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Mental Illness Among Women Attending A National Mental Health Referral Center in Kenya: Unpacking Predisposing Factors and Interventions

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ABSTRACT

Background: Mental illness is an escalating global public health menace that affects women disproportionately. This study aimed to assess the prevalence and factors contributing to mental illness among Kenyan women alongside the interventions explored to manage the conditions.
Subjects and Method: This was a mixed-method study comprising retrospective case series analysis of 285 inpatient records of women seeking mental health services at a national referral center in Nairobi, Kenya, and key informant interviews involving mental health service providers, from January 2022 to June 2022. The Variables of this study were sociodemographic data. Information was collected on socioeconomic factors, mental illness profiles, and mental illness interventions. Data analysis was performed using SPSS version 23 and thematic analysis.
Results: Bipolar mood disorder (42%), schizophrenia (33%), and psychosis (25%) were the most prevalent mental conditions. While strained relationships (38%), financial challenges (35%), death of a loved one (29%), and substance abuse (27%) frequently contributed to mental illness, psychotherapy, and psychoeducation were pivotal in patient management. Poor government funding hindered in-service training initiatives as well as training and recruitment of community health workers, contributing to the unavailability of free counseling services. Despite these hurdles, the hospital explored alternative means to ensure access to mental healthcare including offering admission fees waivers, implementing repatriation programs, and subsidizing the costs of medications for psychotic patients.
Conclusion: This study highlights the complex factors affecting women's mental health in Kenya and rallies for increased support towards holistic mental healthcare interventions for this vulnerable population. Improving mental health literacy to reduce stigma associated with mental illness, and addressing financial, as well as hospital-related administrative barriers, can enhance access to mental health care.

Keywords: Mental health, mental illness, schizophrenia, psychosis, psychotherapy, stigma

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BACKGROUND

Mental illness, typified by a clinically marked disturbance in emotional regulation, cognition, or behavior, has become an increasingly major public health concern in current times. Close to one billion people globally suffered from mental illness in 2019, with anxiety and depressive disorders placing top (GBD 2019 Mental Disorders Collaborators, 2022). In 2020, in the aftermath of the COVID-19 pandemic, cases of mental illnesses increased precipitously (Santomauro et al., 2021).

Mental disorders have a complex etiology featuring genetic predisposition, environmental factors, or an interplay of both (Assary et al., 2018). For example, a positive family history of either psychiatric, psychosocial, or physical illnesses can precipitate mental illness. Similarly, previous sexual abuse and saddening events such as the death of a loved one can trigger psychiatric ailments (Elliott et al., 2012).

Manifestations of mental illnesses take various forms including altered engagement in social activities, somatic complaints, and perturbed bodily and mental functions. Patients with mental illness encounter changes in sleep patterns, appetite, and even sexual desire. On the other hand, psychological disturbances may be discerned through mood fluctuations, attention deficit, and poor thought processing (Yonatan-Leus et al., 2020).

Unfortunately, women are at a higher risk of developing psychiatric disorders in their lifetime, compared to men. Both biological and environmental factors intertwine in causing this gender-differentiated predisposition to mental illness (Bezerra, 2021). For example, hormonal changes during the menstrual cycle, pregnancy, and postpartum have been associated with mood swings. A decline in estrogen levels may cause fluctuations in brain serotonin levels, ultimately leading to symptoms of depression and anxiety. According to WHO estimates, 1 in 5 pregnant or post-partum mothers in developing countries experience mental disorders (WHO, 2022). If left untreated, this may lead to detrimental health outcomes for both the mother and the fetus. For instance, maternal mental disorders can result in preterm or prolonged labor as well as decreased birth weight. In extreme cases, mothers experiencing severe mental illness may commit suicide (Mota et al., 2019). Similarly, hormonal contraceptives, through their influence on hormonal balance, can impact a woman's mental health (Bezerra, 2021).

Locally, although much less appreciated compared to infectious diseases such as malaria, HIV/AIDs, and TB, available statistics reveal that mental illness is a public health menace and requires more attention than it has received. The Kenya National Commission on Human Rights estimated that 25% and 40% of outpatients and inpatients in Kenya, respectively, suffer from mental disorders. The most frequent diagnoses of these illnesses in general hospital settings are depression, substance abuse, and anxiety disorder (Marangu et al., 2021). The consequences of these disorders in terms of lost health and socioeconomic productivity are profound. For example, depression is ranked by WHO as the single largest contributor to global disability, accounting for 7.5% of all years lived with disability. In addition, depression is a major contributor to suicide deaths, with numbers close to 800,000 per year (WHO, 2017).

Moreover, cultural, and socioeconomic factors put women at great risk of poor mental health. Studies reveal that women living in Kenyan poor informal settlements experience higher rates of sexual, emotional, and physical intimate partner violence, than those living in formal settlements. Poor,

stressful living conditions and cultures that tolerate and justify the abuse of women have propagated the mental turmoil experienced by this subpopulation (Winter et al., 2020; Lambert and Denckla, 2021).

Despite efforts by the Kenyan Ministry of Health to integrate mental health care into primary health care services, there still exists a knowledge and implementation gap. Consequently, there is inadequate knowledge and realization of the health and socioeconomic impact of mental illnesses on the healthcare set-up and general population. Equally, patients with mental illness are at risk of stigmatization which hampers prompt and effective management (Nandikove and Ng'ambwa, 2020). Unfortunately, data estimates by the Kenyan health system on the magnitude and impact of mental health illness in the country are scarce. A lack of adequate infrastructure and resources, together with numerous other pressing health challenges and socioeconomic needs compete for the available inadequate funding. Often, these other health needs are better supported by external donor funding and the Government exchequer, to the negligence of mental health. The lack of sufficient local data on mental health makes it difficult to design an effective national health policy responsive to the mental health needs in the country (Marangu et al., 2021).

This research was conducted at the country's largest national referral and teaching hospital dedicated to mental health. The study aimed to assess the factors that predispose women to mental illness and the interventions that have been used to mitigate these factors. In addition, the prevalence of different types of psychiatric illness among women receiving care within the referral hospital was determined. This work highlights the challenges experienced by women undergoing mental health treatment and identifies opportunities for improved service delivery among this subpopulation of patients. Proactive steps in this regard will ensure positive progress in embedding quality mental health care among this vulnerable population, an urgent need in many countries of low- and middle-income setting.

SUBJECTS AND METHOD

1. Study Design

This was a mixed method study comprising retrospective case series evaluation of patient files and face-to-face interviews with hospital staff who offer admission and mental care services to the patients.

2. Population and Sample

The study was conducted at Mathare National Teaching and Referral Hospital (MNTRH), a public health facility located in Nairobi, Kenya. The hospital provides specialized medical care for psychiatric illnesses, among other mental wellness services, and attracts wide patronage, from both urban and rural settings, beyond the immediate locality. Offering both inpatient and outpatient medical services, the hospital admits invalids with acute psychiatric disorders who cannot afford the treatment costs at private facilities and those who are deemed too distressed to be handled in other public health institutions or the community.

The study sample size was calculated using the Fisher formula as described previously (Jung, 2013) and subsequently corrected using the finite correction factor formula, since the size of the study population, unlike in the Fisher formula, was less than 10,000. Consequently, 278 patient files were the minimum sample size. Simple random sampling was applied to select the files until the required number of files was reached. Participants for face-to-face interviews were identified by convenience sampling.

3. Study Variables

Variables assessed in this study include socio-demographic information, mental health diagnosis, mental health treatment options, barriers, and facilitators to accessing mental health, and strategies adopted by the hospital to enhance access to mental health services.

4. Operational Definition of Variables

The variable of this study was mental health conditions that were reported as diagnosed and recorded by a qualified specialist psychiatrist attached to the hospital facility.

5. Study Instruments

A semi-structured checklist designed to capture information aligned with the objectives of the study was used to collect information from patient files archived at the records department. The checklist included socio-demographic factors (such as age and marital status); socioeconomic factors which highlighted their occupation; type of mental illness, and action points taken by the hospital to remedy the situation.

6. Data Analysis

Data was entered, cleaned, and analysed using the statistical package for the social sciences (SPSS) software version 23.0 and Microsoft Excel 2010. All data was securely kept in a password-protected database and with a backup on Google Drive. Descriptive analysis was completed using frequencies and proportions while insights from face-to-face interviews were summarised into themes.

7. Research Ethics

Ethical clearance was obtained from the Jomo Kenyatta University of Agriculture and Technology Institutional Research and Ethics Committee before the commencement of the study. Further, permission to collect data was granted by management of the hospital before conducting the research. The review of participants' files was done under the direct supervision of the officer in charge of the medical records department and the confidentiality of patients to whom the file records related was maintained using non-personal identifiers.

RESULTS

1. Sociodemographic characteristics

A total of 285 records were surveyed for the study, most of which belonged to women aged 18 to 25 years (58%), married (46%), and actively employed (39%). Students, whether in college or secondary school, accounted for (15%) of the reviewed records.

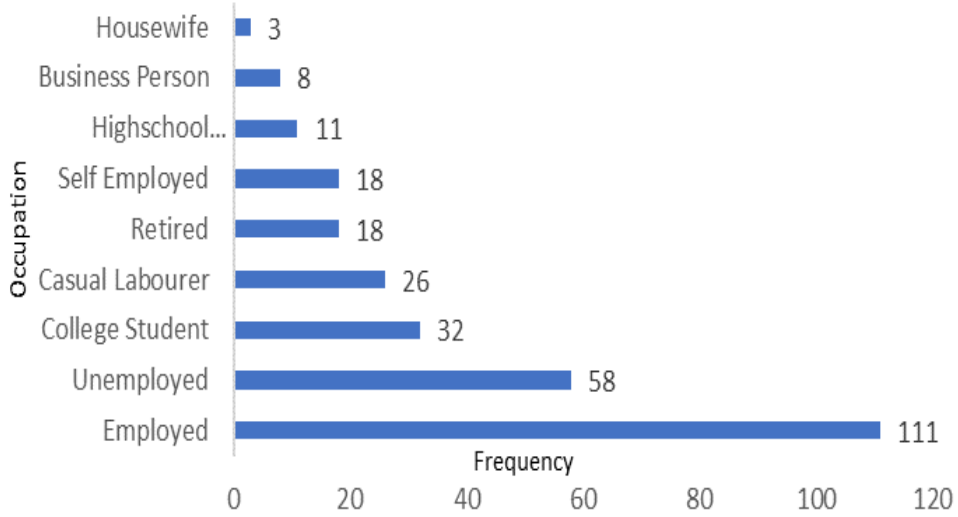

Figure 1. Employment profile of women with mental illness

2. Profile of mental illness, associated symptoms, and contributing factors

Bipolar mood disorder (42.0%), schizophrenia (33.0%), and psychosis (25.0%) were the most common mental illnesses recorded from the hospital records. Other conditions relating to mental illness were due to depression (11.0%), drug and substance abuse disorder cases (5.0%), and anxiety (5.0%). Additional reported conditions, albeit with lower frequency, were Post-Traumatic Stress Disorder (PTSD), eating disorders, Borderline Personality Disorder, Obsessive-Compulsive Disorder (OCD), and Mood Disorders. In some cases, patients were diagnosed with a combination of conditions (20.0%) and most patients (72.0%) reported having suicidal tendencies.

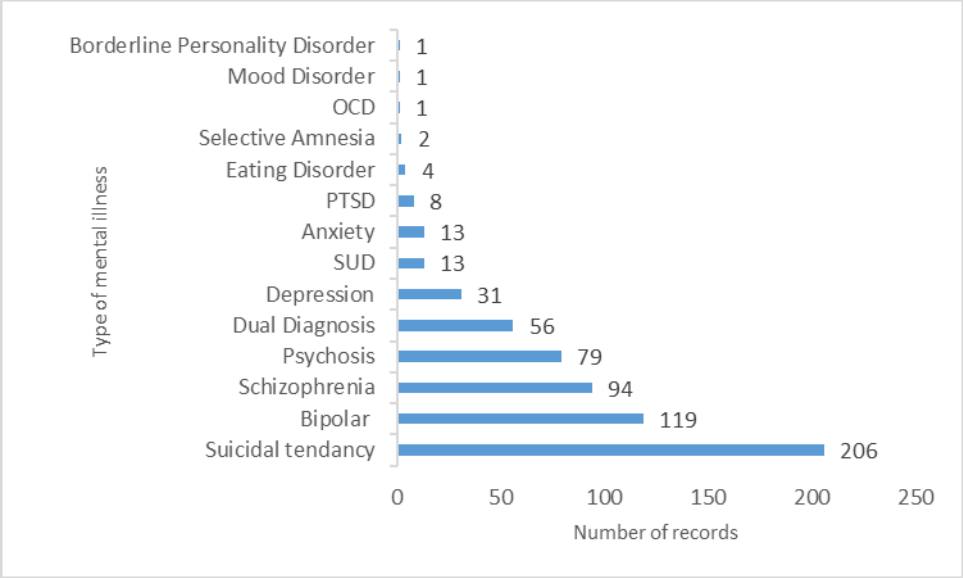

Figure 2. Profile of mental illness among women attending a mental health clinic

3. Factors contributing to mental illness

The most encountered reasons leading to mental illness were family conflict or strained relationships (38.0%), financial challenges (35.0%), and the death of a loved one (29.0%). Alcohol and substance abuse also featured frequently (27.0%) as a precipitating cause of mental illness as was the case with emotional abuse (21.0%) and having a family history of mental illness (21.0%). While strained marital relationships (32.0%), trauma (13.0%), and work-related pressure and harassment (9.0%) were found to be additional triggers of mental illness, some 18 (6.0%) patients were unable to pinpoint the likely cause of their mental situation and another 18 (6.0%) patients identified encounter with failure or disappointment, as well as social media addiction, to be likely reasons leading to the mental illness.

4. Coping with and managing mental illness by patients and family

Several action points were prescribed by the doctors to tackle the mental illness with psychotherapy (72.0%) being the most frequent intervention. Other forms of recommended therapies were family therapy, group therapy, occupational

therapy, and motivational therapy. Psychoeducation (62.0%) was also highly indicated by psychiatrists while 163 (57%) patients were managed using medication. Patient counseling, including Cognitive Behavioral Therapy (27.0%), grief management (27.0%), and rehabilitation from drug and substance abuse (16.0%) were among other instituted interventions. Counseling to address other precipitating factors for mental illness, for example, financial imprudence was also provided.

More than half of the patients (57.0.%) had a social support system that enabled them to cope with the mental illness with nearly half (49.0%) disclosing that they had an optimistic disposition that helped them in their recovery. The desire to be restored to good health (43.0%) and the recognition of bearing parental responsibilities (24.0%) was a contributing elements to the determination in the recovery journey from mental illness.

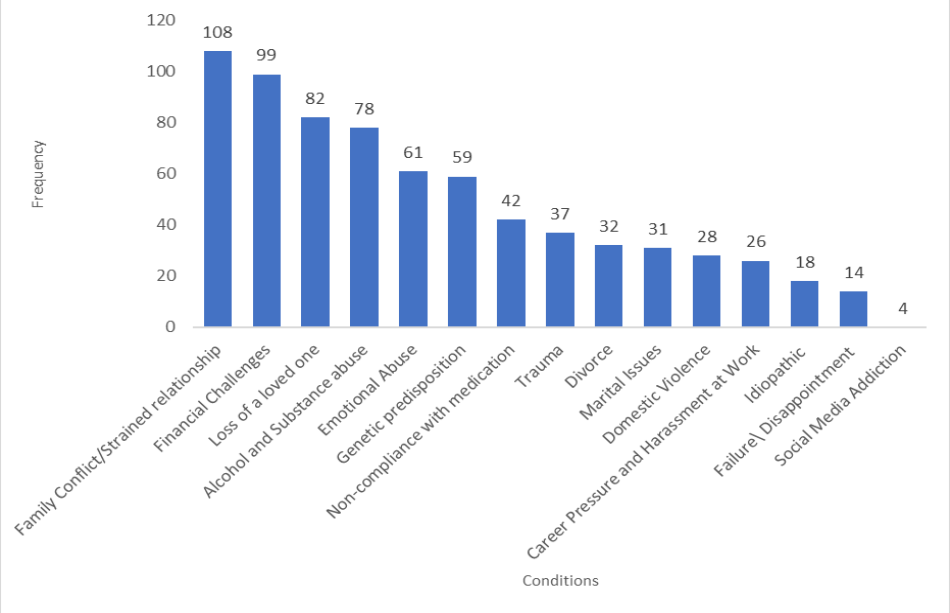

Figure 3. Factors contributing to mental illness among the study population

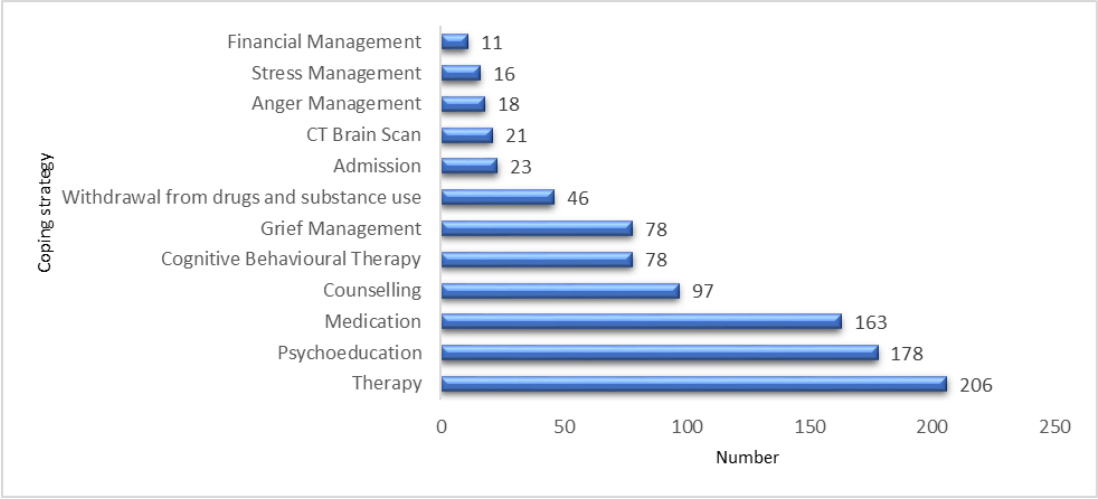

Figure 4. Overview of hospital-based mental illness management practices

5. Institution-based efforts to cater to women with mental illness.

This study obtained information, through focused interviews with the medical personnel involved in offering mental health services at the hospital, on their efforts to support women with mental illness who visited the institution. At the time of the study, the interviewees averred that there was no funding from the government to facilitate activities to prevent mental illness among women. As such, there was no provision for in-service training except for orientation programs for staff members to were barely conversant with the work environment. The respondents further mentioned that no training and recruiting of community health workers, including those with an inclination to offer mental health services, were in place. While counseling services were available, these were charged per session and therefore not within access for most patients due to financial exclusion. Similarly, although a toll-free call service was established at the institution, it was hardly operational. Moreover, no follow-up of the patients treated at the hospital was done and this responsibility was largely shifted to the family members and, where available, support groups.

Nonetheless, the hospital has initiated some strategies to facilitate the care and management of patients with mental illness. For example, the institution waived admission fees for psychotic patients who had run away from home and were brought into the hospital by police officers. Through the hospital's social work department, repatriation programs were mounted to reunite and reintegrate the recovering patients back with their families. The department also handled emergency admission of mental health patients visiting the facility for admission. Ultimately, the expenses associated with medications for mental illness were subsidized in the facility to facilitate broader accessibility for those requiring these services.

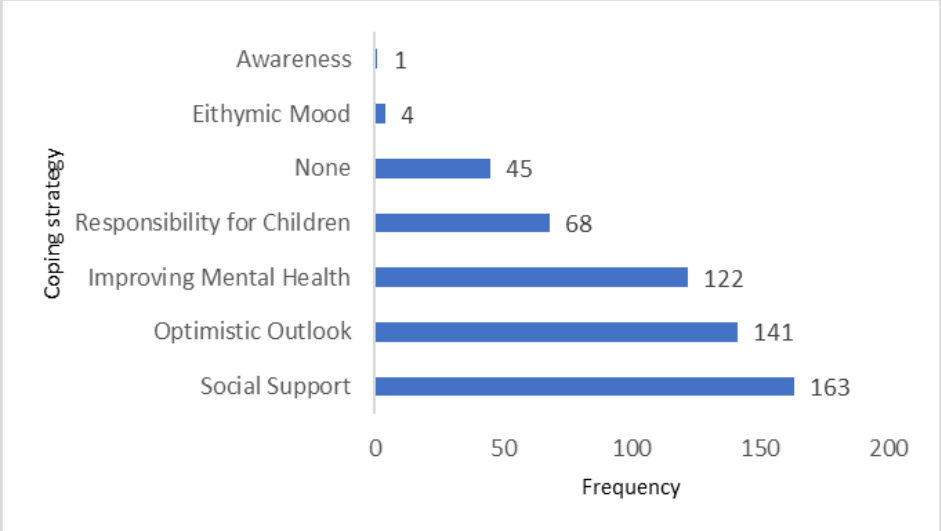

Figure 5. Mental illness coping strategies adopted by family and patients

DISCUSSION

The current study revealed a broad spectrum of psychiatric illnesses among the women receiving care at MNTRH, a national mental illness referral center in Kenya. Bipolar mood disorder (42.0%), schizophrenia (33.0%), and psychosis (25.0%) were the most common diagnoses, while conditions

such as depression (11.0%), anxiety (5.0%), and drug and substance abuse disorder (5.0%) were also prevalent, albeit to a lesser proportion. Notably, suicidal tendencies (72.0%) were also reported by a substantial proportion of patients. Taken together, these features indicate the severity of mental distress experienced among this subpopulation of patients and highlight the dire need for comprehensive mental health care and related services to address the diversity of prevailing psychiatric conditions.

Many of the women seeking mental health services in this study were those in their late teens and young adulthood, aged between 18 and 25 years. This age profile echoes the findings from a previous study and illuminates the mental health challenge that lurks in this critical period of life. The transitions, such as social and professional, that are bound to occur at this junction of life may be accompanied by various stressors and challenges that render this age group vulnerable to suffering mental health issues (Auerbach et al., 2016). Strained relationships, and financial challenges, which are often experienced in the transition to young adulthood, were the most prevalent factors contributing to mental illness in this study. Previous studies have shown that sexual, emotional, and physical intimate partner violence, common in poor informal settlements, exacerbates the mental turmoil experienced by women (Winter et al., 2020; Lambert and Denckla, 2021). Corroborating this observation, a study in Scotland showed that 26.0% of women living in deprived areas reported different levels of mental illnesses compared to 16% of those living in the most affluent areas of that country (Knifton and Inglis, 2020). Therefore, interpersonal dynamics, quality of family relationships, and a harmonious living environment play a central role in enhancing mental health. Equally, the observations underscore the considerable contribution of socioeconomic determinants to the mental health status of mankind. As such, raising public awareness about, and implementing targeted strategies towards, the control of alcohol and substance abuse can contribute to addressing the growing challenges associated with mental health disorders including in low- and middle-income countries such as Kenya. Similarly, support groups incorporating guidance counseling and rehabilitation for those addicted to substance use and championing against intimate partner violence by challenging cultural stereotypes and beliefs that propagate this tendency are imperative for creating a conducive environment for mental well-being (Lambert and Denckla, 2021).

The study shed light on the multifaceted approaches that women patients pursue to manage mental illness challenges with psychotherapy emerging as the most frequent intervention. Psychotherapy continues to play a vital role as a non-pharmacological modality and emphasizes promoting the psychological well-being of a patient. Other commonly employed non-pharmacological approaches to mitigate against effects of mental illness were psychoeducation, and family- and group- therapy. In a previous study, patients who were grouped to receive psychoeducation registered greater improvements in the state of their mental illness compared to those who were placed under standard care only (Zhao et al., 2015). The findings of this study support the pivotal role of psychological support and patient education in promoting mental well-being, reinforcing the fact that holistic interventions that address both clinical and psychosocial aspects of a patient are essential for comprehensive mental health care (Thieme et al., 2015). For instance, patients with suicidal tendencies usually benefit from Cognitive Behavioral Therapy (CBT) and Dialec-

tical Behavioral Therapy (DBT) which are usually recommended as adjunctive therapies in these cases and have been demonstrated to be effective in reducing suicidal ideation and self-harm behaviors (Stone et al., 2017).

This study also sought to understand the efforts made by the hospital facility and the challenges experienced in this endeavor. As reported in a similar study setting in Rwanda, stigmatization and financial constraints to support mental health care emerged as the most common barriers to mental health services utilization (Muhorakeye and Biracyaza, 2021). To address some of these challenges, the management has implemented diverse strategies including offering admission fee waivers and subsidized medication costs to patients seeking mental health services. In addition, once a patient has stabilized and is assessed to be safe for reintegration with their family, a repatriation program has been established to facilitate this transition. Despite the hospital demonstrating such great initiatives, there remain challenges related to funding of mental health care, in-service training of mental health social workers and carers, and poor capacity for follow-up care. Low levels of government funding for mental health prevention activities and the training and recruitment of mental health workers were notable barriers that hindered access to mental health counseling services; these must be tackled if the vision for affordable and accessible mental health care is to be realized. Importantly, strengthening the integration of mental health care into primary health services is crucial, along with targeted efforts to reduce stigma and improve mental health literacy among the population (Marangu et al., 2021).

This study provides useful insights into the status of mental health services in Kenya although the results need to be interpreted in the context of limitations inherent to the study. For example, by its retrospective nature, responses received from interviews may be subject to recall bias while the reliance on hospital records to retrieve information may not capture fully the spectrum of mental health experiences in the population. Moreover, although it features the only national referral psychiatric center in the country, it is possible that many other patients with mental illness are distributed considerably across the country whose profiles and experiences could not be captured. Future longitudinal studies that apply qualitative approaches are recommended to facilitate a deeper understanding of the complex factors influencing mental health among women in different settings in the country.

In conclusion, this study provides valuable insights into the mental health challenges faced by women attending the national mental health center in Kenya, with bipolar mood disorder, schizophrenia, and psychosis being common diagnoses. These findings highlight the vulnerability of young women during life transitions and identify factors including strained family relationships, financial difficulties, the death of a loved one, and substance abuse as significant contributors to mental illness. Psychotherapy, psychoeducation, and various counseling and therapeutic interventions are essential in the management of these mental health challenges. It is crucial to address the multifaceted factors impacting women's health in Kenya and the study demonstrates the need for improved funding, in-service training, and follow-up care to enhance sustainable mental health services.

AUTHOR CONTRIBUTION

RN and LW conceptualized and designed the study; RN, DC, SM wrote the initial draft of the manuscript; RN, DO, GM conducted

data analysis; AK, DO, LN and GM revised the manuscript; LW and GM supervised the research and manuscript writing, respectively. All authors approved the final draft for publication.

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This study did not receive any financial support.

CONFLICT OF INTEREST

There is no conflict of interest in this study.

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