EXAMINING PARENTAL MENTAL HEALTH AS A MEDIATING FACTOR BETWEEN FAMILY DYSFUNCTION AND SCHOOL-AGED CHILDREN'S MENTAL HEALTH IN MALINDI, KENYA

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MASTER OF ARTS IN COUNSELING PSYCHOLOGY

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DECLARATION

I declare that the work in this dissertation has not been previously published or submitted elsewhere for award of a degree. I also declare that this my own original work and contains no material written or published by other people except where due reference is made and author duly acknowledged.

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Signature …… …… Date …19/08/2025……

I do hereby confirm that I have examined the master's dissertation of.

[Mercy A. Were]

And have certified that all revisions that the dissertation panel and examiners recommended have been adequately addressed.

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ABSTRACT

Mental health is essential to the cognitive, emotional, social, and psychological development of children. Existing literature highlights that early childhood mental health challenges can lead to poor developmental outcomes, impaired academic performance, and reduced quality of life. In Kenya, mental health disorders among school-aged children—such as depression, anxiety, behavioral issues, and suicide—are on the rise. This study examined parental mental health as a mediating factor between family dysfunction and the mental health of school-aged children in Malindi, Kenya. Specifically, it investigated the direct effect of family dysfunction on children's mental health, the impact of family dysfunction on parental mental health, and the combined predictive influence of both variables on child mental health outcomes.

Guided by Structural Family Theory and Bronfenbrenner's Ecological Systems Theory, the study employed a descriptive cross-sectional design targeting children aged 6 to 18 years attending public schools. Stratified and systematic random sampling was used to select households, and data were collected through semi-structured questionnaires administered to parents and primary caregivers. Quantitative data were analyzed using SPSS version 27, applying Pearson's correlation and multiple linear regression. Findings revealed that the relationship between family dysfunction and children's mental health was statistically insignificant ($F = 1.552$, $df = 1, 328$, $p = .214$). Similarly, family dysfunction showed no significant impact on parental mental health ($B = -0.053$, $p = .188$), and neither variable significantly predicted children's mental health outcomes. The study recommends interventions focused on family role clarification, counseling, and community-based mental health support. These findings offer valuable insights for parents, educators, mental health practitioners, and policymakers, and underscore the need for longitudinal research to explore causal relationships and evaluate the long-term effectiveness of family-centered interventions.

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I would like to thank my supervisors for the immense guidance, support and revealing comments that they have consistently had on the whole process of the research work.

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DEDICATION

This dissertation is dedicated to my father, John Were, whose unwavering encouragement, faith, and belief in my abilities have been a constant source of inspiration. To my boss, Alexander, for his exceptional support and understanding throughout this academic journey. To my beloved husband and children, whose patience, love, and sacrifices sustained me during the many moments when my studies demanded my time and presence elsewhere. To my house manager, Lilian Ochieng, for stepping up to support my family when my presence was demanded more in my academics. Finally, to my dear siblings, may the insights and findings of this study serve as a meaningful guide as you raise and nurture your own families.

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OPERATIONALIZATION OF TERMS

Term **Operational Definition**

Authoritarian Parenting: A Rigid and authoritarian parenting style that lays greater stress on compliance and punitive measures than on communication and interpersonal affiliation. It usually denies a child his or her freedom and expression of emotions.

Blended Family: A family that is created when two partners who share children with their former partners come together, and this scenario usually involves stepparents and stepsiblings. Such families might experience role ambiguity and adjustment problems.

Dysfunctional Parenting: Exhibiting parenting behaviors that are defined as inconsistent, neglectful, controlling, authoritarian, emotionally unavailable, or abusive. This has the potential to affect the emotional well-being and progress of a child adversely.

Emotional Neglect: A type of dysfunction in which the caregiver regularly overlooks the emotional needs of the child, resulting in a sense of rejection, self-worthlessness, and psychological turmoil.

Parental mental health: Parental mental health (PMH) is defined as the current level of emotional distress and psychological functioning exhibited by parents/primary caregivers, specifically symptoms of depression, anxiety, and psychological stress, as perceived and reported by the respondent. In this study PMH is measured by caregiver responses to Section C (items 17–24)

of the questionnaire. Higher scores indicate greater parental psychological distress (worse parental mental health).

Family Dysfunction: Family dysfunction refers to patterns of interaction, relationships, and family conditions that consistently disrupt harmony, emotional support, and stability within the household, thereby impeding the emotional and social development of children. In this study, family dysfunction is operationalized through three measurable subdimensions:

i. Family Conflict and Violence (section B): Frequency and intensity of verbal or physical conflicts, disrespectful communication, and emotional neglect among family members.

ii. Family Structural Disruptions (section D): Instability arising from divorce, separation, single parenting, remarriage, or frequent changes in family composition and caregiving arrangements that cause emotional strain within the household.

Each subdimension is assessed using a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree) with higher scores indicating greater family dysfunction.

High-Conflict Family: A family that is marked by numerous, severe, and unrewarded conflicts, usually subjecting children to verbal aggression, emotional discomfort, or even physical abuse.

Mental Health Disorders: Clinically considerable patterns of erratic or behavioral signs that interfere with the functioning of a child in a school, home, or societal environment. These can be anxiety, depression, conduct disorder, attention-deficit hyperactivity disorder (ADHD), and somatic complaints.

Children's Mental Health Status: Children's mental health refers to the emotional, behavioral, and social functioning of school-aged children as perceived by their parents or guardians. In this study, it represents the extent to which children exhibit emotional stability, positive social interactions, and adaptive behaviors in the context of family experiences. Operationally, it is measured through the Children's Mental Health and Behavior dimension (Section E) capturing:

i. Emotional Well-being: Presence of anxiety, sadness, or loss of interest in daily activities.
ii. Behavioral Adjustment: Restlessness, concentration difficulties, and hyperactivity.
iii. Social Functioning: Interaction with peers, social withdrawal, and ability to recover from family-related stress.
iv. Academic Functioning: Effect of family-related tension on school performance and focus.

The variable is measured using a 5-point Likert scale (1 = Strongly Disagree to 5 = Strongly Agree), with higher aggregate scores indicating poorer child mental health.

School-Aged Children: School-aged children are individuals aged between 6 and 18 years who are actively enrolled in primary or secondary schools within Malindi Sub-County. For this study, their mental and emotional functioning is reported by parents or guardians based on observable behaviors at home and in relation to school experiences.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter provided a summary of the research through presenting the background, the problem statement, research variables, and objectives, the study's research questions as well as the significance and scope of the study. These elements helped define the study's focus and justified the need for the research.

1.2 Background to the Study

A nurturing and stable family environment played a fundamental role in promoting mental health among children, fostering their psychological, social, and emotional development. Providing love, open communication, and emotional support helped children develop resilience, confidence, and positive social behaviors. When families became dysfunctional, however, supportive dynamics failed and gave rise to negative psychological consequences. Children growing up in dysfunctional families were at high risk of developing mental illnesses, including anxiety, depression, substance addiction, conduct and impulse-control disorders, and emotional regulation impairments.

Domestic violence, emotional neglect, physical abuse, parental conflict, and parental absence were some of the key factors leading to family dysfunction. Such dysfunctional relationships were documented to seriously affect children's mental health, creating conditions where they found it challenging to build safe attachments, regulate emotions, and initiate healthy social interactions (Mphaphuli, 2023). In particular, children who lived in blended families with stepparents or stepsiblings often faced role confusion, divided loyalties, and emotional strain, all of which escalated mental health challenges (Ganong & Coleman, 2017).

International research further confirmed the long-term risks of family dysfunction. Dong et al. (2004) found that children exposed to domestic violence were more likely to display antisocial behavior, poor school performance, and later criminal tendencies compared to non-exposed peers. The World Health Organization (WHO, 2023) estimated that nearly one billion children worldwide had experienced some form of domestic violence, underlining the severe influence of dysfunctional families on child mental health. Such children often suffered from emotional inhibition, internalized feelings, and loneliness that might persist into adulthood (Vodnik, 2019; Kidwell, 2024). These patterns highlighted the need for localized research on family dysfunction and child mental health, particularly in Malindi Sub-County, Kenya, where family structures were diverse and often complex.

In developed countries, studies showed that about 16% of children aged 3 to 17 experienced at least one mental health condition, with family-related factors such as single parenthood, parental mental illness, and lack of structured mental health care playing major roles (Okwori, 2022). Similarly, an Australian study reported that 79% of children with parents diagnosed with mental illness exhibited anxiety and mood disorders, emphasizing the direct link between parental well-being and child development (Bitta et al., 2017).

In Sub-Saharan Africa, similar findings were observed. In South Africa, Masilo (2012) reported that children from substance-affected households experienced emotional withdrawal, poor academic performance, and behavioral problems. In Kenya, Ndetei et al. (2016) revealed that 37.7% of children in upper primary school suffered from mental health conditions such as conduct disorders, emotional disorders, and somatic complaints. Risk factors included parental separation, maternal employment, and inconsistent parenting.

Despite these findings, there remained limited research that directly focused on Malindi Sub-County, Kenya, where unique family dynamics such as high rates of remarriage, blended families, and parental absence due to tourism-related employment might have created specific risks. This study, therefore, targeted school-aged children aged 6 to 18 years in Malindi Sub-County and their parents or caregivers as the sample population, with the aim of understanding how family dysfunction directly affected their mental health outcomes.

1.3 Statement of the Problem

In Kenya, pediatric mental health issues gained momentum among school-aged populations. The World Health Organization (2001) claimed that many mental illness cases in the life of a person had their onset in childhood or adolescence. Mathai et al. (2021) added that the risk of worsening progressively accumulated from childhood. WHO reported that 10 to 20 percent of the victims more vulnerable to mental disease were children and adolescents (WHO, 2024b; Sacco et al., 2024). According to WHO, depression, for instance, was linked to suicide, the third greatest cause of death for children aged 15 to 19, and was ranked as the ninth major cause of illness and impairment in adolescents (WHO, 2020; WHO, 2023).

In Kenya, thirty-seven-point seven percent of school-aged children experienced mental disorders. The disorders were characterized by somatic complaints (29.6 percent), affective disorders (14.1 percent), and conduct disorders (12.5 percent) (Ndetei et al., 2016). Ndetei and colleagues added that risk factors for these disorders included a working mother and parents who were separated or divorced. There were cases where children even committed suicide, yet such suicidal thoughts were very rare in the past (Ndetei et al., 2016). In the daily news, there were also reports of violence in families where some cases escalated to the extreme, with parents either killing children by burning them alive or hacking them with sharp objects

(Ombati, August 17, 2023). These instances reflected severe dysfunctionality in families. Beyond extreme cases of abuse, family dysfunction also manifested in more complex family structures such as blended families, where children lived with stepparents and stepsiblings due to remarriage. These arrangements, while not inherently harmful, posed adjustment challenges, including emotional detachment, unclear parental roles, and families experienced loyalty conflicts that had a profoundly negative effect on children's mental health (Ganong & Coleman, 2017).

Malindi Sub-County, Kenya registered a significantly high burden of mental health problems among children (25.6 percent), which was higher than the global prevalence of approximately 14.3 percent (WHO, 2020; WHO, 2023). According to Bitta et al. (2017), 15.8 percent of all retrospective health record contacts related to psychiatric conditions in their study on "An Overview of the Mental Health Care System in Kilifi, Kenya," involved patients aged 20 years or younger, 25.6 percent of whom were children under 14 years. Another study by Kariuki et al. (2017), titled "Burden, Risk Factors, and Comorbidities of Behavioral and Emotional Problems in Kenyan Children: Gaither et al. (2000) in their paper Management of Mental, Emotional and Behavioral Problems in a Population-Based Study expressed that the percentage of total behavioral and emotional problems was 13. Externalizing problems were 10 percent (95% CI 9–11), and internalizing problems were 22 percent (95% CI 21–24).

Despite studies being conducted on this topic, a critical gap remained due to the rising number of mental health cases as reported by local mainstream media and scholarly research (Kariuki et al., 2017; Bitta et al., 2017; Ndetei et al., 2016). Some children were also involved in drug and substance abuse. Additionally, no studies had specifically focused on the contribution of family dysfunctionality to the prevalence and incidence of behavioral mental

health problems among children in Malindi Sub-County, Kenya. Moreover, limited research explored how children from blended families in the region experienced and internalized psychological stress related to complex household relationships and transitions.

The study conducted in Kilifi County focused on the broader overview of mental health care systems using the WHO Assessment Instruments. This current study narrowed the focus to Malindi Sub-County, Kenya, a sub-region within Kilifi County, and relied on primary data to enhance specificity. It therefore reduced the scope and provided a more localized perspective, complementing existing research. While previous studies assessed mental health in children, they did not address the influence of dysfunctional families on children's mental health. By incorporating an analysis of blended family dynamics, this study broadened the understanding of modern family-related stressors affecting children's mental well-being in Malindi.

Therefore, this study sought to bridge this gap by examining how family dysfunction (including violence, neglect, and complex family structures) influences the mental health of school-aged children in Malindi Sub-County, and how parental mental health mediates this relationship. By localizing the analysis and integrating the parental mental health variable, the study provides greater understanding of how family environments shape children’s emotional and behavioral outcomes in contemporary Kenyan contexts.

1.4 Purpose of the Study

The overall purpose of this research was to evaluate how dysfunctional family environmental settings affected the well-being of school-aged children in Malindi Sub-County, Kenya.

1.5 Objectives of the Study

The current study was guided by the following objectives:

i. To examine the direct effect of family dysfunction on children's mental health.
ii. To examine the effect of family dysfunction on parental mental health.
iii. To assess the combined predictive influence of family dysfunction and parental mental health on children's mental health

1.6 Research Questions

i. Does family dysfunction directly affect children's mental health?
ii. Does family dysfunction affect parental mental health?
iii. Do parental mental health and family dysfunction together predict children's mental health?

1.7 Research Hypothesis

H_0: Family dysfunction and parental mental health do not significantly predict children's mental health status in Malindi Sub-County.

H_1: Family dysfunction and parental mental health significantly predict children's mental health status in Malindi Sub-County.

1.8 Justification of the Study

This study's objective was to examine parental mental health as a mediating factor between family dysfunction and the mental health of school-aged children in Malindi, Kenya, Kenya. Malindi was chosen as the research location because of its known high rate of childhood mental health issues, as identified in regional assessments. Despite growing national attention on child mental health, there remained a lack of sub-county-level research that specifically

examined how family structure and dysfunction contributed to emotional and behavioral disorders among children within this context.

This study was particularly relevant because it explored not only traditional signs of dysfunction, such as parental divorce, conflict, and neglect, but also emerging family structures such as blended families. Blended households, which involved stepparents and stepsiblings, may have introduced adjustment challenges, emotional uncertainty, and inconsistent parenting practices that influenced children's psychological well-being. These dynamics were often underexplored in current Kenyan literature and required focused investigation to inform effective mental health strategies.

Many stakeholders were interested in the findings of this study. Parents became more aware of the influence of family dynamics on the emotional and psychological development of their children, creating more favorable conditions in the home environment. Teachers were in a better position to identify the signs of distress and change in behavior among the learners. The Ministry of Education and Health could also have employed the findings to enforce mental health policies and design school-based intervention programs.

The study further offered a contribution to the scholarship and policy debate on Kenyan children's and adolescents' mental health, given its localized findings that could be used to create future evidence-based policies. The insights produced also benefited community-based organizations and child welfare advocates who sought to support children as they grew up in different family environments.

1.9 Scope of the Study

The research took place in Malindi Sub-County, Kenya, which was part of Kilifi County. It examined the interconnection between family dysfunction and the mental health of

school-aged children. The study focused on children aged 6–18 years, capturing learners at both primary and secondary school levels. Participants included the primary caregiver or household head, as they were best placed to provide information on family relationships, parenting styles, and the general psychosocial environment of the home.

The research explored different forms of family dysfunction, including parental hostility, neglect, separation, and structural disturbances, which were often common in blended families. These factors were evaluated against the psychological and emotional well-being of children.

The study design was expected to generate knowledge on how school-aged children in Malindi developed mental health conditions as a result of family environments. The geographical scope was limited to Malindi Sub-County; however, the findings may have offered insights applicable to other sub-counties with similar socio-cultural contexts. Thematically, the study focused on the health and emotional outcomes of children as influenced by dysfunction in the home environment.

The following delimitations further shaped the scope. First, the study was limited to Malindi Sub-County and did not extend to the wider Kilifi County or other regions in Kenya. Second, only school-aged children aged 6–18 years were included, thereby excluding younger children and out-of-school youth. Third, the research primarily examined family-related dysfunction, while other external factors, such as peer pressure or community violence, were considered only indirectly. These delimitations were necessary to ensure feasibility, focus, and depth within a master ’s-level study.

Finally, the study assumed that respondents would provide honest and accurate information regarding their family experiences and mental health concerns. It also assumed

that family dysfunction was a key factor influencing the mental health of school-aged children, even though other external factors might have also played a role. It was further assumed that the data collection instruments would yield reliable, valid, and meaningful data to support analysis and conclusions.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter provided a literature evaluation on the correlation between family dysfunction and the mental health of a school-aged child. It addressed different types of family dysfunction, such as parental conflict, neglect, and substance abuse, and its major theme was a blending of families. The chapter also covered empirical research on the psychological implications of such dysfunctions and gave detailed theoretical underpinnings that led to the conception of the study as well as the conceptual perspective of the same.

2.2 Empirical Literature Review

This chapter provided a literature evaluation on the correlation between family dysfunction and the mental health of a school-going child. It addressed different types of family dysfunction, such as parental conflict, neglect, and substance abuse, and its major theme was a blending of families. The chapter also covered empirical research on the psychological implications of such dysfunctions and gave detailed theoretical underpinnings that led to the conception of the study as well as the conceptual perspective of the same.

2.2.1 Dynamics of Family Violence and Abuse in Child Mental Health

The family environment played a fundamental part in shaping the mental, emotional, and social well-being of children. Dysfunctional family dynamics, particularly those involving domestic violence, emotional abuse, parental discord, and neglect, were consistently linked to a heightened risk of mental health disorders in children. These experiences disrupted emotional stability and impeded developmental processes, potentially leading to lifelong psychological consequences. From an Ecological Systems Theory perspective, family violence and abuse

represented adverse microsystem influences that shaped children's development within their immediate environment. From Minuchin's Structural Family Theory, such violence also reflected a breakdown of family boundaries and roles, creating instability that led to dysfunction.

In a landmark study conducted in the United States, Dong et al. (2004) examined data from 17,337 adults enrolled in the Adverse Childhood Experiences (ACE) Study, assessing the long-term influences of childhood maltreatment and dysfunctional households. The findings revealed that individuals exposed to domestic violence and parental conflict during childhood had significantly higher rates of antisocial behavior, depression, and school failure, and were more likely to engage in criminal behavior. This study was foundational in understanding how early exposure to violence affected developmental outcomes. It directly informed the present study by linking exposure to family violence with adverse outcomes among school-aged children in Malindi Sub-County, where similar risks may have existed.

The World Health Organization (2020), in a global situational analysis involving 133 countries, reported that children exposed to family violence, whether physical, emotional, or psychological, faced a heightened risk of developing persistent mental health conditions such as anxiety and depression. This risk increased when children also experienced parental mental illness or substance abuse. Such findings underscore the universality of family dysfunction as a determinant of child mental health and justified localized research in Malindi to understand its context-specific manifestations.

In South Africa, Masilo (2012) conducted a qualitative study involving 50 children aged 10 to 16 living in households affected by substance abuse and domestic violence in Gauteng Province. The children showed symptoms of emotional withdrawal, low academic

performance, and disruptive behavior in school. Many also experienced neglects of basic needs such as healthcare, food, and education. These outcomes illustrated the compounding effect of violence, poverty, and family instability on children's well-being. This supported Bronfenbrenner's model by showing how microsystem-level dysfunction interacted with exosystemic stressors such as poverty to amplify risk. From Minuchin's perspective, the findings also demonstrated how blurred or weak parental roles led to neglect and poor regulation of children's emotional needs.

In Kenya, a national survey by Ndetei et al. (2016) involving 2,071 school-aged children from both rural and urban settings, including Nairobi, Nakuru, and Mombasa, found that 37.7% of the children exhibited symptoms of mental health disorders. Key contributing factors included exposure to domestic violence, emotional neglect, and parental separation. The study revealed that children from violent homes reported more somatic complaints, conduct disorders, and depressive symptoms than those from stable households. This large-scale Kenyan evidence reinforced the need to examine how these dynamics played out within Malindi Sub-County, sharpening the current study's contribution to national mental health discourse. Here, Ecological Systems Theory highlighted how dysfunction within the microsystem (family) spilled over into the mesosystem (school and peer relationships), while Structural Family Theory helped explain how weak or conflicting boundaries within violent homes destabilized children's emotional security.

In relation to family structure, Ganong and Coleman (2017) conducted a mixed-methods study involving 1,200 children aged 8 to 15 from urban communities in the United States who were living in blended families. The study identified loyalty conflicts, role ambiguity, and difficulty forming attachments with stepparents as common issues, significantly associated with anxiety, depression, and behavioral disorders. These findings offered valuable

insights for Malindi Sub-County, where family restructuring and remarriage were common. Blended family arrangements, as part of the family microsystem, may have created psychological strain that interacted with other dysfunctions such as violence or neglect. This connected directly with Minuchin's theory, as blended families often struggled with unclear family roles and weak boundaries, and with Bronfenbrenner's theory, as these disruptions in the microsystem affected children's wider mesosystem functioning (e.g., school adaptation).

In conclusion, evidence from international, regional, and local studies confirmed the widespread effects of family violence and domestic abuse on children's mental health. While global research emphasized developmental risks and long-term consequences, African-based studies highlighted the intersection of violence with poverty, unmet basic needs, and restricted access to mental health services. In Kenya, high rates of domestic violence and emotional neglect significantly affected children's well-being. These findings directly aligned with Bronfenbrenner's Ecological Systems Theory, where the family microsystem exerted the most immediate influence on child development and interacted with exosystem and mesosystem factors to worsen outcomes. They also aligned with Minuchin's Structural Family Theory, which explained how role confusion, boundary violations, and parental conflict created dysfunctional family environments that undermined children's mental health.

2.2.2 Influence of Parental Mental Health on Child Development

The mental health of their parents strongly shaped a child's psychological, emotional, and behavioral development. Parents experiencing psychological distress such as depression, anxiety, or substance-related disorders often struggle to provide consistent care, emotional support, and effective parenting. In such environments, children were more likely to develop mental health problems. From an Ecological Systems Theory perspective, parental mental health challenges functioned as proximal processes within the child's microsystem, influencing

their ability to regulate emotions, cope with stress, and build secure attachments. From Minuchin's Structural Family Theory, parental psychological distress disrupted the functioning of parental subsystems, weakening family roles and boundaries and creating instability that undermined children's emotional development. These challenges may have been intensified in contexts of poverty and limited access to mental health services, such as Malindi Sub-County.

Recent studies confirmed this relationship. Richardson et al. (2022), in a survey of over 800 school-aged children (6–14 years) and their parents in Texas, found that parental depression and chronic psychological stress were significantly associated with children's anxiety, depression, and conduct disorders, alongside academic decline and social withdrawal. Similarly, Mokdad et al. (2021), in a cross-country analysis covering over 15,000 families, reported that children of parents with untreated mental health conditions were twice as likely to show emotional and behavioral problems compared to those with mentally healthy parents.

In Sub-Saharan Africa, Okwori (2022), studying 75 families in rural Nigeria where at least one parent had a diagnosed mental health disorder, observed that children frequently developed chronic anxiety, low self-esteem, and interpersonal difficulties. The lack of early intervention, coupled with economic hardship, limited children's resilience and coping mechanisms. Cluver et al. (2019), working with more than 3,000 adolescents in South Africa, further found that parental depression was strongly associated with suicidal ideation and internalizing problems, especially in communities marked by poverty and social stigma. These findings illustrated how the exosystem and macrosystem in Bronfenbrenner's theory, such as poverty, stigma, and health system weaknesses, interacted with the microsystem to heighten children's psychological vulnerability. From Minuchin's view, the data emphasized how disrupted parental roles within dysfunctional households directly eroded the caregiving structure needed for healthy child adjustment.

Within Kenya, the relationship was equally evident. Kalil (2020), in a study of 110 children aged 9–16 in Nairobi's informal settlements, reported that parental depression and substance abuse significantly predicted emotional withdrawal, psychosomatic complaints, and poor academic performance. Similarly, Ndetei et al. (2016), in a nationwide study of 2,071 school-aged children, found that those from households with mentally ill parents exhibited higher rates of conduct disorders, somatic complaints, and depressive symptoms, particularly where poverty and domestic violence were also present. More recently, Kariuki et al. (2020), in a study of 1,022 Kenyan children, confirmed that parental mental illness was a significant risk factor for internalizing and externalizing problems. Here, Bronfenbrenner's framework highlighted how dysfunction in the family microsystem interacted with mesosystem factors such as poor school performance to compound harm, while Minuchin's theory clarified how inconsistent parental roles and weak boundaries created unstable environments that reinforced these outcomes.

In Malindi Sub-County, these risks were compounded by socio-economic deprivation, high levels of substance abuse, and reliance on extended family structures. Such localized factors intensified the effects of parental psychological distress, leaving children vulnerable to anxiety, depression, emotional instability, and behavioral problems. This aligned with Ecological Systems Theory by showing how microsystem dysfunction interacted with exosystem-level deprivation, and with Structural Family Theory by demonstrating how blurred caregiving roles within extended or blended families compromised children's emotional stability. This highlighted the importance of the present study, which sought to examine how parental mental health challenges contributed to mental health disorders among school-aged children in Malindi, thereby filling a crucial gap in Kenyan-focused research.

2.2.3 Family Disruptions and Behavioral Adjustment in Children

Family disruptions such as separation, divorce, single parenting, and the formation of blended families significantly influenced children's behavioral and emotional development. These disruptions often created unstable home environments marked by inter-parental conflict, unclear family roles, and inconsistent caregiving. From an Ecological Systems Theory perspective, these disruptions altered the child's microsystem and mesosystem interactions, undermining emotional stability and adaptation. From Minuchin's Structural Family Theory, such disruptions weakened family subsystems, blurred boundaries, and generated role ambiguity, leaving children without the clear structure and stability necessary for healthy adjustment. Children in such contexts were more vulnerable to internalizing disorders like anxiety and depression, as well as externalizing behaviors such as aggression and defiance, which persisted into adolescence and adulthood and impaired academic and social functioning.

Recent longitudinal studies reinforced this. Richardson et al. (2022), in a study of 860 children from divorced and remarried households in Texas, found that exposure to parental conflict and unclear family roles was strongly associated with higher rates of anxiety, depression, and behavioral difficulties. Similarly, Brown et al. (2021), using data from over 5,000 adolescents in the U.S., confirmed that children in disrupted families had significantly poorer academic performance and emotional regulation compared to peers in intact households. These findings not only highlighted how disruptions in the microsystem affected emotional and behavioral outcomes but also illustrated Minuchin's principle that breakdowns in parental roles destabilized children's regulation and functioning.

In Sub-Saharan Africa, Otwombe et al. (2019), studying 3,200 adolescents in South Africa, found that parental separation and blended family arrangements were linked to elevated depression and conduct problems, particularly in low-income households. In Kenya, Kalil

(2020), in a study of 120 children in Nairobi's informal settlements, reported that children in single-parent and remarried families faced higher risks of emotional distress, academic underperformance, and anxiety, often worsened by financial strain and limited parental availability. More recently, Kariuki et al. (2020), involving 1,022 Kenyan children, found that inconsistent parenting following divorce or separation significantly predicted both internalizing and externalizing disorders. These African findings further supported Bronfenbrenner's exosystem perspective, as poverty and limited resources exacerbated the risks of disrupted households, while Minuchin's framework helped explain how inconsistent parenting reflected weakened family boundaries that left children emotionally vulnerable.

Further Kenyan evidence was provided by Ndetei et al. (2016), who surveyed 2,071 school-aged children and reported that those from disrupted families had higher rates of depression, social withdrawal, and hostility. Khasakhala et al. (2021) added that adolescents from stepfamilies in Nairobi reported increased psychological distress and difficulties in peer relationships, reinforcing the risks associated with blended family structures. In terms of theory, these findings aligned with the mesosystem concept in Bronfenbrenner's model, since disrupted families affected children's ability to engage positively with peers, and with Minuchin's theory, which stressed how loyalty conflicts and unclear hierarchies in stepfamilies eroded children's emotional security.

In Kilifi County, which neighbors Malindi, Bitta et al. (2017) conducted a regional study of children from disrupted families and low-income households, finding high levels of depression, anxiety, and school absenteeism, particularly where parental remarriage and substance abuse co-occurred. Given the socio-cultural proximity of Kilifi to Malindi, these findings were likely reflective of challenges within Malindi's family systems.

Cultural norms and economic pressures in Malindi Sub-County, such as high remarriage rates and reliance on extended family arrangements, further intensified children's adjustment difficulties. Without adequate emotional preparation or consistent support, these disruptions compounded psychological vulnerability, highlighting the urgent need for localized research. By drawing on Ecological Systems Theory, this study examined how family disruptions within the microsystem interacted with wider exosystem pressures such as poverty and stigma, while Minuchin's Structural Family Theory helped interpret how role ambiguity and weak boundaries in disrupted and blended families contributed to children's maladjustment. The current study, therefore, sought to analyze how family disruptions influenced the mental health of school-aged children in Malindi, contributing evidence for targeted interventions in Kenya's coastal context.

2.2.4 Blended Families and Their Influence on Child Mental Health

Blended families, also referred to as stepfamilies, were increasingly common globally due to rising rates of divorce, separation, and remarriage. These family units were formed when one or both partners entered a new marriage with children from prior relationships. While blended families may have provided renewed social structures, they also presented unique challenges such as role ambiguity, divided loyalties, strained parent–child relationships, and difficulties in sibling integration. From the lens of Bronfenbrenner's Ecological Systems Theory, these challenges occurred within the child's microsystem. They disrupted developmental processes, while Minuchin's Structural Family Theory highlighted how blurred boundaries, weak parental subsystems, and unclear roles created dysfunction that undermined children's adjustment. Together, these perspectives suggested that blended families may have heightened vulnerability to emotional and behavioral problems.

Ganong and Coleman (2017), in a study of over 300 children aged 10–17 from various stepfamily arrangements in the United States, found that children in blended families were significantly more susceptible to anxiety, emotional withdrawal, and depressive symptoms compared to those in nuclear families. These outcomes reflected Minuchin's principle that divided loyalties and ambiguous boundaries destabilized family subsystems, while also aligning with Bronfenbrenner's view that conflict in the microsystem spilled over into children's emotional well-being. Building on this, Brown et al. (2021), analyzing data from 5,200 adolescents in the U.S., reported that children in blended households exhibited higher risks of school disengagement and peer conflict, underscoring the long-term social consequences of family restructuring.

Finkelhor et al. (2016), in a large-scale longitudinal study of over 1,400 children aged 8–16 across several U.S. states, found that stepfamily environments were associated with elevated behavioral problems, aggression, and difficulties in peer relationships compared to intact families. The authors attributed these problems to unresolved parental conflict and inconsistent caregiving, which Minuchin interpreted as a breakdown of the parental subsystem, while Bronfenbrenner highlighted the influence of such instability on children's school and peer mesosystem interactions. More recently, Strohschein and Chiu (2019), in a Canadian cohort study of 2,100 adolescents, confirmed that the effects of remarriage on child adjustment remained significant even after controlling for socio-economic status, suggesting that stepfamily dynamics independently predicted mental health risks.

In Africa, Masilo (2012) conducted a qualitative study with 45 children aged 9–15 in South Africa, showing that blended family dynamics often produced low self-esteem, emotional neglect, and social withdrawal. These outcomes illustrated the structural theory's focus on weak or poorly defined step-parent/child roles, which compromised children's sense

of stability. Cluver et al. (2019), studying over 3,000 South African adolescents, further demonstrated that disrupted family structures, including remarriage, were strongly correlated with depression and suicidal ideation, especially in households facing poverty and stigma. From an ecological perspective, these findings also showed how macrosystem-level stressors, such as poverty and stigma, amplified the risks posed by blended family dysfunctions.

In Kenya, Ndetei et al. (2016) surveyed 2,071 school-aged children nationwide and found that those in blended families were more likely to present with anxiety, depression, and conduct disorders, alongside difficulties bonding with stepparents or new siblings. Khasakhala et al. (2021), in a study of 758 adolescents in Nairobi, reinforced these findings by reporting that stepfamily membership significantly increased the risk of internalizing problems such as depression and externalizing behaviors such as aggression. These studies supported Minuchin's assertion that blurred roles and loyalty conflicts were central stressors in stepfamilies, while also confirming Bronfenbrenner's point that microsystem instability undermined children's broader adaptation.

In Malindi Sub-County, anecdotal evidence and regional reports indicated that remarriage and stepfamily formation were increasingly common due to cultural acceptance of remarriage. Children in these families often faced sibling rivalries, emotional detachment from stepparents, and difficulties adjusting to new household norms. These were classic examples of structural family dysfunction, where role ambiguity and disrupted boundaries destabilized children's emotional security. At the same time, ecological systems theory highlighted how cultural norms in the macrosystem and community stigma in the exosystem exacerbated these risks. If unaddressed, these stressors could have led to sadness, anxiety, poor academic achievement, and long-term behavioral challenges. Despite the prevalence of such dynamics,

empirical research specific to Malindi was scarce, limiting the ability to design targeted interventions.

This study therefore sought to address this gap by examining how blended family dynamics uniquely affected the mental health of school-aged children in Malindi Sub-County, Kenya. By jointly applying Ecological Systems Theory and Minuchin's Structural Family Theory, the research showed how role ambiguity, divided loyalties, and blurred boundaries within blended families (structural dysfunction) interacted with socio-economic and cultural pressures at the micro-, meso-, and macro-system levels to shape child development. The findings were intended to inform future policy and interventions to support children in blended families within the region.

2.2.5 Patterns of Mental Health Disorders Among School-Aged Children

Mental health conditions among school-aged children have been an escalating global public health concern. These disorders often manifested as anxiety, depression, conduct problems, attention deficit hyperactivity disorder (ADHD), and somatic complaints. Such conditions interfered with academic performance, emotional stability, and social relationships. They were frequently linked to adverse family environments such as domestic violence, parental psychological distress, and inconsistent caregiving. From an ecological systems theory perspective, these conditions emerged when negative family-level microsystem influences undermined children's capacity to adapt within school and peer contexts. From Minuchin's structural family theory, such dysfunction arose when parental and sibling subsystems lacked clear boundaries, communication was disrupted, and role expectations became ambiguous, leading directly to children's maladjustment.

According to the World Health Organization (2021), one in seven adolescents aged 10–19 worldwide lived with a mental health disorder, with depression, anxiety, and behavioral problems being the most common. A multi-country study by Kessler et al. (2018), involving more than 13,000 children across five continents, confirmed that exposure to trauma or chronic family stress increased the likelihood of developing anxiety and mood disorders two to threefold compared to peers from stable households. These findings resonated with ecological theory's emphasis on the long-term influence of microsystem adversity, and with Minuchin's framework that highlighted how poorly functioning family structures transmitted stress and instability to children.

In Sub-Saharan Africa, the burden of child mental health problems was well documented but often underdiagnosed due to stigma and inadequate services. Kinyanda et al. (2019), in a Ugandan study of 1,110 adolescents, found that exposure to domestic violence and parental mental illness was significantly associated with depression and suicidal ideation. In Kenya, Ndetei et al. (2016) assessed 2,071 school-aged children and reported a national prevalence of 37.7%, with conduct disorders, depression, and somatic complaints most common. Risk factors included parental separation, exposure to violence, and substance abuse. Kariuki et al. (2020), in a study of 1,022 Kenyan children, similarly found that adverse family environments were strong predictors of both internalizing and externalizing disorders. These Kenyan studies aligned with structural family theory in showing that when family roles broke down and inter-parental conflict was high, children's mental health was destabilized, while ecological systems theory explained how these disruptions extended into children's peer and school environments.

Regionally, Bitta et al. (2017) conducted a mental health survey in Kilifi County among children under 14 and found that 25.6% had psychiatric conditions, most commonly depression

and conduct disorders. These were strongly associated with parental conflict, divorce, and poverty. Given Malindi's socio-cultural proximity to Kilifi, these findings provided important contextual insights. Both theoretical perspectives helped explain these outcomes: structural dysfunction at the family level (blurred roles, weak parental subsystems) combined with ecological stressors (poverty and limited services at the exosystem level) to heighten risk.

In Malindi Sub-County, while precise prevalence data were scarce, school-based reports and community health records consistently pointed to growing challenges such as academic disengagement, emotional instability, and behavioral problems. Teachers and community health volunteers particularly noted increased vulnerability among children from blended families, disrupted households, or homes affected by parental absence due to tourism-related employment. Here, structural theory explained how stepfamily role conflicts or absent parental subsystems generated instability, while ecological theory emphasized how these family risks interacted with community- and school-level pressures to affect children's outcomes.

The current study, therefore, sought to address this gap by identifying the specific mental health disorders affecting school-aged children in Malindi Sub-County. By integrating ecological systems theory and structural family theory, the study examined how poorly functioning family structures (e.g., ambiguous roles, disrupted subsystems, loyalty conflicts) interacted with broader socio-economic and cultural pressures at multiple ecological levels to influence child mental health. This localized evidence was intended to inform interventions aimed at supporting both emotional well-being and academic success in Malindi.

2.3 Theoretical Framework

This section presented two theoretical frameworks that guided the study: Minuchin's Structural Family Theory and Bronfenbrenner's Ecological Systems Theory. These theories provided great insights into how to perceive the influence of family dysfunction, especially that of blended families, on the mental health of children who attended school.

2.3.1 Minuchin's Structural Family Theory

The Structural Theory of the Family (Minuchin, 1974) underscored the importance of family architecture and the position of individuals in the family. According to the theory, family systems were comprised of several subsystems (e.g., parental subsystems, sibling subsystems), which required well-defined boundaries, roles, and rules to perform efficiently. These boundaries were too rigid or too permeable, resulting in breakdown of communication, conflicts, and ambiguity of roles, leading to dysfunction. The consequences of these disruptions could be severely detrimental to the emotional and psychological growth of a child; behavioral problems and emotional problems were common outcomes of these occasions (Minuchin, 1974).

The theory was of special interest when it came to looking at the interaction in the context of blended families, as children who lived in such structures encountered special difficulties. The sensitive role of stepparents and stepsiblings following the remarriage process introduced confusion, divided loyalties, and disrupted bonds, leading to extreme emotional stress. According to the Minuchin framework, this dysfunctionality within blended families also led to problematic character development. It caused anxiety, depression, and behavioral problems in children, as they struggled to adapt to the new family structure (Ganong & Coleman, 2017).

With regard to this study, the Structural Family Theory developed by Minuchin enabled the researcher to study the role of dysfunctional family structure, especially in blended families, in causing mental health issues among school-aged children. Working towards research questions like determining the nature of family dysfunction within Malindi Sub-County, Kenya, and how it relates to the mental complications of children, our research aimed at analyzing the family roles and boundaries considered by Minuchin to be key to healthy emotional regulation within a child and their overall well-being. Using this theory, we explored how role ambiguity, loyalty discrepancies, and attachment interference in blended families worsen mental illnesses in children, such as behavioral problems, melancholy, and anxiety. The theory was also useful in informing our discussion on interventions that addressed family role reorganization and modalities of communication in alleviating mental problems in children.

2.3.2 Bronfenbrenner's Ecological Systems Theory

The Ecological Systems Theory, developed by Bronfenbrenner in 1979, offered a thorough framework for comprehending the various environmental layers that affect a person's development. This theory emphasized that children were affected by multiple conserved systems, each of which influenced their growth in different ways. The microsystem, which included immediate environments such as the family, school, and peers, was considered the most influential in shaping a child's development. The mesosystem encompassed the interactions between microsystem elements (e.g., the influences of family dynamics on school performance). In contrast, the exosystem comprised more societal influences (e.g., community influences, media), which influenced the child indirectly. The outermost macrosystem was composed of broader cultural, political, and economic factors that shaped the environment in which children grew up.

The microsystem was a key focus within the context of family dysfunction, which influenced the emotional, cognitive, and social development of the children. This included family dysfunction (parental conflict, drug use, or neglect) that resulted in a chaotic environment that adversely affected the emotional control and mental health of the child. The mesosystem was equally important as it integrated family relations with other environments, where dysfunctional family effects were observable, such as school. For example, children who lived in dysfunctional households found it difficult to have healthy relationships at school or demonstrated negative academic outcomes because of emotional turmoil related to household instability (Kalil, 2020). The exosystem and macrosystem further facilitated these outcomes, as they led to larger societal Influences like the scarcity of mental health treatment, poverty, or community violence that triggered an increase in the emotional burden of children (Gerrans & Byrd, 2021).

This theory was also specifically applicable in terms of cognizing the manner in which family dysfunction, such as the complications of blended family set-ups, affected the mental health of children. The presence of stepparents, stepsiblings, and rearrangement of roles in blended families added to emotional instability, role ambiguity, and loyalty conflicts that Influenceed the well-being of the children. Bronfenbrenner stated that these dysfunctions did not come in isolation but rather combined and interacted with other environmental factors, such as peer relationships and school performance, to compound their overall effect on the mental well-being of a child. This study aimed to apply family dysfunction using Bronfenbrenner's Ecological Systems Theory in Malindi Sub-County, Kenya, particularly in blended family contexts, and examined how it interacted with other environmental factors (e.g., community resources, school environment) to influence children’s emotional and behavioral outcomes.

Using this theory allowed us to broaden the scope of the study in order to observe the external environmental factors of family dysfunction in relation to mental health, offering a more comprehensive understanding of how family dysfunction extended beyond the structure of the family unit to affect the children's health and welfare. The results were used to interpret the role of the different systemic factors related to emotional and behavioral disorders in children in Malindi and provided insight into the significance of multi-vocational interventions that tackled family elements in addition to other environmental factors.

2.4 Conceptual Framework

The study focused on three major variables, family dysfunction, parental mental health, and children's mental health status, organized according to their roles as the independent, mediating, and dependent variables, respectively.

The independent variable, family dysfunction, was conceptualized as the overall disruption of normal family functioning that undermines the emotional and psychological well-being of children. It encompassed three major dimensions: family violence, which included physical, verbal, sexual, and emotional abuse as well as neglect; family structure, referring to experiences of divorce, separation, single parenting, and blended family arrangements; and family conflict and communication breakdown, which captured persistent quarrels, poor conflict resolution, and limited emotional support among family members. Together, these dimensions represented the broader social and relational environment within which children develop.

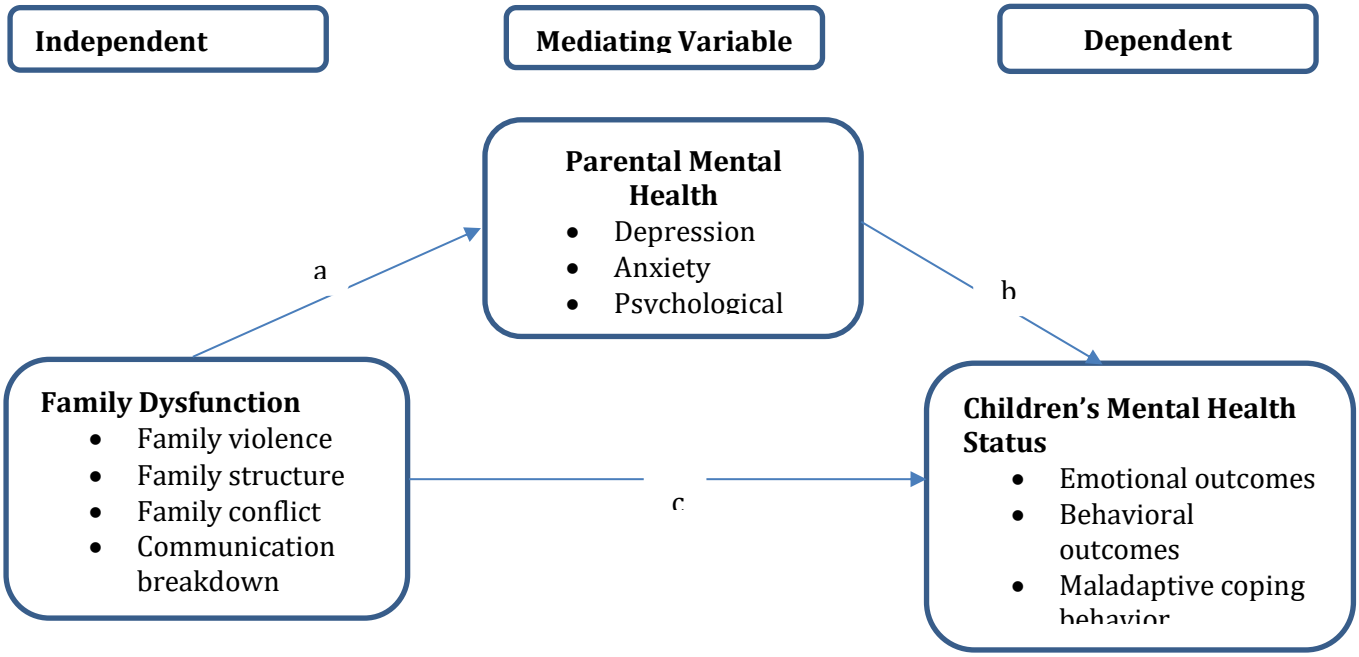
The mediating variable, parental mental health, referred to the psychological and emotional state of parents that could influence their capacity to provide stable and nurturing care. It was operationalized through three key indicators: depression, anxiety, and psychological distress. These indicators captured parents' affective symptoms, emotional

regulation challenges, and stress levels arising from family instability and daily life pressures. Parental mental health was theorized to serve as a pathway through which family dysfunction transmits its effects to children's mental health outcomes.

The dependent variable, children's mental health status, represented the emotional and behavioral functioning of school-aged children within the family setting. It was measured through three dimensions: emotional outcomes, including anxiety and depression; behavioral outcomes, such as conduct problems, aggression, and social withdrawal; and maladaptive coping behaviors, reflected in substance use and somatic complaints. Collectively, these indicators provided a comprehensive picture of how children's psychological well-being is affected both directly by family dysfunction and indirectly through parental mental health challenges.

FIGURE 1:

Conceptual Framework



Source: M Were, (2025).

TABLE I:
Conceptual Pathways And Theoretical Justification

Pathway	Description	Theoretical Basis & Justification
"a" Family Dysfunction → Parental Mental Health	Dysfunctional family environments (characterized by conflict, violence, neglect, unclear roles, and boundary violations) create chronic stress, emotional exhaustion, and depressive symptoms in parents. Marital discord, economic strain, and disrupted hierarchies erode parental coping capacity.	**Minuchin's Structural Family Theory** posits that family health depends on clear boundaries, stable hierarchies, and adaptive subsystems. When these structures collapse (e.g., enmeshed or disengaged subsystems), parental distress increases. Dysfunction in the marital or parental subsystem disrupts emotional homeostasis, making parents vulnerable to anxiety and depression.
"b" Parental Mental Health → Child Mental Health	Parents experiencing psychological distress (depression, anxiety, emotional instability) provide inconsistent or withdrawn caregiving. Children internalize this distress through emotional contagion, poor attachment, or modeling maladaptive behaviors.	**Bronfenbrenner's Ecological Systems Theory** situates the parent–child relationship within the *microsystem*, where direct interactions profoundly affect development. Parental mental health shapes the child's immediate emotional environment. Additionally, **Attachment Theory** and **Social Learning Theory** explain that children model parental affect

Pathway	Description	Theoretical Basis & Justification
		regulation and interpret parental mood as a cue for their own emotional safety.
"c" Family Dysfunction → Child Mental Health (Direct Path)	Even without the mediation of parental mental health, exposure to violence, neglect, or unstable family structures (single or blended families) directly undermines children's sense of security, predictability, and belonging, leading to internalizing (anxiety, depression) and externalizing (conduct disorder, substance use) problems.	**Bronfenbrenner's Ecological Systems Theory** emphasizes that disruptions within the *microsystem* (family) directly affect a child's developmental trajectory. Family dysfunction alters the social ecology of the child's immediate environment, limiting protective factors such as stability, nurturance, and communication. Structural disorganization (Minuchin) thus operates as a proximal risk factor for child maladjustment.
Family Dysfunction → Parental Mental Health → Child Mental Health (Mediated Pathway)	Family dysfunction first increases parental psychological distress, which then diminishes parenting quality and transmits emotional instability to children. This two-step mechanism captures	Integrating **Minuchin's Structural Family Theory** (focus on family subsystems and boundaries) and **Bronfenbrenner's Ecological Systems Theory** (focus on nested environmental influences) provides a holistic view: structural breakdown at

Pathway	Description	Theoretical Basis & Justification
	intergenerational transmission of distress within family systems.	the family level filters through parental functioning to affect child mental health. The *mediating role of parental mental health* thus operationalizes how dysfunction within one subsystem spills over into others.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter described the research methods and procedures used to examine the association between family dysfunction and the mental health status of school-aged children in Malindi Sub-County, Kenya. It presented the study design, location, population, sampling techniques, data collection procedures, and analysis methods. The chapter also outlined ethical considerations and discussed measures taken to ensure validity and reliability. The chosen methodology was intended to ensure systematic, ethical, and accurate data collection aligned with the study objectives.

3.2 Research Design

The study employed a descriptive cross-sectional design to examine associations between different forms of family dysfunction and the mental health status of school-aged children at a specific point in time. This design allowed for the simultaneous measurement of multiple variables without inferring causation. It provided an efficient and cost-effective approach for identifying patterns and relationships between family dynamics (e.g., violence, parental distress, family structure) and children's mental health outcomes in Malindi Sub-County.

3.3. Study Location

The study was conducted in Malindi Sub-County, located in Kilifi County, on the Kenyan coast. Malindi was characterized by diverse family structures and socio-economic challenges, including high rates of family instability, parental separation, and domestic violence, factors that aligned closely with the study's focus on family dysfunction and child mental health. Previous research in Kilifi County had reported a high prevalence of psychiatric

disorders among children (Bitta et al., 2017; Ndetei et al., 2016), yet limited attention had been given to the specific family-related factors influencing these outcomes.

Malindi's unique socio-cultural context, marked by blended family arrangements, financial insecurity, and limited access to mental health services, provided an ideal setting to examine the associations between family dysfunction and the mental health status of school-aged children. Insights from this study were expected to inform community-based interventions and contribute to broader understanding of similar coastal and low-resource settings in Kenya.

3.4 Study Population

The study population consisted of households in Malindi Sub-County, Kilifi County, with school-aged children aged 6 to 18 years. The household served as the unit of analysis. In contrast, the primary caregiver or household head acted as the key respondent, as they were best placed to provide information on family relationships, parenting styles, and the general psychosocial environment of the home. This approach was consistent with studies examining family influences on child mental health, where caregivers' perspectives were used as valid proxies for household-level experiences (see Goodman et al., 2018; Mbagaya et al., 2020).

Inclusion in the study was limited to households that had resided in Malindi Sub-County for at least six months, had at least one child enrolled in school, and were willing to provide informed consent. Households without school-aged children or those whose members declined participation were excluded. The population was expected to include families from a range of socio-economic backgrounds such as urban poor, middle-income, and rural-urban transitional households, reflecting Malindi's socio-cultural diversity.

Malindi's household population of approximately 63,854 individuals (Kenya National Bureau of Statistics [KNBS], 2019) was distributed across ten administrative wards, each with distinct family and community characteristics. The area exhibited multiple forms of family

arrangements, including nuclear, single-parent, separated, and blended families. These variations offered a valuable context for analyzing how different family structures and dysfunctions, such as violence, parental distress, or separation, were associated with children's emotional well-being, behavioral adjustment, and academic outcomes.

The inclusion of this broad household population enhanced representativeness and the generalizability of findings. Furthermore, given the limited number of localized studies focusing on the intersection of family dysfunction and child mental health in coastal Kenya (Ndetei et al., 2016; Bitta et al., 2017; Nyongesa et al., 2022), this study sought to fill an important knowledge gap. Understanding the family-level dynamics influencing mental health among school-aged children would contribute to developing contextually appropriate interventions and inform policies on child protection, family therapy, and school mental health support within the sub-county and beyond.

TABLE 3. 1:

Population Distribution

Ward Name	**Estimated Household Population**	**Percentage of Total (%)**
Barani	7,199	11.3%
Ganda	4,970	7.8%
Gede	7,440	11.7%
Kijiwetanga	4,161	6.5%
Madunguni	3,194	5.0%
Malimo	1,398	2.2%
Malindi Central	6,927	10.9%
Malindi North	3,362	5.3%

Malindi South	10,162	15.9%
Watamu	6,741	10.6%
Total	**63,854**	**100%**

Source: Kenya National Bureau of Statistics, 2019

3.5 Sampling Procedure

Sampling was the process of selecting a representative portion of the population for the purpose of conducting a study (Simkus, 2023). Given the large number of households in Malindi Sub-County, Kenya, it was not feasible to involve every household in the study. As such, a representative sample was selected so that results of the study were valid and generalizable; ethical, cost-effective, and efficient.

A method of stratified random sampling was employed. The households were stratified based on the different administrative wards within Malindi Sub-County. Each of the wards represented a stratum. Households within each stratum were selected proportionally, reflecting the ward's share of the household population in the entire county. After the wards were drawn, the households were selected randomly, after which systematic sampling was done to ensure that the sample was random and well-organized. This approach ensured that the findings of the study were applicable to other individuals of Malindi Sub-County, Kenya, since it was not only rigorous but also effective in the data collection process.

3.5.1. Sample Size

The sample size was of the essence because it determined that the results of the study were statistically significant and represented the household population of Malindi Sub-County, Kenya. Due to a high number of households in Malindi Sub-County, it was not possible to

include all of the households in the study. Thus, a representative sample was chosen to produce valid and generalizable findings.

The Yamane Formula of sample size determination was utilized in calculating the sample size since it was commonly used in social science studies when the population was finite (Yamane, 1967). The formula is given as:

Sample size (n)=N/{(1+N) $(e)^2$

Where:

N is the total population

(n) is the Sample size

(*e*) is the margin of error

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

n = 63,854/ {1 + 63,854 $(0.05)^2$

n = 63,854/ {1+ 63,854 * 0.0025}

n = 63,854/ (1 + 159.635)

n = 63,854/ 160.635

n = 397.35

n = 398

Thus, the required sample size for this study was 398 households.

To ensure proportional representation across the wards in Malindi Sub-County, Kenya, the sample size was distributed across the various wards in proportion to their estimated household populations. The breakdown of the sample size allocation is presented as follows:

TABLE 3. 2:

Sample Size Of Population

Ward Name	**Estimated Household Population**	**Sample Size (Proportional)**
Barani	7,199	45
Ganda	4,970	32
Gede	7,440	47
Kijiwetanga	4,161	27
Madunguni	3,194	21
Malimo	1,398	9
Malindi Central	6,927	45
Malindi North	3,362	22
Malindi South	10,162	66
Watamu	6,741	44
Total	**63,854**	**398**

Note. This table presents the estimated household population and proportionally determined sample size for each ward included in the study population.

3.5.2. Sampling Techniques

The study used a stratified random sampling method to ensure that all administrative wards (strata) within Malindi Sub-County were adequately represented. Each ward represented a stratum, and households were selected proportionately based on the ward's share of the total population.

After stratification, systematic random sampling was used to select households within each ward. A list of households was obtained for every ward, a random starting point was chosen, and then every nth household was selected until the required sample size for that ward was achieved. For instance, if a ward had 1,000 households and 50 were required for the sample, the sampling interval was 20, meaning every 20th household was picked after the random start.

This combination of stratified and systematic sampling ensured proportional representation, minimized selection bias, and made the results generalizable to the entire population of Malindi Sub-County.

3.6. Data Collection Procedure

This study collected data using a systematic and ethical data collection process. Ethical clearance was provided by the Scientific and Ethical Research Committee of KCA University, and approval from the National Commission for Science, Technology, and Innovation (NACOSTI) was obtained. Authorization was also sought at the local level in Malindi Sub-County, Kenya.

The research assistants were oriented on the aims of the study, ethical considerations, and methods of data collection, using a standardized script developed for this study to ensure consistency and minimize bias in the explanation of questionnaire items. They distributed and collected the questionnaires and maintained neutrality and consistency in their interactions with the participants. All participants gave informed consent before the data collection process commenced, and they were fully informed of the aim of the study, its procedures, and their rights. A drop-and-pick-later approach was utilized, allowing participants time to fill out the questionnaires at an opportune time. The data collection process lasted about two weeks.

Unique identification codes were applied to ensure that the confidentiality of the participants was maintained, and no personally identifiable data were gathered. The data collected were safely kept, and only the researcher and permitted personnel could view the data.

The researcher oversaw the data collection process to avoid unethical practices and maintain data integrity. Afterward, the data were checked for completeness and entered into statistical software for analysis version 27. This systematic method provided reliable and valid data to determine the consequences of dysfunctional families on the mental health of school-aged children in Malindi Sub-County, Kenya.

3.6.1 Data Collection Techniques and Tools

The study utilized a structured, researcher-developed questionnaire as the principal tool for quantitative data collection. The questionnaire was systematically designed to capture data on the major study variables, family dysfunction (independent variable), parental mental health (mediating variable), and children's mental health status (dependent variable)—in alignment with the conceptual framework and research objectives. The instrument was divided into five sections (A–E) as follows:

Section A: Demographic Information collected background data on respondents, including gender, age group, marital status, relationship to the child, education level, occupation, household income, and household size. This information provided the socio-economic and demographic context for interpreting the key variables.

Section B: Family Conflict and Violence measured the family dysfunction construct through items reflecting family conflict, communication breakdown, neglect, and emotional or physical violence. Statements such as "Family members often raise their voices or argue

intensely" and "There is emotional neglect in our family" captured relational and behavioral dimensions of dysfunction within the household.

Section C: Parental Mental Health focused on the mediating variable, parents' or caregivers' emotional and psychological well-being. Items were designed to assess indicators of depression, anxiety, and psychological distress, including statements such as "One or both parents often appear sad or withdrawn" and "A parent frequently experiences sleep problems due to stress." These items helped quantify parental emotional functioning and coping capacity within the family context.

Section D: Family Structure and Disruption further extended the family dysfunction construct by capturing structural instability and transitional stressors such as divorce, separation, single parenting, and blended family arrangements. Statements like "Parental separation or divorce has caused emotional distress in the household" and "Frequent changes in caregivers affect our children's emotional stability" gauged how family composition dynamics influence stability and emotional climate.

Section E: Children's Mental Health and Behavior addressed the dependent variable, focusing on children's emotional, behavioral, and adaptive functioning. This section included items such as "Children show sadness or loss of interest in daily activities" and "Family stress often affects children's sleep or appetite," reflecting symptoms of anxiety, depression, and maladaptive coping behaviors.

Each item in Sections B–E was rated on a five-point Likert-type scale ranging from 1 = Strongly Disagree to 5 = Strongly Agree, allowing quantitative assessment of intensity and frequency of experiences across domains. The structure enabled the computation of composite scores for each construct, facilitating correlation and regression analyses in line with the study

hypotheses. The questionnaire incorporated adapted and contextually validated items from established instruments such as the Family Assessment Device (FAD) (Epstein et al., 1983) and the Strengths and Difficulties Questionnaire (SDQ) (Goodman, 1997), ensuring both cultural relevance and construct validity. Expert reviews by child psychologists and social researchers ensured content validity, while internal consistency reliability was evaluated using Cronbach's alpha coefficients for each subscale.

3.6.2. Administration procedures

Trained research assistants conducted face-to-face administration of the questionnaire to parents or primary caregivers of school-aged children (6–18 years) in sampled households within Malindi Sub-County. They followed a standardized administration protocol, including informed consent, uniform introduction, and assurance of confidentiality. The tool was available in both English and Kiswahili to enhance comprehension. A pilot study, involving approximately 10% of the total sample in a demographically comparable area within Kilifi County (Kilifi North, Kilifi South, Ganze, Malindi, Magarini, Rabai, and Kaloleni), was carried out before the main data collection. Feedback from the pilot informed refinements in item clarity, translation accuracy, and scale reliability, thereby enhancing the questionnaire's psychometric soundness and cultural appropriateness.

3.7 Validity and Reliability of the Research Instruments

Ensuring the validity and reliability of research instruments was critical in achieving credible and dependable study findings. This section outlined the steps that were taken to test and strengthen the accuracy and consistency of the questionnaire used in the study.

3.7.1 Pilot Study

The data collection tools and procedures were pre-tested in a pilot study, which preceded the main study. This assisted in establishing any ambiguities or problems in the questionnaire, ensuring that the questions were straightforward, and determining the time required to complete it. The pilot test was conducted at Kilifi County (Kilifi North, Kilifi South, Ganze, Malindi, Magarini, Rabai, and Kaloleni), a location close to Malindi Sub-County, Kenya, which was similar in terms of demographic characteristics to Malindi Sub-County but did not include the final study sample. The pilot study used approximately 40 households, which were about 10 percent of the total sample size.

The responses provided by participants contributed to the revision of the questionnaire, the clarification of unclear questions, and the overall structure to enhance the reliability and relevance of the tool. The pilot study results also helped to gauge the time needed to complete the entire survey and the practicality of the data collection exercise. Based on the results of the pilot study, the research instruments were adjusted to ensure the success of the main study.

3.7.2. Validity of the Research Instruments

The validity of the research instruments ensured that the data collection tools measured what they were supposed to measure. To guarantee content validity, the questionnaire underwent a review by professionals in psychology, family studies, and mental health to confirm that the questions were exhaustive, precise, and consistent with the objectives of the research. Suggestions by the research supervisor and colleagues were also sought to develop tools that exhausted all dimensions of the research topic.

The researcher also integrated responses from the pilot study to improve the instruments so that they presented clarity in capturing necessary information. The study augmented the

validity of the tools in the following ways: the instrument was designed so that the conceptual framework and the aims of the research led to consistency in tool content. Such a procedure guaranteed that the tools provided useful indicators of the connection between family dysfunction and the mental health of children and yielded sufficient and meaningful data for analysis.

3.7.3. Reliability of the Research Instrument

Reliability is the degree of consistency and stability of the research tool in ascertaining the intended variables. To achieve dependability of the questionnaire, the researcher carried out a pilot study to determine the internal reliability of the instrument. Reliability was calculated using Cronbach's Alpha coefficient, which determines the extent to which the items in a scale are compatible with one another. The acceptable Cronbach's Alpha value was set at 0.7 and above to determine the reliability of the instrument.

Besides internal consistency, the researcher also tested the stability of the instrument's results over time using test-retest reliability. Respondents included in the pilot study were retested after a brief interval to verify response consistency in a sample of participants. All items with low reliability were revised or deleted to enhance the overall reliability of the instrument.

Test reliability played a critical role in providing coherent and stable data to ensure the validity of the study's findings. The instrument was then revised, and the main data collection procedure commenced so that reliable data could be collected to analyze how dysfunctional family environments affect the mental health of children.

3.8. Data Analysis Techniques

After data collection, all questionnaires were carefully screened for completeness, accuracy, and internal consistency before data entry. The quantitative data was then be coded and analyzed using the Statistical Package for the Social Sciences (SPSS) Version 27. Data analysis proceeded in several phases consistent with the study objectives, hypotheses, and conceptual framework.

3.8.1 Preliminary Data Handling

Data was first cleaned to check for missing values, outliers, and inconsistencies. Descriptive statistics, including frequencies, percentages, means, and standard deviations, were computed to summarize demographic characteristics (Section A) and to profile the distribution of scores across the major constructs: Family Dysfunction (Section B and D), Parental Mental Health (Section C), and Children's Mental Health (Section E). This stage provided a general overview of the prevalence and nature of family and mental health indicators in the sampled households.

3.8.2 Descriptive and Bivariate Analysis

Descriptive analyses summarized levels of family dysfunction and mental health indicators. To address the first research objective, identifying the relationship between family dysfunction and parental mental health, Pearson's Product-Moment Correlation Coefficient (r) was computed to determine the strength and direction of associations among key variables. This included examining sub-dimensions such as family conflict, structure disruptions, and emotional neglect against parental distress indicators (e.g., anxiety, depression, stress).

3.8.3 Mediation and Pathway Analysis

In line with the conceptual framework guided by Structural Family Theory and Ecological Systems Theory, the analysis moved beyond simple associations to test the mediating role of Parental Mental Health in the relationship between Family Dysfunction (independent variable) and Children's Mental Health (dependent variable). The analysis followed Baron and Kenny's (1986) mediation procedure, supported by regression-based mediation testing using SPSS version 27. The following regression equations will be estimated:

- **Path a**: Family Dysfunction → Parental Mental Health
- **Path b**: Parental Mental Health → Children's Mental Health
- **Path c**: Family Dysfunction → Children's Mental Health (total effect)
- **Path c′**: Family Dysfunction → Children's Mental Health (direct effect, controlling for Parental Mental Health)

Significant indirect effects (a × b) will indicate mediation, suggesting that family dysfunction influences children's mental health partly through its effect on parental mental health.

3.8.4 Multiple Regression and Control Variables

Multiple Linear Regression Analysis was then conducted to assess the predictive strength of family dysfunction (e.g., conflict, violence, structure disruption) on children's mental health outcomes.

3.8.5 Significance Testing and Presentation

All inferential statistical tests were conducted at a 5% level of significance ($p < 0.05$). The findings were presented using tables, charts, and graphs, aligned to the study's specific objectives and hypotheses. The final interpretation emphasizes both direct and indirect

pathways among variables, illustrating how family dynamics shape child mental health outcomes through the mediating mechanism of parental mental health.

3.9. Ethical Considerations

Ethical considerations were observed meticulously to safeguard the rights, dignity, and confidentiality of all research participants. Prior to data collection, the researcher sought ethical approval from the KCA University Board of Postgraduate Studies (BPS) and the Scientific and Ethical Research Committee. Subsequently, a research permit was obtained from the National Commission for Science, Technology, and Innovation (NACOSTI) in accordance with national regulatory requirements.

All participants will give informed consent with effective communication regarding the purpose of the study, the procedure, and the voluntary nature of participation. The participants will also be notified that they can withdraw from the study at any time without any penalty. Personal identifiable information will not be collected to preserve the privacy of participants, and responses will be anonymized.

All data will be stored safely and used exclusively for academic purposes. Confidentiality will also be maintained by storing all questionnaires in a locked cabinet or in an encrypted electronic document. Research assistants will be trained on ethical rules to ensure they do not breach participants' rights and that all data will be treated with due diligence. All aspects of ethical consideration will be given primacy in the study to uphold research integrity and safeguard participants.

CHAPTER FOUR

DATA ANALYSIS, PRESENTATION AND INTERPRETATION

4.0 Introduction

This chapter presents the analysis, interpretation, and discussion of data collected from respondents in Malindi Sub-County. The analysis is organized according to the study's specific objectives, which sought to examine the influence of family conflict and violence, parental mental health, and family structure and disruption on the mental health and behavior of school-aged children. Both descriptive and inferential statistics were employed to interpret the data. The results are presented in tables and narratives that highlight the relationships among the key study variables, followed by an interpretation of their implications in relation to the study's theoretical framework and literature.

4.1 Response Rate

The response rate was 82.9 percent, and the non-response rate was 17.1 percent, as 330 out of the 398 questionnaires that were handed out to respondents in Malindi Sub-County were properly filled and returned, and 68 were not returned.

TABLE 4. 1:

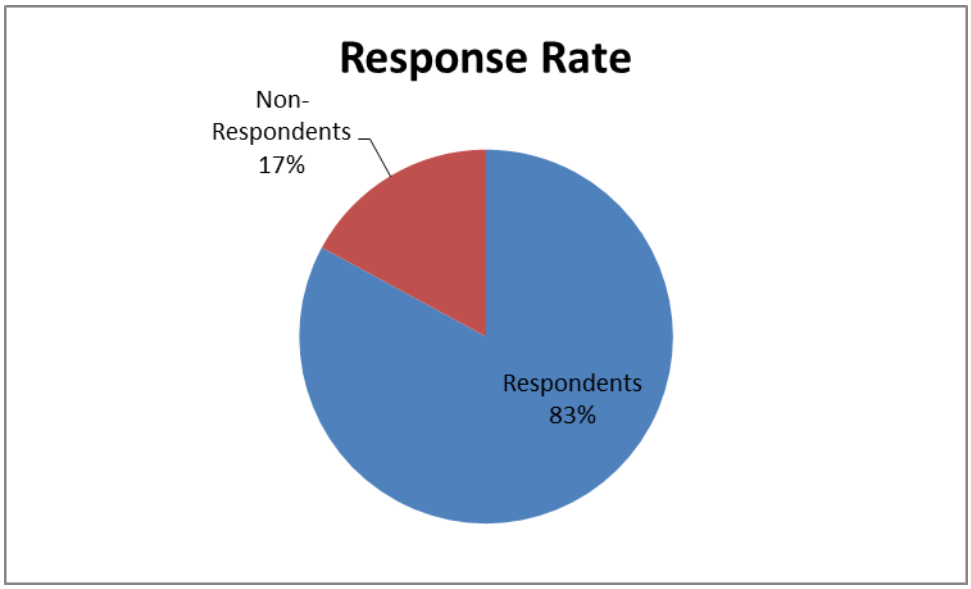
Response Rate

Category	Frequency (n)	Percentage (%)
Respondents	330	82.9%
Non-Respondents	68	17.1%
Total	398	100.0%

Note. Source: Field data (2025)

FIGURE 4. 1:

Response Rate



Note. Source: Field data (2025)

This is also an excellent level of participation since the academic research response rates above 70 percent are acceptable (Mugenda and Mugenda, 2003). The large rate increases the representativeness and reliability of the study results.

4.2 Demographic Finding of Respondents

This section presents the demographic characteristics of the respondents, providing essential background information on their gender, age, marital status, education level, occupation, income, and household composition.

4.2.1 Gender of the Respondents

The research aimed at establishing the gender of the respondents. Table 4.2 and Figure 4.2 summarize the findings.

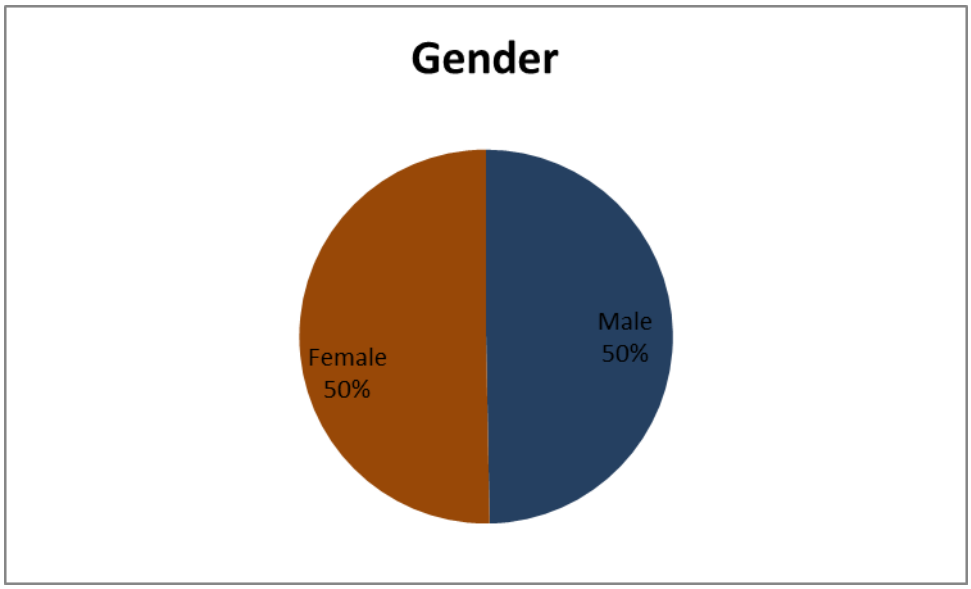
TABLE 4. 2:
Gender Of The Respondents

Gender	Frequency	Percent
Male	164	49.7
Female	166	50.3
Total	330	100.0

Note. Source: Field data (2025)

FIGURE 4. 2:

Gender Of The Respondents



Note. Source: Field data (2025)

Table 4.2 and Figure 4.2 results reveal that 49.7 percent of respondents were males, and 50.3 percent were females. This means that the research had a near equal representation of both genders, so that both male and female viewpoints were well represented. The equal representation of respondents also contributes to the credibility of the results since it reduces gender biases in responding to family relationships and child mental health.

From an analytical perspective, this near parity in gender distribution was particularly important because family roles and caregiving responsibilities often differ by gender. In the context of this study, it allowed for a more comprehensive understanding of how both fathers and mothers perceive and experience family dysfunction and its influence on children's mental health. This balanced representation strengthens the reliability and generalizability of the study findings to households within Malindi Sub-County.

4.2.2 Age Group of Respondents

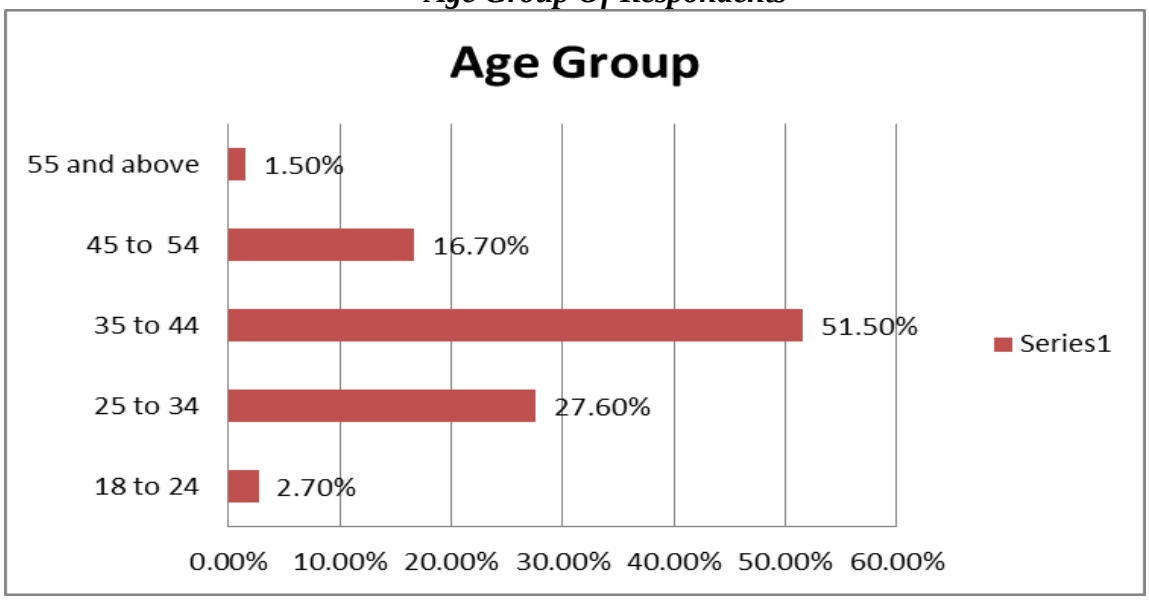
The research aimed at establishing the age of the respondents in the Malindi Sub-County. Table 4.3 and Figure 4.3 provide the results.

TABLE 4.
Age Group Of Respondents

Age Bracket	Frequency	Percent
18 to 24	9	2.7
25 to 34	91	27.6
35 to 44	170	51.5
45 to 54	55	16.7
55 and above	5	1.5
Total	330	100

*Note***.** Source: Field data (2025)

FIGURE 4. 3
Age Group Of Respondents



Note. Source: Field data (2025)

Table 4.3 and Figure 4.3 results above show that most of the respondents are in the age range 35-44 years, constituting 51.5 per cent of the total respondents, with 27.6 per cent in the age range 25-44 years, and 16.7 per cent of the total respondents in the age range 45-54 years. A lesser percentage of 2.7% was between the ages of 18 to 24 years, and 1.5% was at 55 years and above. Such distribution means that the majority of the respondents were fully grown adults in their prime parenting years and thus had the best characteristics of giving the right information about family dynamics and the mental health of the school-aged children. The diversity in terms of age groups is also an indication that the study was able to get various experiences and mindsets of different generations of parents and caregivers.

These results mean that the study involved people who are actively raising children, making their responses more reliable. Having few older and younger respondents also gave the study a wider view of how family issues affect children of different age groups. This variety makes the findings completer and more useful for understanding families in the Sub-County.

4.2.3 Marital Status of Respondents

The research aimed at identifying the marital status of the respondents with the intention of knowing family structures where school-aged children are brought up. The findings have been summarized in Table 4.4 and Figure 4.4 below.

TABLE 4. 3

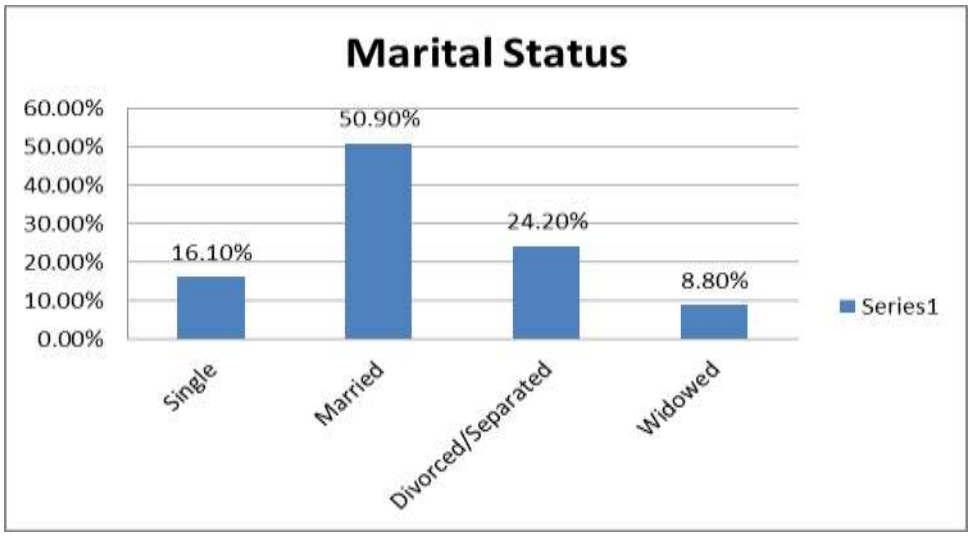
Marital Status Of Respondents

Marital status	Frequency	Percent
Single	53	16.1
Married	168	50.9
Divorced/Separated	80	24.2
Widowed	29	8.8
Total	330	100

*Note***.** Source: Field data (2025)

FIGURE 4. 4

Marital Status Of Respondents



Note. Source: Field data (2025)

Table 4.4 and Figure 4.4 show that most of the respondents, 50.9% were married, 24.2%

divorced or separated, 16.1% single, and 8.8% widowed. This is distributed so that 50 percent of the respondents belonged to healthy marital arrangements, and a considerable percentage to broken family arrangements (divorced, separated, or widowed). The fact that most of the respondents belonged to non-intact families underscores the instability of the family in Malindi Sub-County, which could be a contributing factor to emotional and psychological problems of children. These findings can be attributed to the fact that the study aims to investigate the role of family dysfunction on the mental health of school-aged children.

4.2.4 Relationship to the Child(ren)

The research aimed at determining the attachment of the respondents to the children under their care. The relationship contributes to the contextualization of the type of family structure featured in the study. The findings are in Table 4.5 and Figure 4.5 below.

TABLE 4. 4

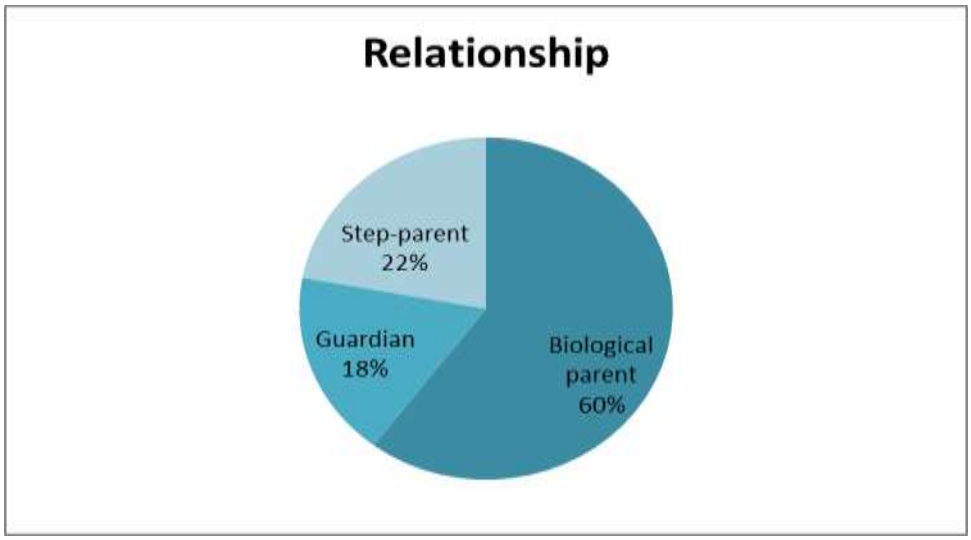
Relationship To The Child (Ren)

Relation to the child	Frequency	Percent
Biological parent	199	60.3
Guardian	58	17.6
Step-parent	73	22.1
Total	330	100

Note. Source: Field data (2025)

FIGURE 4. 5:

Relationship To The Child (Ren)



Note. Source: Field data (2025)

According to the results of Table 4.5 and Figure 4.5, 60.3% of the respondents were biological parents, 22.1% were step-parents, and 17.6% were guardians. This distribution implies that although the bulk of the respondents were biological parents, a significant percentage bore the status of non-biological parenting, which was a diverse family set-up in Malindi Sub-County. It is important to note that 22.1% step-parents represent the increasing popularity of blended families within the region. This observation can be especially applied to the study, as blended and guardian-led households are commonly linked to the role ambiguity, difficulties in adjusting, and even emotional tension among children, which are among the issues being examined in this study.

4.2.5 Highest Education Level Completed

The study sought to determine the highest education level attained by the respondents, as education can influence parenting styles, awareness of children's mental health, and approaches to handling family challenges.

TABLE 4. 5

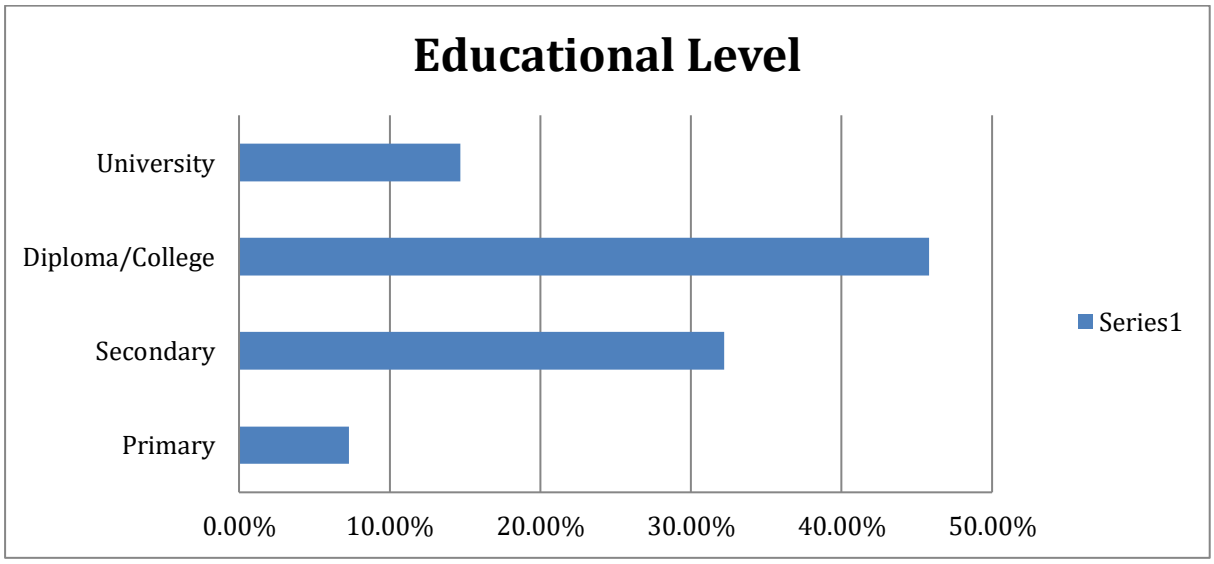
Highest Education Level Completed

Education Level	Frequency	Percent
Primary	24	7.3
Secondary	106	32.2
Diploma/College	151	45.8
University	49	14.7
Total	330	100

*Note***.** Source: Field data (2025)

FIGURE 4. 6:

Highest Education Level Completed



Note. Source: Field data (2025)

As shown in Table 4.6 and Figure 4.6, slightly more than half of the respondents (50.9%) were married, while 24.2% were divorced or separated, 16.1% were single, and 8.8% were widowed. This distribution indicates that about half of the respondents were in stable marital unions, whereas a significant proportion belonged to non-intact family arrangements

such as divorce, separation, or widowhood. The predominance of respondents from non-intact families suggests a level of family instability in Malindi Sub-County, which may have implications for the emotional and psychological well-being of school-aged children. These findings align with the study's focus on examining how family dysfunction influences children's mental health outcomes.

4.2.6 Occupation of Respondents

The study examined respondents' primary occupations to assess their socio-economic status, which may influence family stability and children's mental health. The table below displays the results.

TABLE 4. 6:

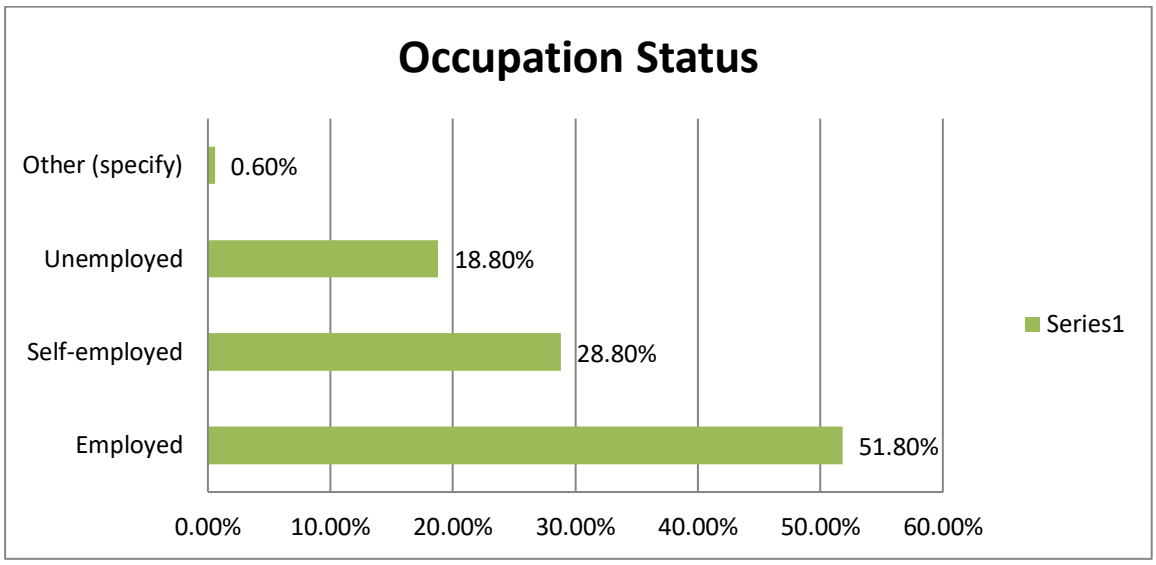
Occupation Of Respondents

Employment status	Frequency	Percent
Employed	171	51.8
Self-employed	95	28.8
Unemployed	62	18.8
Other (specify)	2	0.6
Total	330	100

Note. Source: Field data (2025)

FIGURE 4. 7

Occupation Of Respondents



Note. Source: Field data (2025)

The respondents, as indicated in Table 4.7 and Figure 4.7, showed that 51.8% were employed, 28.8% were self-employed, 18.8% were unemployed, and only 0.6% belonged to other categories that included casual or seasonal employees. This distribution shows that a majority of the respondents had a steady income, either formally employed or self-employed. Nevertheless, the percentage of individuals without employment was quite high (18.8%), which can lead to financial pressure and family stress, which is regularly attributed to family dysfunction and poor child mental health resilience. According to the findings, economic stability is a crucial factor in parenting capacity and emotional availability towards children, as well as the role of socioeconomic support in the process of overcoming mental health issues in the family.

These results show that economic stability plays an important role in family functioning. Families with a steady income are often better able to provide for their children's needs and maintain a supportive home environment. On the other hand, unemployment or irregular income may lead to stress, conflict, and limited emotional support, all of which can

contribute to mental health challenges among children. The findings highlight the need for social and economic programs that support families facing financial hardship in Malindi Sub-County.

4.2.7 Income Level (Monthly Household Income in KES)

The study sought to determine the monthly levels of household income of the respondents with a view to testing whether they are economically disadvantaged and whether this condition is usually associated with the functioning of the family and the mental health of the children. Table 4.8 and Figure 4.8 show the results.

TABLE 4. 7:

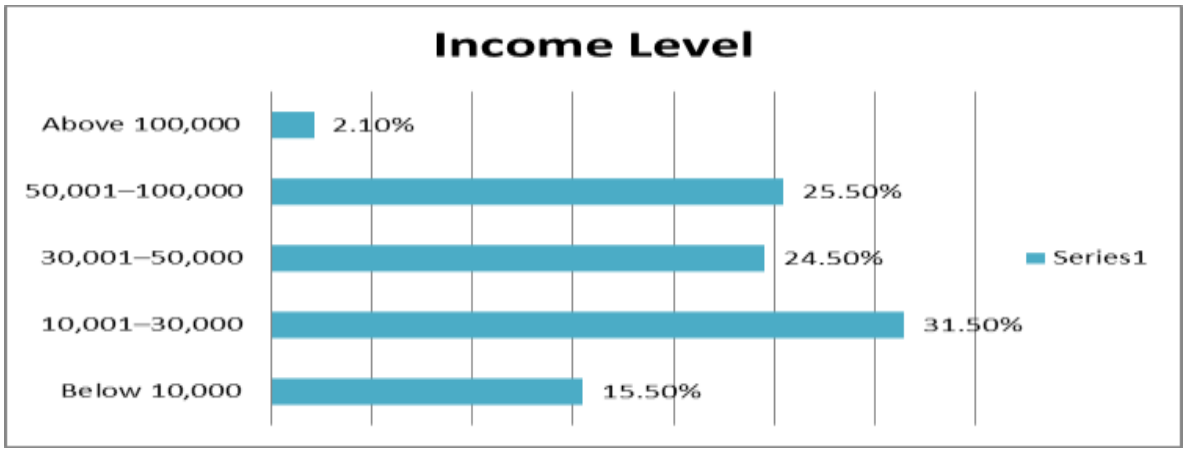
Monthly Household Income Of Respondents (In KES)

Monthly Income Range	Frequency	Percent
Below 10,000	51	15.5
10,001–30,000	104	31.5
30,001–50,000	81	24.5
50,001–100,000	84	25.5
Above 100,000	7	2.1
Total	330	100

Note. Source: Field data (2025)

FIGURE 4. 8

Monthly Household Income Of Respondents (In KES)



Note. Source: Field data (2025)

Table 4.7 and Figure 4.8 results indicate that a majority of the respondents were in the bracket of 31.8% and 25.7% that earned between KES 10,001-30,000 and between 50,001-100, 000 respectively. The smaller percentage of 15.6% s earned less than KES 10,000, and those who earned more received higher earnings of KES 100,000 and above. This distribution reveals that the majority of the respondents are found in the low- to middle-income groups, illustrating the overall economic status of the family households in Malindi Sub-County. Economic limitations in families with low income might also cause stress, conflict, and emotional tension, which may subsequently influence the family stability and mental health of children. Income diversity is also useful in studying the interaction between socio-economic status and family dysfunction to affect child well-being.

The findings suggest that income level is an important factor in family stability and children's emotional well-being. Families with lower incomes may face financial stress that can lead to conflicts, limited access to quality care, and reduced emotional support for children. On the other hand, middle- and higher-income families may have better access to resources that promote healthy child development. The income diversity in this study provided a clear

picture of how financial differences influence family functioning and children's mental health in the community.

4.2.8 Household Size

The paper attempted to identify the number of members in a household so as to establish the family set up of the respondents. Another essential indicator of the social and economic background of the environment the children are brought up in is household size.

TABLE 4. 8

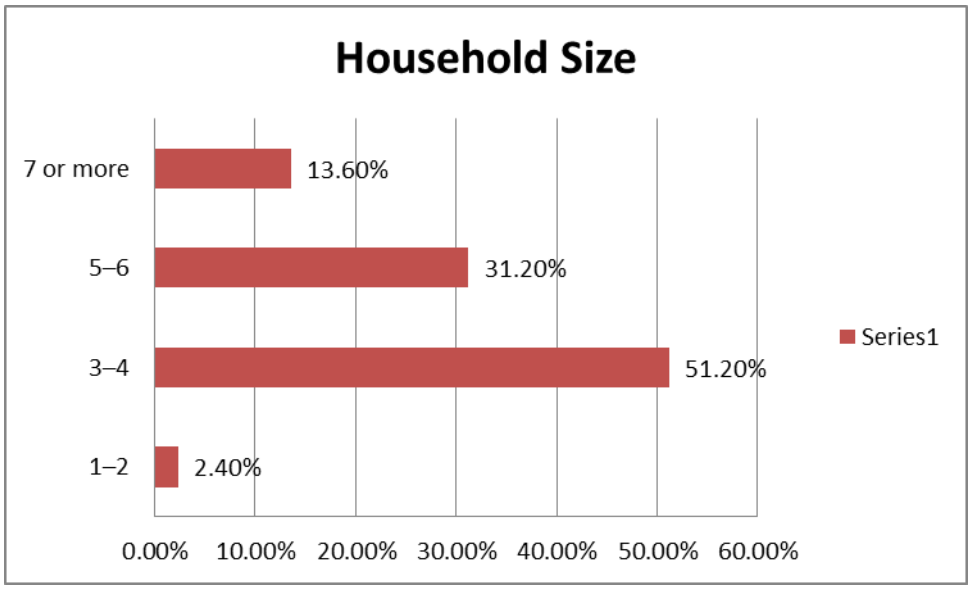
Household Size Of Respondents

No. of Family members	**Frequency**	**Percent**
1–2	8	2.4
3–4	169	51.2
4–5	5	1.5
5–6	103	31.2
7 or more	45	13.6
Total	**330**	**100**

*Note***.** Source: Field data (2025)

FIGURE 4. 9

Household Size Of Respondents



*Note***.** Source: Field data (2025)

A summary of the findings presented in Table 4.8 and Figure 4.9 shows that over half of the respondents (51.2 percent) had 3–4 household members, 31.2 percent had 5–6 members, and 13.6 percent had seven or more members, while only 2.4 percent had 1–2 members. This means that most families in Malindi Sub-County have moderate to large household sizes, which is typical of many Kenyan family structures. Larger families often face challenges such as limited financial resources, reduced parental attention, and increased caregiving stress, which may influence the emotional and behavioral well-being of children.

This finding is important to the study because it helps explain how family size can shape children's mental health outcomes. Families with more members may struggle to provide individual support and resources, which can contribute to anxiety, stress, or low academic performance among children. Understanding this relationship helps the study highlight the role of household size in family functioning and child mental health in Malindi Sub-County.

4.3 Findings as per Research Objectives

4.3.1 Family Dysfunction and Children's Mental Health

4.3.1.1 Descriptive Statistics for Family Dysfunction and Children's Mental Health

The study aimed to determine the effects of a dysfunctional family on the mental health and behavioral outcomes of children. Nine statements were created and given descriptive statistics that were concerned with emotional well-being, social functioning, and academic performance of children.

TABLE 4. 9:

Descriptive Statistics For Children's Mental Health And Behavior

	Count	Mean	Standard Deviation
Children in the household often seem anxious or worried.	330	3.1424	1.0319
Children show sadness or loss of interest in daily activities.	330	2.7970	1.0739
Family issues affect children's concentration on schoolwork.	330	3.1970	1.0974
Children avoid social interactions due to family tension.	330	2.7576	1.0440
Children's academic performance is negatively affected by family challenges.	330	3.5061	.9746
Children in our household exhibit restlessness or hyperactivity.	330	3.1030	1.0143
Children find it difficult to get along with peers.	330	3.1091	.9833
Family stress often affects children's sleep or appetite.	330	3.5091	.9588
Children struggle to recover emotionally after family conflicts.	330	3.5212	.9555

Note. Source: Field data (2025)

Table 4.9 indicates that the respondents generally agreed that family dysfunction affects the emotional and behavioral well-being of children, as evidenced by mean scores ranging from 2.76 to 3.52. The greatest mean was obtained in the statement of family conflicts and tension. The statement Children struggle to recover emotionally after family conflict had the highest mean (M= 3.52, SD =0.96), which implies that children experiencing family tensions or conflicts do not easily get back to their emotional stability. Likewise, Family stress frequently influences the sleep or eating habits of children (M=3.51, SD =0.96), and Family challenges have a negative influence on the academic performance of children (M = 3.51, SD 0.96 also recorded high mean values).

The fact that the family issues influence the concentration of children on the schoolwork (M = 3.20, SD = 1.10) and children are often anxious or worried (M = 3.14, SD = 1.03) also supports the idea that family stress is expressed through anxiety, distraction, and emotional discomfort of children, which may impair cognitive and social development in them. Furthermore, Children find it difficult to get along with peers (M = 3.11, SD = 0.98), and Children in our household exhibit restlessness or hyperactivity (M = 3.10, SD = 1.01) which implies that behavioral problems, e.g., irritability, hyperactivity, and social withdrawal, are also the typical reactions to dysfunctional family settings.

On the other hand, less mean scores have been identified in the following ones, which are, Children show sadness or loss of interest in daily activities (M = 2.80, SD = 1.07) and Children avoid social interactions due to family tension (M = 2.76, SD = 1.04), thus, emotional withdrawal and social avoidance are also present, but to a smaller extent, compared to anxiety or academic-related effects.

In general, these findings suggest that children who are subjected to dysfunction in the

family develop emotional distress, a lack of everyday social interactions, and lower academic achievements. The stability of the mean scores of moderate and high levels on most items indicates that family instability influences people multiply and broadly. The ecological system theory by Bronfenbrenner explains that within the microsystem of the child, the family environment has a significant influence on the emotional growth and conduct of a child. Stress, conflict, or parental inadequacy therefore negatively affects children by weakening their mental health, causing concentration problems, social adaptation, and overall psychological well-being.

4.3.1.2 Inferential Statistics Family Dysfunction and Children Mental Health

Does family dysfunction directly affect children's mental health?

As per the first objective of this study. The table below displays the results of Linear regression analysis, Analysis of Variances, and the coefficients of correlation between dysfunctional families and the mental health of school-aged children.

Regression 1:

Total Effect (Path c)

TABLE 4. 10:

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.069[a]	.005	.002	3.070

a. Predictors: (Constant), Family Dysfunction score

Note. Source: Field data (2025)

TABLE 4. 11:

ANOVA Analysis

ANOVA[a]

Model		Sum of Squares	Df	Mean Square	F	Sig.
1	Regression	14.629	1	14.629	1.552	.214[b]
	Residual	3091.177	328	9.424		
	Total	3105.806	329			

a. Dependent Variable: Children mental health status

b. Predictors: (Constant), Family Dysfunction score

Note. Source: Field data (2025)

TABLE 4. 12:

Correlation Coefficients

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	30.588	1.571		19.471	0
	Family Dysfunction score	-0.047	0.037	-0.069	-1.246	0.214

a. Dependent Variable: Children mental health status

Note. Source: Field data (2025)

The analysis revealed that family dysfunction explains only a small portion of the variance in children's mental health, with an $R2 = 0.005$, indicating that only 0.5% of the

variability in children's mental health can be attributed to family dysfunction. The relationship between family dysfunction and children's mental health was found to be statistically insignificant, as evidenced by the F-value of 1.552 (df = 1, 328) and a p-value of 0.214, which exceeds the conventional significance threshold of 0.05. Furthermore, the regression coefficient (B = -0.047) showed a weak negative effect, but the p-value of 0.214 indicates that this relationship is not significant.

These findings suggest that family dysfunction, in isolation, does not significantly predict the mental health status of children. Although the direction of the relationship aligns with expectations, indicating that higher levels of family dysfunction are associated with poorer mental health in children the effect is weak and not statistically significant. The beta coefficient of -0.069, coupled with the high p-value, further supports the conclusion that while family dysfunction may have a negative influence, the evidence is insufficient to claim a meaningful effect on children's mental health.

4.3.2 Family Dysfunction and Parental Mental Health

4.3.2.1 Descriptive Statistics for Parental Mental Health

The paper has studied the degree to which parental psychiatric problems were apparent in the surveyed families. The descriptive statistics were calculated in determining variables like sadness, anxiety, stress management, and expressing emotions of parents.

TABLE 4. 13:

Descriptive Statistics For Parental Mental Health

	Count	Mean	Standard Deviation
One or both parents often appear sad or withdrawn.	330	2.9788	.9658

A parent frequently feels anxious or worried.	330	3.1030	1.1170
Parents sometimes struggle to manage stress or daily challenges.	330	3.1121	1.1256
Parental mood changes create tension in the family.	330	2.6333	.9686
Parents rarely express positive emotions or support toward family members.)	330	3.2970	.8939
A parent frequently experiences sleep problems due to stress.	330	3.0939	1.1354
Parents in our household rarely express positive emotions.	330	3.1030	1.1224
Family responsibilities often feel overwhelming to one or both parents.	330	3.0879	1.1224

Note. Source: Field data (2025)

Table 4.13 shows that the mental health issues of parents among respondents are moderate, as the mean scores are between 2.63 and 3.30. The highest mean (M = 3.30, SD = 0.89) was obtained in the statement of Parents rarely express positive emotions or support of family members, which presupposes that a significant number of parents are emotionally exhausted or have a lower tendency to show care. This could be an indication of the existence of long-term stress, exhaustion, or depressive tendencies that curb the parental affection and support. The statements that parents are sometimes anxious or worried (M = 3.10, SD = 1.12), feel nervous or worried (M = 3.10, SD = 1.12), and that parents in our household are seldom happy (M = 3.10, SD = 1.12) only prove the idea that anxiety, stress, and emotional suppression are common phenomena among parents. Similarly, a statement such as A parent often has sleep

problems because of stress (M = 3.09, SD = 1.14) implies that psychological pressure is influencing the physical health and the functioning of parents in their daily lives. The mean of the statement One or both parents often seem sad or withdrawn was 2.98 (SD = 0.97), which is used to affirm that emotional withdrawal is a fairly common practice in many homes. The least mean was seen in Parental mood changes create tension in the family (M = 2.63, SD = 0.97), which indicates that although mood fluctuation is there, it may not necessarily lead to open family disagreement.

All in all, the results show that parental stress, anxiety, and emotional unavailability are significant problems in families in the Malindi Sub-County. The average scores, which are predominantly over 3.0, indicate that a considerable proportion of parents display symptoms of psychological distress that have the potential to affect the home environment and, therefore, the psychological well-being of the school-aged children. In Bronfenbrenner's interpretation of the Ecological Systems Theory, these mental health issues of parents interfere with the microsystem of the child by reducing emotional support, stability, and positive role-modeling, making children more vulnerable to the insecurity of emotional and behavioral problems.

4.3.2.2 Inferential Statistics Family Dysfunction and Parental Mental Health

Does family dysfunction affect parental mental health?

The table below displays the result of a regression analysis made to determine an association between Family dysfunction and mental health. This was the second objective of this study.

Regression 2:

Path a (IV → Mediator)

TABLE 4. 14:

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.073[a]	.005	.002	3.322

a. Predictors: (Constant), Family Dysfunction score

Note. Source: Field data (2025)

TABLE 4. 15:

ANOVA[a] Analysis

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	19.228	1	19.228	1.742	.188[b]
Residual	3620.55	328	11.038		
Total	3639.77	329			

a. Dependent Variable: Parental mental health

b. Predictors: (Constant), Family Dysfunction score

Note. Source: Field data (2025)

TABLE 4. 16:

Correlation Coefficient[a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	26.64	1.7		15.669	0
Family Dysfunction score	-0.053	0.041	-0.073	-1.32	0.188

a. Dependent Variable: Parental mental health

Note. Source: Field data (2025)

The analysis of the relationship between family dysfunction and parental mental health revealed that the model was not statistically significant, as indicated by R2=0.005R^2 = 0.005R2=0.005, F (1,328) =1.742F (1, 328) = 1.742F (1,328) =1.742, and a p-value of 0.188. These results suggest that family dysfunction does not have a meaningful impact on parental mental health. The regression coefficient (B = -0.053) indicates a slight negative effect; however, the p-value of 0.188 shows that this relationship is not statistically significant.

The findings imply that family dysfunction, in this sample, does not appear to significantly predict parental mental health, which was proposed as the mediator in the study. Despite the negative direction of the relationship, the weak association and non-significant p-value suggest that family dysfunction does not have a detectable or substantial impact on parental mental health in this context.

4.3.3 Parental Mental Health, Family Dysfunction, and Children's Mental Health

Do parental mental health and family dysfunction together predict children's mental health?

The third objective of this study was to determine the association between parental mental health, dysfunctional family, and the children's mental health. The models below display the results from ANOVA, R Square, and the coefficients of correlation.

TABLE 4. 17:

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.074[a]	.005	-.001	3.073

a. Predictors: (Constant), Parental mental health, Family Dysfunction score

Note. Source: Field data (2025)

TABLE 4. 18:

ANOVA[a] Analysis

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	16.941	2	8.471	0.897	.409[b]
Residual	3088.87	327	9.446		
Total	3105.81	329			

a. Dependent Variable: Children mental health status

b. Predictors: (Constant), Parental mental health, Family Dysfunction score

*Note***.** Source: Field data (2025)

TABLE 4. 19:

Correlation Coefficients[a]

Model	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	29.915	2.08		14.384	0
Family Dysfunction score	-0.045	0.038	-0.067	-1.205	0.229
Parental mental health	0.025	0.051	0.027	0.495	0.621

a. Dependent Variable: Children mental health status

Note. Source: Field data (2025**)**

The analysis examining the combined effect of family dysfunction and parental mental health on children's mental health revealed that the model was not statistically significant. With R2=0.005R^2 = 0.005 R2=0.005, F (2,327) = 0.897 F (2, 327) = 0.897 F (2,327) = 0.897, and a p-value of 0.409, the results indicate that neither family dysfunction nor parental mental health meaningfully predicts children's mental health outcomes. Specifically, family dysfunction (B = -0.045, p = 0.229) and parental mental health (B = 0.025, p = 0.621) both failed to demonstrate statistically significant effects on children's mental health.

When both predictors were entered into the model simultaneously, neither family dysfunction nor parental mental health significantly predicted children's mental health. The direct effect of family dysfunction (c′) remained weak and non-significant, while the mediating

role of parental mental health was also found to be negligible, suggesting that parental distress does not contribute meaningfully to the relationship between family dysfunction and children's mental health.

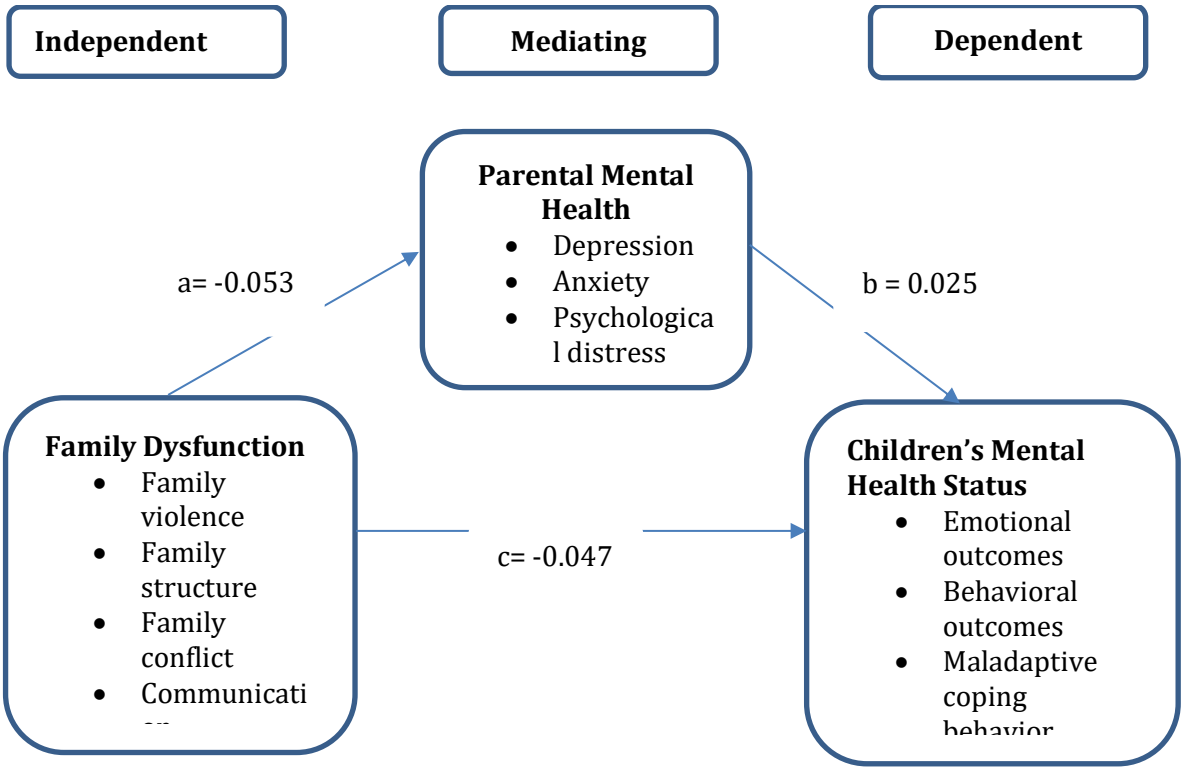
The calculation of the indirect effect, obtained by multiplying the unstandardized coefficients from Paths a and b, resulted in a value of -0.001325 (a=−0.053a = -0.053a=−0.053, b=0.025b = 0.025b=0.025). This indirect effect is very small and unlikely to be statistically significant. Since both paths in the mediation model were individually non-significant, the mediation effect is effectively negligible. In practical terms, these results suggest that parental mental health does not mediate the relationship between family dysfunction and children's mental health in this dataset.

4.4 Conceptual framework

Effects of Family Dynamics on Child Mental Health

FIGURE 2:

Effects Of Family Dynamics On Child Mental Health



The framework illustrated in Figure 2 outlines how family dysfunction influences children's mental health status, both directly and indirectly through parental mental health. This model is grounded in two key theoretical frameworks: Minuchin's Structural Family Theory and Bronfenbrenner's Ecological Systems Theory. The model incorporates three key variables: family dysfunction as the independent variable, parental mental health as the mediating variable, and children's mental health status as the dependent variable.

Family dysfunction is conceptualized to include elements such as family violence, disrupted family structures, and relational instability, all of which are believed to negatively impact both parental and child mental health. Parental mental health, captured through indicators of psychological distress such as depression and anxiety, is proposed to mediate the

relationship between family dysfunction and children's mental health. Children's mental health status, the dependent variable, encompasses emotional difficulties, behavioral problems, and maladaptive outcomes, which are assumed to be influenced by family dysfunction and the mental health of the parents.

The mediation model tests three key paths:

- The first path (a) examines whether family dysfunction predicts parental mental health, with a coefficient of $a=-0.056$, indicating that family dysfunction may exacerbate parental psychological distress.
- The second path (b) investigates whether parental mental health influences children's mental health, with a coefficient of $b=0.025$, suggesting that parental distress may have a mild effect on the emotional and behavioral difficulties experienced by children.
- The third path (c) evaluates the direct effect of family dysfunction on children's mental health, with a coefficient of $c=-0.045$, indicating a direct negative relationship between family dysfunction and children's mental health, although this effect is weak and statistically insignificant.

The indirect effect is calculated by multiplying the coefficients from paths a and b, resulting in an indirect effect value of -0.0014. This represents the mediated influence of family dysfunction on children's mental health through parental mental health.

The findings from the analysis suggest that while family dysfunction may directly influence children's mental health, the mediation effect through parental mental health is minimal. The statistical results indicate that both the direct effect of family dysfunction on children's mental health and the indirect effect through parental mental health are weak and not statistically

significant in the current dataset. Consequently, although family dysfunction appears to have a negative impact on children's mental health, parental mental health does not significantly mediate this relationship in this study's context.

4.5 Discussion of Findings

This study set out to examine whether parental mental health mediates the relationship between family dysfunction and children's mental health status. Contrary to theoretical expectations and much of the existing literature, which suggests that family dynamics profoundly shape psychological well-being within households, the findings from this dataset did not reveal a statistically significant mediation pathway. The total effect of family dysfunction on children's mental health was weak and non-significant, indicating that higher levels of family dysfunction were not reliably associated with poorer mental health outcomes among children. This challenges long-standing assumptions within family systems theory and developmental psychology, which posit that dysfunction directly undermines child well-being. Furthermore, the proposed mediator, parental mental health, did not significantly relate to family dysfunction, nor did it significantly predict children's mental health when controlling for family dysfunction. The indirect effect was negligible, reinforcing the conclusion that parental mental health does not mediate the relationship between family dysfunction and children's mental health in this sample.

Several factors may explain these unexpected results. Measurement limitations could have weakened the observed associations if the instruments used did not fully capture the nuanced dimensions of dysfunction or mental health. Additionally, contextual and cultural variables such as socioeconomic status, community cohesion, and collective coping might moderate these relationships, implying that the effects of family dysfunction are not universal but

context-dependent. Moreover, because the data were cross-sectional, they could not capture the evolving nature of interactions between family dynamics, parental well-being, and child outcomes over time. Longitudinal research could reveal temporal effects that emerge only with prolonged exposure to family dysfunction.

Although the observed relationships were not statistically significant, these findings do not diminish the relevance of family or parental well-being to child mental health. Instead, they underscore the complex and multifactorial nature of psychosocial processes influencing children's development. The absence of direct or mediated effects highlights the need for models that incorporate additional mechanisms, such as parenting practices, peer relationships, or school environments. It is also important to consider moderating factors that shape how family dysfunction affects children across different contexts.

In comparison to previous research, the current findings diverge from several established models in developmental and clinical psychology. For instance, Zhou et al. (2025) found that family dysfunction and parenting stress were significantly associated with children's mental health problems, particularly in contexts involving bullying, but that neighborhood support buffered these effects. Such findings suggest that strong community or school-based support systems may mitigate the negative influence of family dysfunction, potentially explaining the weak relationships observed in this study. Similarly, Kganyago Mphaphuli (2023) argued that nurturing family environments characterized by open communication and emotional cohesion are essential for healthy child development, while dysfunction erodes psychological well-being. However, the current findings suggest that dysfunction may not automatically translate into adverse outcomes unless other mediating or moderating factors, such as socioeconomic adversity, parental coping capacity, or cultural norms, are present.

Moreover, Jones et al. (2021) found that family conflict mediated the relationship between parental stress and child outcomes, particularly among families at risk for maltreatment. Their study highlights the importance of examining specific types of dysfunctions (e.g., conflict, neglect, abuse) rather than using global dysfunction scores. In contrast, the present study employed a composite index of family dysfunction, which may have diluted the effects of specific dysfunctional processes more directly linked to mental health outcomes. Taken together, these comparative studies suggest that contextual factors, such as neighborhood support, socioeconomic conditions, and cultural resilience, may buffer or amplify the effects of family dysfunction. Furthermore, specific forms of dysfunction (e.g., parental conflict, emotional neglect) may be more predictive of children's outcomes than composite measures. Family risk status, such as poverty, domestic violence, and parental substance use, may also moderate the direction and magnitude of associations between family functioning and mental health.

These findings may reflect the resilience and adaptive coping mechanisms embedded within the Malindi Sub-County context. Extended family networks, faith-based communities, or culturally grounded support systems might play compensatory roles that buffer children from the psychological consequences of family dysfunction. Thus, the non-significant results do not necessarily contradict existing theory but rather underscore the importance of studying how family processes operate within specific ecological and cultural environments. The current findings also suggest several directions for future research and practice. Future studies should aim to disaggregate family dysfunction into its constituent domains, such as emotional neglect, parental conflict, and financial strain, to capture the heterogeneity of family processes. By focusing on specific dysfunctions, researchers can better understand which elements of family dynamics are most predictive of children's mental health outcomes. Additionally,

incorporating contextual moderators, such as social support networks, school climate, cultural values, and neighborhood safety, would help explain the variance in child outcomes more comprehensively. Longitudinal designs are essential for capturing the delayed or cumulative effects of family dysfunction, enabling researchers to clarify the temporal ordering between family dynamics, parental well-being, and child mental health over time.

Adopting mixed-method approaches, integrating both quantitative and qualitative perspectives, would allow for a deeper exploration of the lived experiences and coping strategies of families. Such approaches can illuminate the complex, dynamic nature of family functioning and how it impacts children's psychological development across diverse communities. Practically, these findings caution educators, counselors, and policymakers against assuming linear cause–effect relationships between family dysfunction and child mental health. Instead, interventions should be ecologically sensitive, leveraging community strengths and targeting specific family risk factors. Efforts to promote parental well-being, strengthen parenting practices, and enhance community support structures are essential. By addressing these issues, stakeholders can foster resilience and positive mental health outcomes among children, particularly in contexts marked by family dysfunction. This will help create a more supportive environment for children's development, enabling them to thrive despite the challenges posed by family-related stressors.

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CHAPTER FIVE

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

5.1 Introduction

This chapter summarizes the study's key findings, conclusions, and recommendations, based on an investigation into parental mental health as a mediating factor between family dysfunction and the mental health of school-aged children in Malindi, Kenya. The discussion is guided by the study's objectives and critically assesses the relevance of the results to the research problem. Drawing from the findings, this chapter provides practical recommendations for parents, educators, counselors, and policymakers to address the identified challenges. It also highlights potential areas for future research by pointing out gaps that emerged during the study, thereby contributing to the advancement of knowledge in this field.

5.2 Summary of Findings

This study examined how family disruptions, family dysfunction, and parental mental health influence the emotional and behavioral well-being of school-aged children in Malindi Sub-County, Kenya. The research focused on understanding how different forms of family instability, such as conflict, poor communication, single parenting, and parental mental distress, influence the mental health outcomes of children. A total of 330 respondents participated in the study, and data were analyzed using descriptive and inferential statistics supported by thematic interpretation.

The findings revealed that family disruptions, including frequent arguments, lack of communication, parental separation, and changes in caregivers, were common in many

households. Most respondents reported moderate levels of family conflict and instability, which were linked to emotional distress, anxiety, and low self-esteem among children. The correlation analysis showed a weak but positive relationship between family disruptions and children's mental health, suggesting that children from unstable homes were more likely to experience stress, anxiety, or behavioral difficulties. Although the relationship was not statistically significant, the results indicate that disruptions in family structure and communication reduce emotional security in children, affecting their concentration, relationships, and sense of safety.

The study also found that family dysfunction, such as lack of mutual respect, emotional neglect, and unresolved tension, was strongly linked to emotional and behavioral problems in children. Children in dysfunctional homes often showed anxiety, sadness, restlessness, and poor school performance. The results further revealed that children exposed to constant family tension struggled to recover emotionally after conflicts. These findings show that family dysfunction weakens the emotional foundation of the home and limits children's ability to cope with challenges. When families fail to communicate or maintain harmony, children are more likely to develop emotional instability, social withdrawal, and reduced academic focus.

The study also established that the mental health of parents plays an important role in determining the emotional and behavioral well-being of their children. Many parents were found to experience stress, anxiety, and emotional exhaustion, which limited their ability to provide emotional support and stability at home. The results showed a weak but positive relationship between parental mental health and children's emotional and behavioral outcomes. This means that when parents are emotionally distressed, children are more likely to show signs of anxiety, restlessness, or difficulties in relationships and schoolwork. Although the relationship was not statistically significant, the findings highlight that parental well-being has

an indirect but important effect on the mental health of children.

Overall, the study concluded that family conditions play a major role in shaping children's emotional and psychological health. Children who live in stable, supportive, and communicative homes are more likely to develop confidence, good behavior, and emotional stability. On the other hand, children raised in families affected by conflict, dysfunction, or parental distress often show signs of stress, anxiety, and poor social adjustment. The findings align with the Ecological Systems Theory and the Structural Family Theory, which explain that the family environment forms the foundation for a child's development. Improving family relationships, communication, and parental mental health can therefore strengthen children's resilience and promote their emotional well-being.

5.3 Conclusions

Although the hypothesized mediation model was not supported, this study offers valuable insights into the complex, context-specific nature of child mental health and its determinants. The findings highlight the need to move beyond linear models of family dysfunction and child mental health, emphasizing the multifaceted interplay between family systems, parental well-being, and the broader sociocultural environment. The absence of a statistically significant mediation pathway underscores the complexity of the relationships between these variables and suggests that child mental health cannot be understood solely through the lens of family dynamics or parental mental health alone.

This study calls for more ecologically grounded and context-specific research that considers how family dysfunction, parental mental health, and children's mental health outcomes are shaped by a variety of contextual factors, including socioeconomic status, community cohesion, and cultural norms. These factors may moderate or mediate the relationships between family dynamics and child mental health, making it essential to explore

these variables in greater depth. Researchers and practitioners must adopt frameworks that not only account for the immediate family environment but also integrate broader societal influences that affect child development.

By expanding the scope of research to include these broader social and cultural contexts, it will be possible to develop more comprehensive, culturally responsive, and contextually relevant models for promoting children's mental health. Such frameworks can better address the needs of children in Kenya and similar settings, where family structures, social support systems, and cultural practices significantly influence child development. The findings of this study, while not conclusive in proving a mediation pathway, provide a foundational understanding of the complex dynamics at play and offer a starting point for future research and interventions aimed at supporting children's mental health in diverse contexts.

5.4 Recommendations of the Study

The findings and conclusions of this study underscore the need for targeted interventions to mitigate the adverse effects of dysfunctional family dynamics on the mental health and behavioral development of school-aged children in Malindi Sub-County and similar contexts. The following recommendations are proposed;

5.4.1Strengthen Family Counseling and Conflict Resolution Initiatives

Family counseling and conflict resolution programs should be expanded across schools, religious institutions, and community centers to support families in managing interpersonal challenges and enhancing communication. Trained counsellors and social workers should facilitate regular guidance sessions for parents and guardians, focusing on emotional regulation, anger management, and constructive problem-solving. These interventions are

expected to reduce domestic tension, foster mutual understanding, and minimize incidences of familial violence.

5.4.2 Reinforce Social Support Systems for Non-Traditional Families

Community-based support networks should be established and strengthened to empower single-parent households, widowed caregivers, and blended families. Parenting groups, mentorship programs, and empowerment initiatives can serve as safe spaces for caregivers to share experiences and acquire effective parenting strategies. These networks promote resilience and foster positive family environments.

5.4.3 Enhance Parental Mental Health Awareness and Support Services

Greater emphasis should be placed on educating parents about stress management and encouraging them to seek psychological support when needed. Collaborative efforts between local health departments and non-governmental organizations should provide mental health screenings, counseling services, and psychoeducation programs, particularly for parents experiencing emotional, social, or economic strain. Improving parental emotional well-being is directly linked to the psychological health and stability of their children.

5.4.4 Integrate Mental Health Support within Educational Settings

Schools should play an active role in promoting children's mental health by implementing early detection and intervention systems for emotional and behavioral issues. Educators and school counselors must be trained to recognize signs of psychological distress and respond with appropriate referrals or support. Additionally, curricula should incorporate Social-Emotional Learning (SEL) to cultivate emotional intelligence, resilience, and healthy interpersonal relationships among students.

5.4.5 Develop and Enforce Family-Centered Policies and Child Protection Measures

Government agencies and child welfare organizations should formulate and implement policies that promote family stability, safeguard children's rights, and encourage healthy parenting practices. Public awareness campaigns should aim to reduce stigma surrounding mental health care and counseling. Furthermore, the enforcement of child protection laws must be strengthened to shield children from harmful family environments.

These recommendations advocate for a multi-sectoral approach involving families, educational institutions, healthcare providers, community organizations, and policymakers. Such collaborative efforts can foster emotionally supportive home and learning environments where children feel safe, understood, and nurtured. Addressing family dysfunction holistically is essential for enhancing children's emotional well-being, social competence, and academic performance in Malindi Sub-County and comparable regions.

5.5 Suggestions for Further Research

This study examined the influence of dysfunctional family environments on the mental health of school-aged children in Malindi Sub-County, Kenya. While the findings were insightful, several areas warrant further investigation to deepen understanding and inform more targeted interventions.

5.5.1 Comparative Studies Across Cultural and Regional Contexts

Future research should explore similar dynamics in other regions and cultural settings across Kenya. Comparative studies would help determine whether patterns of family dysfunction and child mental health outcomes are consistent across diverse socio-economic and cultural environments. Such investigations could reveal region-specific challenges and inform context-sensitive interventions.

5.5.2 Longitudinal Research on Psychological Development

Long-term studies are needed to assess the enduring psychological effects of family dysfunction. Research should examine how sustained exposure to familial discord, instability, or parental stress influences children's emotional and behavioral development into adolescence and adulthood. Longitudinal data would provide critical insights into developmental trajectories and inform preventive strategies.

5.5.3 Qualitative Approaches to Family Perceptions

Future studies should incorporate qualitative methods—such as interviews and focus group discussions—to capture nuanced perspectives from children and parents. These approaches would complement quantitative findings by offering deeper insights into how family life is perceived and experienced within different households

Further research should adopt a holistic and interdisciplinary approach, integrating psychological, social, and educational perspectives. Such a framework is essential for advancing the well-being and mental health of children across diverse family structures and contexts.

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FAMILY DYSFUNCTION AND ITS INFLUENCE ON THE MENTAL HEALTH OF SCHOOL-AGED CHILDREN IN MALINDI SUB-COUNTY, KENYA

QUESTIONNAIRE

Serial number	

Title: Family Dysfunction and Mental Health of School-Aged Children in Malindi Sub-County, Kenya

Dear Respondent,

This questionnaire is designed to collect information for an academic study on how family relationships and environments relate to the mental well-being of school-aged children in Malindi Sub-County, Kenya. Your participation is entirely voluntary, and your responses will be kept strictly confidential. The information gathered will be used for research purposes only.

Please respond honestly to each question. Do not write your name on the form.

If you have any questions or concerns, you may contact the research assistant or the lead researcher at any time.

Section A: Demographic Information

1) Gender:

□ Male □ Female □ Prefer not to say

2) Age group:

□ 18–24 □ 25–34 □ 35–44 □ 45–54 □ 55 and above

3) Marital status:

□ Single □ Married □ Divorced/Separated □ Widowed

4) Relationship to the child(ren):

□ Biological parent □ Guardian □ Step-parent □ Other (specify) _____

5) Highest education level completed:

□ No formal education □ Primary □ Secondary □ Diploma/College □ University

6) Occupation:

□ Employed □ Self-employed □ Unemployed □ Other (specify) _____

7) Monthly household income (KES):

□ Below 10,000 □ 10,001–30,000 □ 30,001–50,000 □ 50,001–100,000 □ Above 100,000

8) Household size:

□ 1–2 □ 3–4 □ 5–6 □ 7 or more

Instructions for Sections B–E

Please indicate the extent to which you agree with each statement using the following scale:

1 = Strongly Disagree 2 = Disagree 3 = Neutral 4 = Agree 5 = Strongly Agree

Section B: Family Conflict and Violence

S/No	Statement	SD	D	N	A	SA
		1	2	3	4	5
9)	Family members often raise their voices or argue intensely.					
10)	Physical conflict sometimes occurs among family members.					
11)	Family members use harsh or disrespectful language when angry.					
12)	There is little mutual respect among family members.					
13)	Family problems are often handled with tension and unresolved arguments.					
14)	Family members often avoid communication to prevent arguments.					
15)	There is emotional neglect in our family (e.g., lack of attention or affection).					
16)	Disagreements in our family are often handled with anger rather than calm discussion					

Section C: Parental Mental Health

S/No	Statement	SD	D	N	A	SA
		1	2	3	4	5
17)	One or both parents often appear sad or withdrawn.					
18)	A parent frequently feels anxious or worried.					
19)	Parents sometimes struggle to manage stress or daily challenges.					

S/No	Statement	SD	D	N	A	SA
		1	2	3	4	5
20)	Parental mood changes create tension in the family.					
21)	Parents rarely express positive emotions or support toward family members.)					
22)	A parent frequently experiences sleep problems due to stress.					
23)	Parents in our household rarely express positive emotions.					
24)	Family responsibilities often feel overwhelming to one or both parents.					

Section D: Family Structure and Disruption

S/No	Statement	SD	D	N	A	SA
		1	2	3	4	5
25)	Parental separation or divorce has caused emotional distress in the household.					
26)	Introduction of a step-parent or new siblings has led to family conflicts.					
27)	Single parenting has created emotional or financial strain in the family.					
28)	Frequent changes in family composition disrupt family routines.					
29)	Family members often struggle to adjust to new family arrangements.					

S/No	**Statement**	**SD**	**D**	**N**	**A**	**SA**
		1	**2**	**3**	**4**	**5**
30)	Frequent changes in caregivers affect our children's emotional stability.					
31)	Financial strain following separation has affected our family's functioning.					

Section E: Children's Mental Health status

S/No	Statement	SD	D	N	A	SA
		1	2	3	4	5
32)	Children in the household often seem anxious or worried.					
33)	Children show sadness or loss of interest in daily activities.					
34)	Family issues affect children's concentration on schoolwork.					
35)	Children avoid social interactions due to family tension.					
36)	Children's academic performance is negatively affected by family challenges.					
37)	Children in our household exhibit restlessness or hyperactivity.					
38)	Children find it difficult to get along with peers.					
39)	Family stress often affects children's sleep or appetite.					
40)	Children struggle to recover emotionally after family conflicts.					

Thank you for your time and honest participation. Your input will help enhance understanding of family well-being and child mental health in the community.

APPENDIX IV: NACOSTI RESEARCH LICENSE

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: 248470

Date of Issue: 06/October/2025

RESEARCH LICENSE

This is to Certify that Ms.. Mercy Akinyi Were of KCA University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in on the topic: IMPACT OF DYSFUNCTIONAL FAMILIES ON THE MENTAL HEALTH OF SCHOOL- GOING CHILDREN IN MALINDI SUB - COUNTY KENYA for the period ending : 06/October/2026.

License No: NACOSTI/P/25/4180350

248470

Applicant Identification Number

Ag. Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

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

See overleaf for conditions

APPENDIX V: KCAUSERC ETHICAL CLEARANCE

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KCA UNIVERSITY SCIENTIFIC & ETHICS REVIEW COMMITTEE

REF: KCAU/SERC/SEASS022 Date: 8TH SEPTEMBER, 2025

TO: MERCY A. WERE (23/08255)

Dear Sir/Madam,

RE: IMPACT OF DYSFUNCTIONAL FAMILIES ON THE MENTAL HEALTH OF SCHOOL-GOING CHILDREN IN MALINDI SUB - COUNTY KENYA

This is to inform you that the KCA University Scientific Ethics Review Committee (KCAUSERC) has reviewed and approved your research proposal. Your application approval number is ***KCAUSERC/SEASS022***. The approval period is ***8th September, 2025 – 8th September, 2026.***
This approval is subject to compliance with the following requirements.

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

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

Yours sincerely,

Dr. Caroline Ntara,
Chairperson,
KCA University Scientific & Ethics Review Committee.