the researcher to obtain data during visits in the homes where alcohol was brewed; this was used to assess effect of alcoholism on psycho-social development of pupils in of primary schools in Bungoma County. The guide consisted of a list of items that assisted in obtaining valuable information on the behavior of alcoholic parents in homes in the presence of their children. Each FGD was composed of 8 participants who were picked from drinking and non-drinking parents to give opinions concerning their children's psychosocial development. The study conducted 3 FGDs, one from each sub county.

Table 3.4: Summary of objectives, research design, population units and data collection instruments

Objectives	Research design	Study variables	Sampling strategy	Data collection instruments	Appendix
i. Determine the magnitude of alcoholism among parents	Descriptive survey	Money spent on alcohol, frequency of consumption, nature of alcohol drug, domestic violence	Simple random, stratified purposive	Questionnaire Interviews FGDs	II III IV, V,VI,VII VIII, IX
ii. Examine the nexus between parental alcoholism and psychosocial development	Correlation	Low self-esteem, delinquency, academic difficulties, attachment, distrust, isolation, relationships	Purposive, simple random, stratified	Questionnaires Interviews FGDs	II III IV, V,VI,VII VIII, IX
iii. Evaluate strategic options children's psychosocial development among alcoholic parents	Evaluation	Government Policies, Peer Counseling, Church involvement, School involvement, Community involvement	Purposive, simple random, stratified	Questionnaire Interviews FGDs	II III IV, V,VI,VII VIII, IX

Source: *Researcher, 2015*

3.8 Piloting of Research Instruments

Piloting study was done to enhance the questionnaire's validity. A pilot study was conducted on 27(7%) pupils, from two public primary schools in Vihiga County that were not part of the study sample. According to Mugenda & Mugenda (2003), the pretest sample should be between 1% and 10% of the actual sample. The results of the pilot test were used to identify areas where the questionnaire required correction like changing the order of questions, underlining key terms in the questions and use

of simple English language in questions to obtain more information on the study objectives.

3.9. Validity and Reliability of Research Instruments

This section covers the validity and reliability of the instruments used in the study.

3.9.1 Validity

Validity is the accuracy and meaningfulness of inferences, which are based on the research results. The data collection instruments were given to two groups of experts in the field of psychology. One group was requested to ascertain how adequately their content measures the knowledge, skills or behaviors that the test was intended to measure. The second group was asked to determine whether the set of items or checklist accurately represented the concept under study (Mugenda & Mugenda, 2003).

The researcher critically considered each item to see if it contains a real representation of the desired content and see if it measured what it was supposed to measure after considering the constructs (concepts) to be measured. Content validity was determined to establish representation of the items with respect to components of parental alcoholism on psycho-social development of pupils of Primary schools in Bungoma County (Wiersma, 1991). In order to ensure validity of the instruments, the developed instruments were presented to my supervisors at Masinde Muliro University of Science and Technology to evaluate their applicability and appropriateness of the content, clarity and adequacy in relation to the research objectives and research questions. Construct validity was ensured by using short,

simple and precise questions capturing only necessary information, minimizing biases and avoiding sensitive issues. This was validated by my supervisors from Masinde Muliro University of Science and Technology.

3.9.2 Reliability

Reliability is the measure of the degree to which a research instrument yields consistent results or data after repeated trials. Coefficient of stability of 0.8 was used to estimate the degree to which the same results could be obtained with a repeated measure of accuracy (Orodho, 2005; Bordens & Abbott, 2005) of the same group within a short interval of time to determine the reliability. Piloting of the data collection instruments was done in two public primary schools that were not part of the sample and the process was repeated after an interval of two weeks. Inadequate variables were discarded or modified in order to achieve consistent results.

To ensure the instrument was reliable, the reliability method was used to test the level of consistency and reliability (Sekaran, 2003). Therefore, Cronbach's Alpha coefficient (α) was used to measure the internal consistency of the instrument. Alpha's coefficient ranges in value from 0 to 1. It was used to describe the reliability of the instrument for multi-point formatted scales (i.e., 1 = very dissatisfied to 5 = very satisfied). The higher the value, the more reliable the instrument was. Firstly, the consistency of respondents' answers to all items was assessed. The reliability test was carried out and the findings were as presented in Table 3.5.

Table 3. 5: Reliability Statistics

Cronbach's Alpha	Number of questionnaire Items
.881	39

From the reliability statistics carried out using SPSS version 21, the Cronbach's Alpha coefficient value α was 0.881 for all the 39 questionnaire items. The reliability of coefficient of 0.6 and above is accepted as a good measure of reliability.

3.10 Data Analysis

The quantitative data generated in the study was analyzed with the help of Statistical Package for Social Sciences (SPSS version 21). Descriptive statistics such as frequency distributions and percentages were used to describe the data, chi square for testing for relationships between independent and dependent variables and Pearson r to measure the strength of the linear association between any two variables(Kothari, 2004; Orodho,2005) in objectives(i) and (ii)in the study. Pearson correlation coefficient ranges between +1 and -1, with 0 indicating that there is no relationship between the variables. The strategies to answer objective (iii) were listed. Qualitative data generated from interviews and FGD was analyzed qualitatively in prose form under each objective item. The summary is as presented in Table 3.6.

Table 3. 6: Summary of Research objectives, Research designs, Data collection instruments and Data analysis

Objective	Research design	Data analysis
i. Determine the magnitude of alcoholism among parents	Descriptive survey	Descriptive statistics and qualitative analysis
ii. Examine the nexus between parental alcoholism and psychosocial development	Correlation	Descriptive statistics, chi square, Pearson r and qualitative analysis
iii. Evaluate strategic options to enhance children’s psychosocial development among alcoholic parents	Evaluation	Descriptive statistics and qualitative analysis

Source: Researcher, 2015

3.11 Ethical Considerations

Permission to conduct the study was obtained from the Research Committee at Masinde Muliro University of Science and Technology, Appendix XI and a research Permit and Research Authorization from the National Council of Science, Technology and Innovation (NACOSTI) in Kenya, Appendix XII. The purpose of the research study was clearly explained to the respondents after which their consent was sought. Consent for the pupils to take part in the study was given by their parents, Appendix II. Anonymity and confidentiality of study participants was safeguarded by using numbers instead of names on the questionnaires and interview schedules. Participation in the study was strictly voluntary. The researcher also ensured that no psychological harm was caused to the respondents by avoiding asking embarrassing questions, or using threatening language (Mugenda &

Mugenda, 2003). Any statements that would lower the respondents' self-esteem were avoided. Privacy of the respondents was also accorded to them and none of their identities was disclosed.

3.12 Limitations of the Study

The first limitation of this study was that some participants may have underreported or misreported the parents' consumption of alcohol due to stigma or social desirability associated with alcohol consumption. To minimize this, assurance of confidentiality and reason for the study as for academic purposes only was explained to the participants before giving them the questionnaires, conducting the interviews and forming the FGDs.

The second limitation of this study was the wide area the County covers and the spread of schools. Bungoma County measures 2,206.9 square kilometers, therefore schools are many kilometers away from each other, and hence this caused challenges to the researcher who visited them. This was mitigated by using motor cycles (*boda boda*) as means of transport to access schools located in the interior parts of the county.

3.13 Summary

The chapter has given the research designs that were employed in this study. The study site, which was Bungoma County, was also discussed. Sampling strategy employed to arrive at the sample size was also illustrated. Data collection instruments, both primary and secondary tools were extensively discussed in this chapter. Validity and reliability of research instruments have been elaborated as well as the data analysis tools. The chapter also contains information on ethical

consideration while the research was being carried out and the limitations of the study.

CHAPTER FOUR

MAGNITUDE OF ALCOHOLISM AMONG PARENTS IN BUNGOMA COUNTY, KENYA

4.1 Introduction

The findings of this chapter were realized from Bungoma County, Kenya. Data was gathered about the magnitude of parental alcoholism and psychosocial development of primary school pupils. Quantitative data was collected from 400 respondents using questionnaires as shown in Appendix II supplied to the pupils. Qualitative data was collected from Class teachers, Guidance and Counseling teachers, Deputy Head teachers, Parents and Teachers Committee members, Education Officers and Probation Officers using interviews. Further qualitative data was gathered using Focus Group Discussions from drinking parents. The collected data was analyzed through running frequencies and cross tabulations. The findings were then represented in tables, graphs, charts and in narrative form.

4.2 Questionnaire Return Rate

The study used one questionnaire for the sampled groups which was made up of pupils from public primary schools in Bungoma County, Kenya. Table 4.1 shows the Questionnaire Return Rate for the sampled group that participated and returned. A total of 400 questionnaires were issued to the respondents out of which 399 questionnaires were correctly filled and returned. This constituted 99.8% of which was considered adequate and in line with Kothari (2004) who recommended that a

return rate of more than 50% was acceptable in social science research. The results are presented in Table 4.1.

Table 4. 1: Questionnaire Return Rate from Pupils in Bungoma County, Kenya

Sampled group	Total issued	Total returned	Percent Returned
Pupils	400	399	99.8
Totals	400	399	99.8

Source: Field Data, 2018

The high number of return rate could be associated with the fact that the questionnaires were issued early enough to the respondents and thus they had adequate time to fill and return. Secondly, given the nature of the study on parental alcoholism and psycho-social development among pupils in primary schools in Bungoma County, Kenya, respondents might have felt the study was relevant and would shade more light on improving their lives, hence responding to them promptly.

4.3 Demographic Characteristics of Respondents

Demographic characteristics of respondents refer to their background information. Several questions were asked in order to establish their background information. The questions comprised information on the their gender, age, number of sisters, number of brothers, religion, whom they stay with, occupation of parent, whether they attend school, whether they have ever drunk alcohol, any member of the family drinking and the frequency of drinking in a week. These are discussed under the following sub-sections.

4.3.1. Distribution of Pupils by gender

The study sought to determine the percentages by gender of pupils who responded to the questionnaires.

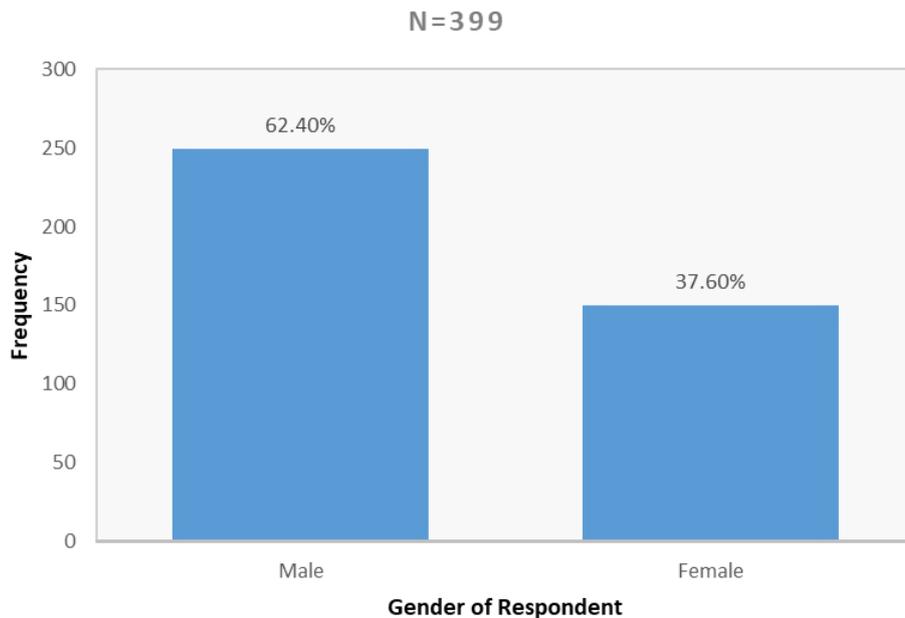


Figure 4.1: Distributions of Pupils by Gender in Bungoma County, Kenya

Source: Field Data, 2018

Figure 4.1 shows that out of 399 pupils who participated in the study, 249 (62.4%) were male while 150 (37.6%) were female. This could be attributed to the facts that of the children of drinking parents, more male pupils in Bungoma County, Kenya go to school as compared to the female pupils. Alternatively, this could be due to the fact that more male pupils are born in Bungoma County, Kenya as compared to the female pupils. Information from one of the class teachers indicated that girls get married off early as gifts to drinking friends of the parents and in homes where brewing takes place, the parents use the girls to sell alcohol. Some of the girls are sent by their drinking mothers to also get food for the family using their bodies. This

in turn gets their mind off schooling. In a study in Bungoma on effects of illicit brews on the youth, the sample had 65.4% males and only 34.6% females (Masinde, 2014). This is in line with secondary data that gave the number of male pupils to be 213,144 compared to the female ones who were 209,177 at the time of the study (Bungoma County Education Office, 2014).

4.3.2 Distribution of Pupils by Age

The study sought to establish age distribution of the pupils. From the research findings, most of the pupils were of age 14-17 years representing 345(86.5%) of the sample followed by over 17 years who were 44(11%). The least group was 10-13 years who were represented by 10 (2.5 %). Summary of the results is shown in Table 4.2.

Table 4.2: Distribution of Pupils by Age in Bungoma County, Kenya

Age Group	Frequency	Percent	Cumulative Percent
10- 13	10	2.5	2.5
14 – 17	345	86.5	89
Over 17	44	11	100
Total	399	100.0	

Source: Field Data, 2018

This is a stage of adolescence that can think constructively and make decisions on risks they are likely to encounter. It is possible that the over 17 year’s group had repeated classes due to the alcoholic parents’ failure to provide basic needs. Alternatively, they may have had responsibilities for their own and other’s care (Escandon & Galvez, 2005). Literature supports this that children of alcohol abusers are at greater risk of attention and conduct problems at school, repeating a grade, low

academic performance, skipping school days, dropping out of school and low school bonding (Mylant *et al.*, 2002; Serec *et al.*, 2012).

4.3.3 Number of Sisters of Pupils

The study sought to determine the number of sisters the respondents had. The study found that out of 399 pupils who participated in the study, 48(12%) had seven sisters and above, 134 (33.6%) had one to three sisters, 210 (52.6%) had four to six sisters while the remaining 7(1.8%) had no sister in the family. Majority of the respondents 64% had at least four sisters. This implied most families had sister sibling composition in Bungoma County. As noted by Bronfenbrenner (1994), family composition is important in this study. In addition older siblings' desire to use and their actual use of alcohol have also been shown to be predictors of younger siblings' later relationship to alcohol (Velleman, 2009). Protective family factors include being raised in a small family, large age gaps between siblings and engagement in a range of family based activities (Velleman & Templeton, 2007). The question was therefore relevant to the current research findings.

The results are shown in Figure 4.2.

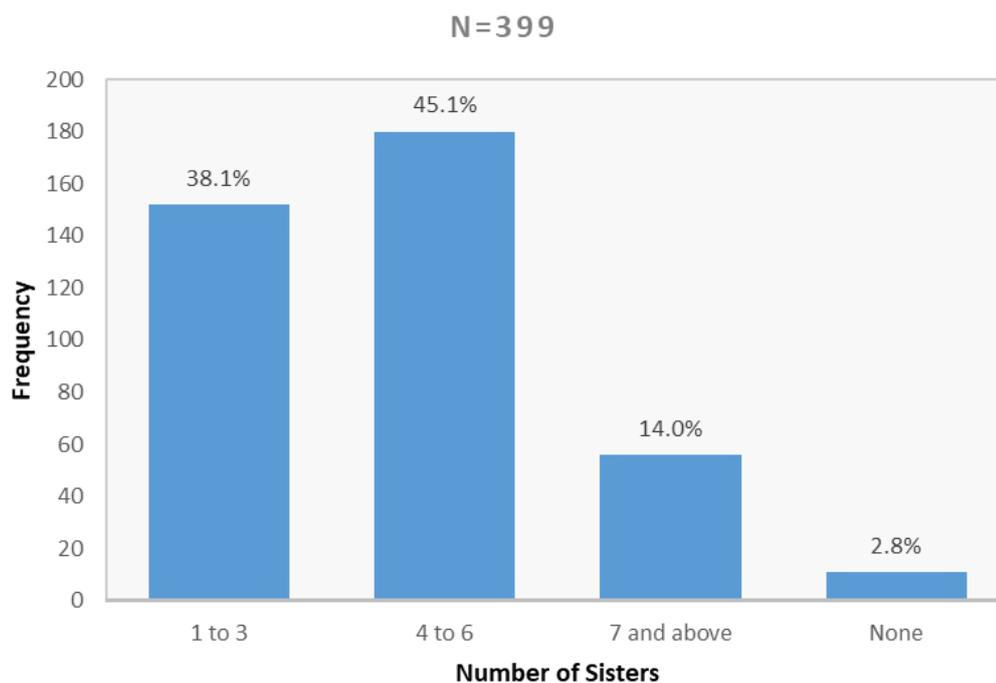


Figure 4. 2: Number of Sisters of the Pupils in Bungoma County, in Kenya

Source: Field Data, 2018

4.3.4 Number of brothers to the Pupil

The study sought to determine the number of brothers the respondents had. From the findings, 56(14%) out of 399 pupils had 7 brothers and above, 152(38.1%) had 1 to 3 brothers, 180(45.1%) had 4 to 6 brothers while the remaining 11(2.8%) had none. A majority of the respondents 236(59.1 %) had at least four brothers. The results are shown in Table 4.3.

Table 4. 3: Number of brothers of the Pupils in Bungoma County, Kenya

Total Number	Frequency	Percent	Cumulative Percent
7 and Above	56	14.0	14.0
1 to 3	152	38.1	52.1
4 to 6	180	45.1	97.2
None	11	2.8	100.0
Total	399	100.0	

Source: Field Data, 2018

As noted by Bronfenbrenner (1994), family composition is important in this study. In addition older siblings' desire to use and their actual use of alcohol have also been shown to be predictors of younger siblings' later relationship to alcohol (Velleman, 2009). Protective family factors include being raised in a small family, large age gaps between siblings and engagement in a range of family based activities (Velleman & Templeton, 2007). The question was therefore relevant to the current research findings.

4.3.5 Distribution of Pupils by Religion

The study sought to establish the religious groupings of the pupils. From the findings, 284(71.2%) of the respondents were Christians, 87(21.8%) were Islam, 22(5.5%) belonged to the traditional indigenous faith and the remaining 6(1.5%) had other religious groups. The results implied majority of the respondents 93% were of Christian faith. The results were summarized in Figure 4.3.

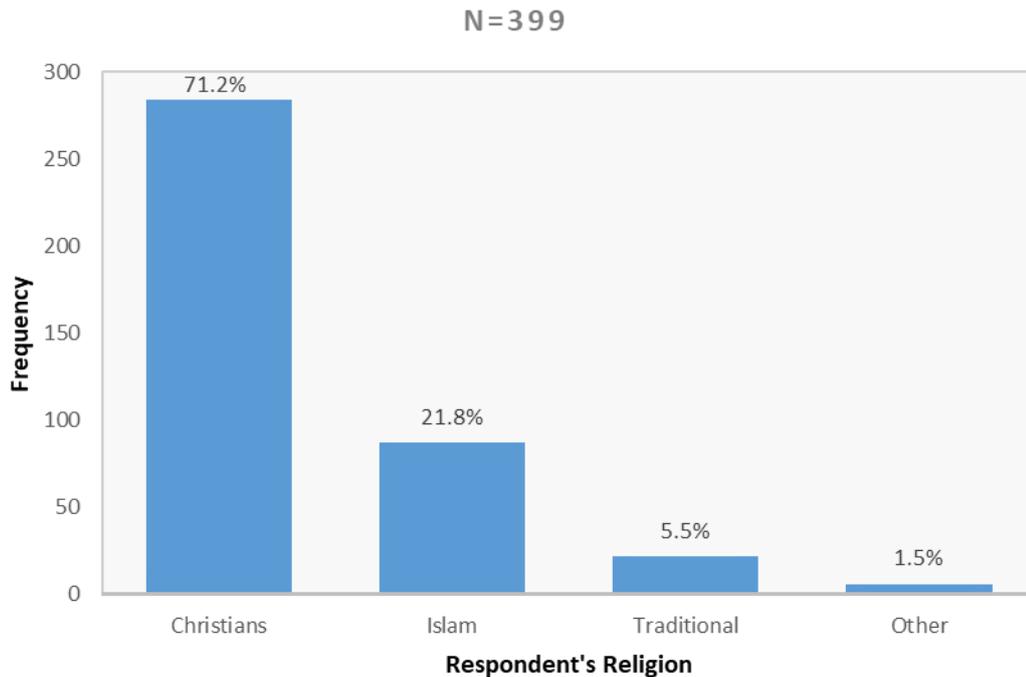


Figure 4.3: Distribution of Pupils by Religion in Bungoma County, Kenya

Source: Field Data, 2018

Past studies reveal that Protestant leaders such as Luther, Calvin, the leaders of the Anglican Church and even the Puritans did not differ substantially from the teachings of the Catholic Church: alcohol was a gift of God and created to be used in moderation for pleasure, enjoyment and health (Houghes, 2001).

Religious beliefs influence drinking culture; for instance, Thais often provide alcohol for the holy image of God and drink it after the ceremony has ended. In Thailand, Buddhism is a major religion as almost 95% there are Buddhists. According to the 'Five Precepts' in Buddhism, the fifth precept refers directly to alcohol consumption as it states that alcohol and illegal drugs should be avoided. Religion influences Thai practicing Buddhist adolescents regarding alcohol consumption more so than non-practicing (Glomjai, 2015).

According to Hettige and Paranagama (2005), drinking is not a socially approved custom among Sinhalese, Tamils and Muslims. Frequent drinkers could be found among Roman Catholic and other Christian population and this community is more westernized. Most of the time heavy drinkers can be found among Tamil estate workers. Cheap illicit brews are popular among them. It is also noted that drinking among Muslims is low compared to other ethnic groups. Drinking of Sinhalese/Buddhist is lower than Tamil/ Hindu people in the country. Drinking is high among Sinhala and Tamil Roman Catholic group (Hettige & Paranagama, 2005).

Burris et al. (2011) found that religious practices could apply a protective effect against underage alcohol consumption. Religious commitment functioned as a protecting influence, although spiritual transcendence actually worked in the opposite way and acted as a risk factor for alcohol consumption. This highlights the importance of studying religious communities with regard to alcohol consumption. In view of this, religious groups of the respondents were critical in this study.

4.3.6 Home Language among Pupils

The study sought to establish the home language of pupils who participated in the study. From the results, 175(43.9%) respondents spoke Kiswahili, 180 (45.1%) spoke kiBukusu, 36 (9%) spoke kiTachoni and the remaining 8 (2%) belonged to other home languages. Majority of the respondents were of Bukusu origin. Summary of the findings is shown in Table 4.4.

Table 4. 4: Home Language among Pupils in Bungoma County, Kenya

Home Language	Frequency	Percent	Cumulative Percent
Kiswahili	175	43.9	43.9
Kibukusu(vernacular)	180	45.1	89.0
Kitachoni (vernacular)	36	9.0	98.0
Others	8	2.0	100.0
Total	399	100.0	

Source: Field Data, 2018

According to Loke and Mak (2013), family background is the primary source of transmission of cultural factors that may underpin individual differences in children as they grow up. In view of this, cultural background which goes hand in hand with home language was important to this study.

4.3.7 Whom the Pupil stays with

The study sought to establish from the respondents who participated in the study who they stayed with. The summary of the findings was as shown in Table 4.5. Out of 399 Pupils who participated in the study, 167 (41.9%) were found to stay with both parents, 116(29.1%) stay with one parent, 116(29.1%) stay with grandparents. Majority of respondents 232 (58.2%) stay with either one parent or grandparents. This could be attributed to the fact that some of the respondents might have been born with a single parent, one died or there was negligence by the other parent. This motivated the study further to establish why majority of the respondents were not staying with both parents.

Table 4.5: Whom the Pupil stays with in Bungoma County, Kenya

Whom	Frequency	Percent	Cumulative Percent
Both parents	167	41.9	41.9
One parent	116	29.1	70.9
Grand Parents	116	29.1	100.0
Total	399	100.0	

Source: Field Data, 2018

Brown *et al.* (2006) noted that adolescents whose both parents relationship is good and one that appreciates shared family activities had a positive role in modeling the adolescent's health and overall development. The society can add policies that can help parents in taking the required steps. A study by Kumpfer (1998) posits that young people, who came from high stress families and dysfunctional families, had a big risk of alcohol problems. Young people who defined their family as somewhat authoritative tended to drink less than young people who described their family as neglectful parents (Adalbjarnardottir & Hafsteinsson, 2001). Furthermore, the young people who came from a single-parent family were more intense alcohol users than those who had both a mother and father in the family (Kask, Markina and Podana, 2013).

Ajilore *et al.* (2016) noted that there is a correlation between parental alcohol abuse and sons' and daughter's behavioral problems and less parental supervision during childhood and adolescence. In other words, when both parents supervise their

children, there is a likelihood the children will be modeled well. Therefore the question on whom do you stay with was important to the study. Therefore, the question whom do you stay with was relevant to the current research findings.

4.3.8 Occupation of Parents of Respondents

The study sought to determine the occupation of the parents as a measure of which groups of parents had problems with their children. Occupation was divided into five categories: Government employed, Factory worker, Self-employed, Retired and the Unemployed. These are the main occupations of people in Bungoma. Government employed includes teachers, doctors. The main factories where parents could work included coffee, tobacco and paper. The self-employed included Boda Boda riders, Farmers and Business People. Retired meant that they were formally government employed but now due to advanced age were no longer in employment but could be otherwise occupied. The unemployed were unoccupied in any income generating project. Summary of findings was as shown in Figure 4.4.

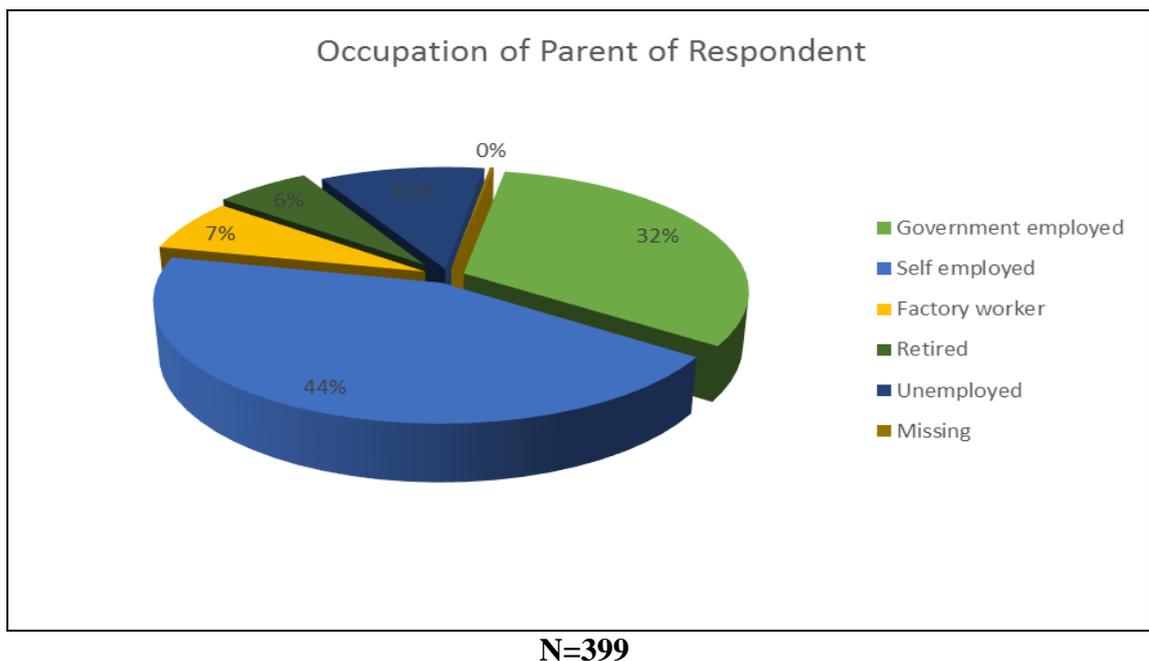


Figure 4. 4: Occupation of Parent of Respondent in Bungoma County, Kenya

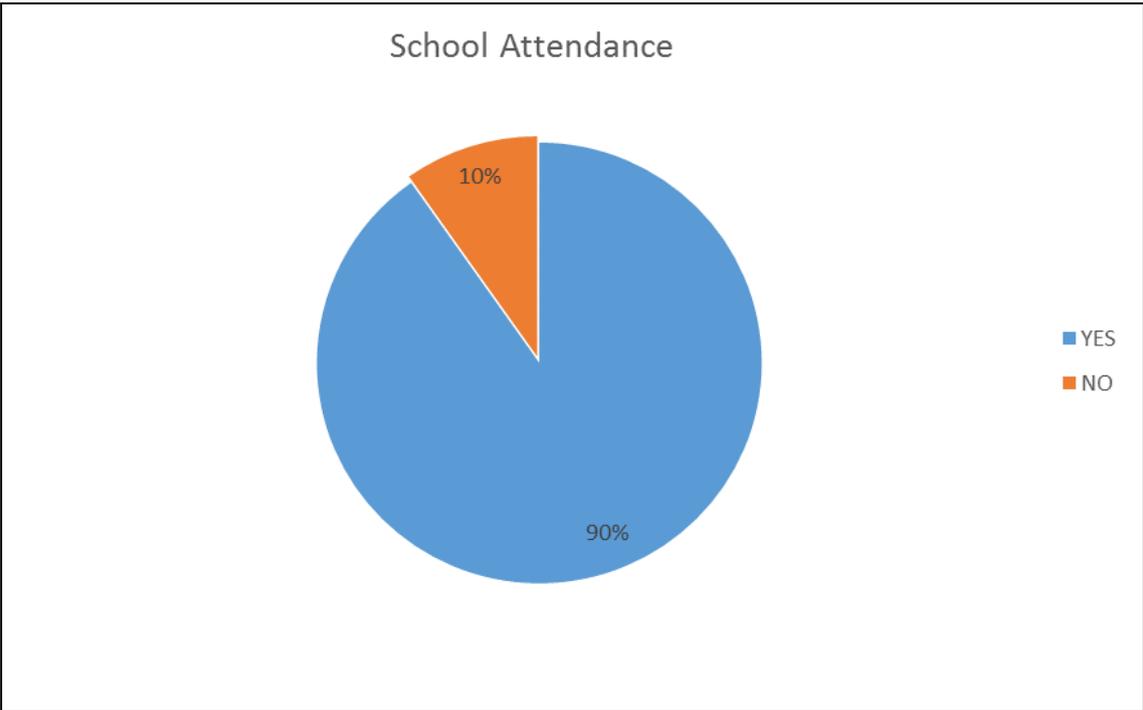
Source: Field Data, 2018

The results of Figure 4.4 responded to by pupils showed that a majority of parents were self-employed 175(43.9%) and the least group 25(6.3%) were retired. The results implied majority of the respondents were engaged in self-employment activities. This could be attributed to high levels of unemployment by government jobs in Kenya.

Serec *et al.* (2012) noted that families with alcoholic parents have been reported to have higher unemployment rates and lower economic status. In addition, middle and higher income respondents are less likely to report alcohol related harm to children compared to respondents on low incomes (Laslett *et al.*, 2012). Hence occupation of the parent was key in the research findings.

4.3.9 Regular School Attendance among Pupils

The pupils were asked whether they always attended school. The Yes and No results are summarized in Figure 4.5. Most of the respondents 360(90%) were found to be attending school regularly while the remaining 39 (10%) were not attending school regularly. The reason behind majority of respondents attending school is due to the Government of Kenya education policy of free primary which demands that all school going children attend school for free. Some of the reasons for not attending school always were: lack of school items, lack of interest with school work, and helping parents with home chores. Despite this, most pupils attended school regularly.



N=399

Figure 4. 5: Regular school attendance of Pupils in Bungoma County, Kenya

Source: Field Data, 2018

According to Tomczyk *et al.* (2015), school climate mediates the association between peers and adolescent alcohol use. A positive school climate was associated with lower alcohol-related outcomes among students and peers. School organization variables have a significant moderating influence on the association between peer and adolescent alcohol use. Teacher-student ratios were associated with adolescents' alcohol use; when teacher-student ratios were high, the adolescents' problem behavior was great. In addition, children of alcohol abusers are at greater risk of attention and conduct problems at school; repeating a grade, low academic performance, skipping school days and dropping out of school and low school bonding (Serec *et al.*, 2012, Mylant *et al.*, 2002). Poor academic performance may be linked in some way to prenatal exposure to alcohol due to maternal drinking. Fathers' drinking may have similar effects on children's school and educational outcomes. It has been found that a father's problem drinking can be a chronic stressor and this environmental influence could account for poorer outcomes in children at school (Farrell *et al.*, 2015).

Parental alcoholism puts children at risk for emotional and adjustment problems which include, hyperactivity, relationship difficulties, aggression, school absenteeism and drug use (McWhirter, *et al.*, 2007). Alcohol can also cause inconsistency in parenting; when a child does not receive consistent responses to their behavior, they may not feel safe to try new behaviors, which can stunt emotional growth (Lang, *et al.*, 1999). Therefore the question on school attendance was critical in this study.

Anecdotal evidence suggests that money spent on alcohol is often not available for other purposes like housing, rent or school fees (Tunnard, 2002). Children dealing with parental problem drinking have spoken of the shortage of finances for clothes, food and bills, and of their own money being borrowed in times of financial need (Tunnard, 2002). Living conditions can also be poor, with large amounts of household financial resources directed towards the procurement of drugs and alcohol (Tunnard, 2002). Health complications commonly associated with alcohol abuse and dependence can also lead to medical costs which have the potential to further increase the financial strains on families dealing with such problems (Butterworth, 2003). To further compound these difficulties, alcohol problems are more common in low-income single parent families, meaning that additional financial pressures are commonly placed on families that have fewer economic resources to draw on (CASA, 2005).

Australian data from the 1997 NSMHWB suggest that lone mothers who receive financial assistance from the government are almost four times more likely than other mothers to report alcohol and other substance use disorders (Butterworth, 2003). Women on welfare who are dependent on alcohol or other drugs also report more barriers to employment than women on welfare that do not have a substance use disorder. Barriers to employability include domestic violence, mental health problems, legal problems, child welfare investigations and fewer job skills (Morgenstern *et al.*, 2003). These barriers decrease the chances of alcohol- and

substance-dependent women achieving the financial security often associated with stable employment. However, financial strains can also impact on the involvement of families in treatment because reduced or limited income often means that these families cannot afford to receive treatment in private or specialized facilities. Families where one or both parents have an alcohol-related problem may have reduced access to treatment, or access to treatment that is inadequate to deal with the cluster of problems that such individuals and their families typically experience (Mitchell *et al.*, 2001).

Alcohol-related problems can also impede job performance, leading to reduced earnings or loss of employment (Booth & Feng, 2002). In one Australian study of children of parents who were engaged in a drug or alcohol treatment program in Victoria, it was found that 97.9 per cent of substance misusing parents were unemployed. Only 17 per cent of those unemployed were actively seeking work, and the 2.1 per cent who were employed were all employed on a part-time basis (Gruenert, Ratnam & Tsantefski, 2004). Of those families in the study, 92.8 per cent also reported an annual household income of less than \$20,000 (\$384 weekly) which primarily came from government social benefits payments (Gruenert *et al.*, 2004). This is low compared to the median Australian household income of \$40,664 (\$782 per week) from the 2001 Census data (ABS, 2006). It is important to note, however, that the numbers in this clinical sample were small (N = 118, comprising 48 children and 70 members of their extended families) and only 27.1 per cent were seeking treatment primarily for alcohol. Another 48.9 per cent sought primary illicit drug treatment and had a secondary problem with alcohol. The sample also most likely represented the more severe range of drug and alcohol problems, with most of the

adult participants having long histories of substance dependency. A high proportion of the sample reported poly-substance use (79.2 per cent), multiple rehabilitation attempts (70.3 per cent had accessed a detoxification service at least once), previous criminal offences (70 per cent), and low educational attainment (82.2 per cent had not completed Year 12) (Gruenert *et al.*, 2004).

Large representative studies drawn from samples in the US were more equivocal in their findings regarding the association between problem drinking and employment. Mullahy and Sindelar (1991; 1993), for example, found that problem drinking had a negative impact on employment for both men and women in a large representative sample (N = 23,805). A similar trend was identified in a later study; however, these results were not found to be statistically significant (Mullahy & Sindelar, 1996). Another study of problem drinkers found that there was no relationship between being an at-risk drinker and employment for women, and only a small positive relationship was detected for men (Feng *et al.*, 2001). As these studies utilized cross-sectional designs it is possible that a range of other unmeasured characteristics may account for the relationship between employment and problem drinking. Such characteristics may include poor health status, low educational attainment or co-morbid psychiatric problems (Booth & Feng, 2002).

Results from a longitudinal study conducted in six southern states of the US (N = 658) found that individuals who indicated at initial interview that they drank seven or more drinks on an average drinking day were six times more likely to be unemployed

than those who did not meet this criterion at the six month follow-up (Booth & Feng, 2002). Of those who were working at follow-up, individuals who drank seven or more drinks per day were less likely to be employed for as many weeks over a six month time period than participants who drank less. The effect of heavy drinking on employment was found to be as important as the influence of educational attainment, a major predictor of labour force status in most studies (Booth & Feng, 2002). This association between employment and heavy drinking was found after controlling for recent health status, negative life events and other drug use. Australian data from the 2007 NSMHWB survey support this finding, showing that participants who met criteria for alcohol abuse in the past 12 months were unable to perform, or had to cut down on, normal activities for an average of 2.4 days out of the past 30, while those with alcohol dependence reported 3.7 days out of role, compared to only 1.5 days for those with no alcohol use disorder (Teesson *et al.*, 2010).

Epidemiological studies have also explored the relationship between income and problem drinking. Some studies have found positive relationships between alcohol consumption and earnings (Berger & Leigh, 1988), whilst others have identified negative relationships (Feng *et al.*, 2001). It appears that the relationship between income and drinking depends on the pattern of alcohol consumption under examination. When the focus is on moderate drinking, it has been found that income increases are positively associated with alcohol consumption (Berger & Leigh, 1988). Moderate drinkers also appear to earn more than their non-drinking counterparts (Bryant *et al.*, 1993). However, when the focus is on problem drinking, as defined by DSM-III alcohol use disorders, increased alcohol consumption is

associated with a significant reduction in earnings (Mullahy & Sindelar, 1993). However, as previously discussed, problem drinking is also related to employment. As such, problem drinking may affect income indirectly by reducing employment, rather than directly influencing the wages of workers (Feng *et al.*, 2001).

Conversely, employment status may also have an influence on problem drinking. Life transitions such as getting married and becoming pregnant are shown to reduce problem drinking. Becoming employed is also associated with a decrease in alcohol dependence, specifically for older males, which attribute to increased responsibility and structure (Verges *et al.*, 2012).

United States longitudinal data from the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC) (N = 34,653) also revealed increased work stress and increased financial resources can lead to the onset and recurrence of alcohol dependence. This research suggests that the effects of alcohol on employment, and vice versa, are likely to vary as a function of age, sex and other life transitions/factors (Verges *et al.*, 2012).

The relationship between alcohol use and financial strain is multi-factorial. Financial strain has, for example, been associated with a range of other factors likely to affect family functioning including parental depression and negative parenting practices (Lyons, Henly & Schuerman, 2005), child abuse and neglect (Leventhal & Brooks-

Gunn, 2000), and poor parent-child interactions (Schiffman, Omar & McKelvey, 2003). It is likely that the link between problematic alcohol use and financial strain is mediated by these kinds of factors. In support, a cross-sectional study using structural equation modeling (N = 1,424) found that depression mediated the relationship between financial strain and drinking to cope, and similarly, drinking to cope mediated the relationship between depression and alcohol consumption and problems (Peirce *et al.*, 1994). In this study, financial problems were independently associated with both depression and alcohol use, with gender and race variables moderating the effect of these relationships. The direction of these relationships are not clear; for example, financial problems and alcohol use may be reciprocally related, where financial problems may increase depression and problem drinking in the short term, or where problem drinking increases financial difficulties and depression in the long term (Peirce *et al.*, 1994).

4.4 Magnitude of Alcoholism among Parents

The first objective of the study was to determine the magnitude of alcoholism among parents in Bungoma County. This was done by finding out who drank alcohol, how much alcohol was drunk and how often alcohol was drunk. The summary of findings is discussed in the following subsections.

4.4.1 Drinking in the family of Pupils

The respondents were asked whether any member of their family drank alcohol. A substantial number 179 (42.6%) responded 'YES'. This showed that the family members who drank were either seen by the children or acted in a manner that was

obvious to the children that they had drunk alcohol. Asked to indicate who in the family drank alcohol, a substantial number 138(34.7%) indicated father, 29(7.34%) felt that that their mothers were involved in taking alcohol. From the results, out of 399 pupils who participated in the study, 179 (42.6%) of the respondents confirmed one of the members in the family drank alcohol while 229(57.4%) said none of the members in the family drank alcohol. This implies almost 50 % of the respondents had one member in their family who drank alcohol.

Table 4.6 shows the results of drinking in the family.

Table 4. 6: Drinking in the family of Pupils in Bungoma County, Kenya

Response	Frequency	Percent	Cumulative Percent
Yes	179	42.6	42.6
No	229	57.4	100.0
Total	399	100.0	

Source: Field Data, 2018

Past studies revealed that the earliest alcoholic beverages may have been made from berries or honey and wine brewing originated in the wild grape regions of the Middle East (Litten *et al.*, 1997). Oral tradition recorded in the Old Testament asserts that Noah planted a vineyard on Mt. Ararat in what is now eastern Turkey (Genesis 9:20). In Sumer, beer and wine were used for medicinal purposes as early as 2,000 B.C (Institute of Medicine, 1996).

Other research findings also revealed that in the late second century, several heretical sects rejected alcohol and called for abstinence. By the late fourth and early fifth

centuries, the Church responded by asserting that wine was an inherently good gift of God to be used and enjoyed. While individuals may choose not to drink, to despise wine was heresy. The Church advocated its moderate use but rejected excessive or abusive use as a sin. Those individuals who could not drink in moderation were urged to abstain (Hughes, 2001).

Another cross-sectional study by Wu, Chong, Cheng, and Chen (2007) in Taiwan investigated family relationships, deviant peer influence and adolescent alcohol use in a sample of 780 grade nine students. Measures of family characteristics, school factors and peer influence were used, with peer influence including peer relationships, deviant peer behavior and alcohol use. The study reported that substance use was predicted by perceptions of poor family relationships and deviant peer relationships (Wu *et al.*, 2007). There are two major limitations in this study: that cross-sectional research did not allow causal inference and all family, school and peers measures were self-reported.

A study in the Netherlands used multiple data sources to examine whether the association between friends' drinking norms and male adolescent alcohol use was moderated by peer influence. Using a sample of 73 male adolescents with the average age of 17 years, the study comprised three parts: a baseline class-room questionnaire assessment, a chat room experience and a multiple time diary assessments to measure alcohol use. Peer influence susceptibility was defined as the change in adolescent responses before and after exposure to peer norms (Teunissen *et al.*, 2016).

A cross-sectional study conducted in Illinois (USA) with a sample comprised of 259 students aged 14-18 sought adolescents' self-reported perceptions of four types of parental messages that may influence alcohol use intentions. Those four messages were parents' references to the negative consequences of alcohol use, parents' references to their own past experiences with alcohol use, parents' conditional permissive messages and parents' views on drinking alcohol responsibly (Kam, Basinger, & Abendschein, 2017). This study examined how parent-child alcohol-specific verbal messages indirectly related to adolescents' alcohol use intentions, focusing on parents' own experiences to create a 'teachable moment' to discuss alcohol with their children. Adolescents perceived their parents' conversations regarding parents' own experiences as a sign of honesty and trust. This study noted that adolescents learning behavior from parents may be an important model (Kam *et al.*, 2017).

Protestant leaders such as Luther, Calvin, the leaders of the Anglican Church and even the Puritans did not differ substantially from the teachings of the Catholic Church: alcohol was a gift of God and created to be used in moderation for pleasure, enjoyment and health; drunkenness was viewed as a sin; Houghes (2001). Further past studies reveal that drunkenness would come to be defined as a threat to industrial efficiency and growth. Problems commonly associated with industrialization and rapid urbanization were also attributed to alcohol. Thus, problems such as urban crime, poverty and high infant mortality rates were blamed on alcohol, although "it is likely that gross overcrowding and unemployment had much to do with these problems; Kennedy and Mukerji (1986). Over time, more and more personal, social and religious/moral problems would be blamed on alcohol.

And not only would it be enough to prevent drunkenness; any consumption would come to be seen as unacceptable. Groups that began by promoting temperance- the moderate use of alcohol - would ultimately become abolitionist and press for the complete and total prohibition of the production and distribution of beverage alcohol Houghes (2001). The decision to drink by both adults and young people is motivated by a variety of factors; enjoyment, lifestyle, rites of passage, parental influence and cultural acceptability of drinking. In many countries, drinking is traditionally considered normative behavior and an integral part of daily life. The introduction of children to alcohol beverages often occurs early within the family, and in a way that integrates drinking into other common place activities (WHO, 2013).

Qualitative data generated from the interview schedule with one Children's Officer had the following:

I see most men drank. When asked why they engage in drinking illicit brew commonly referred to here as *chang'aa*, they say they were taught by their parents and great grandparents used to drink and therefore it is part of their tradition to get drunk. The Government has helped with the idea of free primary education. Otherwise majority of children here would not be in school now. Most men wake up as early as 6 am to go and drink. Some women also get drunk but later on in the day but the cases are fewer.

Source: Field Data, 16th January, 2017

The interview schedule revealed that the members of the family that drunk were mostly fathers. A small number of mothers also drank alcohol.

One of the class teachers had this to report;

Actually, most of the time drinking can make problems in the family and I see it in our home. In my case, I don't want the person I marry to drink. If I say 'no no' to his drinking all the time and if I ask why you drink all the time when there is a discussion like that it can mean a fight in the family. It can destroy love, because he may go out with friends most of the time for

drinking..... What I see my mother go through when my father is drunk is bad. If my future husband gets drunk it may be an even bigger problem....I better remain single. Another thing is if we think about money. If they spend money on alcohol, then they have less concern about the family. Actually, when we think about the future, it is not a good thing for a family. As a girl, I think that if husband addicted to alcohol it is a problem. What I have seen makes me not like men who drink alcohol.

Source: Field Data, 18th January, 2017.

4.4.2 Frequency of Drinking among Parents of Pupils

The respondents were asked about the frequency of the drinking of the members in the family in order to establish whether there were problems in the family as a result of a parent's drinking. The results were shown in Table 4.7

Table 4. 7: Frequency of Drinking Alcohol among Parents of Pupils in Bungoma County, Kenya

Frequency	Frequency	Percent	Cumulative Percent
Nearly everyday	221	55.4	55.4
Sometimes	114	28.6	84.0
Only during ceremonies	52	13.0	97.0
Not applicable	12	3.0	100.0
Total	399	100.0	

Source: Field Data, 2018

The results in Table 4.7 reveal that out of 399 respondents who participated in the study, 221(55.4%) had parents who nearly drank every day, 114(28.6%) drank sometimes, 52(13%) drank only during ceremonies while the remaining 12 (3%) felt it was not applicable. From these results, majority of the parents are regular drinkers.

The researcher made an observation in different parts of the county about this scenario. Most brewers opened their premises as early as 6 am in the morning on daily basis. The researcher observed familiar faces each day during the research findings. The photographs were also taken during the study though they were not shared due to confidentiality of the respondents.

Qualitative data generated through interview from one of the Head teachers had the following to say;

Most of the pupils who come to school late on daily basis blame it on their fathers who come home late at night drunk. They claim the parents do not provide them with soap for bathing in the morning. Others claim they hang around homes to wait for their sleeping fathers to wake up and give them money for books and pens. It is really a difficult situation for some of the pupils. A smaller number claim their mothers also drink alcohol and therefore they wait till late in the morning to ensure their younger siblings are safe before they come to school. We have reached a point of not punishing them because it is not their fault. It is worth to noting that most of the pupils from such backgrounds do not perform well in class. *Source: Field Data, 25th September, 2016.*

Respondents reported knowledge of *chang'aa* selling places, despite its illegal status at the time of the study. A report from one the FGDs stated:

Our neighbors are drunk every evening; one is very abusive, talking on top of his voice. The other sometimes misses the way home and has to be directed by sympathizers, others are found staggering and talking nonsense. *Source: Field Data, 24th January, 2017*

Another respondent in the same group had this to say:

Most of these drunks are men, women do not drink as much because of the responsibilities they have in the home, and they cannot afford buying drinks every day.

Source: Field Data, 24th January, 2017

In response to the question “what is the frequency of your drinking”, the drinking parents in one of the FGDs had the following to say;

We drink as long as we have money. We are men, what would we be doing at home all the time? Our fathers used to drink, it is in the family. We are not abusive like others, we come home after drinking, and our children have never been sent away from school. We are alright.

Source: Field Data, 19th January, 2017

From the research check list, the survey showed that the second generation alcohol was the most available, affordable and accessible type of alcohol in the County. Nearly 90% of the respondents reported that this type of alcohol was both easily available and moderately available, 91.2% felt it was both very affordable and accessible and two-thirds felt that it was accessible in both very many and many selling places. Only a paltry 2.8% reported lack of knowledge of its availability. On the other hand, from the FGDs, *chang’aa* and traditional liquor were reported to be the least available and accessible types of alcohol. Nonetheless, it is an important note that one-quarter of the respondents reported knowledge of *chang’aa* selling places, despite its illegal status at the time of the survey. This in part reflects ineffective legal enforcement against the brew.

The research findings are in line with past studies which reveal that parental alcohol misuse brings disruption to family functioning. In general, such families perceive their environments to be less cohesive; they lack ritual and routines; they tend not to

positively express feelings, warmth or caring; and have higher levels of unresolved conflict (Burke, Schmieid & Montrose, 2006). Parental alcohol use can result in impaired parenting (Sher *et al.*, 1991). Parental monitoring (i.e. awareness of a child's whereabouts) (Stattin & Kerr, 2000) and consistent discipline are important aspects of the parent-child relationship which may be disrupted by parental drinking problems (King & Chassin, 2004). Monitoring is particularly important during adolescence when a parent's close attention to adolescent activities can prevent substance use, delinquency and other risky behaviors (Beck, *et al.*, 2004). Parental alcohol use can result in poor parent child relationships. Parental attitudes towards their child's alcohol use have been associated with a lower risk of regular drinking (Velleman, 2009).

One of the first studies to identify patterns of alcohol consumption was conducted by Cochrane and Bal (1990). This community survey collected data from participants from random samples of 200 each of English, Sikh, Muslim and Hindu men in Wolverhampton and Birmingham, all matched for age (17-69 years). The study concluded that overall, Muslim men were people who drank the least amount of alcohol, Hindu men followed. Sikh and white men reported approximately the same level of alcohol intake. However, more Sikh than white men consumed alcohol regularly. The majority of Muslim men (90.5%) reported that they never consumed alcohol or had not consumed alcohol in the past year. However, most respondents reported that they consumed alcohol once or twice per week. The review of the literature suggested that there was a continuous variation in alcohol consumption by youth from different ethnic backgrounds (Cochrane & Bal, 1990).

The findings on young people in England from a study done by Williams *et al.* (2010) showed that the most popular drinks were beer/lager/bitter/cider while the most popular drink among girls was alcopops. On average, they had consumed 2.6 units of alcohol over the past seven days, and the number of units consumed varied by school year from under 4 units among years 7-8 to over 20 units among years 12-13. One unit stands for 10 ml of pure alcohol (Williams *et al.*, 2010). The total 2017 both young people and parent samples indicated that the most common reason for alcohol consumption was due to peer pressure (54%). However, about their own behavior the young people most frequently said it tastes nice (41%). When asked about the consequences of drinking heavily, 58% reported knowledge of risks to their own health followed by 27% having the potential of becoming involved in crime or violence (Williams *et al.*, 2010).

Parental alcohol problems rarely exist in isolation from other difficulties such as parental mental health issues (Harwin *et al.*, 2010), parental drug use, financial hardship (Girling *et al.*, 2006) and parental separation or loss. Families with alcoholic parents have been reported to have higher unemployment rates and lower economic status (Serec *et al.*, 2012).

Middle and higher income respondents are less likely to report alcohol related harm to children compared to respondents on low incomes (Laslett *et al.*, 2012). The results were also supported by information from FGD's that in homes where brewing

took place, the respondents got in contact with the alcohol and they often modeled what their parents were doing. This was in line with the fact that the increased availability of alcohol at home was associated with high levels of alcohol use (Zundert, *et al.*, 2006). The findings are similar to those of a mixed method cross-sectional study in Portugal to understand alcohol use among 13 year old school students. This study had both quantitative and qualitative components: a self-administered questionnaire to a sample of 2036 students, and a semi structured interview (N=30). This study intended to assess the reason for and consequences of drinking as perceived by adolescents and discover their views on prevention strategies (Fraga *et al.*, 2011).

The results of the Portugal study demonstrated that more than 50% of 13 year olds had drunk alcoholic beverages at least once in their lifetime. There are likely cultural reasons for the high proportion of adolescents who had experienced alcohol by 13 years, probably due to the tradition of home consumption with meals. Results indicated that adolescents only identified minor and temporary consequences of drinking alcohol but most recognized that the drinking can be harmful and lead to addiction that is difficult to treat. However, participants only perceived the consequences for the person who drinks and not how this could affect others (Fraga *et al.*, 2011). Despite the strengths of the mixed-method model which allowed both objective measures of behavior and in-depth analysis of several features of this behavior researchers noted that a limitation of the study may be related to not having enough information about parents' behavior and parental roles (Fraga *et al.*, 2011).

4.4.3 Perception of Pupils on Parents' Drinking

The study sought to find out the perception of children regarding their parents' drinking using the CAGE questionnaire. The results were summarized in Table 4.8.

In response to statement one: "Have you ever thought that one of your parents had a drinking problem?". 146 (37.1%) said Yes while the remaining 251 (62.9%) said No. This implied that a majority of the pupils said No though the number that said Yes was almost 40 %. In statement two: "Have you ever lost sleep because of a parent's drinking?". Out of those who responded to the study, 102(25.6%) said Yes while the remaining 297(74.4%) said No. In statement three: "Did you ever encourage a parent to stop drinking?". Out of those who participated in the study, 173(43.3%) said Yes while the remaining 226 (56.6%) said No.

Table 4.8: Perception of Pupils on Parents' drinking in Bungoma County, Kenya

No	Statements	YES		NO		Total	
		N	%	N	%	N	%
i	Have you ever thought that one of your parents had a drinking problem?	148	37.1	251	62.9	399	100.0
ii	Have you ever lost sleep because of a parent's drinking?	102	25.6	297	74.4	399	100.0
iii	Did you ever encourage a parent to stop drinking?	173	43.4	226	56.6	399	100.0
iv	Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?	173	43.4	226	56.6	399	100.0
v	Did you ever argue or disagree with a parent when she or he was drunk?	109	27.3	290	72.7	399	100.0
vi	Did you ever threaten to run away from home because of a parent's drinking?	76	19.0	323	81.0	399	100.0
vii	Has a parent ever yelled or hit you or other family members when drank?	128	32.1	271	67.9	399	100.0
viii	Have you ever heard your parents fight when one of them was drank?	128	32.1	271	67.9	399	100.0
ix	Did you ever protect another family member from a parent who was drinking?	158	39.6	241	60.4	399	100.0
x	Did you ever feel like hiding or pouring a parent's bottle of alcohol?	139	34.8	260	65.2	399	100.0

Source: Field Data, 2018

In statement four: “Did you ever feel alone, scared nervous, angry or frustrated because a parent was not able to stop drinking?”. Out of those who participated in the study, 173 (43.4%) said Yes while the remaining 226(56.6%) said No. Again nearly half of the respondents felt lonely, scared, nervous, agree or frustrated because one of their parents was not able to stop drinking.

In statement five: “Did you argue or disagree with a parent when she or he was drunk?”. Out of 399 respondents, 109(27.3%) said Yes while 290 (72.7%) said No.

In statement six: “Did you ever threaten to run away from home because of a parent’s drinking?”. Out of those who participated in the study, 76 (19%) said Yes while 323 (81%) said No. In statement seven: “Has a parent ever yelled or hit you or other family members when drunk?”. Out of those who participated in the study, 128(32.1%) said Yes while the remaining 271 (67.9%) said No. In statement eight: “Have you ever heard your parents fight when one of them was drunk?”. Out of those who participated in the study, 128 (32.1%) said Yes while 271 (67.9%) said No. In statement nine: “Did you ever protect another family member from a parent who was drinking?”. Out of 399 respondents who participated in the study, 158 (39.6%) said Yes while the remaining 241 (60.4%) said No. In statement ten: “Did you ever feel like hiding or pouring a parent’s bottle of alcohol?”. Out of those who participated in the study, 139 (34.8%) said Yes while the remaining 260 (65.2%) said No.

The responses on the ten statements from the respondents on “YES” had at least 19.0% and at most 43.4% to the questions indicating that there were cases in the

sample where the parents were alcoholic. There are various studies that are in line with the current research findings.

The study further used chi square to determine the degree of association between the pupils feelings, experiences and attitudes about alcoholic parents. From the findings, chi square value $\chi = 35.981$ at $p = 0.05$ was recorded. This value was significant which implied that pupil's feelings, experiences and attitudes were significantly affected by parental alcoholism.

The current findings are supported by a longitudinal study by Mares *et al.* (2011), who examined the role of parents' alcohol use, parents' alcohol-related problems, and attitudes towards youth alcohol use in alcohol-specific communication. This study consisted of 428 Dutch families, both parents and adolescents, with adolescents aged 13-15. They had surveyed annually for five years. Parents' alcohol consumption, parents' alcohol related problems, parents' alcohol-specific attitudes, alcohol specific communication, adolescents' excessive drinking and adolescents' alcohol-specific problems areas were included in the questionnaire (Mares *et al.*, 2011).

The results of the Dutch families study recognized the different impact of paternal and maternal factors on adolescent drinking. When fathers express strict alcohol-specific attitudes both parents talk more often about alcohol with their children but the attitudes of mothers did not show this effect. However, the research indicated that paternal strict alcohol-specific attitudes about alcohol were associated with lower

adolescent alcohol use. The researchers emphasized that both parents' alcohol use and the alcohol related problems were associated with excessive drinking by adolescents (Mares *et al.*, 2011).

Another study in support to the current research findings was a cross-sectional study conducted by Loke and Mak (2013) who examined the family process, parenting style and the influence of friends' substance use on risk behavior of adolescents. The questionnaire used in this study included questions on students' perceptions of family process, substance use (smoking, drinking and alcohol and using drugs), their parents' and friends' smoking behavior, their acceptance of smoking, the demographic characteristics of the adolescents and their family structure. The researchers reported that most of the questions had been used in previous research and they adopted and modified questions to suit their context, with content validity assessed by a panel of three experts (Loke & Mak, 2013).

In a study a sample of 805 adolescents completed the questionnaires. Sample participants were categorized into two age groups: 11-15 and 16-18, with more boys (73%) than girls (27%) in the study. The study found that more participants had fathers than mothers who smoked or used alcohol. About one quarter of students had friends who smoked or drank alcohol. It was noted that more of the adolescents were satisfied with role fulfilment by their mothers than by their fathers (Loke & Mak, 2013). They reported that as children look up to their parents as role models, adolescents saw parents' smoking or drinking as acceptable behavior which they can

emulate. The findings confirmed that the smoking or drinking habits of parents were associated with adolescent smoking and drinking (Loke & Mak, 2013).

Loke and Mak (2013) concluded that familial influences were important factors in the development of adolescents. As parents are role models, parents provide support and control to guide their adolescents in their development. The quality of the parent-child relationship was another factor influencing the development of risk behavior. A poor child-parent relationship, as reflected by less time spent in activities together and increased conflict between adolescents and with parents, was a factor associated with risky behavior. On the other hand, parents with warmth, love, care, acceptance, respect, and appropriate level of monitoring could encourage positive psychosocial development in adolescents (Loke & Mak, 2013).

Separately another study that supports the current findings was a cross-sectional study conducted in Illinois (USA) which was part of a larger research project on adolescents. The sample comprised 259 students aged 14-18 with the study seeking adolescents' self-reported perceptions of four types of parental messages that may influence alcohol use intentions. Those four messages were parents' references to the negative consequences of alcohol use, parents' references to their own past experiences with alcohol use, parents' conditional permissive messages and parents' views on drinking alcohol responsibly (Kam, Basinger & Abendschein, 2017).

This study examined how parent-child alcohol-specific verbal messages indirectly related to adolescents' alcohol use intentions, focusing on parents' own experiences to create a 'teachable moment' to discuss alcohol with their children. Adolescents

perceived their parents' conversations regarding parents' own experiences as a sign of honesty and trust. This study noted that adolescents learning behavior from parents may be an important model (Kam *et al.*, 2017).

In addition, Hoque and Ghuman (2012) conducted a cross-sectional study in South Africa with a total of 704 16-18 year old adolescents, to understand their perception of parental practices relating to adolescent alcohol use. The researchers examined adolescents' perceptions of their own alcohol use, parental alcohol use and the associated behavior and family rules regarding alcohol use. They reported that 54% of participant adolescents have consumed alcohol at some time in their life. The study noted that a large number of mother/female guardians and father/male guardians do not allow drinking at home. Adolescents were more likely to use alcohol in households where parents drank. Hoque and Ghuman (2012) found a significant association between parental alcohol use and adolescent alcohol use, and parents' views on their adolescents' alcohol drinking.

The qualitative research from Portugal (noted above) from Fraga *et al.* (2011) also discussed alcohol consumption at home, perhaps reflecting cultural norms where drinking is acceptable at family meals. Adolescents who reported that they drink at home may reflect their parents' approval of their drinking and easy access to alcohol at home. On the other hand, researchers noted that parents may acquiesce to their adolescents drinking alcohol at home and their knowledge of their children's drinking may reflect efforts to protect adolescents from heavy drinking outside the home.

Moreover, a similar longitudinal study in Upper New York State, with a sample of 2573 high school students, Nash et al. (2005) examined the relationships among family environment, peer influence, stress, self-efficacy and adolescents' alcohol use. The study found that as adolescents begin spending more time with their friends and less time under parental supervision, influence shifts from parents to peers. Adolescents with more positive family environments demonstrated greater self-efficacy in refusing alcohol use and were less susceptible to peer influence enticing them to drink. Peer influence and stress were positively related to subsequent alcohol use whereas self-efficacy was negatively related to it.

In one of the focused group discussion with the respondents, the study established that most pupils were not free to interact with the researcher. This was attributed to the background where they come from. The characters they were exhibiting showed that they were suffering in silence. Those, whose response was not in affirmative with the research findings, might be attributed to the fact that they were hiding the information from the researcher with a view to safeguard their parent's involvement in alcoholism.

4.5 Summary

From the research findings, the respondents were almost of equal number in terms of gender although the majority were male. The data collected from questionnaires, interview schedules, and focus group discussions revealed in equal measure that most of the parents in the area of study drank alcohol. Many of the children modeled from their parents the habit of drinking alcohol.

CHAPTER FIVE

THE NEXUS BETWEEN PARENTAL ALCOHOLISM AND PYSCHOSOCIAL DEVELOPMENT OF PUPILS IN BUNGOMA COUNTY, KENYA

5.1 Introduction

This chapter presents the findings of objective two which was to: examine the nexus between parental alcoholism and the psychosocial development of primary school, measured using Pearson correlation coefficient at 0.01 significance, two tailed. The sections covered included psychological development and social development. The aspects covered were: children being close to parents, expression of emotions like crying and worrying, being on their own, keeping friends and ability to do things just like classmates by the respondent. The findings are discussed in the following sub section. This chapter also dealt with the influence of parental alcoholism on social development. The aspects that were covered included the respondent responding to: I have trouble keeping my mind on studies, I go out of school without permission, I drink *chang'aa*, I can tell lies, my parents are very strict and I eat at specific times at home.

5.2 Parental Alcoholism on Psychological Development of Primary School

Pupils

Respondents were asked several questions regarding psychological development. In order to achieve this objective, the respondents who participated in the study were asked to give their opinion on the extent at which they agreed or disagreed with the

statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. They are discussed in the following subsections.

5.2.1 Closeness to Parents among Pupils

The first question respondents were asked was with regard to how close they were to their parents. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were as shown in Figure 5.1.

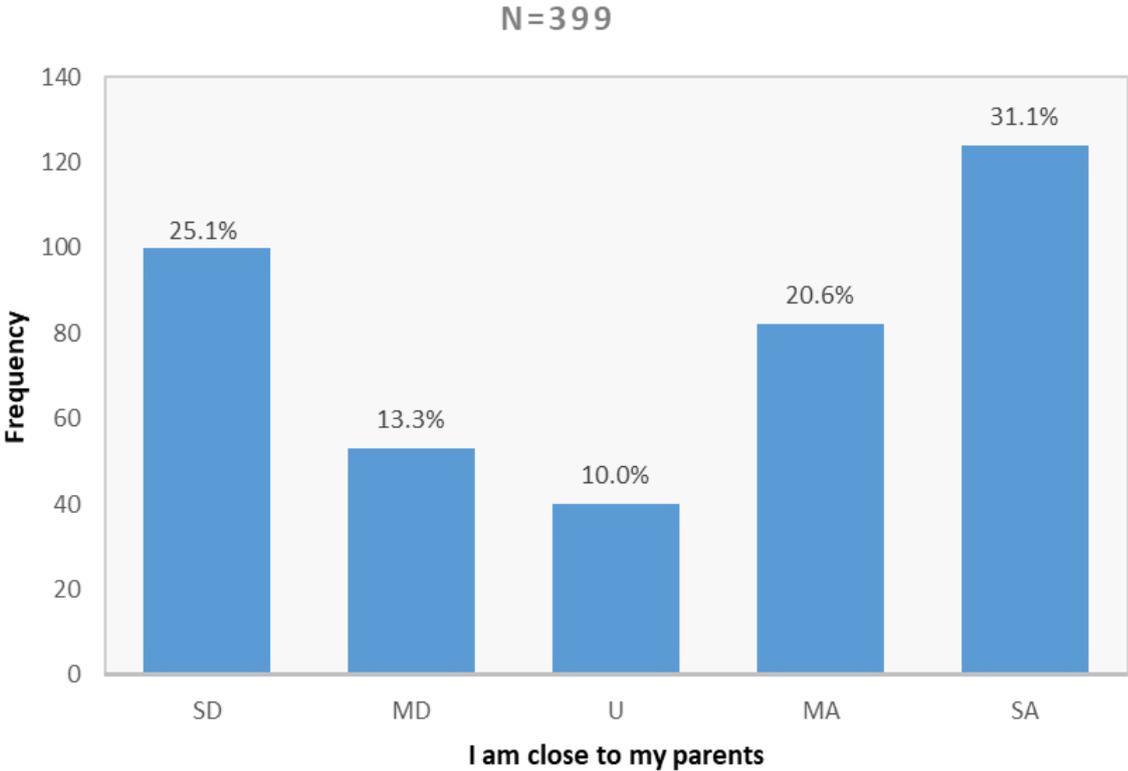


Figure 5. 1: Responses of “I am close to my parents” in Bungoma County, Kenya

Source: Field Data, 2018

Out of those who responded, 100(25.1%) strongly disagreed, 53(13.3%) mildly disagreed, 40(10%) were uncertain, 82(20.6%) mildly agreed while the remaining 124 (31.1%) strongly agreed. Majority of the respondents 51.7% agreed that they are close to their parents. However, the remaining 48.4 % disagreed they are close to their parents. The reason behind this could be due to the fact that their parents were ever drinking and thus the children tended to shy away from them.

Similar response was recorded from one of the interview schedule by the Children Officer who had the following opinion;

Most of the children with whom we interact confirm to us that they don't share their problems with their parents. They record that whenever their father in most cases comes home, he is harsh and drunk to a level they do not air out their grievances. Most of them end up making wrong decisions. It is the highest time parents should consider giving an ear to their children. Some are said to come home late at night when the children are asleep. In the morning they leave for school when the parents are still asleep. It is a big challenge to us to contain the situation owing to the fact that we don't stay with them.

Source: Field Data, 23rd January, 2017

According to the theory of Psychosocial Development by Erik Erickson, children who have a strong physical and emotional relationship with their parents, whose basic needs are met in a warm, loving and consistent manner develop trust, and hence become secure. Children of alcohol abusers are at greater risk of attention and conduct problems at school, repeating a grade, low academic performance, skipping school days, dropping out of school and low school bonding (Mylant *et al.*, 2002; Serec *et al.*, 2012). Poor academic performance may be linked in some way to prenatal exposure to alcohol due to maternal drinking. Fathers' drinking may have similar effects on children's school and educational outcomes.

Farrell, Barnes and Banerjee (2015) found that a father's problem drinking can be a chronic stressor and this environmental influence could account for poorer outcomes in children. In particular, having a father with a reputation as a problem drinker may place additional stress on the child, particularly when they reach adolescence, a period of increased sensitivity and anxiety. Alcoholic parents may be less encouraging of academic success in their children and may not place as much emphasis on academic achievement or provide supportive environments for their children's academic success. For example, they may not monitor children's activities at home regarding their schoolwork, homework and exam preparation because of their drinking patterns and associated behaviors.

According to present literature, children who live with parents who misuse alcohol report feeling socially excluded, isolated, frequently being left alone, not being loved and have feelings of low self-worth (Burke *et al.*, 2006). Furthermore, research studies indicate that children are less likely to drink when their parents are involved with them and when they and their parents report feeling close to each other. In addition to the information used from the Belfast Youth Development Study, 23 current service users aged 7-14 years shared their experiences of living with parental substance misuse in order to inform various aspects of the research process including research questions/hypotheses and recommendations for policy and practice. They spoke about the importance of getting support from significant adults; sharing their experiences with other children in similar circumstances; and the coping strategies

they found helpful including involvement in sports, music and art (Hawkins *et al.*, 2007).

Pearson correlation was done with other questions relating on closeness to parents on psychological development. From the research findings in Table 5.1, the respondents who were very close to their parents were negative on enjoying being on their own ($r = -0.139$, $p = 0.005$). This is to say that it is very hard for a child to be very close to the parents and still enjoy being on their own. I am close to my parents' had a positive relationship ($r = 0.159$, $p = 0.001$) with 'I am able to do things just like my age mates'. This indicates that for this study, most children valued the relationship with their parents.

The summary of the results are as shown in Table 5.1.

Table 5. 1: Correlation of Closeness to Parents with other Psychological Development variables in Bungoma County, Kenya

		1	2	3	4	5	6	Gender
1	Pearson	1	.065	-	-	.018	.159**	-.024
	Correlation			.139**	.057			
	Sig.(2-tailed)		.197	.005	.258	.722	.001	.629
	N	399	399	399	399	399	399	399

Key: 1= I am very close to my parents, 2= I never cry, 3= I enjoy being on my own, 4= I find myself worrying most of the time, 5= I have trouble keeping friends, 6= I am able to do things just like my age mates

Source: Researcher, 2018

5.2.2 Never crying among pupils

The respondents were asked to indicate whether they never cry. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where:

Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Figure 5.2.



N=399

Figure 5.2: Responses of never crying among Pupils in Bungoma County, Kenya

Source: Researcher, 2018

From the results in Figure 5.2 out of 399 respondents, 128(32.1%) strongly disagreed, 64 (16%) mildly disagreed, 43 (10.8%) were uncertain, 79 (19.8%) mildly agreed while the remaining 85 (21.3%) strongly agreed that they never cry. Majority of the respondents 235(58.9 %) disagreed they never cry. This implied majority of the respondents therefore cry in their lives. Ideally, children of alcoholics therefore have every reason to cry because of the frustrations that they undergo. According to Erik Erickson, children who have a strong physical and emotional relationship with their parents, whose basic needs are met in a warm, loving and consistent manner develop trust, and hence become secure.

From an interview schedule, one of the senior teachers reported the following;

It is very easy to identify a child whose parents drink all the time. They do not contain themselves, they easily break down in tears when asked anything. I am in charge of discipline in my school. Whenever teachers bring to me cases relating to pupils, I normally establish their background before I render punishment on them. It is technical since as a school, we try to contain all pupils. May be some have rough time with parents at home and we do not want to make their lives difficult in school as well.

Source: Field Data. September, 26th, 2016.

The research findings are in agreement with a study by Pathirana (2016) on child-parent relationships in Sri Lanka who found that majority of participants reported a happy, pleasant relationship, close bond and non-conflictive parent-child relationship. Further, the researchers indicated that adolescents who are engaged in a supportive and attentive relationship with their parents were very positive about their parents, but those with uncaring and distant relationships have negative attitudes towards their parents (Pathirana, 2016). Another study highlighted that since the parent-child connectedness is one of the major factors in adolescent health and risk-

taking behavior in Sri Lanka, addressing this is an immediate research need (Agampodi, *et al.*, 2008).

The current findings are also similar to those by Bronfenbrenner (1994), who affirms that adolescent behavior is significantly influenced by the micro-system of the family, with parents playing an important part. Adolescence is a time of transition for both parents and adolescents. On the one hand, adolescents should be given a room by parents to explore, develop and grow. On the other hand, since adolescents are still not fully mature, therefore parents are very important providing guiding and monitoring (Steinberg, 2001). Some studies recognized that adolescents model their alcohol behavior on their parents' patterns, context, and attitudes (Kam *et al.*, 2017; Loke & Mak, 2013; Mares *et al.*, 2011). Parent-child relationships such as parental engagement and parental attachment have been linked to adolescents' alcohol use in various studies, with attention paid to the individual elements of parental engagement such as monitoring, controlling and communication. (Bourdeau *et al.*, 2012; Ryan *et al.*, 2011). Since adolescence is a key period for developing patterns of substance use and abuse that can continue into adulthood, it is also the appropriate moment for prevention (Fraga *et al.*, 2011).

However, recent literature has it that children who live with parents who misuse alcohol report feeling socially excluded, isolated, frequently being left alone, not being loved and have feelings of low self-worth (Burke, Schdmied & Montrose 2006). Research studies indicate that children are less likely to drink when their

parents are involved with them and when they and their parents report feeling close to each other. The other questions were directly correlational although insignificant.

This was supported by an interview with one of the Senior Teachers who reported the following;

It is true that most of the children from alcoholic homes may not show openly that they are frustrated. Some of them shade tears in silence and are very bitter within them. Sometimes as human beings, we sympathize with them. We try our level best to guide them while in school. We are forced to go an extra mile to talk to their parents. We only hope one day these parents will change for the better.

Source: Field Data, October 20th, 2016

The study further carried out Pearson correlation on the question 'I never cry' with other questions on psychological development.

The results in Table 5.2 show that there is a statistically significant negative correlation between the statement 'I never cry' ($r = -0.1$, $p = 0.46$) with I enjoy being on my own. In other words, children who cry enjoy being on their own in families that have alcoholic parents.

The summary of the results is shown in Table 5.2.

Table 5. 2 : Correlation of respondents ‘I never cry’ with other aspects of Psychological Development in Bungoma County, Kenya

		1	2	3	4	5	6	Gender
2	Pearson Correlation	.06	1	-	-.013	.07	-.074	.078
		5		.100*		0		
	Sig.(2-tailed)	.19		.046	.795	.16	.142	.121
		7				5		
	N	399	399	399	399	399	399	399

Key: 1= I am very close to my parents, 2= I never cry, 3= I enjoy being on my own, 4= I find myself worrying most of the time, 5= I have trouble keeping friends, 6= I am able to do things just like my age mates

Source: Field Data, 2018

The findings are in line with a past study by Steinberg & Morris, (2001) on parent-adolescent relationships, adolescent problem behavior, puberty, the development of the self and peer relations which demonstrated that parental engagement with their adolescents could lead towards increasing competence and psychological well-being in adolescents’ lives and contribute to healthy adolescent psychosocial development. Parental engagement makes the child more receptive to parental influence, enabling more effective and efficient socialization. Those adolescents are less likely to engage in alcohol use (Steinberg, 2001).

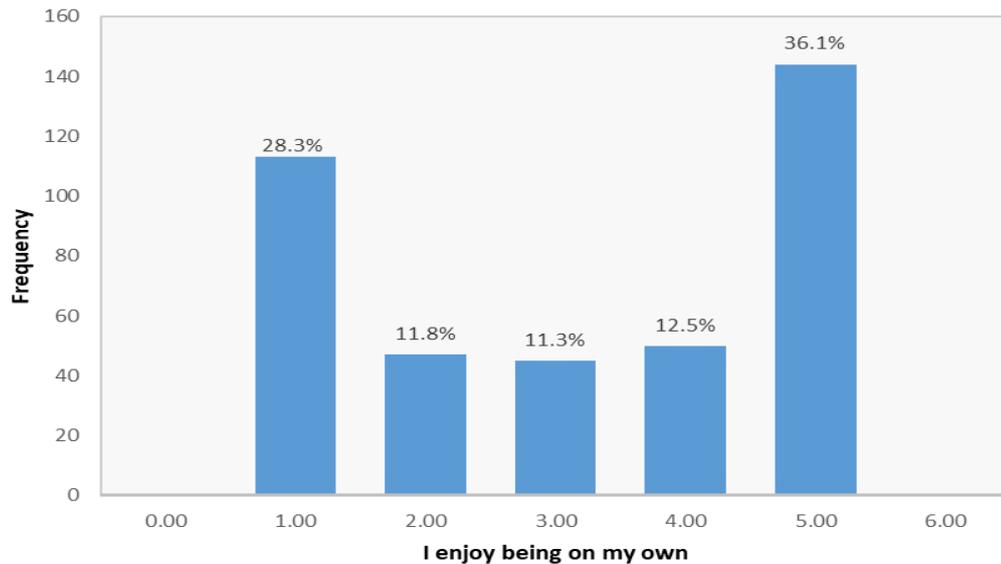
Separately, the research findings are in agreement with a qualitative study by Parvizy *et al.* (2005) who investigated adolescent perspectives on addiction. Their findings indicated that the parental influence is an important factor in developing a healthy

life-style for adolescents. One of the five themes that emerged from interviews with 41 adolescents in Tehran included the relationship between family, health and addiction. The study noted that this emerging theme contained three subthemes: parents as role models, parents as indifferent and hidden drug abuse.

Parvizy, *et al.* (2005) reported that participants perceived that exhausted parents, who hold several jobs, who do not understand their children's development needs and are completely out of touch with them, can be a major reason for adolescents' substance abuse. Overall results suggest that effective family relationships are important for adolescents to develop healthy lifestyles (Parvizy *et al.*, 2005). Parents engage using different parental strategies, styles, and approaches to support the development and health of adolescents. A comprehensive set of parenting strategies, styles and approaches have been identified through previous studies on parent-child relationships on alcohol initiation and alcohol use, with the key components of parental engagement being monitoring, controlling, and communication (Kao & Carter, 2013).

5.2.3 Enjoy Being on their Own among Pupils

The respondents were asked to indicate whether they enjoy being on their own. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Figure 5.3.



Mean = 3.16
 Std. dev = 1.673
 N = 399

Figure 5. 3: Descriptive Statistics of respondents ‘enjoying being on their own’ in Bungoma County, Kenya

Source: Field Data, 2018

From the results in Figure 5.3, out of 399 respondents, 144 (36.1%) strongly agreed they enjoyed being on their own, 50 (12.5%) mildly agreed, 45 (11.3%) were uncertain, 47 (11.8%) mildly disagreed while the remaining 113 (28.3%) strongly disagreed. The results indicate almost equal reaction in terms of the response. However, the response clearly indicated they enjoy being on their own to be higher if summed up with those who were uncertain. Karl Pearson correlation was carried out between the statement ‘I enjoy being on my own’ with other statements regarding psychological development and the results were summarized in Table 5.3.

Table 5. 3: Correlation of ‘I enjoy being on my own’ with other statement of Psychological Development of Pupils in Bungoma County, Kenya

		1	2	3	4	5	6	Gender
3	Pearson	-	-	1	.206**	.248**	-	-.091
	Correlation	.139**	.100*				.032	
	Sig.(2-tailed)	.005	.046		.000	.000	.530	.069
	N	399	399	399	399	399	399	399

Key: 1= I am very close to my parents, 2= I never cry, 3= I enjoy being on my own, 4= I find myself worrying most of the time, 5= I have trouble keeping friends, 6= I am able to do things just like my age mates

Source: Field Data, 2018

From the research findings, as summarized in Table 5.3, there was a negative relationship between the respondents who enjoyed being on their own were close to their parents

($r = -0.139$, $p = 0.005$). This indicates that children who enjoy being on their own are not close to their parents. Taken conversely, children who are close to their parents do not enjoy being on their own. This is true in real life situations where parent attachment is a buffer to any psychological distortions. Children of drinking parents are known to adopt a range of behaviors to cope with their situation, including detachment, avoid the drinking parent, keeping the problem a secret, switching off, blaming oneself or feeling guilty (Gilvary, 2005).

The findings concur with a study by Mares *et al.* (2011) that used a sample of 428 Dutch families including the father, mother and adolescents from two age groups who were surveyed three times in 5 years. The study used samples from families with at least two children aged 13-16 years. An alcohol-specific communication scale consisted of eight specific domains: negative consequences of use, peer pressure resistance, encouragement to choose non-drinking friends, media portrayal of alcohol, encouragement not to use, telling the adolescents not to use, and rules about use and discipline.

Problem drinking has been shown to have a major impact on the social life of families. Where a parent suffers alcohol dependence or problem drinking, spouses and children may be isolated and less able to obtain support from social and health care support systems. The value of community connectedness and social support for children is now recognized as a protective factor against the development of future problems (Gruenert *et al.*, 2004). Community connectedness and social support can assist in the development of children's pro-social skills, enhance supervision, and promote positive self-esteem (Gilligan, 2000; Fuller, 2001). Social isolation may therefore act as a risk factor for the maladjustment of children dealing with parental alcohol misuse.

Tunnard (2002) suggests that children of problem drinkers have little time for social activities because of the increased caregiving responsibilities and household duties they often take on. Children of problem drinkers may also experience a feeling of shame about their home circumstances (Boyd & Mackey, 2000), causing them to

distance themselves from other children and from adults such as teachers, who otherwise may be able to offer social support (Tunnard, 2002). Children of problem drinkers also report more difficulties with peer relationships including fewer friends to socialize with, lower confidence in making friends, and avoidance by both their peers, and the parents of peers who discourage friendships with such children (Tunnard, 2002). Additionally, house, school and neighbourhood moves are often common for families of problem drinkers, making it difficult for children to establish and maintain social connections and to engage with their communities. In one study it was found that children of parents with severe drug and alcohol problems had attended approximately two different schools, and moved house over five times by the average age of 7.4 years (Gruenert *et al.*, 2004). Extracurricular sporting and recreation activities can be a good source of social support for children; however, due to the financial strains often experienced by families dealing with parental problem drinking there may not be enough money to afford participation in these kinds of activities (Gruenert *et al.*, 2004).

Epidemiological data from the US such as the National Comorbidity Survey (NCS) a nationally representative household survey conducted in the US (N = 8,098), show that personality disorders also commonly co-occur with alcohol use disorders (Grant *et al.*, 2008; Helzer & Pryzbeck, 1988; Kessler *et al.*, 1997). The findings from the research data indicate that for those who met lifetime criteria for BPD, 58.3 per cent also met a lifetime diagnosis of an alcohol use disorder (Gianoli *et al.*, 2012). While the causal links or factors associated with these comorbid disorders is not well known, BPD traits are predictive of future problems with alcohol use, and poor

prognosis is observed for those with comorbid and alcohol use disorder compared to those with only one disorder (Gianoli *et al.*, 2012). Past 12-month alcohol dependence was reported in 18 per cent of cases and 50.7 per cent reported substance use in the past 12 months, with greater prevalence amongst men with BPD compared to women (Grant *et al.*, 2008). When comorbidity was controlled for, alcohol dependence remained significant but any association with alcohol abuse disappeared, suggesting that these associations may be accounted for by factors common to both disorders.

Similarly, parental antisocial personality disorder (ASPD) and trait characteristics also appear to be important in the relationship between parental alcohol dependence and family functioning. Zucker *et al.*, (1996) conducted a study in which alcohol-dependent fathers (N = 311) were subtyped according to whether they had a high-level history of antisocial behavior during both childhood and adolescence or no sustained history of antisocial behavior. The researchers hypothesized that family risk would be greatest when the parents' psychopathological risk structure had been in place across the lifespan. Results revealed that antisocial alcohol-dependent fathers have denser family histories of alcohol use disorders, lower intellectual functioning, and significantly higher levels of non-alcohol-related psychopathology compared to non-antisocial alcohol-dependent fathers. Antisocial alcohol-dependent parents were also shown to display more aggressive behavior and conflict, and were lower in socioeconomic status than were the non-antisocial alcohol dependent parents and the control group (Zucker *et al.*, 1996).

Moss, *et al.* (2001) compared mother-reported psychiatric disorders and problem behavior scores in pre-adolescent children with antisocial alcohol-dependent fathers, non-antisocial alcohol-dependent fathers, and children whose fathers were without either disorder (N = 639). Children from the antisocial alcohol-dependent group showed elevated rates of major depression, conduct disorder, attention deficit hyperactivity disorder (ADHD), oppositional defiant disorder and separation anxiety disorder when compared to both other groups of children. These children also had higher internalizing and externalizing problem behavior scores than the other two groups of children; there were no significant differences between children with non-antisocial alcohol-dependent parents and controls.

Hussong *et al.* (2007) integrated the analyses of two independent longitudinal studies (N = 1,050 adolescents and at least one or both of their parents), which used a high risk design to assess children with subtypes of alcohol-dependent parents; alcoholism only, alcoholism and depression, alcoholism and ASPD, and compared them with depressed parent-only controls on their externalizing behaviors, measured by the aggressive and delinquent behavior sub-scales on the Child Behavior Checklist and Youth Self Report. Consistent with the aforementioned findings, children whose parents were both diagnosed with alcohol disorders and those whose parents had comorbid alcohol use disorder and depression were found to exhibit greater externalizing symptoms than children whose parents were only diagnosed with depression. Hussong,*et al.* (2007) discussed this as evidence for an intergenerational susceptibility for developing antisocial characteristics with a risk of later development of adult alcoholism.

Psychosocial wellbeing is an important area of functioning that can be affected (both positively and negatively) by alcohol use. With regard to social/leisure functioning, there is fairly consistent evidence that older or elderly problem drinkers (both in and out of treatment) tend to have social/leisure problems in the form of loneliness and low social support (Schonfeld & Dupree, 1991), fewer social resources (Brennan & Moos, 1990), lower social integration (Hanson, 1994), lower satisfaction with social relationships (Meyers *et al.*, 1982), social isolation, and fewer satisfying leisure activities (Graham, Carver & Brett, 1995). A recent longitudinal study of 8,271 adolescents provided supporting evidence that drinking predicted lower socio-emotional and academic functioning (Crosnoe, Benner & Schneider, 2012). However, the authors emphasized that the social context of drinking is significant in the socio-emotional functioning of adolescents, whereby teen drinkers felt marginalized within schools with dense networks of low-rate drinking. However, the inverse relationship has also been found, where high socialization has found to be associated with increased drinking for male adolescents (Cumes-Rayner *et al.*, 1992). This finding is also relevant for adults, where expectations of social effects of alcohol and peer-network heavy drinking were significant predictors of both husbands' and wives' own heavy drinking (Leonard & Homish, 2008). Thus, it appears that the social context and expectancies of drinking rather than alcohol use per se are associated with negative impacts on individuals and families.

The low population density in rural Australia means that many of these Australians are faced with social isolation. Whilst the potential for social isolation is likely to vary between rural areas, individuals in these areas are at greater risk of social

isolation due to the barriers involved in getting together with others. NDSHS data from 2010 indicate that people living in remote or very remote areas were more likely to drink at high levels for lifetime risk (30.5 per cent compared to 18.6 per cent in major cities) and also for single occasion risk (25.8 per cent compared to 14.9 per cent in major cities) (AIHW, 2011).

Mares *et al.* (2011) found that parental alcohol problems were strongly associated with the frequency of parent-child alcohol-specific communication. Parents communicated more about alcohol with their children when they experienced problems due to their own drinking. When mothers communicated with their children about alcohol, this was associated with lower levels of adolescent alcohol related problems.

Respondents who enjoyed being on their own in this study also found themselves worrying most of the time ($r= 0.206$, $p= 0.000$). According to literature, children of alcoholic parents are known to experience a lot of distress due to the fact that the father is unavailable (Shankar, 2000). Respondents who enjoyed being on their own had trouble keeping friends ($r= 0.248$, $p=0.000$). Keeping on their own made friends also keep off their company.

The Guidance and Counseling teachers in one interview schedule reported that

In most cases, children who come from alcoholic parents, irrespective of their gender, always keep to themselves. They are not free with anybody. It is difficult to get through to them

Source: Field Data, October, 10th 2016

5.2.4 Worrying most of the time among pupils

The respondents were asked to indicate whether they worry most of the time. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Table 5.4.

Table 5. 4: Worrying most of the time among respondents in Bungoma County, Kenya

Response	Frequency	Percent	Cumulative Percent
SD	140	35.1	35.1
MD	29	7.3	42.4
U	18	4.5	46.9
MA	92	23.1	69.9
SA	120	30.1	100.0
Total	399	100.0	

Source: Field Data, 2018

The results in Table 5.4 show that out of 399 respondents, 140 (35.1%) strongly disagreed they do not worry most of the time, 29 (7.3%) mildly disagreed, 18 (4.5%) were uncertain, 92 (23.1%) mildly agreed while the remaining 120 (30.1%) strongly agreed. Majority of the respondents 222 (53.1%) agreed that they worry most of the time.

One of the Guidance and Counseling teachers in an interview schedule had the following to report;

Children of drinking parents or even those who stay with relatives who always drink, quite often like being on their own. Even when they are put them in groups, they will not contribute actively to the discussion. They are always quiet. It is hard for them to make new friends as well. They normally have a problem socializing with the rest of their peers.

Source: Field Data; September 23rd, 2016

Karl Pearson correlation was carried out between the statement ‘I worry most of the time’ with other statements regarding psychological development and the results are summarized in Table 5.5.

Table 5. 5: Correlation of worrying most of the time with other statements on psychological development among respondents in Bungoma County, Kenya

		1	2	3	4	5	6	Gender
4	Pearson	-	-	.206**	1	.212**	-.048	.049
	Correlation	.057	.013					
	Sig.(2-tailed)	.258	.795	.000		.000	.342	.325
	N	399	399	399	399	399	399	399

Key: 1= I am very close to my parents, 2= I never cry, 3= I enjoy being on my own, 4= I find myself worrying most of the time, 5= I have trouble keeping friends, 6= I am able to do things just like my age mates

Source: Field Data, 2018

From the research findings, as summarized in Table 5.5, respondents who worried most of the time also enjoyed being on their own ($r=0.206$, $p=0.000$). They may have been worried most of the time about the drinking parent, as to whether the parent would come back alive. The responsibilities that were left to the young children like

cooking for themselves or looking after younger siblings or the drunken parents may also cause them a lot of distress.

Worrying most of the time was statistically significant to having trouble keeping friends ($r=0.212$, $p=0.000$). According to teacher counselors, some of the children of drinking parents worry about their future and think that nobody understands them, so they keep off from their peers. These are the children requiring a lot of psychosocial assistance in order to face the future brightly.

5.2.5 Trouble keeping friends among Pupils

The respondents were asked to indicate whether they had trouble keeping friends. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1.

The results of Table 5.6 show that out of 399 respondents who participated in the study, 117 (29.3%) strongly disagreed they have trouble keeping friends, 33 (8.3%) mildly disagreed, 57 (14.3%) were uncertain or not sure, 104(26.1%) mildly agreed while the remaining 88 (22.1%) strongly agreed. Majority of the respondents 192 (48.2%) agreed they have trouble keeping friends. The results are summarized in Table 5.6.

Table 5. 6: Trouble keeping friends among pupils in Bungoma County

Response	Frequency	Percent	Cumulative Percent
SD	117	29.3	29.3
MD	33	8.3	37.6
U	57	14.3	51.9
MA	104	26.1	77.9
SA	88	22.1	100.0
Total	399	100.0	

Source: Field Data, 2018.

The same voice was echoed from an interview schedule by one of the Senior

Teachers who said that:

Of course you know children like playing at their tender age. However, in most cases, you will always find those from alcoholic background disagreeing with their friends. Hardly a week goes before I handle such cases. In fact it is very normal and you can always find out the effect they have from the parents who do not pay attention to them. In such a case, do you think they can keep any friendship? It is almost impossible.

Source: Field Data, September 23rd, 2016.

The same was echoed from the interview schedule from Class teachers and Guidance and Counseling teachers. The respondents had the following to say;

Children from drinking homes are unhappy with themselves; they lack attachment with their parents and personal basic needs. As a result, they see themselves as unique, different from other pupils and thinking that no one can understand them.

Source: Field Data, September 23rd, 2016.

Karl Pearson correlation was carried out between the statement ‘I worry most of the time’ with other statements regarding psychological development and the results were summarized in Table 5.7.

Table 5. 7: Correlation between ‘I have trouble keeping friends’ with other statements on Psychological development of Pupils from Alcoholic Parents in Bungoma County, Kenya

		1	2	3	4	5	6	Gender
5	Pearson	.018	.070	.248**	.212**	1	-	-.117
	Correlation						.038	
	Sig.(2-tailed)	.722	.1655	.000	.000		.453	.060
	N	399	399	399	399	399	399	399

Key: 1= I am very close to my parents, 2= I never cry, 3= I enjoy being on my own, 4= I find myself worrying most of the time, 5= I have trouble keeping friends, 6= I am able to do things just like my age mates

Source: Field Data, 2018

From the research findings, as summarized in table 5.7, there was a statistically significant correlation between the statement ‘ I have trouble keeping friends’ with ‘I enjoy being on my own’ ($r=0.248$, $p=0.000$) and ‘I find myself worrying most of the time’ ($r=0.212$, $p= 0.000$).

According to Erik Erickson, children whose basic needs are not met in a warm, loving and consistent manner develop mistrust and hence become insecure, are anxious, are likely to become antisocial, unable to make friends and unable to cooperate with others.

5.2.6 Doing things Like Age Mates among Pupils

The respondents were asked to indicate whether they are able to do things like their age mates. The respondents who participated in the study were asked to give their

opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Figure 5.4.

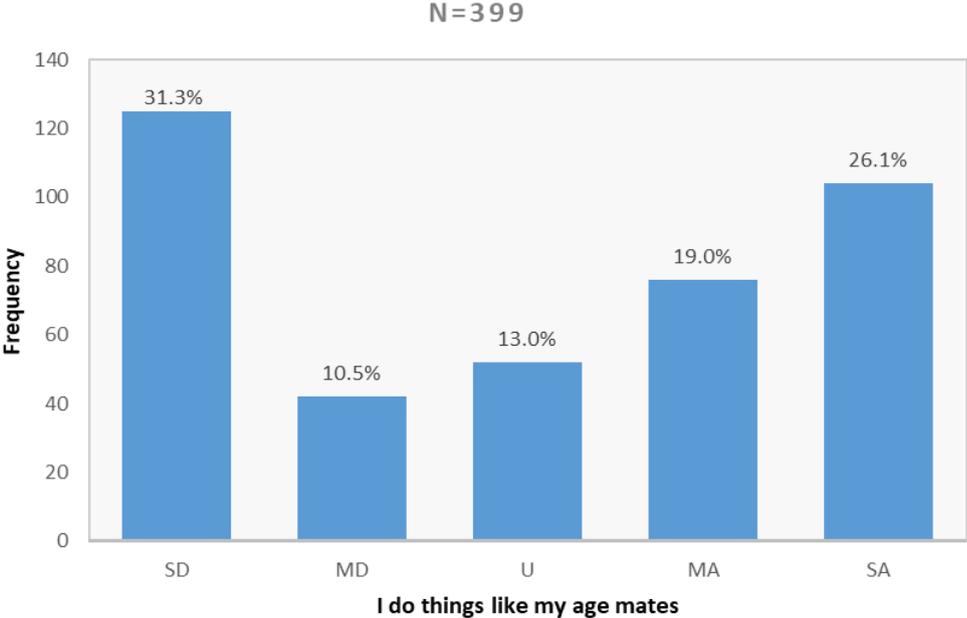


Figure 5. 4: Descriptive results of respondents doing things like age mates in Bungoma County, Kenya

Source: Field Data, 2018

From the results in Figure 5.4, out of 399 respondents who participated in the study, 104(26.1%) strongly agreed they do things like their age mates, 76 (19%) mildly agreed, 52 (13%) were uncertain, 42 (10.5%) mildly disagreed while the remaining 125 (31.3 %) strongly disagreed. The response raised mixed reactions from the response as opposed to other questions. However, it is worthy to note that 180 (45.1%) of the respondents agreed they do things like their age mates.

The same view was generated from the interview schedule by the Children Officers.

One of the respondents had the following to say;

If you want to know a child who comes from a background where parents drink, give him or her a task, with other children in a group, in most cases, they will either finish last or they will hardly attempt. If you ask them why, they will not respond as well. Some can even start crying, isolate themselves from the rest and keep off completely. In other words, you don't need any other test. That is enough.

Source: Field Data, January 30th, 2017.

The study further carried out Pearson correlation between the statement 'I am able to do things like my age mates' with other statements on psychological development and the results were as shown in Table 5.8.

Table 5. 8: Correlation of 'I am able to do things like my age mates' and other statements on psychological development among pupils of alcoholic parents in Bungoma County, Kenya

		1	2	3	4	5	6	Gender
6	Pearson	.159**	-.074	-.032	-.048	-	1	-.020
	Correlation					.038		
	Sig.(2-tailed)	.001	.142	.530	.342	.453		.690
	N	399	399	399	399	399	399	399

Key: 1= I am very close to my parents, 2= I never cry, 3= I enjoy being on my own, 4= I find myself worrying most of the time, 5=I have trouble keeping friends, 6= I am able to do things just like my age mates

Source: Field Data, 2018

Results as summarized in Table 5.8 indicated that there was a statistically significant correlation between the statement 'I am able to do things just like my age mates' with 'I am close to my parents' ($r=0.159$, $p=0.001$). Being able to do things just like

my age mates is a sign of positive self-esteem. This means that the respondents who were close to their parents drew strength from their relationship, and were able to go through psychosocial development successfully. Further, the respondents who were close to their parents were negative ($r = 0.139$, $p=0.000$) on enjoying being on their own as previously stated. This is true in real life situations where parent attachment is a buffer to any psychological distortions. The respondents who were close to their parents were also 'able to do things just like my age mates' with ($r=0.159$, $p=0.000$). This is an indication of high self-esteem which is generated by the attachment to their parents.

According to Erik Erickson, a child who is given opportunities to experience success and mastery develops a feeling of superiority and is happier than other children and is motivated to want to achieve in social life. The strong emotional relationship that is warm, loving and consistent between a child and the parent makes the children learn to trust him and become secure. Later in life, the child is motivated to initiate own plans and engage in more initiatives. The success in these initiatives makes the child happier with feelings of superiority.

The respondents who enjoyed being on their own had 'trouble keeping friends' with significance ($r= 0.248$, $p=0.000$) and they found themselves worrying most of their time with $r=.206$. Research indicates that children whose parents drink exhibit behaviors such as lack of friends and withdrawal from friends (Brooks, 2004; Burke, Schmied & Montose, 2006). Similarly, the respondents who worried most of the time had trouble keeping friends with significance $r=.212$ and enjoyed being on their own.

The respondents who were able to do things just like their classmates had positive relations with their parents of significance ($r=0.159$, $p=0.000$).

This is in line with studies that indicated that children who grow up without a caring parent and who are always on their own because of a parent's absence due to drinking become emotionally stunted (Shankar, *et al.*, 2000).

5.3 Gender and Psychological Development among Pupils

From the six statements, the study conducted Karl Pearson correlation between the statement and gender to establish whether there existed any statistical significant association with psychological development. The results were summarized in Table 5.9.

Table 5. 9: Correlation between Gender and Psychological Development among Pupils of Bungoma County, Kenya

Statements on Psychological Development	Pearson r value	Gender Sig.(2-tailed)P value
I am very close to my parents	-0.024	0.629
I never cry	0.078	0.121
I enjoy being on my own	-0.091	0.069
I find myself worrying most of the time	0.049	0.325
I have trouble keeping friends	-0.117	0.060
I am able to do things like my age mates	-0.020	0.690

Source: Field Data, 2018

The results in Table 5.9 show that the statement 'I am very close to my parents' had no statistically significant correlation with gender given that $r = -0.024$, at $p = 0.629$. The same scenario is seen in other statements whose p values were above 0.05 in all the cases. This therefore implied that there was no significant relationship between psychological development and gender in this study. This is to say that both sexes were equally affected by a parent's drinking.

The study used chi square to determine the degree of association between the pupils psychological development and parental alcoholism. From the findings, chi square value $\chi^2 = 13.112$ at $p = 0.05$ was recorded. This value was significant, which implied that pupil's psychological development is significantly affected by parental alcoholism.

5.4 Parental Alcoholism and Social Development of Primary School Pupils

The respondents were to respond to various questionnaire items on the subject regarding social development in a home of alcoholic parents. The findings are discussed in the following subsections.

5.4.1 Trouble keeping mind on studies among Pupils

The respondents were asked to indicate whether they had trouble keeping their mind on studies. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Figure 5.5

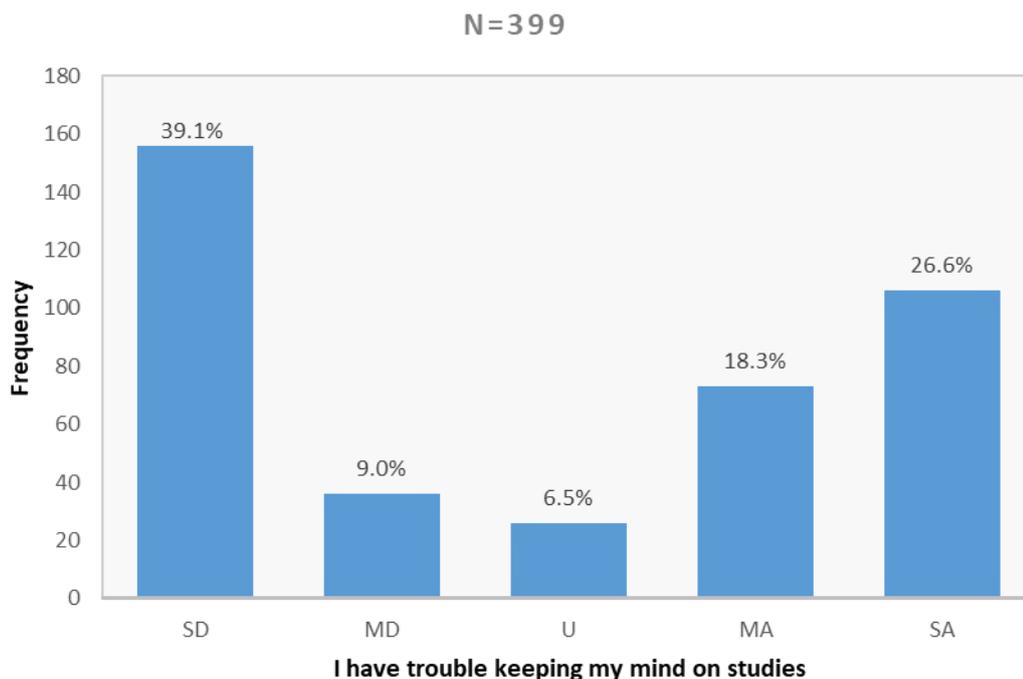


Figure 5. 5: Trouble keeping mind on studies among respondents in Bungoma County, Kenya

Source: Field Data, 2018

Results in Figure 5.5 show out of 399 respondents who participated in the study, 106(26.6%) strongly agreed they have trouble keeping their mind on studies, 73(18.3%) mildly agreed, 26(6.5%) were uncertain, 36(9%) mildly disagreed while the remaining 156(39.1%) strongly disagreed. Majority of the respondents 297 (74.5%) agreed. The research findings show that a sizeable number of respondents had trouble keeping their mind on studies.

A member of the parents/teachers committee in the interview schedule reported that:

I don't know how some of these children manage to pass examinations, most of the time they appear as if they are daydreaming, they are absent minded. Some are already initiated into sex with older men as they assist their parents sell *chang'aa*. How can such a learner keep her mind on studies?

Source: Field Data, January 25th, 2017

The study further carried out correlation between the statements ‘I have trouble keeping my mind on studies’ with other statements regarding social development.

Summary of the results was as shown in Table 5.10.

Table 5. 10: Correlation of having trouble keeping mind on studies with other social development questions among respondents of Bungoma County, Kenya

		1	2	3	4	5	6	Gender
1	Pearson correlation	1	.271**	.093	.047	-	-	-.001
	Sig.(2-tailed)		.000	.064	.352	.409	.795	.977
	N	399	399	399	399	399	399	399

Key: 1= I have trouble keeping my mind on studies, 2= I go out of school without permission, 3= I drink chang’aa, 4= I can tell lies, 5= my parents are very strict, 6= I eat at specific times at home

Source: Field Data, 2018

The results summarized in Table 5.10 show the statement ‘ I have trouble keeping my mind on studies’ positively correlates with the statement ‘ I go out of school without permission’ given $r= 0.271$ at $p=0.000$. Studies support this fact that in homes where parents drink, their children exhibited the following behaviors: school failure, truancy and school dropout (Brooks, 2004).

Other studies have examined the association between relationship breakdown and per capita alcohol consumption (Lester, 1997; Caces *et al.*, 1999). Lester (1997) conducted a time series analysis of data from the US and Europe between 1950 and 1972 and found that among seven of the eight nations studied, the more alcohol consumed per capita, the higher the divorce rate. Caces *et al.*, (1999) examined the

per capita consumption of alcohol in the US between 1934 and 1987. Results there indicated that a consumption increase of one litre of alcohol per capita brought about a 20 per cent increase in the divorce rate. Reciprocally, an increase of 1/1000 in the divorce rate also led to a 10 per cent increase in alcohol expenditure (Caces *et al.*, 1999). These results provide support for the notion that a bidirectional influence may exist between alcohol consumption and divorce rates. This in turn reflected on children's' psychosocial development.

A number of longitudinal studies conducted internationally have examined the relationship of alcohol use specifically to separation and divorce. Wilsnack *et al.*, (1991) compared 143 problem drinkers and 157 non-problem drinkers in a female sample over a five-year period. Results indicated that the relationship between alcohol use and divorce or separation was moderated by problem drinking status at baseline. Among non-problem drinkers, higher average consumption and frequency of intoxication at baseline were related to separation and divorce across time. Interestingly, divorce or separation was found to predict lower levels of subsequent alcohol dependence among problem drinkers. These results suggest that separation and divorce were more likely to follow, than precede, heavier drinking in women (Wilsnack *et al.*, 1991).

Power and Estaugh (1990) examined a large (N = 9,337) representative cohort of young people in Great Britain and found that partnerships among heavy drinkers were relatively unstable. Examination of drinking levels at ages 16 and 23 indicated that relationship breakdown was common in young men and women who had been

heavy drinkers at both time points and among those increasing consumption between adolescence and early adulthood. The direction of effect could not be established because the temporal sequencing of partnership breakdown and heavy drinking was not clear over the seven-year period (i.e. difficult emotional relationships and excessive drinking may occur simultaneously). However, relationship breakdown was confounded by other factors including economic status, housing tenure, and having children. In a later follow-up of the cohort, Power, Rodgers and Hope (1999) examined the relationship between heavy alcohol consumption and marital status at age 23 and 33 (N = 11,405). The study found that 23-year-old heavy drinkers were not significantly more likely to divorce than those who did not drink heavily. However, marital separation was accompanied by short-term increases in heavy drinking, suggesting that alcohol may be used as a temporary means of coping with relationship breakdown and its concomitants (Power and Estauth, 1990).

Teesson, *et al.*, (2010) examined the prevalence of comorbidity between alcohol use disorders and anxiety disorders using the 2007 NSMHWB data. Australians with an alcohol use disorder were found to be almost three times more likely to be diagnosed with an anxiety disorder than those without an alcohol use disorder and 3.5 per cent of the sample met criteria for combined affective, anxiety and substance use disorder (Teesson, Slade & Mills, 2009). The odds of agoraphobia and obsessive-compulsive disorder were both significantly increased in respondents with an alcohol use disorder. Burns and Teesson (2005) reported that the co-occurrence of alcohol dependence and anxiety-related disorders such as posttraumatic stress disorder, panic

disorder and social phobia was related to both increased severity of alcohol dependence symptoms and increased treatment seeking.

An Australian private hospital drug and alcohol treatment sample (N = 104) revealed that comorbid disorders were not significantly related to treatment attendance or self-report measures of substance use. 92 per cent of the sample met diagnoses for at least one other mental disorder, including major depression, generalized anxiety, and borderline personality disorder (BPD). Further evidence indicates that it was the severity of depression symptoms at the nine-month follow-up which significantly predicted fewer days abstinent from substance use in the past 30 days (Dingle & King, 2009). Conversely, substance use has also been shown to increase the risk of affective disorders. A meta-analysis of 17 published studies revealed that substance-using women reported significantly higher rates of postpartum depression than control subjects, indicating that prenatal substance use predicted postpartum depression symptoms. However, the authors acknowledge that this relationship may be mediated by other socio-demographic risk factor (Ross & Dennis, 2009).

While there has been consistent support for the relationship between anxiety disorders and alcohol use disorders, these datasets offer conflicting evidence for the relationship between alcohol use and affective disorders. The 2007 NSMHWB study found that those diagnosed with an alcohol use disorder were no more likely than the rest of the sample to meet criteria for a comorbid affective disorder such as depression or bipolar disorder (Teesson *et al.*, 2010). In contrast, the previous survey in 1997 found that those with an alcohol use disorder were four times more likely to

have an affective disorder. The cross-sectional nature of these epidemiological studies means it is difficult to determine why these results differ. These conflicting results may be attributed to changes in the comorbidities of these disorders over time, or they may also suggest increased efficacy of treatment for those with affective disorders, but not for those with anxiety disorders (Burns & Teesson, 2002).

Locke and Newcomb (2003) conducted a 16-year prospective study of women (N = 305) using a community sample in which alcohol use was identified as a significant predictor of marital dissatisfaction. The study also found that comorbid alcohol involvement and dysphoria during young adulthood was a stronger predictor of relationship maladjustment in adulthood than either alcohol involvement or dysphoria alone.

Other evidence suggests that the predictive relationship between marital dissatisfaction and problem drinking may be bi-directional. In several prospective studies, marital functioning has been shown to predict the likelihood of relapse and time to relapse among people in treatment for alcohol dependence (Maisto, McKay & O'Farrell, 1998; O'Farrell *et al.*, 1998). Moreover, in a community study of 1,675 married couples in the US, baseline marital dissatisfaction was prospectively associated with a diagnosis of alcohol abuse or dependence at the 12-month follow-up (Whisman *et al.*, 2006). Both male and female spouses who were dissatisfied with their marriage at baseline were 3.4 times more likely to have a diagnosis of alcohol use disorder at follow-up than satisfied spouses, after controlling for demographic variables and history of alcohol use disorders. However, the generalizability of the

findings is limited because only 14 people met criteria for current alcohol use disorder at follow-up (Whisman *et al.*, 2006).

Leonard & Homish (2008) followed up a sample of 634 couples at their first- and second year anniversaries using prospective time-lagged analyses and found that decreased marital satisfaction was associated with discrepant heavy drinking. This refers to reported differences between marital partners in their frequency of drinking to intoxication and in the frequency of heavy drinking of six or more drinks. These authors reported in an earlier study that greater levels of marital satisfaction usually occurred when partners drank together at similar quantities and frequencies (Leonard & Homish, 2008). A later follow-up of this cohort revealed that among those with high marital satisfaction, marriage is associated with a decline in drinking behaviors and reduced risk for alcohol problems. For those who continued to display heavy drinking and alcohol use problems up to four years after marriage, the identified predictive factors were pre-existing alcohol problems and heavy drinking prior to marriage, antisocial characteristics, and family history of alcohol abuse, negative effect, and alcohol expectancies. Such a state of affairs puts children at risk of developmental disorders (Leonard & Homish, 2008).

Data also suggest that congruence between partners in drinking behaviors may positively influence marital satisfaction. Floyd *et al* (2006) studied individually rated positive and negative marital behaviours in 132 couples, comparing alcohol-dependent and nondependent combinations of husbands and wives. They also examined the influence of antisocial behavior in the husband, noting that the

comorbid prevalence of alcohol use disorders in those with antisocial personality disorder was 74 per cent (Floyd *et al.*, 2006). They found that irrespective of the alcohol dependence status of the wife, more hostile behaviors occurred in relationships where the husband had antisocial behaviors and was alcohol dependent. However, there were a greater proportion of positive behaviors when alcohol dependence was congruent, i.e. where either both of the spouses or neither of the spouses had a diagnosis related to alcohol use (Floyd *et al.*, 2006).

Supporting the notion of the relevance of matched drinking behaviors, a large and representative longitudinal study (N = 4,589) conducted in the US between 1992 and 2000 found that discrepant drinking levels rather than actual drinking levels in partners were predictive of marital dissolution. This study also found that history of problem drinking by either spouse was not associated with an increased risk of divorce (Ostermann *et al.*, 2005).

A large body of research has been dedicated to understanding the relationship between alcohol use disorders and intimate partner or marital violence. A strong relationship has consistently been identified between male-perpetrated intimate partner violence and alcohol problems (Finney, 2004; Heyman, O'Leary & Jouriles, 1995; Holtzworth-Munroe *et al.*, 1997; Leonard & Jacob, 1988; Leonard & Senchak, 1993; Quigley & Leonard, 2000). Maritally violent men are significantly more likely than a wide variety of comparison groups to abuse alcohol (Holtzworth-Munroe *et al.*, 1997). Physically aggressive episodes have been shown to be four times as likely as verbally aggressive episodes that involve a husband's drinking (Quigley & Leonard, 2000; Testa, Quigley & Eiden, 2003). These episodes are also more likely

to result in injury to the victim and consequent reporting to the police if the partner was drinking at the time of the incident (Thompson & Kingree, 2006). In Australia, alcohol is involved in around 50 per cent of domestic and sexual violence cases (English *et al.*, 1995).

The Australian component of the International Violence against Women Survey found that some 35 per cent of women recalled their partners being under the influence of alcohol on the last occasion of partner violence. The survey also found that women whose husbands got “drunk a couple of times a month or more” were three times more likely to experience domestic violence than women whose partners drank less (Mouzos & Makkai, 2004).

Treatment studies provide further evidence of a link between alcohol abuse and intimate partner violence. These studies indicate that marital violence is overrepresented among individuals seeking treatment for alcohol use disorders, and reciprocally, that alcohol abuse is overrepresented among individuals seeking treatment for domestic violence. Among men entering treatment for alcohol dependence in the United States, the annual prevalence of partner violence is 50 to 70 per cent, and the prevalence of severe, potentially injurious violence is 20 to 30 per cent. These rates are four to eight times higher than the prevalence statistics for demographically similar non-alcohol-dependent men (O’Farrell & Murphy, 1995; O’Farrell *et al.*, 2003). Another study found that around 40 per cent of men in treatment for partner violence report a current diagnosis of alcohol use disorder. According to the study, the odds of any male-to-female aggression were more than

eight times higher on days when men drank than on days of no alcohol consumption. Similarly, the odds of severe male-to-female physical aggression were more than 11 times higher on days of men's drinking than on days of no drinking (Fals-Stewart, 2003).

A study examined the relationship between proximal alcohol consumption and intimate partner violence in a clinical sample of alcohol-dependent men. Results indicated that alcohol consumption was present prior to both psychological and physical aggression, yet the quantity of alcohol consumed by the husband was significantly higher prior to violent conflicts. Not only was alcohol present during the vast majority of conflicts for this sample, but alcohol was also a very common topic of conflicts, reported by over half of the respondents for both violent and non-violent conflict events (Murphy *et al.*, (2005).

There is some evidence that female victims of male-perpetrated violence are more likely to be dependent on alcohol than non-victims (Miller, Wilsnack & Cunradi, 2000). Women who report regular alcohol use or abuse have been shown to be between 2.2 and 3.4 times more likely to be physically abused by their intimate partners than non-drinkers (Grisso *et al.*, 1999; El-Bassel *et al.*, 2000). An Australian study of 267 substance-dependent women found that 59 per cent (138 women) had experienced any physical or sexual assault as an adult, and 81 of these women had been sexually or physically assaulted by their partners. Of those women who were assaulted by a partner, 24 per cent reported they were intoxicated at the time of the assault and 59 per cent reported their partner was under the influence of alcohol or

other drugs (Swift, Copeland & Hall, 1996). Leonard (1993) identified associations between wives' excessive alcohol consumption and their husbands' violence; however, after controlling for husbands' alcohol consumption, the relationship was no longer significant. In another study of newlywed couples, wives' heavy drinking did not emerge as a significant predictor of husband aggression (Leonard, 1993). Taken together, there is mixed evidence for a relationship between female heavy drinking and male-perpetrated physical violence.

Other research has examined whether women's drinking is related to their own use of physical aggression toward their partners. One US study found that couples who reported any female alcohol-related problems were at significantly greater risk for female-to-male violence than couples who reported no alcohol-related problems (Cunradi *et al.*, 1999). A secondary analysis of a national survey of youths aged 17 to 21 years (N = 808) found that there was a stronger relationship between heavy drinking and fights after drinking in females than in males (Wells *et al.*, 2007). Another study conducted in the US found that among perpetrators of domestic violence and irrespective of racial background, 15 to 22 per cent of women who perpetrate violence against their partners reported drinking at the time of the event. These findings suggest that alcohol may also increase the risk for female-to-male physical aggression in women who drink heavily. Taken together, there is evidence of an association between alcohol use and domestic violence, and that the level of alcohol use relates to the level of violence (Caetano *et al.*, 2001).

5.4.2 Going out of school without permission among Pupils

The respondents were asked to indicate whether they go out of school without permission. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Table 5.11.

Table 5. 11: Descriptive Statistics of Going out of School without Permission among Pupils in Bungoma County, Kenya

SA		MA		U		MD		SD		TOTAL	
N	%	N	%	N	%	N	%	N	%	N	%
78	19.5	34	8.5	36	9.0	37	9.3	214	53.2	399	100

Source: Field Data, 2018

The results in Table 5.11 reveal that out of 399 respondents, 78 (19.5%) strongly agreed they go out of school without permission, 34 (8.5%) mildly agreed, 36 (9%) were undecided, 37 (9.3%) mildly disagreed, while the remaining 214 (53.2%) strongly disagreed. From the research findings, it was evident over 100 respondents went out of school without permission.

Upon carrying out Pearson correlation between the statement ‘I go out of school without permission’ and other statements on social development, the findings were as summarized in Table 5.12.

Table 5. 12: Correlation of the statement “Going out of school without permission” with other social development statements among respondents of Bungoma County, Kenya

		1	2	3	4	5	6	Gender
2	Pearson	.271**	1	.136**	.149**	-.195**	.010	.082
	correlation							
	Sig.(2-tailed)	.000		.006	.003	.000	.849	.101
	N	399	399	399	399	399	399	399

Key: 1= I have trouble keeping my mind on studies, 2= I go out of school without permission, 3= I drink alcohol, 4= I can tell lies, 5= my parents are very strict, 6= I eat at specific times at home

Source: Field Data, 2018

From the research findings summarized in Table 5.12, the respondents who were pupils in this study, and who went out of school without permission, had trouble keeping their mind on studies ($r=0.271$ at $p=0.000$). This could be as a result of school failure, or the challenges being faced at home, including taking care of younger siblings. Similarly, those respondents who went out of school without permission were found to drink alcohol ($r=0.136$, $p=0.006$). A study of 13-19 year olds from South Africa found that when parents used alcohol frequently, their adolescents had an increased likelihood of exposure to alcohol-risk related behaviors (Hoque & Ghuman, 2012) like going out of school without permission, and taking too long to complete their studies or dropping out of school completely.

Furthermore, the respondents who went out of school without permission had a negative correlation with (r=- 0.195, p=0.000) with parents being very strict. This indicates that in homes where parents were drinking and were very strict, they enforced rules for appropriate behavior.

Past studies reveal that families where one or both parents abuse alcohol are more likely than others to include yelling, insults and serious arguments between family members, making the home an unstable environment for children (Kumpfer & DeMarsh, 1985; Sher, 1991). As part of the 2002 NSDUH, data were collected from 68,126 respondents on the number of children in the US living with substance-abusing or substance-dependent parents. Results indicated that parents dependent on or abusing alcohol in the past year were significantly more likely to report household turbulence than parents who did not have an alcohol use disorder (SAMHSA, 2004). This household turbulence was defined as frequent insults, yelling, serious arguments and threats of physical violence. In Scotland, 2.5 per cent of children (N = 24,302) are estimated to live in households where violence had occurred after the perpetrator had been drinking, and 1.2 per cent of children (N = 11,665) witnessed these acts of violence (Manning *et al.*, 2009).

Studies have also shown that children as young as six expect more verbal and physical aggression by an adult towards his/her spouse when the adult is thought to be intoxicated versus sober (El-Sheikh & Elmore-Staton, 2007). Exposure to family violence has been shown to have a range of effects on children's development, with

both age and gender of the child being important; outcomes may include poor sleep and health, externalising and aggressive behaviours, and internalising behaviours and depression (Dawe *et al.*, 2007).

Whilst these studies suggest that family violence may be a common feature of family life for individuals affected by alcohol use disorders, much of the current Australian research on problem drinking and family violence has focused on Indigenous and Torres Strait Islander Australians and their experiences. Non-Indigenous studies on family violence have tended to focus on intimate partner violence and child abuse, and are covered elsewhere in this review. The term family violence is often used by Indigenous people to refer to a broader experience of violence than implied by the term intimate partner violence (Stanley *et al.*, 2003). This broader experience includes physical forms of violence, complemented by non-physical forms such as social, verbal, economic and psychological violence. This also includes a broader range of potential perpetrators and victims, including, for example, aunts, uncles, cousins, extended family members and the community more generally (Blagg, 2000). This definition reflects the fact that within Indigenous culture the victims and perpetrators of family violence may be an individual or a group, and that the term 'family' means 'extended family' which covers a network of interconnected and transgenerational kinship relationships (Memmott *et al.*, 2001).

Reviews of family violence in Indigenous communities have shown that the incidence of violence is disproportionately high when compared with non-Indigenous communities, and that rates of violence are both escalating in frequency

and becoming more serious in nature (Memmott *et al.*, 2001). In 2002, the National Aboriginal and Torres Strait Islander Social Survey (NATSISS, N = 9,359) found that 21 per cent of Indigenous Australians aged 15 years and over reported that they felt family violence was a particular problem in their community; family violence was seen as more of a problem in remote areas and in overcrowded dwellings (ABS, 2004). Snowball and Weatherburn (2008) used this same dataset to reveal that within the Indigenous population, high-risk alcohol consumption doubles the rate of victimization more than any other single factor, from 10.1 per cent to 20 per cent. Additional risk factors increased the likelihood of alcohol-related violence, such as being a member of the stolen generation or exposure to financial stress, unemployment, family breakdown and geographic or housing mobility (Snowball & Weatherburn, 2008). Family violence in Indigenous communities is also often disproportionately directed towards women, with Indigenous women 34 times more likely to be hospitalized for assault-related injuries than non-Indigenous women (Bryant, 2009). Although some communities appear to be less violent than others, Aboriginal and Torres Strait Islander women from all communities identify violence as one of their greatest worries, and for many of these women this violence was associated with alcohol consumption by the offender (Bolger, 1991).

The 2004 NDSHS (N = 463) found that approximately 38 per cent of urban Indigenous Australians reported being victims of alcohol-related verbal abuse and 13 per cent were victims of physical abuse (Al-Yaman, Van Doeland & Wallis, 2006). Moreover, approximately 41 per cent of substance-related verbal abuse and nearly 20 per cent of substance-related physical abuse experienced by Indigenous people was

reported as being perpetrated by relatives of the victims (Al-Yaman *et al.*, 2006). Rates of Indigenous spouse or partner homicides are 13 times more likely to be alcohol-related than non-Indigenous intimate partner homicides (Dearden & Payne, 2009). Research indicates that within these communities alcohol is a common factor which exacerbates the seriousness of the conflict, rather than being the cause of violence (Memmott *et al.*, 2001).

In their meta-analyses of the literature on family violence in Indigenous communities, Blagg (1999) and Memmott (2001) both identified multi-causal models in which alcohol was one of numerous situational factors underlying family violence. It has been suggested that the link between alcohol misuse and violence in Indigenous communities is related to the concepts of disinhibition, behavioural expectancies and 'allowing' violence to occur by providing a socially accepted excuse for it, rather than being a direct causal mechanism (Hennessy & Williams, 2001). For example, an individual may try to explain away antisocial behaviour by using phrases such as: "I was drunk, I couldn't help it", "I didn't know what I was doing", or "I don't remember" (Bolger, 1991; Memmott *et al.*, 2001). In support, Australian research indicates that Indigenous offenders are significantly more likely to attribute their offending to alcohol than non-Indigenous peers (Putt, Payne & Milner, 2005). Whilst family violence and problem alcohol use appear to be particular problems in Australian Indigenous communities, one is not a sufficient or necessary cause of the other. This is evident by the fact that not all Indigenous people who use alcohol become violent; while violence continues to occur in many alcohol-free Indigenous communities (Memmott *et al.*, 2001).

5.4.3 Drinking Alcohol among Pupils

The respondents were asked to indicate whether they drink alcohol. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Table 5.13.

Table 5. 13: Descriptive Statistics of drinking alcohol among pupils in Bungoma County, Kenya

SA		MA		U		MD		SD		TOTAL	
N	%	N	%	N	%	N	%	N	%	N	%
34	8.5	18	4.5	34	8.5	35	8.8	276	69.2	399	100

Source: Field Data, 2018

The results in Table 5.13 show that out of 399 respondents who participated in the study, 34 (8.5%) strongly agreed they drink alcohol, 18 (4.5%) mildly agreed, 34 (8.5%) were uncertain, 35 (8.8%) mildly disagreed while the remaining 276 (69.2%) strongly disagreed. From the findings, over 50 respondents agreed that they drink alcohol. This could be due to the fact that their parents also drank alcohol and thus their children modeled their behavior.

Further, the study performed Pearson correlation between the statement ‘I drink alcohol’ with other statements on social development. The findings were summarized in Table 5.14.

Table 5. 14: Correlation of ‘I drink alcohol’ with other statements on social development among Pupils in Bungoma County, Kenya

		1	2	3	4	5	6	Gender
3	Pearson	.093	.136**	1	.166**	.054	-	.011
	correlation						.080	
	Sig.(2-tailed)	.064	.006		.001	.284	.113	.833
	N	399	399	399	399	399	399	399

Key: 1= I have trouble keeping my mind on studies, 2= I go out of school without permission, 3= I drink alcohol, 4= I can tell lies, 5= my parents are very strict, 6= I eat at specific times at home

Source: Field Data, 2018

From the research findings in Table 5.14, the respondents who drank alcohol also went out of school without permission ($r=0.136$, $p= 0.006$) and told lies ($r=0.166$, $p=0.001$). Literature supports the view that parental alcohol misuse may be a source of vulnerability of drug related problems in their children (Escandon &Galvez, 2005). Children of alcoholic parents often have conduct problems such as lying, stealing, fighting and truancy; they tell lies in order to protect their parents (Leadership, 2007).

In this study, there was no significant relationship between drinking *chang'aa* and gender. However, data from key informants indicated that many of the children of alcoholic parents who drank alcohol were boys because of the African permissive

society of allowing boys more freedom than girls especially after the coming of age. The study findings are in line with several past studies.

Family forms the immediate environment for an individual. It influences the development and behavior of individuals towards the use of substances. Scottish Schools Adolescent Lifestyle and Substance Use (SALSUS) (Black *et al.* 2010) reported that young people aged 15 in Scotland were willing to tell their family about their substance use. On the other hand, this trend was low among the young people aged 13. The behavior of peers, parents and family members towards smoking, alcohol use and other substances highly affects young people's decisions regarding substance use and abuse. If young people thought that their families would disapprove of their drinking habits, they did not tell them (Dishion & Kavanagh, 2000).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) reported that about 23% of current drinkers have alcoholic parents, and about 35% have alcoholic family members (NIAAA, 2006). More than 6 million or one out of every four, U.S. children under age 18 are exposed to family alcohol abuse or alcohol dependence (Grant, 2000; Office of Applied Studies, 2002). In Korea, alcoholism is also prevalent, and the lifetime rate of alcoholism has reached over 20% in adults (Kim, 2002; Korean Alcohol Research Foundation, 2005). The findings are similar to a study conducted in Kerala state, India, which noted that the prevalence of lifetime alcohol among adolescents aged between 12-19, showed a prevalence increasing with age (Jaisoorya *et al.*, 2016). A study from a developing country, Italy, reported

that the drinking behaviours in the country are changing toward at-risk patterns, particularly among the young. This is as a result of binge drinking; heavy episodic drinking, which is drinking to become drunk as well as alcohol consumption outside meals (Nierenberg, 2015).

A global school-based student health survey was conducted using data from twelve developing countries, Botswana, Grenada, Indonesia, Kenya, Myanmar, the Philippines, Saint Lucia, Saint Vincent and the Grenadines, the Seychelles, Thailand, Trinidad and Tobago, and Uganda. The prevalence of alcohol use was varied widely across countries. It ranged from a low of 1.6% in Myanmar to a high of 60.1% in the Seychelles. The current drinking rate of junior high schools boys was 20.5% and senior high school boys was 36.2 in 2004. The prevalence of junior and senior girls was 20% and 34.1 respectively (Osaki et al., 2009). A systematic review of the literature was conducted in Brazil to recognize the prevalence of adolescents alcohol use. According to the review, the prevalence of adolescents aged 10-19 alcohol use was 23% to 67.7% (Barbosa Filho *et al.*, 2012).

A cross-sectional survey conducted in a rural and ethnically diverse community with a sample of year 6 and year 12 students in Mississippi USA noted that the prevalence of drinking varies from 32.2% to 72%. Another research used a sample from the age range 12 to 17 and recognized that the prevalence of adolescents' alcohol use has reported as 33.1% in age 16. Above noted studies also emphasized that the alcohol use becomes more common in increasing age in all the countries and these numbers are slightly different in different research in each country (McDermott *et al.*, 2013).

Vantamay (2009) conducted a cross-sectional survey of 1,200 students in six universities about alcohol consumption among university students aged 18-24 years in Bangkok, Thailand. The researcher found that adolescents are sometimes likely to ask their parents or peers for information regarding health and alcohol use. Here the students see how parents can act as sources of information and models for educating their children with regards to the use of alcohol. However the parents' advice and education will of course depend on their own attitudes towards alcohol consumption. Assanangkornchai *et al.*, 2002; Chaveepojnkamjorn and Pichainarong, 2007) found that Thai parents do not often provide the best education or advice surrounding alcohol use. Parents do not often act as good role models for their children, and often are the root cause of their children's drinking patterns (Assanangkornchai *et al.*, 2002; Chaveepojnkamjorn & Pichainarong, 2007).

Assanangkornchai *et al.* (2002) researched the effects of paternal drinking, conduct disorder and childhood home environment on the development of alcohol use disorders in the Thai population (n=312 aged 18 and over). The findings showed that there was a significant relationship between having a father who enjoyed drinking and the occurrence of drinking-related problems in children. It was more likely that if fathers consumed lots of alcohol, then their children would do the same. A study that explored spirituality in families and its role in the prevention of drug abuse among adolescents concluded that the belief and behavior of parents and other family members shaped the behavior of young people (Mulvihill *et al.*, 2005).

Kumpfer (1998) noted that young people, who came from high stress families and dysfunctional families, had a big risk of alcohol problems. Young people who defined their family as somewhat authoritative tended to drink less than young people who described their family as neglectful parents (Adalbjarnardottir & Hafsteinsson, 2001). Furthermore, the young people who came from a single-parent family were more intense alcohol users than those who had both a mother and father in the family (Kask *et al.*, 2013).

Family bonding provides strength to the relationship between children and their parents. Ideally, young people should abide by the norms and culture of the family, and obey their parents on grounds of the hierarchy of the family structure (Jones *et al.*, 2006). At this age, the impact of the family is most prominent as, according to the model proposed by Erikson (Crain, 2011), young people are at the time when they are faced with the 'psycho-social crisis', trying to find their identity. The appeal role models are very important at this point, and they are likely to shape the young people's attitude towards drinking.

Kumpfer & Alvarado (2003) suggested that adolescence is a period of great stress and anxiety for both the young person and their families. Additionally, other researchers argue that young people passing through adolescence may exhibit nonsocial, unethical behavior during this phase in life, for instance, deviant behavior may involve drinking, violent activities with friends, theft, sexual assaults, rash driving and substance abuse (Berk, 2013). Literature shows that these types of behavior may be reduced by means of family influence, which accounts for the

important role that parents play. The chapters dedicated to the analysis of the survey questionnaires and to the participatory action research further identified youth drinking behavior as well as the place occupied by the family within the Thai culture (Velleman, 2009).

In the United States of America, 0.05 - 2.0 per 1000 births have FAS while in South Africa, one of the highest incidences of FAS globally the figures are 19- 23 per 1000 births (WHO, 2013), with the greatest prevalence reported in the Western Cape (Hoque & Ghuman, 2010). It is believed that one and two-thirds of all children with special education needs were affected by their mother's alcohol intake during pregnancy. FARR estimates that there are about 6 million people who are mentally physically disabled by the effects of alcohol. Adult sons of alcoholic parents see doctors more often while the daughters have reproductive problems and have high rates of an eating disorder, bulimia (Hoque & Ghuman, 2010).

A study carried out by Kumpfer & Alvarado (2003) exploring the impact of the family on young people's attitude towards drinking has revealed that parents are the most influential factors in alcohol and drug prevention and healthcare interventions. Discussing in detail the implications of binge drinking across the UK population, together with the possible ways to mitigate its negative consequences, several studies have shown that the role of parents can be further strengthened by skill training, communication development, parental monitoring and parental involvement in prevention programs. The effectiveness of the family structure, family members and parents play a part in shaping the young people's development into adulthood

(Kumpfer & Alvarado, 2003; Ary *et al.*, 1999; Center for Substance Abuse Prevention, 2000).

Physical problems can continue into childhood and beyond, with children from a very early age experiencing tremors, seizures and epilepsy. There is also an increased risk of a younger child being harmed because of poor hygiene, lack of safety precautions or being left for long periods of time unsupervised, in the care of an older sibling, or with someone outside of the family who may not be appropriate (Horgan, 2011).

Velleman & Templeton (2007) summarize years of work and describe a range of ways in which children living in families with a heavy-drinking parent are reported to have been affected, including by disruptions to family rituals such as birthdays, by changes in and reversal of parent-child roles, by disturbed school attendance, eating and bedtime routines, by limited or more aggressive communication, by diminished social connectedness, and by lack of finances and worsening relationships.

At one end of the spectrum of harm, parental drinking may mean parents model poor drinking behaviors. Research suggests that parental drinking patterns, of both mothers and fathers, can contribute to increased problematic drinking patterns for their children (Raitasalo 2011; Smith *et al.*, 1999; Wilks *et al.*, 2006; Yu 2003). Parents may also find it difficult to maintain routines and, for instance, be unable to take children to organized early morning sports matches because they are 'hung over' (Velleman & Templeton 2007). At the other extreme, parental drinking may

play a role in accidental child deaths, infanticide, assault, and extreme cases of neglect and child abuse (Victorian Child Death Review Committee 2009). Problems associated with a parent's drinking may be limited (e.g. affecting supervision at one-off social functions) or ongoing, such as potentially affecting a child's development over many years if the child is inadequately fed, clothed and looked after (Laslett *et al.*, 2010).

A small Australian mixed methods action research study of parents in treatment for drug or alcohol dependencies and their children showed that intoxication and withdrawal could impair parents' ability to prepare meals, maintain household cleaning, keep school routines, respond to children's emotional needs, and supervise and manage risk of injury, including neglect or harm of their children by others (Gruenert *et al.* 2004). Parents in this study reported that during times of active alcohol or other drug use they themselves were more irritable, intolerant or impatient toward their children, used harsher discipline, were less responsive to their children's needs, yelled more and let go of routines, including getting their children to school. They also reported that they let their children take on adult roles, including caring for younger siblings (Gruenert *et al.* 2004).

Other studies have shown a range of negative effects on children of problem drinkers, including depression and reduced intellectual development (Barber & Crisp 1994; Dawe *et al.*, 2007; Straussner 1994). Dawe *et al.* (2007) reviewed and summarized case-control studies comparing children of alcohol-dependent parents with children of non-alcohol-dependent parents, and reported that these provide

some evidence that higher levels of internalizing disorders (e.g. anxiety and depression) and externalizing disorders (e.g. conduct disorder and aggression) were more common in children of alcohol-dependent parents than non-alcohol-dependent parents. On the other hand, only a minority of children of alcohol-dependent parents were negatively affected (West & Prinz 1987 cited in Dawe *et al.* 2007). A summary of international literature on the impact of a family member's drug use including alcohol on children between the ages of two and 12 years, discussed neglect, harm or abuse which in severe cases are the potential triggers for intervention by child protection agencies, exposure to hostility and conflict, the impact of alcohol on family functioning, and the associated child behavioral problems (Dawe *et al.*, 2007).

Studies have provided the perspective of affected children themselves on the harms experienced from a parent's or carer's drinking. In an Australian survey of children who called the telephone help service 'Childline', parental alcohol misuse was identified by children as connected to a broad range of problems, including the child running away, violence in the home, physical abuse, sexual abuse, neglect and poor family relationships (Tomison, 1996). In the UK and Finland, focus groups with children and reviews of the literature revealed that children of substance-using parents felt ashamed, that they had missed out on their childhood, had normalized negative situations that a child should not have to deal with, and had felt anxious about their own safety. In addition, children reported being concerned for their parents in relation to the effects of their drinking. They were upset by their parents' quarrelling and violence when they drank, and felt that their families did not function as they should (Adamson & Templeton 2012; Raitasalo, 2011). They felt they were

not prioritized in their parents' lives and that they were neglected and physically hurt. It was noted that in Finland many of these children had developed methods for coping with some of these problems and had suggestions about what might help other children in the same situations (Raitasalo, 2011).

In the 2008 HTO Survey, more respondents reported being harmed by the drinking of strangers than by the drinking of people they knew. However, if respondents reported they were more severely harmed, they were more likely to report that they had been affected by someone they knew, for example a household member, relative or friend. Of the 2,649 respondents completing the survey, 778 people (29 per cent of the sample; 282 men and 496 women) identified that they knew at least one drinker whose drinking had negatively affected them (Laslett *et al.*, 2010). Women were more likely to be affected than men by the drinking of those they knew, and this was even more the case for young women (aged 18 to 29 years). Fourteen per cent of women in this age group reported that they had been substantially affected by the drinking of a household member, non-household relative, intimate partner or friend, compared to only five per cent of young men. The majority of the people who were negatively affected by the drinking of someone they knew indicated that they had been affected by a family member (including current spouse) or intimate partner (i.e. boyfriend, girlfriend or ex-partner) or relative in or outside of their household (Laslett *et al.*, 2010).

In the 2008 HTO Survey, 17 per cent of respondents reported that they had been affected by a relative or intimate partner in the past year: seven per cent of

respondents reported that they were affected by a household member and 11 per cent by a relative or intimate partner outside the household. Among the 446 respondents, the most commonly reported harm from the problematic family drinker was being involved in a “serious argument that did not involve physical violence” (63 per cent). Almost three quarters (74 per cent) of those who lived with the problematic family drinker reported a serious argument. This harm was also common amongst those affected by the dividing of non-household problematic family drinkers. The harms translated to children living in a home where there were arguments, threats and lack of attachment (Laslett *et al.*, 2010).

In the 2010 HTO Report, the harms to children reported were, in the first instance, based on key markers from response agencies for which statistics were available – Fetal Alcohol Syndrome (FAS), child abuse, child deaths and hospitalizations. The study also used survey responses to measure the prevalence of more widespread harms to children as a result of others’ drinking. Respondents who reported either that they lived in a household with children under 18 years or that they had responsibility for children but did not live with them, for example, a father or mother not currently living with the child or children are termed ‘carers’. In response to specific questions about harms children in their families experienced, carers most commonly reported that in the previous 12 months children were yelled at, criticized or verbally abused (8 per cent) because of others’ drinking. Smaller percentages reported witnessing serious violence in the home (3 per cent), that children were left unsupervised or in unsafe situations because of others’ drinking (3 per cent) or that

children were physically hurt because of others' drinking (1 per cent)(Laslett *et al.*, 2010).

In response to a more general question in the 2008 HTO Survey, 17 per cent of carers reported that the drinking of other people had negatively affected their child or children "a little" (14 per cent) or "a lot" (3 per cent) in the past year (Laslett *et al.*, 2010). A total of three per cent of carers reported that their children were harmed "a lot" by someone else's drinking. Applying this percentage to the number of Australian families, and multiplying by the average number of children per household, an estimated 142,582 children were harmed "a lot" by others' drinking in 2008. Overall, an estimated 1,045,598 children were affected by others' drinking at least "a little" or in a specific way in the past year. Thus, according to the 40 carers who reported their children had been left unsupervised, this occurred an average of five times in the previous 12 months, and half of this group experienced this two or more times. A child or children being yelled at, criticized or verbally abused – the most common type of harm reported (9 per cent) – occurred an average of 14 times over the year (Laslett *et al.*, 2010).

From the findings, those carers who reported they have children in the household, and indicates that respondents were statistically significantly more likely to report that their children had been affected by others' drinking in any way if they had older children (13 to 17 years) than if they had children in the younger age group (0 to 12 years). However, for the specific measures of harm, the differences in prevalence between these age groups were not significant. There was also no statistically

significant difference by age in the subjective judgments of whether carers' children had been affected a lot or a little (Laslett *et al.*, 2010).

Overall, from the study, carers with children in the household were not significantly more or less likely to report that their children had been affected by others' drinking than those whose children were not in the household. However, carers with children both in and out of the household were more likely to report that their children had been affected by one or more specific types of harm. This group of carers was more likely to report that their children had been verbally abused because of others' drinking than those carers with children in the household only (21 per cent versus 7 per cent). Somewhat counter-intuitively, carers with children outside the household were more likely to report that their children witnessed violence in the home because of others' drinking than those with children in the household (10 per cent versus 2 per cent) (Laslett *et al.*, 2010).

5.4.4 Telling lies among Pupils

The respondents were asked to indicate whether they can tell lies. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Table 5.15.

Table 5. 15: Descriptive Statistics of telling lies among pupils in Bungoma County, Kenya

SA		MA		U		MD		SD		TOTAL	
N	%	N	%	N	%	N	%	N	%	N	%
94	23.6	65	16.3	44	11.0	46	11.5	150	37.6	399	100.0

Source: Field Data, 2018

Results in Table 5.15 show that out of 399 respondents who participated in the study, 94 (23.6%) strongly agreed they can tell lies, 65 (16.3%) mildly agreed, 44 (11%) were not sure or uncertain, 46 (11.5%) mildly disagreed while the remaining 150 (37.6%) strongly disagreed. From the findings close to 160 students out of 399 admitted they can tell lies.

The Pearson correlation results between the statements ‘I can tell lies’ with other statements on social development were summarized as shown in Table 5.16. From the research findings as summarized in Table 5.16, the respondents who told lies in this study had trouble keeping their mind on studies ($r=0.149$, $p=0.003$), drank alcohol ($r=.0166$, $p=0.001$) and they went out of school without permission ($r=.149$). Most of the family members who drank alcohol were fathers.

The research findings go hand in hand with several past studies. The child may feel ashamed to invite friends at home and may fear asking for help. There is evidence of high levels of distress in children of alcoholic parents (Shankar, *et al* 2000). A study by Merky (1993) postulates that when children are feeling bad about themselves, or

they are feeling unworthy, unloved or rejected, they turn to drugs and substance abuse.

Table 5. 16: Correlation between the statements ‘I can tell lies’ with other statements on social development among respondents of Bungoma County, Kenya

		1	2	3	4	5	6	Gender
4	Pearson correlation	.047	.149**	.166**	1	-	.062	.119*
	Sig.(2-tailed)	.352	.003	.001		.535	.216	.018
	N	399	399	399	399	399	399	399

Key: 1= I have trouble keeping my mind on studies, 2= I go out of school without permission, 3= I drink alcohol, 4= I can tell lies, 5=my parents are very strict, 6= I eat at specific times at home

Source: Field Data, 2018

Findings from a study among college students in the U.S, in regard to distress associated with parental alcohol abuse, it was found that among 3,214 college students who sought counseling, those who were raised in a home in which a parent had problematic drinking behavior reported more overall distress than those who were not raised in such an environment. In addition, participants who had parents with problematic drinking behavior were found to have higher levels of problematic drinking themselves. Participants who were unsure about problematic parental drinking reported high levels of distress also, leading to the possibility that the

unsure participants either had no knowledge of or were unwilling or unable to confront a possible reality of parental alcoholism (Shankar *et al.*, 2000).

A cross-sectional study by Wu, Chong, Cheng, and Chen (2007) in Taiwan investigated family relationships, deviant peer influence and adolescent alcohol use in a sample of 780 grade nine students. Measures of family characteristics, school factors and peer influence were used, with peer influence including peer relationships, deviant peer behavior and alcohol use. The study reported that substance use was predicted by perceptions of poor family relationships and deviant peer relationships (Wu *et al.*, 2007). There are two major limitations in this study: that cross-sectional research did not allow causal inference and all family, school and peers measures were self-reported.

A study in the Netherlands used multiple data sources to examine whether the association between friends' drinking norms and male adolescent alcohol use was moderated by peer influence. Using a sample of 73 male adolescents with the average age of 17 years, the study comprised three parts: a baseline class-room questionnaire assessment, a chat room experience and a multiple time diary assessments to measure alcohol use. Peer influence susceptibility was defined as the change in adolescent responses before and after exposure to peer norms (Teunissen *et al.*, 2016).

A cross-sectional study conducted in Illinois (USA) was part of a larger research project on adolescents. The sample comprised 259 students aged 14-18 with the

study seeking adolescents' self-reported perceptions of four types of parental messages that may influence alcohol use intentions. Those four messages were parents' references to the negative consequences of alcohol use, parents' references to their own past experiences with alcohol use, parents' conditional permissive messages and parents' views on drinking alcohol responsibly (Kam *et al.*, 2017). This study examined how parent-child alcohol-specific verbal messages indirectly related to adolescents' alcohol use intentions, focusing on parents' own experiences to create a 'teachable moment' to discuss alcohol with their children. Adolescents perceived their parents' conversations regarding parents' own experiences as a sign of honesty and trust. This study noted that adolescents learning behavior from parents may be an important model (Kam *et al.*, 2017).

Fraga *et al.*, (2011) conducted a mixed method cross-sectional study in Portugal to understand alcohol use among 13 year old school students. This study had both quantitative and qualitative components: a self-administered questionnaire to a sample of 2036 students, and a semi structured interview (N=30). This study intended to assess the reason for and consequences of drinking as perceived by adolescents and discover their views on prevention strategies. The results of this study demonstrated that more than 50% of 13 year olds had drunk alcoholic beverages at least once in their lifetime. There are likely cultural reasons for the high proportion of adolescents who had experienced alcohol by 13 years, probably due to the tradition of home consumption with meals. Results indicated that adolescents only identified minor and temporary consequences of drinking alcohol but most recognized that the drinking can be harmful and lead to addiction that is difficult to

treat. However, participants only perceived the consequences for the person who drinks and not how this could affect others (Fraga *et al.*, 2011). Despite the strengths of the mixed-method model which allowed both objective measures of behavior and in-depth analysis of several features of this behavior researchers noted that a limitation of the study may be related to not having enough information about parents' behaviour and parental roles (Fraga *et al.*, 2011).

Children of alcohol abusers are at greater risk of attention and conduct problems at school, repeating a grade, low academic performance, skipping school days and dropping out of school and low school bonding. Poor academic performance may be linked in some way to prenatal exposure to alcohol due to maternal drinking. Fathers' drinking may have similar effects on children's school and educational outcomes (Serec *et al.*, 2012; Mylant *et al.*, 2002). A father's problem drinking can be a chronic stressor and this environmental influence could account for poorer outcomes in children. In particular, having a father with a reputation as a problem drinker may place additional stress on the child, particularly when they reach adolescence, a period of increased sensitivity and anxiety. Alcoholic parents may be less encouraging of academic success in their children and may not place as much emphasis on academic achievement or provide supportive environments for their children's academic success. For example, they may not monitor children's activities at home regarding their schoolwork, homework and exam preparation because of their drinking patterns and associated behaviors (Farrell *et al.*, 1995).

Furthermore, poor school performance may lead to school failure and affect future progression to higher education and subsequent employment opportunities. Young people's connectedness with school has proven to be a protective factor; a strong social bond with school is associated with diminished involvement in a range of adolescent health-risk behaviours (Bond *et al.*, 2005). Other school attributes including extracurricular activities and teachers have all been found to modify school connectedness (McNeely *et al.*, 2002). Where some elements of parenting skills may be deficient, teachers have been shown to help compensate for lack of parental warmth and support at home particularly for those families on a low income; positive relationships with teachers have been shown to be beneficial in motivating low SES students and can have positive effects for students at risk (Wehlage, 1989). Overall stabilizing activities such as school, clubs, sports and religion can be beneficial in helping a young person to develop a sense of self and self-esteem (Velleman & Templeton, 2007).

Engaging with stabilizing people outside the family can be a positive factor in the development of resilience. However, parental alcohol misuse may impair a child's ability to go places (for instance parent can't drive if drunk) and make friends (for instance unable to invite friends home) (ISPCC, 2010). The ability to seek external support may also be hampered due to finances, parents' permission (Velleman & Templeton, 2007) or location. Individual disposition appears to be more important for females whereas external support is more important for males (Werner, 1993). In addition, while the support of friends appears to be an important protective factor for young people, others suggest that many young children may find it hard to make

friends (Werner, 1993). While strategies of detachment, avoidance and withdrawal (Werner & Johnson, 1999) in dealing with a parent can be very effective, they can result in attachment and relationship difficulties later in life (Harwin *et al.*, 2010).

Serec *et al.*, (2012) found that children of alcoholics aged 12-18 years reported spending more time in sedentary activities such as watching television, internet, listening to music and less time in physical activities. reported heavier use of technology; text messaging, emails, and watching television among adolescents with an alcoholic parent which was also associated with earlier and heavier substance use during adolescence (McCauley Ohannessian, 2009).

In a study by Mclaughlin *et al* (2016), Children of problem drinkers demonstrated resilience via engagement in activities and relationships outside the family environment. At 14 years of age, the greater the parents' alcohol use, the greater the number of evenings their children spent outside the home particularly when the father was a drinker. By 15 years of age, there was an association between increased number of evenings spent at a friend's house and mothers' drinking, for boys. The likelihood of spending time with members of the opposite sex was greater for girls whose parents drank more. In their study, there was no association between parental drinking and child reports of peer problems difficulties in making friends, spending time alone). The greater the parents' levels of alcohol use, the more likely their children spent time on the following activities: hanging around on the streets, going to a café/shopping with friends, going to discos/ parties and baby-sitting for their family. Children whose parents drank at higher levels were less likely to go to a

youth club, afterschool/homework club or attend a place of worship. A number of activities were associated with parental drinking for girls: listening to Compact Discs, going to the park/playground, going to a sports club/team or leisure centre. Parental drinking was not associated with spending time watching Television, reading books/magazines or playing computer/game consoles or doing homework (McLaughlin *et al.*, 2016).

Hoque & Ghuman (2012) conducted a cross-sectional study in South Africa with a total of 704 16-18 year old adolescents, to understand their perception of parental practices relating to adolescent alcohol use. The researchers examined adolescents' perceptions of their own alcohol use, parental alcohol use and the associated behavior and family rules regarding alcohol use. They reported that 54% of participant adolescents have consumed alcohol at some time in their life. The study noted that a large number of mother/female guardians and father/male guardians do not allow drinking at home. Adolescents were more likely to use alcohol in households where parents drank. The study found a significant association between parental alcohol use and adolescent alcohol use, and parents' views on their adolescents' alcohol drinking (Hoque & Ghuman, 2012).

A qualitative research in Portugal also discussed alcohol consumption at home, perhaps reflecting cultural norms where drinking is acceptable at family meals. Adolescents who reported that they drank at home may reflect their parents' approval of their drinking and easy access to alcohol at home. On the other hand, researchers noted that parents may acquiesce to their adolescents drinking alcohol at home and

their knowledge of their children's drinking may reflect efforts to protect adolescents from heavy drinking outside the home (Fraga *et al.*, 2011)

The study by Pathirana (2016) on child-parent relationships in Sri Lanka found that majority of participants reported a happy, pleasant relationship, close bond and non-conflictive parent-child relationship. Further, the researchers indicated that adolescents who are engaged in a supportive and attentive relationship with their parents are very positive about their parents, but those with uncaring and distant relationships have negative attitudes towards their parents (Pathirana, 2016). Another study highlighted that since the parent-child connectedness is one of the major factors in adolescent health and risk-taking behavior in Sri Lanka, addressing this is an immediate research need (Agampodi *et al.*, 2008).

5.4.5 Strict Parenting among Pupils

The respondents were asked to indicate whether their parents were very strict. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Table 5.17.

Table 5. 17: Descriptive statistics of strict parenting among Pupils in Bungoma County, Kenya

SA		MA		U		MD		SD		TOTAL	
N	%	N	%	N	%	N	%	N	%	N	%
214	53.6	80	20.1	12	3.0	40	10.0	53	13.3	399	214

Source: Field Data, 2018

Results in Table 5.17 show that out of 399 respondents who participated in the study, 214 (53.6%) agreed they have strict parents, 80 (20.1%) mildly agreed, 12 (3%) were uncertain, 40 (10%) mildly disagreed while the remaining 53 (13.3%) strongly disagreed. From the findings nearly 300 respondents agreed their parents were strict.

Pearson correlation between the statement ‘I have strict parents’ with the other statements on social development was summarized in Table 5.18.

Table 5. 18: Correlation of ‘I have strict parents’ with other statements on social development among respondents in Bungoma County

		1	2	3	4	5	6	Gender
5	Pearson correlation	-.041	-	.054	-	1	.090	-.050
	Sig.(2-tailed)	.409	.000	.284	.535		.074	.322
	N	399	399	399	399	399	399	399

Key: 1= I have trouble keeping my mind on studies, 2= I go out of school without permission, 3= I drink alcohol, 4= I can tell lies, 5= my parents are very strict, 6= I eat at specific times at home

Source: Field Data, 2018

From the research findings, as summarized in Table 5.18, in situations where parents were very strict, the respondents were going out of school without permission ($r = -0.195$, $p = 0.000$). The relationship between the two aforementioned statements is negative. This indicated that parents' strictness helped the respondents to keep in school. This was supported by class teachers and key informants who said that children who were let loose by parents who were also drinking made children avoid school, sometimes in order to fend for family needs. Parents who drink are known to be indifferent and distance themselves from their children.

Past studies reveal that communication problems of families affected by parental problem drinking have been documented in a number of studies using the Marital Interaction Coding System (MICS) Investigators videotaped discussions amongst family members, and then coded these discussions using the MICS. The MICS allowed trained observers to classify verbal and non-verbal communication into four summary categories: positive, negative, problem-solving, and congeniality. The positive category consisted of positive evaluations of the speaker in regard to other family members for example, agreement and approval. The negative category included instances of negative evaluation for example, disagreement and criticism. The problem-solving category consisted of efforts made towards discussing and resolving problems. Finally, the congeniality category reflected smiles, laughter and unrelated talking (Jacob *et al.*, 2001).

Results from studies that had used the MICS showed that families affected by parental problem drinking exhibited more negative communication, less positive

communication, less congeniality, and impaired problem-solving capabilities when compared to unaffected controls (Haber & Jacob, 1997; Jacob *et al.*, 1991; Jacob *et al.*, 2001; Moser & Jacob, 1997). These patterns were documented in parent-child interactions, as well as in interactions between spouses (Jacob *et al.*, 1991; Moser & Jacob, 1997).

Problems in communication also appear to differ as a function of parental characteristics other than drinking per se. For example, two studies examining the differential effects of parent gender found that families affected by maternal alcohol misuse exhibited higher levels of negative communication and lower levels of positive communication compared to both: (a) families affected by paternal problem drinking alone; and (b) controls (Haber & Jacob, 1997; Moser & Jacob, 1997). In another study, families affected by marital distress in conjunction with maternal alcohol misuse were shown to exhibit higher levels of negative communication compared to families independently managing maternal problem drinking or marital distress but not both (Kelly *et al.*, 2000).

Studies have also found that in families where paternal drinking (with no concomitant maternal alcohol misuse) is accompanied by antisocial personality or aggression (Leonard & Roberts, 1998), communication is particularly impaired. Taken together, these results suggest that factors such as parent gender, marital distress, and both paternal antisocial personality and aggression might interact with parental alcohol misuse to compound impairments in family communication. However, no causal associations between these constructs have been established

since none of the reported studies used longitudinal data, and there was insufficient control for a range of possible confounding variables. It remains possible that other factors associated with both alcohol and communication problems such as comorbid psychopathology, socioeconomic status, or education level explain these findings (Jacob *et al.*, 2001)

Jacob *et al.*, (1991) attempted to identify impaired communication practices specific to families characterized by alcohol misuse by comparing families with an alcohol misusing father (without any concomitant disorder such as depression), families with a depressed father without any concomitant alcohol use disorder, and families in which the father exhibited no psychiatric or alcohol related disorder. Lower rates of congeniality and problem-solving in father-child discussions were identified in both the alcohol misusing and depressed groups relative to the control group. The study found that a general distress factor, that would account for both alcohol disorder and depression may best explain impairment in parent-child communication, rather than something unique to alcohol use disorders per se (Jacob *et al.*, 1991).

Other studies have examined the cohesion of families affected by parental alcohol misuse using the Family Environment Scale (FES). The FES is a self-report measure that consists of 10 scales, including the Family Cohesion Scale, which measures the feeling of support and togetherness within a family. Studies have administered the FES to caregivers and children in examining the impact of parental alcohol problems on family cohesion and organization (Jester *et al.*, 2000). Both studies reported lower levels of family cohesion and organization among families characterized by parental alcohol use problems (Jester *et al.*, 2000; Bijttebier *et al.*, 2006). These cross-

sectional studies are unable to determine causality, providing two possible explanations: (a) that low cohesion families experience less support and vulnerable parents may be more likely to use alcohol as a maladaptive coping mechanism; or (b) that alcohol misuse creates additional stressors which interfere with maintaining trust, forgiveness and family cohesion (Scherer *et al.*, 2012).

A study using the FES with Indigenous Australians (N = 99) found that despite alcohol predicting high family conflict and aggression, there was no association between family cohesion and alcohol misuse (Kelly & Kowalyszyn, 2003). Inconsistent findings between these studies may be the result of methodological limitations, including low sample sizes in the alcohol-affected groups, disparate cultural subgroups that is to say Dutch families, African American women and Indigenous Australians, and the low reported internal consistency of the FES subscales in some studies (Bijttebier *et al.*, 2006).

Parental alcohol use problems have been cross-sectionally associated with poor family communication and cohesion in a number of studies, no evidence of causality can at this stage be inferred based on the available literature. It would seem plausible that there may be a general distress factor among alcohol-affected families that contributes to poor communication and cohesion, but that this is not specific to alcohol affected families alone. Prospective research on parental alcohol use disorders and family functioning is needed to untangle these complex pathways of influence (Bijttebier *et al.*, 2006).

5.4.6 Eating at specific times at home among Pupils

The respondents were asked to indicate whether they eat at specific time at home. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Table 5.19.

Table 5. 19: Descriptive statistics of eating at specific times at home among Pupils in Bungoma County, Kenya

SA		MA		U		MD		SD		TOTAL	
N	%	N	%	N	%	N	%	N	%	N	%
207	51.9	72	18.0	20	5.0	30	7.5	70	17.5	399	100

Source: Researcher, 2018

Summary of the research findings on eating at specific times show, as pointed out in Table 5.19, out of 399 respondents, 207 (51.9%) strongly agreed they eat at specific times at home. In addition, 72 (18%) mildly agreed, 20 (5%) were uncertain, 30 (7.5%) mildly disagreed, while the remaining 70 (17.5%) strongly disagreed. Majority of the respondents, over 280 out of 399 who participated in the study agreed they eat at specific time at home.

One of the respondents from a FGD had the following opinion;

My next door neighbor drinks every day, but the children are always hungry. They either beg for food or steal or pick food leftovers from high school. In fact, if it wasn't for sympathetic cooks at the high school, that family could be dead from starvation. The mother of those children is very hard working; she

harvests over ten bags of maize every year, but all her labour is in vain because the husband sells most of it in order to buy alcohol.

Source: Field Data, March 7th, 2017.

Pearson correlation between the statements ‘I eat at specific time at home’ with other statements on social development, the summary is as shown in Table 5.20.

Table 5. 20: Correlation of the statements ‘I eat at specific times at home’ with other statements among Pupils in Bungoma County, Kenya

		1	2	3	4	5	6	Gender
6	Pearson correlation	-.013	.010	-	.062	.090	1	.069
				.080				
	Sig.(2-tailed)	.795	.849	.113	.216	.074		.168
	N	399	399	399	399	399	399	399

Key: 1= I have trouble keeping my mind on studies, 2= I go out of school without permission, 3= I drink alcohol, 4= I can tell lies, 5= my parents are very strict, 6= I eat at specific times at home

Source: Field Data, 2018

The Pearson correlation results shown in Table 5.20, the statement ‘I eat at specific times at home’ had no relationship with the other statements on social development.

Information from interviews however yielded that in most homes where there was a drinking parent, the children sometimes went without food or ate irregularly. This is because the parents’ preoccupation with alcohol made them forget about their children’s need for food so that the children had to look for food and missed school. In other homes, drinking parents sold the available food for drink.

Past studies reveal that families with an alcohol abusing parent have poorer organization compared to families unaffected by alcohol abuse (Tubman, 1993). This may be due to the fact that with increasing patterns of abuse, substance dependence becomes the central organizing principle of the family at the expense of regular rituals and routines (Dawe *et al.*, 2007). Family Systems Theories identify organization and regular activities, such as routines and rituals, as the cornerstone of structure, predictability and stability for healthy families. As a result, it is likely that the maintenance of organization, rituals and routine may serve as a protective factor for families affected by parental problem drinking (Haugland, 2005).

Empirical studies have indicated that problem drinking is commonly associated with disruptions to everyday family routines. In one Australian longitudinal study (N = 260 male adolescents and their parents), fathers' heavy drinking was associated with rarely or never eating dinner at home together (Cumes-Rayner *et al.*, 1992). Furthermore, 89 per cent of these sons reported that their families rarely or never spent evenings together, and 66 per cent reported that their families never or rarely spent weekends together. Cumes-Rayner and colleagues (1992) also found that families with heavy drinking fathers were more likely to have heavy drinking sons and more difficulty settling disagreements at home, and surmised that it was the sons who absented themselves from home activities rather than the fathers. In a Norwegian study of 23 families, Haugland (2005) found that paternal problem drinking was associated with disruptions to the structure of many every day events. These events included family routines and rituals associated with mornings, meal

times, bedtimes, discipline, leisure activities and children's social contact with their peers. However, this effect was found to be largely displaced by the compensatory role of the non-problem-drinking mother, who usually worked hard to maintain the structure of usual routines and rituals (Haugland, 2005).

Empirical studies of parental problem drinking and family rituals and routines have been limited by their exploratory nature, small sample sizes, lack of a control comparison group and their focus on paternal drinking. Considering the central role of the mother in family organization, it is plausible that studies of maternal problem drinking, or families in which both parents abuse alcohol, may find stronger associations between parental problem drinking and disruptions to family organization and routine. The extent to which these disruptions impact on both family life and children is also likely to vary depending on the presence of other risk factors such as marital conflict, family violence, separation or divorce, and ambivalent and unpredictable parenting (Haugland, 2005).

Research suggests that unpredictability and instability associated with a lack of routines and rituals may contribute to maladjustment in children of problem drinkers, specifically, it may contribute to children's problem drinking in adult life, and an increase in anxiety-related health disorders. A cross-sectional study (N = 68 couples) showed that family ritual disruption is significantly associated with an increased risk of alcohol problems in adult offspring of problem drinkers (Bennett *et al.*, 1987). Bennett and colleagues found that maintaining family rituals during periods of parental problem drinking appeared to protect children from developing problems

with alcohol later in life (Bennett *et al.*, 1987). However, another study found little evidence for an association between family rituals and alcohol problems in adult offspring of problem drinkers. Rather, a strong association was found between disruption of family rituals and an increased prevalence of health disorders in these children later in life. The study found that families dealing with problem drinking who are able to maintain routines and rituals may also be distinguishable from those who are not by other characteristics, such as lower levels of conflict, divorce or family violence (Fiese, 1993). These protective characteristics are also likely to contribute to child adjustment, and to mediate or moderate the relationship between child adjustment and a lack of routines and rituals associated with parental problem drinking (Fiese, 1993).

5.5 Gender and Social Development among Pupils of Alcoholic Parents

From the six statements, the study conducted Karl Pearson correlation between the statement and gender to establish whether there existed any statistical significant association with social development. The results were summarized in Table 5.21. The results in Table 5.21 show there was no statistically significant correlation between statements on social development and gender except for statement on telling lies which had $r = 0.119$, $p = 0.05$. The results imply telling lies among children goes hand in hand with their gender. In other statements, there was no significant association between them and gender since their p values were above 0.05 in all the cases. This therefore implied that there was significant relationship between social development with regards to telling lies and gender in this study.

Table 5. 21: Correlation between Gender and Social Development among pupils of Bungoma County, Kenya

Statements on Social Development	Gender	
	Pearson r value	Sig.(2-tailed) p value
I have trouble keeping my mind on studies	-0.001	0.977
I go out of school without permission	0.082	0.101
I drink alcohol	0.011	0.833
I can tell lies	0.119	0.018
My parents are very strict	-0.050	0.322
I eat at specific times at home	-0.069	0.168

Source: Field Data, 2018

The study used chi square to determine the degree of association between the gender of pupils social development and parental alcoholism. From the findings, chi square value $\chi^2=56.453$ at $p= 0.675$ was recorded. This value was insignificant which implied that pupil's gender is insignificantly affected by parental alcoholism. In other words, the effect of parental alcoholism affects equally irrespective of the gender of the pupils.

5.6 Self Esteem Test of Pupils

The study carried out a self-esteem test to check on the status of the pupil's self-esteem using the 'Sorensen Self-Esteem Test' (Sorensen, 2003) in APPENDIX V. The criteria for determining self-esteem was as follows; 0 to 4 ticks placed (\checkmark)

implied good self-esteem, 5 to 10 ticks placed (√) implied fair self-esteem, 11 to 18 ticks placed (√) implied moderately low self-esteem while 19 and above ticks placed (√) implied low self-esteem. The pupils were to place a tick (√) next to the number of each statement that they found to be true about them. Summary of the research findings were summarized in Table 5.22.

Table 5. 22: Self- Esteem Test of Pupils in Bungoma County, Kenya

Number of (√)	Frequency	Percent	Cumulative Percent
More than 19	183	47.5	47.5
11 to 18	140	36.4	83.9
5 to 10	44	11.4	95.3
0 to 4	18	4.7	100.0
	385	100.0	

Source: Field Data, 2018

From the results of Table 5.22, those who placed more than 19 ticks (√), were 183 (47.5%), 11 to 18 ticks were 140 (36.4%), 5 to 10 ticks were 44 (11.4%) while the remaining 18 (4.7%) had placed between 0 to 4 ticks. From the self-esteem test, majority of the respondents 183 (more than 19 ticks placed (√), had low self-esteem followed by moderately low self-esteem 140 (36.4%) (placed 11 to 18 ticks (√). Only 44 (11.4%) had fair self-esteem since 5 to 10 ticks (√) were placed and the remaining 18 (4.7%) had good self-esteem (0 to 4 ticks were placed (√).

5.7 Summary

The results indicate that most children who came from alcoholic backgrounds, where parent (s) are/were serial drinkers were not close to their parents. Most of these children were crying all the time and majority of them would always want to be on their own. Majority of the children worried most of the time and had low self-esteem. They also had a problem keeping friends in case they had any. The children found themselves not able to do things like their age mates. The study also concluded that there was no significant relationship between psychological development and gender in this study. This is to say that both sexes were equally affected by a parent's drinking. From the research findings, majority of the children whose parents are alcoholic have trouble keeping their mind on studies. Secondly, most of the children who come from alcoholic backgrounds go out of school without permission. In addition, a sizeable number of these children from alcoholic homes also drank alcohol. Majority confirmed they can lie, though it was gender sensitive. From the research findings, majority of the children confirmed they eat at specific times at home.

CHAPTER SIX

STRATEGIC OPTIONS TO ENHANCE CHILDREN'S PSYCHOSOCIAL DEVELOPMENT AMONG ALCOHOLIC PARENTS OF BUNGOMA COUNTY, KENYA

6.1 Introduction

This chapter sums up the strategies to enhance children's psychosocial development among alcoholic parents that were generated from respondents who were pupils using questionnaires; teachers, parents, Sub-County Directors of Education, Children Officers and key informants, using interview schedules and focus group discussions. The strategies are a measure of humanitarian assistance that can be given to children of alcoholic parents to enhance their psychosocial development. The strategies grouped under the following sub sections: social psychological and humanitarian assistance in emergency management are discussed.

6.2 Social Strategies

The respondents were asked to give possible interventions they felt would help reduce the impact of parental alcoholism on social development of primary school children and hence enhance psychosocial development of their children. The response on the findings was as discussed in the following subsections:

6.2.1 Policies and Regulations by Administration and the Government

The respondents were asked to indicate whether the area chief should discourage drinking alcohol. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a

Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Table 6.1.

Table 6. 1: Responses to ‘Our area chief should discourage drinking alcohol’ in Bungoma County, Kenya

	Frequency	Percent	Cumulative Percent
SD	27	6.8	6.8
MD	1	.3	7.0
U	37	9.3	16.3
MA	136	34.1	50.4
SA	198	49.6	100.0
Total	399	100.0	

Source: Field Data, 2018

From the results in Table 6.1, 334(83.7%) of the pupils agreed that the area chief should discourage drinking of alcohol.

The interview schedules and FGDs carried out supported the results from the pupils.

One of the respondents held the following opinion;

In the chief’s baraza’s, and school parents’ meetings, parents should be sensitized on the need to stay sober, take up their parental roles of providing basic needs and be role models to their children.

Source: Field Data, February 8th, 2017

Another respondent noted that:

The young children too, need to be reminded about their right to free education in primary schools as a Government policy in Kenya and the need to be in school always.

Source: Field Data, February 8th, 2017

In one interview schedule, one of the Children Officers had the following to say:

The Government policy on alcohol should be enforced, by stern action being taken against alcohol sellers and especially to school going children. Alcohol availability to be reduced by pouring alcohol, imposing heavy taxes, fines and jail terms to all people found brewing and selling alcohol. I also suggest the Government should build rehabilitation centers and force drinking parents to be admitted there can be another means of reducing alcohol consumption in our area.

Source: Field Data, February 8th, 2017

Past studies reveal that at policy level, prevention strategies include age restrictions on the availability and purchase of alcohol in different places. For some countries, it is illegal for young people under 18 years of age to purchase alcohol for their own use (ICAP, 2013). In Kenya, selling, supply and giving of giving of alcohol to any person under the age of 18 is an offence under the Alcoholic Drinks Control Act 2010. Under this Act, “No person shall sell, supply or provide knowingly an alcoholic drink to a person under the age of eighteen (18) years (ADCA, 2010).Lawmakers have implemented policy strategies that focused on: reducing alcohol availability for young people, restricting commercial access, regulating the content of alcohol advertisements and its exposure to young people, reducing economic and social access and raising the Minimum Legal Drinking Age (MLDA). Moreover, laws about blood alcohol concentration limits and drinking and driving have been developed to ensure that the risk for harm is minimized for young people who drink (ICAP, 2013).

6.2.2 Engaging in Other Viable Economic Activities other than Selling Alcohol

The respondents were asked to indicate whether alcohol sellers should be forced to engage in other economic activities other than selling alcohol. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results are summarized in Table 6.2.

Table 6. 2: Responses to ‘Alcohol sellers should engage in other economic activities’ in Bungoma County, Kenya

	Frequency	Percent	Cumulative Percent
SD	27	6.8	6.8
MD	9	2.3	9.0
U	55	13.8	22.8
MA	163	40.9	63.7
SA	145	36.3	100.0
Total	399	100.0	

Source: Researcher, 2018

Descriptive results in Table 6.2 show majority of the respondents 309 (77.3%) were of the opinion alcohol sellers should get engaged in other economic activities other than selling alcohol. This would reduce the risk of children modeling their parents in drinking.

From FGDs, similar views were held by the respondents. One of the respondents held the following view;

I wonder why these women keep on destroying other people’s families and marriages. They need to be told that to earn a living is not only dependent on selling alcohol. They can roast maize, sell vegetables, cereals and so on to survive. Something needs to be done.

Source: Field Data, 12th October, 2017

This would act as a prevention measure for parents and their children accessing alcohol easily. This is in line with a study which concluded that it was also important to reduce the number of alcohol outlets in neighborhoods where minors resided and increase enforcement to limit distribution of alcohol to minors (Gmel, 2016).

6.2.3 Abolishment of Local Brews by the Government

The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results were summarized in Table 6.3.

Table 6. 3: Responses to ‘Local brews should be abolished by the Government among pupils’ in Bungoma County, Kenya

Response	Frequency	Percent	Cumulative Percent
SD	45	11.3	11.3
MD	18	4.5	15.8
U	47	11.8	27.6
MA	108	27.1	54.6
SA	181	45.4	100.0
Total	399	100.0	

Source: Field Data, 2018

The results in Table 6.3 shows that majority of the respondents 289 (72.5%) indicated local brews should be abolished by the Government.

From the interview carried out in one of the FGDs, one of the respondents had the following opinion;

The major problems we have around here are the homes brewing local liquor. I wonder if the local administration is aware or they seem to assume a lot. In my own opinion, I would suggest all the clubs are closed if indeed the county Government for instance wants to help alcoholic homes.

Source: Field Data, October, 2017.

6.2.3 Church Preaching on Drinking

The respondents were asked to indicate the pastors in local churches should preach on drinking. The respondents who participated in the study were asked to give their opinion on the extent they agree or disagree with the statements provided on a Likert scale of 1-5 where: Strongly agree (SA)=5, Mildly Agree(MA)= 4, Uncertain (U)= 3, Mildly Disagree (MD)= 2 and strongly disagree (SD) = 1. The results are summarized in Table 6.4

Table 6. 4: Responses to ‘Our church pastor should preach about drinking among pupils’ in Bungoma County, Kenya

Response	Frequency	Percent	Cumulative Percent
SD	54	13.5	13.5
MD	2	.5	14.0
U	36	9.0	23.1
MA	154	38.6	61.7
SA	153	38.3	100.0
Total	399	100.0	

Source: Field Data, 2018

The results in Table 6.4 show that a majority of the respondents 307(76.9%) felt the church should actively participate in eliminating alcoholism through preaching about the dangers of along on psychosocial development. The remaining 56 (14%) disagreed that the church ought to be involving in preaching against drinking alcohol. Probably this could be because the drunken parents may not attend church at all.

6.3 Psychological Strategies

The study established whether psychological strategies could be used to reduce the effect of drunkenness in alcoholic homes. The results were as discussed in the following sub sections.

6.3.1 Uncles or Aunts Talking to the Parents

The respondents were asked to indicate whether uncles and aunties need to talk to their parents on alcoholism. The interview schedules and FGDs had the following to report from some of the respondents:

One of the things to note is that drinking parents are absent from home most of the time and that in homes where alcohol is brewed, the children are exposed to alcohol and they see their parents drunk and sometimes abusive. In such cases, such parents need to be sensitized on the need to be available for their children. I wish to encourage uncles and aunties to be on the forefront in talking to them about the possibilities of stopping drinking. It becomes unbearable for the children to be exposed to the parent's drinking and abuse regularly.

Source: Field Data, 12th September, 2016

Family members should apply these implications to talk to drinking parents and their children about alcohol, on learning to drink safely at home, other drinking practices and environments, and the consequences of alcoholism (Valentine *et al.*, 2010).

The Adolescent Transition Program (ATP) is an example of a community level strategy. It focuses on parental training for effective communication with young people and early adolescents who are at risk of alcohol abuse. It is also a multifaceted strategy involving school, family, parental group meetings and peers (Dishion & Kavanagh, 2003).

6.3.2 Teachers talking to pupils about Parental Alcoholism

The respondents felt that sensitization of the parents on their need to remain sober, be good role models to their children was a key intervention.

From the interview schedule carried out, one of the class teachers had the following to say;

I suggest that Guidance and Counseling teachers be employed by the Teachers Service Commission and their sole purpose be, offering psychosocial help to pupils from homes where parents drink. Another intervention is the introduction of feeding programmes in all learning institutions. This is to make sure that every child from a difficult background has at least a meal a day.

Source: Field Data, February, 2017

The review of literature also suggests that prevention programs of alcohol misuse, especially family-based interventions such as the Family-Strengthening Approaches (Kumpfer & Alvarado, 2003) showed long-term results. The family-strengthening approach is focused on developing and promoting activities, services and programs that are designed to consolidate the interpersonal relationships among the family members, with a focus on contributing to the healthy development of adolescents. Kumpfer, Alvarado, and Whiteside, (2003) reviewed family-level prevention strategies. These included: Family Therapy, Family Education, Behavioral Parental training, Family Skills training and In-home Family Support. They concluded that

family-level interventions were two to nine times more effective than those solely focused on children. These included school-based, individual-based and peer-based strategies.

It has been suggested that the core components of Family Level prevention programs should be incorporated, and integrated, into other substance abuse prevention and intervention programs. The core attributes of family-level strategies include enhanced interaction, the ability to build resilience among young people towards substance abuse, and engaging families who are otherwise hard to reach (Small, 2010).

Particularly, when children reach adolescence and begin to establish a clear sense of their own identity and an ability to make decisions for themselves, parents' verbal communication is the direct way of expressing parents' ideas and thoughts to their adolescents (Jackson, Bijstra, Oostra, & Bosma, 1998). A number of important studies have examined the relationship between adolescent-parent communication and adolescents' alcohol use (Mares *et al.*, 2011; Martyn *et al.*, 2009; van der Vorst, Burk, & Engels, 2010). Parental monitoring is represented by parents' knowledge of their children's behavior and activities when they are not under direct supervision. When parents are effective monitors, adolescents are less likely to engage in problem behavior including alcohol use. Ineffective parental monitoring may be due to lack of skills on the part of parents. Behavioral skills are essential for parental monitoring and need to vary with the age of adolescents. As a child matures, new monitoring skills are required to recognize adolescent behaviour (Dishion & McMahon, 1998).

Monitoring is widespread, and it reflects parental efforts to control and manage their children. Strong parental monitoring can both deter adolescents from engaging with alcohol in the first place and reduce the risk of future use (Stattin & Kerr, 2000).

According to Jones *et al.* (2007), school-based interventions were the most commonly applied interventions. The Life Skills Training (LST) was a school-based prevention strategy which has often been explored and evaluated by researchers. There were less, but positive results in minimizing the indicators of alcohol or other drug abuse. Life Skills Training was created in the attempt to prevent the use of drugs, alcohol and tobacco among young people. The methods used involve developing social and self-management skills, as well as skills for resisting peer pressure. This represents an example of an approach that addresses the cause of the problem. Extracurricular activities and sports are also reported to reduce problems associated with alcohol abuse among adolescents. Jones *et al.*, (2007) stated that school-based prevention strategies were most widely used to develop and implement universal drug prevention programs. This is similar to the National Institute for Health and Clinical Excellence guidelines on interventions in schools to prevent and reduce alcohol use among young people (NICE, 2007).

A longitudinal study conducted by Tomczyk *et al.* (2015) in Germany analyzed the school climate and the association between peers and adolescents' alcohol use. A sample of 2490 children participated in the final stage of the study. At baseline, the participants' mean age was 10.8 years and 13.3 years at 36 months follow up. The measures were assessed by a self-reported questionnaire. According to Tomczyk *et*

al., (2015), the findings of this study indicated the significant moderating and mediating effects of school climate. Class climate mediates the association between peers and adolescent alcohol use. A positive class climate was associated with lower alcohol-related outcomes among students and peers. School organization variables have a significant moderating influence on the association between peer and adolescent alcohol use. Teacher-student ratios were associated with adolescents' alcohol use, when teacher-student ratios were higher, the greater the adolescents' problem behavior (Tomczyk *et al.*, 2015).

Alcohol availability research broadly suggests that an extra outlet will contribute to some extra amount of alcohol of alcohol-related harm in its vicinity (Gmel *et al.*, 2016).

6.4 Humanitarian Assistance in Emergency Management

The last two phases in the Disaster Management Cycle encompass response and recovery. The aim of emergency response is to provide immediate assistance to maintain life, improve health and support the morale of the affected population. Humanitarian action must maximise the participation and involvement of the local affected populations in the humanitarian intervention. In most emergency situations, a significant percentage of the population is resilient enough to be able to participate in the efforts deployed during the emergency and reconstruction phases (Warfield, 2002).

One of the key principles—even at the very beginning of an emergency—is to identify local capacities and/or resources, support teamwork and strengthen existing

resources. Programmes designed and piloted in different contexts often lead to inappropriate, largely ineffective or even harmful interventions that cannot last over the long term. The aim of emergency response is to provide immediate assistance to maintain life, improve health and support the morale of the affected population. Humanitarian organizations are often strongly present in this phase of the disaster management cycle (Warfield, 2002).

As the emergency is brought under control, the affected population is capable of undertaking a growing number of activities aimed at restoring their lives and the infrastructure that supports them. There is no distinct point at which immediate relief changes into recovery and then into long-term sustainable development. There will be many opportunities during the recovery period to enhance prevention and increase preparedness, thus reducing vulnerability. Ideally, there should be a smooth transition from recovery to on-going development. Recovery activities continue until all systems return to normal or better. Recovery measures, both short and long term, include returning vital life-support systems to minimum operating standards; temporary housing; public information; health and safety education; reconstruction; counseling programs; and economic impact studies. Information resources and services include data collection related to rebuilding, and documentation of lessons learned (Warfield, 2002).

6.5 Summary

The research findings on possible strategic options to enhance children's psychosocial development among alcoholic parents show that the respondents were

of the opinion that there is need for the Community and both Central Government and County Government to be involved in fight alcohol in Bungoma County. The strategies suggested include; church leadership to preach about the dangers of alcoholism, the area chief to organize meetings to talk to parents, alcohol brewers to engage in other viable economic activities, schools to organize for employment of guiding and counseling teachers and family members to get involved in talking to the parents and children on the dangers of alcohol consumption.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction

This chapter is a summary of the study results from which conclusions are drawn, recommendations made suggestions for further research made from “Parental alcoholism and its influence on psychosocial development among primary school pupils in Bungoma County, Kenya”. They are presented according to the following sub thematic areas.

7.2 Summary of Findings

This section consists of summary of findings from the three objectives: i. Determine the magnitude of parental alcoholism among parents in Bungoma County, ii. Examine the nexus between parental alcoholism and psychosocial development primary school pupils in Bungoma County and iii. Evaluate strategic options to enhance children’s psychosocial development among alcoholic parents in Bungoma County.

7.2.1 Magnitude of Alcoholism among Parents in Bungoma County

The study found out that of 399 respondents who participated in the study, 179 (42.6%) of the respondents confirmed that one of the members in the family drank alcohol, 221(55.4%) had parents who drank nearly every day. 146(37.1%) thought that one of their parents had a drinking problem. The parent who drank most was the

father. Few mothers drank, because of the responsibilities in the home and the inability to afford buying alcohol every day.

Data from Interview schedules and Focus group discussions confirmed that there was heavy drinking by some parents and most of the parents who drank were fathers. The drinking premises were open very early in the morning and the children were aware of the drinking places and saw their parents drink.

7.2.2 The nexus between parental alcoholism and psychosocial development of pupils in Bungoma county

From the findings, many children were not close to their parents 153 (38.4%). The reason behind this could be due to the fact that the drinking parents spent little time with their children and so attachment was low. The findings showed that majority of the respondents cry most of the time. Ideally, children of alcoholics have every reason to cry because of the frustrations that they undergo. Most respondents opted to be on their own as opposed to staying with alcoholic parents. In addition, most respondents cry in their lives when in the hands of alcoholic parents.

Children from alcoholic homes worried most of time and hence, it was difficult for them to keep friends. According to teacher counselors, some of the children of drinking parents worried about their future thinking that nobody understood them, so they kept off from their peers.

The study established that the respondents who were close to their parents drew strength from their relationship, and were able to go through psychosocial child development successfully. Further, the respondents who were close to their parents

were negative ($r = 0-.139$, $p=0.000$) on enjoying being on their own as previously stated. This is true in real life situations where parent attachment is a buffer to any psychological distortions. The respondents who were close to their parents were also 'able to do things just like my age mates' with ($r=0 .159$, $p=0.000$). This is an indication of high self-esteem which is generated by the attachment to their parents. The results showed the statement 'I am very close to my parents' had no statistically significant correlation with gender given that $r= -0.024$, at $p = 0.629$. The same was applicable in other statements whose p values were above 0.05 in all the cases. This therefore implied that there was no significant relationship between psychological development and gender in this study. This is to say that both sexes were equally affected by a parent's drinking.

The research findings showed a sizeable number of respondents having trouble to keep their mind on studies. From the research findings, 112(28%) of respondents went out of school without permission. This could be as a result of school failure, or the challenges being faced at home, including taking care of younger siblings. From the findings, over 52(13%) pupils in primary school agreed they drank alcohol. This could be due to the fact that their parents also drank alcohol and thus they modeled them. From the research findings, the respondents who drank alcohol also went out of school without permission ($r=0.136$, $p= 0.006$) and told lies ($r=0.166$, $p=0.001$). From the findings 159(39.9%) respondents admitted they told lies.

Furthermore, the research findings showed that the respondents who told lies in this study had trouble keeping their mind on studies ($r=0.149$, $p=0.003$), drank alcohol

($r=.0166$, $p=0.001$) and went out of school without permission ($r=.149$). Most of the family members who drank alcohol were fathers. The respondents were asked to indicate whether their parents were very strict. 294(73.7%) respondents who participated in the study agreed their parents were strict.

From the research findings, in situations where parents were very strict, the respondents were going out of school without permission ($r= -0.195$, $p= 0.000$). The relationship between the two aforementioned statements is negative. This indicated that parents' strictness helped the respondents to keep in school. This was supported by class teachers and key informants that children who were let loose by parents who were also drinking made children avoid school, sometimes in order to fend for family needs. Parents who drink are known to be indifferent and distance themselves from their children.

The results showed there was no statistically significant correlation between statements on social development and gender except for statement on telling lies which had $r= 0.119$, $p=0.05$. The results imply telling lies among children goes hand in hand with their gender. There was no significant association between other statements and gender since their p values were above 0.05 in all the cases. This therefore implied that there was significant relationship between social development with regards to telling lies and gender in this study.

7.2.3 Strategies to enhance psychosocial development among pupils in Bungoma County

The research findings on possible strategic options to mitigate and enhance children's psychosocial development among alcoholic parents show that the respondents were of the opinion that there is need for the society and both Central Government and County Government to be involved in fight against parental alcoholism in Bungoma County. The strategies suggested include: church leadership to preach about the dangers of bringing up children in an alcoholic background; the area chief to organize meetings to sensitize parents on responsible parenting, so that their children grow up in secure environments; alcohol brewers to engage in other viable economic activities so that pupils are not exposed to alcohol at an early age; schools to organize for employment of guiding and counseling teachers and family members to get involved in talking to the parents on the dangers of parental alcoholism on their children.

Children from alcoholic homes in Bungoma County, irrespective of gender, are affected by parental alcoholism and hence require assistance.

7.3 Conclusions

The following conclusions were made from the research findings.

- i. Bungoma County has a large number of parents who are alcoholic, 55.4 % of whom are fathers. The parents are away from home most of the time on drinking sprees and as a result, they are not involved in income generating projects. They contribute largely to the poverty of Bungoma County.

- ii. Parental alcoholism negatively influences the psychosocial development of their children irrespective of gender. This is seen in the delinquency, less attachment to parents and peers and low self esteem of pupils from alcoholic homes.
- iii. Schools, churches, and the local administration are key in the prevention and mitigation of parental alcoholism in Bungoma County. These groups of people are known to the drinking parents and their school going children and can therefore offer help on individual and group basis.

7.4 Recommendations

The following recommendations were made from the research findings.

- i. There should be proper implementation of the County Alcoholic Drinks Control Bill and capacity enhancement for the County Government team handling alcohol control.
- ii. Pupils require skills of coping with alcoholic parents. The County Education Office should ensure that there are paid up trained counselors in schools who should give counseling and do strict follow up on pupils with alcoholic parents. Peer counselors they train.
- iii. The Community should be sensitized on the adverse effects of alcohol through seminars by the County Government and involve the local administration and the churches. The Members of Parliament should work on reducing the availability of alcohol to children and grownups by setting up income generating projects.

7.5 Suggestion for further research

The following suggestions are made for further research:

- i. A study should be done to establish the relationship between alcoholism and the media.
- ii. The study was done in Bungoma County. Further studies should be carried out in other parts of Kenya to compare findings.
- iii. The study did not cover Government interventions on alcoholism. Therefore a study should be conducted to determine the strategies undertaken by the Government to reduce the effects of alcoholism on teachers and pupils in Bungoma County.

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APPENDICES

APPENDIX 1: INTRODUCTION LETTER TO RESPONDENTS

Dear Respondent,

I am a Doctor of Philosophy student at Masinde Muliro University of Science and Technology conducting a study on ‘The effects of parental alcoholism on psychosocial development of primary school children in Bungoma County’.

You have been selected to participate in this study so that you assist us come up with strategies to reduce the impact of alcoholism on growing up children.

Your participation is purely voluntary and any information you give will only be used for the purpose of this study. To maintain confidentiality and anonymity, your **name** will **not** be written anywhere on the survey sheet.

Thank you.

Yours faithfully,

Eunice N Libusi

APPENDIX 2: INFORMED CONSENT STATEMENT FOR PARENTS

NO.

SUB-COUNTY.....

DATE.....

INFORMED CONSENT STATEMENT FOR PARENTS

I,.....give permission for my child
..... of class..... to participate in the research study entitled “
Parental alcoholism and its influence on psychosocial development of primary school
pupils in Bungoma County, Kenya. The study has been explained to me and my
questions answered to my satisfaction.

APPENDIX 3: QUESTIONNAIRE FOR PUPILS

QUESTIONNAIRE FOR PUPILS

No.....

Sub-County.....

Date.....

Type of School.....

Please tick against the appropriate response.

Demographic Data of Pupils

1. Your Gender: Male { } Female { }
2. Your age group 10-13 { } 14-17 { } Above 17 { }
3. Number of sisters: 1-3 { } 4-6 { } 7 and above { }
4. Number of brothers: 1-3 { } 4-6 { } 7 and above { }
5. Religion: Christians: { } Islam { } Traditional Indigenous faith { } others { }
6. Home Language: Kiswahili { } Bukusu { } Tachoni { } others { }
7. Whom do you stay with? Both parents { } one parent { } Grandparent { }
8. Occupation of parent: Government employed { } Factory worker { }
Self-employed { } Retired { } Unemployed { }
9. Do you always attend school?
Yes { } No { }
If no, what are the reasons for not attending school always?
Sickness { } Lack of school fees { }
Lack of school items { } others { }

10. Have you ever drunk alcohol? Yes { } No { }

11. Do any members of your family drink alcohol? Yes { } No { }

If Yes, who?.....

12. How many days in a week do they drink alcohol?

Nearly every day { } Sometimes { }

Only during ceremonies { } Not applicable { }

The following statements represent some feelings, experiences or ideas people have.

Select

ONE of the responses that represent your feelings about each of them.

Strongly Agree {SA} Mildly Agree {MA} Uncertain{U} Mildly Disagree {MD}

Strongly Disagree {SD}

Psychological development

1. I am very close to my parent(s) {SA} {MA} {U}
{MD} {SD}

2. I never cry {SA} {MA} {U} {MD}
{SD}

3. I enjoy being on my own {SA} {MA} {U} {MD}
{SD}

4. I find myself worrying most of the time {SA} {MA} {U} {MD}
{SD}

5. I have trouble keeping friends {SA} {MA} {U} {MD}
{SD}

6. I am able to do things just like my age mates {SA} {MA} {U} {MD}
{SD}

Social development

7. I have trouble keeping my mind on studies {SA} {MA} {U}
{MD} {SD}

8. I go out of school without permission {SA} {MA} {U} {MD}
{SD}

9. I drink alcohol {SA} {MA} {U} {MD}
{SD}

10. I can tell lies {SA} {MA} {U} {MD}
{SD}

11. My parents are very strict {SA} {MA} {U} {MD}
{SD}

12. I eat at specific times at home {SA} {MA} {U} {MD}
{SD}

Strategies for enhancing psychosocial development in pupils

The following statements represent some strategies to mitigate the effect of alcoholism on pupils. Select **ONE** of the responses that represent your feelings about each of them.

Strongly Agree {SA} Mildly Agree {MA} Uncertain {U} Mildly Disagree {MD}

Strongly Disagree {SD}

13. Our area chief should discourage drinking alcohol {SA} {MA} {U}
{MD} {SD}
14. Alcohol sellers should engage in other activities {SA} {MA} {U}
{MD} {SD}
15. Local brews should be abolished by the Government {SA} {MA} {U}
{MD} {SD}
16. Our church pastor should preach on drinking {SA} {MA} {U} {MD}
{SD}
17. My uncles/aunts need to talk to our parent(s) {SA} {MA} {U} {MD}
{SD}
18. Teachers should talk to our parent(s) on drinking {SA} {MA} {U} {MD}
{SD}

x. Did you ever feel like hiding or pouring a parent's bottle of alcohol?

Yes { }

No { }

Source: Jones, 1994

APPENDIX 5: SELF-ESTEEM TEST FOR PUPILS

Instructions: Place a tick (✓) next to the number of each statement that you find to be true.

Statement	✓
I generally feel anxious in new social situations where I may not know what is expected of me.	
I find it difficult to hear criticism about myself	
I fear being made to look like a fool	
I tend to magnify my mistakes and minimize my successes	
I am very critical of myself and others	
I have periods in which I feel devastated and/or depressed	
I am anxious and fearful much of the time	
When someone mistreats me I think that I must have done something to deserve it	
I have difficulty knowing who to trust and when to trust	
I often feel like I don't know the right thing to do or say	
I am very concerned about my appearance	
I am easily embarrassed	
I often compare myself to others	
I think others are very focused on--and critical of—what I say or do	
I fear making a mistake which others might see	
I often feel depressed about things I have said and done, or things I failed to say or do	
I felt inferior or inadequate as a child	
I often get defensive and strike back when I perceive I am being criticized	
I try to avoid conflict and confrontation	
I tend to think that I have higher standards than others	
I often think that others don't respect me	
I am very fearful of criticism, disapproval, or rejection	

Source: Sorensen (2006)

APPENDIX 6: INTERVIEW SCHEDULE FOR SUB-COUNTY ADMINISTRATION OFFICERS, AND CHILDREN OFFICERS

Sub-County..... Date.....

1. Is alcohol consumption a major problem in your Sub-County? Explain.
2. What is the age of the people who drink most in this Sub-County? Give possible reasons?
3. What child problems are associated with parental alcoholism in this Sub-County?
4. How can the problem of parental alcoholism be addressed in this community?
5. Are there cases that have been reported to you on alcoholism?
6. Do you think there is need to stop alcoholism?
7. Who are the key people that need to be involved in fighting alcoholism
8. Is the local leadership doing anything to stop alcoholism in Bungoma County?
9. Is the church on the forefront in fighting alcohol in Bungoma County?

APPENDIX 7: INTERVIEW SCHEDULE FOR EDUCATION OFFICERS

Sub-County..... Date-----

1. Are there many cases of primary school dropouts in this Sub-County? Give possible reasons for your answer.

2. What are some of the reasons for children dropping out of school in this Sub-County?

3. Do you encounter cases of drunken teachers in your office? How often? Why?

4. What child problems are associated with parental alcoholism in this Sub-County?

5. How can the problem of parental alcoholism be addressed in this community?

6. Are there cases that have been reported to you on alcoholism?

7. Do you think there is need to stop alcoholism?

8. Who are the key people that need to be involved in fighting alcoholism

9. Is the local leadership doing anything to stop alcoholism in Bungoma County?

10. Is the church on the forefront in fighting alcohol in Bungoma County?

APPENDIX 8: INTERVIEW SCHEDULE FOR HEAD TEACHERS AND PTACOMMITTEE

Sub-County.....

Date.....

1. Do you consider alcohol consumption a major problem in this community?

Explain your answer

2. Which ages of people drink most in this Sub county?

Explain your answer

3. What are some of the problems that are encountered by children from alcohol abusing homes?

4. What are some of the intervention measures that can be taken to reduce the impact of parental alcoholism on children in this school?

5. What child problems are associated with parental alcoholism in this Sub-County?

6. How can the problem of parental alcoholism be addressed in this community?

7. Are there cases that have been reported to you on alcoholism?

8. Do you think there is need to stop alcoholism?

9. Who are the key people that need to be involved in fighting alcoholism

10. Is the local leadership doing anything to stop alcoholism in Bungoma County?

11. Is the church on the forefront in fighting alcohol in Bungoma County?

APPENDIX 9: INTERVIEW SCHEDULE FOR GUIDANCE AND COUNSELING TEACHERS, CLASS TEACHERS AND SENIOR TEACHERS

Sub-County.....

Date.....

1. Do you consider alcohol consumption a major problem in this community?

Explain your answer

2. Which ages of parents that drink most in this Sub-County?

Below 15 years { } 16-24 yrs { } 25-40 yrs { } above 40 yrs { }

Explain your answer

3. What are some of the problems experienced by children from alcohol abusing homes?

4. What intervention measures can be taken to reduce the impact of alcohol on children's development in this school?

5. What child problems are associated with parental alcoholism in this Sub-County?

6. How can the problem of parental alcoholism be addressed in this community?

7. Are there cases that have been reported to you on alcoholism?

8. Do you think there is need to stop alcoholism?

9. Who are the key people that need to be involved in fighting alcoholism

10. Is the local leadership doing anything to stop alcoholism in Bungoma County?

11. Is the church on the forefront in fighting alcohol in Bungoma County?

APPENDIX 10: FOCUSED GROUP DISCUSSION

1. Do you feel it is acceptable for people in your age to use alcohol?
2. At what age do you feel it is acceptable?
3. Why do young people of your age drink alcohol?
4. Where can people your age obtain alcohol(Retail access/Social access) (For example: liquor store, bar, a restaurant, friends, parents, other family member, home (without parents' knowledge)
5. How easy is it for people at your age to obtain alcohol from various sources?
6. How often do people your age have access to alcohol at social settings such as parties at a friend place or unsupervised location?
7. Do your parents have any say in how you select your friends?
8. What kinds of things do you think most parents in your community would say about people your age drinking?
9. How do parents (yours? Your friends'?) approach the idea of young people drinking?
10. What are your own family rules for drinking alcohol?
11. What is your relationship with your parents regarding alcohol?
12. What kinds of alcohol advertising have you noticed in your life?

APPENDIX 11: RESEARCH AUTHORITY FROM MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY



MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY (MMUST)

Tel: 056-30870
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P.O Box 190
Kakamega – 50100
Kenya

Office of the Dean (School of Graduate Studies)

Ref: MMU/COR: 509079

Date: 15th October 2015

Eunice Nambaka Libusi
CDM/H/10/10
P.O. Box 190-50100
KAKAMEGA

Dear Ms. Libusi,

RE: APPROVAL OF PROPOSAL

I am pleased to inform you that the Senate of Masinde Muliro University of Science and Technology acting on the advice of the Board of the School of Graduate Studies approved your proposal entitled: *'Parental Alcoholism and Psychosocial Development among Primary School Pupils in Bungoma, Kenya'* and appointed the following as supervisors:

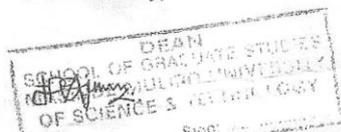
1. Dr. Moses Poipoi
2. Dr. Ruth Naliaka

You will be required to submit through your supervisor(s) progress reports every three months to the Dean SGS. Such reports should be copied to the following: Chairman, Centre for Disaster Management and Humanitarian Assistance Committee and Chairman, Disaster Management and Sustainable Development.

It is the policy and regulations of the University that you observe a deadline of three years from the date of registration to complete your PhD thesis. Do not hesitate to consult this office in case of any problem encountered in the course of your work.

I once more congratulate you for the approval of your proposal and wish you a successful research.

Yours Sincerely,



PROF. PETER ODERA
AG. DEAN, SCHOOL OF GRADUATE STUDIES

