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Mental Health Knowledge, Anticipated Discrimination and Social Functioning Among Women Living with Psychosocial Disability in Rural Kenya

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Abstract Levels of mental health awareness in rural Kenya remain very low with higher levels of stigma and discrimination towards people with psychosocial disabilities, especially for women. This study aimed to describe the levels and correlates of mental health knowledge, discrimination and social functioning among rural women with psychosocial disabilities in Kenya. We randomly recruited 25 women living with psychosocial disabilities in a rural county. Mental health knowledge was measured by Mental Health Knowledge Schedule (MAKS), anticipated

discrimination was measured by Questionnaire on Anticipated Discrimination while social functioning was measured using the Social Functioning questionnaire. The mean age of study participants was 36.6 ± 3.0 and the mean score of MAKS was 21.9 ± 30 . The most endorsed item was referring a friend with mental illness to a professional to seek help. The prevalence of low social functioning was 64%. In terms of identification of mental illness, majority (88%) identified depression as a mental illness. Higher mental health knowledge was associated with a higher level of education ($p = 0.012$), being self-employed as opposed to unemployed ($p = 0.018$) and earning monthly income ($p = 0.023$). The most frequent reason for anticipated discrimination was friends and neighbors knowing about their mental health problems (24.0%). Anticipated discrimination was associated with participants who had ever been treated for a mental health problem ($p = 0.05$). Poor social functioning was significantly correlated with the number of years lived with disability ($p < 0.001$). Poor mental health awareness and discrimination against people with psychosocial disabilities limit their functioning, health-seeking and recovery in Kenya. There is need for prioritization of mental health services and increased mental health awareness to improve health-seeking behavior, social participation and recovery for persons with psychosocial disabilities.

Supplementary Information The online version contains supplementary material available at <https://doi.org/10.1007/s40737-021-00258-0>.

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Introduction

Mental neurological and substance use disorders are a significant cause of the global burden of disease affecting more than 1 billion people globally and were the leading cause of years lived with disability (19%) [1]; with the majority of people affected living in low and middle-income countries (LMIC) [2]. Psychosocial disabilities are those disabilities that arise from barriers to social participation experienced by people who have or who are perceived to have mental conditions or problems [3].

Based on the social model of disability, adverse social determinants of psychosocial disability include poverty, unemployment and reduced access to education [4]. People with disabilities often face unmet needs in accessing community services and perceive negative social attitudes, lack of physical accessibility and lack of information [5]. Amongst persons with psychosocial disability, women face even higher experienced discrimination as compared to their male counterparts, have poor social functioning [6] and often have low access to mental health literacy programs [7]. In addition, women are at higher risk compared to men on account of lower economic and social status of women and girls, gender-based violence and harmful or gender-discriminatory practices [8–10]. In rural Kenya, there is a high prevalence of early marriages and girls do not have equal access to education as their male counterparts.

There is very limited evidence on anticipated discrimination, mental health knowledge and social functioning among women with psychosocial disability in LMICs, especially in rural setting. Although studies abound on the sociodemographic characteristics of persons with psychosocial disabilities, most of the studies are in high income settings or urban areas where factors existing in the setting may mediate observed effects. In this study, we set out to examine mental health knowledge, anticipated discrimination, and social functioning amongst women with psychosocial disability in Tana River County as part of a larger study seeking to improve work and employment

[11]. This study aimed to investigate: (1) the rates of anticipated discrimination, mental health knowledge and social functioning, (2) the associations of mental health knowledge, discrimination and social functioning with sociodemographic characteristics, and (3) the association between Mental health knowledge, anticipated discrimination and social functioning. Findings from this study will add to exiting body of knowledge on lived experiences of affected individuals and help policy makers and interested parties to evolve context relevant interventions.

Materials and Methods

Study Design and Population

A cross-sectional study design was employed. The target population were women with psychosocial disabilities living in Tana River County, Kenya. We recruited women living with psychosocial disabilities in Tana River County who were clinically stable and not actively ill at the time of the study. Participants who met the inclusion criteria were randomly recruited from the community through a network of non-governmental organization that works with persons living with disability. Participants answered researcher administered questionnaires in English or Swahili language, the official languages in Kenya.

Study Setting

Tana River County is one of the poorest in Kenya, ranked number 43 out of 47 with majority of its population living below poverty line [12]. The rate of poverty is at 76.9%, which is higher than the national average of 45.9%. The inhabitants are constantly faced with starvation, inadequate access to healthcare, low literacy levels, unemployment, and insecurity. There is a high prevalence of early marriages and responsibility of managing cattle, which limits them from accessing education rights [13]. Tana River County did not have a psychiatrist or psychologist at the time of conducting this study. There are no official statistics on number of people with psychosocial disability (PWPD), but the number is projected to be higher considering the high levels of stigma towards mental illness and the lack of access to mental health services.

Measures

Socio-Demographic Characteristics

Socio-demographic variables which included age, marital status, highest level of education, type of employment, residence, mental health condition and treatment and perception of daily activities, tasks, job or business in the past month were collected using a researcher designed questionnaire.

Mental Health Knowledge Schedule (MAKS)

Stigma-related and disorder-specific mental health knowledge were assessed using the MAKS [14]. The MAKS has been found to have adequate test–retest reliability (0.71 Lin’s concordance statistic) and moderate internal consistency (Cronbach’s $\alpha = 0.65$) in a British sample [14]. The MAKS has been used in a variety of mental health knowledge and stigma-related studies globally [15–17].

Questionnaire on Anticipated Discrimination (QUAD)

Questionnaire on anticipated discrimination (QUAD) is a 14-item questionnaire, developed at the Institute of Psychiatry, King’s College London [18]. It is used to assess anticipated discrimination. The scale consists of fourteen items rated on a 4-point Likert scale from “strongly disagree” to “strongly agree.” Items in which a respondent strongly agrees with have a value of 3 while 0 point reflects a response in which the respondent strongly disagrees with higher scores indicating greater anticipated discrimination. A mean score is calculated for the QUAD in addition to count score of the number of areas of life in which individuals expected anticipated discrimination. The QUAD is a reliable, valid and acceptable measure which can be used to identify key life areas in which people may personally anticipate discrimination, and an overall tendency to anticipate discrimination [19].

Social Functioning Questionnaire (SFQ)

Social functioning was assessed using an eight-item social functioning questionnaire (SFQ). The SFQ is a self-reported scale which provide a quick assessment of social functioning. The responses are on a four-point

non-uniform scale ranging from 0 to 3 giving a total score range of 0–24. A score of 10 or more indicates impaired social functioning [20]. The SFQ was developed from social functioning schedule (SFS) and has been found to have adequate test–retest reliability, interrater reliability as well as construct validity [20, 21]. The SFQ questions cover diverse life domains that includes work, home, relationship, financial problems, sexual life and relationship (Table 2). The SFQ has been previously used among persons living with mental disability in Nairobi, Kenya [22].

Statistical Analysis

Descriptive statistics were applied to determine socio-demographic characteristics. Individual Items frequencies, means and standard deviation were used to summarize the measures. Mann–Whitney U Test, Kruskal Wallis Test and Pearson correlations were used to identify socio-demographic factors associated the outcome variables depending on the distribution of the independent variables. All analyses were conducted using IBM SPSS version 23 (IBM, New York USA).

Results

The mean age of the participants was 36.6 years and median 32 years. Close to half (48%) had primary level of education, 40% had no formal education, while 12% had secondary school level of education. In terms of self-reported mental health conditions bipolar disorders was leading with ($n = 9$; 36%), followed by schizophrenia and other psychotic conditions. Table 1 presents the socio-demographic characteristics of the respondents.

Statements Covering Stigma-Related Mental Health Knowledge

As shown Fig. 1, 68% agreed that ‘Most people with mental health problems want to have paid employment’ (mean 3.8), and more than three quarters reported that ‘If a friend had a mental health problem, I know what advice to give them to get professional help’ (80.0%) (mean 4.1) and that ‘People with severe mental health problems can fully recover’ (80%) (mean 4.2). Seventy five percent (75%) agreed that

Table 1 Socio-demographic characteristics of the respondents

Category	Category	Frequency (N = 25)	Percentage (%)
Marital status	With a partner	9	36.0
	Without a partner	16	64.0
Level of education	No formal education	10	40.0
	Primary education	12	48.0
	Secondary education	3	12.0
Employment status	Self-employed	4	16.0
	Unemployed	21	84.0
Residence	Own house	5	20.0
	Stays with family	15	60.0
	Tenant	5	20.0
Self-reported diagnosis	Schizophrenia and other psychotic disorders	6	24.0
	Bipolar disorders	9	36.0
	Depression	4	16.0
	Others	6	24.0
Ever been treated for mental health problem	No	2	8.3
	Yes	22	91.7
	Non-response	1	
Daily activities, tasks, job or business in the past month	Not at all stressful	4	16.0
	Not very stressful	9	36.0
	A bit stressful	12	48.0
Age	Mean (SD)	36.6 (14.0)	
	Median	32.0	
	Range	(18–70)	
Number years lived with disability	Mean (SD)	19.6 (15.4)	
	Median	18.0	
	Range	(1–50)	
Monthly income (ksh.)	Mean (SD)	1120 (2818.4)	
	Median	0	
	Range	(0–10,000)	

“Medication can be an effective treatment for people with mental health problems (mean 4.1). About $\frac{3}{4}$ (76%) of the respondents agreed that “Psychotherapy can be an effective treatment for people with mental health problems” (mean 4.0) and None of respondents (0.0%) agreed that ‘Most people with mental health problems do not go to a healthcare professional to get help’ (mean 1.9).

Identification of Various Types of Mental Illness

A higher percentage of participants showed signs of basic knowledge about mental illnesses, as shown by

their affirmative responses. Respondents were most likely to agree that depression (88%) was a type of mental illness (mean 4.4). Recognition of schizophrenia, bipolar disorder, and drug addiction was 80% each with mean of 4.1; 4.0 and 4.2 respectively. Ninety-two percent of the respondents disagreed that Grief and Stress was a type of mental illness. The mean score of MAKS was 42.1; SD = 3.9. Additional information available in *supplementary material Table 1*.

Figure 2 presents the results of extent of anticipated discrimination among the respondents. The most prevalent reason for anticipated discrimination was for the items “If friends know about my mental health

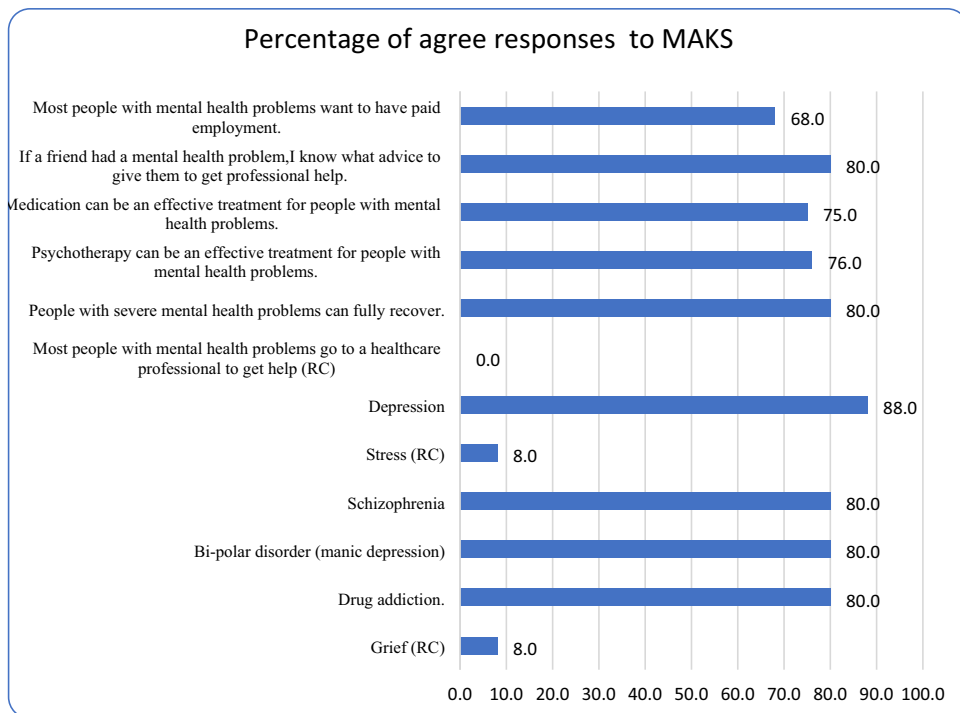


Fig. 1 Percentage of ‘agree’ responses to the individual items of Mental health knowledge schedule. *Note.* ^{R,C} Denotes reverse coded items

problem, they will treat me unfairly” and “If people in my neighbourhood know I have a mental health problem, they will treat me unfairly” in which 24% of the respondents agreed to the statements. None of the respondents (0%) agreed with statements on discriminations regarding religious officials, community, and health staff. *The mean score of QUAD was 0.91; SD = 0.27. Additional information is provided in the supplementary material Table 2.*

Table 2 presents the results of social functioning items as well as the mean and level of functioning. The mean social functioning score was 9.80; SD = 9.80. Close to 2/3rd (64%) of the respondents had low social functioning.

MAKS vs Socio-Demographics

There was a significant association between MAKS scores and education level of the participants ($p = 0.012$). Participants with secondary school level of education had significantly higher MAKS scores (mean 24.33; SD = 0.57) as compared to those with primary education (mean 23.00; SD = 2.76) and those with no formal education (mean 19.80; SD = 2.44).

Participants who were employed had significantly higher MAKS scores (mean 25.00; SD = 1.41) as compared to those who were unemployed (mean 21.29; SD = 3.84), $p = 0.018$. There was a positive correlation between MAKS scores ($r = 0.452$, $p = 0.023$) and monthly income. Although not statistically significant ($p = 0.062$) participants who had been treated with a mental health problem had higher MAKS scores (mean 22.23; SD = 2.93) as compared to those who had not been treated (mean 18.00; SD = 1.41).

QUAD vs Socio-Demographics

There was a significant association between QUAD scores and ever being treated with a mental health problem ($p = 0.05$). Participants who had been treated with a mental health problem had higher anticipated discrimination mean scores (mean 0.93; SD = 0.28) as compared to those who had not been treated (mean 0.68; SD = 0.05).

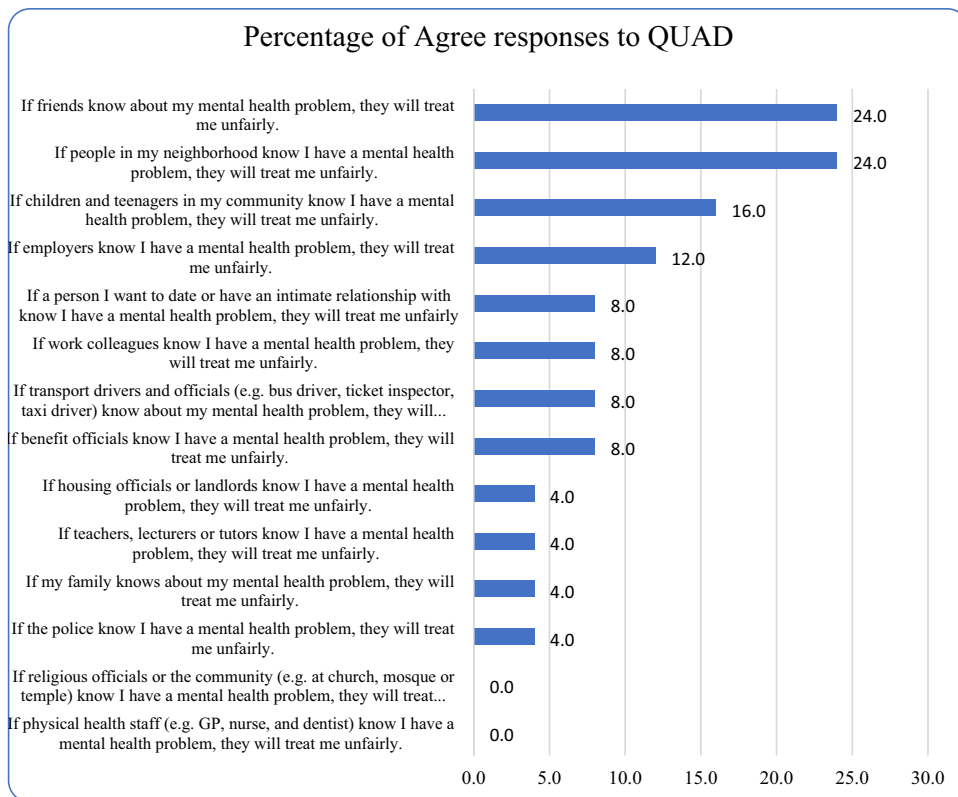


Fig. 2 Percentage of agree responses to the individual items of the Questionnaire on Anticipated discrimination

SFQ vs Socio-Demographics

There was a positive correlation between the number years lived with disability ($r = 0.529$, $p < 0.001$) and the social functioning scores. Although not statistically significant ($p = 0.096$), participants who were staying with their families had higher social functioning scores (mean 10.47; SD = 2.13) as compared to those who were staying in their house (mean 9.40; SD = 1.14) and those who were tenants (mean 8.20; SD = 2.28). Table 3 shows the scores of MAKS, QUAD and Social functioning by Socio-demographic variables.

Discussion

This study sought to investigate the mental health knowledge, anticipated discrimination and social functioning and their associations with sociodemographic characteristics among rural women with psychosocial disabilities in Kenya. The study found

that majority of these women were unemployed, single and staying with their families. These high rates of unemployment have implications of social participation and independent living and highlights the high burden of socioeconomic challenges amongst rural women with psychosocial disabilities. Previous studies have reported on the relationship between poverty and mental illness [23]. Even though our study did not measure poverty levels, the unemployment status and absence of economic independence could be an indicator of increased financial vulnerability.

Majority of the study participants had basic knowledge about mental illness. Participants who had a higher level of education had significantly higher MAKS scores. This is supported by previous studies in different contexts that showed that higher education level is correlated with deeper knowledge in various domains of mental health. Such knowledge is shown to improve the quality of life of people with psychosocial disabilities [24, 25]. Our findings conform to the idea that higher general level of education also correlates to better mental health knowledge. Therefore, it is

Table 2 Responses to individual Items of Social functioning

	Social functioning	Response	Frequency (N = 25)	Percentage (%)
1	I complete my tasks at work and home satisfactorily	Most of the time	11	44.0
		Quite often	9	36.0
		Sometimes	4	16.0
		Not at all	1	4.0
2	I find my task at work and at home very stressful	Not at all	8	32.0
		Sometimes	15	60.0
		Quite often	1	4.0
		Most of the time	1	4.0
3	I have no money problems	Slight worries only	2	8.0
		Definite problems	10	40.0
		Very severe problems	13	52.0
4	I have difficulties in getting and keeping close relationships	No problems at all	9	37.5
		Occasional problems	4	16.7
		Some problems	11	45.8
5	I have problems with my sex life	No problems at all	9	37.5
		Occasional problems	6	25.0
		Moderate problems	9	37.5
6	I get on well with my family and other relatives	Yes, Usually	11	45.8
		No, Some Problems	4	16.7
		No, Severe Problems	9	37.5
7	I feel lonely and isolated from other people	Not at all	6	24.0
		Not usually	16	64.0
		Much of the time	3	12.0
8	I enjoy my spare time	Very much	3	12.0
		Sometimes	20	80.0
		Not at all	2	8.0
Social Functioning		High Social Functioning (< 10)	9	36
		Low Social Functioning (> = 10)	16	64
Social Functioning		Mean ± SD	9.80	2.4

essential that interventions that seek to support persons with psychosocial disabilities prioritize improvement of overall education access for people with psychosocial disabilities and the need to focus the mental health awareness campaigns on women with lower educational levels. Previous studies have shown that generally in Africa, there is a poor understanding of mental illness [26–28].

Yu et al. [29] in their study on health seeking intentions and preferences in China found that gender was a key determinant of health seeking behavior. This could therefore explain why majority of the participants in the study had already sought medical

help for their conditions. Further, they also noted that higher education, higher social health and mental health knowledge and physical causal attribution were predictors of health care seeking. It is pertinent to state that although majority of our study participants had at one point sought medical care, services were limited, and most are not currently receiving treatment.

The most reported source of anticipated discrimination was in regard to friends, neighbors and teenagers in the community. However, they did not anticipate any discrimination from religious officials and health staff. This implies that interventions should target these groups to reduce the impact of

Table 3 Differences in scores of MAKS, QUAD and SFQ by Socio-demographic Variables

Variables	Category	MAKS Mean ± SD	<i>p</i>	QUAD Mean ± SD	<i>p</i>	SFQ Mean ± SD	<i>p</i>
Age ^a	18–30 years	21.00 ± 3.13	0.113	1.00 ± 0.32	0.456	10.00 ± 2.37	0.453
	31 and above	22.57 ± 2.79		0.84 ± 0.20		9.64 ± 2.02	
Marital Status ^a	With a partner	22.22 ± 3.03	0.665	0.88 ± 0.28	0.345	9.11 ± 1.76	0.206
	Without a partner	21.69 ± 3.04		0.93 ± 0.27		10.19 ± 2.29	
Level of Education ^b	No formal education	19.80 ± 2.44	0.012	0.85 ± 0.14	0.526	10.50 ± 2.17	0.300
	Primary Education	23.00 ± 2.76		0.95 ± 0.23		9.33 ± 2.15	
	Secondary education	24.33 ± 0.57		0.98 ± 0.68		9.33 ± 2.08	
Employment Status ^a	Self-employed	25.00 ± 1.41	0.018	0.77 ± 0.34	0.682	8.25 ± 2.06	0.144
	Unemployed	21.29 ± 2.85		0.94 ± 0.25		10.10 ± 2.07	
Residence ^b	Own house	21.20 ± 1.92	0.401	0.93 ± 0.35	0.808	9.40 ± 1.14	0.096
	Stay with family	21.60 ± 3.48		0.94 ± 0.24		10.47 ± 2.13	
	Tenant	23.40 ± 1.95		0.80 ± 0.30		8.20 ± 2.28	
Ever Been Treated for mental health problem ^a	No	18.00 ± 1.41	0.062	0.68 ± 0.05	0.054	11.00 ± 0.00	0.341
	Yes	22.23 ± 2.93		0.93 ± 0.28		9.59 ± 2.20	
Daily activities, tasks, job or business in the past month. ^b	Not at all stressful	21.75 ± 3.30	0.951	1.07 ± 0.32	0.589	9.00 ± 0.82	0.436
	Not very stressful	21.67 ± 3.39		0.90 ± 0.32		10.11 ± 2.09	
	A bit stressful	22.08 ± 2.84		0.86 ± 0.21		9.83 ± 2.52	
Years Lived with disability	Spearman correlation	0.024	0.908	− 0.135	0.521	0.529	< 0.001
Income in Kshs. per Month	Spearman correlation	0.452	0.023	− 0.088	0.677	− 0.306	0.136

^aMann-Whitney U Test; ^bKruskal Wallis Test

discrimination on people with psychosocial disabilities, especially the women. Further, our study found that anticipated discrimination was more for those who had been treated with a mental health problem. Even though a small percentage of the respondents indicated that employers would unfairly treat them in the event they found that they had a mental health problem, these rates could be higher in the population considering that majority of the respondents in this study were un-employed.

Majority of the participants in the current study had low social functioning in the areas of execution of daily tasks, personal and familial relationships, financial concerns, sexual health and leisure activities; with an association with anticipated discrimination for those who had been treated with a mental health problem. The low social functioning in our study participants is worrisome and perhaps not surprising on account of the high rates of unemployment. Consequently, individuals with previous experiences of discrimination were less likely apply for jobs, engage in education or have interpersonal relationships. In addition to the impact of mental illness, the

association between mental illness, unemployment and impaired social functioning has been previously reported [22, 30–32]. Although we did not find significant differences between low social functioning and sociodemographic characteristics, other studies have found significant association with employability [22]. This could partially be explained by the fact that our sample was small and that only 16% were self-employed and 84% were unemployed.

While majority of respondents in this study had low social functioning, it is notable that participants staying with their families had higher social functioning scores. This finding is corroborated by a previous study which showed that family and social network are relevant for recovery and wellbeing in person with psychosocial disabilities [33]. It is also important to note that risk of psychosocial disability is associated with poverty, low education and unemployment and limits physical accessibility and access to information which limits social participation [5]. This is true for the current study where majority of the participants were unemployed and had low levels of education. Furthermore, it is estimated that more than 60% of the

population are living on less than one USD a day with heavy reliance on subsistence farming [12].

Most of the participants reported a desire for paid employment. This finding is very interesting and highlights the desire of most persons with psychosocial disabilities for work and employment and the need for interventions to support their right to employment. There was a significant association between MAKS and employment. The study participants who were employed had significantly higher MAKS scores compared to those. Furthermore, participants treated with a mental health problem had higher MAKS scores compared to those who had not been treated. A study by Devine et al. [34] found that individuals with psychosocial disability who were employed had higher scores of mental health knowledge compared to those who were unemployed [34]. Participants' mental health and employment status may influence their narratives of wellbeing. Although in this study we found no correlation between unemployment and social functioning, it is interesting to note the similarity in the percentage of those who were employed and self-reported poor social functioning. Previous studies have shown in addition to factors of specific to mental illness, some of the barriers to employment, included work identity crisis, non-supportive work environments, social economic status and social exclusion. Moreover, support from families played a huge factor in seeking of employment for PWPDP [35]. Psychosocial interventions are effective for improving social functioning when delivered in out-patient and primary care levels [36, 37]. This is because poor functioning is a risk for other emerging mental health problems which might lead to marginalization and economic disadvantage in the long term [38]. According to Lund and colleagues the vicious cycle of poverty and depression may be explained by social drift and causation [39]. Therefore, participant's unemployment status may worsen their experience of mental illness and poverty, which may also have predisposed them to mental illness. Previous studies have reported that poor mental health status is associated with low productivity, increased stigma and an increase in health expenditure [5, 39]. It is essential to state that the small sample of our study population may limit the generalization of the findings. Future studies with higher samples are needed to investigate correlations between these domains and compare different settings. Additionally, further research should examine why

previous treatment for mental illnesses leads to higher expectations of discrimination.

Conclusion

Our study revealed that women who are employed and have a higher level of education have higher levels of mental health knowledge and better health seeking behaviors. Education plays a role in improving health seeking behaviours for people with psychosocial disabilities, thus the need for enhanced mental health awareness particularly for rural people with low levels of education. Poor social functioning and discrimination are some of the factors that impede work and employment for women with psychosocial disability. Mental health is a human right and the provision of basic health services in addition to opportunities of education, work and employment is likely to improve the lives of women with psychosocial disabilities in Tana River and Kenya. It is essential that the government as a duty bearer prioritizes and addresses the health and socioeconomic needs of women with psychosocial disabilities to ensure their recovery and equitable participation in society.

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Data Availability Data is available upon written request to the corresponding author.

Declarations

Conflict of interest The authors declare that they have no competing interests.

Ethics Approval The study protocol was approved by Maseno University Ethics Review Committee (MUERC/00851/20).

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