

Effects of Emotional Regulation Skills on Promoting Mental Wellness among Youth in Kapseret Sub-County, Kenya

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Abstract: This study examined the effect of a structured emotional regulation skills module on mental wellness among youth aged 13-24 in Kapseret Sub-County, Uasin Gishu County, Kenya, identified as the psychoeducation component with the strongest empirical support within a broader four-component parent study. A convergent parallel mixed-methods design combined a quasi-experimental comparison of an intervention group (n = 20) and a non-equivalent control group (n = 20) with phenomenological in-depth interviews (n = 5). The intervention group completed a five-week psychoeducation programme; both groups then completed a five-point Likert questionnaire (Cronbach's alpha = .96 for the emotional regulation subscale). Simple linear regression showed that emotional regulation skills significantly predicted mental wellness (beta = .54, t = 5.10, p < .001), the strongest association among the four psychoeducation components tested. The intervention group scored substantially higher on emotional regulation (M = 4.76, SD = 0.22) than the control group (M = 2.93, SD = 0.17), and interview data converged with this result, describing a shift from impulsive reaction to reflective pausing and constructive dialogue. Emotional regulation training appears to be a high-yield, low-cost component for youth mental health programming in similar Kenyan community settings, with direct relevance for teachers, counsellors, and programme administrators designing time- and resource-constrained interventions. The findings support prioritising emotional regulation content in community-delivered psychoeducation curricula for non-clinical, peri-urban youth populations in Kenya and comparable East African settings.

Keywords: Emotional regulation, Kenya, Mental wellness, Psychoeducation, Youth.

I. INTRODUCTION

Adolescence and youth are widely recognised as a period of heightened vulnerability to emotional and behavioural difficulty. The World Health Organization [1] estimates that one in seven 10- to 19-year-olds worldwide lives with a diagnosable mental disorder, and unaddressed distress at this stage of life carries forward into adult psychopathology, reduced educational attainment, and risk behaviour. In Kenya, youth in rapidly urbanising peri-urban settlements confront a distinctive constellation of stressors, including unemployment, academic pressure, and family strain, that existing school- or clinic-based mental health services rarely reach. Community-based psychoeducation, in which structured, non-clinical skills training is delivered directly to at-risk groups, has been proposed as a scalable response to this gap, yet much of the evidence base originates in high-income or clinical settings and treats psychoeducation as an undifferentiated whole rather than isolating which of its components carries the intervention's effect [2], [3].

The need is concrete in the study locality. Kapseret Sub-County, Uasin Gishu County, is among the fastest-growing sub-counties in the county and includes one of its largest informal settlements, a setting associated with elevated rates of school dropout, substance use, and gender-based violence. County-level data from the 2022 Kenya Demographic and Health Survey indicate that 11% of girls aged 15-19 in Uasin Gishu County had begun childbearing, that adolescents accounted

for 27% of reported gender-based violence cases and 13% of antenatal attendance, and that youth aged 15-24 accounted for 39% of new adult HIV infections in the county [4]. Against this backdrop, interventions capable of measurably strengthening how young people manage emotion and conflict, rather than only providing information about mental health, are of practical as well as academic interest.

Existing Kenyan evidence on psychoeducation is concentrated among adult clinical populations, including nurses coping with occupational stress [5], women managing anxiety [6], and diploma students screened for depression and substance use [7], or among institutionalised and already-symptomatic adolescents [8], [9]. Community-dwelling, non-clinical youth in ordinary peri-urban settlements, and the specific contribution of emotional regulation training within a multi-component curriculum, remain comparatively under-examined.

A four-component psychoeducation curriculum, comprising stress management, emotional regulation, psycho-spiritual, and psycho-social modules, was piloted with youth aged 13-24 in Kapseret Sub-County using a convergent mixed-methods, quasi-experimental design [10]. Regression analysis across the four components showed that emotional regulation skills carried the strongest statistical association with overall mental wellness of the four ($\beta = .54$, $t = 5.10$, $p < .001$), ahead of stress management ($\beta = .48$, $p = .001$), psycho-social skills ($\beta = .44$, $p = .001$), and psycho-spiritual interventions ($\beta = .39$, $p = .003$), and qualitative interview data converged closely with this quantitative signal. Because psychoeducation programmes delivered by community organisations and county youth departments typically operate under tight resource and time constraints, identifying which single component yields the greatest measurable benefit has direct implications for how such programmes are designed, sequenced, and funded. This article isolates and reports that finding in full, rather than presenting the parent study's complete four-objective dataset.

Framed within Beck's [11] cognitive behaviour theory, under which distorted, reactive thought patterns are understood to drive both emotional distress and dysfunctional behaviour, and skills that interrupt this pattern are expected to improve wellbeing, the study tested the hypothesis that emotional regulation skills significantly predict mental wellness among youth, and explored, through in-depth interviews, how participants experienced and applied those skills in daily life. The specific objective was to determine the effects of emotional regulation skills on promoting mental wellness among the youth of Kapseret Sub-County, Kenya.

II. LITERATURE REVIEW

A. Theoretical Framework

The study was anchored in Beck's [11] cognitive behaviour theory, which holds that emotional difficulty is closely linked to negative and distorted patterns of thought, and that behaviour follows from how those thoughts are appraised. Under this framework, teaching young people to notice a triggering thought, pause before reacting, and re-appraise a situation before responding is expected to reduce impulsive, emotion-driven behaviour and, over time, to improve overall psychological wellbeing. Cognitive behaviour theory was selected as the primary lens for the emotional regulation module because, unlike theories oriented toward observational learning or belief restructuring alone, it explicitly models the sequence from thought to affect to action that the module's skills (labelling emotions, pausing, and choosing a response) were designed to interrupt.

B. Emotional Regulation and Youth Mental Wellness: Empirical Review

A growing body of research links structured emotional regulation training to improved youth psychological outcomes, although findings on its comparative strength relative to other psychoeducation components are mixed. Mert [12] evaluated an emotional intelligence-oriented psycho-educational programme with 22 secondary school students using a pre- and post-test control group design; despite the small sample necessitating non-parametric tests, the experimental group showed statistically significant gains in emotional quotient, problem-solving, and decision-making relative to controls. Working with 265 university students, Fteiha and Awwad [13] found a significant positive association between emotional intelligence and active, problem-focused coping with stress, concluding that youth who could name and manage their emotions coped more adaptively than those who could not. Natali et al. [14] demonstrated that even a single, brief psychoeducation and skills-training session for caregivers and teachers of adolescents was well received and considered likely to reduce risky adolescent behaviour, suggesting that emotional-regulation-oriented content can produce meaningful effects even at low intervention "doses."

Clinical trial evidence reinforces this pattern. Lorentzen et al. [3], in a randomised controlled trial of a six-session cognitive behavioural treatment for adolescents aged 14-17 with emotional disorders, found significant reductions in anxiety and

depressive symptoms attributable to the emotion-focused intervention. Klim-Conforti et al. [2] similarly reported that school-based cognitive behavioural skills interventions improved resilience, emotional coping, and mental health awareness among youth participants. A recent systematic umbrella review by Saccaro et al. [15] synthesising interventions that target emotion regulation across clinical and non-clinical populations concluded that such interventions produce consistent, moderate-to-large improvements in psychological outcomes, and identified skills-based, structured programmes, rather than purely psychoeducational information delivery, as the more effective format. In the Kenyan context, Mutiso et al. [8] found that combined life-skills and psychoeducation programming significantly reduced internalising and externalising problem scores among institutionalised adolescents relative to controls, while Olashore et al. [16], working with HIV-positive adolescents in Botswana, showed that a brief psychoeducation and problem-solving intervention produced sustained reductions in depressive symptoms at 24-week follow-up.

A further point of convergence across this literature is that emotional regulation is consistently defined in behavioural, not merely affective, terms: the capacity to monitor, evaluate, and modify an emotional response before it is acted upon [15], operationalised through mindfulness, delay before acting, cognitive reframing, and self-care. This behavioural framing matters for programme design, because it implies that the relevant outcome is not simply how calm a young person reports feeling, but whether a measurable change occurs in how they act when provoked, a distinction the present study's mixed-methods design was able to test directly by pairing self-report scale scores with participants' own descriptions of behaviour change.

C. Research Gap

Collectively, this literature establishes that emotion-focused psychoeducation is effective, but the evidence is drawn overwhelmingly from clinical or institutional samples, from programmes that isolate emotional regulation as the sole intervention component, or from contexts outside East Africa. Few studies have tested emotional regulation as one module within a broader, community-delivered psychoeducation curriculum for ordinary, non-clinical youth in a Kenyan peri-urban setting, and fewer still have used a convergent mixed-methods approach that allows quantitative effect estimates to be checked against participants' own accounts of how the skills operate in daily life. The present study addresses this gap.

III. MATERIALS AND METHODS

A. Research Design

The parent study used a convergent parallel mixed-methods design. A quasi-experimental design, comparing a purposively assembled intervention group against a non-equivalent control group without random assignment, guided the quantitative strand, while a phenomenological design guided the qualitative strand. Both groups completed the same structured questionnaire following the intervention period; a subset of the intervention group also took part in in-depth interviews. The two data strands were collected over the same period and merged at the interpretation stage to determine convergence.

B. Setting and Population

The study was conducted in Kapseret Sub-County, Uasin Gishu County, Kenya, an area comprising five locations with a combined population of 198,499 as of the 2019 census, up from 141,813 in 2009, reflecting rapid rural-urban migration and youthful population growth [17]. The target population comprised youth aged 13-24 years resident in the sub-county.

C. Sampling

A combination of purposive, stratified, and simple random sampling was used to select 40 participants: 20 assigned to the intervention (experimental) group and 20 to the control group. Stratification ensured equal representation of male and female participants, and simple random sampling was applied within each of the sub-county's five locations to select two boys and two girls per location. Following the five-week intervention, five members of the intervention group were purposively selected to take part in a focus group discussion.

D. Instruments

Data were collected using a self-constructed, structured questionnaire and a semi-structured in-depth interview guide. The questionnaire used a five-point rating scale (Never = 1 to Always = 5) and included a seven-item emotional regulation subscale (e.g., "I can recognise negative emotions before reacting impulsively," "I can manage anger and frustration effectively") and an eight-item mental wellness outcome scale. Content validity was established through expert review by

the study supervisors and specialist psychologists, followed by piloting with five youth from a neighbouring, non-participating location. Internal consistency, assessed using Cronbach's alpha on the full study sample, was excellent for both the emotional regulation subscale ($\alpha = .963$) and the mental wellness scale ($\alpha = .974$), exceeding the conventional .70 threshold. The in-depth interview guide contained open-ended questions exploring how participants managed strong emotions and how emotional self-control affected their wellbeing, and was pre-tested alongside the questionnaire.

E. Procedure

The intervention group completed a five-week structured psychoeducation programme, of which one module specifically targeted emotional regulation skills (recognising triggers, pausing before reacting, and practising respectful dialogue). The control group received no intervention during the same period. Questionnaires were administered to both groups; the analysis reported here concerns the post-intervention comparison between the two groups. The focus group discussion with five intervention-group participants was conducted after the five-week programme and audio-recorded with participants' consent.

F. Data Analysis

Quantitative data were analysed in SPSS using descriptive statistics (means and standard deviations) to summarise group scores, followed by Pearson product-moment correlation and simple linear regression to test the hypothesis that emotional regulation skills significantly predict mental wellness. Hypotheses were tested at a 5% significance level ($\alpha = .05$), with the null hypothesis rejected where $p < .05$. Interview data were transcribed and analysed thematically, with categories and themes developed inductively around the study's constructs. Quantitative and qualitative results were then integrated through a joint display to assess convergence between the two data strands.

Trustworthiness of the qualitative strand was addressed through member checking, in which interview summaries were returned to participants for verification; through audio recording and detailed procedural documentation to support dependability; through researcher neutrality in recording responses to support confirmability; and through detailed description of the study context to support transferability, following the criteria set out by Nowell et al. [18].

G. Ethical Considerations

Ethical approval and a research permit were obtained from the relevant university and national research authorities (NACOSTI) before data collection, together with authorisation from the county administration. Informed consent was obtained from participants aged 19 years and above, informed assent from participants aged 13-18 years, and consent from parents or guardians of minor participants. Confidentiality was maintained throughout through coded, anonymised data, and participants were informed that the study was strictly academic in purpose.

IV. RESULTS

A. Sample Characteristics

All 40 selected participants completed the questionnaire (100% response rate in both groups). Participants were evenly split by gender (50% male, 50% female) and spanned the full 13-24 age range, with the largest cluster (35.0%) aged 16-18 years. All participants identified as Christian and as students.

B. Group Comparison on Emotional Regulation

Table I presents item-level and overall mean scores on the emotional regulation subscale for the intervention and control groups.

TABLE I. GROUP COMPARISON ON THE EMOTIONAL REGULATION SUBSCALE

Code	Item	Exp. M (SD)	Ctrl M (SD)	Overall M (SD)
ER1	I can identify my emotions before reacting.	4.85 (0.37)	2.75 (0.44)	3.80 (1.11)
ER2	I can express my feelings appropriately.	4.65 (0.59)	2.85 (0.37)	3.75 (1.03)
ER3	I think carefully before making important decisions when emotional.	4.60 (0.68)	2.95 (0.22)	3.78 (0.97)
ER4	I am able to practise dialogue when I face a difficult situation.	4.80 (0.41)	2.20 (0.41)	3.50 (1.34)
ER5	I can recognise negative emotions before reacting impulsively.	4.95 (0.22)	2.90 (0.31)	3.92 (1.07)

Code	Item	Exp. M (SD)	Ctrl M (SD)	Overall M (SD)
ER6	I communicate respectfully even when I disagree with others.	4.55 (0.51)	2.90 (0.31)	3.72 (0.93)
ER7	I can manage anger and frustration effectively.	4.95 (0.22)	3.95 (0.22)	4.45 (0.55)
—	Overall Emotional Regulation Subscale	4.76 (0.22)	2.93 (0.17)	3.85 (0.97)

Source: Field survey data (2026); $n = 20$ per group; scale: 1 = Never to 5 = Always.

The intervention group scored higher overall ($M = 4.76$, $SD = 0.22$) than the control group ($M = 2.93$, $SD = 0.17$), a difference of 1.83 scale points. The largest gains were on recognising negative emotions before reacting impulsively ($M = 4.95$) and managing anger and frustration effectively ($M = 4.95$). The largest gap between groups was on engaging in constructive dialogue during difficult situations ($M = 2.20$ in the control group versus $M = 4.80$ in the intervention group).

C. Regression Analysis

Simple linear regression tested the hypothesis that emotional regulation skills significantly predict mental wellness. Table II presents the regression coefficient, test statistic, and hypothesis decision.

TABLE II. SIMPLE LINEAR REGRESSION OF EMOTIONAL REGULATION SKILLS PREDICTING MENTAL WELLNESS

Variable	β	t	p	Decision
Emotional Regulation Skills	.536	5.101	<.001	Reject H_{02}

Source: Field survey data (2026); $\alpha = .05$; H_{02} = second null hypothesis (no significant relationship between emotional regulation skills and mental wellness).

Emotional regulation skills were a significant, positive predictor of mental wellness ($\beta = .536$, $t = 5.101$, $p < .001$), and the null hypothesis of no relationship was rejected. Of the four psychoeducation components examined in the parent study, emotional regulation produced the highest standardised coefficient and the lowest p-value of the four.

D. Qualitative Findings

Thematic analysis of the focus group discussion identified two themes. The first, a shift from impulsive reaction to pausing and processing, reflected participants' accounts of how they responded to strong emotion before and after the intervention. One participant explained:

"Whenever I got angry before, I used to react immediately without thinking, which usually caused big arguments. After the sessions, I learned to step back, breathe, and think about the consequences before I speak." (FGD member 5)

The second theme, constructive dialogue and reduced interpersonal conflict, captured participants' descriptions of calmer communication with family and peers:

"Managing my emotions has given me peace. Even when I disagree with my parents or friends, I no longer yell. We sit down and talk it through calmly, which saves me a lot of headache and guilt." (FGD member 1)

E. Correspondence Between Quantitative and Qualitative Findings

The thematic categories identified in the interview data corresponded, item by item, with the quantitative subscale results. The high survey scores for recognising emotional triggers and managing anger paralleled participants' descriptions of pausing before reacting, and the item-level weakness in constructive dialogue observed in the control group paralleled interview accounts of pre-intervention conflict becoming calmer, negotiated disagreement afterward.

V. DISCUSSION

This convergence between the quantitative and qualitative strands suggests that the measured effect reflects a genuine, experientially recognisable change in how participants managed emotion, rather than an artefact of the measurement instrument alone.

The finding that emotional regulation skills were the strongest single predictor of mental wellness among the four psychoeducation components tested is consistent with, and extends, prior evidence on emotion-focused intervention. It

aligns with Mert [12], whose emotional intelligence-oriented programme produced significant gains in emotional and decision-making outcomes among secondary school students, and with Fteiha and Awwad [13], who linked emotional intelligence to more adaptive, problem-focused coping with stress. The magnitude and consistency of the present result also echo Saccaro et al.'s [15] systematic umbrella review, which found that structured, skills-based emotion-regulation interventions outperform general psychoeducational information delivery, a pattern reflected here in the specificity of the gains: participants did not merely report feeling calmer in the abstract but described concrete behavioural change, pausing, labelling emotion, and choosing dialogue over confrontation, which is precisely the mechanism cognitive behaviour theory predicts.

Read against Beck's [11] cognitive behaviour theory, the pattern of results is consistent with the theory's central claim that behaviour follows from how a triggering thought or situation is appraised, rather than from the emotion itself. The intervention did not attempt to eliminate participants' anger, sadness, or fear; it instead taught a specific cognitive sequence, noticing the emotion, pausing, and reappraising the situation before responding, that sits between stimulus and behavioural reaction. That this narrow, teachable sequence produced the largest measured effect of the four psychoeducation components, larger than the more diffuse stress management and psycho-social modules, offers some support for the theory's more specific claim that intervening at the point of cognitive appraisal, rather than at the level of general coping resources or social support, is where psychoeducation exerts its strongest leverage on behaviour. This reading should be treated cautiously, however, since the quasi-experimental design compared components delivered within the same broader programme rather than testing emotional regulation content in isolation.

The result is notable for occurring outside the clinical and institutional contexts in which most of the prior evidence was generated. Where Lorentzen et al. [3] and Klim-Conforti et al. [2] demonstrated emotion-regulation gains within formal mental health services and school-based programmes respectively, and Mutiso et al. [8] worked with institutionalised Kenyan adolescents, the present sample comprised ordinary, community-dwelling youth recruited through local administrative structures rather than referral pathways. That a comparatively brief, five-week, community-delivered module produced the strongest effect of the four components tested suggests that emotional regulation content may be an efficient entry point for psychoeducation programmes operating with limited time and resources, a consideration of direct relevance to county youth departments and community organisations in similar Kenyan settings.

The qualitative accounts also suggest a social mechanism, not only an intrapsychic one. Participants repeatedly framed emotional regulation not as private symptom relief but as a relational skill: the ability to pause before reacting was described chiefly through its consequences for family and peer relationships, reducing arguments, restoring calm, and easing guilt. This is consistent with the notably low control-group score on constructive dialogue during difficult situations ($M = 2.20$), the single weakest item across the whole subscale, which suggests that the absence of trained emotional regulation may manifest most visibly in interpersonal friction rather than internal distress alone. Programme design that foregrounds relational scenarios and dialogue practice, rather than emotion labelling in isolation, may therefore be warranted.

Set against the county-level indicators cited in the introduction, including elevated adolescent involvement in gender-based violence and antenatal attendance in Uasin Gishu County [4], the relational framing participants gave emotional regulation is worth noting. If, as several participants suggested, the absence of regulation skills manifests as escalating household and peer conflict rather than only private distress, then emotional regulation training may plausibly intersect with the drivers of some of these broader outcomes, though the present design cannot establish such a causal chain and this connection should be treated as a hypothesis for future research rather than a demonstrated effect. Within the more limited claim the data do support, that a short, community-delivered module measurably changed how youth reported managing anger and conflict, the finding nonetheless strengthens the case for treating emotional regulation as core, rather than supplementary, content in youth-focused psychoeducation in comparable Kenyan settings.

Several limitations qualify these findings and should guide their interpretation. The sample was small ($n = 40$) and drawn from a single sub-county, limiting statistical power and generalisability beyond similarly situated Kenyan peri-urban youth. Group assignment was non-random, and although both groups were surveyed before and after the intervention period, the comparison reported here is a post-intervention, between-groups comparison rather than a pre-post, within-groups analysis; baseline equivalence between groups was therefore never formally tested. This leaves selection bias, the possibility that the two groups already differed systematically before the intervention began, as a plausible alternative explanation for some of the observed difference, and the true magnitude of change attributable to the intervention may differ from the raw group difference reported. The narrow within-group standard deviations observed, alongside several items approaching the scale

ceiling, further raise the possibility of social desirability or acquiescence bias in self-report. Future research should adopt a randomised design or, at minimum, report baseline scores and use analysis of covariance to adjust post-test differences for pre-existing group differences, together with larger, multi-site samples that would allow the emotional regulation effect to be tested for robustness across different Kenyan communities.

VI. CONCLUSION

This study set out to determine the effect of emotional regulation skills on mental wellness among youth in Kapseret Sub-County, Kenya, having identified it as the psychoeducation component with the strongest empirical support within a broader four-component curriculum. Emotional regulation skills significantly and substantially predicted mental wellness, and qualitative accounts converged with this result, describing a shift from impulsive, conflict-prone reactions to reflective, dialogue-based responses. The finding indicates that training young people to recognise emotional triggers, pause before reacting, and communicate constructively is not a peripheral add-on to youth mental health programming but plausibly its most efficient single lever.

Four practical implications follow. First, county youth departments and community organisations designing time- or resource-constrained psychoeducation programmes should prioritise emotional regulation content where only one module can be delivered. Second, because participants described the skill's benefits chiefly in relational terms, curricula should foreground dialogue practice and conflict scenarios rather than emotion-labelling exercises alone. Third, vocational institutes and youth polytechnics, which currently have limited structured emotional-skills content, represent a natural, already-existing delivery channel for scaling this component beyond the pilot setting. Fourth, faith-based organisations and community mentors, who already command the trust of youth in settings such as Kapseret, are well placed to reinforce dialogue and pause-before-reacting skills informally between formal programme sessions, extending the module's reach at negligible additional cost.

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ETHICAL AND COMPLIANCE STATEMENTS

Ethics Approval and Consent: Ethical clearance and a research permit were obtained from the relevant university ethics structures and the National Commission for Science, Technology and Innovation (NACOSTI) prior to data collection. Informed consent, parental consent, and youth assent were obtained as applicable.

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