

# KNOWLEDGE AND PERCEPTIONS ABOUT MENTAL ILLNESSES AMONG KENYAN IMMIGRANTS LIVING IN JYVASKYLA, FINLAND

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<p>ABSTRACT</p> <p>The purpose of the study was to find out the perceptions and the knowledge about mental illnesses among Kenyan immigrants living in Finland. The aim is to provide information that can be utilized in health care sector, by policy makers and different stakeholders when planning and carrying out culturally sensitive health care services for immigrants. The research was carried out among Kenyan immigrants living in Jyväskylä, Finland.</p> <p>The qualitative method was used to carry out the study. The data collection was done by interviewing three Kenyans who had lived in Finland for more than one. The interviews were conducted in May 2013 and data collected was analysed by using thematic analysis.</p> <p>The finding showed that Kenyans interviewed had knowledge about mental illnesses. Most of them were aware of sorts of treatments and services available for mentally ill people. Despite having knowledge about mental illnesses and believing that mental illnesses can be cured, they still maintain cultural beliefs and perceptions about mental illnesses. Therefore, there is need for more education in order to eradicate the above cultural beliefs among Kenyans regarding mental illnesses.</p> <p>Further study could be done on the same subject using large number of participants incorporating Kenyans living in other cities of Finland. This is because the study was only done in Jyväskylä and Kenyans are currently living all over Finland.</p>		
Keywords Mental illnesses, mental knowledge, perceptions, mental disorders		
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## 1. INTRODUCTION

Kenya is located in sub-Saharan region of Africa. Being one of the developing countries, it is faced with challenges in terms of poverty, economic decline, and lack of enough resources to meet the health needs and demands; mental health of the population being one of the concern (Kiima, Njenga, Okonji & Kigamwa 2004).

In Kenya there is shortage of mental health specialist, facilities, ignorance and stigma; however this lowers provision of quality psycho-social care (IRIN 2012). Lack of public knowledge about mental illness, inadequate number of psychiatrists have been found to be factors behind negative perceptions and attitudes public have towards mentally ill people and mental illness (Mindfreedom Kenya 2008).

The interest of this topic came up from observing how mental health in Finland is given priority, as compared to Kenya where citizens appears to have limited knowledge concerning mental illness. The purpose of the study was to find out the perceptions and the knowledge about mental illness among Kenyan immigrants living in Finland. The aim of the study is to provide information that can be utilized in health care sector, by policy makers and different stakeholders when planning and carrying out culturally sensitive health care services for immigrants.

## 2. DEFINATIONS AND CONCEPTS OF MENTAL HEALTH

Health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity WHO (2001:3). However, Andrew and Henderson (2005:1) added spiritual aspect and defined health as state of complete physical, mental, spiritual and social well-being and not merely the absence of disease or infirmity.

Mental health is defined as a state of good health or well-being, in which a person is able to cope with normal stressors of life, and can make rational decision concerning his or her daily life and simply not absence of sickness (WHO 2011). Mental health has many determinants such as psychological, social, biological and environmental factors which interact in different ways. Demographic factors such as age, gender and ethnicity are also vital determinants of mental health. These factors can affect mental health positively or negatively. Positive factors enhance and protect positive mental health thus reducing risk of developing mental disorder. However negative factors increase the possibility that mental disorders will occur (Barry & Jenkins 2007 p.5).

These factors are classified into three key areas. The first key area is Structural level factors which includes social, cultural and economic factors. The second is community level factor which includes sense of recognition, social involvement and sense of residency. The third factor is personal level which includes the ability to cope with thoughts and feelings, to manage life and ability to cope with stressful situation (Barry & Jenkins 2007 p.5). On the other hand, mental health knowledge expounds knowledge and beliefs about mental disorders, which assist in their recognition, management, or

prevention. Mental health knowledge also involves the capacity to identify specific disorders, knowing how to seek mental health information knowledge of risk factors and causes, of self-treatments, and of attitudes that promote recognition and appropriate help-seeking (Chikomo 2012)

Mental illness is defined as medical or psychological conditions that disrupt a person's moods, thinking, ability to cope with others and daily functions thus diminishing one's capacity for coping with ordinary demands of life (NAMI, 2011) According to Chikomo2011, mental illness is a psychiatric illness which symptoms are mostly characterized by behavioral or psychological impairment of functioning. It is usually associated with distress, disease, response to a particular event, or limited to social relations.

In clinical perspective, mental illness can be defined as a clinically identifiable set of symptoms relating to emotions, thinking, or behavior, usually associated with distress and impaired functions leading to activity limitations (DHA 2005).

## 2.1 Prevalence of mental illness

According to world Health report 2001, Mental and behavior disorders are not selective; therefore, they can affect anybody from any country or society regardless of gender, age, income or social status. The problem is common such that it's affecting more than 25% of all people at some times during their lives. It's also stated that the prevalence of mental illness among adult population at any given time is 10%. The report continues by stating that, around 20% of all patients visiting primary health care have been reported to have one or more mental health disorder.

In United States an estimated 26.2 percent of Americans from 18 years and above, about one out of four adults suffer from a diagnosable mental disorder yearly ,as applied to 2004 US census with population estimate of 57.7 million people. Mental illnesses are ranked to be the major cause of disability in Canada and US (NIMH 2012).

In African continent the prevalence of mental illnesses remains unknown due to lack of reliable records in facility- based information systems. The data available can only be found in form of estimate figures (Duncan 2012).Furthermore, (WHO 2010) pointed out that it was difficult to get clear picture as data collection was patchy. But according to Ndetei (2012) 'All indicators from the available epidemiological data suggest that the patterns and prevalence of mental disorders in Africa are similar to those found in High Income Countries, but that is as far as the similarities go'.

In Africa, 50% countries have mental health policies but many laws are out of date, where 70% of countries allocate less than 1% of their total health budget on mental health. Unavailability of reliable information concerning mental



illness, make it hard for policy makers to give priority despite the economic and social costs (WHO 2005).

Kenya is listed as one of the 70% African countries that sets aside less than 1% of its health budget to mental health care, even though one-quarter of the patient going to the hospital appears to have mental health symptoms.(Duncan 2012). A study done in Kenya (2012) to determine the prevalence of common mental disorders and socio-demographic risk factors showed that: Most common mental disorders largely comprise mixed anxiety depression (6.1%), panic disorder (2.6%), generalized anxiety disorder (1.6%) and depressive episodes (0.7%) (Jenkins , Njenga, Okonji, Kigamwa, Baraza, Ayuyo, Singleton, McManus &Kiima 2012).

### **3. TYPES OF MENTAL AND BEHAVIOR DISORDERS**

According to Chikomo (2011), mental illness is a psychiatric illness which symptoms are mostly characterized by behavioral or psychological impairment of functioning. It is usually associated with distress, disease, response to a particular event, or limited to social relations. Mental illnesses are neither as a result of personal weakness, lack of character or poor background. The good news is that there is possibility of people recovering from mental illness or disorder if they actively participate in an individual treatment plan (NAMI, 2011).

In this section the researchers are going to focus on the most common mental health disorders or illnesses. The most common mental disorders include depression, generalized anxiety disorder, panic disorder, phobias, social anxiety disorder, obsessive-compulsive disorder, and post-traumatic stress disorder (BPS & RCP, 2011).

#### **3.1 Depression**

Depression is a form of mental disorder that is characterized by lack of interest and enjoyment, low mood and variety of associated emotional, cognitive, physical and behavioral symptoms (BPS & RCP 2011). According to Mayo clinic (2012), depression is defines as medical illness that causes a constant feeling of sadness and loss of interest. "In United States depression affects 5-8 percent of adults each year. This corresponds to 25 million Americans who have an episode of depression yearly. Women are mostly affected by depression than men. Roughly 70 percent of women undergo depressive episode as compared to men(NAMI 2011). Depressive disorders

can prevail in different forms such as major depressive disorders and dysthymic disorder, Psychotic depression and Postpartum depression (postnatal depression).

Major depressive disorders is where the patient suffer from combination of symptoms that weaken his or her ability to cope with daily life activities, example , to eat, sleep ,work, study and pleasurable activities. Major depressive disorder can be disabling, to the extent of preventing one from performing normally. Dysthymic disorder (dysthymia)or mild chronic depression is where the patient have depressive episode for long period, may be more than one year. The symptoms of Dysthymic disorder are not as severe as in major depression. However, it does not disable the patient as in major depressive disorder though; the patient may find it hard to function normally. Psychotic depressive disorder is a severe illness where patient experience symptoms such as delusions, hallucinations or withdrawing from reality (MTN 2009).Postpartum depression (postnatal depression) is a type of depression that affects women after giving birth. It is characterized by episodes of fatigue, sadness reduced libido, crying, anxiety, and irregular sleeping patterns. Typically, this type of depression can happen within four to six months or even after several months (MNT2011).

### **3.2 Generalized anxiety disorder (GAD)**

Generalized anxiety disorder is a disorder characterized by worries which are long-term intense and excessive, the disorder is a quite common with high rate of comorbidity. In some cases, these excessive worries may interfere with daily operation, as people suffering from may exhibit physical symptoms such as fatigue, irritability and sometimes trembling. The cause of the disorder is

not fully know, but it is believed be caused by changes in brain chemical as well as genetics, life experience and stress.

(Evans,Ferrando,Findler,Stowell,Smart,Haglin 2008).The risk factors associated with generalized anxiety disorder are; female gender, childhood trauma, chronic or serious illness, genetics, stress, personality and substance abuse. (Simon 2009)

Generalized anxiety disorder has 5.7% estimated life time prevalence and the diagnosis is mostly associated with poor social and occupational functioning, distress as well as impaired quality of life (Roemer &Orsillo 2007).

Roemer&Orsillo (2007) continues by saying that generalized anxiety disorder is associated with impairment in multiple domains as per recent study done in primary care setting. The disorder affects about 25% Americans adults in their lifetime (Simon 2009). Normally ,psychological counseling and use of medications improves generalized anxiety disorder .To add on this ,lifestyle changes, relaxation techniques and learning coping skills can also help to improve the Generalized anxiety disorder (Mayo Clinic 2011)

### **3.3 Panic disorder**

Panic disorder is characterized by panic attacks which are sudden and repeated attacks of fear which last for several minutes or even longer. Panic attacks are associated with fear of disaster or losing control even in absence of real danger. It's also associated with strong physical reaction which may feel like heart attack and can occur at any time. A person with panic disorder may feel ashamed and discouraged because he or she cannot carry out normal life routines. The person normally worry about possibility of another attack

happening and try to avoid situations and places which may trigger the attack. Panic disorder usually begins at late teen age or early adulthood affecting more women than men. Panic attacks do not necessarily develop to panic disorder (NIMH 2010).

Panic disorder is believed to be caused by genetic dysfunction in brain chemical (neurotransmitters) such as dopamine, norepinephrine and serotonin. The condition has moderate heritability rates of 0.3% to 0.6% in estimation. Furthermore, life experience such as injury, illness, interpersonal conflicts, drug abuse and stress can cause panic disorder. (Memon 2011) . There are several types of Panic attacks such as; unexpected panic attacks, which have no warning indication or cue. Situationally bound panic attacks reappear predictably in temporal relationship to the cause. These attacks are associated with a specific phobia-type diagnosis. According to NHS (2012), one out of ten persons experience occasional panic attacks triggered by stressful event. In UK, estimates of one person out of hundred gets panic disorder which normally develops when they are in early adulthood.

### **3.4 Phobias**

Phobia is a form of anxiety disorder which is characterized by strong, irrational fear of something has little or no actual danger. There are different types of phobias such as, Acrophobia which is fear of height, Agoraphobia which is fear of public places, claustrophobia is the fear of closed-in places, social phobia a fear of social gatherings, hydrophobias fear of water (Medline Plus 2012). Normally, fear becomes phobia when one has exaggerated sense of danger about a particular situation or object (Murphy 2011). Usually, phobia

symptoms are not experienced until one face the situation or object that one fears. Examples of phobia symptoms can be; sweating, pounding heart, trembling, feeling unsteady and so on (Murphy 2011).

### **3.5 Obsessive-compulsive disorder (OCD)**

Obsessive –compulsive disorder is form of anxiety disorder that is characterized by unpleasant involuntary thought, that result to fear or worries by frequent upsetting thoughts (obsessions) and feeling irresistible urge to repeat certain behaviors (compulsions) aimed at reducing associated anxiety (NIMH 2010).According to Robinson, Smith, & Segal (2012),People with obsessive-compulsive disorder can be categorized as follows; Washers, they have hand washing and cleaning compulsions because they fear being contaminated. Checkers, they have habit of checking things repeatedly that they relate with danger, example whether the door is locked .Doubters and sinners, they are afraid of making mistakes with fear of punishment. Counters and arrangers, they are the people obsessed with keeping thing in order and proportional example, numbers, colors and arrangement. Hoarders, they compulsively hoard things that they don't need or use because they fear something bad if they through anything away.

### **3.6 Post-Traumatic Stress Disorder (PTSD)**

Post-Traumatic Stress Disorder is a serious condition that develops after a person has experienced or witnessed a terrifying event in which serious physical harm occurred or was threatened. People with post traumatic stress disorder have changed or damaged response to fear of frightening situation. They may feel frightened even if there is no danger. Post-Traumatic Stress Disorder can affect any person at any age or sex. This includes people who

have experienced incidence of war, accidents, sexual assaults, disasters, abuse and other serious experience. However, not everybody who has Post-Traumatic Stress Disorder has experienced traumatic episode, but one can get after a friend or family member is harmed or experiences danger (NIMH 2013).

Post-Traumatic Stress Disorder can be characterized by re-experiencing symptoms such as bad dreams and frightening thoughts, avoidance symptoms such as staying away from people, places and losing interest in previous enjoyable activities .The disorder is also characterized by Hyperarousal symptoms such as being tensed easily, difficulty sleeping and being easily worried (NIMH 2013).

#### **4. KNOWLEDGE AND PERCEPTIONS ABOUT MENTAL ILLNESSES**

In this section the researchers will describe knowledge and perceptions people have concerning mental illnesses, as per studies done in different countries worldwide.

Limited knowledge and devastating perceptions about mental illnesses remains a concern in various countries of the world especially in developing countries. This Lack of knowledge about mental illnesses has been found by various studies as a key cause of devastating beliefs people have about causes of mental illnesses. Some people belief that mental illnesses are not diseases but equated to possession of evil spirit, witchcraft or curse (Chikomo 2012).

Different Studies have shown that beliefs about causes of mental illnesses may affect patterns of seeking help, follow up and responses to treatment. For example, a study conducted in Nigeria showed that the negative attitude towards mentally ill persons is fuelled by lack of public knowledge concerning mental illnesses. The study went on by stating that, the help-seeking behavior of mentally ill persons is widely affected by public attitude and beliefs about mental illnesses (Kabir<sup>1</sup>, Iliyasu<sup>1</sup>, Abubakar<sup>1</sup> and Aliyu 2004). Another study done in Malaysia showed that, people equated the cause of mental illnesses to supernatural agents, possessions by spirits and witchcrafts. There are also myths that, mental ill persons are unpredictable, they can never be normal, are associated with danger and violence and psychiatric treatment is likely to cause brain damage as evidence by patient's



robotic-like expressions. This believes hinders help-seeking behavior of mentally ill persons (Khan,Hassali,Tahir& Khan 2011)

To continue, another study carried out in Kenya to determine the knowledge, attitude, beliefs and practice of mental illnesses among staff in general medical facilities found that, despite the staff's knowledge on recognition, diagnosing and treatment of mental illnesses, they still maintained their cultural views of mental illnesses. They had a view that mentally ill people are worthless, dirty, senseless, dangerous and unpredictable. The negative stereotypes and stigmatizing attitudes society has towards mentally ill persons leads to behavior that worsens the mind of a sick person (Ndetei, Khasakhala, Mutiso, Mbwayo2011).

Study done in Hong Kong to determine stigmatizing attitude towards individuals with mental illnesses showed that, there was high level of stigmatizing attitudes in the community. For example beliefs about the parents cause mental illnesses, strong opposition against establishing psychiatric community facility near their locality and unemployment for people with mental illnesses thus increasing burdens on clients' relatives by denying them practical and social support (Tsang & Tam 2003).

Another study done in Tanzania to determine knowledge and perception of community about mental illnesses revealed that community knowledge about mental illnesses was very poor. There was belief that mentally ill people cannot perform regular job, have friends and integrates in the community (Chikomo 2011).Religious misconception that mental illnesses are caused by sin, since intentionally breaking God's commandments results to behavior that is hurtful to self and to others (Chikomo 2011).Therefore, negative beliefs

about causes and lack of adequate knowledge have been found to be a key cause of negative attitudes people have about mental illnesses.

On the other hand, improved knowledge about mental illnesses has been reported to result in better attitude towards mentally ill people. Believing that mental illnesses are treatable can encourage mentally ill people to seek early treatment or help, thus resulting into better outcome (Khan, Hassali, Tahir & Khan 2011).

In Western world, mental illnesses are usually believed to be caused by psychosocial factors like childhood experiences or social environment. Despite biological factors being recognized as contributing factor to mental illnesses, they are not considered as important as environmental factors (Khan, Hassali, Tahir & Khan 2011). Although some studies imply that severe mental illnesses, such as schizophrenia are more likely to be caused by genetic factors, compared to common mental disorders, such as depression (Jorm, 2000). Causes of mental illnesses differs from each other from inborn chemical imbalance responsible for the development of illnesses like depression, bipolar disorder, and schizophrenia, to brain diseases, to psychosocial causes.

A survey carried out in Japan found that the most often cause of mental illness was problems in interpersonal relationships (Chikomo 2011). Correspondingly, a survey done in south Africa among 55% Afrikaans speaking, showed that 83% stated that schizophrenia was caused by difficulties in work or family relationship, or life stressful events (psychosocial stress). Whereas 42.5% thought it was brain disease or hereditary (medical disorder) (Chikomo 2011).

World Health Organization has acknowledged that, knowledge about the cause of mental illness varies across cultures and has never been favorable worldwide, thus calling need for public education and greater openness about mental illness. As a result, improved knowledge about causes of mental illness may lead to improved help seeking behavior and promote supportive attitudes to the mentally ill. Furthermore, adequate public knowledge about mental illness is one way to deal with negative perceptions people have towards mentally ill people (Chikomo 2011).

## **5 MENTAL ILLNESSES AS A CHALLENGE IN KENYA**

Kenya is one of the African countries located in Eastern part of Africa. It is borders Somalia to the east, Uganda to the west, Tanzania to the south, Sudan to the north and Indian Ocean to the southeast (State house Kenya's website.). According to (CIA 2013), Kenya had an estimate population of 43,013,341 by July 2012. Kenya has different ethnic groups which are Bantus, Cushites and Nilotes. These ethnic groups possess numerous indigenous languages whereby, English and Swahili are the official languages. Kenya has different religious groups such as Protestant 45%, Roman Catholic 33%, Muslim 10%, indigenous beliefs 10%, other 2% of which majority are Christian (CIA 2013),

The exact cause of most mental illnesses is not well known, although research has found that it can be caused by biological factors such as genetics, infection, brain defect and substance abuse. Psychological factors such as trauma, neglect loss of loved one and inability to relate with others can also cause be

one cause. Again, environmental stressors such as domestic violence and death are another cause (Katz 2012). This makes mental illnesses to remain a challenge.

In Kenya, shortage of specialists for mental illness has contributed to low psycho-social care. A big gap for treatment whereby there are 81 psychiatrists to care for population of 41.6 million, the big number of psychiatrists are in private sectors as compared to public sector which has about 25 psychiatrist and majority are in urban areas of which large population is in rural areas (IRIN 2012).

Poverty has usually been understood as lack of basic needs such as insufficiency of food, shelter and insufficiency of income to acquire what is necessary. In Kenya, poverty is one cause of mental illness. Most poor people live with intellectual and mental disabilities, for example poor grain harvest and low production of food experienced in 2007 and 2008 in many areas of the country resulted in hunger and left many people with mental distress. (Oginga 2009)

Traumatic events such as post election violence that was experienced after the 2007 general elections in Kenya, left numerous people from different communities with psychological scars .The affected people were left homeless ,displaced and vulnerable to human stressors such as rape and torture.(Oginga 2009)

## 5.1. Knowledge and beliefs about mental illness in Kenya

Kenya is one of the developing countries rich in social, extended family and cultural resources, though it is faced with challenges in terms of poverty, economic decline, and lack of enough resources to meet the health needs and demands; mental health of the population being one of the concern.(Kiima, Njenga, Okonji&Kigamwa2004).

Mental illness is widely misunderstood and stigmatized in Kenya. Most families have little or no knowledge about mental illness and how to support those who are ill. Mentally ill people are made fun of, blamed and criticized for their sickness. In many societies people believes that mental illness is not a disease but a curse that is caused by witchcraft and evil spirits. (USPKENYA 2012).

Although mental illness is misunderstood and stigmatized, the current situation indicates some improvements whereby local organizations are being formed and work in partnership with the government ministries. For example the pilot project in Kangemi informal settlement which has successfully incorporated mental health services in to the existing primary health care system. The project has managed to train health staffs in co-operation with government ministries of health and local government authorities. Also, traditional healers have benefited by receiving training in diagnosis and treatment of mental illnesses. Due to this co-operation, they have started to refer mentally ill people they are unable to cure to the clinic.(Basicneeds.org, read on 2<sup>nd</sup> June 2013)

## 5.2. Perceptions about mental illnesses in Kenya

The perception people have about mental illnesses has influence on the attitude towards people who are mentally ill. The discriminating behavior and attitudes which are negative towards mentally ill people are usually referred to as stigmas. The negative stereotypes and stigmatizing attitudes society has towards mentally ill persons, leads to behavior that worsens the mind of a sick person (Chikomo 2012). Due to these negative stereotypes and stigmatization, mentally ill persons become reluctant to seek treatment, help and develop fear of disclosing their mental problems (Chikomo 2012).

In Kenya, mental illness is widely misunderstood and stigmatized. Many people believe that mentally ill people are the only ones who are dirty collecting rubbish on the streets and some being locked in houses. Mentally ill people are made fun of, blamed and criticized for their sickness. In many societies mental illness is equated to madness and some equate mental illness to demon possession. ( USPKENYA 2012).

Studies have shown that negative attitudes towards people with mental illness are widespread among Kenyans. For example, a study carried out in Kenya to determine the knowledge, attitude, beliefs and practice of mental illness among staff in general medical facilities found that, despite the staff's knowledge on recognition, diagnosing and treatment of mental illness, they still maintained their cultural views of mental illness. They had a view that mentally ill people are worthless, dirty, senseless, dangerous and unpredictable. (Ndetei, Khasakhala, Mutiso, Mbwayo 2011 ).

## **6. PURPOSE, AIM, AND RESEARCH QUESTIONS OF THE STUDY**

The purpose of the study is to find out knowledge and perceptions about mental illnesses among Kenyan immigrants living in Jyväskylä, Finland. The aim of the study is to provide information which can be utilized in health care sector, by policy makers and different stakeholders when planning and carrying out culturally sensitive health care services for immigrants.

In order to achieve the purpose and aims of the research, the following questions were addressed.

1. What are the perceptions of Kenyan immigrants about mental illnesses?
2. What knowledge do Kenyans immigrants have about mental illnesses?
3. How has living in Finland affected the perception of Kenyan immigrants towards mental illnesses?

## 7. IMPLEMENTATION OF THE RESEARCH

### 7.1 Research Methodology

The study used a qualitative method; Qualitative research method is a way to gain insight through discovering meanings, not only by establishing causality but through improving the understanding of the whole (Polit & Beck 2008, 219). Polit & Beck continues by saying that a qualitative research method is a means of exploring the depth, richness and understanding of phenomenon as they exist in the real world. According to Shank (2002 p.5) qualitative research is “a form of systematic empirical inquiry into meaning “By systematic he means that the data will be in a planned and orderly manner, following the rules agreed by the members of the qualitative research community. By empirical he means that this type of inquiring information is based on the world of experience. In this case the researchers try to understand how other make the good judgment of their experiences.

However, Denzin and Lincoln(2000 p.3) argues that qualitative research includes an interpretive and naturalistic approach: This means that qualitative researchers study things in their natural settings, attempting to make sense of, or to interpret phenomena in terms of the meanings people bring to them. Qualitative research was used in this study because the researchers want to find out the perceptions and knowledge Kenyans immigrants in Jyvaskyla Finland have about mental illnesses. According to Bailey C,2002, qualitative research investigates the way and how of decision making not only when, what and where.



## 7.2 Recruitment and Participants

In this research, the purposive sampling technique was used to recruit the group. Purposive sampling is a type of non-random sampling whereby decisions concerning units to be used in the sample are taken by the researcher, following some criteria such as willingness and capacity to participate in the search or have knowledge concerning the research issue. This means the researcher selects units to be sampled based on their knowledge and the productivity of sample to answer the research questions ( Burns & Grove. 2nd edition). Three Kenyans who had stayed in Jyväskylä, Finland for more than one year were selected into the sample group. It seems that after one year people have started adapting to new culture.

The participants are individuals participating in a study by actively taking part in a research (Polit & Beck 2008, 55). In this study the participants were Kenyan immigrants living in Jyväskylä, Finland. The participants were contacted by phone call and face to face to seek their consent to participate in the study. Those who agreed to participate and meet the criteria of selection were included in the study and were requested to sign a consent form. According to Lobiondo (2006, 261), exclusion and inclusion is used to select the sample from the possible units. Inclusion criteria includes characteristics the participant should have in order to participate and exclusion criteria are characteristics which will exclude individuals from the study (Bloom & Trice 2007). The inclusion criteria for the study was Kenyan immigrant who had lived in Jyväskylä, Finland for more than a year. The exclusion criteria for the

sampling group were Kenyans who had stayed in Finland for less than one year and not willing to participate.

### **7.3 Data Collection**

The researchers collected the data in May 2013. The interviews were facilitated by use of theme interview. Themes are broad categories of information that tries to define a setting or describe what happened. This gives interviewer a chance to explore particular response further (Schorn 2000). The interviews were conducted using three themes, which were based on research questions. The interview questions were prepared in English (Appendix 1). Before the commencement of data collection, the purpose of the study was explained to the participants. They were also provided with consent form (appendix 2) which they were supposed to sign if they agreed to participate in the interview.

The interviews were conducted individually face-to-face and tape-recorded to ensure that no verbal productions were lost and large amount of data was stored at the same time. Face -to -face interview enables the researcher to establish relationship with the participants thus gaining their co-operation. The researcher is also able to clarify unclear answers and when appropriate, seek follow-up information (Leedy and Ormrod 2001). As defined by (Polkinghorne 2005, 137 – 145), face-to-face interview is a method of data collection technique where the subject or the interviewee gives the needed information verbally in face to face situation. It continues as a professional conversation that consists of a give-and-take dialectic in which the interviewer follows the conversational threads opened up by the interviewee and guides the conversation toward producing a full account of the experience under investigation. Face to face interview has also other advantages in increasing

the dependability which includes serious approach by respondent resulting in accurate information. It also makes it possible for interviewer to ask and clarify in-depth questions and he or she can give help if there is a problem. Furthermore, it gives a room for investigating motives, feelings and characteristics of respondent such as tone of voice, facial expressions and hesitation (Opdenakker 2006). Participants chose to be interviewed at interviewers homes where they were more comfortable doing the interviews. In average, every interview took 15-25 minutes per each interviewee

#### **7.4 Data Analysis**

The data analysis was done during summer 2013, using thematic analysis method. Thematic analysis is a qualitative analytical method which is used to identify, analyze and report themes by reading and re-reading the data. However, it searches for themes which appear as being important to the description of the phenomenon. (Fereday & Muir-Cochrane 2006)

The authors listened to the audio taped data many times and transformed it into a written format using formal English. The data was written down word by word but all the information which could have revealed the identity of the participants such as names was omitted. The transcribed data produced average notes of 2A4 sized papers of Microsoft word 2007 per interviewee, the font was Palatino Linotype and size used was 12. The total notes of the three participants totaled to 6 pages.

The authors familiarized with the content and themes by reading the data in details. The identification, definition of categories and theme coding was done. The authors assigned different colors to different themes in order to

differentiate them. The responses from participants which fall on the same theme were compiled together and give same color. Themes were derived from research questions. The responses that were not in relation to the themes were removed. When reporting the results suitable quotes in the data were used to illustrate the meaning of themes.

## 8. FINDINGS

### 8.1 Knowledge about mental illnesses

One of the participant defined health as state where body, soul and mind are well intertwined to deliver all functions of the human being while mental illnesses are where the mind is not in a good working condition .Another one said that health is physical and mental wellness of the body and mental illnesses is state of the mind where one is not in peace.

*... Health is having a good state of condition without illness, disease, deformity that affects daily living. Mental illnesses is where you have a disturbance that can affect the way you perceive things,... or the way you interact with people or do daily activity .*

Different views were raised about causes of mental illnesses. One of the participants said that mental illnesses can be caused by lack of exercise, poor lifestyle and poor diet. Whereas another participant thought that stress, drug addiction and unconducive environment can cause mental illnesses. The third participant said that upbringing, circumstances like the environment one is subjected to, abuse of substances like alcohol and drugs and genetics deformities.

Participants had different views concerning the sorts of treatment given to mentally ill people. One participant said that mentally ill people are isolated from society and some are taken to hospital depending with condition they are in. Another participant said that change of the environment, family and community support can alleviate some mental problems like stress and depression. However another participant thought that use of medication and psychiatric counseling can be a cure for mental illnesses.

About services available for mentally ill people, out of the three interviewees, one had no idea about services available for mentally ill people in Kenya. The other two of the participants were aware of Mathari mental hospital which is the main mental hospital in Kenya. According to one of them;

*“I know Mathari mental institution, that cater for all mental health related issues, they get medication care and aggressive are rocked up and given severance. However they are all given same kind of treatment despite of difference in mental cases which he thinks is not good. Other hospitals diagnoses and send them to mathari,”*

The participants gave their views concerning services given to mentally ill people in Finland though one of the participants had no idea concerning the services given to mentally ill people in Finland. From the views of the one participants,

*“Mental illnesses are taken seriously, there is a clear distinction between children and adult and treatment delivered by specialist”.*

while the other one said that patients are categorized according to severity of the mental problem they have. There is well planned psychiatric services. In Finland there are organized services, able to know what next, they prepare you early.

## 8.2 Perceptions about mental illnesses

The participants had different perceptions concerning mental illnesses and mentally ill people. One of the participants perceives mentally ill persons as mad people. The other participant perceives mental illness like any other illness and should be checked at an early stage.

*“I perceive mental illness like any other illness and should be checked at an early stage.”*

Participants had different views cornering mental ill people having friends and job. One of the participant said that it is not possible for mentally ill people to have friends because he thinks that they have low level of interaction. He added that, mentally ill people cannot have job and maintain them because he thought mental illness is a condition that affect the functionality of the brain and one need brain to perform work and maintain it. Another participant thought that mentally may work and make friends but depending on the stage of the illness.

*“they can work and make friends depending on the stage of the illness. In first stage, mentally ill people can make friends and they can carry out their daily activates, the problems is when people brand you as mentally challenged that when there are afraid of what you may do.”*

Participants had related views concerning beliefs about mental illness; they believe that mental illnesses can be cured using medical therapy and they also thought that some needs spiritual interventions. They also shared cultural beliefs such as mental illness can be caused by witchcraft, curse or punishment due to wrong doing.

*“Metal illnesses can be differently categorized. Some believe that people are mentally challenged because their mother did something long or witch craft”*

### **8.3 Living in Finland and perceptions about mental illnesses**

All the participants gave positive comments about how living in Finland has affected their perceptions about mental illness. One participant said that he has come to realize that mental illnesses are treatable. He never thought that depression is an illness, but his views have changed. He perceives depression as an illness which can be treated. The other participant said that he used believe that mental illness is due to personal fault but for now the perception he had have changed. Whereas another participant said that living in Finland has been an eye opening for her. According to her she has realized that mental illness is not due to bewitching; is an illness like any other illness the difference is that it's not physical illness.

*“I used to believe mental illness was due to personal fault but now I can have empathy to mentally ill people than before”*

*“Living in Finland has been eye opening; realized most can be cured, nothing like bewitching. Mental illness is just like any other illness difference is that it's not physical but it has to do with mind”*

## **9 DISCUSSION**

### **9.1 Ethical Issues**

According to Pilot (2008), the participants in a research study should not be exposed to circumstances which they are not prepared to. They should be guaranteed that the information they provide will be confidential and it will not be used in any way apart from agreed reasons.

When people are used as research participants, the researcher has to minimise harm and maximise benefits. Therefore the researcher must stick on codes and ethics for protecting human rights. Furthermore the researcher must be prepared to stop a research if there is reason to suspect that its continuation can cause harm (Polit&Beck 2010).

The purpose and the aim of the study were explained to the participants. The participants were requested to participate in the study at their own will. They were also requested to sign the consent form that guaranteed them that autonomy, confidentiality and anonymity will be maintained. Participants were also assured that the information they gave will be destroyed after completing the study.

### **9.2 Credibility, Dependability and Transferability**

As most qualitative researchers seek to evaluate the quality of data findings, Polit& Beck (2010) came out with four major ways to establish trustworthiness of qualitative data .Credibility of data is the first criterion which emphasizes on the confidence in the truth of the data and its interpretation process. In the research process it is important for the researcher to establish confidence in the truth of the research finding (Graneheim&Lundman 2003).In order to



establish credibility, it is also important to choose the most appropriate method of data collection (Graneheim & Lundman 2003). In this study face to face interviews were used and the interviewees' responses were recorded according to the way they stated them, thus ensuring credibility.

Dependability is the second criteria, which refers to the consistency of the data over time and conditions. Furthermore, dependability must be able to justify if the study results would be repeated in case the inquiries were replicated in the same context and with same participants (Polit and Beck 2010, 492). To ensure dependability of research findings, the researchers used face to face interview method in order to ensure that the interviewees understand and answer the questions appropriately.

Transferability is the third criteria, referring to the extent to which the results of a qualitative research can be utilized by other population or settings which are same with those in the study. To facilitate transferability, it is important to give a clear and distinct description of culture and context, selection and characteristics of participants, data collection and process of analysis (Parahoo 2006, p. 410). In this study, the descriptions of all the parts of the study were given accurately. Therefore, the study can be used to provide information which can be utilized in health care sector, by policy makers and different stakeholders when planning and carrying out culturally sensitive health care services for immigrants.

The fourth criteria is conformability which establishes that the data results and interpretation are linked, which means they are not assumptions. In order to achieve this criterion the results must reflect participants response and the condition of the inquiry and not the biases or perspective of the researcher (Polit & Beck 2010, 492). In this study the participants were allowed to express

their opinion and perspectives about knowledge and perceptions in their own words.

### **9.3 Discussion about main findings**

According to the findings of the study, the participants had distinguishable knowledge about what health is and what mental illnesses are. They understood the relationship between health and mental illnesses. As stated by WHO (2001:3), Health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity while According to Chikomo2011, mental illness is a psychiatric illness which symptoms are mostly characterized by behavioral or psychological impairment of functioning. It is usually associated with distress, disease, response to a particular event, or limited to social relations.

Misuse of drugs was mentioned by two participants as cause of mental illnesses according to their knowledge. Environmental stressors, genetic deformities and poor lifestyle were also mentioned as causes of mental illnesses. These findings are similar to those documented by Katz (2012), in his research he found that mental illnesses can be caused by biological factors such as genetics and substance abuse, psychological factors and environmental stressors.

Findings found that there are various treatments given to mentally ill people. Respondents said that, change of the environment, family and community support can alleviate some mental problems like stress and depression. It was also mentioned that mentally ill people can be taken to hospital and be given medication therapy and psychiatric counseling. Mathare mental hospital which is the main mental hospital in Kenya was mentioned by two

participants as a place where mentally ill people can get mental health services. This was an indicator that they were aware of services meant for mentally ill people in Kenya.

Participants perceived mental illnesses like any other disease though one perceives mentally ill people as crazy people. The respondents also thought that it is possible for the mentally ill people to have friends, enjoy social life and have job. However, one respondent perceived it would be hard for the mentally ill persons to socialize and have a job because of their low level of interaction. This is similar to a study done by Chikomo (2011), to determine knowledge and attitudes of Kinondoni community towards mental illness. The study showed that it's hard for people with mental illnesses to have good friends.

According to the findings the participant had personal beliefs that mental illnesses can be cured by medical therapy although they had cultural beliefs that some mental illnesses need spiritual interventions if the cause is witchcraft, curse or punishment due to wrong doings. This is similar to a study done by Ndeti, Khasakhala, Mutiso, Mwayo (2011) to determine the knowledge, attitude, beliefs and practice of mental illness among staff in general medical facilities in Kenya. The study found that, despite the staff's knowledge on recognition, diagnosing and treatment of mental illness, they still maintained their cultural views of mental illnesses. However, living in Finland has positively affected participants' perceptions about mental illnesses. Their way of thinking about causes of mental illnesses has greatly improved. They now take mental illnesses as any other illness but not an illness caused by personal fault

## 10. CONCLUSION AND RECOMMENDATIONS

The study findings demonstrate that the participants had knowledge about mental illnesses. Most of them were aware of sorts of treatments and services available for mentally ill people. Medical therapy, psychiatric therapy, family support and environmental change were mentioned by respondents as ways of tackling mental illnesses.

However, despite having knowledge about mental illnesses and believing that mental illnesses can be cured, they still maintain cultural beliefs or perceptions such as mental illness can be caused by witchcraft, curse or punishment due to wrong doing. Therefore, there is need of more education in order to eradicate the above cultural beliefs among Kenyans regarding curses of mental illnesses.

The researchers recommends further study to be done on the same subject using large number of participants, incorporating Kenyans living in other cities of Finland. This is because the study was only done in Jyväskylä and Kenyans are currently living all over Finland.

## 11. REFFERENCES

Andrews, G. & Henderson, A.S. 2005. Public knowledge and attitudes to mental disorders: a limiting factor in the optimal use of treatment services.

Bailey C, Froggatt K, Field D, Krishnasamy M. The nursing contribution to qualitative research in palliative care 1990-1999: a critical evaluation. *J AdvNurs*. 2002 Oct;40(1):48-60.

Bloom K. C. & Trice L. B. (2007) Sampling. In *Introduction to Nursing Research .Incorporating Evidence-Based Practice* (Boswell C. & Cannon S., eds), Jones and Bartlett Publishers, Boston, p. 121-140.

Bulletin of the World Health Organization 2010. The mental health workforce gap in low- and middle-income countries: a needs-based approach. Published 22<sup>nd</sup> Nov 2010. Accessed on 26.12.2012

<http://www.who.int/bulletin/volumes/89/3/10-082784/en/index.html#>

Burns Nancy & Grove Susan K. *THE PRACTICE OF NURSING RESEARCH: conduct, critique& utilization*. 2<sup>nd</sup> Edition

Central Intelligence AgencyCIA . 2011. *The World Fact Book: Kenya*. Revised 18<sup>th</sup> January 2013, Accessed on 31st January 2013.

<https://www.cia.gov/library/publications/the-world-factbook/geos/ke.html>

Chikomo John Geoffrey 2011, knowledge and attitudes of the kinondoni community towards mental illness.

Duncan Jonathan 2012. Africa is a country. The delusions in decontextualizing mental illness. December 14, 2012. Accessed on 26.12.2012

<http://africasacountry.com/2012/12/14/the-delusions-in-decontextualising-mental-illness/>

Denzin N. and Lincoln Y. (Eds.) (2000). Handbook of Qualitative Research. London: Sage Publication Inc.

Department of Health and Aging (DHA) 2005. Homelessness and mental health linkages: review of national and international literature. modified: May, 2005. Accessed on 10<sup>th</sup> dec 2012

<http://www.health.gov.au/internet/publications/publishing.nsf/Content/mental-homeless-toc~mental-homeless-1~mental-homeless-1-3>

Evans Susan a, Ferrando Stephen, Findler Marianne, Stowell Charles, Smart Colette, Haglin Dean 2008. Mindfulness-based cognitive therapy for generalized anxiety disorder. Journal of Anxiety Disorders 22 (2008) 716–721. Posted 18 July 2007

Fereday, J. & Muir-Cochrane, E. 2006. Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. International journal of qualitative methods 5 (1) March 2006.

Graneheim, U. & Lundman, B. 2003. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. Nurse education today. 2004. 24, 105–112.

Hector W.H. Tsang and Phidias K.C. Tam 2003. Stigmatizing attitudes towards individuals with mental illness in Hong Kong: implications for their recovery.

Published online: 5 JUN 2003

Journal of Community Psychology, Vol. 31, No. 4, 383–396 (2003)

Hon. Oparanya Wycliffe Ambetsa 2010. Minister of State for Planning, National Development and Vision 2030. 2009 population & housing Census results. 31st August, 2010

Integrated Regional Information Networks (IRIN) Kenya: Poor state of mental healthcare, Updated: Thursday, 03 May 2012.

<http://www.unhcr.org/refworld/country,,,,KEN,,4ed8af112,0.html>

Jenkins Rachel, Njenga Frank, Okonji Marx, Kigamwa Pius, Makheti, Baraza James Ayuyo, Singleton Nicola, McManus Sally and Kiima David 2012. Prevalence of Common Mental Disorders in a Rural District of Kenya, and Socio-Demographic Risk Factors. Published: 9 May 2012.

Kabir<sup>1</sup> Mohammed, Ilyasu<sup>1</sup> Zubair, Abubakar<sup>1</sup> Isa S and Aliyu Muktar H, Perception and beliefs about mental illness among adults in Karfi village, northern Nigeria, BMC International Health and Human Rights 2004, 4:3, Published: 20 August 2004,

BMC [<http://www.biomedcentral.com/1472-698X/4/3#B4>]

Katz Marina, 2012. WebMD. Anxiety & Panic Disorders Health Center.

Reviewed on February 20, 2012. Accessed on 9.2.2013.

<http://www.webmd.com/anxiety-panic/mental-health-causes-mental-illness>

Khan TM, MA, Hassali H Tahir , Khan A 2011.A Pilot Study Evaluating the Stigma and Public Perception about the Causes of Depression and Schizophrenia.3 Jan 2011.

Iranian J Publ Health, Vol. 40, No.1, 2011, pp.50-56

Kiima David Musau, Njenga Frank G., Okonji Max M. O. and Kigamwa Pius A. Kenya mental health country profile, Informa Health care 2004,Vol. 16.

Accessed on 28.4.2012.

[<http://informahealthcare.com/doi/abs/10.1080/09540260310001635096>]

Robinson Lawrence, Smith Melinda, and Jeanne Segal 2012.Obsessive-Compulsive Disorder (OCD): Symptoms and Treatment of Compulsive Behavior and Obsessive Thoughts. Updated: November 2012, Accessed on 6<sup>th</sup> Jan 2012.

[http://www.helpguide.org/mental/obsessive\\_compulsive\\_disorder OCD.htm#top](http://www.helpguide.org/mental/obsessive_compulsive_disorder OCD.htm#top)

Roemer Lizabeth & Orsillo Susan M. 2007.An Open Trial of an Acceptance-Based Behavior Therapy for Generalized Anxiety Disorder.Behavior Therapy 38 (2007) 72–85

Leedy.P.D&Ormrod.J.E 2001,Practical Research: Planning and Design, 7<sup>th</sup>edn, Merrill perentice Hall, Upper Saddle River, New Jersey.

Mayo Clinic Staff 2011,Generalized anxiety disorder Sept 2011

<http://www.mayoclinic.com/health/generalized-anxiety-disorder/DS00502>



McDonald, & O'Hara 1998, cited in Health Education Authority 2001, Making it happen: a guide to delivering mental health promotion, UK Department of Health, London, Available at [www.nelf.nhs.uk/nsf/mentalhealth/makeithappen/ch3/3\\_0.htm](http://www.nelf.nhs.uk/nsf/mentalhealth/makeithappen/ch3/3_0.htm).

Medical new today(MNT 2009). What Is Depression? What Causes Depression? Article Date: 07 Apr 2009 - 10:00 PST. Accessed on 1<sup>st</sup> Jan 2013. <http://www.medicalnewstoday.com/articles/8933.php>

Medical new today(MNT 2013).What Is Postpartum Depression? What Is Postnatal Depression?Article Date: 03 Nov 2011 - 17:00 PDT. Accessed on 1<sup>st</sup> Jan 2013 <http://www.medicalnewstoday.com/articles/237109.php>

MediLexicon's Medical Dictionary. Depression. Accessed on 1<sup>st</sup> Jan 2013. <http://www.medilexicon.com/medicaldictionary.php?t=23823>

Medline Plus 2012. Phobias .updated on 10 December 2012. Accessed on 6<sup>th</sup> Jan 2013. <http://www.nlm.nih.gov/medlineplus/phobias.html>

Memon Mohammed A 2012. Panic Disorder. Updated: Mar 29, 2011. Accessed on 6<sup>th</sup> Jan 2013. <http://emedicine.medscape.com/article/287913-overview>

Mental health: a state of well-being, World Health organization October 2011.

WHO: [[http://www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/)]

MINDFREEDOM KENYA (MF-K), "Mind Kenya, Mind Africa", Mental Health in Kenya, Mindfreedom Kenya October 2008. MF-K  
[\[http://www.nsue.ie/m/uploads/files/MINDFREEDOM\\_KENYA\\_MF-K.pdf\]](http://www.nsue.ie/m/uploads/files/MINDFREEDOM_KENYA_MF-K.pdf)

Murphy Beth, Mind 2012. Understanding phobias. Published 2011. ISBN 978-1-906759-25-4  
[http://www.mind.org.uk/help/diagnoses\\_and\\_conditions/phobias](http://www.mind.org.uk/help/diagnoses_and_conditions/phobias)

(NAMI), National Alliance on mental illness, 2011. Mental illness: What is Mental Illness: Mental Illness Facts;  
 NAMI: [\[http://www.nami.org/template.cfm?section=about\\_mental\\_illness\]](http://www.nami.org/template.cfm?section=about_mental_illness) web site

National Institute of Mental Health 2013. Post-Traumatic Stress Disorder .U.S. Department of Health and Human Services .National Institutes Of Health. Reviewed: January 03, 2013

(NIMH) National Institute of Mental Health 2012. The Numbers Count: Mental Disorders in America. Modified: December 21, 2012. Accessed on 25<sup>th</sup> dec 2012.  
<http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml>

(NIMH) National Institute of Mental Health 2010. Panic Disorder. U.S. Department of Health and Human Services. National Institutes of Health (NIH). Publication no. TR 10-4679. Revised 2010

(NIMH) National Institute of Mental Health 2010. Obsessive-compulsive disorder. U.S. Department of Health and Human Services. National Institutes of Health. NIH publication no. TR 10-4676. Revised 2010

Ndetei DM, Khasakhala LI, Mutiso V, Mbwai AW, Department of Psychiatry, University of Nairobi, Nairobi, Kenya and Africa Mental Health Foundation (AMHF), Nairobi, Kenya. Knowledge, attitude and practice (KAP) of mental illness among staff in general medical facilities in Kenya: practice and policy implications. African Journal of Psychiatry July 2011;14:225-235.. AJPSY [<http://www.ajol.info/index.php/ajpsy/article/viewFile/69605/57616>]  
 NHS 2012. Panic disorder. Last reviewed: 21/04/2012. Accessed on 6<sup>th</sup> Jan 2013. <http://www.nhs.uk/conditions/panic-disorder/pages/introduction.aspx>

Oginga Allan 2009. Basic needs in Kenya Rural Program: Respecting the rights and needs of mentally ill people living in Laikipia, Meru South, Nyeri, and Nyandarua. Baseline Study Report. October 2009

Polit, F. and Beck, C. 2008. Nursing research: 8th Ed: Generating and Assessing Evidence for Nursing Practice. Lippincott Williams & Wilkins

Polkinghorne, D. 2005. Language and meaning: data collection in qualitative research. Journal of counseling psychology. 52 (2). 137 – 145.

Polit, F. and Beck, C. 2008. Nursing research: 8th Ed: Generating and Assessing Evidence for Nursing Practice. Lippincott Williams & Wilkins

Polit, F. D. & Beck, T. C 2010. Nursing research: 7th Ed: Appraising Evidence

for Nursing Practice. Lippincott Williams & Wilkins

Raymond Opdenakker 2006. Forum: Qualitative Social Research. Advantages and Disadvantages of Four Interview Techniques in Qualitative Research. 11 – September 2006. FQS: Volume 7, No. 4, Art. Accessed on 1<sup>st</sup> June 2013.

<http://www.qualitative-research.net/index.php/fqs/article/view/175/391>

Schorn Ariane 2000. Forum: Qualitative Social Research. The "Theme-centered Interview". A Method to Decode Manifest and Latent Aspects of Subjective Realities. 23 – June 2000. FQS: Volume 1, No. 2, Art. Accessed on 2<sup>nd</sup> June 2013.

<http://www.qualitative-research.net/index.php/fqs/article/view/1092/2395>

Simon Harvey 2009. Anxiety disorders - Risk Factors. Reviewed on 22<sup>nd</sup> Jan 2009

[http://www.umm.edu/patiented/articles/who\\_gets\\_anxiety\\_disorders\\_000028\\_3.htm](http://www.umm.edu/patiented/articles/who_gets_anxiety_disorders_000028_3.htm)

Shank, G. (2002). Qualitative Research. A Personal Skills Approach. New Jersey: Merrill Prentice Hall

State House Kenya. Kenya in Brief. Accessed on 31<sup>st</sup> January 2013.

<http://www.statehousekenya.go.ke/kenya.html#kenya4>

The British Psychological Society & The Royal College of Psychiatrists, 2011. Common mental health disorders: Identification and pathways to care.

The world health report 2001 - Mental Health: New Understanding, New Hope

WHO[<http://www.who.int/whr/2001/en/>]

(USPKENYA) Users and Survivors of Psychiatry in Kenya, 2012, Last Updated 04th April 2012.

[<http://www.usp-kenya.com/>]

(WHO) World Health Organization. 2001. Burden of mental and behavioral disorders. Geneva.

World Health Organization. Mental Health Atlas 2005. Geneva: World Health Organization; 2005.

## **12. APPENDEXIS**

### **12.1 Appendix1: Theme questions**

#### **Knowledge about mental illnesses**

1. How do you perceive health?
2. What is mental illness?
3. In your opinion, what causes mental illness?
4. What sorts of treatment are given to mentally ill people?
5. What services are available for mentally ill people in Kenya?
6. What do you know about mental health services in Finland?

#### **Perceptions about mental illnesses**

1. How do you perceive mentally ill people
2. What do you think about mentally ill people and having friends?
3. What do you think about mentally ill people and having job and maintaining them?
4. What believes do you have about mental illnesses?
5. What the cultural believes do you share about mental illnesses?

#### **How has living in Finland affected perceptions about mental illnesses?**

1. Compare your perception about mental illness while in Kenya and now.  
How do you perceive mental illness now?

## 12.2 Appendix 2: Consent form

I am signing this consent form to allow the mentioned students to carry a study about Knowledge and perceptions about mental illnesses among Kenyans living in Jyvaskyla, Finland. As a volunteering participant, I allow them to use tape recording equipment during the interview. I am also aware that I have right to withdraw from the interview at any time.

I am assured that confidentiality will be maintained throughout the study, and there is no way I will be identified from the data analysis in the research. Finally, i understand that all the tape-recorded information and personal Information is merely for the purpose of the research and it will not affect my safety in any way.

Date and place

Participant

Signature

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Researchers' signature

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Bancy Kinyua

Edel Njagi

