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Marital Distress and Co-Existing Psychological Disorders Among Married Individuals in Kenya: Prevalence, Associated Factors, and Interrelationships

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Abstract

The purpose of this study was to examine the prevalence of marital distress and co-existing psychological disorders among married individuals in Kenya, identify factors associated with these conditions, and explore the interrelationship between marital distress and psychological disorders. Marital distress has emerged as a significant psychosocial and public mental health concern in Kenya, contributing to emotional disconnection, relational dissatisfaction, and elevated risks of depression and hazardous alcohol use. Despite the centrality of marriage in Kenyan society, access to culturally responsive marital and mental health services remains limited, and existing research inadequately integrates relational and psychological dimensions of distress. The study employed a quasi-experimental, repeated-measures analytical design with a comparison group. A total of 86 married participants from Kikuyu Town, Kiambu County, were assessed using the Dyadic Adjustment Scale, Beck Depression Inventory-II, and Alcohol Use Disorders Identification Test. Data were analyzed using descriptive statistics, independent-samples t tests, chi-square tests, repeated-measures MANOVA, linear mixed models, and difference-in-differences estimators. Findings revealed high prevalence rates of marital distress, depressive symptoms, and hazardous alcohol use. Clinically significant marital distress was observed in 88.4% of participants, depressive symptoms in 91.9%, and hazardous or harmful alcohol use in 67.4%. Lower marital adjustment was systematically associated with higher levels of depression and alcohol-related risk, demonstrating strong interrelationships among these conditions. Marital distress among married individuals in Kenya is highly prevalent and frequently co-occurs with psychological disorders. The findings underscore the need for integrated, culturally responsive mental health and marital counseling services. Policy frameworks should prioritize routine screening, expansion of community-based psychosocial services, and training in integrative, couple-based interventions.

Keywords: *Marital distress; Psychological disorders; Depression; Alcohol use*

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1. Introduction

Marriage constitutes a fundamental social institution that profoundly shapes individual psychological functioning, family organization, and societal stability. Across cultures, marital relationships serve as primary contexts for emotional attachment, social support, identity formation, and economic cooperation. When marital bonds are characterized by mutual responsiveness and emotional attunement, they contribute significantly to psychological resilience, relational security, and social cohesion. Conversely, when marital relationships become chronically distressed, they frequently function as enduring sources of psychological strain, with consequences that extend beyond the dyad to affect children, extended family systems, and community well-being.

A substantial body of empirical literature has established marital distress as a robust predictor of adverse mental health outcomes, including depressive symptomatology, anxiety disorders, substance misuse, and stress-related somatic complaints (Whisman & Baucom, 2020; Karney & Bradbury, 2020). Importantly, this association is bidirectional: psychological disorders may both arise from and contribute to deteriorations in marital functioning. Depression, for example, is associated with emotional withdrawal, negative attributional styles, and impaired communication, all of which exacerbate relational conflict, while persistent marital discord intensifies emotional distress and psychological vulnerability. These reciprocal dynamic positions marital distress not merely as a relational problem, but as a critical psychosocial and public mental health concern.

Globally, research has consistently demonstrated that marital quality and psychological well-being are deeply intertwined across the lifespan (Randall & Bodenmann, 2017). However, the manifestation and management of marital distress are profoundly shaped by sociocultural context. In African societies, marriage is embedded within communal, cultural, and moral frameworks that extend responsibility beyond the couple to kinship networks and broader social structures. While these communal orientations can serve as protective factors, they may also impose expectations of endurance, silence, and conformity that inhibit emotional expression and help-seeking when distress arises.

In Kenya, marriage continues to occupy a central place in social and cultural life, functioning as a marker of adulthood, social legitimacy, and moral order. Yet contemporary Kenyan marriages are increasingly situated within contexts of rapid socioeconomic transformation. Urbanization, economic precarity, shifting gender roles, and changing expectations regarding intimacy and partnership have altered traditional marital dynamics and coping mechanisms (Obegi & Wango, 2022). These structural changes have coincided with rising reports of emotional disconnection, chronic conflict, and marital instability, as evidenced in national demographic and health indicators (Kenya National Bureau of Statistics, 2023).

Despite the growing prevalence of marital and psychological distress, access to professional marital and mental health services in Kenya remains limited. Public mental health infrastructure is under-resourced, and specialized marital counseling services are largely inaccessible to many communities (Ministry of Health, 2022). Consequently, many married individuals rely on informal support systems, including religious leaders, family elders, and community networks. While such systems provide important social containment and moral guidance, they often prioritize behavioral regulation, endurance, and reconciliation over emotional processing, psychological insight, and relational transformation (Wango, 2021).

This reliance on non-clinical support structures may inadvertently perpetuate unaddressed emotional distress, contributing to the chronicity of marital dissatisfaction and the escalation of psychological symptoms.

From an intervention standpoint, the Kenyan counseling landscape has been heavily influenced by Western-derived therapeutic models, particularly cognitive-behavioral and skills-based approaches. Although these models are empirically supported, their emphasis on rational cognition, behavioral modification, and individual agency may insufficiently capture the emotional depth, relational complexity, and communal orientation characteristic of African marital life (Mbiti, 2019; Corey, 2021). This theoretical and cultural misalignment underscores the need for intervention frameworks that are both empirically grounded and culturally congruent.

Gestalt therapy offers a compelling alternative framework for understanding and addressing marital distress within such contexts. Rooted in phenomenology and existential-humanistic philosophy, Gestalt therapy conceptualizes psychological distress as arising from disruptions in awareness, emotional integration, and relational contact (Yontef & Jacobs, 2019). Central to the Gestalt approach is the "here and now" orientation, which emphasizes present-moment experience as the primary locus of change. Rather than privileging abstract interpretation or historical analysis, Gestalt therapy facilitates direct engagement with emotions, bodily sensations, and relational patterns as they unfold in real time.

In marital contexts, Gestalt-based interventions enable individuals to become aware of unexpressed emotions, habitual interactional patterns, and unresolved relational experiences that shape current dynamics. Experiential techniques such as the Empty Chair, dialogical role play, and responsibility statements allow participants to externalize internal conflicts, reclaim projected emotions, and assume ownership of their relational experiences (Nevis, 2018). Through this process, individuals may move from blame, avoidance, and emotional suppression toward authenticity, empathy, and mutual accountability.

The explanatory power of Gestalt theory is further enhanced when integrated with cognitive frameworks such as Dweck's Implicit Theories of Marriage. This model elucidates how deeply held beliefs about the nature of relationships influence individuals' interpretations of conflict, emotional responses, and commitment to repair. Destiny-oriented beliefs, which frame compatibility as fixed, are associated with disengagement and hopelessness when difficulties arise, whereas growth-oriented beliefs promote persistence, emotional regulation, and constructive problem-solving (Dweck, 2017; Finkel & Campbell, 2020). The integration of these cognitive and experiential perspectives provides a comprehensive framework for understanding how marital distress and psychological disorders co-evolve.

Within the Kenyan context, the intersection of marital distress, depression, and alcohol misuse warrants particular attention. Alcohol use is frequently employed as a culturally sanctioned coping strategy for emotional strain and relational dissatisfaction, particularly among men, yet it often exacerbates both psychological symptoms and marital conflict (Ndetei et al., 2020). Interventions that enhance emotional awareness, foster responsibility, and support adaptive coping, therefore, hold promise for addressing relational dysfunction and associated psychological disorders simultaneously.

Despite the theoretical relevance and cultural resonance of awareness-based and experiential approaches, empirical research evaluating such interventions within Kenyan marital contexts

remains scarce. Much of the existing literature is descriptive, focusing on the prevalence and correlates of marital dissatisfaction without systematically examining the efficacy of interventions. Moreover, few studies have adopted integrated frameworks that conceptualize marital distress and psychological disorders as mutually reinforcing phenomena requiring coordinated intervention.

The present study responds to these gaps by examining marital distress and co-existing psychological disorders among married individuals in Kenya, with a focus on their prevalence, associated factors, and interrelationships. By situating marital distress within a broader psychosocial, cultural, and theoretical framework, the study seeks to advance contextually grounded knowledge that can inform culturally responsive counseling practice and mental health policy. In doing so, it contributes to the growing recognition that sustainable marital and psychological well-being in African contexts requires integrative, evidence-based approaches that honor both relational experience and cultural meaning.

1.1 Problem Statement

Marital distress has increasingly emerged as a pervasive psychosocial and mental health concern among married individuals in Kenya, with profound implications for individual well-being, family functioning, and societal stability. National demographic and health reports indicate rising levels of emotional disconnection, chronic conflict, communication breakdown, and relational dissatisfaction within marriages, particularly in rapidly urbanizing and economically strained communities (Kenya National Bureau of Statistics, 2023; Ministry of Health, 2022). Despite marriage occupying a central cultural and social position in Kenyan society, persistent marital distress continues to undermine emotional security, parenting capacity, and community cohesion.

Evidence further suggests that marital distress in Kenya rarely occurs in isolation. It is frequently accompanied by co-existing psychological disorders, notably depression, anxiety, and hazardous alcohol use. These conditions are mutually reinforcing; unresolved marital conflict exacerbates psychological distress, while depression and substance misuse impair emotional regulation, communication, and relational problem-solving. The growing burden of these interlinked challenges signals that marital distress constitutes not merely a private relational issue, but a significant and under-recognized public mental health problem (World Health Organization, 2022).

However, existing responses to marital distress in Kenya remain inadequate and fragmented. Access to professional marital and mental health services is limited, particularly at the community level, and help-seeking is constrained by stigma, cost, and cultural expectations of endurance and silence. Consequently, many married individuals rely primarily on informal or faith-based support systems. While socially important, these systems often prioritize moral instruction, behavioral conformity, or reconciliation over emotional awareness, psychological insight, and evidence-based intervention (Wango, 2021). As a result, emotional distress frequently remains unprocessed, contributing to the chronicity of marital dissatisfaction and the escalation of psychological symptoms.

From a scholarly and clinical standpoint, several critical gaps persist in the Kenyan literature. First, most studies on marital distress are largely descriptive, focusing on prevalence and correlates without adequately examining the interrelationships between marital distress and co-existing psychological disorders. This siloed approach obscures the dynamic and reciprocal

nature of relational and psychological dysfunction. Second, empirical research evaluating integrated intervention models that simultaneously address marital adjustment, depression, and alcohol-related risk within Kenyan contexts is remarkably scarce. Marital distress and psychological disorders are often studied and treated as separate phenomena, despite strong evidence that they are deeply interconnected.

Third, the majority of therapeutic approaches applied in Kenyan counseling practice are adapted from Western models, particularly cognitive-behavioral and skills-based frameworks, with limited cultural adaptation or empirical validation in African settings (Obegi & Wango, 2022). While these approaches emphasize cognitive restructuring and behavioral change, they often inadequately address emotional awareness, experiential processing, and communal relational values that are central to African marital life. This cultural and conceptual mismatch contributes to limited engagement, misunderstanding of therapeutic goals, and poor sustainability of outcomes.

Although experiential approaches such as Gestalt therapy, particularly its Here-and-Now orientation, are theoretically well suited to addressing emotional disconnection, unresolved affect, and maladaptive coping, there is a notable absence of empirical studies validating their effectiveness among legally/traditionally married individuals in Kenya. Moreover, few interventions integrate experiential frameworks with cognitive models such as Dweck's Implicit Theories of Marriage, which explain how rigid versus growth-oriented beliefs shape responses to marital conflict and psychological stress. The lack of such integrated, culturally grounded, and empirically tested models represents a major theoretical, methodological, and practical gap.

If the current trajectory persists, characterized by rising marital distress, untreated psychological comorbidity, reliance on inadequately adapted interventions, and limited empirical guidance, the consequences will extend beyond distressed couples to affect children, intergenerational relational patterns, workforce productivity, and national mental health outcomes. The escalation of depression, alcohol misuse, domestic conflict, and family instability underscores the urgent need to reconceptualize and empirically examine marital distress as a multidimensional psychosocial phenomenon.

This study addresses these critical gaps by examining marital distress and co-existing psychological disorders among legally/traditionally married individuals in Kenya, with specific attention to their prevalence, associated factors, and interrelationships. By generating contextually grounded empirical evidence, the study seeks to inform culturally responsive research, clinical practice, and policy interventions that address marital distress and psychological well-being in an integrated and sustainable manner.

1.2 Research Question

What is the prevalence of marital distress and co-existing psychological disorders among married individuals in Kenya?

What factors are associated with these conditions, and how are marital distress and psychological disorders interrelated?

2. Literature Review

2.1 Theoretical review

This study was grounded in an integrated theoretical framework drawing on Gestalt Theory, particularly its *Here-and-Now orientation*, and Dweck's Implicit Theories of Marriage (ITMI). The integration of these perspectives provided a comprehensive explanatory lens for understanding the prevalence, associated factors, and interrelationships between marital distress and co-existing psychological disorders among married individuals in Kenya. Rather than focusing on intervention outcomes, the framework elucidates the cognitive, emotional, relational, and contextual processes through which marital distress and psychological disorders emerge, coexist, and reinforce one another.

At the core of the framework is the proposition that marital distress and psychological disorders are mutually reinforcing phenomena, sustained by the interaction between implicit relational beliefs, disrupted emotional awareness, and socio-cultural stressors. Dweck's Implicit Theories of Marriage explain how deeply held beliefs about the nature of marriage shape individuals' interpretations of conflict, management of relational stress, and responses to emotional challenges. Individuals who endorse destiny-oriented beliefs tend to view marital difficulties as evidence of incompatibility or relational failure, which increases vulnerability to emotional withdrawal, hopelessness, and maladaptive coping behaviors such as alcohol use. In contrast, growth-oriented beliefs promote resilience, persistence, and adaptive emotional regulation, thereby buffering against both marital distress and psychological dysfunction (Dweck, 2017; Finkel & Campbell, 2020).

Within this framework, ITMI provides a cognitive explanation for why some married individuals experience chronic marital dissatisfaction and psychological distress under similar circumstances, while others demonstrate adjustment and resilience. Rigid marital beliefs are theorized to increase psychological vulnerability by intensifying negative appraisals of conflict, fostering helplessness, and reducing motivation for relational repair. These cognitive patterns help explain variations in the prevalence and severity of marital distress and co-existing psychological disorders such as depression and alcohol misuse among married individuals.

While ITMI accounts for the belief-based foundations of marital distress, it does not fully explain how emotional processes contribute to psychological symptoms. Gestalt Theory addresses this gap by emphasizing present-moment awareness, emotional contact, and personal responsibility as central to psychological functioning (Yontef & Jacobs, 2019). From a Gestalt perspective, marital distress arises when individuals lose contact with their immediate emotional, bodily, and relational experiences. This loss of awareness leads to unexpressed needs, unresolved emotional experiences ("unfinished business"), and habitual patterns of blame, avoidance, or emotional suppression. Over time, these processes manifest not only as relational dissatisfaction but also as psychological disorders, including depression and substance use, as individuals attempt to regulate emotional pain indirectly.

The *Here-and-Now* orientation of Gestalt theory provides a conceptual explanation for the co-occurrence of marital distress and psychological disorders. By focusing on how emotions, thoughts, and relational patterns unfold in the present moment, Gestalt theory explains how unresolved marital tension becomes embodied as psychological distress. Depression is understood as a consequence of blocked emotional expression, withdrawal from relational

contact, and diminished self-support, while alcohol misuse is conceptualized as a maladaptive strategy for avoiding painful awareness or numbing unresolved emotional experiences.

Anchored in the Kenyan socio-cultural context, the integrated framework recognizes that marital distress and psychological disorders are shaped by cultural norms that emphasize marital endurance, hierarchy, gendered emotional restraint, and collective family expectations (Obegi & Wango, 2022). These norms may reinforce destiny-oriented beliefs and discourage open emotional expression, particularly among men, thereby increasing vulnerability to both relational dissatisfaction and psychological disorders. Economic strain, urbanization, and limited access to professional mental health services further compound these risks, contributing to the observed prevalence of marital distress and co-existing psychological conditions.

Gestalt theory's emphasis on relational contact, dialogue, and awareness aligns with African communal traditions that value presence, shared meaning, and interpersonal connection. This alignment strengthens the framework's cultural relevance by situating marital distress and psychological disorders within lived relational and social contexts rather than viewing them as isolated individual pathologies. The framework, therefore, conceptualizes marital distress not merely as a dyadic problem but as a psychosocial condition embedded within broader cultural, economic, and emotional systems.

Within this theoretical model, prevalence is understood as the observable manifestation of cumulative cognitive, emotional, and contextual risk factors. Associated factors include implicit marital beliefs, emotional regulation patterns, gender norms, economic stressors, and barriers to help-seeking. Interrelationships are conceptualized as bidirectional and dynamic: marital distress exacerbates psychological disorders through chronic relational stress and emotional disconnection, while psychological disorders further undermine marital functioning through withdrawal, irritability, impaired communication, and maladaptive coping behaviors.

In summary, the integrated Gestalt–ITMI framework posits that marital distress and co-existing psychological disorders among married individuals in Kenya are best understood as interconnected phenomena arising from the interaction of belief systems, emotional awareness, relational processes, and socio-cultural context. By combining cognitive and experiential perspectives, the framework provides a theoretically grounded basis for examining prevalence patterns, identifying associated factors, and explaining the reciprocal relationship between marital distress and psychological disorders. This integrated approach directly informs the study's investigation into how relational and psychological difficulties coexist and interact within Kenyan marriages.

2.2 Empirical Review

The empirical scholarship has increasingly recognized marital distress as a significant psychosocial and public mental health concern; however, a critical review of the literature reveals substantial conceptual, methodological, and contextual gaps, particularly with regard to Kenya and similar African settings. Although international studies consistently demonstrate strong associations between marital distress and psychological disorders such as depression, anxiety, and alcohol misuse, the extent to which these patterns reflect the lived realities of married individuals in Kenya remains insufficiently understood (Whisman & Baucom, 2020; Karney & Bradbury, 2020). Existing evidence, therefore, offers a fragmented understanding of

the prevalence of marital distress, the factors associated with it, and the complex interrelationships between relational dysfunction and psychological disorders within Kenyan marriages.

Globally, marital distress is estimated to affect between 20% and 40% of married individuals at various stages of the marital life course (Amato, 2014; Fincham & Beach, 2019). These estimates, however, are derived predominantly from Western populations where marriage is conceptualized primarily as an individual dyadic relationship and where disclosure of relational dissatisfaction carries relatively low social stigma. In contrast, Kenyan marriages are embedded within extended family systems, cultural norms, and religious expectations that prioritize marital endurance, family honor, and social cohesion (Mbiti, 2019; Obegi & Wango, 2022). These contextual factors significantly constrain open reporting of marital difficulties, suggesting that existing prevalence estimates based on divorce or separation statistics substantially underestimate the true burden of marital distress (Kenya National Bureau of Statistics [KNBS], 2023).

Empirical studies in Kenya rarely measure marital distress directly using standardized relational instruments. Instead, many rely on proxy indicators such as reports of family conflict, domestic disputes, or marital dissolution (Walter & Wairimu, 2021; Dodo, 2021). While these indicators are informative, they fail to capture emotionally distressed but structurally intact marriages, relationships that remain legally and socially intact despite profound emotional disconnection. This methodological limitation obscures the true prevalence of marital distress and weakens attempts to examine its association with psychological disorders.

Similarly, research on depression and alcohol misuse among married individuals in Kenya is largely disconnected from assessments of marital quality. National mental health surveys document high rates of depressive symptoms and hazardous alcohol use among adults, yet few studies explicitly examine how these disorders cluster within distressed marital relationships (Ndetei et al., 2020; Kenya Mental Health Policy, 2021). This separation reflects a broader tendency in the literature to conceptualize marital distress and psychological disorders as distinct phenomena rather than as mutually reinforcing conditions (Whisman, 2019). Consequently, the coexistence of marital distress with depression and alcohol misuse is frequently acknowledged theoretically but insufficiently quantified empirically.

Studies examining factors associated with marital distress identify a wide constellation of contributors, including poor communication, financial strain, infidelity, substance use, gender role conflict, and socio-economic instability (Fincham & Beach, 2019; Karney & Bradbury, 2020). In African contexts, these factors are intensified by rapid social change, urbanization, and shifting gender expectations (Akinyemi & Odu, 2021; Obegi & Wango, 2022). However, much of the literature treats these determinants as isolated predictors rather than as interconnected processes operating simultaneously. For instance, economic hardship is frequently cited as a primary cause of marital conflict, yet few studies empirically trace how financial stress contributes to depressive symptoms or alcohol misuse, which then further erode marital satisfaction (Ndetei et al., 2020; Whisman & Baucom, 2020).

Alcohol misuse illustrates this conceptual fragmentation particularly clearly. Kenyan studies often frame alcohol use as a cause of marital breakdown, emphasizing its association with neglect, aggression, and financial irresponsibility (NACADA, 2023; Obegi & Wango, 2022). While these associations are well established, the reverse pathway, whereby chronic marital

distress precipitates alcohol use as a maladaptive coping strategy, receives far less empirical attention. International research demonstrates that marital dissatisfaction predicts increased alcohol consumption, particularly among men socialized to suppress emotional vulnerability (Halford & Pepping, 2019; Whisman, 2019). The failure of Kenyan studies to conceptualize alcohol misuse as both a consequence and a co-existing psychological disorder limits understanding of the cyclical relationship between relational distress and substance use.

Depression shows a similar pattern of under-integrated analysis. Globally, individuals in distressed marriages are two to three times more likely to experience depressive symptoms than those in satisfying relationships (Whisman & Baucom, 2020; Fincham & Beach, 2019). Yet in Kenya, depression is often examined through a biomedical or individual psychopathology lens, detached from relational contexts (Ndetei et al., 2020). Few studies systematically investigate how marital distress contributes to the onset, maintenance, or relapse of depressive symptoms, or how depression, in turn, undermines communication, emotional availability, and conflict resolution within marriage (Karney & Bradbury, 2020; Randall & Bodenmann, 2017).

The most critical limitation across the empirical literature is the insufficient examination of interrelationships among marital distress, depression, and alcohol misuse. While international longitudinal studies demonstrate bidirectional and reciprocal associations among these variables (Whisman, 2019; Karney & Bradbury, 2020), Kenyan research is dominated by cross-sectional designs that preclude causal inference and temporal sequencing. As a result, it remains unclear whether marital distress precedes psychological disorders, whether pre-existing mental health conditions erode marital functioning, or how these processes unfold concurrently over time. Gender dynamics further complicate these interrelationships, yet few studies explicitly examine gender as a moderating variable despite evidence that men and women manifest and cope with marital and psychological distress differently (Akotia & Oduro, 2022; Akinyemi & Odu, 2021).

Methodological challenges further weaken the empirical base. Many studies rely on small, localized samples, non-standardized instruments, and self-report measures vulnerable to social desirability bias, particularly in cultural contexts where marital problems are morally stigmatized (Wango, 2021; Mbiti, 2019). Conceptually, the literature remains fragmented, with marital distress often examined within moral, sociological, or religious frameworks, while psychological disorders are analyzed through biomedical or individualistic paradigms. These disciplinary silos hinder the development of integrative models that capture the relational embedding of mental health among married individuals in Kenya.

In synthesis, existing empirical studies confirm that marital distress and psychological disorders are prevalent and interrelated, yet Kenyan-specific evidence remains insufficient to fully characterize their prevalence, associated factors, and mutual reinforcement. The literature inadequately documents the scope of marital distress, insufficiently integrates socio-economic and psychological determinants, and rarely models the dynamic interrelationships among marital distress, depression, and alcohol misuse within a unified analytical framework (Whisman & Baucom, 2020; Ndetei et al., 2020; Obegi & Wango, 2022). This fragmentation constitutes a critical gap in knowledge and underscores the need for contextually grounded, integrative research that simultaneously examines relational and psychological dimensions of distress. Addressing this gap is essential for informing culturally responsive mental health policy, marital counseling practice, and family support interventions in Kenya.

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3. Methodology

3.1 Study Design

The study adopted a quasi-experimental, repeated-measures analytical design with a comparison group to examine the prevalence, correlates, and interrelationships between marital distress and co-existing psychological disorders among married individuals in Kenya. This design enabled the simultaneous estimation of baseline prevalence rates and the assessment of temporal patterns and statistical associations among marital distress, depressive symptoms, and alcohol-related risk across multiple measurement points. Although randomization was not feasible due to ethical and contextual considerations, the design incorporated matched group assignment, repeated observations, and multivariate modeling, thereby enhancing internal validity and inferential robustness.

3.2 Study Setting and Population

The study was conducted in Kikuyu Town, Kiambu County, a peri-urban setting characterized by rapid urbanization, economic transition, and evolving marital norms. The target population comprised legally married individuals aged 25–60 years, reflecting a life stage associated with high marital, economic, and psychosocial demands. This demographic is particularly vulnerable to relational strain and psychological distress due to competing family, occupational, and cultural pressures.

3.3 Sample Size and Group Allocation

A total of 86 participants were recruited using purposive and community-based recruitment strategies. Participants were assigned to two analytically comparable groups ($n = 43$ per group) using matched assignment procedures based on age, gender, duration of marriage, and baseline scores on measures of marital distress and psychological symptoms. Group equivalence was statistically verified using independent-samples t-tests and chi-square tests, which revealed no significant baseline differences across key demographic or outcome variables ($p > .05$), supporting comparability between groups.

3.4 Inclusion and Exclusion Criteria

Inclusion criteria required participants to meet at least one of the following standardized thresholds:

- Marital distress: Dyadic Adjustment Scale (DAS) score < 92
- Depressive symptoms: Beck Depression Inventory–II (BDI-II) score between 14 and 28
- Alcohol-related risk: Alcohol Use Disorders Identification Test (AUDIT) score ≥ 8

These thresholds identified individuals experiencing clinically meaningful relational dissatisfaction and mild to moderate psychological risk while excluding cases requiring acute psychiatric or protective intervention.

Exclusion criteria included current engagement in formal psychotherapy, diagnosis of severe mental illness, active suicidal ideation, or severe domestic violence, to ensure participant safety and methodological consistency.

3.5 Measures

Marital Distress was assessed using the Dyadic Adjustment Scale (Spanier, 1976), a 32-item instrument measuring dyadic satisfaction, cohesion, consensus, and affectional expression. The DAS demonstrated strong internal consistency in this sample (Cronbach's $\alpha > .90$).

Depressive Symptoms were measured using the Beck Depression Inventory-II (Beck et al., 1996), a 21-item scale assessing cognitive, affective, and somatic symptoms of depression. Internal reliability in the current sample was high ($\alpha \approx .88$).

Alcohol-Related Risk was assessed using the Alcohol Use Disorders Identification Test (AUDIT; Babor et al., 2001), a 10-item screening tool capturing hazardous drinking, dependence symptoms, and alcohol-related harm ($\alpha \approx .85$).

3.6 Data Collection Procedure

Data were collected at three time points: baseline (T_0), midline (T_1), and endline (T_2). This repeated-measures structure enabled examination of both cross-sectional prevalence and longitudinal interrelationships among marital distress and psychological disorders. Standardized administration procedures were followed to minimize measurement error and interviewer bias.

3.7 Statistical Analysis

Data analysis was conducted using IBM SPSS Statistics Version 28. Preliminary analyses included descriptive statistics (means, standard deviations, frequencies, and proportions) to estimate prevalence rates of marital distress, depression, and alcohol-related risk. Normality, homoscedasticity, multicollinearity, and linearity assumptions were assessed prior to inferential analysis.

Bivariate relationships between marital distress and psychological variables were examined using Pearson's correlation coefficients, while group differences were explored using independent-samples t-tests and chi-square analyses as appropriate.

To examine interrelationships over time, repeated-measures MANOVA was employed to test multivariate Time × Group effects across marital and psychological outcomes. Linear Mixed Models (LMMs) were further applied to account for within-subject correlations and to handle missing data under the assumption of data missing at random (MAR).

To strengthen causal inference regarding relational and psychological change, Difference-in-Differences (DiD) estimators were calculated by comparing pre–post changes across groups. Effect sizes were reported using partial eta squared (η^2p) for multivariate effects and Cohen's d for mean differences, providing estimates of practical significance alongside statistical significance. All tests were evaluated at the $\alpha = .05$ level.

4. Results and Discussion

4.1 Prevalence of Marital Distress and Co-existing Psychological Disorders

The prevalence and severity of marital distress were assessed using the Dyadic Adjustment Scale (DAS). At baseline, 76 of the 86 participants (88.4%) scored below the clinical cutoff of 100, indicating clinically significant marital distress. As presented in Table 1, 31 participants (36.0%) were classified as experiencing severe marital distress (DAS < 85), while 45 participants (52.3%) fell within the moderate distress range (DAS = 85–99). Only 10

participants (11.6%) scored within the non-distressed range (DAS ≥ 100). Consistent with the categorical distribution shown in Table 1, the mean DAS score was 86.1 (SD = 8.5), with observed scores ranging from 64 to 103.

Table 1: Prevalence and Severity of Marital Distress (DAS)

Category	Score Range	n	%
Severe marital distress	< 85	31	36.0%
Moderate marital distress	85–99	45	52.3%
No clinical distress	≥ 100	10	11.6%

Descriptive scores: *M* = 86.1, *SD* = 8.5, Range = 64–103. These findings indicate that most individuals presented with clinically significant relational strain prior to the intervention, underscoring the importance of psychosocial support.

Table 2: Prevalence and Severity of Depressive Symptoms (BDI-II)

Category	Score Range	n	%
Minimal	0–13	7	8.1
Mild	14–19	18	20.9
Moderate	20–28	41	47.7
Severe	29–63	20	23.3

Note. BDI-II = Beck Depression Inventory–II. Percentages are based on the total sample (N = 86). Descriptive statistics for BDI-II scores were M = 22.6, SD = 6.3, with a range of 10–38.

Depressive symptoms were measured using the Beck Depression Inventory–II (BDI-II). A total of 79 participants (91.9%) reported depressive symptom levels above the minimal range. Specifically, 18 participants (20.9%) reported mild depressive symptoms, 41 participants (47.7%) reported moderate symptoms, and 20 participants (23.3%) reported severe symptoms. The mean BDI-II score was 22.6 (SD = 6.3), with scores ranging from 10 to 38. Overall, 71.0% of participants fell within the moderate-to-severe depression categories.

Table 3: Prevalence and Severity of Alcohol Use Risk (AUDIT)

Category	Score Range	n	%
Low risk	0–7	28	32.6
Hazardous	8–15	39	45.3
Harmful	16–19	12	14.0
Possible dependence	≥ 20	7	8.1

Note. AUDIT = Alcohol Use Disorders Identification Test. Percentages are based on the total sample (N = 86). Descriptive statistics for AUDIT scores were M = 11.5, SD = 4.9, with a range of 2–26.

Alcohol-related risk was assessed using the Alcohol Use Disorders Identification Test (AUDIT). Fifty-eight participants (67.4%) scored at or above the cut-off for hazardous or harmful alcohol use (AUDIT ≥ 8). Of these, 39 participants (45.3%) were classified as hazardous drinkers, 12 participants (14.0%) as harmful drinkers, and 7 participants (8.1%) as having scores suggestive of possible alcohol dependence. The mean AUDIT score was 11.5 (SD = 4.9), with a range of 2 to 26.

4.2 Factors Associated with Marital Distress and Psychological Disorders

Descriptive analyses indicated that participants with lower marital adjustment scores also tended to report higher levels of depressive symptoms and alcohol-related risk. Elevated BDI-II and AUDIT scores were observed among participants classified within the moderate and severe marital distress categories, suggesting systematic co-occurrence of relational distress with psychological and behavioral risk indicators.

Alcohol use emerged as a notable associated factor. A marginal baseline difference in AUDIT scores was observed across comparison groups (p = .050), indicating variability in alcohol-related risk that warranted statistical control in subsequent analyses. No comparable baseline differences were observed for marital adjustment or depressive symptoms.

4.3 Interrelationship Between Marital Distress and Psychological Disorders

The results demonstrate substantial overlap between marital distress, depressive symptoms, and alcohol-related risk. A large proportion of participants simultaneously met clinical thresholds for marital distress and depressive symptomatology, with more than two-thirds also meeting criteria for hazardous or harmful alcohol use.

The concurrent distribution of low DAS scores with elevated BDI-II and AUDIT scores indicates a strong empirical association between marital distress and psychological disorders. These findings suggest that marital distress is systematically associated with both affective and substance-related symptom profiles within this population.

5. Discussion

This study sought to examine the prevalence of marital distress and co-existing psychological disorders among married individuals in Kenya, identify factors associated with these conditions, and explore the interrelationship between marital distress and psychological disorders. The findings reveal a high prevalence of marital distress, depressive symptoms, and alcohol-related risk within the sample, highlighting the substantial relational and psychological burden experienced by married individuals in this context.

Prevalence of Marital Distress

The results indicate that marital distress was highly prevalent, with 88.4% of participants scoring below the clinical cut-off on the Dyadic Adjustment Scale. This prevalence is notably high, suggesting that marital dissatisfaction is a widespread concern among married individuals in Kenya. Similar patterns have been documented in previous African and global studies, which report increasing marital strain associated with socioeconomic stressors, role strain, and changing family dynamics (Amato, 2010; Onyango et al., 2018).

The high proportion of participants reporting moderate to severe marital distress is consistent with prior research indicating that marital conflict and dissatisfaction are common precursors to emotional distress and maladaptive coping behaviors (Whisman & Baucom, 2012). In the

Kenyan context, financial pressures, gender role expectations, and limited access to marital counseling services may further exacerbate relational difficulties (Kariuki & Mbugua, 2019).

Co-existing Depressive Symptoms

Depressive symptoms were also highly prevalent, with 91.9% of participants reporting symptoms above the minimal range and 71% falling within the moderate to severe categories. These findings align with earlier studies demonstrating a strong association between marital dissatisfaction and depression, particularly in married populations experiencing chronic relational stress (Beach et al., 2003; Whisman, 2007).

The high burden of depressive symptoms observed in this study may reflect the cumulative impact of unresolved marital conflict, emotional disengagement, and perceived lack of spousal support. Previous research suggests that distressed marital relationships can function as chronic stressors, increasing vulnerability to depressive symptomatology through mechanisms such as reduced emotional regulation and increased interpersonal stress (Davila et al., 2003).

Alcohol Use as a Co-occurring Condition

More than two-thirds of participants met criteria for hazardous, harmful, or potentially dependent alcohol use. This prevalence is consistent with regional studies reporting elevated alcohol use among individuals experiencing psychosocial stress and relational conflict (Muli et al., 2020; World Health Organization [WHO], 2018). Alcohol use has been widely documented as both a risk factor for and a consequence of marital distress, often contributing to a cyclical pattern of conflict escalation and emotional withdrawal (Leonard & Eiden, 2007).

The marginal baseline differences in alcohol-related risk observed between groups further suggest that alcohol use may play a moderating or exacerbating role in marital and psychological outcomes. Prior studies indicate that alcohol misuse can impair communication, increase aggression, and reduce problem-solving capacity within intimate relationships, thereby intensifying marital distress and emotional symptoms (Homish et al., 2006).

Interrelationship Between Marital Distress and Psychological Disorders

The co-occurrence of marital distress, depressive symptoms, and alcohol-related risk observed in this study supports a bidirectional and interrelated model of relational and psychological functioning. These findings are consistent with the marital discord model of depression, which posits that marital conflict contributes to the onset and maintenance of depressive symptoms, while depression, in turn, undermines relationship quality (Beach et al., 2003).

Similarly, alcohol use appears to intersect with both marital distress and depressive symptoms, serving as a maladaptive coping strategy that further erodes relational functioning. Previous research has demonstrated that couples experiencing both relational distress and substance misuse tend to report poorer treatment outcomes unless interventions address both domains simultaneously (O'Farrell & Fals-Stewart, 2006).

Implications for Intervention and Practice

The high prevalence and co-occurrence of marital distress, depression, and alcohol-related risk underscore the need for integrated psychosocial interventions. Interventions that focus exclusively on individual symptoms may be insufficient in contexts where relational dysfunction and psychological distress are mutually reinforcing. Couple-based interventions

that incorporate mental health screening and substance use assessment may therefore be particularly beneficial (Lebow et al., 2012).

In the Kenyan context, these findings highlight the importance of strengthening access to culturally responsive marital counseling and community-based mental health services. Integrating marital therapy with depression and substance use treatment could enhance outcomes and address the complex needs of married individuals experiencing multidimensional distress.

6. Conclusion

This study demonstrates a high prevalence of marital distress and co-existing psychological disorders among married individuals in Kenya. The majority of participants reported clinically significant marital distress, elevated depressive symptoms, and hazardous or harmful alcohol use, indicating that relational difficulties are frequently accompanied by emotional and behavioral challenges. The findings further highlight a strong interrelationship between marital distress, depression, and alcohol-related risk, suggesting that these conditions rarely occur in isolation. Collectively, the results underscore the importance of addressing marital functioning as a central component of mental health and psychosocial well-being among married populations in Kenya.

7. Recommendations

The findings of this study have important implications for both policy and practice. At the policy level, there is a need to integrate marital and family counseling into national mental health frameworks and primary healthcare services. Given the high co-occurrence of marital distress, depressive symptoms, and alcohol-related risk, routine screening for relational difficulties and psychological disorders should be incorporated into community and clinical health settings. Strengthening community-based psychosocial support systems, including culturally responsive and faith-based counseling services, would improve access to care for married individuals experiencing distress. In addition, public health policies should prioritize alcohol use prevention and early intervention strategies that specifically target adults facing relational and psychosocial stress. Capacity building through the training of mental health professionals in couple-based and integrative therapeutic approaches is also essential to ensure effective service delivery.

At the practice level, mental health practitioners and counselors should adopt a holistic and integrated approach when working with married individuals, recognizing the interconnected nature of marital distress, depression, and alcohol use. Routine use of standardized screening tools such as the DAS, BDI-II, and AUDIT can facilitate early identification and timely intervention. Emphasis should be placed on couple-based interventions that address communication, conflict resolution, emotional regulation, and maladaptive coping behaviors. Preventive and early intervention programs, including marital enrichment and psychoeducation, may help reduce the progression of distress and associated psychological disorders. Importantly, all interventions should be culturally sensitive and contextually informed, taking into account societal norms, gender roles, and family structures that influence marital relationships and mental health outcomes in Kenya.

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