Mental Disorders and Help-Seeking Behavior among Adults Attending Nyeri County Referral Hospital, Kenya

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Abstract

Mental illness has become a growing concern of public health which based on World Health Organization has affected roughly 500 million persons across the globe. What is more worrying however is that due to high level of stigmatization in society there has not been timely response and decisiveness on the part of patients or caregivers on seeking help. This has in turn increased the disease burden since it is relatively less understood. While most studies have attributed low uptake of mental health services to help-seeking manners of persons having mental infection, it does not go without mention that there is little on record of how the disease has affected the lives of many in Kenya. This study with particular interest in Nyeri County investigated the prevalence of mental disorders based on various socio-demographic characteristics of adult patients attending Nyeri County Referral Hospital. The paper further conducted an assessment of the help-seeking behaviour among patients. The study was anchored in the health belief model and employed a cross-sectional survey design. The study targeted Adults attending Nyeri County Referral Hospital from which a sample of 200 respondents were purposeful selected. Questionnaire guide was used to collect data which was later analysed descriptively. The study established that women were more affected than men and that seeking help was intentional among the patients despite the fact that some respondents could not seek help for fear of intimidation or lack of trust in the system. Nonetheless, most (79%) respondents had intentions of seeking mental health help in future even though they did not know where to get the help from. The study recommends that public health officials should diversify the channels of health messages on mental health services to reach majority of people.

Keywords: Adults, Help-seeking behavior, mental disorders, Prevalence, Disease burden Nyeri County

INTRODUCTION

Mental disorders exact a massive disease burden on people all over the world (Bifftu, Takele, Guracho &Yehualashet, 2018). As established by Kilbourne et al. (2018), mental disorders are liable globally for thirty-two percent of disability years as well as thirteen percent of disability altered life years. According to Hausmann-Mueala, Muela Ribera and Nyamongo (2013), health-obtaining behaviour is unswervingly associated with disease occurrence, complication and prevalence. To minimize morbidity and mortality therefore, early identification of symptoms, intervention via visiting healthcare facilities, and conformity with effectual treatment must be done.

Based on the World Health Organisation (WHO) (2014), mental health is a status of complete mental, physical as well as social well-being. However, there are mental disorders that impair this state. They entail unipolar depressive disorder, bipolar

disorder, alcohol and drug use disorders, schizophrenia, obsessive and compulsive disorders and panic disorders (WHO, 2009). The Centre for Disease Control (CDC) (2017) defines mental illness as a disorder commonly characterized by regulation of thought, mood, and/or behaviour that affect an individual to the extent that social integration becomes problematic.

Five out of the top ten leading causes of disability are mental illnesses (Bifftuet al., 2018). WHO (2010) indicates that a single person among 4 in the globe will be affected by neurological or mental disorders at certain times in their life and also estimates that roughly four hundred and fifty million persons globally presently experience mental wellbeing issues. Anxiety and depressive disorders were responsible for the many of the mental disorders diagnosed globally in 2015 and are frequently identified as common mental disorders (CMDs). Approximately three hundred and twenty-two million people internationally suffered from depression and another 264 million from anxiety disorders in the same year (CDC, 2017).

According to European Brain Council (2014) and the European Colleague of Neuropsychopharmacology (2013), the single-year occurrence of various type of mental disorder is roughly twenty-seven per-cent in the European adult population. One in every six people are reportedly facing a common mental health problem (for instance depression and anxiety) in every particular week in England (Manus, Bebbington, Jenkins & Brugha, 2016). In the United States, mental illness is a vital public wellbeing crisis in itself where around twenty-five percent of grownups have mental illnesses according to CDC (2017). The National Survey of Mental Health and Wellbeing (NSMHWB, 2018) established occurrence of mental disorder of twenty-seven percent for those between eighteen and twenty-four years in Australia. Even in sub-Saharan Africa, where communicable diseases are frequent, mental disorders are responsible for almost ten percent of the entire disease burden (Tomlinson & Lund, 2012).

One among four Kenyans will experience mental ill health at one time in their lives and another 20-40% of those obtaining outpatient services in hospitals experience a single or numerous mental disorder (Republic of Kenya (RoK), 2015). According to Ndetei, Ongecha and Mutiso (2007), about 4% clinician discovery rate for mental disorders implies that several psychiatric disorders in all-purpose medical facilities stay undiagnosed and thus, are not managed. Different studies published in journals show that schizophrenia and bipolar mood disorders are the main types of conditions affecting adults (Odhiambo, 2016).

There are 12 county referral hospitals that offer mental health services (RoK, 2015). However, Merab (2016) reports that Kenya has only eighty-eight psychiatrists and four hundred and twenty-seven nurses trained to care for the sicknesses in the fourteen mental health hospitals having a bed capacity of 15-25. Notably, the mental health services uptake and in turn the health outcomes of mentally ill populations is highly dependent on health seeking behaviour (Musoke, Boynton, Butler&Musoke, 2014). This paper's discussion is therefore based on various demographic characteristics, mental disorders and the health-seeking behaviour with a focus on adults attending Nyeri County Referral Hospital.

REVIEW OF LITERATURE

Health-seeking behaviour is described as any activity carried out by persons who consider themselves as being ill or having a health problem so as to find a suitable

remedy (Patle & Khakse, 2015). It is a term that is used interchangeably with health seeking and is expressed as a component of illness behaviour as well as health behavior (Rahman, 2016). The conclusions made include all existing health care alternatives such as seeing a private or public and or customary health care facility, self-medication and utilization of home medications or not to use the existing health services (Chauhan, Purty, Samuel& Singh, 2015).

Early symptoms of mental disorders are not constantly visible to lay persons; the seeking of treatment for a mental illness is therefore sometimes delayed (Marthoenis, Aichberger & Schouler-Ocak, 2016). This is a vital alarm for public health since mental health illnesses have substantial emotional and physical consequences on persons as well as their families. In addition, less utilization of wellbeing care services places intense socio-economic load on national economies (Swami, 2012).

A major objective of campaigns focused on raising mental health service utilization is the improvement of public attitudes to seeking professional assistance for mental health issues (Angermeyer, van der Auwera, Carta & Schomerus, 2017). However, Nsereko, Kizza, and Kigoziet (2015) report that people who suffer from mental health problems more often holdup seeking professional assistance, or evade it totally, and therefore extensively compromise suitable care together with treatment. Readiness to seek professional assistance for an emotional problem is radically linked with help-seeking and treatment utilization as noted by Mojtabai, Evans-Lacko, Schomerus & Thornicroft, (2016). To gain understanding therefore on the help-seeking behaviors and mental disorders among the adult population attending Nyeri County Referral hospital, this study employed the health belief model as discussed here under.

Health Belief Model

The health belief model was created in the early 1950s by social scientists at the United States Public Health Service so as to recognize the failing of people in adopting disease avoidance approaches or screening tests for the early detection of disease (Glanz, Marcus, Lewis & Rimer, 1997). According to Glanz, Rimerand Lewis (2002), it is a structure for stimulating persons to take constructive health measures that utilizes the need to shun a negative health effect as the major motivation. When used in mental health utilization, this form gives a framework for generating and assessing programs meant for increasing mental health responsiveness along with suitable use (Henshaw & Freedman-Doan, 2009).

The Health Belief Model (HBM) hypothesizes that messages seeking to increase utilization of healthcare services will accomplish best behavior transformation if they effectively aim at perceived obstacles, profits, self-effectiveness, and dangers of not taking any action (Jones, Jensen, Schere et al., 2015). According to the model, an individual affected by a mental health problem will take a health-associated action, for instance use medication; see a counselor, psychologist or a psychiatrist if they experience that a depression or stress can be shunned and the individual must have a constructive anticipation that by taking medicine or seeing a professional, he/she will evade a harsh mental health problem (Henshaw & Freedman-Doan, 2009).

Several individuals having depression face trouble seeking assistance (Magaard et al., 2017). Castonguay, Filer and Pitts (2016) analyzed narratives created through interviews with people who sought treatment which help in understanding the process of seeking help. The authors scrutinized these narratives within the frame of the health belief model and afterward engaged in evolving, thematic coding in every category. They suggested that, for depressed persons, one's doubt concerning the condition

together with treatment drives every health belief model element. Interpersonal indications to action help in reducing doubt by offering guidance as well as confirmation that help was required.

Nobiling and Maykrantz (2017) used the Health Belief Model (HBM) in exploring perceptions regarding mental illness and mental health service use and self-medication amid college scholars. The scholars were having or not having mental illness history. Prime care givers were noted as a critical prompt to action. Marijuana, alcohol as well as prescription medications were the most recurrent and favored substances utilized for self-medication. An Australian study by O'Connor (2013) which aimed at identifying predictors of help seeking behaviour in youthful people found out that perceived benefits were more significant than barriers. This implies that barriers were extraneous whenever persons trusted that they would gain from seeking help. Moreover, perceived susceptibility did not predict help seeking behaviors, except instances where persons were health cognizant.

Developing nations in Africa and other regions have an alike profile of inadequate human resources for mental health, deprived funding, a high unsettle requirement for services as well as a low formal prioritization of mental health. This state is deteriorated by misunderstandings concerning the bases of mental disorders, stigma and biasness that commonly leads to destructive practices against individuals with mental illness (Abdulmaliket al., 2014). Mental health in Africa's health and development policy agenda has been abandoned due to the mentioned challenges together with poverty, dangerous illnesses and poor leadership (Akyeampong, Hill & Kleinman, 2015). Based on Sankoh, Sevalie and Weston (2018), the section has 1·4 mental health employees per one hundred thousand individuals compared with a global average of 9·0 per 100 000.

Funding for African healthcare is lower as compared to other sections of the globe infact less than 5% of the Gross Domestic Product (GDP) is used on healthcare as opposed to about seven percent in America and Europe. Furthermore, few African World Health Organization (WHO) member nations have employed mental health policies (42%) as opposed to nations in all other WHO areas comprising Eastern Mediterranean, the Americas, Europe, and Western Pacific the Americas, and South-East Asia with more than fifty percent (Reuter, McGinnis &Reuter, 2016). The brutally inhibited resources for mental health service in poorly developed sections like Sub-Saharan Africa emphasize the necessity for excellent public mental health literacy as a possible added mental health resource (Atilola, 2015).

According to WHO (2015), Angola and Malawi lacked psychiatrists even though Malawi has since effectively employed a single one. This means there exists at least a single psychiatrist in every million individuals in Africa (WHO, Mental Health Atlas, 2005). As in other African states, Kenya has a scarcity of mental health experts and this may have resulted in a number of individuals particularly the ones residing in rural areas seeking informal health providers (IHPs) such as traditional healers (THs) and faith healers (FHs)to cure mental infections (Musyimiet al., 2017). The state uses just roughly 0.05% of its health financial plan on mental health based on World Health Organization (2015) and around seventy percent of mental health amenities in the state are situated in the Nairobi, its capital city.

The Kenya Health Policy (2014 – 2030) provides ways to enhance reasonable minimization in the Kenya general illness in order with the Kenya Constitution, 2010 and with the country's Vision 2030. This sector ensures that the Country achieves the

top potential health standards in a way that match with the needs of the population. The Kenya Mental Health Policy (2015-2030) offers a mechanism of enhancing mental health systems transformations in Kenya. It agrees with the Constitution of Kenya 2010, the Kenya Health Policy (2014-2030), Vision 2030 as well as the worldwide commitments. The Constitution of Kenya 2010, in article 43(1a) gives that "every person has the right to the highest attainable standard of health, which includes the right to healthcare services" and mental health is included. This rule aims at addressing the orderly challenges, arising issues and alleviate the trouble of mental health issues and diseases. The Kenya Mental Health Policy (2015-2030) aims at attaining maximum health states and competence of every person through following policy measures as well as approaches. The objective of this policy is accomplishment of the utmost mental health standard.

A Kenyan study by Musyimi et al. (2017) aimed at exploring disputes experienced by educated informal health suppliers referring persons having suspected mental infections for treatment, as well as possible opportunities to counteract the challenges. Results showed that throughout the original intake stage, challenges incorporated patients' distrust of informal health suppliers as well as cultural misinterpretation together with stigma linked to mental sickness. Treatment communications matters were noted throughout the treatment stage. Varied suggestions for resolving these challenges were prepared at every stage.

This study will therefore sort to add to the body of knowledge on mental disorders and mental health help-seeking behaviors among adults attending Nyeri county and referral hospital.

METHODOLOGY

This study adopted a cross-sectional survey design. A cross-sectional survey collects data to make inferences about a population of interest at one point in time. Hall (2013) describes cross-sectional surveys as snapshots of the populations about which they gather data. According to Sekaran and Boungie (2010), population refers to the entire group of people, events or things of interest being investigated. The study targeted adults attending Outpatient department of Nyeri County Referral Hospital. This hospital was preferred due to the low (9%) utilization of mental health services compared to similar facilities. The facility is also a level five hospital and attends to a diverse population across the counties in Central region of Kenya. The facility receives about 400 patients in the outpatient department daily. The sample size determination was conducted using Slovin's formula. It gives the expert a deliberation of how enormous his illustration size must be guaranteeing a reasonable precision of results.

$n = N / (1 + N e^2)$ where
N represents the sample size,
N represents the population
E is the margin of error
Therefore, in a population of 400 persons,
$n=400/ (1+400*0.05^2)$ =200 respondents
The study used a sample of 200 respondents.

Purposive sampling technique was used to select the respondents. This strategy was preferred due to the nature of the research site, which is a critical healthcare facility and therefore participants had to be at a state of health that allowed them to participate. The

population sampled were all adults between the ages of 18 to 90 years as they are the majority utilizers of the outpatient department at Nyeri County referral hospital.

Primary data was collected using the General Health Seeking Questionnaire (GHSQ). According to Gulliver et al. (2012), the intentions scale of the GHSQ has adequate psychometric properties. The scale exhibits sound internal consistency (Cronbach's α = .70) and test-retest reliability (r = .86), modest predictive validity and strong convergent evidence for criterion validity. Previous studies such as Rickwood et al. (2005), Roche (2013), Cakar and Savi (2014), Salaheddin and Mason (2016), Sun et al. (2017) used this questionnaire to asses help seeking intentions in previous studies.

The data collection period was one week. This was done at the outpatient department of Nyeri county referral hospital in collaboration with the healthcare workers at the department who after conducting the triage would refer the patients that were willing to participate in the study to the researcher or administer the questionnaire to those who would be able to fill it n without assistance. The collected data was then analyzed using Statistical Package for Social Sciences (SPSS) at 95% confidence level. Descriptive statistics comprising frequencies, percentages, mean and standard deviation were used to present the study findings as the research was primarily empirical.

RESULTS AND DISCUSSION

This paper aimed at highlighting mental disorders and help-seeking behaviour among adults visiting Nyeri county referral hospital. The author first draws attention to the demographics of the respondents in order to establish which categories of people were most affected by the illness. Discussed in this section is therefore the socio-demographic characteristics and help-seeking intentions for adults attending the outpatient department of Nyeri County hospital. All the 200 adults attending Nyeri County Referral Hospital who were identified to take part in the survey responded and therefore after coding and editing of the questionnaires, 100% response rate was achieved for analysis.

Socio-Demographic Characteristics of Respondents

Socio-demographic characteristics assessed in the study included gender, education level, age, marital status, occupation, income and religion. The findings are presented in Table 1.

The findings show that slightly over half (58%) of the respondents were female while the male respondents accounted for 42% of the participants. This shows that both genders were well represented in the study and reflect the composition of the general population. The findings also show that 38% of the respondents were from twenty-one (21) to thirty years (30) whereas 32% aged from 31-40 years. This implies that majority of the study participants were youth since over half of the participants were made of people less than 35 years of age.

The findings show that 40% had acquired college education while 28% had acquired secondary education. This shows that the sample was made up of well-educated people since majority (80%) of the respondents had acquired at least secondary education and over half (52%) had acquired post-secondary education. Therefore, would be perceptive of education with regards to mental disorders via distribution of pamphlets and brochures with the information. On marital status, the findings show that 49% of the respondents were single while 41% were married. On religion, the vast majority (97%) of the respondents were Christians. This was expected as Christianity is the

major religion in the region of study area. It may also play a factor in their perception of mental disorders although further study would be required to ascertain this. In addition, the study established that 39% of the respondents were self-employed while 33% were unemployed. This was expected due to the experienced high rates of unemployment in Nyeri County. On income, the findings show that 48% of the respondents had income below KES 10,000 while an equal number (48%) had an average monthly income of between KES 10,001 and those who earned KES 25,000 accounted for 31% of the respondents. This shows that majority of the participants were in the low-income bracket. Previous studies have sited low income as one of the factors impacting help seeking behaviours due to cost implications and therefore affecting the severity of mental disorders at the time the patient seeks out mental health services (Dempster et al, 2015). There is a need to establish through more research if this is the case with the population of Nyeri County as it is beyond the scope of this study.

Table 1: Socio-Demographic Characteristics of Respondents

Characteristic	Category	Frequency	Percentage
Gender	Male	83	42
	Female	117	58
Age	<20	9	5
	21-30	76	38
	31-40	63	32
	41-50	24	12
	51-60	8	4
	61-70	12	6
	71-80	5	3
	81-90	3	2
Education level	None	6	3
	Primary	33	17
	Secondary	56	28
	College	80	40
	University	23	12
Marital status	Single	97	49
	Married	81	41
	Divorced	7	4
	Separated	5	3
	Widowed	7	4
Religion	Christian	191	97
	Muslims	4	2
	Others	3	1
Occupation	Employed	56	28
	Self employed	78	39
	Unemployed	66	33
Income per Month (Kshs.)	<10,000	48	34
	10,001-25,000	48	34
	25,001-50,000	29	21
	50,001-75,000	13	7
	75,001-100,000	2	1
	>100,001	1	1

Help-Seeking Intentions

Help-Seeking Behaviourfor Personal or Emotional Problems

The help seeking behaviour of respondents for personal or emotional problems are shown in Table 2.

Table 2: Help-Seeking Behaviourfor Personal or Emotional Problems

Party	N	Min	Max	Mean	SD
Intimate partner	193	1	4	2.99	1.066
Friend	191	1	4	2.85	0.908
Parent	189	1	4	3.01	1.092
Other relatives/family member	192	1	4	2.63	1.010
Mental wellbeing expert	190	1	4	2.92	1.066
Telephone help line	186	1	4	1.66	0.875
Doctor/GP	190	1	4	3.01	0.970
Minister/ spiritual leader	190	1	4	2.47	1.087
I would seek no assistance from anybody	192	1	4	1.26	0.616
I would seek assistance from a different person unlisted above	170	1	4	1.45	0.836

The most popular choice of where respondents were likely to seek help was from a doctor (M=3.01, SD= 0.97) and parent (M=3.01, SD=1.092). Other popular choices included intimate partner (M=2.99, M=1.066) mental health professional (M=2.92, SD=1.066) and friend (M=2.85, SD=0.908). The findings show that intentions of not seeking help was extremely unlikely (M=1.26, SD=0.601). It was also established that help seeking intentions of respondents for personal or emotional problems were high with medical professionals. However, close family members were the most popular choice with whom the respondents were most likely to seek help from. The implication with this is medical professionals need to be equipped with skills and tools for screening for mental disorders. A study to establish if the health personal is well equipped, however, would better guide protocols to be curated to this end. The public should also be made aware of key symptoms to look out for with mental disorders in order to seek help earlier before they progress.

Help-Seeking Behaviour for Suicidal Thoughts

Table 3 shows the help seeking behaviour of respondents with suicidal thoughts. Presence of suicidal thoughts is classified as a major symptom across the spectrum of mental disorders (DSM V, 2013).

Table 3: Help-Seeking Behaviourfor Suicidal Thoughts

Party	N	Min	Max	Mean	SD
Intimate partner	188	1	4	2.96	1.023
Friend	188	1	4	2.77	0.947
Parent	184	1	4	2.70	1.143
Other relatives/family member	190	1	4	2.54	1.021
Mental wellbeing expert	191	1	4	2.91	1.006
Telephone help line	188	1	4	1.74	0.901
Doctor/GP	185	1	4	2.78	1.058
Minister/ spiritual leader	187	1	4	2.50	1.133
I would seek no assistance from anybody	187	1	4	1.33	0.781
I would seek assistance from a different person unlisted above	175	1	4	1.35	0.727

The most popular choice from where respondents were possibly to look for assistance was intimate partner (M=2.96, SD=1.023) and mental health professional (M=2.91, SD=1.006). The findings show that intentions of not seeking help were extremely unlikely (M=1.35, SD=0.727). This therefore implies that help-seeking intentions for

suicidal thoughts were high with close family members and mental health professionals being the most popular choices. An article published in 2018 in the standard newspaper cited the chief police commander reporting there were 4 suicides daily in Nyeri county averaging 120 monthly deaths by suicides. While the study shows respondents were likely to reach out for help in case of suicide thought, there is need for more scientific study into the phenomenon within Nyeri County in order to inform intervention.

Reasons for not Seeking Mental Health Help

The author also thought it wise to understand the reasons why some respondents did not seek for help.

Table 4: Reasons for Not Seeking Mental Health Help

Reason	Frequency (n=133)	Percent
Fear	44	33
Lack of trust in the system	24	18
Never needed the services	32	24
No reason	27	20
Others	7	5

Table 4.4 shows that 33% of those who had never sought help was due to fear of stigma while 24% indicated that they had never needed the services and 20% had no reason for not seeking mental health services. There is need to create awareness with regards to mental diseases together with facilities that offer mental wellbeing services

Future Help-Seeking Behaviour

Respondents who did not seek for help were asked to indicate if they would seek help in future and the response provided in Table 5

Table1: Future Help-Seeking Behaviour

	Response			
	Yes		No	
	N	%	N	%
Intends to seek mental health help in future	148	79	40	21
Knows where to get mental health help	88	48	95	52

Majority (79%) of respondents had intentions of seeking mental health help in future while others (52%) did not know where to get the help. This is shown in Table5. This implies there is little awareness as far as mental health services along with mental infections are concerned.

CONCLUSION

From the study, there is a need for awareness creation of mental disorders because, while the help seeking behaviour is low the intentions are high. The limitation with the study is that it did not screen for specific mental disorders but for general symptoms associated with mental disorders. This however shed a light that most people could be suffering from a mental disorder. Another limitation is that it used a questionnaire which creates a challenge of verifiability.

RECOMMENDATIONS

Future studies should include a focus group and a tool screening for specific mental disorder in order to give a more in-depth outlook. Studies should also include mental health professionals as participants to offer more insight on the uptake of mental health services. A similar study should also be conducted in private hospitals for comparative purposes.

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