ATTRIBUTIONS OF MENTAL ILLNESS AMONG YOUNG PEOPLE SEEKING PSYCHIATRIC TREATMENT IN KENYATTA NATIONAL HOSPITAL IN NAIROBI.

A RESEARCH DISSERTATION SUBMITTED AS PART OF THE FULFILMENT FOR THE REQUIREMENT FOR A MASTERS OF SCIENCE DEGREE IN CLINICAL PSYCHOLOGY

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DECLARATION

I, the undersigned, declare that this dissertation "***Attributions of Mental Illness among Young People Seeking Psychiatric Treatment in Kenyatta National Hospital in Nairobi***" is my original work and has not been submitted to any other college, institution or university other than the University of Nairobi for academic credit.

Signed . . . . . October 2016

Judy .W. Mbuthia

APPROVAL

This thesis has been presented for examination with our approval as the appointed supervisors.

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DEDICATION

My most heartfelt gratitude go out to God. My parents, daughter Abigail, brothers and sisters, thank you for your priceless leadership, support, encouragement and care.
Judy, Ruth, Rachael, Mercy & Janet, I treasure your friendship and love.

ABBREVIATIONS

AIDS: Acquired Immune Deficiency Syndrome

AU: African Union

DSM-V: Diagnostic and Statistical Manual of Mental Disorders fifth Edition

DA: disclosure Analysis

ERC: Ethics Review Committee

HIV: Human Immunodeficiency Virus-

IPA: Interpretative Phenomenological Analysis

KNH: Kenyatta National Hospital

LoC: Locus of Control

NYP: National Youth Policy

PTI-P: Private Theories Interview - Patient version

UoN: University of Nairobi

WHO: World Health Organisation

OPERATIONAL DEFINITION OF TERMS

Youth; Individuals in the republic of Kenya who have attained the age of 18 years but have not attained the age of 35 years.

Attributions; The cause of an action or behaviour.

Mental illness; Set of symptoms relating to emotions, thinking or behaviour, associated with distress and impaired functions leading to activity limitations.

ABSTRACT

Individuals from different cultural backgrounds make different attributions of illness, health, diseases, symptoms and treatment. Attributions play an important role in formation of understanding concerning health. These understandings of health form a cognitive schema that influences the way patients make attributions.

In Kenya, the youth attributions of mental illness had not been studied, hence this study was the first to report the findings related to the youth's attributions on mental illnesses at the Kenyatta National Hospital.

The objectives of the study were; 1) To investigate the attribution of mental illness held by youth in Kenya, 2) To find out the youth's preferred type of treatment, and the predicaments that hinder effective psychotherapy related to the attributions. This aimed at improving the mental health care of patients and psychotherapy outcomes.

Semi structured interviews were carried out with 10 young individuals aged 19 to 25, and had been diagnosed with a psychological disorder for the first time and were undergoing treatment. The amount of time used in the study was 250 hours.

By use of a designed interview guide, In-depth individual interviews ranged from 30 to 45 minutes. Data was be transcribed verbatim and produced texts that were used to generate coding categories. Analysis was done by use of an Interpretative Phenomenological (IPA).

The 10 clients interviewed attributed their causes of mental illness or psychological distress to be as a result of Bio-Psycho-Social factors such as parents' separation or divorce, death of a loved one and medical conditions such as epilepsy. As a result, knowledge was gained that will assist those who help the youth in overcoming challenges to their self-development, social integration and successful transition to adulthood. Clients interviewed felt that there is a need to put their cultural beliefs, underlying social circumstances as well as expectations in assessment and treatment processes.

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CHAPTER ONE

1.0 INTRODUCTION

Previously, research has shown that the views and understandings as well as expectations of youth patients are predictors of psychotherapy outcome (Werbart & Levander 2005).
Mental and behavior illnesses are not discriminatory hence can affect anyone from different country or society irrespective of gender, age, income or social class (WHO 2013). The report further asserts that about 20% of patients attending primary health care have been diagnosed with one more mental disorders.
Each year, about 20% of youth experience a mental health condition globally (Patel et al. 2007). The prevalence of psychiatric disorders seen in youth has increased extremely in the past few years. Major Depressive disorder is the most prevalent with 4 % of 12 to 17 years old and 9 % of 18- to 24- years old youth reported to be with Major Depressive disorder worldwide (Khasakhala et al. 2013). In Kenya, common mental disorders largely comprise of mixed anxiety and depression, 6.1%, panic disorders 2.6 %, generalized anxiety disorders 1.6% and depressive disorders 0.7 %
(Jenkins et al. 2012).

BACKGROUND INFORMATION

1.1. The Attribution Theory

Guided by Weiner's attribution theory (1980), the aims of the study were to gain an in-depth understanding of the Kenyan youth's attributions of mental illness and the possible or preferred method of treatment. The research also focused on stigma as an independent domain and its association with mental illness.

Attribution refers to the assessments of the cause of an action or behaviour (Galvin & Coope 2006). It also refers to the internal l (thinking) and external (talking) process of interpreting and understanding what is behind our own and others' behaviours.

The attribution theory explains an occurrence and determine the cause of the happening or behavior. The theory starts with the idea that individuals are driven to understand the causes of the happenings or behavior. This desire is alleged to grow out of individual wish to understand, foresee and control the environment (Heider Fritz et al. 1958; Jones & Davis 1965; Kelley 1967). According to Weiner's theory (Weiner et al. 1988; Weiner 1980), there are three dimensions of causal attributions which include:

Locus of Control. (Internal Vs. External)

A person's belief that the events that occur in one's life are either as a result of personal control and efforts or an outside force like luck or fate is referred to as Locus of control (LoC).

According to Heider Fritz et al. (1958) patients produce attributions based on two bases of information which helps to identify the origin of the event and in this what current thesis, the origin of the illness.

I. Internal attributions also referred to as dispositional attributions: Founded on something within the individual whose behaviour is being observed, a patient's natural character. Patients with an internal LoC trust that decent or bad well-being is directly linked to their own actions. They often attribute a diagnosis of illness to current or past behaviours (Wallston et al. 1978).

II. External attributions, also known as situational attributions: The attribution is centred on somewhat external to the individual, which has nothing to do with who they are but the state they are in, or the setting. The external LoC lets an individual to place the

cause of disorder outside personal control and responsibility, allowing an individual to circumvent a sense of blame or guilt (Wallston et al. 1978).

Controllability (controllable vs. uncontrollable)

Weiner's controllability dimension concerns a situation that is regarded as controllable if the individual is personally able to guide, influence or prevent it. It is the extent to which the individual has control over the cause, as perceived by observers.

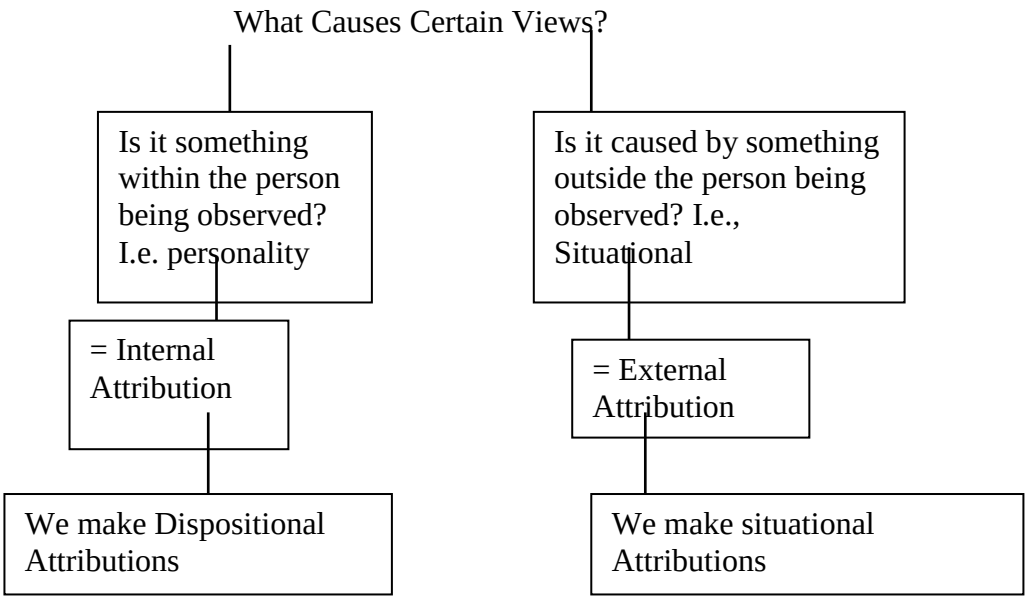
Försterling (2001) used "drunkenness" as an example to describe the controllability of causes. He suggested that "drunkenness" is perceived as a controllable cause. According to Fostering, causes that can neither be influenced nor guided such as a physical handicap, for example blindness, are regarded to as being uncontrollable (Försterling 2001).

Stability (Stable or Unstable)

Stability is the time-based nature of causes (Weiner 1980). Some causes remain stable overtime while others increase or decrease.

Causal attributions are more important when viewed as stable and unchanging as opposed to unstable and fluctuating. The course of mental illness increasingly deteriorates, leading to an irrational outcome and damage of self-governing functions.

Figure 1.1: Attributions flow chart



Stigma as an independent Domain

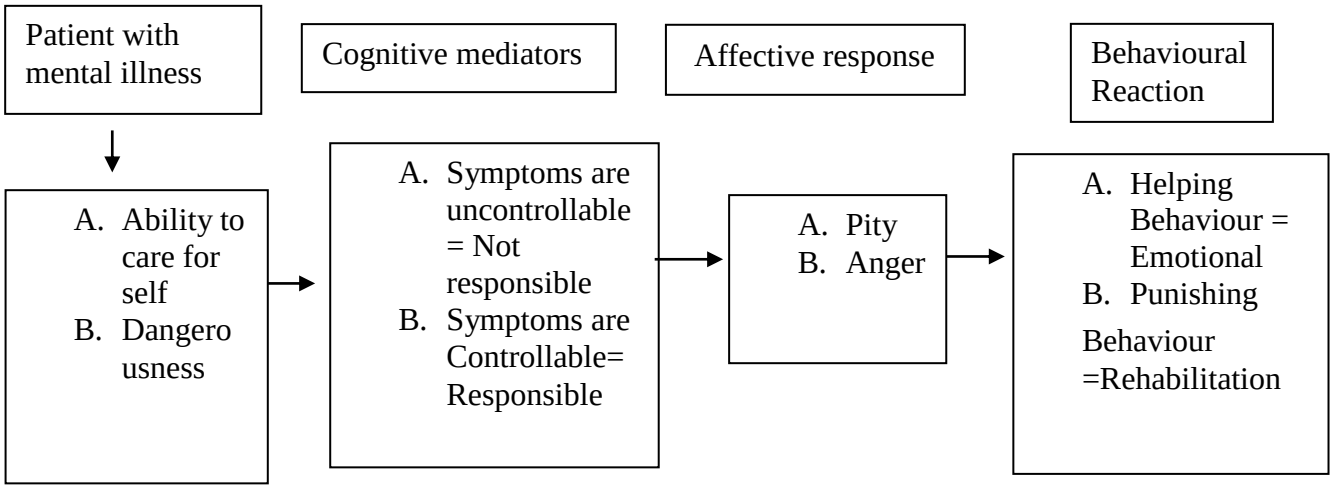
Stigma is defined as a social scratch that leads to questioning of associates of a group, such as people with mental illness (Major & Eccleston 2005). According to Rüsch et al. (2005), the negative properties of stigma among individuals with mental illness lessen self-esteem and health care application, the insight of public reduction, and discrimination. Hence, understanding the causes of stigmatization attitudes, and effective methods of reducing them, has great likely for refining the lives of individuals with mental ailment.

As deliberated earlier, attribution theory deals with how actions are clarified, and the influence of those explanations on the insight of people. The theory foretells that uncontrollable behaviours are highly likely to be branded than controllable behaviours. For example, people have more optimistic boldness toward individuals with problems that are biologically caused than those that are externally caused (Corrigan & Kleinlein 2005; Weiner et al. 1988).

This outcome was verified by Weiner and colleagues by paralleling attitudes about behaviourally produced illnesses such as AIDS, child abuse, drug abuse, and obesity, and biologically caused disorders such as Alzheimer's, cancer, heart diseases and Paraplegia. Their outcomes exhibited that behavioural causes led to fewer support and pity, and added anger, than biological causes. This difference is clarified by the lack of personal obligation and control linked with biological causes (Weiner et al. 1988; Corrigan & Kleinlein 2005). Consequently, this helps in explaining why the label of mental illness may carry more branding weight than the label of physical disease.

Further research proposes that unique attributions about physical versus psychiatric disabilities may be affected by culture. African Americans with incapacities appear to be judged more severely than European Americans with the equal disabilities (Rush 1998).

Figure 1.1.1. : The relationship between stigma and locus of control (LoC)



1.2: Interpretative Phenomenological Analysis (IPA)

A phenomenological study explores participants' perceptions or account of an event as opposed to attempting to produce an objective record of the event. IPA tries to appreciate the lived involvements of partakers and how they make logic of their (participants) experience.
IPA was the approach used for data analyses due to the following reasons:
IPA is steady with research aims since it is loyal to the examination of how people make sense of their foremost life experiences (Smith et al. 2009). It is a phenomenological method as it centres on discovering experiences in its own terms rather than endeavouring to reduce it to predefined categories (Smith et al. 2009). This means that it is explanatory in that the researcher tries to make sense of the participants' experiences (Smith et al. 1997; Smith et al. 2009).
IPA is concerned with own experience and also includes analysis, involving a reflection of a given situation, and in this case being the attributions of youth with psychological disorders towards mental illness.
IPA is idiographic in nature because it is apprehensive with illuminating something about the experience of each of the persons involved and being capable to give a comprehensive end about the participant group.

The objective of IPA is not to make untimely generalities about bigger populations but rather to reach at more common statements carefully, and only after the cautious analysis of individual cases (Smith et al. 2009; Smith et al. 1997).

The approach is committed to detail and depth of analysis as well as empathetic on how a certain experiential happening or relationship has been understood from a particular context by diverse individuals or groups.

With the above reasons, IPA's utility has since been demonstrated within clinical psychology research and expanded energy within the field of health psychology (Nunn 2009).

Below was the rationale behind selecting IPA over three types of qualitative analysis that were considered as probable options.

Grounded Theory is considered more of a sociological methodology which draws on union within a larger section to support wider theoretical justifications. On the other hand, IPA is more psychological, concerned with giving a more detailed and nuanced justification of the personal experiences of a smaller sample, and therefore was vital in keeping with the research aims (Smith et al. 2009).

While Discourse analysis (DA) is doubtful concerning the availability of thoughts and centres on language in relations of its function in assembling social truth, IPA is concerned with understandings and sense-making. These thoughts are not plainly accessible from spoken reports but IPA employs a critical process leading to meaning-making of the verbal reports (Smith et al. 2009; Smith et al. 1997).

Narrative analysis represents storied ways of communicating and knowing, hence the analytical method is focused on a one way meaning-making such as a story teller, while IPA considers narratives in the of participants views in sense making (Smith et al. 2009).

CHAPTER TWO

2.0 LITERATURE REVIEW

As noted above, there are various aspects that determine patient's views and attributions of mental illness. The below review of literature looked into different factors that have led to these attributions in different countries and in different age groups.

2.1 Youth and Mental Illness

In most cases, youth feel prone to deal with mental health disorders wholly on their own (Sheffield et al. 2004), but when they seek assistance, they tend to use more informal services systems often being counsel from family and friends beforehand allowing for professional help. This is expressly so for emotive difficulties (Boldero & Fallon 1995; Rickwood et al. 2004).

According to research done by Rickwood et al. (2004), parents, friends, and educators are the three supreme springs of support amongst youth with mental illnesses. Thus, in efforts to mend facility use among youth, it is imperative to keep in mind that they habitually select to seek help from the above familiar sources. To enlarge formal amenities around these support structures would consequently be likely to increase utilization.

Research has recognised that the community embraces negative opinions about mental illness, one of them being that mentally ill youth are risky, random, and unpleasant people, and more so, questionable to be industrious members of the community (Corrigan & Kleinlein 2005). These negative sensitivities have been exceptionally persistent regardless of the progresses in scientific understanding of mental illness and far determinations to advance public understanding (Pescosolido et al. 2010). Also the negative attitudes and misunderstandings are not likely to materialise fully driven in adulthood. Rather, they are likely to have their heritages in childhood and progress steadily until youth.

Labelled children may face misunderstanding and undesirable outlooks by their peers. Dismissal, mocking and injury to self-esteem as well as unwillingness to seek or accept mental health management are among the probable values and most important during youth phase.

In young persons, psychological conditions account for an enormous section of the disease weight in all cultures. Deprived psychological health is powerfully correlated to other health and growth alarms in young people particularly lower learning triumphs, substance abuse, violence, and poor procreative and erotic healthiness.

Mental illnesses which comprise of behavioural and mental health problems such as depression, anxiety, substance abuse, aggressive disruptive behaviour, and post-traumatic stress disorders are the prominent reasons of adjustments complications in young people. They contribute intensely to ill health and absent efficiency across the lifespan.

The youth are at a better threat of several mental health conditions as they passage from childhood to old age (Kessler et al. 2005). Young people are developing in an environment marked by prevalent poverty, inadequate educational openings, high HIV/AIDS frequency, well-known conflict, and feeble social controls.

2.2 Culture and Mental Illness

Culture is defined as a means to feeling, thinking and behaving, which is not biologically but socially derived from one generation to the next (Aina & Morakinyo 2011). There are two main schools currently that explain the relationship between culture and psychotherapy.

One is the universalistic school which debates that the necessary psychopathology of mental illness is widespread. This creates an assumption that instruments aimed and authenticated for evaluating and quantifying psychopathologies in the Western nations can be applied internationally.

Second is the relativistic school which advocates the idea that aetiological factors of psychopathologies are impacted by cultural factors. Aina & Morakinyo (2011) refer to various diseases named culture-bound syndromes, where cultural factors are known to play major aetiological function.

African patients' are more likely to presume a mental health specialist to offer a realistic and divine reason behind a psychological illness. For instance, a study done in Ethiopia found out that Ethiopians were highly to attribute psychological illness to paranormal causes such as oaths or non-physical control (Teferra & Shibre 2012). Hence, to successfully treat these illnesses, the therapies should be both solid like herbal treatment and divine.

Research carried out in Uganda publicised that the word 'depression' is not entirely culturally acknowledged (Okello & Ekblad 2006). Similar research in Nigeria established that people react with fear, evasion and irritation towards individuals' mental illness. The stigma related

to mental sickness can be ascribed to lack of education, fear, spiritual thinking, and over-all bias (Arboleda-Flo'rez 2002).

In an on-going research project, Manasi et al. (2014) state that most psychotherapy approaches applied in Kenya have been developed for western countries and cultures. This hence raises the question if these approaches are well-suited with other non-Western cultures. Murray et al. (2010) indicate that there are promising outcomes in the cultural adaptations of existing psychotherapy interventions.

2.3 Religion and mental Illness

Mental ill health is a common condition in the general population. Personal attribution and experience with psychological ailment is prospective to sway attitudes, which as an outcome will affect the aid seeking process.

In Malaysia for example, the belief that an individual's mental illness is begun by mystical supremacies ensued in greater use of old-style healers and marginal obedience with medication delivered by Western biomedical sciences (Razali et al. 1996).

A similar case was reported in South Africa where psychiatric patients thought that their sickness was as a result of supernatural forces and opted for spiritual treatment for their illnesses (Sharif et al. 2003).

Fakacha in Vaughn et al. (2009) states that most black Africans report that illnesses are due to religious issues such as evil spirits. The disorders are also credited to struggle and strain between good and sinful, or harmony and unrest.

Helman on the other hand recommends that persons attribute sources of disorder to 1) factors within individuals themselves such as negative sentiments or bad practises, 2) natural environmental features like microorganisms and contamination, 3) factors associated with others or the social world like relational stress, medicinal amenities and 4) supernatural aspects including fate, God and native beliefs like witchery (Helman 1990).

A Nigerian study showed a third of the respondents (34.3 %) mentioned drug ill use as the main cause of mental illness. Divine rage and the will of God were seen as the second prevalent reason (18.8 %), followed by witchcraft and spiritual control (11.7 %). Very limited quoted genetics, family interactions, or socio-economic eminence as possible activates (Arboleda-Flo'rez 2002).

People who grip the understanding that psychological illness is the product of sin, moral disobedience, personality or individual softness could be reluctant to seek proficient help

(Shebabaw et al. 2014). Those with mental health complications often delay pursuing trained help due to factors such as fear of being diagnosed as mentally ill, lack of confidence in mental health professionals, and lack of resources to cover the expenses. In addition, a person's view of the sternness of the sickness and its cause affects their help seeking behaviour (Boldero & Fallon 1995).

In developing states, patients appear to strive for traditional medicine as part of their management not only due to trust that their ailment is caused by a supernatural strength but also believe that traditional cures are effective (Jamesa & Peltzer 2012).

In association to the Western people, African patients attribute illness to a spiritual or social cause rather than psychological or scientific foundations. Therefore, medical doctors in various African countries give emphasis to the whole body, mind, and soul (L. M. Vaughn et al. 2009).

The traditional medicine may be necessary for the spiritual remedial while the western biomedicine may be needed for the somatic healing (Rowe & Allen 2004). The spiritual aspect practises a central part in a patient's worldview that conditions the patient's interpretation and reaction to life experiences; this hence give details why patients would attempt a religious faith when ill (Rowe & Allen 2004).

People with mental illness in some Kenyan communities, are treated as outcasts, having been cursed due to their past malignancies. Hence, this stigmatisation is also a reason as to why patients in Kenya seek medical attention from the traditional as well as faith healers.

For the sick, the faith healers offer rituals and prayers which are more culturally acceptable options. According to Ndetei et al. (2013), mental health in Kenya is highly influenced by these healers. Ndetei, believes that poor access to alternative medical treatments as well as poverty is the reason for this. Another reason might be that the healers are flexible in terms of payments since they accept both money and other commodities.

2.4 Caregivers / Health Staff and Mental illness

A study carried out in Kenya to define the understanding, attitude, beliefs and training of mental complaint among staff in over-all medical amenities found that despite the staff's knowledge about acknowledgement, identifying, and cure of psychological illnesses, they still upheld their traditional outlooks on mental disorder.

They had an observation that mentally ill persons are insignificant, unclean, irrational, unsafe and unpredictable. The negative labels and defaming approaches society has concerning

mentally ill persons lead to behaviour that as a result, deteriorate the situation of the patient (Ndetei et al. 2011).

To conclude, the above concepts give an overview of different thoughts, understanding as well as behaviours held by different individuals, in regards to mental illness and their help seeking behaviours. This further prompted the researcher to investigate at length how Kenyan youth make sense of mental illness.

From the above past studies, it is evident that spiritual and cultural traits as well as stigma have a dominant role in the patient's meaning-making of their mental illness and the subsequent preferred psychotherapy intervention which could be either traditional or conventional means of treatment.

2.5 Problem Statement

Mental illness affects every segment of the population including children and youth, impacting on the national development of a country. More so, the belief held by the community about the causes of mental illness is likely to impact on treatment seeking behaviour.

Available literature from developing countries show that mental health is attributed to factors such as evil spirits, stigma and cultural beliefs (L. Vaughn et al. 2009), (Helman 1990) and (Ndetei et al. 2011). Cultural components comprising of social attitudes, peer group rules, religious beliefs, family morals, and other societal cultural factors are strongly allied to the behaviour of youth leading to different attributions towards mental illness.

This has resulted in too many youth suffering from mental illness to avoid consultations by professional mental health workers. Awareness and respect of these elements and other principal social statuses of individuals ought to be reflected when addressing youth psychological conditions.

2.6 Rationale and Justification

From the above review of literature, there was no research done to specifically investigate the youth's attribution of mental illness and the effects of these attributions on the youth's choice of treatment, hence the relevance of this study, which was to help in resolving this gap.

2.7 Significance of the study

There are many misperceptions about mental illness. At present just like any other developing country, mental illness is recognized as a significant health problem in Kenya, despite the fact that there is limited accessibility of mental health professionals.

Studying youth's attributions of mental illness was important for several reasons. Attributions help people predict future behaviour and often accurate attributions can reduce uncertainty (Heider Fritz et al. 1958).

The attributions held by Kenyan youth on mental illness was not a researched area hence difficult to predict the future patterns of help seeking attitude or behaviour among the youth, and how they actually make sense of a particular mental illness.

However, this research did not only help in preventing such predicaments that might have been a hindrance to effective psychotherapy outcomes, but also helped in assessing the youth's preferred type of help / psychotherapy.

By gathering mental illness-related attributions held by the youth, it was possible to identify the attributions that help or hinder positive outcome of psychotherapy. As a result, critical knowledge was gained that will assist those who try to help the youth in overcoming challenges to their self-improvement, social incorporation, and successful transition to maturity.

Additionally, disseminating methodically based material was critical in supporting successful advancement and socialization of youth as well as for thought-provoking false impression on mental illness and disregarding stigma. More so, this information will empower the significant patrons, including youth, families, youth care benefactors, and societies for effecting change in youth mental health care.

2.8 Research Questions

The study questions for the thesis were; "*What do psychiatric youth patients attribute as causes of their mental illness?"* And *"What do they believe will help them?"*

2.9 Research Broad Objective

Was to determine the attributions of mental illness held by youth in Kenya

2.10 Research Specific Objective

Was to find out the youth's preferred type of treatment and the predicaments that hinder effective psychotherapy related to the attributions.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Study Design

This was be an exploratory qualitative design, using structured interviews backed on the Private theories interview-patient version, (PTI-P). Purposive sampling method was employed, in keeping with the interpretative phenomenological analysis (IPA) requests to have a lesser sample scope. With the use of a purposive sampling method, it was possible for the researcher to carry out data review and analysis in conjunction with the data collection process.

3.2 Study site Description

Participants were recruited from Kenyatta National Hospital (KNH) youth clinic. KNH is the largest referral hospital in Kenya with 1,500 bed capacity. The youth psychiatric clinic offers counselling and psychotherapy services to patients referred from within and outside the hospital, with patients coming from different parts of the country, hence, the study population represented youth from different parts of the country.

Most clients are referred from various schools, colleges and universities, but also it is a clinic for walk- in cases and emergencies. The youth psychiatric clinic is open every weekday, from 7.30 am to 5pm, and roughly 10 new patients are registered each week and 15 more new patients during school holidays that are April, August and December. The clinic is overseen by residential psychiatrics; psychiatrics nurses and psychotherapists.

The services are offered free to all clients regardless of type of mental illness, hence a constant flow of clients. This enabled the researcher to carry out the interviews within a short period of time. It is also a training setting for Nairobi University students who are pursuing various mental health courses at both the Bachelor's and Master's level. The clinic offers referral services for further treatment such as rehabilitation and admission of critical cases at the Kenyatta National Hospital and Mathari Hospital.

3.3 Study Population

Youths at the clinic were the study population. However, only those at the ages between 19 to 25 years, who had been diagnosed with a psychological disorder or mental illness for the first time, were on treatment, and fluent in English or Swahili language were viable for the study.

3.4 Inclusion Criteria

Youths aged 19-25 years and were attending the clinic for the first time were aimed at. They were also to be on treatment and fluent in either Swahili or English. Only those who gave consent to participate in the study after meeting the inclusion criteria were interviewed.

3.5 Exclusion Criteria

Youth patients with severe mental illness and those who did not meet the inclusion criteria above were excluded from the study.

3.6 Sample size Determination and Sampling Method

Sixteen participants were recruited. However, by the 13th participant, the information received had reached saturation. The researcher analysed the 10 most detailed transcripts. It's important to note that saturation in a qualitative study with a homogenous group occurs at the 12th participant (Guest et al. (2006). The age of the participants was considered in sampling. By the use of purposive sampling method, new patients who met all the inclusion criteria at the start of data collection were approached. Both female and male patients were sampled.

3.7 Recruitment and Consenting Procedures

Patients who agreed to participate were issued with an explanation of the research protocol. Refusal to participate in the study did not affect the way in which the clients were subsequently treated. No rewards was be given for participation. The consent from was signed by both the participants and a witness.

3.8 Ethical Procedures

After clearance from the ERC/UON-KNH to conduct the research was obtained, the researcher requested for assistance from the in-charge at the youth clinic, and obtained a room within the clinic for data collection. Every new client registered at the clinic for the first time and met the inclusion criteria was approached to be recruited in the study.

3.9 Data Collection Instruments/Materials

A brief socio-demographic questionnaire was used to capture key demographic information. It included the age of the patient, Kiswahili and English literacy levels, educational level and gender of the participants to synthesize this information with their interviews as such. As this is a qualitative work, other than simple frequency counts or situating specific issues, this information has limited value.

A Private theories interview (PTI-P) - and-*Attributions Focused Questionnaire (AFQ)* Guides were developed together. Data was gathered by use of semi-structured interviews with open-ended questions encouraging exploration of experiences within the conceptual framework. Five items in Private Theories Interview patient version (PTI-P) and the attribution model by (Weiner 1980) were used to guide the aim of the study. The items are: What is the problem? How did the problems arise? How can the problems be remedied? What has changed? What is your view of others and yourself?

Each of these questions was paired with a domain from the attribution theory AFQ which resulted in expanding the framework and the scope of the analyses. The domains adapted from Wieners attribution theory were: Locus of Control (Internal vs. External), Controllability (controllable vs. uncontrollable) Stability (Stable or Unstable) and Stigma as an independent Domain.

PTI-P aims to capture the interviewee´s attempts to give meaning to his or her interpersonal, psychic and somatic distress while including these experiences in his or her private context of meaning (Philips et al. 2007).

Through PTI-P, the interviewer wants to seize the interviewee´s private ideas and narratives about the difficulties they experience and how they have arisen. It is in the interviewer's interest to endeavour and facilitate for the interviewee to get to their private knowledge. The interviewer needs to adopt a distinct attitude, and let go of own attitude and knowledge about

the area that is examined in order to understand and interpret the patient´s narrative (Levander 2006).

Since PTI-P was developed in Sweden, there were concerns that the questions would not be applicable in the Kenyan culture. In order to enhance cultural sensitivity and adapt the questions to this context, the questionnaire was translated into kiswahili and two Kenyan psychologists in clinical training examined the interview- questions and gave suggestions on a few adjustments. The AFQ was mapped on to these questions to create a subset of categories that explain the attributions used by participants in understanding their problems and thinking about how these could be resolved.

Three pilot- interviews were also conducted at the youth clinic to further adapt the questions and to make the interviewees accustomed to the interview guide and the context. The adjustments of the guide were only on a linguistic level and para-phrasing.

3.10 Quality Assurance Procedures

Data was organized, collated, and participants made anonymous. Audio records were transcribed verbatim, and analysis was be done systematically and rigorous and studied for themes. A pilot study was done by conducting individual interviews for the researcher's practice and preparation.

3.11 ETHICAL CONSIDERATIONS

The study was reviewed by the Kenyatta National Hospital and University of Nairobi Ethical Review Committee, and the respondents gave written informed consent. The socio-demographic tool was anonymized and the data collected was safely stored without any identifiers. The researcher was trained in qualitative interview techniques and had regular supervision with her mentors on using IPA as well as analysing the data thematically. The participants in distress were encouraged to continue with the psychotherapy and there were referral mechanisms built in the study if anyone was self-harming or at high risk.

Benefits: The study aimed at understanding the attribution of psychological disorders among youth patients as well to inform the mental health staff at the youth clinic about issues that may help or hinder their attempts at treating psychiatric youth patients. This has helped in improving the mental health care of patients and the psychotherapy outcomes.

Risks: There were no potential risks in the study despite the sensitivity of the subject since the participants were already on treatment for a psychological disorder. Therefore, the researcher was cautious and observant to ensure the interview followed all ethical procedures and knew when to stop if an individual was visibly distressed.

Voluntarism: No youth patient was coerced or forced to participate in the study.

Follow up Schedules: The duration of the individual interviews was approximately 30 to 45 minutes. They were conducted on a mutually agreed time after consultation with the youth participants and after signing of informed consent. The study took a duration of six months.

3.12 Data management and Analysis

Designed semi-structured interviews were administered and audio-recorded. This was be followed by transcription and data analysis using IPA.

In total sixteen interviews were conducted, with ten interviews included in the final analysis. The other interviews were excluded due to several reasons. The first three interviews were pilot interviews to adapt the interview guide to the culture since it had not been used in Kenya before.

Others were excluded after the researcher assessed them as being too fragile to tolerate the interview. Some participants were excluded since they were not to fit the inclusion criterion of having a mental health problem. These participants were at the clinic for the first time and had as a result not yet been given a proper diagnosis when they were interviewed for the study.

Below are the analytical steps undertaken by the researcher by use of IPA.

- Step 1 to ensure that all experiential material about PTI-P and AFQ were adequately answered in the data.
- Step 2 -Transcription: Verbatim transcription of the semantic content of each individual interview based on audio recording.
- Step 3- Reading and Re-reading: Immersion in the data, active engagement with the data, searching for richer, detailed sections. Searching for contradictions and inconsistencies.
- Step 4 - Initial Noting: Noting anything of interest. Identify specific ways participant talks about an issue. An unstructured commentary. Describe what matters to participant and the meaning of those things. Note language used and context. Descriptive comments (content of what participant said), linguistic comments (specific

use of language by participant) conceptual comments (interrogative level and interpretive) and translating from Swahili to English.

- Step 5 - Developing Emergent Themes: Based on Step 2. Reducing volume of data but capturing complexity. Mapping interrelationships, connections and frequency.
- Step 6 - Probing for Relations across Emergent Themes: Recording how the themes seem to fit together and allied to research questions. Abstraction (developing superordinate themes), (emergent theme becomes superordinate theme), separation (identifying oppositional themes), contextualization (relate themes to life events), numeration/frequency (identification of how often a theme is discussed), meaning (what function are the themes serving for the individual).
- Step 7- Observing for Patterns across Cases: Connections between/across interviews, steady core themes, recognize individual and shared meanings. Ensure analysis retains a strong interpretive focus
- Step 8- Merging the core themes with the attribution dimensions: we started by identifying which attributions were most prominent and collating this information in simple frequencies and at the same time used PTI framework to make sense of the bigger picture as to which themes were being articulated by our participants

The researcher continuously triangulated this information with three supervisors and sought feedback on her work. Steps 7 and 8 were directly undertaken with one of the supervisors and the information then was shared with others for their oversight. The researcher kept on reworking the data until no more iteration was needed and the entire research team felt satisfied with the thematic analyses and IPA led AFQ and PTI analyses.

CHAPTER FOUR

4.0 RESULTS

Six psychosocial attributions themes of mental illness relevant for Kenyan youths were identified; in the analyses. The researcher classified the participant's responses into three categories: psycho-social, medical causes and preferred form of interventions, i.e., "What do psychiatric youth patients attribute as causes of their mental illness?" and "What do they believe will help them?" fed into themes. The table 1 lists the themes arranged from the most prominent to the least as derived from frequency count carried out amongst the 10 clients interviewed. Table one and two shows the three classifications.

Table 1: Psycho-Social Themes as Per Frequency and Gender Ratio

Core Themes(Psycho-Social Category)	**Frequency**	**Gender Ratio**
Depressive spiral of negative thoughts and emotions	10 Clients	All clients. 6 female clients: 4 male clients
Adjustment and behavioral problems in school and college and experiencing externalizing symptoms	8 Clients	4 male clients: 4 female clients

Stigma and rejection from significant others and a tendency towards self-stigma	8 Clients	5 Female Clients: 3 Male Clients
Negative Childhood Experiences	7 Clients	4 female clients: 3 male clients
Overwhelming Challenges and lack of support in transitioning from one stage to the next	6 Clients	4 male clients: 2 female clients
Dysfunctional families and broken ties	4 Clients	2 female clients: 2 male clients

Table 2: Medical Causes and Preferred form of interventions

Medical Causes and Preferred form of Treatment	**Frequency**	**Gender Ratio**
Medical causes and psychopathologies limiting intervention	3 clients	1 male : 2 female
Affirmation of Psychotherapy as the most suitable intervention	9 Clients	6 female clients: 3 male clients
Valuing pharmacological support in their overall treatment	1 clients	1 male client: 0 female client

A. Psychosocial causes of distress:

The researcher found a number of thoughts and experiences that participants recounted as being the psychosocial causes of their worries as described by the below core themes.

Theme 1: Depressive spiral of negative thoughts and emotions.

All the ten clients shared in their interviews that the negative thoughts and emotions were the core reasons of their illnesses and source of distress. The sub-theme was anger leading to thoughts such as "I am a failure."

Anger was a result of past heartaches and undesired experiences such as separation or divorce between parents, parental negligence and abuse, poor performance, being teased by peers in school among others.

The end results due to the negative emotions was that the clients ended up in wrong peer groups and risky behaviours such as using alcohol and bhang, drop in school performance and disintegrating with family unit.

- The PTI question 1 was most reflective of this spiral of thinking that the participants struggled to get out of.

  "I had a disagreement with mum. She wants me to be like her and I cannot. She separated with my dad and now she wants me to go live with my uncle who is very tough. She is also planning to go for further studies abroad." 20 years old young man

  "....I had a tough childhood, my brother uses drugs and abuses me. I also lost my dad at a young age……" 22 years old female

Theme 2: Adjustment and behavioural problems in school and college and experiencing externalizing symptoms

This theme captured the participants' thoughts about the need to be accepted by peers, family and teachers. It also showed the difficulty one may have in finding a friend who would guide and influence in a positive way.

Four male and four female participants shared their negative experiences with high peer pressure in high school or colleges that led them to doing things they were forced to. The clients felt that their friends had a negative impact on their mental health, by introducing them

to addiction or by not being good friends. Having a specific social life was a factor that impacted their mental health.

The clients reported to have used alcohol or bhang due to peer pressure. Those in high schools possessed phones within the school compound which was against the school rules leading to suspension. Some clients described the peer pressure as a need to fit within the circles of friends due to fear of being rejected by peer members. Having had family conflicts, emotional distress and adjustment problems, the use of drugs and alcohol and associating with negative peer groups was inevitable for the young adults.

- *PTI and AFQ question: What is it that leads you to seek treatment today?*

  "My friend and I had a phone in school. During prep time, the teacher on duty caught us playing games. We have been suspended for 2 weeks and told to go back with our parents….." 19 years old female

  "I started taking alcohol after high school. I thought it was normal for those in university to take alcohol since now you are a grown up. I hope to stop completely as it is the cause of bend palsy that I have…." 21 years old male

Theme 3: Negative Childhood Experiences

Death of a loved one experienced by clients at young age was thought of as a cause of a problem, or as something that worsened the situation and consequently mental health. Poverty, parents' divorce, abusive and controlling parents, rejection from peer members are some of the childhood experiences that were attributed to cause of mental illness. Females' more than male clients attributed to this causes.

- *PTI and AFQ question: What is it that leads you to seek treatment today?*

  "My dad does not care. Since the illness started he has never sent money for medication. He went and got another wife. He only sends money for food and my sister. But for my medication, he has never send……" 24 years old female

  "…I used to love my father but when my sister was born, it's like he forgot about me. He only cared about her. I started talking to boys and eventually lost my virginity. I still feel bad about it....." 19 years old female

"My mum died. I still don't know how to deal with that. She was my favourite person. Always cheering me up. I was her only child. I have no dad. I felt lost and never gotten over this. I do not understand myself anymore"25 years old female

These negative experiences had a negative impact on client's mental health. At a young age, the clients had to deal with situations that left them emotionally crippled. Seven clients had a childhood experience that they attributed to be the cause of their mental illness hence seeking help.

Theme 4: Overwhelming Challenges and lack of support in transitioning from one stage to the next

The male clients interviewed shared to have this theme as a cause of their illnesses while two females' participants expressed the same. The six clients described the challenges of transiting from one phase of life to another while some were challenged in fitting in to a boarding college. The clients described the new school boarding environment as a place of too much freedom where they got to experience in unwanted behaviours such as use of drugs and engaging in pre- married sex. Other older youth reported to have challenges in coping with the fast moving years and yet have not attained their desired goals, as compared to their age mates. Frustrations, anger and self-blame was a common feeling in both the young youths in boarding schools and those in colleges/ universities.

- *PTI and AFQ question: Tell me about some (other) important experiences or events in your life that you associate with your difficulties and how the problems began.*

  "I repeated form IV then joined university where I am studying mass communication. In the first semester, I started having wired feelings and thoughts. I felt like I do not fit in to the school culture. People were just having fun. Right left and centre. Then I got myself in this group of girls who had money from their boyfriends and older men. I wish I did not join them. Somehow I lost my virginity….." 22 years old female

"I am not comfortable with my life. I have not achieved the things I have wanted to achieve. Just the way my life is going…..my career…Everything is moving slowly. Am in a stage where I want to do new things and find my own place in life"24 year old male

"Since I went to boarding school in class six my performance dropped and was always punished for it…." 20 years old male

Due to challenges in transiting to new environment (day to boarding school), death of a loved one, lack of finances or strained relationships with significant others, four clients described their poor performance as a cause to their psychological distress. Some maintained this to be the main cause of their mental illness while others thought if they had better child up bring or did not have to face difficulties in their childhood lives, they would have performed much better.

"I used to think a lot after failing my KCSE. I was wondering what next? This is when I started having too much headache and a lot of fear"22 years old female

Theme 5: Dysfunctional families and broken ties.

Four clients, male and female attributed to having a conflictual relationship with their care giver as a cause to their psychological distress. Coming from un-supportive families, abusive parents or siblings, parent child discrimination or preference, separation and divorce as well marital conflicts describes the participants' thoughts of their upbringing or family life as a factor to their current psychological distress.

These issues resulted to emotional turmoil in client's thoughts and feelings leading to need for psychological help. Some clients reported of an unstable upbringing due to their abusive and alcoholic parents. They felt that their family environment made them lose their childhood, either through fear of their parents or by being forced to act as an adult and take responsibility for the family as a child, while other younger siblings were not allowed to work. A traumatic childhood was described as an impacting factor later in life that resulted to low self-esteem and consequently self-stigma.

A 19 years female client reported to have had hated the day her younger sister was born.

"Dad started neglecting me and it is like all the love I had for him ended. He still prefers my

sister and I feel like she is more special than me. May be it is because she is named after mum to my dad."

A client reported to have had no connection with his mum due to lack of motherly affection and attention since he was very young, *"I grew up with my extended family since mum had travelled out of the country for further studies. When she came back, she was a stranger to me. We still do not have a relationship." (19 years old male client)*

- *PTI and AFQ question*: *Tell me about some (other) important experiences or events in your life that you associate with your difficulties and how the problems began*

  "I stay with my mum and brother. We are not close to each other and am not free to talk to them since they do not care about my opinion. I just keep quiet" 20 years old male

  "I am angry at my dad. Very much. He listens to his relatives more than he listens to us. Like now I wanted to go further my education in UK but a sister to my dad said I should not go because I am epileptic. My dad agreed with her. He does not like supporting me. But one day I will prove them wrong. I will work hard and show them that epileptic people can do great in life."23 years old female

Theme 6: Stigma and rejection from significant others and a tendency towards self-stigma

Five out of 10 clients attributed stigma from others as a causal reason to their illness. Rejection, being teased and Feeling judged by relatives was common among the five clients. Peer pressure was mostly described by the participants with substance abuse, where friends could be viewed as a way into using.

Stigma and rejection from significant others

- *PTI and AFQ question: In relation to the psychological issues, what is your view on others and yourself?*

  "When am alone, I feel great. But when am with my mother I feel bad because my mum thinks am unimportant"19 years old male

"My friends used to undermine me because my mum was old, deaf and dump. And we were very poor. I had no friends when growing up. They hated me"25 years old female

An individual's closest relationships can have a damaging effect on their mental health as indicated by the narratives quoted above. The clients viewed their family life as an important factor for their mental health. The feelings of betrayal or indifference from a parent negatively impacts the psychological wellbeing of an individual.

Self-Stigma

Out of the 10 clients interviewed, 4 clients reported to have low self-esteem and fear of disclosure due to self-stigma. This was as a result of childhood experiences such as loosing virginity at a young age, being suspended for using drugs in school, rejection or discriminated against by parents and peer members and lose of identity due to transitional challenges.

- *PTI and AFQ question: In relation to the psychological issues, what is your view on yourself?*

  "I used to be a hyper child but am now introverted. I do not want my friends to know that I came for counselling. I also did not tell my mum……..Also when I feel like everyone knows am not a virgin. I don't want to hang out with boys so that they do not find out about this."19 years old female

"After being caught with bhang, people viewed me as a peddler making me feel so bad and couldn't face people after that incident. My self-esteem was affected. Some friends deserted me."19 years old male

B. Medical Conditions and psychopathologies limiting intervention

Three organic conditions were mentioned as cause to mental illness. 1) Epilepsy, 2) Bell's palsy and 3) Psychosis. Neurological disorders are imperative and less documented causes of illness in Sub-Saharan Africa. Epilepsy is a noteworthy contributor to the load of neurological illness in Kenya.

- *PTI and AFQ question: What are your thoughts about the psychological issues you are experiencing?*

"I was diagnosed with epilepsy when I was a young child. Growing up as an epileptic person is very challenging. People do not want to be associated with you, my father does not care about me. May be he thinks I am a burden, since he doesn't buy my medicine. Were it not for epilepsy, I would be so happy. I have never been happy in my entire life. But I will prove people wrong. I want to show them that I can achieve my goals despite being epileptic."24 years old female.

This was a cause to anger and emotional burden that the client shared. She went on to describe her pain as "too much to bear." She thought that her unhappiness was due to the fact that she has always been epileptic and having to face stigma from close relatives and friends.

• *PTI and AFQ question: What are your thoughts about the psychological issues you are experiencing?*

"I cannot feel one side of my mouth. It is not there. I have gone for physiotherapy but still… so my dad being a psychiatrist thought I counselling would help solve the issue. But am fine. It is only this side of the mouth that is bringing me down and I am not myself."22 years old male

• *PTI and AFQ question: What are your thoughts about the psychological issues you are experiencing?*

"…….Then I started getting headaches. Too much fear and thoughts. When I went to hospital, the doctor said I had psychosis. Yes I have tried to Google what that means. It is not easy to live with that and when you tell people they say you are chizzy."22 year old female

From the quotes above, it is evident that biological causes of mental illness were associated with fear of the illness and stigma from other relatives which led the patients to be withdrawn.

C: Various preferences for what might be curative

Nine out of the 10 clients' interviewed reaffirmed the tremendous value of psychotherapy as the most effective mode of intervention. One of our participants had psychotherapy experience before that prompted him/her to continue with that when the need arose this time around.

Theme 1: Affirmation of Psychotherapy as the most suitable intervention

The theme indicates that the participants wanted concrete ways to move on from their current situation by suggestions from a professional. It also shows how several of the participants wanted to engage in the counselling process and believed that they could learn and improve their life situation from it.

- *PTI and AFQ question: What do you think is needed for your illness to be cured or might ease your pain?*

> *"My dad often takes us for counselling just to make sure all is well. Prayers are good but I prefer something tangible such as counselling*."
> 22 years old male

Others wanted to learn coping mechanisms to help them handle themselves in various situations. Either by learning how to manage their feelings in a constructive way or focus on things that they viewed as important in their life.

> *"With anger, I believe I can control myself. The only person I cannot control is my dad. So I let him be. But I need to know how to stop over reacting when I get angry"24 years old female*

Seven clients believed that their negative childhood experiences caused their problems and still affected them, and these needed to be managed in order to move on with life. A good quote is from the20 year's old female who lost her mum at a young age.

> *"I still do not know how to deal with her demise. I want to understand myself better and be more productive in life. I am growing old. I need to know how to deal with mum not being around."*

She believed that working through her past experiences would lead to a more productive life and consequently psychologically healthy. The client went on to state that she needed the support from a professional counsellor in order to come into terms with her mum's death. Therefore these participants thought that the positive coping mechanisms came from an interface with a professional namely a psychotherapist were important in coming into terms with their earlier experiences and reshaping their lives.

A 19 years old male client who had been suspended from school said that peer pressure as a cause to his psychological as well as emotional pain.

> *"If I had listened to my inner voice that was telling me to avoid those guys, I would be so ok. I would be in school like other students. I will*

be attentive to my thoughts when asked to do something next time. Also, to be counselled on peer pressure will also help me learn to say no"

A 24 years old young woman participant considered going back to so that she could be happy.

"If I get the scholarship to UK, I will be happy. I want to be a better person and be busy. Being busy has helped me a lot. Now I do not concentrate with dad who doesn't help me with buying medicine. I also volunteer and get paid. Being busy helps a lot. But when idle, I get to think a lot and get angry over small issues."

Being involved in activities that clients enjoy and being in-tune with individuals' feelings and thoughts was related to having a positive mental health.

Professional counselling was emphasized over other alternatives means of coping. Involving in different activities that did not yield positive impact brought in the need for counselling. Being in peer groups leading to peer pressure was one of way that some clients thought would be a solution to their psychological challenges. This was mostly among those who got into substance use/abuse.

One of the female client had tried various solutions like going to church and talking to friends but that did not get her the solutions she needed.

"I used to go to church and share with my girlfriends but I was not content. I tried alcohol, cigarettes and generally going out for social events to feel ok but the pain was too deep in me. Especially after losing my dad and the insults I get from my brother. But the drinks did not help. I think counselling will be good for me at this stage in my life….."
20 years old female

Other Clients reported a positive impact of therapy from previous sessions in other clinics. Another client preferred professional therapy as opposed to talking to friends and relatives which is a common way of stress relief in African settings. Some clients' queried on the side effects that medication is said to have. Hence preference for therapy.

"I do not share my issues with other people. People are superficial and cannot be trusted. I prefer counselling.my friend had advised me to ask for anxiety drugs but I am not ready for medication…"
22 years old male.

This led to more exploration of different strategies that clients had thought of and practiced as a way to ease their pain. Those who were involved in misconduct behaviours in school that

got them into suspension reported to be wiser when choosing friends. Listening to parental advice, getting involved in extracurricular activities like sports and making use of their talents were the strategies that the clients had put into consideration and practiced. They believed that this would not only make them better people, but also help them improve in school performance, time management and forming bonds with people whom they shared the similar goals in life.

So as to reconnect with family members where the clients felt there was a need to do so, family therapy or counselling was discussed.

> *"If possible, I will ask my mum to come with me in next session. May be if the counsellor told her that I cannot be like her she will understand and stop being too harsh on me and having so high expectations form me." 19 years old male client.*

Theme 2 Valuing psycho-pharmacological support in their overall treatment

One male client out of 10 clients said to prefer medication as a form of treatment.

> *"I am not a people person at all. Am hoping to be given some stress medicine and I will be good. Talking to people feels strange especially for a man. Men do not share their personal information." 20 years old male.*

This could be viewed in the Kenyan cultural context where men are said not to be emotional or should not share their personal feelings.

To summarize the results / findings various causal explanations were reported with external events being the most attributed to clients psychological distress. Straining family relations, school performance and peer pressure from friends are some of the external causes. These were associated with stigma from significant others, leading to self-stigma and shame of disclosure in some clients. 99% of the clients interviewed choose therapy or counselling as preferred choice of treatment. With was to be incorporated with other activities such as being involved in sports, choosing friends with similar goals and reconnecting with parents for parental advice.

CHAPTER FIVE

5.0 DISCUSSION

Unprocessed psychological ailment is a momentous universal health issue. Socio-demographics and help-seeking Socio-demographic alterations in help-seeking have been at length established in the literature, with gender being the most regularly reported significant factor predicting people's help-seeking.

Previous researches show that clients had more than one causal explanations for their mental illness which relates with this thesis as well. Clients attributed their problems to poor performance in school and stressful events related to family and friends and death of a family member.

Researches completed in western countries about public views concerning causes of mental illnesses reported they primarily held beliefs to be social factors such as demanding life events, traumatic experiences, family problems, and social hindrance (Furnham & Chan 2004); (Magliano et al. 2004); (Nakane et al. 2005)(Angermeyer & Matschinger 2001).

Researches carried out by Muga & Jenkins, 2008; Ikwuka, Galbraith, & Nyatanga, 2013; Samouilhan & Seabi, 2010 show that some people hold biological explanations for their mental illness. This was, was found in the present study as 3 of the participants mentioned epilepsy, Bell's palsy and psychosis as biological cause of their problems.

African researches such as Thwaites, Dagnan, Huey, & Addis, 2004; Adewuya & Makanjuola, 2008 attribute mental illness to external causes. Lingman & Lydén, 2015 found that causes such as poverty, negative family up bring were prevalent among young people who sought for psychological help.

Environmental and social causal attributions have been found prevalent in previous researches and so is the case in this current research. In Ghana for instance, participants mentioned issues such as unhealthy living conditions, lack of social support, relationships problems, society pressures, loneliness and failure in life as reasons for becoming mentally ill, (Kyei et al. 2014).

A survey carried out in Nigeria found that as many as a third of the participants suggested that possession by evil spirits could be a cause of mental illness, which was not the case in this present study. However, in this same study, majority held the bio psychosocial causes such as

drug and alcohol misuse, traumatic event/tremor, stress, bodily mishandling and genetic inheritance as the reasons of mental illness (Gureje et al. 2005).

Ethiopia's recent studies exhibited addition of Biological and psychosocial factors as causes of mental instabilities in accumulation to the age old spiritual and charmed views (Astalin 2013). On the other hand a recent survey in a nearby area, a small town in western Ethiopia, reported bio psychosocial problems such as poverty, stress and drug abuse were believed to be imperative glitches for mental illness besides religious/magical views such as God's will or attack by evil spirit, (Mulatu 1999). A similar finding of predominantly psychosocial and supernatural retribution as causes of mental than physical illnesses in North-western Ethiopia challenging the previous report that lay Ethiopians exclusively believe in spiritual factors as causes of mental illnesses was also stated (Teferra et al. n.d.)

According to Mamah et al., (2013), youths' perceptions about mental illness in Kenya, spiritual explanations were highly prevalent as a cause to mental illness. In the present study the attribution to a spiritual cause was not mentioned by the 10 clients. This study was carried out at Kenyatta National Hospital which is a city location, and the clients interviewed had acquired a high school education with free access to the services offered at the youth clinic which could have influenced results findings in this thesis in regards to spiritual attributions of mental illness.

Three clients in the study talked about biological causes when asked about their mental illness. In spite of this, medication was mentioned by one client as preferred treatment, and of which the client was not among the three that attributed biological cause of mental illness but rather based his need of medication on African context by reporting that men do not talk about their emotional issues, hence preferred medication instead of therapy.

In a latest multisite study in Africa, the occurrence of epilepsy extended from 0.7 to 1.5 percent; in one systematic analysis, the age-precise prevalence ranged from 0.3 to 1.1 percent with a bimodal spreading with peaks at ages 20 to 29 and 40 to 49.

The treatment gap for epilepsy, the ratio of individuals who necessitate treatment, but do not receive it, nears 100 percent in many low-income countries. Untreated epilepsy results in distressing public concerns and unfortunate health outcomes. For example, children with epilepsy who have a seizure at school may be let go or detested, while adults may be banned from marriage or work. In addition, persons with epilepsy have greater psychological distress, more physical injuries such as splintering and burns, and increased death (Meyer & Ndetei 2015).

Bell's palsy do affect persons of any stage, the average age of inception being 40 years (Chuk & Nw 2009) The frequency is lowest in children beneath 10 years old; rises from the ages of 10 to 29, remains unchanging at the years of 30 to 69, and is highest in people over the age of 70. Mamah et al., 2012 showed a fairly high (45.5%) teenage and young adult lifetime prevalence of signs suggesting psychosis-risk in a section within Nairobi, Kenya.
B. Meyer & Garcia-Roberts, (2007) reported that clients preferred talking to someone about their mental health problems since it was helpful. The nine clients out of ten had tried other activities before to be incorporated with counselling sessions. For example, prayers, being responsible in improving their mental health, focusing on talent, avoiding bad peer company, taking note of parental advice could be said to be associated to the therapeutic methods of interpersonal therapy and behavioural activation in Cognitive Behavioural Therapy (Jacobson et al. 2001).
Study done in Pakistan again, closely half of the respondents reported psychiatric session to be the particular utmost important management stride (Zafar et al. 2008). This shows people living in non-western countries validate contemporary western medical attention for mental health problems in addition to the present native ways and means. They inclined to be more sensible and diversified in their approach and were will agreeable to try mixtures for treatment. Their views tend to be more self-motivated and friendly to change as the situation demands which is alike to other outcomes from non-western countries (Saravanan et al. 2008).
However, in this study it was evident that the private theories of several participants were influenced by Western views of pathogenesis and cure for mental illness. For instance, many of the participants spoke of psychotherapy/counselling as a cure when asked about remedy for their mental illness. Some also spoke of an assessment and diagnosis as helpful. Few clients mentioned believing in a biological cause of their problems, something which have been found in previous research. The apparent existence of Western conceptions could be the result of the participants being, what Sunday & Ibadan, 2004 describes as transitional Africans. Transitional Africans have received a Western education and, therefore, incorporate both the African and Western values. This could be also because the participants of this study were sampled from KNH-Youth centre which is known as the place where urban youth can go for counselling.

It is important to focus on how attribution framework can help expand patient's private theories/experiences about their problems and their perceived solutions. The attribution model

by Weiner's attribution theory (Weiner 1980) was used to guide the aim of the study. The domains used as a guide were: Locus of Control. (Internal Vs. External) Controllability (controllable vs. uncontrollable) Stability (Stable or Unstable) and Stigma as an independent Domain.

1. **Bio-psychosocial causes Vs. Internal and External Locus of control**

Introducing locus on control attribution to make sense of this experience the researcher felt that those individuals with an internal locus of control were reasonably quick-witted in directing their own behaviours once they were familiarised to psychotherapy.

The participants with an outward locus of control do not have a contributing factor (Aslan 2014) and consequently take longer time to identify how the change could be made. A case in point is that feelings such as anger, fear and thoughts of being well or the need to deal with one's stressors are some of the internal/ dispositional factors leading to seeking treatment that the participants talked about.

These clients were well in control of their feelings and thoughts. However, their psychological stressors had roots in some external, uncontrollable traumatic factors such as separation from parents, death of a loved one and excessive stigmatization and discrimination from others. According to Rotter's explanation of exterior locus of governor, events or outcomes hinge on factors managed by environmental influences such as destiny or affluence outside of individual's control.

Thus, the researcher posit that External locus of control might be damagingly related with problem-focused coping when one is tensed. This might be because feelings of anger, sadness, self-stigma and fear do emerge from external factors such as death of a loved one or client being rejected by peers and family members.

2. **Following the same logic, valuation of psychotherapy might be higher in those with Internal Locus of Control**

An emotional reaction is the product of internal processes, such as bitterness and hatred. Each client had a need for letting go these emotional struggles. Putting into consideration that these are within the client's internal locus of control, this hence explains the second conjecture that the internal locus of control might be absolutely associated with the acceptance and early progressive engagement with psychotherapy so as to be able to regulate their emotions and rechanneled efforts even in the face of external stressors.

3. **Stigmatizing contexts and relationships**

Stigma from others can often lead to excessive feelings of contempt and anger that triggers hostile behaviour and other externalizing symptoms. (Corrigan & Watson 2002). Unlike

physical disabilities, persons with psychological illness are perceived by the public to be in control of their disabilities and accountable for causing them. Furthermore, research respondents are less likely to pity persons with mental illness, instead reacting to psychiatric disability with anger and believing that help is not warranted (Corrigan 2002). This is in agreement with this research as reported by one client who attributed her psychological distress to epilepsy and consequently was neglected by his father, who does not buy her medication nor pays her school fees.

Discrimination can also appear in public opinion about how to treat people with mental illness. For example, one client reported to withdraw from family functions due to stigma and discrimination from his immediate family members and relatives. It is worth noting that the behavioural impact (or discrimination) that results from public stigma may take four forms: withholding help, avoidance, coercive treatment, and segregated institutions.

Research also suggests that, instead of being diminished by the stigma, many persons become virtuously irritated because of the unfairness that they have experienced (Crocker & Major 1989). This kind of response permits people to change their roles in the mental health system, becoming more enthusiastic participants in their treatment strategy and every so often pushing for improvements in the quality of services (Corrigan 2002). It is due to these external attribution (stigma from others) that various clients felt the need to seek and be committed to psychological therapy. Hence it can be argued that the clients viewed this external attribution as an un-stable attribution factor that could be changed through therapy and hence a controllable attribution as well, since they thought that by being in therapy, they were at a higher position of controlling how they felt and even reacted towards external attribution which in this case was stigma from others.

4. Self-stigma as another variant of stigma and its links with attribution controllability

Prejudice turned internal leads to self-discrimination. Investigation suggests self-stigma and fear of rejection by others lead many persons to not pursuing life prospects for themselves. Self-esteem suffers, as does confidence in one's future as indicated by clients interviewed in this research. Some felt lost and wanted to find their place in the society. An individual with psychological sickness may experience shrunk self-esteem/self-efficacy, anger, or relative irrelevance depending on the considerations of the circumstances (Corrigan & Watson 2002). From the clients interviewed in this research, self-esteem was viewed as one causal reason to psychological illness while in other clients, it was motivating factor to seeking help so as to be able to be productive citizens. A client reported the need for help in order to be able to regain

self-esteem and confidence as she was before. Therefore, self-stigma was an internal attribution that was viewed as a reason for seeking help since it was within the clients' controllable ability.

5.1 Study Limitations

Participants were interviewed after they had counselling session with their therapist and diagnosis made. This might have influenced the clients own thoughts and perceptions on mental illness and cure. However, the designed questionnaire guide was structured in a way that the client's personal perceptions on these issues were expressed, independent from therapist's thoughts. The study cannot be generalised to other youth centres -either urban or rural, being a quantitative study.

5.2 Conclusion

The study aimed to investigate the attribution of mental illness held by youth in Kenya. The results show diverse theories about causation and cure among the participants. Similar results as previous research were found (Kyei et al. 2014; Mamah et al. 2013; Muga & Jenkins 2008; Samouilhan & Seabi 2010) in Africa and noted that many attribute the cause of their problems to an external source and a few mentioning spiritual explanations. Biological causes were mentioned by few participants, agreeing with previous research. The beliefs regarding treatment concerned both professional help and the belief of non-professional help such as talking to someone or doing things by yourself to get better. Most research about etiological beliefs have investigated peoples' beliefs about mental illness in general and have not concerned peoples' private theories of their own mental illness. Thus, this study have expanded the research field

5.3 Recommendations

This was the first study of attribution of mental illness among the youths to be conducted at Kenyatta National Hospital and in Kenya. Some of the treatments currently used in Kenya have been proven helpful in the region (Bolton et al. 2015), but there is still a need to evaluate most of the practiced therapies in the country . Gaining more knowledge of patients' private theories about pathogenesis and cure can be of importance in order to improve the mental health care in the country.

This study was carried out in an urban setting with young adults. Hence, there is a need to make further research on how individuals in rural settings and of older age think about their mental illness and possible cure. It would also be interesting to investigate how psychiatrist and other mental health care staff in this culture conceive mental illness and balance the Western and traditional views of pathogenesis and remedy.

This study can give an increased knowledge of how patients in Kenya can think about cause and remedy of their mental illness. The variety of theories found indicates that it could be of importance to investigate a patient's theories at the beginning of a contact in order to provide the best-adapted treatment for the patients and consequently, make the mental health care more effective. This study contributes with important knowledge for the psychology programme broadening the competency of cultural psychology. It also sheds light on some of the differences which may exists regarding private theories between and within cultures, which is important knowledge in an increasingly multi-cultural world.

5.4 Research Work Plan

Activities	**Year 2015**
Research Proposal Preparation	January
Presentation/Approval of Proposal	April
Approval from KNH/UON/ERC	July
Pilot Study	August
Data Collection, Data Entry and Analysis	September-December 2015
Complete Dissertation Document	July 2016

5.5 Budget

The researcher was deservingly awarded a seed grant award by Partnership for Mental Health Development in Sub-Saharan Africa (PaMD) after a competitive selection, hence bringing this work into a successful completion.

Budget Category	Description	Amount KES
Research and Dissertation Fee	Research fee payable to the university.	145, 000.00
Supplies, Data collection material	Audio Recorder, Printing and stationary	21,000.00
Storage devices	External Hard Disk and Laptop	100,000.00
ERC Fee	Charges for KNH-UoN-ERC proposal review	2,000.00
Recurring Expenses	Transport to and from site and lunch	10, 000.00
Total Amount		278,000.00

REFERENCES

Adewuya, A.O. & Makanjuola, R.O.A., 2008. Lay beliefs regarding causes of mental illness in Nigeria: Pattern and correlates. *Social Psychiatry and Psychiatric Epidemiology*, 43(4), pp.336–341.

Aina, O. & Morakinyo, O., 2011. Culture–bound syndromes and the neglect of cultural factors in psychopathologies among Africans. *African Journal of Psychiatry*, 14.

Angermeyer, M.A.T.T.C. & Matschinger, H., 2001. Causal beliefs and attitudes to people with schizophrenia rend analysis based on data from two population surveys in Germany. , pp.0–4.

Arboleda-Flo'rez, J., 2002. What causes stigma? *World Psychiatry*, 1(1), pp.25–26.

Aslan, Ş., 2014. The Effect Of Self- Emotıon Appra isal And External Locus Of Control On Problem- Focused Copi ng Wıth Stress. , pp.599–606.

Astalin, P.K., 2013. Qualitative research designs: a conceptual framework. *International Journal of Social Science & Interdisciplinary Research*, 2(1), pp.118–124. Available at: indianresearchjournals.com.

Boldero, J. & Fallon, B., 1995. Adolescent help-seeking: what do they get help for and from whom? *Journal of Adolescence*, 18, pp.193–209.

Bolton, P. et al., 2015. Group Interpersonal Psychotherapy for Depression in Rural Uganda : A Randomized Controlled Trial. , pp.1–9.

Chuk, A.B. & Nw, J.N., 2009. Facial Nerve Paralysis in Imo State , Nigeria. *Asian Journal of Medical Sciences*, 1(2), pp.39–41.

Corrigan, P.W., 2002. Empowerment and serious mental illness: Treatment partnerships and community opportunities. *Psychiatric Quarterly*, 73(3), pp.217–228.

Corrigan, P.W. & Kleinlein, P., 2005. *The Impact of Mental Illness Stigma.*,

Corrigan, P.W. & Watson, A.C., 2002. The paradox of self-stigma and mental illness. *Clinical Psychology: Science and Practice*, 9(1), pp.35–53.

Crocker, J. & Major, B., 1989. Social stigma and self-esteem: The self-protective properties of stigma. *Psychological Review*, 96(4), pp.608–630.

Försterling, F., 2001. *Attribution. An introduction to theories, research, and applications*,

Furnham, A. & Chan, E., 2004. Lay theories of schizophrenia - A cross-cultural comparison of British and Hong Kong Chinese attitudes, attributions and beliefs. *Social Psychiatry and Psychiatric Epidemiology*, 39(7), pp.543–552.

Galvin, K.M. & Coope, P.J., 2006. *Making Connections: Reading in Rational Communication*

4th ed., Los Angeles: Roxbury Publishing Company.

Gureje, O. et al., 2005. Community study of knowledge of and attitude to mental illness in Nigeria. *The British journal of psychiatry : the journal of mental science*, 186, pp.436–441.

Heider Fritz et al., 1958. The Psychology of Interpersonal Relations. *The Journal of Marketing*, 56, p.322.

Helman, C.G., 1990. *Culture, Health and Illness*,

Ikwuka, U., Galbraith, N. & Nyatanga, L., 2013. Causal attribution of mental illness in south-eastern Nigeria. *The International journal of social psychiatry*. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23680764.

Jacobson, N.S., Martell, C.R. & Dimidjian, S., 2001. Behavioral Activation Treatment for Depression: Returning to Contextual Roots. *Clinical Psychology: Science and Practice*, 8(3), pp.255–270. Available at: http://dx.doi.org/10.1093/clipsy.8.3.255.

Jamesa, C. & Peltzer, K., 2012. Traditional and Alternative Therapy for Mental Illness in Jamaica: Patients' Conceptions and Practitioners' Attitudes. *African Journal Traditional Complementary Alternertives Medical*, 9(1), pp.94–104.

Jenkins, R. et al., 2012. Prevalence of common mental disorders in a rural district of Kenya, and socio-demographic risk factors. *International Journal of Environmental Research and Public Health*, 9, pp.1810–1819.

Jones, E.E. & Davis, K.E., 1965. From Acts to Dispositions: The Attribution Process in Social Psychology. In *Berkowitz, L. Advances in experimental social psychology*. New York: Academic Press, pp. 219–266.

Kelley, H.H., 1967. Attribution theory in social psychology. In *Nebraska Symposium On Motivation*. pp. 192–238.

Kessler, R.C. et al., 2005. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of general psychiatry*, 62, pp.593–602.

Khasakhala, L. et al., 2013. Major depressive disorder in a Kenyan youth sample: relationship with parenting behavior and parental psychiatric disorders. *Annals of general psychiatry*, 12(1), p.15. Available at: http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=3660220&tool=pmcentrez&rendertype=abstract.

Kyei, J.J. et al., 2014. Supernatural belief systems, mental health and perceptions of mental disorders in Ghana. *International Journal of Culture and Mental Health*, 7(2), pp.137–

151. Available at: https://www.lib.uwo.ca/cgi-bin/ezpauthn.cgi?url=http://search.proquest.com/docview/1520887759?accountid=15115\nhttp://vr2pk9sx9w.search.serialssolutions.com/?ctx_ver=Z39.88-2004&ctx_enc=info:ofi/enc:UTF-8&rfr_id=info:sid/ProQ:psycinfo&rft_val_fmt=info:of.

Levander, S., 2006. How do you understand and explain to yourself your problems and difficulties ? , pp.1–5.

Lingman, M. & Lydén, J., 2015. Private theories about pathogenesis and cure among young psychiatric patients in Kenya - a Thematic Analysis.

Magliano, L. et al., 2004. Beliefs about schizophrenia in Italy: a comparative nationwide survey of the general public, mental health professionals, and patients' relatives. *Canadian journal of psychiatry. Revue canadienne de psychiatrie*, 49(5), pp.322–30. Available at: http://www.ncbi.nlm.nih.gov/pubmed/15198469.

Major, B. & Eccleston, C.P., 2005. Stigma and social exclusion. In *The social psychology of inclusion and exclusion*. pp. 63–87.

Mamah, D. et al., 2012. A survey of psychosis risk symptoms in Kenya. *Comprehensive Psychiatry*, 53(5), pp.516–524.

Mamah, D. et al., 2013. Knowledge of psychiatric terms and concepts among Kenyan youth: analysis of focus group discussions. *Transcultural psychiatry*, 50(4), pp.515–31. Available at: http://tps.sagepub.com.libaccess.lib.mcmaster.ca/content/50/4/515.short.

Manasi, K. et al., 2014. *Psychotherapy for Mental Illness in Kenya: Towards an Outcome-Informed Practice*,

Mbwayo, a W. et al., 2013. Traditional healers and provision of mental health services in cosmopolitan informal settlements in Nairobi, Kenya. *African journal of psychiatry*, 16(2), pp.134–40. Available at: http://www.ncbi.nlm.nih.gov/pubmed/23595533.

Meyer, A. & Ndetei, D., 2015. Providing Sustainable Mental Health Care in Kenya : A Demonstration Project. , pp.137–170.

Meyer, B. & Garcia-Roberts, L., 2007. Congruence between reasons for depression and motivations for specific interventions. *Psychology and psychotherapy*, 80(Pt 4), pp.525–42. Available at: http://doi.wiley.com/10.1348/147608306X169982\nhttp://www.ncbi.nlm.nih.gov/pubmed/17999783\nhttp://onlinelibrary.wiley.com.ez.statsbiblioteket.dk:2048/doi/10.1348/147608306X169982/full.

Muga, F.A. & Jenkins, R., 2008. Public perceptions, explanatory models and service utilisation regarding mental illness and mental health care in Kenya. *Social Psychiatry*

and Psychiatric Epidemiology, 43(6), pp.469–476.

Mulatu, M.S., 1999. Perceptions of Mental and Physical Illnesses in North-western Ethiopia: Causes, Treatments, and Attitudes. *Journal of Health Psychology*, 4(4), pp.531–549.

Murray, K.E., Davidson, G.R. & Schweitzer, R.D., 2010. Review of refugee mental health interventions following resettlement: Best practices and recommendations. *American Journal of Orthopsychiatry*, 80, pp.576–585.

Nakane, Y. et al., 2005. Public beliefs about causes and risk factors for mental disorders: a comparison of Japan and Australia. *BMC psychiatry*, 5, p.33.

Ndetei, D.M. et al., 2011. Knowledge, attitude and practice (KAP) of mental illness among staff in general medical facilities in Kenya: practice and policy implications. *African journal of psychiatry*, 14, pp.225–235.

Nunn, A.L., 2009. *Eating Disorder and the Experience of Self: An Interpretative Phenomenological Analysis*. University of Hertfordshire.

Okello, E.S. & Ekblad, S., 2006. *Lay concepts of depression among the Baganda of Uganda: a pilot study.*,

Patel, V. et al., 2007. Mental health of young people: a global public-health challenge. *Lancet*, 369(9569), pp.1302–1313.

Pescosolido, B.A. et al., 2010. "A Disease Like Any Other"? A Decade of Change in Public Reactions to Schizophrenia, Depression, and Alcohol Dependence. *American Journal of Psychiatry*, 167(11), pp.1321–1330.

Philips, B., Wennberg, P. & Werbart, A., 2007. Ideas of cure as a predictor of premature termination, early alliance and outcome in psychoanalytic psychotherapy. *Psychology and psychotherapy*, 80(Pt 2), pp.229–245. Available at: http://www.ncbi.nlm.nih.gov/sites/entrez?Db=pubmed&DbFrom=pubmed&Cmd=Link&LinkName=pubmed_pubmed&LinkReadableName=Related Articles&IdsFromResult=17535597&ordinalpos=3&itool=EntrezSystem2.PEntrez.Pubmed.Pubmed_ResultsPanel.Pubmed_RVDocSum.

Razali, S.M., Khan, U.A. & Hasanah, C.I., 1996. Belief in supernatural causes of mental illness among Malay patients: impact on treatment. *Acta psychiatrica Scandinavica*, 94, pp.229–233.

Rickwood, D. et al., 2004. Educating young people about mental health and mental illness: evaluating a school-based programme. *International Journal of Mental Health Promotion*, 6, pp.23–32.

Rowe, M.M. & Allen, R.G., 2004. Spirituality as a Means of Coping with Chronic Illness.

American Journal of Health Studies, 19(1), pp.62–67.

Rüsch, N., Angermeyer, M.C. & Corrigan, P.W., 2005. Mental illness stigma: Concepts, consequences, and initiatives to reduce stigma. *European Psychiatry*, 20, pp.529–539.

Rush, L.L., 1998. Affective Reactions to Multiple Social Stigmas. *The Journal of Social Psychology*, 138, pp.421–430.

Samouilhan, T. & Seabi, J., 2010. University students' beliefs about the causes and treatments of mental illness. *South African Journal of Psychology*, 40(1), pp.74–89.

Saravanan, B. et al., 2008. Perceptions about psychosis and psychiatric services: A qualitative study from Vellore, India. *Social Psychiatry and Psychiatric Epidemiology*, 43(3), pp.231–238.

Sharif, S.A., Ogunbanjo, G.A. & Malete, N.H., 2003. Reasons for Non-compliance to Treatment among Patients with Psychiatric Illness: A Qualitative Study. *African Journals Online*, 45(4), pp.10–13.

Shebabaw, M.E. et al., 2014. Perceived Causal Attribution of Psychological Disorders and Treatment Seeking Behavior in Gondar, Northwest Ethiopia. *Innovare Journal of Social Sciences*, 2(4). Available at: http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=1&cad=rja&uact=8&ved=0CCIQFjAA&url=http://innovareacademics.in/journals/index.php/ijss/article/download/2224/1353&ei=lf7RVOj0Mqi37Abyv4GACQ&usg=AFQjCNF3TX5yBObW5MrtgmOmJCpKZfmhJg&sig2=Xxo8CPWsQL.

Sheffield, J.K., Fiorenza, E. & Sofronoff, K., 2004. Adolescents' willingness to seek psychological help: Promoting and preventing factors. *Journal of Youth and Adolescence*, 33, pp.495–507.

Smith, J.A., Flowers, P. & Larkin, M., 2009. *Interpretative phenomenological analysis: theory, method and research*,

Smith, J.A., Flowers, P. & Osborn, M., 1997. Interpretative phenomenological analysis and the psychology of health and illness. In *Material discourses of health and illness*. pp. 68–91.

Sunday, E. & Ibadan, I., 2004. Mental Health and Psychotherapy ' through ' the Eyes of Culture : Lessons for African Psychotherapy. *Trans*, (15), pp.1–11.

Teferra, S., Ababa, A. & Ababa, A., Perceived Causes of Severe Mental Illnesses and Preferred Treatment for the Mentally Ill among the Borana Semi-Nomadic Community , Southern ST : soloteferra@yahoo.com TS : shibreteshome@yahoo.com LS : lars.jacobsson@psychiat.umu.se Abstract Background Con. , pp.1–27.

Teferra, S. & Shibre, T., 2012. Perceived Causes of Severe Mental Disturbance and Preferred Interventions by the Borana Semi-nomadic Population in Southern Ethiopia: A Qualitative Study. *BMC Psychiatry*, 12(79).

Thwaites, R. et al., 2004. The Reasons for Depression Questionnaire (RFD): UK Standardization for clinical and non-clinical populations. *Psychology and psychotherapy*, 77(Pt 3), pp.363–74. Available at: http://www.ncbi.nlm.nih.gov/pubmed/15355587.

Vaughn, L., Jacquez, F. & Baker, R., 2009. Cultural health attributions, beliefs, and practices: Effects on healthcare and medical education. *Open Medical Education journal*, pp.64–74. Available at: http://www.benthamsciencepublisher.com/open/tomededuj/articles/V002/SI0016TOMEDEDUJ/64TOMEDEDUJ.pdf.

Vaughn, L.M., Jacquez, F. & Baker, R.C., 2009. Cultural Health Attributions, Beliefs, and Practices: Effects on Healthcare and Medical Education. *The Open Medical Education Journal*, 2, pp.64–74.

Wallston, K.A., Wallston, B.S. & DeVellis, R., 1978. Development of the Multidimensional Health Locus of Control (MHLC) Scales. *Health education monographs*, 6, pp.160–170.

Weiner, B., 1980. A cognitive (attribution)-emotion-action model of motivated behavior: An analysis of judgments of help-giving. *Journal of Personality and Social Psychology*, 39(2), pp.186–200.

Weiner, B., Perry, R.P. & Magnusson, J., 1988. An attributional analysis of reactions to stigmas. *Journal of personality and social psychology*, 55, pp.738–748.

Werbart, A. & Levander, S., 2005. Understanding the incomprehensible: Private theories of first-episode psychotic patients and their therapists. *Bulletin of the Menninger Clinic*, 69, pp.103–136.

WHO, 2013. The world health report 2013: Research for universal health coverage. *World Health Organization Press*, p.146.

Zafar, S.N. et al., 2008. Perceptions about the cause of schizophrenia and the subsequent help seeking behavior in a Pakistani population - results of a cross-sectional survey. *BMC psychiatry*, 8, p.56.

CHAPTER SIX

6.1 APPENDIX 1: CONSENT FORM FOR THE PARTICIPANT

Introduction: My name is Judy Mbuthia and I am a Clinical Psychology student at the University of Nairobi. I am conducting a research that is aimed at investigate the ascriptions that youth have on issues related to mental disorders, that may be a hindrance to effective treatment process.

Study Title: Attributions of mental illness among young people seeking psychiatric treatment in Kenyatta National Hospital in Nairobi.

Benefits: There will be no direct benefits to you as an individual. It is hoped that the study will be of benefit to other service users by developing a body of knowledge that demonstrates the attributions held youth on psychological issues. In addition, thinking on the issues asked in the interview guide may help you in developing new insights.

Compensation: No monetary rewards will be given.

Risks and alternative treatment: This study will be based on semi-structured interview guide. During the interviews, some painful or frightening subjects may come up. It may be beneficial to the subjects to discuss these with professional counsellors who are available at the youth clinic. In cases where the emotional reactions are overwhelming, referral for further psychological assessment and support will be recommended.

Confidentiality and Data protection: All data will be held confidentially. Cases shall be assigned numbers so that names do not appear in the database. All information will be anonymised and nobody will be able to identify individual respondents from any reports or publications arising from this study.

Voluntarism: Participation in this study is entirely voluntary. You alone can decide whether to take part or not. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time or a decision not to take part will not affect your routine working relations with your therapists or any staff at the hospital.

Contact: If you feel this study has harmed you in any way, or if you have concerns you can contact:

The Secretary, Kenyatta National Hospital Ethics research Committee, Kenya Ethics Office, KNH/UoN-ERC, P.O. Box 20723-00200, KNH Nairobi Kenya, and Tel. 2726300 Ext. 44102. Or send a message on this number and I will call you back.-0720227006.

Thank you very much.

Yours sincerely,

Judy Mbuthia,

MSc. Clinical Psychology Student

Department of Psychiatry

University of Nairobi.

Participant's statement

I have read this consent form. I have had my questions answered in a language that I understand by the principal investigator. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary and that I may choose to withdraw any time. I freely agree to participate in this research study.

I understand that all efforts will be made to keep information regarding my personal identity confidential.

By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

I agree to participate in this research study:

NAME……..

SIGNATURE…….

DATE……

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above and believe that the participant has understood and has freely given his/her consent.

NAME……..

SIGNATURE…….

DATE……

6.2 APPENDIX 2: DEMOGRAPHIC QUESTIONNAIRE

TO BE FILLED ONCE AT THE END OF FIRST THERAPY SESSION BY CLIENT

Study Title: Attributions of mental illness among young people seeking psychiatric treatment in Kenyatta National Hospital in Nairobi.

Client ID; _____ (File Nr)

Date; _____

Gender:

___ Male

___Female

Age: _____ years

Knowledge of English Language (Please tick and specify language)

Read	**Write**	**Speak**
Easily _ Not Easily _	Easily _ Not Easily _	Easily _ Not Easily _

6.3 APPENDIX 3: THE DESIGNED QUESTIONNAIRE GUIDE.

Thank you for the willingness to participate. My name is Judy Mbuthia, a post graduate student pursuing masters in clinical psychology. As part of my study, I am conducting this interview so as to gain understanding on your meaning-making to your interpersonal, psychic and somatic distress. You are the expert in this. There are no right or wrong answers. What you say is of great value so feel free to discuss with me. Be honest but don't say something that may make you feel uncomfortable. The interview will be tape recorded. This will enable me write a good report of our interview. We have 45 minutes to hold the interview. At the end of our interview, I will allow you to ask any questions regarding your illness.

The Conceptual Framework for (Private theories interview patients version) PTI and Attributions Focused Questionnaire (AFQ)

What is it that leads you to seek treatment today?	• Internal locus of control • External locus of control
What are your thoughts about the psychological issues you are experiencing?	• Controllability • Uncontrollability
Tell me about some or other important experiences or events in your life that you associate with your difficulties and how these problems	• Stability • Instability
In relation to the problem (MI) how do you see yourself and others around you?	• Experiencing stigma • Not experiencing stigma
What do you desire that would ease your pain/distress?	• Desired treatment plan or cure • No suggestions as such

Thank you for sharing your thoughts with me. I appreciate your time and interest in the study. You are free to ask questions and if there are none, we've come to the end of our interview. Thank you.

6.4 Nyongeza 4: Zana za Utafiti

Mwanzo: Jina langu ni Judy Mbuthia, mwanafunzi katika Chuo Kikuu cha Nairobi. Ninatekeleza uchunguzi unaonriwa mafikira ambayo wanarika wanasheheni kuhusu magonjwa ya akili ambayo inaweza kuwa kizuizi kwa mchakato ufanisi matibabu.
Faida: Hakuna faida ya moja kwa moja kwako, lakini inaaminika kuwa uchunguzi huu utasaidia wengine kupata ujuzi utakaofafanua mawazo ya vijana/wanarika kuhusu maswali ya saikolojia. Zaidi ya hayo kama mtu binafsi, kufikiri juu ya masuala katika mwongozo wa mahojiano inaweza kukusaidia kuendeleza ufahamu mpya.
Fidia: Hamna malipo ya fedha utakayolipwa.
Hatari na matibabu mengine: Kuna Maswala chungu au ya kushangaza yanaweza ibuka. Ni muhimu kuzungumuzia mambo haya kwa kina na wahudumu waliopo katika zahanati ya wanarika. Hisia zikizidi, ni muhimu kumuona mwana saikolojia kujadiliana kwa mapana na marefu zaidi.
Usiri na uhifadhi wa data: habari zozote zitakuwa za siri. Kesi zitapewa nambari ili majina yasitambulike au kujulikana. Ujumbe wote utawekwa kwa siri na hakuna yatakayeweza kutambua watoa habari katika toleo lolote au machapisho yanayotokana na utafiti huu.
Kujitolea: Kushiriki katika utafiti huu ni hiari kabisa. Wewe peke yako unaweza kuamua kama utashiriki au la. Kama mshirika katika utafiti huu una uhuru wa kujiuzuru wakati wowote na uamuzi huo hautaathiri uhusiano wako wa kazi na mshauri au na ofisi yeyote ya hospitali hii.

Kuwasiliana: Kama unajisikia utafiti huu unakudhuru kwa namna yoyote ile, au kama una wasiwasi unaweza kuwasiliana na:

Katibu Mkuu, Kamati ya Maadili ya utafiti, Kenyatta National Hospital, Afisi ya Maadili, (KNH / UON-ERC)

Sanduku la posta 20723-00200, KNH Nairobi Kenya, Simu: 2726300 Ext. 44102.

Au kutuma ujumbe kwenye namba hii na Mimi nitakupigia simu-0720227006.

Asante sana.

Wako mwaminifu,

Judy Mbuthia, MSc. Clinical Psychology

Mwanafunzi Idara ya Psychiatry

Chuo Kikuu cha Nairobi.

Fomu Ya Makubaliano

Nimesoma fomu hii na maswali yote niliyokuwa nayo yameelezwa na mtafiti. Nashiriki katika mahojiano haya kwa kujitakia mimi mwenyewe bila kushawishiwa na yeyote. Ninaelewa kwamba kila juhudi itafanywa kuhakikisha kwamba yale yanayonihusu yatakuwa siri. Kwa kutia fomu hii sahihi haimanishi kwamba haki zangu za kisheria hazitakiukwa katika utafiti huu

Jina……..

Sahihi…….

Tarehe…….

Msimamo Wa Mtafiti

Mimi kama mtafiti nimeshaeleza mtu atakayehusika katika utafiti huu mambo yote katika utafiti huu. Naamini kwamba anashiriki katika utafiti huu kwa nia yake mwenyewe na ameshaelewa yote yanayohusu utafiti huu.

Jina…….

Sahihi……

Tarehe…….

NYONGEZA YA PILI

Fomu hii ijazwe mara moja na mteja baada ya mwisho wa kipindi cha kwanza cha nasaha.

Nambari ya mteja……..(nambari ya faili)

Tarehe: ……

Jinsia:

…….Mwanaume

……mwanamke

Umri…

Ujuzi wa lugha ya kiingereza (weka alama (tick)

KUSOMA	KUANDIKA	KUZUNGUMZA
Kwa ufasaha……	Kwa fasaha……	Kwa ufasaha……..
Bila ufasaha……	Bila ufasaha……	Bila ufasaha……..

NYONGEZA YA TATU

Nakushukuru kwa kujitolea kushiriki. Jina langu ni Judy Mbuthia, mwanafunzi wa uzamili katika somo la nasaha, Mojawapo ya kipengele cha somo langu ni kufanya mahojiano, kuelewa baadhi ya vipengele vya somo hili. Wewe ni stadi katika nyadhfa hii. Hakuna jibu lililo sahihi au lisilo sahihi. Lolote utakalo sema ni la manufaa kubwa na hivyo basi kuwa huru kuzungumza nami, kuwa mwaminifu lakini usiseme lolote ambalo litakuathiri. Mahojiano haya yatahifadhiwa katika kanda ili kuniwezesha kuandika ripoti bora baada ya mahojiano. Nakadiria mahojiano haya yatatumia dakiki. Baada ya mahojiano nitakupa nafasi kuniuliza maswali kuhusu maradhi yako.

Nini kilichosababisha utafute matibabu leo?	Motisha wa kibinafsi na motisha unaotokana na athari
Unafikiriaje kubuni mambo ya kisaikolojia unayoyapitia?	Kujizuia
Nieleze kutokana na tajriba yako mambo ambayo unafikiria yamesababisha shida ulizo nazo?	Uimara
Je watu au wewe unajidharau kutokana na ugonjwa wako wa akili? Matibabu	Dharau
Unafikiria ni nini kinachohitajika ili wewe upone au upunguze maumivu yako	Matibabu yanayotamaniwa

Asante sana kwa fikira zako na kushauriana name. Zaidi kwa kujitolea kunipa muda wako na vilevile kuwa makini katika utafiti huu. Sasa nakupa nafasi uniulize swali kuhusu ugonjwa wako, ikiwa huna swali basi nitahitimiza majadiliano haya.

Asante sana

6.5 APPENDIX 5: CLEARANCE LETTER FROM ETHICS-UIVERSITY of NAIROBI

6.6 APPENDIX 6: CLEARANCE LETTER FROM KENYATTA NATIONAL HOSPITAL YOUTH CLINIC