International Journal of Science and Research (IJSR)
ISSN: 2319-7064
SJIF (2022): 7.942

Perception of Mental Illness in a Peri - Urban Community in Kenya

Lucy Jilly Akinyi[1], Agnes Masese Ogeto[2], Moses Ambili[3], Ruth Mokaya[4], Irene Chesire[5]

[1, 2, 3, 4, 5]Moi University, School of Medicine, P. O. Box 4606 – 30100, Eldoret

[1]Corresponding Author Email: *lucyjillyakinyi[at]gmail.com*

Abstract: ***A community's perception of mental illness explains the help seeking behaviour or lack thereof. There is little research on how mental ill - health is perceived in peri urban communities in middle and low resource settings. This study aimed to assess the perception of mental illness among adults in these communities specifically their attitude, knowledge, and care of the mentally ill. Using stratified sampling, 288 adults aged 18 - 50 years were selected; 58% were females. Data was collected using a Community Attitudes to Mental Illness Questionnaire (CAMI), analysed and results presented in form of descriptive statistics and tables. Majority of the participants, 63.2% had negative opinions on mental health. In relation to their experiences, 2.8% had lived/living with mentally ill, 13.2% worked/working, 5.6% neighboured/ neighbouring, and 1.4% had a close friend. On future relations 20.8% would live with the mentally ill, 8.7% work with, 11.5% neighbour and 3.5% would have close friendship. On knowledge of types of mental illness, majority had knowledge on drug addiction (100%) and depression (57.6%), few had knowledge on Schizophrenia (19.1%), Stress (4.5%), Bipolar (5.9%), and Grief (4.5%). On help seeking behavior for mental illness, about a half (48%), would go to hospital, 26% talk to family/friend, and 2% would talk to employer. Half of the respondents (49%) acknowledged an increase in stigma and discrimination. Overall, this investigation underscores a pervasive and distorted understanding of mental illness within the studied peri - urban community.***

Keywords: Help seeking behavior, Mental illness, Mental health, Perception

1. Introduction

The global landscape of mental health presents an escalating challenge, exerting significant impacts on public health, human rights, and economic frameworks universally[27, 28]. According to the World Health Organization, an estimated 450 million people globally grapple with mental disorders, constituting 12% of the overall global disease burden[25]. Despite its pervasive nature, mental illness often remains undiagnosed, particularly within rural communities where resources and awareness about mental health may be scanty. Stigmatization and negative attitudes toward mental illness have perpetuated misconceptions, hindering affected individuals from recognizing symptoms, seeking timely treatment, and integrating into societal structures such as employment, housing, or relationships[9]. Recognizing the gravity of this issue, stigma has been recognized as a barrier to be addressed, emphasizing its role as a pivotal impediment in community health[22, 29]. Such a stigma not only affects those with mental disorders but also permeates perceptions about various health conditions, underlining the need to assess community beliefs, knowledge, and attitudes toward mental health comprehensively.

The pervasive nature of mental health challenges is evident in contexts marked by traumatic experiences like conflicts, displacements, or diseases such as HIV/AIDS. Dr. Frank Njenga's characterization of Africa as a 'traumatized continent' encapsulates the profound implications of mental illness in such settings[19]. Despite these realities, a lingering question persists: do individuals exposed to these adversities seek professional mental health interventions? Community - based mental health research endeavors emphasize the importance of understanding and bolstering social structures that enhance collective efforts to address mental health issues[22]. However, a pervasive lack of knowledge about mental disorders coupled with stigma continues to impede effective care, necessitating comprehensive assessments of community perceptions. Such insights are crucial for informing health policies and expanding support systems, particularly in resource - constrained settings like peri - urban communities in Kenya. Cultural nuances, knowledge frameworks, and social networks significantly shape individuals' decisions regarding accessing mental health care. Addressing cultural impediments and promoting informed perspectives can foster more inclusive treatment environments[5]. This study endeavors to elucidate the perceptions surrounding mental illness within the peri - urban community, aiming to enhance health - seeking behaviors and facilitate more inclusive mental health interventions.

Numerous studies have underscored the profound impact of cultural beliefs, attitudes, and knowledge gaps on mental health perceptions and access to care[5, 30, 31]. Negative stereotypes, fueled by misconceptions and lack of awareness, perpetuate stigmatization, creating barriers to recovery, integration, and overall well - being[3]. Such challenges are not unique to Kenya; similar misconceptions and cultural biases prevail in various settings globally, underscoring the imperative to explore and address community perceptions across diverse cultural contexts[32]. Despite advancements in psychiatric understanding, we hypothesize that pervasive stigmatization and misconceptions about mental illness persist, influencing health - seeking behaviors, treatment adherence, and societal integration especially in middle - and low - income regions. In Kenya, prevalent misconceptions, often rooted in cultural beliefs and inadequate knowledge, further exacerbate the challenges faced by individuals with mental health disorders[23]. Addressing these issues necessitates a comprehensive exploration of community perceptions in

their attitudes, knowledge and help seeking behaviourtoward mental illness, providing a foundational understanding to inform policy, interventions, and support mechanisms tailored to the unique contexts and challenges faced by peri - urban communities.

2. Methods

For this study, a cross - sectional research design was adopted, facilitating the collection of data from participants at a singular time point without altering their environment or circumstances. The chosen study area was the Langas County assembly ward in Kenya, situated within the Kapseret constituency of Uasin Gishu County. Encompassing an approximate population of 127, 167individuals over an area of about 46.50 square kilometers, Langas is a significant informal high - density residential region located approximately 7 kilometers south of Eldoret town along the Eldoret - Kisumu Road[32]. Langas was identified as the ideal study location due to its representation of Eldoret's urban population in terms of ethnic diversity and varied income levels. While most residents are low - income earners engaged in the informal sector through wage employment, self - employment, or casual labor, the settlement also includes middle and high - income earners involved in the formal sector[19].

The study targeted adults aged between 18 and 50 years residing in households within the selected area. Sampling was conducted using a systematic approach, where every fifth household within Langas County was selected, and adults aged 18 - 50 residing therein were interviewed using the Community Attitudes towards Mental Illness questionnaire III (CAMI). The sample size of 288 adults was determined using the formula proposed by Fisher et al., considering a 25% prevalence rate of specific characteristics related to the target population, as indicated by a previous study[33]. Data collection employed the CAMI tool, a standardized scale comprising 27 attitude statements measured on a five - point Likert scale, covering various aspects such as attitudes towards individuals with mental illness, opinions on services, types of mental illness, personal experiences, and perceptions of stigma and discrimination. Sociodemographic data were also incorporated into the questionnaire. Data were analyzed using Microsoft Excel, focusing on descriptive statistics and tabular presentations. Confidentiality, informed consent, and participants' well - being were diligently maintained, employing strategies such as establishing rapport, normalizing sensitive topics, and ensuring anonymity.

However, the study encountered certain limitations. Language barriers necessitated questionnaire verbal translations into Kiswahili and Kalenjin due to respondents limited English proficiency. Additionally, the intended stratified sampling method faced challenges, deviating from the original plan of selecting participants from every fifth household.

3. Results

Socio- demographic characteristic of participants

A total of 288 individuals agreed to participate in this study. **Table 1** presents the participants characteristics. We categorized the participants by gender, age groups, marital status, religion, educational level, and occupation. Majority of the participants were female (n=168, 58%) and a higher number completed education till the tertiary level (n=99, 49%). Further characteristics in understanding the sample population is in **Table 1**

Table 1: Socio- demographic characteristics among participants

	Number of people (No)	No (%)
1. Gender		
• Female	168	58%
• Male	120	42%
Total	**288**	**100**
2. Age group		
• 18 - 24	60	21%
• 25 - 30	43	15%
• 31 - 36	63	22%
• 37 - 42	39	14%
• 43 - 48	35	12%
• 49 - 54	48	17%
Total	**288**	**100**
3. Marital status		
• Married	91	32%
• Single	60	21%
• Separated	12	4%
• Divorced	30	10%
• Widowed	45	16%
• Cohabiting	50	17%
Total	**288**	**100**
4. Religion		
• Protestant	134	47%
• Catholic	89	31%
• Muslim	5	2%
• Seventh Day Adventist	50	17%
• None	10	3%
Total	**288**	**100**
5. Educational level		
• Primary	67	23%
• Secondary	60	21%
• Tertiary	141	49%
• None	20	7%
Total	**288**	**100**
4. Occupation		
• Business	56	19%
• Teacher	20	7%
• Farmer	90	31%
• Salonist/ Hair stylist	84	29%
• Unemployed	38	13%
Total	**288**	**100**

Perceptions towards Mental illness

(1) Attitudes on Mental illness

To assess individual's perceptions towards mental illness, we averaged the positive vs the negative opinions from the CAMI tool after each participant selected whether they 'agree'/ 'disagree'/ 'unsure' with the opinion**.**

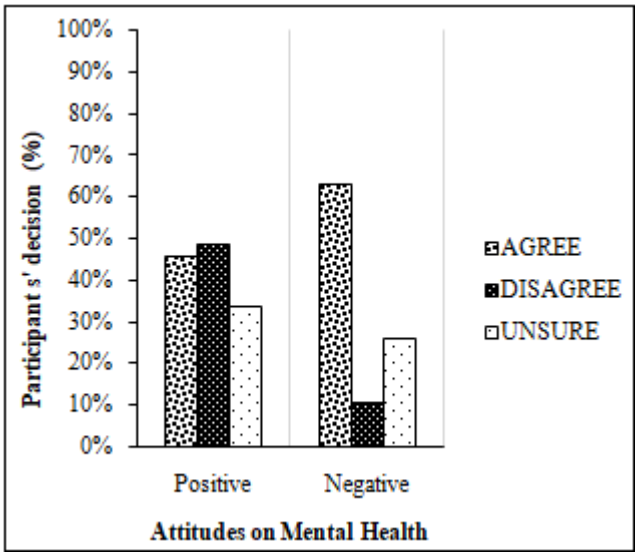


Figure *1* illustrates that 182 (63.2%) participants had negative attitudes towards mental health, and 132 (45.8%) participants had positive attitudes on mental health. This was also evident with 140 (48.6%) of participants disagreeing with the positive opinions of mental health vs 31 (10.8%) who disagreed with the negative opinions of mental health.

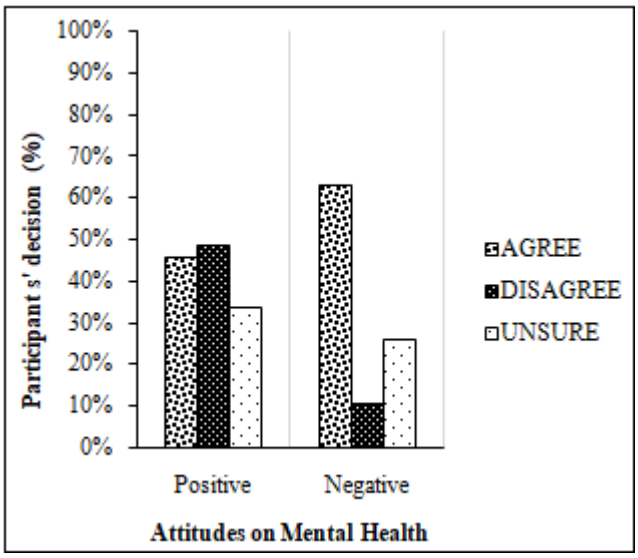
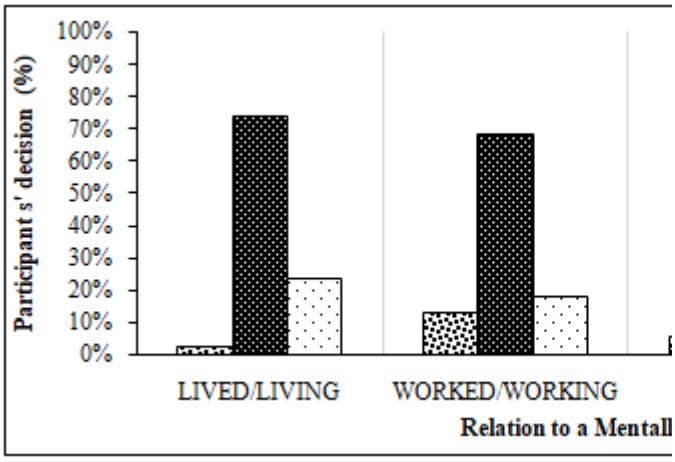


Figure 1: Attitudes towards Mental Health

(2) Care of the Mentally ill

Relation to a mentally ill person/s

Figure *2* illustrates the responses of the participants to relationship with the mentally ill. Overall, a more than average responses of participants had lived/living and worked/working with the mentally ill, i. e., 214 (74.3%) and 197 (68.4%) respectively.



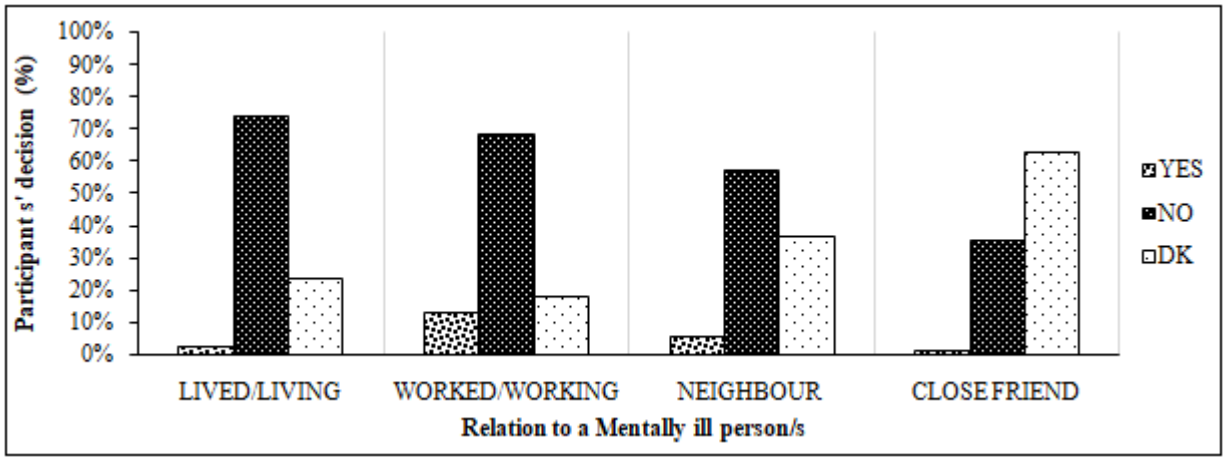


Figure 2: Behaviour in relation to a mentally ill person.

Perceived future relationships with the mentally ill In

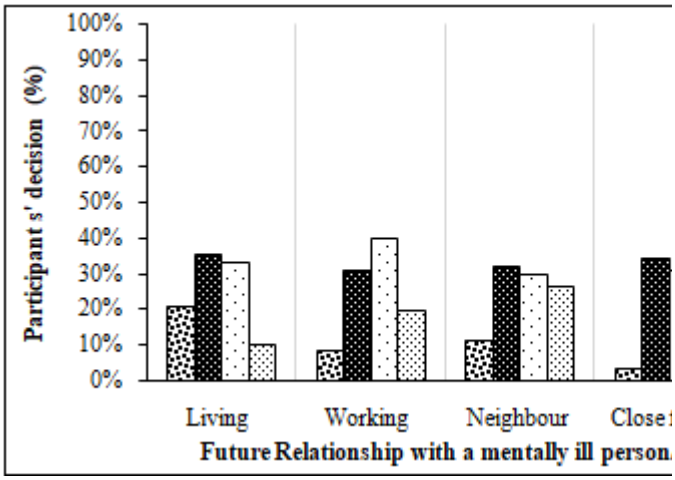


Figure *3*, no participant scores were above a 50% average in all the option choices to have future relations living/ working/ neighbour/ close friend to a mentally ill person. Those who agreed to having future relations with a mentally ill in living 60 (20.8%), working 25 (8.7%), neighbour 33 (11.5%), close friend 10 (3.5%).

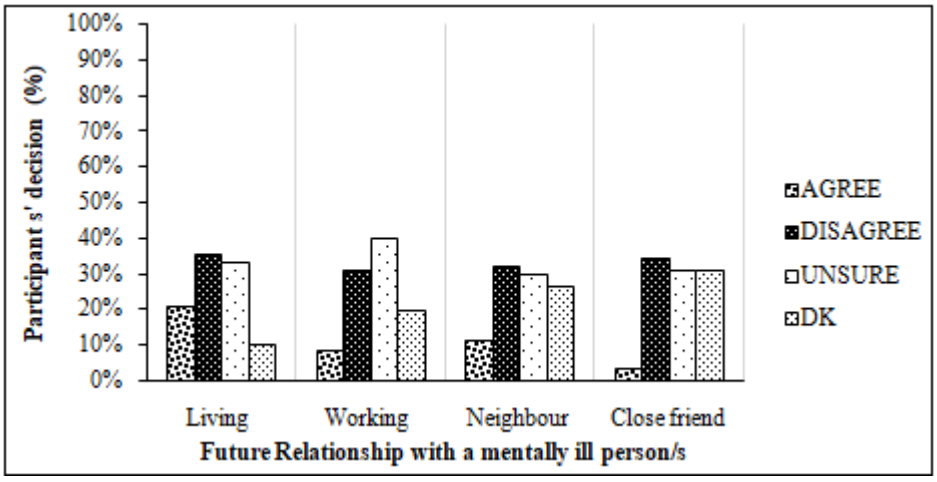


Figure 3: Future relationship with the Mentally ill

(3) Knowledge on various Mental illnesses

In

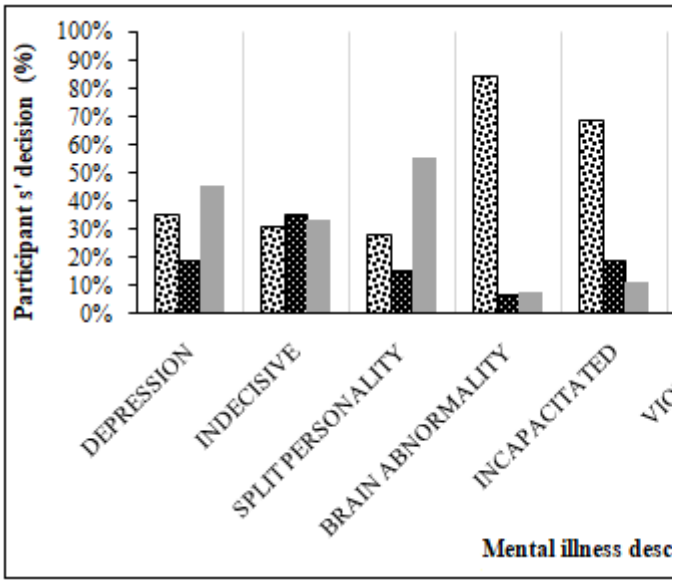


Figure *4* the percentages of participants who selected "agree" for each descriptor are as follows: depression (35.4%), indecisive (31.3%), split personality (28.8%), brain abnormality (85.1%), incapacitated (69.4%), violent (92.7%), schizophrenia (19.1%), and psychotic (96.5%). Notably, high agreement percentages were observed for descriptors like violent and psychotic, indicating potentially stigmatized perceptions, while other descriptors likeschizophreniahad lower agreement percentages.

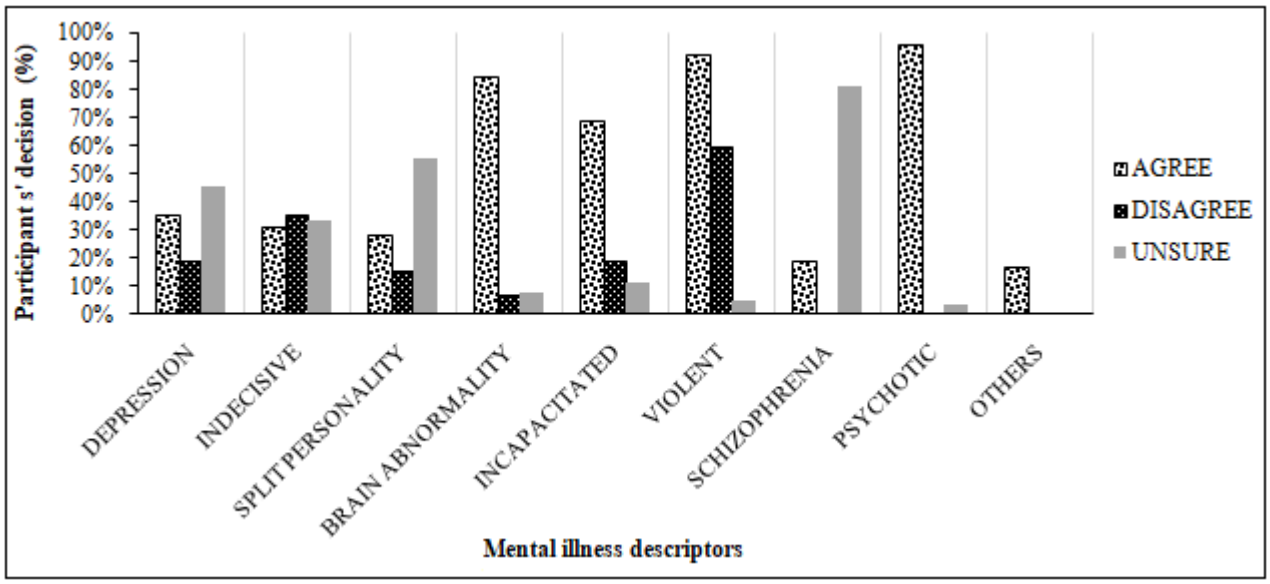


Figure 4: Mental illness descriptors

The results indicate that 57.6% of participants associated depression, 4.5% stress, 19.1% schizophrenia, 5.9% bipolar disorder, and 4.5% grief as types of mental illnesses. Strikingly, 100% agreement was observed for drug addiction as a mental illness

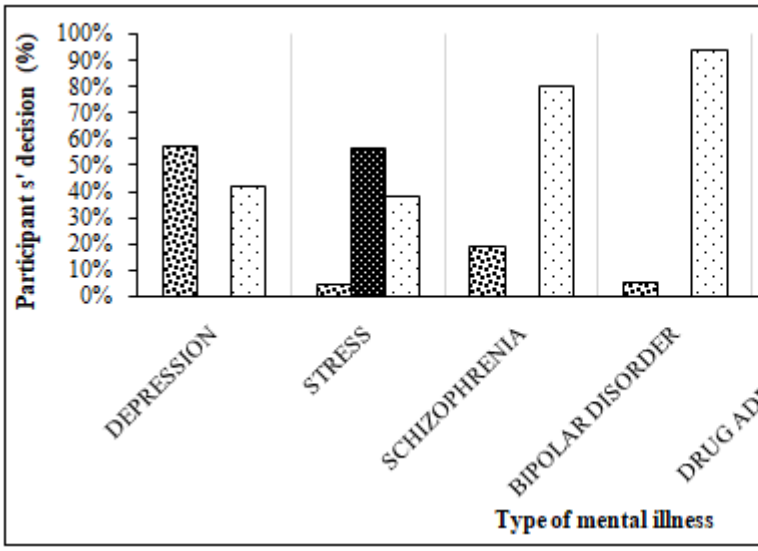


Figure 5.

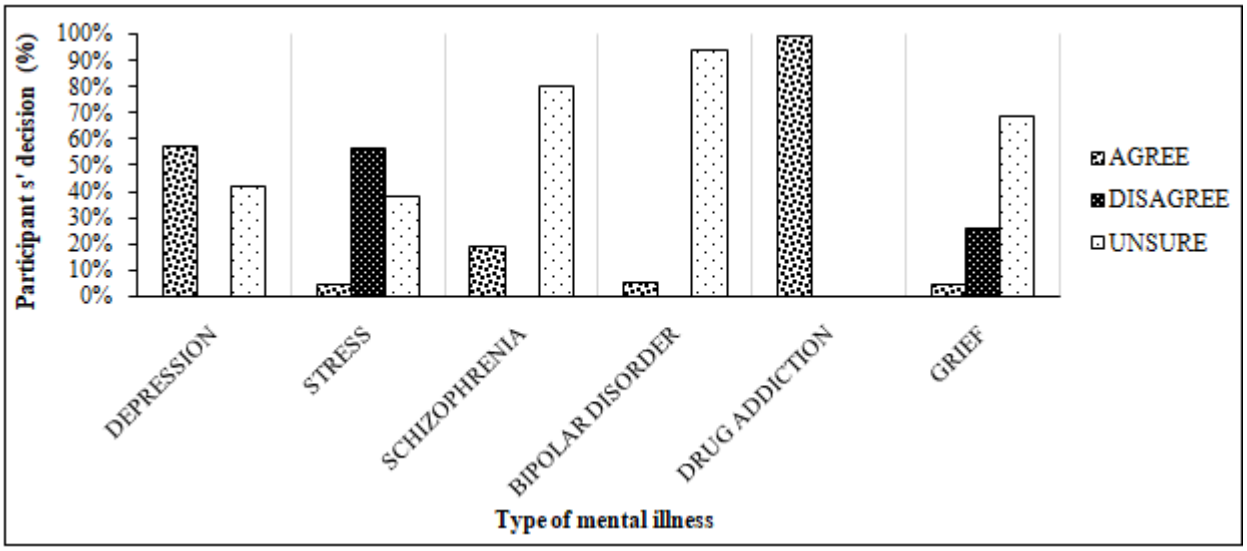


Figure 5: Types of Mental illness

(4) Mental Health seeking Behaviour

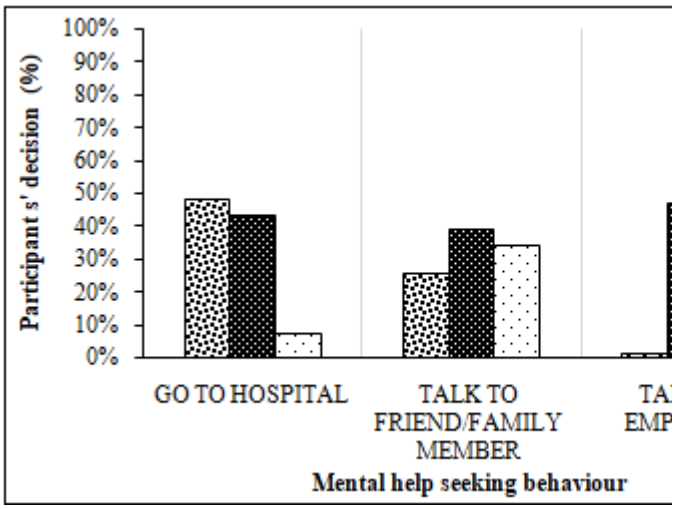


Figure 6 explored responses to mental health problems, revealing that 48% of participants opt to seek help from hospitals, 26% prefer discussing their issues with friends or family members, and only 2% choose to talk to their employers. These findings underscore the diverse approaches individuals take when dealing with mental health concerns, with a significant proportion relying on formal healthcare settings and interpersonal support networks.

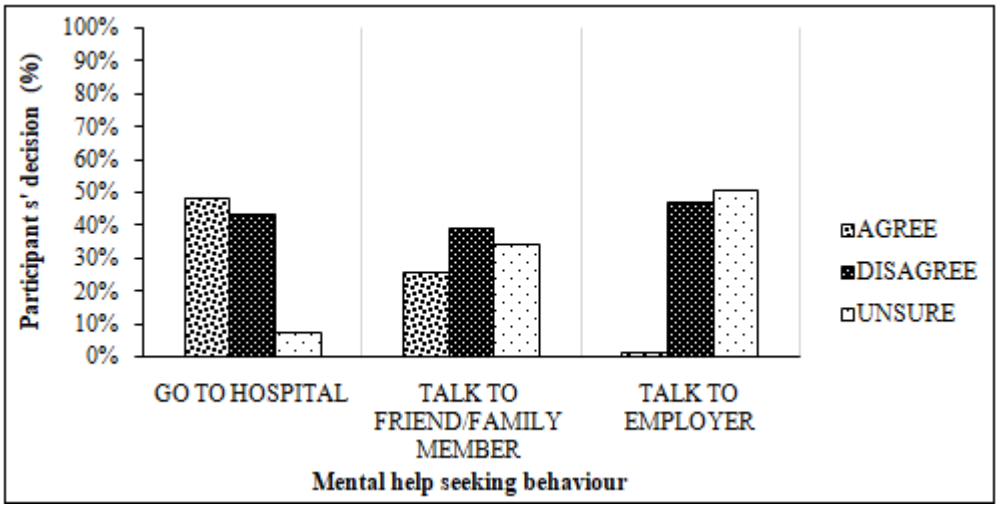


Figure 6: Mental Health Seeking Behaviour

Perceived Mental Health Statistics

The results in **Figure 7** indicate that 49.31% of participants acknowledged an increase in mental illness stigma, while 4.51% disagreed, stating there was no increase. A notable 46.18% responded with "Don't Know." These findings suggest a substantial portion of the participants recognized a perceived rise in mental illness stigma, highlighting the need for further exploration and potential interventions to address and mitigate such perceptions.

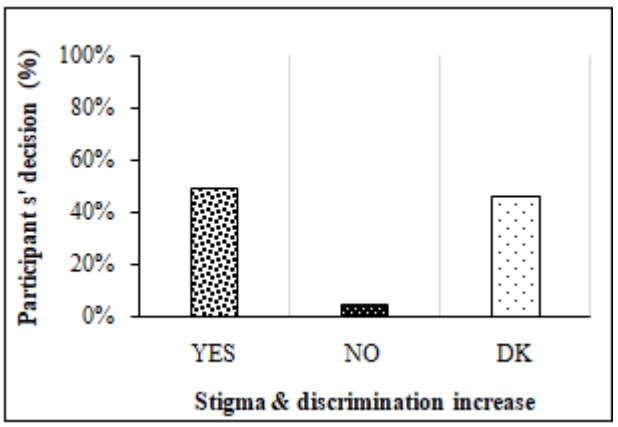


Figure 7: Stigma & discrimination perceived statistics

The aim of this study was to explore the perceptions of mental illness within a peri - urban community by examining the residents' knowledge, attitudes, and provision of care related to mental health. It comes as no shock that 63.2% of the respondents concurred with the unfavorable perceptions regarding mental health. Diverse beliefs, deeply rooted in culture, religion, and other factors, significantly influence perspectives on the origin and characteristics of mental disorders, consequently shaping attitudes toward individuals dealing with mental illness[1, 5]. A study conducted by Abdullah et al. in 2011 examined ethnocultural beliefs and the stigma associated with mental illness, shedding light on the broad spectrum of cultural attitudes and beliefs concerning mental health. [33]. Furthermore, this study revealed that there is an alienation of the mentally ill in both social and work environments both presently and in the future. For instance, the number of people who have ever or are presently living, working, neighbouring and have a close friend with mental illness includes 2.1%, 13.2%, 5.6% and 1.4% respectively. For future relations, those willing to live, work, neighbour and have a close friend with mental illness includes 31.6%, 28.8%, 24.3% and 15% respectively. The above study revealed that more people will be willing to live (31.6%), and work (28.8%) as compared to having a close friend (15%) who is mentally ill.

4. Discussion

Social relationships are important for anyone in maintaining health, but for the mentally ill it is especially important[35]. Even though various research has shown that family engagement for persons with mental illness is beneficial for improved patient outcome, families in these middle to low - income areas may be unwilling to interact with their mentally ill family member[12, 16, 21]. Social isolation is also sometimes due to the unwillingness of others to befriend the mentally ill and the public may avoid them altogether. In this study, the participants were least willing to having close friendship with a mentally ill person, with only 1.4% out of the 288 respondents. This was followed closely by only 2.1% of the respondents willing to live with the mentally ill persons. In this study, all respondents in this study agreed that addiction (100%) was a type of mental illness whilst more than half of the respondents being unsure that schizophrenia (80.9%) and split personality (55.6%) were descriptors of a mental disorder. In addition, half of the respondents agreed that depression (57.6%) is a type of mental illness. These findings concur with a study done on knowledge and perceptions about mental illnesses among Kenyan immigrants living in Jyvaskyla, Finland which stated that the most common mental disorders include depression[12]. The identification of substance abuse, drugs in particular, by all the participants (100%) can make members of the community to be prone to over - generalizations or stereotyping that all people with mental health problems are drug and/or alcohol addicts. Substance abuse (80.8%) was also scored highly by respondents in a study by Gureje et al., to be the type of mental illness[7].

The inability of respondents to identify schizophrenia, bipolar, stress and grief as types of Mental illnesses could be due to lack of health education on mental health and therefore lack of awareness of the types of Mental illness. The unawareness can curb the capability to help a mentally ill person seek proper treatment and in turn lead to misperception about mental illness and negative attitude towards people with mental health problems. The description of mental illnesses which was mostly selected was someone who was suffering from psychosis (96.5%). The next most selected description was someone who was violent (60%) and was closely followed by brain abnormality (85.1%) and someone who is incapacitated (69.4%) suggesting that one must display behavior that attract public attention and is therefore socially disruptive to be recognized as having a mental disorder. This finding is in agreement with what was found in a study done in Ethiopia by Derbies et al., which reported 60%of the respondents reported violent behavior as the signs of mental illness, and about 50.3% of the respondent claimed that they would recognize a person with mental health problems by his or her violent behavior[1]. Mentally ill persons have been described are unpredictable, abnormal and associated with danger and violence. A perception that would induce the community to brand anyone with abnormal behavior as being mentally ill even when this person might be merely acting out. Moreover, this implies that the community would not be able to recognize a person in remission or less severe phases of mental illness. This finding also seem to concur with another study carried out in Kenya to determine knowledge attitudes beliefs and practices of mental illness among staff in general medical facilities, that found that despite knowledge on recognition, diagnosing and treatment of mental illness, they still maintained their cultural views that mentally ill are worthless, dirty, senseless violent and unpredictable[21].

5. Conclusion

There is a widespread distorted perception of mental illness among adults in middle - and low - income regions. Negative opinions towards mental illness may have been brought about by spurious beliefs on the origin of mental illness due to the influence of culturally bred stereotypes. Furthermore, knowledge on different mental illness is to those that present with ‘Amok. ’ The mental health perception that a community hasmay then result to the mentally ill being alienated and shunned from the community’s activities and taking care of them would not be regarded as important to their well - being.

Abbreviations

CAMI: Community Attitudes to Mental illness Questionnaire; WHO: World Health Organization; IREC: Institute of Research and Ethics Committee.

Authors’ contributions

LJA, AMO, MA, RM were involved in writing the first draft of the manuscript, IC conceptualized the idea and supervised the implementation of the study. LJA prepared the final manuscript. All authors read and approved the final manuscript.

Acknowledgments

The authors are grateful to all participants for their cooperation and willingness to participate in the study.

Ethical approval and consent to participate

Ethical approval to conduct the study was sought from The Moi Teaching & Referral Hospital / Moi University College of Health Sciences - Institutional Research and Ethics Committee (MTRH/MU - IREC) in Kenya, and the study Reference Number was IREC/2017/COBES/10. All participants consented before participation.

References

[1] Benti, M., Ebrahim, J., Awoke, T., Yohannis, Z., & Bedaso, A. Research Article Community Perception towards Mental Illness among Residents of Gimbi Town, Western Ethiopia.

[2] Centers for Disease Control and Prevention. (2013, October 4). Mental Health Basics. Centers for Disease Control and Prevention.

[3] Choudhry, F. R., Mani, V., Ming, L. C., & Khan, T. M. (2016). Beliefs and perception about mental health issues: A meta - synthesis. Neuropsychiatric Disease and Treatment, 12, 2807 - 2818. https: //doi. org/10.2147/NDT. S111543

[4] Corrigan, P. (2004). How stigma interferes with mental health care. American psychologist, 59 (7), 614.

[5] Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care.

Psychological Science in the Public Interest, 15 (2), 37 - 70.
[6] Deka, R. S. (2013). A study on attitude of college teachers and students of Guwahati towards the mentally ill. International Journal of Humanities and Social Science Invention, 2 (6), 13 - 15.
[7] Gureje, O. Y. E., Lasebikan, V. O., Ephraim - Oluwanuga, O., Olley, B. O., & Kola, L. (2005). Community study of knowledge of and attitude to mental illness in Nigeria. The British Journal of Psychiatry, 186 (5), 436 - 441.
[8] Hugo, C. J., Boshoff, D. E., Traut, A., Zungu - Dirwayi, N., & Stein, D. J. (2003). Community attitudes toward and knowledge of mental illness in South Africa. Social psychiatry and psychiatric epidemiology, 38, 715 - 719.
[9] Salve, H., Goswami, K., Sagar, R., Nongkynrih, B., & Sreenivas, V. (2013). Perception and attitude towards mental illness in an urban community in South Delhi - A community based study. Indian journal of psychological medicine, 35 (2), 154 - 158. Jorm, A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. The British Journal of Psychiatry, 177 (5), 396 - 401.
[10] Kilonzo, V. O. (2015, February 24). Abandoned and neglected, Kenya's mentall ill suffer in bitter silence. Nation Media Group, p.3
[11] Kinyua, B., & Njagi, E. (2013). Knowledge and perceptions about mental illnesses among Kenyan immigrants living in Jyvaskyla, Finland.
[12] Leong, F. T., & Zachar, P. (1999). Gender and opinions about mental illness as predictors of attitudes toward seeking professional psychological help. British Journal of Guidance & Counselling, 27 (1), 123 - 132.
[13] Longkumer, I., & Borooah, I. P. (2013). Knowledge about and attitudes toward mental disorders among Nagas in North East India. IOSR J Humanit Soc Sci, 1 (4), 5.
[14] Marangu, E., Sands, N., Rolley, J., Mansouri, F., & Ndetei, D. (2014). Mental healthcare in Kenya: exploring optimal conditions for capacity building: opinion paper. African Journal of Primary Health Care and Family Medicine, 6 (1), 1 - 5.
[15] Morrison, R. (2011). Nursing Students' Attitudes toward People with Mental Illness: Do they change after instruction and clinical exposure?.
[16] Ndetei, D. M., Khasakhala, L. I., Kuria, M. W., Mutiso, V. N., Ongecha - Owuor, F. A., & Kokonya, D. A. (2009). The prevalence of mental disorders in adults in different level general medical facilities in Kenya: a cross - sectional study. Annals of general psychiatry, 8 (1), 1 - 8.
[17] Ngui, E. M., Khasakhala, L., Ndetei, D., & Roberts, L. W. (2010). Mental disorders, health inequalities and ethics: A global perspective. International review of psychiatry, 22 (3), 235 - 244.
[18] Nyawira. (2015, January 2). Mental health problems in Kenya and Africa. Lets talk about health and development in Kenya/Africa.
[19] Simiyu, R. R., & Foeken, D. W. (2014). Urban crop production and poverty alleviation in Eldoret, Kenya: Implications for policy and gender planning. Urban Studies, 51 (12), 2613 - 2628.
[20] Time to change. (2014). Attitudes to Menta illness. Preparedness for time to change, 60.
[21] Ndetei, D. M., Khasakhala, L. I., Mutiso, V., & Mbwayo, A. W. (2011). Knowledge, attitude and practice (KAP) of mental illness among staff in general medical facilities in Kenya: practice and policy implications: original. African journal of psychiatry, 14 (3), 225 - 235. Gary, F. A. (2005). Stigma: Barrier to mental health care among ethnic minorities. Issues in mental health nursing, 26 (10), 979 - 999. .
[22] Memiah, P., Wagner, F. A., Kimathi, R., Anyango, N. I., Kiogora, S., Waruinge, S.,. . . & Otiso, L. (2022). Voices from the youth in Kenya addressing mental health gaps and recommendations. International Journal of Environmental Research and Public Health, 19 (9), 5366. Wei, Y., McGrath, P. J., Hayden, J., & Kutcher, S. (2015). Mental health literacy measures evaluating knowledge, attitudes and help - seeking: a scoping review. BMC psychiatry, 15 (1), 1 - 20.
[23] World Health Organization. (2016). World Health Statistics 2016 [OP]: Monitoring Health for the Sustainable Development Goals (SDGs). World Health Organization.
[24] Wyse, S. E. (2011). What is the difference between qualitative research and quantitative research. Snap surveys, 16 - 1.
[25] Wainberg, M. L., Scorza, P., Shultz, J. M., Helpman, L., Mootz, J. J., Johnson, K. A.,. . . & Arbuckle, M. R. (2017). Challenges and opportunities in global mental health: a research - to - practice perspective. Current psychiatry reports, 19, 1 - 10.
[26] Jenkins, R., Baingana, F., Ahmad, R., McDaid, D., & Atun, R. (2011). Social, economic, human rights and political challenges to global mental health. Mental Health in Family Medicine, 8 (2), 87.
[27] Dockery, L., Jeffery, D., Schauman, O., Williams, P., Farrelly, S., Bonnington, O.,. . . & MIRIAD Study Group. (2015). Stigma - and non - stigma - related treatment barriers to mental healthcare reported by service users and caregivers. Psychiatry Research, 228 (3), 612 - 619.
[28] Ward, E. C., Wiltshire, J. C., Detry, M. A., & Brown, R. L. (2013). African American men and women's attitude toward mental illness, perceptions of stigma, and preferred coping behaviors. Nursing research, 62 (3), 185 - 194.
[29] Barney, L. J., Griffiths, K. M., Jorm, A. F., & Christensen, H. (2006). Stigma about depression and its impact on help - seeking intentions. Australian & New Zealand Journal of Psychiatry, 40 (1), 51 - 54.
[30] Golberstein, E., Eisenberg, D., & Gollust, S. E. (2008). Perceived stigma and mental health care seeking. Psychiatric services, 59 (4), 392 - 399.
[31] County Government of Uasingishu. (2023). Retrieved from The County official guide to living, working, visiting and investing in the Eldoret: https: //uasingishu. go. ke/index. php/department/kapseret - subcounty

[32] Fisher, A. A., Laing, J. E., Stoeckel, J. E., & Townsend, J. (1991). Handbook for family planning operations research design.
[33] Abdullah, T., & Brown, T. L. (2011). Mental illness stigma and ethnocultural beliefs, values, and norms: An integrative review. Clinical psychology review, 31 (6), 934 - 948.
[34] Umberson, D., & Karas Montez, J. (2010). Social relationships and health: A flashpoint for health policy. Journal of health and social behavior, 51 (1_suppl), S54 - S66.