

**MAINSTREAM MEDIA REPRESENTATION OF MENTAL HEALTH  
ISSUES IN KENYA: PERSPECTIVES OF HEALTH EXPERTS**

**BY**

**JULIA KAGUNDA**

**A THESIS SUBMITTED IN PARTIAL FULFILLEMENT OF THE  
REQUIREMENTS FOR THE AWARD OF DEGREE OF DOCTOR OF  
PHILOSOPHY IN COMMUNICATION STUDIES TO THE DEPARTMENT  
OF COMMUNICATION STUDIES, SCHOOL OF INFORMATION  
SCIENCES, MOI UNIVERSITY**

**2020**

## DECLARATION

This Thesis is my original work and has not been presented for examination in any other university. No part of this thesis may be reproduced without the prior written permission of the author and/or Moi University.

### Declaration by Candidate:

Julia Kagunda..... Date: .....

SHRD/DPHIL/09/12

### Declaration by Supervisors:

This Thesis has been submitted for examination with our approval as University supervisors.

Dr.MasiboLumala..... Date.....

Senior Lecturer

Department of Communication Studies

Moi University, Eldoret, Kenya

Sis.Dr. Nabushawo C. Justin ..... Date.....

Lecturer

Department of

Moi University, Eldoret, Kenya

**DEDICATION**

This Thesis is dedicated to my late brother, Peter Kihiu, who fought depression when it was least understood.

## ABSTRACT

This study investigated how mainstream media in Kenya represents mental health issues. A critical analysis was needed because globally mental health is on the increase, with 25% of Kenyans affected by mental health related issues. Mental health stakeholders in Sub-Saharan Africa identified media as a critical partner in public education and policy advocacy. It was therefore important to investigate how mainstream media in Kenya represents mental health issues to determine whether there was need for change of style in the presentation of this information. The study sought to answer the following research questions: 1. How are mental health issues represented by the mainstream media in Kenya; 2. What are the perspectives of the mental health experts on how the mainstream media represents mental health issues in view of the situation facing the sector? 3. What informs the way mental health issues are represented by the Kenyan mainstream media? The relativist-interpretivist research paradigm was used, hence the qualitative approach, using the case study method. Data was collected through in-depth interviews and document analysis. Through purposive sampling procedure, I administered in depth interviews with 13 health journalists from 4 mainstream print media houses and 5 TV stations and with 8 mental health experts leading mental health institutions and associations in Kenya. I analyzed the data thematically and consequently, presented the data in narrative form in accordance with the themes. The findings show that mental health issues are underrepresented as compared to other diseases and skewed representation of mental health exists where there is more emphasis on the 'ill' and not mental health; further, mental health challenges are linked to violence and crime and represented as a disease that affects the poor and uneducated. Mainstream media representation deviates from the reality of mental health in Kenya whereby mental health challenges cut across all ages and status. Also, people with mental health challenges are more subjected to violence than vice versa as the media representation seems to indicate. Media routines, journalist's social and cultural orientation, lack of health reporting policy and poor investment in mental health reporting by the mental health stakeholders are the key determinants influencing how mental health issues are represented by the mainstream media in Kenya. Based on this study, I recommend a paradigm shift, where like any core public health programmatic health stakeholders form strong collaboration with the Kenyan media and develop an integrated strategic media advocacy plan with clear targets, training, advocacy and funding in order for the media to make a positive contribution in mental health promotion, which will ultimately make significant contribution in positive mental health outcome. It is imperative that mainstream media houses in Kenya develop health reporting policies.

## TABLE OF CONTENTS

DECLARATION.....	ii
DEDICATION .....	iii
ABSTRACT.....	iv
TABLE OF CONTENTS.....	v
LIST OF TABLES .....	ix
ACKNOWLEDGEMENTS .....	x
LIST OF ABBREVIATIONS .....	xi
OPERATIONAL DEFINITION OF TERMS.....	xiii
CHAPTER ONE: INTRODUCTION .....	1
1. Introduction.....	1
1.1. Background of the Study .....	1
1.1.1. International context.....	3
1.1.2. The African context.....	4
1.1.3. The Kenya context.....	8
1.2. Statement of the problem.....	11
1.2.1. Social problem .....	12
1.2.2. Contextual problem .....	14
1.2.3. Academic problem .....	15
1.3. Research Questions .....	15
1.4. Scope of the Study.....	15
1.4.1. Content scope.....	16
1.4.2. Contextual scope .....	17
1.4.3. Methodological scope.....	17
1.5. Rationale for the Study .....	18
1.6. Summary.....	20
CHAPTER TWO: LITERATURE REVIEW .....	21

2. Introduction.....	21
2.1. Media Representation in Health Promotion.....	21
2.1.1. Mental Health Communication and Media.....	26
2.1.2. Media Representation and Mental health issues .....	29
2.1.3. Desperate Need for Media Advocacy for Mental Health .....	31
2.2. Situating research in the field of communication studies .....	42
2.3. Review of Previous Research in Media Representation of mental Health ...	43
2.4. Review of relevant theories .....	46
2.4.1. Social Construction of Reality .....	46
2.4.2. Framing Theory.....	52
2.5. Conclusion .....	57
CHAPTER THREE: RESEARCH METHODOLOGY .....	59
3. Introduction.....	59
3.1. Philosophical Paradigm of the Study .....	59
3.2. Qualitative Research Approach.....	63
3.3. Case Study Method.....	66
3.4. Study Pre-planning and Sampling Procedure .....	70
3.5. Pilot Study.....	74
3.6. Data Generations Techniques .....	75
3.6.1. In-depth interviews .....	75
3.7. Data Analysis .....	79
3.7.1. Transcription of the data.....	80
3.7.2. Coding and Analysis.....	81
3.8. Trustworthiness of the Study .....	82
3.9. Ethical Considerations .....	86
3.10. Conclusion.....	88
CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND FINDINGS .....	90

4. Introduction.....	90
4.1. Under representation of mental health issues .....	90
4.1.1. Focus on the ‘ill’ and visible symptoms of mental illnesses .....	95
4.1.2. Mental illnesses Represented as diseases linked to Crime, Violence and ‘Outrageous’ acts.....	98
<b>4.1.3. A disease for the poor, rural and uneducated population.....</b>	<b>105</b>
4.1.4. Demeaning language .....	111
4.2. Summary .....	117
CHAPTER FIVE: PERSPECTIVES OF HEALTH EXPERTS ON MEDIA REPRESENTATION OF MENTAL HEALTH .....	119
5. Overview.....	119
5.1. Mainstream Media Representation and the reality of mental health as perceived by mental health experts.....	119
5.1.1. Mental Health’ illnesses’ as a silent disease .....	120
5.1.2. Mental Health Challenges cut across status and age .....	126
5.2. Factors Informing media representation of mental health issues .....	128
5.2.1. Socio-Cultural Factors and their role on representation of mental health.....	128
5.2.2. Journalists Routines and their role in media representation of mental health.....	133
5.2.3. A lack of investment in Mental Health Reporting .....	135
5.2.4. Disjointed and uncoordinated media efforts by mental health stakeholders.....	145
5.2.5. Lack of Media Policy in Health reporting .....	147
5.3. Conclusion .....	147
CHAPTER 6: DISCUSSIONS AND CONCLUSIONS.....	149
6. Overview.....	149
6.1. Summary of key findings.....	149

6.2.1.	Skewed Media representation of mental health issues .....	151
6.2.2.	A representation that deviates from the reality .....	160
6.2.3.	Weak Media Advocacy on mental health issues.....	170
6.2.4.	Lack of Health reporting policies and impact to mental health representation .....	175
6.3.	Conclusions.....	176
6.3.1.	Contributions of this study.....	178
6.3.2.	Implications for policy and practice .....	179
6.3.3.	My Thesis .....	181
6.4.	Further Research.....	181
	REFERENCES.....	182
	APPENDICES.....	193
	Appendix 1: In-depth Interview Guide for Health Journalists.....	193
	Appendix II: In-Depth Interview Guide for Mental Health Experts .....	194
	Appendix III: Media Documents that were Analysed .....	196
	Appendix IV: Research Permit .....	207
	Appendix V: SAMPLE INFORMED CONSENT FORM .....	209



**LIST OF TABLES**

Table 1: Summary of key issues in Chapter One .....	20
Table 2: Summary of Literature Review .....	57
Table 3: Summary of Methodology .....	89
Table 4: Media representation of mental health issues.....	118
Table 5: Reality of mental health in Kenya & Factors informing the media representation .....	148
Table 6: Summary of key findings .....	149

## ACKNOWLEDGEMENTS

First I acknowledge the Lord Jesus Christ who has seen me through this journey, which often proved to be quite tedious. My special thanks and gratitude to my able supervisors, Senior Lecturer, Dr. Lumala Masibo and Lecturer, Sis.Dr. Nabushawo C. Justin for not only supervising me but your words of encouragement and support you gave me.

Secondly, I would like to appreciate the support of Moi University, particularly Dr. Charles Ochieng' Ong'ondo, the former Head of the Department of Communication Studies and the current HOD, Dr. Abraham Mulwo for the support I received from you as I worked on the work.

I am also grateful to the participants of this study, who devoted their time to share their experiences and insights.

I truly thank my husband, KagundaChege and my children Shingai, David and Danny for being my cheer leaders in this journey. You stood by my side, especially as I came to the finishing line, which was a busy season in my life. And I cannot forget my PhD colleagues whom we exchanged ideas and encouraged each other towards getting to the goalpost. Bernice and Stella, He who started this good work in us, has brought it to completion in His beautiful time! Special thanks to my lovely elderly mom, nephew, Dave, siblings and friends who have prayed with me. I am here today because all of you played significant roles in different ways. Abundant blessings!

**LIST OF ABBREVIATIONS**

AIDS	Acquired Immune Deficiency Syndrome
CBO	Community Based Organizations
CHC	Child Health Clinic
CMD	Common Mental Disorders
CCC	Comprehensive Care Clinic
HIV	Human Immuno-Deficiency Virus
IDS	Institute of Development Studies
KNH	Kenyatta National Hospital
KNCHR	Kenya National Commission on Human Rights
KPA	Kenya Psychiatric Association
KCPC	Kenya Counselling and Psychology Association
MH	Mental Health
MHA	Mental Health Acts
MhGAP	Mental Health Global Action Program
MOH	Ministry of Health
MOMS	Ministry of Medical Services
NACC	National AIDS Control Council
NCST	National Council for Science and Technology
NGO	Non-Governmental Organization
NAMI	National Alliance of Mental Illness
PTSD	Post-Traumatic Stress Disorder
SGBV	Sexual and Gender Based Violence
UK	United Kingdom
UON	University of Nairobi

US	United States
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

## OPERATIONAL DEFINITION OF TERMS

**Health Journalists:** In this study they are print and TV reporters who are designated as health reporters in their media houses. In addition, there are editors also involved in editing, amongst other roles, health related stories.

**Mental Health:** The definition used about MH is from WHO (2003) where MH is seen as a state of well-being where every individual realizes his or her own potential and can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. Further, it is seen as a complete state of positive mental well-being and is also defined as a state of well-being whereby individuals recognize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities. In this study, Mental Health is seen as the whole spectrum involving prevention, causes, symptoms and treatment of MH challenges or illnesses.

**Mental illnesses:** It is used interchangeably with Mental Health Conditions and Mental Disorders. But in this study the phrase mental illnesses is used to describe those suffering from mental health related diseases like anxiety disorders, schizophrenia, depression, substance disorder and dementia (WHO report, 2010; Mental health and development: targeting people with mental health conditions as a vulnerable group). It is mainly to do with the ability to manage one's thoughts, emotions, behaviors and interactions with others.

**Mental Health Experts:** In this study, there are defined professionals and stakeholders in mental health and they include psychiatrists, psychologists, and social workers, directors of mental health institutions and chairpersons of professional bodies involved in offering mental health services.

**Mainstream Media:** Traditional forms of mass communication, which include newspaper, television and radio as opposed to digital communication.

**Recovery:** A process by which people who suffer from mental health illnesses are able to work, learn and participate fully in their communities.

**Representation:** Media does not represent reality as it happens out there but selects what to present. It means they re-present reality based on their defined parameters. In this study, the word representation is used to depict what the media chooses to focus on/ or re-present in their reporting of mental health issues.

## **CHAPTER ONE: INTRODUCTION**

### **1. Introduction**

In this chapter I share background information to the study by explaining the academic and social contexts in which the study was conducted. I also state the problem that prompted this study, share the research questions and the scope of the study as well as share the rationale for the study. The chapter concludes with a brief summary of the major issues discussed in this chapter.

#### **1.1. Background of the Study**

This study investigated how the mainstream media in Kenya represents mental health issues, what informs that kind of representation while seeking to understand the perspectives of mental health experts in regard to that representation in light of the situation facing mental health issues in the country.

Globally, the demand for health information has grown exponentially and the media has been identified as an important ally in public health; and especially where information is being sought (Neveena, 2015). In terms of development, media has played a significant role in socio-economic development, which includes medicine and public health (Saraf & Balamurugan, 2018). “Media is instrumental in bringing behavioral changes in knowledge, beliefs, and attitudes about health and healthy behaviors,” points out Sharma and Gupta (2017, p.1).

In Africa, Kigozi et al. (2010) argues that media has been an important stakeholder in health service delivery and has a lot of potential to influence public attitudes through their vital role of sensitization and publicity. In view of that, the mental health stakeholders in Sub-Saharan Africa, have recognized media as a potential partner in

advancing public knowledge and influencing mental health policies (Atilola, 2016). Commenting about Africa and the need for advocacy, Olugbile (2011, p.1) points out: “There is no continent of the world where there is a greater need for home-grown (mental health) advocacy effort than Africa. And yet advocacy is very thin on the ground”.

According to Kiima and Jenkins (2010) public policy advocacy of mental health is a challenge that affects the uptake of the mental health services. Stigma and lack of mental public education has been described as “an endemic issue in Kenya” (Marangu et al., 2014. p .2). However, as much as media has been discussed as a partner, Kenez, O’Halloran and Liamputtong (2015) point out that media’s role to destigmatize and promote helpseeking behavior in health issues is dependent on how journalists select and frame mental health information. Therefore, examining the media representation of this pertinent issue of mental health, which is on increase, becomes important, “given much of society’s knowledge and understanding about public health issues stems from interactions with, and consumption of, the news media – particularly where individuals lack first-hand experience, “ ( p.1). Mental health is one of the issues where public education lacks and the role of media becomes important where it is likely to reinforce the societal beliefs or shape those beliefs depending on how the issues are represented to its audience.

Commenting on media representation, Buckingham (2013) says that media does not just present reality, but they represent it. The way the representation manifests itself is dependent on the media producers, who make choices on what to highlight and what to leave out, whereby they select and make events into stories. Media representations can be real in some ways and not in others hence the need to interrogate how the



mainstream media in Kenya, which is considered credible (Mogambi, Kiai, & Ndati, 2013), represents mental health issues.

### **1.1.1. International context**

Globally, the communication of mental health has been neglected and media practitioners have been accused of negatively skewing the mental health messages (Stuart, 2006; Kenez, O'Halloran & Liamputtong, 2015; Kigozi, 2013; Nyakundi, 2015). However, globally, it is projected that by 2020 mental health challenges will become epidemic and disable more people than complications arising from the AIDS/HIV, heart disease, traffic accidents and wars combined (Ngui et al., 2010). Depression ranks third on the list of the world's top chronic diseases and it is likely to overtake heart disease and cancer to become the single most common chronic disease by 2030 (WHO, 2014). By 2014 around 450 million people were suffering from mental health related conditions, placing the issues as among the leading causes of ill-health and disability worldwide while noting that 40% of all disabilities globally are attributed to mental health challenges. However; two-thirds of those suffering from the illnesses do not seek help from a health professional.

The consequences of not seeking professional help leads to chronic mental health conditions contributing to disability, social and economic loss, increase of school dropout rates, and imprisonment due to crime related to those conditions, and increased suicide rates. For example, in terms of economic loss, the National Alliance of Mental Illness (NAMI) reports that serious mental illnesses costs America \$193.2 billion in lost earnings per year (2015). In the United Kingdom (UK) such illnesses form the largest single cause of disability, contributing almost 23% of the overall burden of disease compared to about 16% for cancer and cardiovascular disease while

economic and social costs of mental health problems in England are estimated at around £105 billion each year (Knapp, McDaid, & Parsonage, 2011).

Consequently, mental health challenges have been described as major cause of morbidity and a burden to the patients, their families and society (Nyamongo, 2013). Unfortunately, as compared to physical illnesses like cancer, heart disease or HIV/AIDS, the mental health public education remains significantly low and public's knowledge about it is comparatively neglected and efforts to improve the same have been described as low (Jorm, 2007; Ngui et al., 2010; Ndeti et al., 2010). It has been pointed out that globally, mental health public education is important for both the general public and health professionals for the early identification, treatment and ongoing support for people with mental challenges (Marangu et al., 2014).

### **1.1.2. The African context**

The way mental health issues are perceived in Africa has been influenced by the three phases the continent has gone through; the pre-colonial, colonial and post-colonial period. In the African traditions mental health issues were mainly perceived as a phenomenon originating from supernatural factors. It was seen as a 'mysterious' occurrence that resulted from social, physical, religious and magical disharmony and that influenced the treatments accorded to those who were perceived as mentally ill (Ngome, Prince, & Mann, 2003). Further, mental illnesses were seen as a situation whereby the victim was prone to interpreting issues haphazardly as registered in his tortured consciousness. African traditional healers used divination to unearth the mental and psychological problems of their patients. In most cases 'patients' were

chained, in order to prevent them either from harming themselves or others (Ozekhome, 1990; Omozokpia, 2004).

The colonial period in Africa introduced a new perspective, as ‘mental illness’ was used as a weapon to oppress the Africans and to describe their backwardness. The colonial governments used mental facilities to jail colonized subjects who posed as a threat to their rule while men and women who dared to question colonial policies were labelled as insane (Swartz, 2009). as cited in “The colonial role of psychiatry did not stop at penetration and pacification but continued to be one of the most potent and effective apparatuses for aiding colonization, oppression, and racialization of African peoples by European powers” (Ibrahim & Morrow (2015, p.1, as cited in Heaton, Ibrahim & McCulloch).

The colonial Mental Health Acts (MHA) has been described as an instrument that was used to politically suppress rebellion and individuals or groups who appeared to be a threat to the colonial establishment as they were detained in mental health facilities. Swartz (2009) as cited in Edgar and Sapire (2000) gives an example of a South African prophet, Nonthetha Nkwenkwe, who was put in a psychiatric facility for 21 years due to her influence and possible threat to the White minority rule. Mahone (2006) describes Elijah Masinde, as another example of a renowned freedom fighter from Kenya, who was declared insane by the colonial administrators and confined to Mathari National Teaching & Referral Hospital (popularly known as Mathare Hospital) for 26 years; from 1945 -1961. Similarly, freedom fighter, Mohamed Abdullah Hassan was described as ‘Mad Mullah’ for opposing the colonial rules (Ibrahim, 2014). Lewis (2002) says that Africans were ‘psychiatrized’ as a way of delegitimizing their quest for freedom. Swartz (2009, p. 1, as cited in Edgar and Sapire

(2000, p. 34) where they comment that colonial authorities: "invariably only confined deranged Africans in asylums when they disrupted the regimes and disciplines of work on white farms, in the kitchens, and mines or when they threatened social peace more generally, whether in the street or 'native reserves.'"

Further, Ibrahim (2014) adds that during the colonial era, in many parts of Africa, the department of mental health was under the command of the inspector of prisons, which contributed to the prevailing stigma amongst Africans to those with mental illness. It meant that mental illnesses were criminalized and equated to crime and dangerousness. But after African nations attained their independence, the treatment and discrimination of those suffering from mental health illnesses did not change.

Ibrahim and Morrow (2015) put it this way:

*Unfortunately, many independent African governments and scholars not only maintained but glorified the colonial status quo, and approximately 60% of African nations currently use the same Mental Health Act used by their colonial powers.(p. 2).*

In the post-colonial era, there is a mixture of the cultural beliefs and criminalization of those with mental health challenges as they are still viewed as dangerous and as outcasts in their society. Nyamongo (2013) says that the social stigma associated with mental health has made mental illness to be a hidden issue in Africa and it is equated to a silent epidemic. As a result, people suffering from mental health challenges are hidden for fear of discrimination and ostracism from their communities. At the household, community and national level mental health issues have been 'shut' down and African governments allocates low budget to the sector, which is also surrounded by old policies. Further, poor health infrastructure, shortage of trained specialists; and

culturally aligned assessment and treatment; and stigma, discrimination and human rights abuses face those with MH challenges and their caregivers (Monterio, 2015).

Elaborating on the discrimination of those suffering from MH challenges, the World Health Organization (WHO, 2010) report titled, *Mental health and development: Targeting people with Mental Health Conditions as a vulnerable group*, says that people with MH challenges experience extremely high rates of physical and sexual victimization, encounter restrictions in the exercise of their political and civil rights, and other public affairs while facing disproportionate barriers in attending school and finding employment. “As a result of all these factors, people with mental health conditions are much more likely to experience disability and die prematurely, compared with the general population,” (p.xxv). Morris (2006) mentions that people facing mental health challenges are one of the “remaining few groups subject to thoughtless labelling,” (p.47) and that pervasive stigma is described as crippling due to the trauma it creates in those already mentally challenged (Beachum, 2010).

Further, current research done in Africa shows that there is a close relation between perceptions people have about mental health issues and help-seeking behaviors. Public understanding of MH issues is still skewed to traditional perspectives. For example, in their findings Kabir et al. (2004) found that the majority of community dwellers in northern Nigeria attributed MH conditions to supernatural factors. In their study, Abbo et al. (2008) found that the predominant views about the causation of mental illnesses in Uganda were clan issues, supernatural causes and substance abuse. Teferra and Shibe (2012) found that majority of people in Ethiopia mostly attributed mental health challenges to factors like spirit possession and bewitchment, ‘exposure to wind’ and subsequent attack by evil spirit in post-natal women.

The results of another study done in Northern Nigeria demonstrated widespread ignorance about causation, mode of transmission and treatment for MH conditions, and only 0.9% of respondents attributed mental illnesses to brain disease while others attributed it to spiritual attack, punishment for evil doing and illicit psychoactive substance use, among other things (Audu et al., (2011). In terms of treatment of MH related issues, treatment decisions are strongly dependent on the perceived cause of the condition, which means that if the perception is supernatural forces; super-powers are also, consulted reducing the chances of seeking treatment from MH professionals or facilities (Abbo et al., 2008; Audu et al., 2011; Ventevogel et al., 2013).

### **1.1.3. The Kenya context**

The media has over the last decade ranked among the fastest growing sectors in Kenya. Demand for media products has continued to increase with consumers showing increased trust in the institutions that form part of the fourth estate. Statistics from the Communications Commission of Kenya (CCK) (currently known as Communications Authority of Kenya) indicate that there are 98 licensed radio stations in the country, more than 20 TV stations and newspapers as well as numerous magazines catering for various niches among Kenyan consumers (CCK website, 2016). These numbers are set to shoot up as the country switches to digital broadcast with the rest of the world over the next four years.

The media landscape has expanded rapidly. It is generally agreed that there is a wide range of sources of information available to the citizens. At the time of this report (April-May 2016), there were four main daily newspapers with national reach, 147 radio station and 67 television stations (Communications Authority of Kenya

and Media Council of Kenya). There were also 15,000 blogs, out of which approximately 3,000 were active (Bloggers Association of Kenya -BAKE).

However, a special report released by the mainstream media in April, 2014 showed that around 25 % of Kenyans are suffering from different types of mental health illnesses “as harsh life pushes them over the cliff” (Kiarie, 2014). The same article quoted a mental health practitioner and Secretary of Kenya Psychiatric Association (KPA), Atwoli (2014) saying that 10 to 15 % of Kenya’s population mainly suffer from depression, anxiety and somatization (a condition where an individual with a mental illness develops physical symptoms). According to Marangu et al. (2014) poverty, unemployment, internal conflict, terrorism, displacement and HIV add to the MH burden. Other factors that trigger mental health challenges in Kenya are drug and alcohol abuse, stress, bloody terror attacks, insecurity, and broken relationships amongst other environmental factors. In April 2014, the largest mental health facility in the country, Mathari National Teaching and Referral Hospital was dealing with about 70 to 80 cases daily in their psychiatric outpatient unit as compared to 40 and 50 in the previous year (Mutisya, 2014).

However, as much as mental health challenges are on increase in the country, stigma has been described as one of the major impediments facing the sector, making people to suffer silently. According to Makanyengo, a psychiatrist and also the chair of department of Mental Health at Kenyatta National Hospital (KNH) in the year 2014:

*...the reality is that there are so many people suffering from mental illnesses who have given up on life but shun professional medical services due to the stigma associated with mental problems,” (Kiarie, 2014, p.14).*

With the realization of stigma, misinformation and stereotypes associated with mental health, Jorm et al. (1997) introduced the term 'Mental Health Literacy' and defined it as the knowledge and beliefs about mental health issues which aid their recognition, treatment and prevention. Further, Ham et al. (2011) says that mental health literacy includes the ability to recognize specific mental illnesses; knowledge on how to seek mental health information, risk factors and causes, and seeking for professional help available. In other words, there are attitudes that promote prevention, recognition and appropriate help-seeking behavior. However, mental health literacy in Kenya has been described as low while stigma and cultural perspectives characterize the sector which is also struggling with poor policies.

In a journal article called, 'Weaning off Colonial Psychiatry in Kenya', Ibrahim and Morrow (2015) observe: "After 51 years of independence in Kenya, colonial laws and practices continue to persecute its citizens, especially those deemed mentally ill" (p.3). Indeed, mental health policy has been one of the greatest challenges facing the mental health sector in Kenya and it remains largely neglected by the government. "Unlike the large scale investments in vertical communicable disease programs, there have been only very limited investments in mental health, mental disorders and other non-communicable diseases," (Kiima & Jenkins, 2010, p.2).

Talking about policy change, Marangu et al. (2015), point out the need for mental health promotion in order for politicians to proactively advocate for mental health care, and for mental healthcare to be integrated in primary care for positive health outcomes. Kiima and Jenkins (2015) point out that the country's mental health care system operates under extremely resource-restricted conditions, in terms of infrastructure, manpower and finances.



According to Marangu et al. (2014), the burden of mental health conditions is expected to continue increasing in low- and middle-income countries such as Kenya due to “epidemiologic transition occurring within these countries characterized by a marked increase in non-communicable diseases such as diabetes, cardiac disease and mental disorders” (p. 2). The WHO 2010 report says that mental health illnesses often affect, and are affected by, other diseases such as cancer, cardiovascular disease and HIV infection/AIDS, and as such require common services and resource mobilization efforts. For example, depression is a risk factor for cancer and heart diseases and there is a close interconnection between mental illness and other physical diseases. Further, depression, anxiety and substance use conditions may occur in patients suffering from physical ailments, which may lead to poor compliance and failure to adhere to their treatment schedules (ibid).

If the public's MH literacy is not improved, it may hinder public acceptance of evidence-based MH care which is connected to the Kenyan situation where majority suffer silently but shun professional medical services due to the stigma associated with mental problems (Kiarie, 2014). Further, public agenda will influence policy agenda.

## **1.2. Statement of the problem**

The main problem that prompted this study can be expressed at three levels: social, contextual and academic.

### **1.2.1. Social problem**

From a social point of view there is increased demand for mental health promotion and one of the critical components of the WHO policy (2013-2020) is to implement strategies for promotion and prevention on mental health. The two specific targets set for each country, which Kenya is part of, are to have two functioning national, multi-sectoral mental health promotion and prevention programmes and the rate of suicide reduced by 10% by the year 2020. Additionally in 2000, WHO had also declared the media as a primary means for governments to reframe the public debate on mental health (WHO Mental Health Global Action Programme; mhGAP, 2002).

However, in Kenya the need for mental health promotion still remains a challenge as a study carried by Nyakundi (2015) indicated. Amongst other barriers, the fear of being labelled as ‘mwenda wazimu’ (mad man) was top on the list for not seeking mental health ailments treatment. Other beliefs found amongst the participants were that witchdoctors can cure mental illnesses while others believed there is no prevention or cure for those conditions. The study showed that stigma and poor knowledge about mental health exist among the Kenyan youth.

Commenting on stigma and lack of mental public education in Kenya, Marangu et al. describe it as “endemic issue in Kenya” (2014,p.2) while public policy advocacy of mental health is a challenge that affects the uptake of the mental health services (Kiima & Jenkins, 2010). However, as stigma persists, characterized by outdated policy, MH challenges continue to increase in Kenya with around 25 per cent of Kenyans suffering from different types of mental health illnesses “as harsh life pushes them over the cliff” (Kiarie, 2014).

With the realization through research, that skewed traditional beliefs and stereotypes act as an impediment to mainstream psychiatry service utilization and a barrier to the formulation and implementation of mental health policies in the region, mental health stakeholders in Sub-Saharan Africa recognized that education on public and policy level cannot be done successfully through the sole effort of mainstream mental health practitioners but a potential partner in advancing public knowledge was singled out as the media industry in the region. “Being the information hub of most civilized societies, the mass media reflects and also shapes public knowledge in relation to issues of life, including mental ill-health,” said Atilola (2016, p. 2). Further, the Kenya Mental Health Policy 2015-2030 outlines mass media as a critical partner in implementing of the policy through its role of positive advocacy and creation of awareness on matters related to mental health (Kenya Mental Health Policy 2015-2030).

Although mass media has been singled out as an important medium of mental health promotion, a study by Nyakundi (2015) looking at mental health communication campaigns, suggested that the Kenyan media fails to play a significant role in mental health promotion. Kenyan psychiatrists, who participated in the study, complained that the media in Kenya stigmatize mental health issues and are not engaged in public education. One of the psychiatrists in the study said:

*The media in Kenya does not do anything useful to inform people about the causes of mental illnesses. They do not seek the opinions of psychiatrists when presenting news about what constitutes mental illnesses. They think they know. Anything that deviates from the norm should be explained by a psychiatrist (Nyakundi, 2015, p. 67).*

In the same study another psychiatrist complained about the Kenyan media saying:

*Media are not interested in promoting knowledge of mental health. They do not give World Mental Health Day any publicity. They have completely ignored mental health issues. This is part of the stigma associated with mental illnesses (Nyakundi, 2015, p. 127).*

In view of media being considered as a critical partner in light of the stigma and increase of MH challenges and the mental health stakeholders indicating their discontentment about how the Kenyan media handled mental health issues, it became important to interrogate how the mainstream media represents mental health issues while looking seeking to establish what informs that kind of representation.

### **1.2.2. Contextual problem**

Contextually, the Kenyan mainstream media released reports indicating that mental health is on increase and 25% of the population are affected by different forms of mental illnesses. At the same time, other media reports indicate that stigma of mental health contributes to citizens not seeking for medical services while some have turned to supernatural powers (Kiarie 2014; Kilonzo, 2015). Although acknowledgement exists that mental health challenges are on increase, coupled with severe stigma, as reported by the media, the pertinent question remained as to what role the media was playing to improve public education of mental health issues.

On the other hand, mental health stakeholders had singled out media as a critical partner in public education and policy advocacy for mental health issues (Atilola, 2016). Furthermore, Marangu et al. (2014) noted that the mental health stakeholder needed to adopt a social marketing approach, and pointed out that such an approach had played an important role in public education of HIV/AIDS. Having pointed media as a critical partner and acknowledging the role of social marketing approach, another pertinent question that this study sought to answer is their perspective about media

representation and their role to see increased and balanced representation of mental health in the mainstream media.

### **1.2.3. Academic problem**

Academically, a review of relevant literature reveals very little research on media representation in Kenya and the rest of Africa. Further, a lot of studies have focused on portrayal of mental illnesses in the media, however, the overall component of mental health is often ignored (Kenez, O'Halloran,&Liamputtong, 2015). Examining media's representation of this pertinent issue is important because health promotion has become a major focus in public health.

### **1.3. Research Questions**

The research questions that guided this study were:

1. How are mental health issues represented in the mainstream media in Kenya?
2. What are mental health expert's perspectives about the mainstream media representation of mental health issues in Kenya in light of the situation facing the sector?
3. What informs the media representation of mental health issues in Kenya?

### **1.4. Scope of the Study**

I present three aspects of the scope to this study: content scope, context scope and methodological scope.

### **1.4.1. Content scope**

In terms of content, media studies mainly consist of production, representation and audience analysis. This study focused on media representation which consists of how the media re-presents its messages to its audiences. The focus of this study was to establish how the mainstream media represents mental health issues and to find the perspectives of mental health experts in regard to that representation in light of the situation facing the mental health sector in the country. Further, the study interrogated what informs the way mental health issues are represented by the mainstream media.

To answer the first two questions in terms of content, I analyzed the understanding that health journalists and mental health experts have on how the mainstream media in Kenya represents mental health issues and I asked the following questions: How are mental health issues represented as compared to how other diseases are represented? What main themes emerge from the way mental health issues are represented by the mainstream media? What kind of language is used by the mainstream media in representation of mental health issues? The second question sought to find out the perspectives of mental health experts on mainstream media representation of mental health issues in light of the situation facing the mental health sector in the country; and I asked the following questions: How is the media representation a reflection of what is facing the mental health sector in the country? How different is the media representation in comparison to the issues facing the mental health sector? The third question sought to understand, from both health journalists and mental health experts, what informs the way mental health issues are represented in the mainstream media; and I asked two specific questions: what factors influence the way mental health

issues are represented in the mainstream media? What is the place of culture in media representation of mental health issues?

#### **1.4.2. Contextual scope**

Contextually, I conducted my study with 13 journalists. Out of the 13, 6 print health journalists, including two editors, were from the four daily newspapers in Kenya while the other 7 were from the leading TV stations in Kenya. However, one of the TV participants was working for an international media house but she was highly recommended by other journalists, having been one of the first health journalists in Kenya. Prior to her move to an international media house, she worked for one of the largest local TV stations. The headquarters and major operations of the media organizations, are based in Nairobi, hence the geographical location of this study.

The 8 mental health experts were drawn from diverse mental health institutions which included hospitals giving mental health services, research institutions, rehabilitation centre, Non-Governmental Organizations (NGO), Community Based Organization (CBO), and the Ministry of Health. The experts comprised of psychiatrists, psychologists, social workers, and directors of mental health associations or organizations. Most mental health professionals and personnel are based in Nairobi as well as the institutions associated with the services. A number of mental health campaigns had also been carried mainly in Nairobi.

#### **1.4.3. Methodological scope**

This was a qualitative study that was philosophically anchored on the relativist and interpretive constructivism ontological and epistemological worldviews, respectively. The study employed the case study method and data was collected through document

analysis, observation and in-depth interviews. I had two cases: one consisting of health reporters and the other consisting of mental health stakeholders. I generated by conducting in-depth interviews with 21 participants while I also observed the participants during the interviews and did media analysis of 5 media reports covering mental health related issues. I analyzed the data thematically and presented the findings in narrative form, with paraphrases and quotations.

### **1.5. Rationale for the Study**

Mental health is a significant public issue globally as well as in Kenya, where 25 per cent of the population are suffering from some form of mental illness (Kiarie, 2014). However, mental health is not prioritized at the policy level and it is characterized with old policies (Marangu, 2014) while public education lacks at the societal level and stigma surround the issue. Traditional beliefs and stereotypes are seen as an impediment to mainstream psychiatry service (Atilola, 2015). Further, Audu et al. (2013) point out that a lot of ignorance persist about causation, diagnosis and remedies available for mental health challenges, and only a few people in Sub-Saharan Africa attribute mental illnesses to brain disease.

Although media's potential to construct positive representations of health issues is known, studies done, especially in the West, show that media portrayal of mental health issues is often negative (Wahl, 2003; Stuart, 2011; Kenez, O'Halloran, Liamputtong, 2015).

In recognition of the important role played by the media in mental health promotion, the WHO in 2000, declared the media as the primary means for governments to reframe the public debate on mental health (World Health Organisation -Mental



Health Global Action Programme- mhGAP, 2002). Additionally, mental professionals singled out media as one of the major tools that could be used in mental health promotion (Audu et al., 2013). This study, therefore, sought to bridge a gap between theory and practice by establishing a link between representation of mental health issues and how that representation compares with the situation facing the sector and underlying determinants that would influence the mainstream media to play an advocacy role for mental health.

The power of media in shaping perceptions and behavior has been recognized in health communication. Mass media interventions are commonly used to encourage healthier behaviors in population groups (Mosdol et al., 2017). This study contributes towards health communication scholarship by studying the factors that influence the Kenyan media in construction of health issues like mental health. Also comparing how health reporting specialists and experts in the field interpret issues, it contributes in designing and implementation of mental health promotion and prevention strategies.

This study contributes to the body of research on media representation of mental health in three broad ways. First, it shows that skewed representation exists where mental health is linked to violence, dangerousness and seen as an outrageous disease that affects the poor and uneducated. Secondly, this study shows that media representation of mental health issues deviates from the reality facing the sector in the country. However, thirdly, this study shows that for media advocacy to be realized, capacity building of journalists is critical while the mental health stakeholders need to take the lead role and form strong collaborations with the mainstream media. Internally, the Kenyan media houses need to develop and implement health reporting

policies to avoid the ambiguity of the language, images and ethical issues faced in the health reporting. While episodic, sensational, and controversy/conflict are predominant, other frames like thematic and contextual need to be integrated to share the narrative of ‘mental health’ not just ‘mental illness’.

## 1.6. Summary

In this chapter, I have presented the background to the study while sharing social, contextual and academic background that informs this study. The key issues arising from this discussion are summarized in Table 1.1. In the next chapter, I situate my study within the discipline of health communication and media and discuss the concept of media representation, theories and recent research on media representation of mental health issues.

**Table 1: Summary of key issues in Chapter One**

- The importance of media representation in health promotion has emerged as an important issue and also its role on mental health promotion recognized
- In Africa, the way mental health issues are perceived, can be categorized in three stages; the pre-colonial, the colonial and post- colonial period
- The media in Kenya is growing and it is considered as a credible channel of communication. The media released reports show that mental health challenges have increased significantly. However, people shy away from medical services due to the stigma and lack of public education. The question then remains as to how the media represents mental health issues realizing that 25% of the population is facing mental health challenges.
- Mental health stakeholders in Kenya have complained that media ignores mental health issues while at the same time there is an information gap on how the mainstream media in Kenya represents mental health issues. In view of this prevailing gap, the importance of critically evaluating how the mainstream media represents mental health issues was discussed bearing in mind that in Sub-Saharan Africa, media is identified as a potential partner.

## **CHAPTER TWO: LITERATURE REVIEW**

### **2. 0 Introduction**

In the previous chapter, I discussed the problem statement: highlighting the social, contextual and academic gap that prompted this study. In this chapter, I discuss health communication and media while also looking closely at the issue of media representation. Besides that, the chapter discusses media portrayal as seen through the socio construction theory while looking at the framing theory in the context of media representation of MH issues.

#### **2.1. Media Representation in Health Promotion**

Globally, health education is a critical aspect of public health promotion as a way to influence health behavior of the target audiences. Dorfman and Krasnow (2014) say that the mission of public health is improving conditions towards maintenance of health and to avoid disability and premature death, making prevention to be critical in health communication, as much as intervention is key. However, Sharma & Gupta (2017) point out that mass media are critical social organization that has wide reach and access to influence individuals and communities in their health education. Mass media not only penetrates to masses but can be used for elongated period to saturate communities with health messages. “Media is instrumental in bringing behavioral changes in knowledge, beliefs, and attitudes about health and healthy behaviors,” argues Sharma & Gupta (2017, p.1). Media plays the role of social agent.

However, as much as media is a critical social agent, media representation has emerged as an important discipline in health communication realizing that the media has the potential to promote health and enhance community and individual empowerment, but that role is dependent on how information and messages are presented (Ahmed & Bates, 2013). Further, Hooker and Pols (2006) argue that most of the knowledge that citizens retain about public health, medicine and disease emerges from the media. "The relationship between medicine and the media has always been intimate, it has also at times been tense and antagonistic, especially because physicians and health officials have not always appreciated the way the media have portrayed health, disease, or their professions," adds Hooker and Pols (2006, p.1). It means that as much as the role of the media is appreciated, antagonism exists, mainly emerging from the way media represents health issues.

According to the Oxford English Dictionary, the term representation constitutes several meanings and it is used in different fields like mathematics, scientific, political, and legal discourses. However, according to Vukcevic (2002), in media studies, representation is an image or likeness or reproduction of something. Representation is seen as a tool for media to reproduce its character and seen as a medium that stands between the 'real' and spectator. The spectator, in this case, are media consumers and 'representation' is what stands between them and the object that the media re-presents.

Representations are embedded in the 24-hour saturated media stream and establish 'norms and common sense about people, groups and institutions.' For example, it will re-create and re-produce issues about mental health and by so doing contribute in how people perceive mental health and those who are mentally ill and the institutions that

serve them. Discussing media representations, Hall (1997) says that representations play a central signifying practices for producing shared meaning; “representation is the production of the meaning of the concepts in our minds through language...to represent something is to describe or depict it, to call it up in the mind description, portrayal or imagination,” (p.16).From that description, it is clear that we reproduce things based on the images in our minds. It becomes a way of depicting the world out there. Borrowing heavily from the works of Ferdinand de Saussure on semiotics, Hall also describes representation “as means to symbolize, stand for, to be a specimen of, or to substitute for,” (1997, p. 16). Representation is not portrayal of things or objects as they happen out there, but it is subjected to one’s definition of an issue; and it is from that viewpoint that one will depict it. Representation serves as the link between concepts and language which enables us to refer to either the ‘real’ world of objects, people or events. It also includes the link between an object and the images used to portray those objects. For example, the images used to depict mental health maybe people who are half dressed or talking to themselves whereas that may be a small representation of those suffering from mental illnesses.

Hall proposes that the media, as a principal form of ideological dissemination, produces re-presentations of the social world via images and portrayals. It becomes re-presentation because it does not give the whole picture but part of the reality based on their perception of the issue or other factors like desire to make news. Ultimately, such ideologies are likely to become ‘naturalized’ and become part and parcel of society as the way people make sense of issues.

Talking about the importance of paying attention to media representations, Dorfman and Krasnow (2013) says that public and policy makers do not consider issues seriously unless they are visible, and one way for them to be visible is when the media bring them to lime light. However, while the visibility of issues, including health issues, is critical, the way issues are re-presented influences how the public and policy makers will embrace and handle those issues. Media advocacy has been recognized as one tool that public health practitioners can use to change health conditions, but, “changing conditions is an inherently political process that demands decision makers wrestle with competing interests for inevitably limited resources,” (Krasnow, 2013, p. 304). One, it is a political process that is influenced by ‘who’ and ‘how’ issues are framed for the media and how the content is shaped for policy makers and other media audiences. Media strategy is important and it must include the message strategy and the messenger, so that citizens and policy makers can participate in the decisions that affect their environment (Dorfman & Krasnow, 2013). However, the success of that role is dependent on how the media messages are strategically presented.

The media plays a critical role in information sharing especially in areas where its consumers do not possess direct knowledge; but on the other hand, it can limit understanding of issues and thereby affect social change (Happer & Philoa, 2013). The media can also reinforce negative beliefs, and instead of contributing to development, it slows down the whole process. In view of that, media representation studies have become critical especially in health communication. Moreover, the media’s power to steer attention to and from public issues often determines which problems will be tackled or ignored by society ((Fursich, 2010).

Media studies are generally divided into three broad areas of inquiry: production, representation and reception. Studies on production are mainly about the nature of the influence exerted by governments, professional organizations and business interests on those responsible for producing various media and how journalists' relationships with sources of information affect media content (Seale, 2003). On the other hand, studies on reception focus on media audiences and how media messages affect them. For example, media producers are also audiences; and it may be critical to find out how what they see in the media may influence what they produce or to what extent do health professionals model their behavior on what they see on the television or how ordinary citizens respond to media messages on issues like safe sex, exercise or seeking services of a psychiatrist.

However, studies on representation are concerned with analysis of media messages themselves. "Such studies may seek for ideological biases, or the discursive dominance of particular themes and constructions, or be concerned with whether messages are likely to promote or damage health," says Seale (2003, p. 2). Some of the questions asked are like 'How does a medical soap opera portray doctors as against nurses?' In line with that, the focus of this study was to explore how the Kenyan mainstream media represent mental health issues, the perspectives of mental health experts on that representation in light of the situation facing the sector in the country and what informs that kind of construction by the mainstream media. Seale says that mass media depictions or representations are not necessarily a true picture of reality; "At best, they are partial truths. The producers of mass mediated messages about health have particular agendas, and this is likely to influence what is shown" (p.2).

Lyons (2000) says that it is critical to evaluate media texts and images because individuals are socially located and gain their beliefs about health and illness from the discourses and constructions that are available to them. Media representations of health, illness and disease produce and reproduce meaning concerning health and illness, for lay people and professionals alike; and media representations mediate individuals' lived experiences. In discussion of health and media representation, Seale (2003) says that due to the nature of media, stories often work by creating and then exploiting oppositions and that applies even in media health. Further, he explains that such stories tend to contain heroes and villains, pleasure and pain, safety and danger, disaster and repair, the beautiful and the ugly, the normal and the freak, cleanliness and dirt, female and male, lay and professional, orthodox and alternative. Such representation maybe viewed as sensational and inaccurate. Further, Hall (1997) adds that since meanings are reproduced, it is imperative to interrogate the meanings of media representation.

### **2.1.1. Mental Health Communication and Media**

Journalists, communication experts, health workers, governments and others have used the media to raise awareness of health problems, while at the same time it has been used to create positive attitudes towards healthful behaviors and to modify unhealthy behaviors. Health communication aims to improve health outcomes by sharing health-related information. Schiavo (2007) describes health communication as an approach that uses various multidisciplinary approach with a view of reaching diverse audiences with a view of influencing, engaging and supporting individuals, communities, health professions, special group, policy makers and the public to champion. The main objective is positive improved health outcomes regardless of



whether the purpose is to introduce, adopt, or sustain a behavior, practice or influence policy. It is clear that there are different audiences reached out to in health communication and they stretch from individuals to communities, policy makers and members of publics; making mass communication one of the effective tools of reaching diverse audience with a goal to create awareness, influence and engage them towards adoption or sustenance of a new behavior (Schiavo, 2007). Mental illness being one of the most stigmatized diseases, health communication is critical when it comes to mental health issues, where individuals, communities and policy makers need to have related messages demystified while creating awareness about the whole spectrum of mental health and influencing them to adopt lifestyles that will see prevention of mental illnesses and help-seeking tendencies for the ill.

Herrman and Jané-Llopis (2012) say that mental health promotion focusses on people adopting and maintaining healthy ways of life and creating living conditions and environments that allow or foster health. Mental health is seen as more holistic and as touching everybody in the community, including those with no experience of mental ailments as well as those who live with illness and disability. Suicide prevention programs are also part of mental health promotion.

Actions that promote health, prevent illness and disability, and support the treatment and rehabilitation of those affected can all contribute to improving mental health. The Ottawa Charter for Health Promotion signed at the First International Conference on Health Promotion (World Health Organization, 1997) considers the individual, social, and environmental factors that influence health and states that healthy policy and supportive environments are critical in health promotion. The Charter outlines five strategies: building healthy public policies, creating supportive environments,

strengthening community action, developing personal skills, and reorienting health services. Through the Charter, health promotion has come to be understood as public health action which is directed towards improving people's control over all modifiable determinants of health.

Alongside health promotion, there is 'Health literacy', which is about communicating health information clearly and understanding it correctly. "Healthy literacy is relevant at all the points along the continuum of care- from wellness and health; to disease prevention and detection; to diagnosis and decision making; to treatment and self-care," (Osborne, 2013, p. 1). In other words, health literacy is about health messages saturating and people having insight in regard to prevention, recognition, management and treatment of diseases. However, studies show that in the public domain mental health is not understood and specific mental illnesses are not recognized and in view of that mental health literacy was coined, which aid the recognition, management, treatment and prevention of mental health (Jormeta, 1997 as cited in Jorm, 2007). "If the public mental health literacy is not improved, this may hinder public acceptance of evidence based mental health. Also, many people with common mental disorder may be denied effective self-help and may not receive appropriate support from others in the community," pointed Jorm (2007, p.394).

Mental health promotion is meant to contribute in shaping public beliefs about MH conditions and increasing their knowledge towards seeking treatment and prevention, as well as influencing their behavior towards persons with mental health challenges (Carol, Phelan,&Bierman, 2013).

### **2.1.2. Media Representation and Mental health issues**

Adamkova, Nawka and Admkova (2012) point out that even in the era of the digital media, printed media remains as one the most frequently source of mental health information. However, studies show that media representations of mental health are often stereotypical, negative and contributes to stigmatization of people suffering from mental illnesses (Goulden et al.,2011; Adamkova, Nawka,& Admkova, 2012)). Globally, mass media communication has often been implicated in not only perpetuating stigmatization but promoting stereotyping of the patients as dangerous, incapable of taking care of themselves, strange, unpredictable and/or incurable.

Television negatively portrays characters with such mental illnesses as bad and failures that are likely to commit violent acts (Land, Nadorff, Shin, Gantz and Angelin 2006 as cited in Pfister, 2014). Further, characters with mental illnesses are depicted as unattractive, failures in life and seldom benefit from treatment (Pfister, 2014). Other common stereotypes of mental health in the media include: childlike, hypersexual, evil, violent, irrational, rebellious free spirit, homicidal maniac, seductress, narcissistic parasite, comedic relief, mad scientist, sly manipulator, and victimized helpless depressed female (Edney, 2004).

Mass media communications have also been accused of using demeaning language in description of mental health issues that perpetuates stigma. For example, a study done in the UK where 1,196 articles in five national newspapers were studied, it was noted that that the five newspapers used the term 'schizo' consistently in reference to the ill (Clement & Foster, 2008). From this study, the issues that stood out were use of schizophrenia terms metaphorically; using descriptors that could be

stigmatizing; failure to put the risk of violence among schizophrenic patients in perspective; and using terms such as “released” in place of “discharged” from psychiatric hospitals – which gives a connotation of imprisonment when one is admitted for psychiatric issues. Other studies have revealed words such as “insane”, “mad”, “lunatic”, “crazy”, “maniac”, “nuts”, “psycho”, among others as other colloquial terms used in media reporting of mental illness.

Another way in which media representation of mental portrays bias is in what they choose to report on. According to Clement and Foster (2008) mass media content often emphasizes not on health but on the illness and contains stories and images that portray explicit ‘abnormal’ behavior as symptoms of mental illnesses. Although there are different types of mental illnesses that depict differently, the media equates mental illnesses to the severe symptoms, visible symptoms who exhibit violence, and cannot be trusted (Adamkova, Nawka, & Admkova (2012). Severe cases of psychotic disorders are equated to all types of mental illnesses.

Whereas Ramasubramanian and Segal (2017) mention that media is critical in forming, maintaining, and countering stigma, in mental health the media often maintains the stigma. The two describe stigma as a socially constructed process of discrediting “those who deviate from social norms...they provide cues about who belongs in a society, which groups are to be devalued, and what sanctions are permissible for stigmatized groups,” (p. 1). From the studies, media representations serve as those who perpetuate stereotypes that influence attitudes toward stigmatized groups.

### **2.1.3. Desperate Need for Media Advocacy for Mental Health**

Mass media has been singled out as one means to address the persistent challenge of stereotypes, poor education and poor policy surrounding mental health issues. First, in 2000, WHO declared the media as a primary means for governments to reframe the public debate on mental health (WHO Mental Health Global Action Programme; mhGAP, 2002). Secondly, in 2013, the Mental Health stakeholders in Sub-Saharan Africa agreed that the media industry in the region would form a critical partner in advancing public knowledge and influencing policy level related to mental health issues. However, an understanding of the history of mental health is critical in order to understand the need for media advocacy.

The definition of mental health has evolved over time and treatment of mental illnesses has for a long time been on a trial-and-error process guided by medical theories and the attitude of the public. Treece et al.(2011) say that in the Middle Ages, insane asylums were created to take care of persons with mentally illness and those asylums were prisons and not treatment centres. The main motive was to remove persons with mental illnesses from the streets. The asylums were filthy, dark and the inmates were chained and treated like animals. However, in 1792, an experiment conducted at an asylum in Paris saw chains removed from the inmates, and to the shock of many, once the inmates were released from the chains, and put into clean, sunny rooms they were able to leave the asylum as a result of their recovery.

According to Leupo (2010) in the BC, mental health challenges were not viewed as an organic problem and “psychology” was also a non-existent concept and people

suffering from mental illnesses were referred to as “lunatics” – a word derived from ‘lunar’ referring to the moon. Leupo continues to say that the Colonial American Society believed that the reason for a person’s “insanity” was a consequence of the presence of a full moon at the time of the person’s birth or if the baby was laid under the light of a full moon.

These were declared outcasts and kept away from the community. However, in the 5<sup>th</sup> century BC, Hippocrates became one of the pioneers in the treatment of mental illnesses from a non-religious and non-superstitious and he introduced the concept that every human body contains four essential fluids namely bile, phlegm, blood and black bile, whose various combinations produce the unique human personalities (Foerschner, 2010). He pointed out that mental illnesses resulted due to imbalance of these bodily fluids and he argued that changing a person’s environment or occupation could cure their illness and if that failed, coming from a medical background, he would administer medication to help correct the person’s faulty state of mind. Even before diagnosis using the DSM was introduced, mental illness at the time was categorized by either melancholy or mania as a result of a crisis (Leupo, 2010). It was assumed that every human being should be born “normal” and any uncontrollable behavior that deviated from the norm was attributed to a deficit in spirituality. Unfortunately, due to the lack of knowledge and understanding of mental health, distress and negative attitudes existed towards mental illnesses persisted even in the 18th century and stigmatization and confinement of patients was high. The mode of confinement was also degrading and inhuman.

In the 1840’s, a female activist known as Dorothea Dix began advocating for better treatment of persons with mental illnesses (Knapp et al., 2011) and for about 40 years

she worked on pushing the United States (US) Government to fund the building of psychiatric hospitals in 32 states. From her perspective, mental illnesses were like any other physical illness and advocated for patients getting professional treatment. That was called the “Moral Management” approach where many families and the communities were relieved because patients could receive treatment as opposed to being banished from the society (Leupo, 2010). This approach emphasized on the environment’s vital role in the recovery of those who suffered from mentally illnesses. Thus, they replaced shackles and chains with beds, pictures and decorations so as to create a homelier atmosphere for the patient. Hypnosis and relaxation techniques were also used to help calm the patient.

However, because of the limitations in funding and expertise to help with treatment, institutional care was harshly criticized and in mid-20th century, outpatient programs were introduced and complemented with psychotropic medication such as Thorazine to reduce symptoms and treat the illness (Treece, Rangarajan, & Thompson, 2011). Introduction of this medication to the treatment process also reduced the length of time that severe patients spent at the psychiatric institutions because the medication could help control the disease. The deinstitutionalization somewhat contributed to reduction of stigmatization of people experiencing mental distress. Outpatient mental care was also believed to improve the quality of life of patients rather than the isolation associated with inpatient mental institutions. In the 1960s, the Mental Health Centres Act in the US restricted psychiatric hospitalization to strictly admitting patients who posed imminent danger to themselves or other people (Interlandi, 2012). Community-based health care was also introduced which brought treatment closer to

the general population even as more psychiatric experts continued to emerge (Lamb & Weinberger, 2005).

Foerschner (2010) observes that significant milestones in mental health concepts and psychology started being seen with development of psychoanalysis by Sigmund Freud – an Austrian neurologist and psychiatrist - in the late 19th and early 20th century. His conviction was that the human mind comprises of three divisions, namely, the id or pleasure principle, the ego and the superego and that the unconscious mind was the source of all psychopathology as it housed the unacceptable human desires and painful memories. As a result of these battles, anxiety would arise and without resolution of these battles of the mind, then mental illness was the end result. His basic treatment was based on the theory that if only an individual was able to access and address the content deeply seated in their unconscious mind, then mental illness could be cured (Myers, 2007). This he attempted to do using hypnosis and free association where the patient shared whatever thoughts came to mind regardless of how trivial they seemed, and that formed the Freudian slips and dream analysis. From those, Freud would track any common themes that could help unlock the person's unconscious to retrieve repressed thoughts and feelings (Myers, 2007). Shock therapy was still used for extreme cases and so was medication. Freud's theory is still being ascribed to even today even though the methods used today are not as strict Freud's were. His principle of how past experiences affect us whether we are aware of them or not is still very essential even in other therapies, as evident in the reality that psychoanalysis was among the first theories in psychology and the study of MH.

Just like in other African countries, an indigenous system of medicine existed in Kenya where traditional healers, including witchdoctors attempted to provide mental



health services. As mentioned in chapter 1, mental health issues in Africa have been defined by pre-colonial, colonial and post –colonial period. In the African traditions, mental health challenges were associated with supernatural forces and currently traditional healers and religious leaders are greatly consulted for mental health services (Ndetei, 2010). According to the colonial period criminalized mental health issues, whereby, those who objected the colonial rules, were put in prison and were labelled insane (Swartz, 2009).

In Kenya, the first mental health hospital in Kenya was Mathari National Teaching and Referral Hospital, which was started in 1910 and operated under various titles, starting with Nairobi Lunatic Asylum(Njenga, 2010). It was used by colonial armed forces to admit the ‘mad’ soldiers during the 1st and 2nd World Wars. Njenga further explains that the Africans, described as ‘native lunatics’ formed more than 95% of the inmates, and endured the poorest conditions and lived in grossly overcrowded situations. However, slightly better facilities were available to the Indians while the ‘best’ wards, food and other amenities were reserved for the Europeans. In 1924, the hospital was renamed Mathari Mental Hospital and that was later changed to Mathari Hospital in 1964.Until 1963 and for a short period thereafter, psychiatrists, senior doctors and nurses deployed at Mathari were all Europeans (Njenga, 2010).

Other historical milestones in regard to the hospital include the opening of the Maximum Security Unit in 1978, which was opened for law offenders with mental health challenges. In 2003, Sitawa (2012) explains that the only Government owned rehabilitation centre for drug and substance abuse disorder treatment was started in the hospital with a bed capacity of 15 but only admitting male patients. However, in 2008, the female ward was opened and the rehabilitative centre now has a bed

capacity of 35 for male and 10 for female. Currently, the hospital has 400 members of staff and a bed capacity of 700. It has grown to a centre for integrated services that includes a pediatric and adolescent psychiatric clinic, diabetic clinic, general outpatient services, maternal and Child Health Clinic (MCH), Voluntary Counselling and Testing (VCT), laboratory, Pharmacy, dental services, Comprehensive Care Clinic (CCC), Mortuary, Radiology, Occupational Therapy, Physiotherapy and TB clinic. However, besides provision of MH services, the other integrated services are hardly known. Whereas the community-based mental health services have become the preferred model for service delivery in the West, in most African countries, like Kenya, the approach is problematic due to strained mental health professionals and as a result, family, traditional healers and religious leaders play a dominant role in dealing with mental health issues (Alem et al., 2008).

Today, mental health, is seen as not only as a state of wellbeing where every individual are in a position to realize their potential, but also where people are in a position to cope with the normal life stresses, while living a productive life and making contribution to community(WHO, 2011). It means that mental health is a complete state of psychological, emotional and societal wellbeing. Further, it is intimately connected with physical health and behavior because some of the symptoms of mental illnesses manifest in physical pain. Consequently, 'mental health' focuses on promotion, which looks at prevention, recognition/diagnoses, management and treatment of mental illnesses. It is also considered part of Public Health, which "is the science and art of promoting health, preventing disease, and prolonging life through the organized efforts of society" (WHO 1998, p. 3).

Mental health challenges cut across age, race, gender and socio-economic status. On the other hand, mental illnesses, refer to all of the diagnosable illnesses, which interfere with thinking, feelings or behavior (WHO, 2002). According to the ICD-10 Classification of Mental and Behavioral Disorders Clinical descriptions and diagnostic guidelines by WHO, mental health problems are classified into eight categories and the word 'disorder' is used for classification. The first category is affective disorders, related to mood, where the mood change is usually associated with a change in the overall level of emotion, perception and activity. The mental illnesses under this group include bipolar affective disorder, depressive disorder, recurrent depressive disorder, persistent mood disorder and dysthymia disorder.

The second category is neurotic or stress-related disorders, where anxiety-related symptoms are the core sign. For some people, the anxiety related symptoms are triggered by defined situations and as much as possible such situations are avoided. Physical or somatic symptoms like palpitations, feeling faint, trembling and muscular tension are often associated with secondary fears of dying, social phobias, specific phobias, panic disorder, generalized anxiety disorder, mixed anxiety and depressive disorder, obsessive-compulsive disorder, adjustment disorders and post-traumatic stress disorder.

The third category is Schizophrenia disorders, which brings together a range of psychotic disorders with schizophrenia being the most common condition. Schizophrenia is characterized by distortions of thinking and perception, and emotions that are inappropriate or blunted. Other disorders include paranoid schizophrenia, hebephrenic schizophrenia, catatonic schizophrenia, schizotypal

disorder, persistent delusional disorders, acute and transient psychotic disorders and schizoaffective disorders.

The fourth category is organic disorders, which comprises a range of conditions that are grouped together on the basis of their having in common a demonstrable etiology in brain injury/disease. Dementia is a syndrome due to disease of the brain in which there is disturbance of memory, thinking, orientation, comprehension, language and judgement. Other disorders include dementia in Alzheimer's disease with early and also late onset, vascular dementia and multi-infarct dementia. Other categories include mental and behavioral disorders due to psychoactive substance abuse, behavioral syndromes associated with physiological disturbances and physical factors, disorders of adult personality and behavior and disorders of psychological development.

Although the mental disorders are classified into 8 categories, this study sought to find out how the mainstream media in Kenya represents mental health as a whole, which includes prevention of diseases and the social and environment context surrounding mental health promotion as opposed to mental illnesses only. The desperate need for mental health promotion is informed by several challenges that are facing mental health challenges globally. For one, mental challenges accounts for about 13% of the global burden of disease and is projected to reach 15% by 2020 when it will "disable more people than complications arising from the AIDS/HIV, heart disease, traffic accidents and wars combined," (Ngui et al., 2010, p. 2). Although it is clear that mental conditions are on increase and having serious disabling implication, the sector has been described as the least prioritized health sector, especially in Africa.

In Africa accessibility of mental services is deficient. Dovi (2013) reports that the ratio for psychiatrist-to-patient in Africa is less than 1 to 100,000 and 70% of African countries allocate less than 1% of the total health budget to mental health. Both West and East Africa are in dire need and Kenya is regarded as comparatively better prepared to cater for those suffering from mental illnesses as much as the situation has been described as wanting. The mental health audit carried by the Kenya National Commission on Human Rights, titled, *Silenced Minds: The Systematic Neglect of Mental Health Systems in Kenya*, showed that the policies and legislation governing the mental health sector are not only outdated but focus on in-patient administration (2011). Further, the Kenyan budget allocates less than 10% of financial resources to the health ministry with 0.5% being allocated to MH services countrywide (Menil, 2013). However, Article 20 (5) of the Kenyan constitution indicates that when allocating resources, the government should make it a priority to ensure the right to health is enjoyed as widely as possible including the vulnerability of particular groups or individuals.

In terms of treatment and medical personnel, as at 2011 there were 77 psychiatrists, 418 MH nurses and 30 clinical psychologists serving a population of slightly below 40 million (Ndeti, 2011). It is against such a background that Thom (2012) described mental as the “orphan child” of policymakers, government officials, activists and civil society, and has become a silent epidemic manifested in high levels of gender violence, child abuse, crime, conflicts, terrorism, poverty, HIV/AIDS, amongst other issues.

Secondly, the need for mental health advocacy is informed by the fact that mental health issues remain as some of the most stigmatized diseases of all human conditions. Morris mentions that persons with mental illnesses are one of the “remaining few groups subject to thoughtless labelling,” (2006, p.47) and that pervasive stigma is described as crippling due to the trauma it creates in those already mentally challenged (Beachum, 2010). Stigmatization associated with the issue has direct bearing in the disability and economic loss associated with MH challenges (Kakuma et al., 2010).

In other words, stigmatization hinders treatment of mental health conditions and excludes such patients from receiving their basic right for health. Furthermore, Ndetei et al. (2010) point out that stigma contributes to psychiatry not being emphasized as a course in the training of the medical personnel in the country. Commenting about stigma and discrimination within the Kenya community, Ndetei (2011) argues that such stigma could result from lack of awareness and understanding about mental health issues. Holding the traditional views, majority of people believe that mental illnesses result from either a familial effect or the evil machinations. On the other hand, persons with mental illness are hardly accorded platforms to express themselves: a position associated with stigmatization where such people are viewed as persons with low intelligence.

Thirdly, advocacy for mental health has become critical in light of the poor public education that persists. As compared to other physical illnesses, public knowledge about mental health issues is comparatively neglected. Research carried in Uganda, indicated that the media was interested and actively involved in health initiatives, but

little attention was devoted to mental health (Kigozi, et al., 2010). The findings indicated that, amongst other factors, mental health issues received scanty coverage, which translate to the public receiving little knowledge from the medium whose role is to inform and educate the masses.

It is in view of this that media was recognized as a powerful tool to deal with the constraints facing the mental health issues. However, a needs assessment on Media Coverage of HIV/AIDS & Health Issues in Africa showed that lack of awareness and information amongst the public is the biggest bottleneck to improving the state of public health in Kenya (African Women and Child Feature Centre, 2010). The media was accused of becoming commercial at the expense of its social responsibility to educate and inform.

Nevertheless, according to Nyakundi (2015) there are some countries where the media has made a significant contribution in mental health promotion and an example is Norwegian Mental Health Campaign, which was a nationwide six (6) months mass media-based publicity and information strategy, which culminated in a six-hour TV broadcast. Quoting Sogaard and Fonnebo (1995), Nyakundi says that the campaign achieved wide penetration, and positioned mental health issues on the cultural agenda in Norway and contributed in changing the knowledge of and attitudes towards mental health problems. The media has been described as a powerful medium in promoting health beliefs and in creating role models for contemporary people (Marinescu & Bianca 2016).

In a country like Kenya where the media landscape has grown tremendously, the media can either play a critical role in mental health promotion or continue to

reinforce the stereotypes, misinformation and knowledge gaps that exist in the public domain.

## **2.2. Situating research in the field of communication studies**

The communication field is wide and has diverse disciplines, which include intrapersonal, interpersonal, inter group, intercultural, public, mass, and organizational communication. Recently other fields in communication have been introduced like Communication for development and Health communication.

Mass communication context targets large audiences and the most common platform include newspapers, television, radios, and other tools targeting masses. This study is situated in the field of mass communication as it looks at the media representations, specifically looking at the mainstream media in Kenya, which consists of several media channels that communicate to a large audience.

In addition, this study is also partially situated in health communication which is an emerging field in communication. Mass media campaigns have been extensively used as a tool for promoting public health (Noar, 2006). Communication campaigns, involving diverse topics and target audiences, have been conducted for decades. Mass media campaigns have generally aimed primarily to change knowledge, awareness and attitudes, contributing to the goal of changing behavior.

In terms of mental health promotion by the mass media, there are studies that have shown improved media representation of mental health resulting yielding positive outcome as discussed here below.



### **2.3. Review of Previous Research in Media Representation of mental Health**

In this section, I present previous research on media representation of mental health with the aim of showing the existing gap in literature on the issue. One of the studies carried out by Nawkova, Nawka and Adammkova (2013) was an international comparative study that looked at the content of media messages about mental health/illness in terms of stigma in three central European countries. Being a content analysis, the study sample comprised all articles identified during a five week long periods in 2007 and were chosen from the six most widely read newspapers and magazines in those European countries. The findings showed that more than half of all articles were negative and reflected stigma towards people with mental illnesses, with psychotic disorders being the most stigmatized. The association of aggressive behavior to the people with mental illness emerged while a sensationalized style of writing was noticed. Whereas the study was based on content analysis and was done in Europe, it concurs with this qualitative study based in developing countries, which shows that the Kenyan mainstream media perpetuates stigma about MH where the ill as represented as violent, dangerous and unpredictable. Additionally, the dominant images used to reflect MH issues are those with psychotic disorder who constitute only 2% of those who suffer from diverse mental illnesses in Kenya.

Another study carried in Australia which examined the portrayal of mental health in Australian daily newspapers (Kenez, O'Halloran, & Liamputtong, 2015) examined how mental health was portrayed as a holistic construct in three major Australian daily newspapers. Mixed methods approach was used incorporating content and thematic analyses, and the data was collected from 3 newspapers. The results of the study showed that newspaper coverage of mental health focused on illness over

wellbeing while psychotic disorders were overrepresented and often linked to violence. However, positive improved portrayal of mental health featured highly, where media stories focusing on managing mental illness and maintaining good mental health were predominant, while stories mentioning examples of people who had recovered was noticed hence “refuting the myth that mental illness is an incurable life sentence... encouraging self-help,” (Kenez, O’Halloran, & Liamputtong, 2015, p.516). One of the recommendations that came from the study is the need for mental health professionals and organizations to forge strong relationships with, and provide education to journalists; just like this study recommended.

Another study was based on the Nigerian and Ghanaian movie industry, popularly called Nollywood where mixed methods of research were used. The aim of the study was to determine the attitudes and perceptions of mental illnesses in Nigerian and Ghanaian movies and its impact on mental health awareness in Ghana. The content analysis showed that they often contained scenes depicting mental illnesses in line with culturally entrenched explanatory models (Atilola, 2015). The content analysis showed frequent use of words like ‘mad man or woman’ and ‘curse’. Stereotypical images of violent person were depicted with sensational forms of recovery were present. However, continued filmic portrayal of mental illness solely from the point of view of cultural explanatory models tends to provide an incomplete representation of the issue. As Shon and Arrigo would argue, “public consumption of such explicit images and charged words raises many troubling policy questions and questioning of media ethics,” (2005, p.6).

Another quantitative content analysis examined Swedish online-press and how mental illnesses are represented in on-line press after the Anders Behring Breivik’s a

terrorist attack in Norway in 2011 (Rasmussen, 2015). Like other studies, this study has shown that press reinforces stereotypes about people with mental health challenges being labeled as unpredictable and dangerous. More than a third of the articles from the opinion section used names like ‘mad man/lunatic or crazy/mad’ while describing those with mental health challenges.

Through literature, this study reviewed how MH issues have been represented in the media. However, a number of gaps exist. Whereas many studies have focused on content analysis of newspapers, this study looks at the traditional mainstream media which consists of TV, newspapers and radio, which are considered as credible channels of communication in Kenya (Mugambi, Kiai, & Ndati, 2013). It goes beyond looking at news but all media content touching on mental health. Literature review demonstrated that, unlike this study, there are hardly perspectives studies, looking at attitudes of health experts on how mainstream media represent MH issues and their experiences while also seeking to understand the determinant factors that influence the way MH issues are represented by the mainstream media. The participants of this study consisted of health experts consisting of Health Journalists and MH Experts, who would be considered as key custodians of media and MH issues. The research methodology used in the study is qualitative research which looks for thick description; while at the same time a case study approach has been used looking at the case of ‘Mental Health’ and not just ‘Mental illnesses’. This study showed that there is skewed representation of MH issues by the mainstream media in Kenya where such issues are associated to crime, violence, and outrageous acts while at the same time the disease is linked to the poor and the uneducated in the society. Mental illnesses are presented as ‘dramatic’ disease, which attracts the media audiences. However, the

media representation deviates from the situation facing the MH sector in the country where MH challenges are not only in the increase but they cut across age, educational and social status while the poor are subjected more to violence than vice versa. Further, this study fills another gap by pointing out what needs to be done in order for the media to represent MH issues in a balanced way so that it can play an integral role of demystifying MH issues and promotion of relevant policies.

## **2.4. Review of relevant theories**

Theories form coherent set of ideas and concepts of how the world (or parts of it) can be explained or understood. Over the years, a lot of research has been conducted to determine the influence of mass media on public perception. Theoretical frameworks have been postulated ranging from the hypodermic needle model that suggests immediate unquestionable acceptance of media messages; to the limited effect theories that suggest that long term exposure to media content could affect perception; to more current models such as the agenda setting theory and Cultivation of Perceptions of Social Reality theory. Many of these studies have concluded that media representation of reality does have a degree of influence on public perception (Gerbner& Gross, 1976; Hawkins & Pingree, 1990). Television is the most powerful medium of framing public consciousness. The power of media in shaping perceptions and behavior has been recognized in health communication. The theories that have been used in reference to this study include socio construction theory and framing theory (Fiske, 1987).

### **2.4.1. Social Construction of Reality**

The social construction of reality is a theory of knowledge of sociology and communication that examines the development of jointly constructed understanding of the world. There are several cardinal principles emphasized in social constructionism, which include: realities are socially constructed; realities are constituted through language; knowledge is sustained by social processes; and reflexivity in human beings is emphasized.

Social construction of reality assumes that people construct or create their understanding of the world and the meanings they give to their encounters with others and to objects. This construction is done jointly or in coordination with others therefore forming a collective reality. They further argue that all knowledge of everyday reality is derived from social interactions. As people interact, they negotiate meaning and form a common perception of reality; their constructions are reinforced and become to be known as part of their objective reality.

On explaining on the theory, Gilban (2014) says that there are three fundamental processes that are responsible for this, which they call externalization, objectivation and internalization. In terms of 'externalize', they explain that people externalize through having an idea, which they externalize by telling somebody else or writing a book or a media story. But that information enters into the social realm; and other people re-tell the story or read the book, and once that happens, the story/book or a media article takes on a life of its own. The idea is expressed and becomes a subject of consciousness for people in that society (objectivation) and has developed a kind of factual existence of truth. Finally, because future generations are born into a world

where this idea already exists, they internalize it as part of their consciousness, as part of their understanding of the nature of the world.

This theory was chosen for this study because it not only fits in media studies but also because it acted as a good reference point in seeing how mental health issues are represented and what informs how they are constructed while examining the role of media in shaping its audience construction of reality. The way MH issues are represented, including the language used in communicating those messages, shapes how the media audiences construct those messages. Additionally, this theory helped in establishing how health journalists construct MH issues, which ultimately, influences how they represent MH issues to their audiences.

In view of social constructionists, cognitive growth occurs first on a social level, and then it can occur within the individual (Vygotsky, 1978; Roth, 2000; Derry, 1999 and McMahon, 1997) as cited in Amineh and Davatgari (2015). The roots of individuals' knowledge are found in their interactions with their surroundings and other people before their knowledge is internalized (Roth, 2000). Social Constructionism has its synthesis from both Symbolic interactionism and interpretivism (Andrews, 2012). Constructivism emerged as the leading metaphor of human learning by the 1980s and 1990s as interest waned in behaviorist and information-processing perspectives (Mayer, 1996) as cited in Liu and Matthews (2005). The origins of constructivism are linked to the philosophies of Socrates, who claimed that teachers and learners should talk with each other and interpret and construct the hidden knowledge by asking questions. Constructionism is also linked to Jean Piaget's "constructivist" views, as well as to Bruner's "constructivist" description of discovery learning (Amineh & Davatgari, 2015).

There two most important elements of the Social Construction of Reality Theory: (a) the assumption that human beings rationalize their experience by creating a model of the social world and the way that it functions and, (b) the belief that language is the most essential system through which humans construct reality (Leeds-Hurwitz, 2009) as cited in Amineh and Davatgari (2015). The language used by the media in communication of MH issues influences how their audiences construct MH issues. Galbin (2014) describes the two terms; socialization and construction. Borrowing form DeFleur and Ball-Rokeach (1989), they define socialization as:

*A complex, long-term, and multidimensional set of communicative changes between individuals and various agents of society that results in the individual's preparation for life and brings all members of a society into sufficient conformity so that social order, predictability, and continuity can be maintained. (p. 208).*

Further, media acts as a socializing agent by constructing reality and then disseminating this *reality* to the mass public. The “social” element is realized when upon receiving the media’s “reality” message; the vast majority agree upon this reality and accept it. Following this pattern, Galbin (2014) notes that social construction may be more appropriately referred to as social *agreement* of reality. On the other hand, the term ‘construction’ implies that the media is “making-up” or “creating” reality. However, that reality is not created blindly since there are gatekeepers in the media who influence how issues will be constructed. And there are many factors that would influence how media messages are constructed. Besides the editors’ role, there are other factors; and one of the objectives of this study was to explore what factors influence how mental health issues are constructed by the media. Further, the media has an influence on the language to use in sharing information, which is an imperative aspect of socialization and construction. In terms of the effect that kind of

socialization and construction will have on its media consumers, Galbrin (2014) comments that it depends in the individual's or community consumption of media content.

Two variants of social constructivism exist; personal constructivism and social constructivism. Personal constructivism emphasizes the intrapersonal process of individual knowledge construction. Amineh and Davatgari (2015) argue that knowledge is individually and distinctively constructed or discovered. Social constructivists on the other hand espouse the central role of the social environment (including media) in learning. Learners are believed to be enculturated into their learning community and appropriate knowledge, based on their existent understanding, through their interaction with the immediate learning environment. Learning is thus considered to be a largely situation-specific and context-bound activity (Eggen & Kauchak, 1999; McInerney & McInerney, 2002; Woolfolk, 2001 as cited in Liu & Matthews, 2005). It is this second variant that this study adopts.

Social constructionists argue that reality is not an objective truth, but rather, there are multiple realities competing for legitimacy. It is the meaning of our experiences and not the ontological structure of the objects which constitute reality (Shutz, 1982). In agreement with this, Berger and Luckmann (1996) make a distinction between objective (the real world irrespective of our perception) and subjective social reality (the images people form of the world). Social ideas and categories (including stereotypes) are socially constructed and then accepted as reality, despite the facts. In the words of Andrews (2012), society is viewed (by Social constructionists) as existing both as a subjective and an objective reality. Meaning is shared, thereby constituting a taken-for-granted reality.



As relates to this study, it is argued that the existing knowledge on mental health in the Kenyan society is socially constructed by individuals as they learn and interact with the larger society and the mainstream media. Media does not give information using a neutral lens, but they generally act in a way that promotes apathy, cynicism and quiescence (Gamson et al., 1992). He further goes on to argue that people walk around with media generated images and those images are used to construct political and social issues and so to change the existing constructs of mental illnesses in the Kenyan society, mediated messages have to re-focus on reconstructing the reality on mental illnesses which is created in the environment. As Lester and Onore (1990) argue, change can occur through having experiences that present and represent alternative systems of beliefs and trying to find a place for new experiences to fit into already held beliefs.

Galbin (2014) argues that the Social Construction theory shows that mass media is one of the various variables through which socialization takes place. Further, he says that there are three other theories that can be specifically linked to social construction theory; namely, Bandura's (1977) social learning theory, which suggests how mass media consumers can learn about societal actions; cultivation theory (Gerbner, 1973) demonstrates how people line their views of the world with those presented in the media and finally, agenda setting (McCombs & Shaw, 1972) presents the notion of how the media frame issues influencing its consumers on issues and events to think about. He argues that these theories draw directly from the assumptions of social construction of reality as he also points out that the notion of gatekeeping directly correlates with agenda setting. Gatekeepers determine what content and what

information in a given content will make it to the public. In other words, gatekeepers set the public agenda or the salience of issues.

#### **2.4.2. Framing Theory**

According to Ireri (2013) framing forms a significant fertile ground for research in mass communication and it is being commonly used in scholarly than agenda-setting and priming, which are the two other leading communication theories. The key function of mass media is cognition and interpretation; and the media not only gives us information, it interprets this information and suggests solutions to problems. It therefore creates frames of thoughts that limit or guide the perception. It is in view of the above that this study referred to framing theory to establish what kind of frames the mainstream media in Kenya uses in representation of MH issues and how those frames compare with the reality facing MH as perceived by MH experts.

Framing is described by Entman (1993) as a process by which some aspects of reality are selected and given prominence so that a problem is discussed, its causes diagnosed, moral judgement suggested and action proposed. The idea is to make selected aspect of perceived reality more salient in a communication text. Additionally, De Vreese (2005) defines framing as persistent patterns of cognition, interpretation and presentation of selection, emphasis and exclusion by which symbol handlers routinely organize discourse. In this study, the framing theory helped in establishing the dominant MH messages that the mainstream media selects and emphasize in their channels while looking at what makes those issues to be more predominant as compared to other issues.

Ileri (2013) describes framing as the central idea that provides meaning to an unfolding strip of events. It plays an important role in unifying information into a package that can influence audiences by selecting, emphasizing and excluding certain ideas, feelings and values. Consequently, media frames in the study were important because the predominant messages passed by the media have the potential to influence the decisions of their audiences. Indeed, Borah (2011, p. 248) says: “news framing influences information processing and the subsequent decision-making processes.” This means that if conflict frames are predominant as far as MH issues are concerned, the media audiences have the likelihood of linking MH to conflictual issues where the ill are defined as people of controversy and conflict, who ought to be isolated. Entman (2007) argues that if agenda setting tells an audience what to think, then framing tells media audiences how to think about an issue. In that light, framing can either promote help-seeking behaviors or discourage the same when it comes to health matters. “Framing, therefore, can have wide-reaching implications for the way a message is delivered, heard, and acted upon,” says Anderson, et al (2017, p. 3).

Frames have functions and shares four functions as indicated here below:

Frames, then, *define problems-determine* what a causal agent is doing with what costs and benefits, usually measured in terms of common cultural values; *diagnose* causes-identify the forces creating the problem; *make moral judgments-evaluate* causal agents and their effects; and *suggest remedies-offer* and justify treatments for the problems and predict their likely effects.

In regard to the above, it is important to find out media representation of mental health issues because a media frame can determine causes of mental ailments based on cultural interpretations. Through the cultural frame, the media has the potential to diagnose mental health conditions wrongly and pass judgment on those suffering from

the disease and the institutions that serve them and can even suggest remedies using the cultural lens and evidence-based medical expert.

One of the key words used in framing is salience, which Entman (1993) describes as making a piece of information more noticeable, meaningful, or memorable to audiences. Describing it further, Entman (1993) borrows from Fiske and Taylor (1991) who observe that “salience enhances the probability that receivers will perceive the information, discern meaning and thus process it, and store it in memory” (p.53). The frame determines whether most people notice an issue and to what extent they understand and remember a problem, as well as how they evaluate and choose to act upon it, an issue that is critical in promotion in mental health.

Framing therefore gives prominence to a certain aspect of reality at the expense of others. It exists in the sender’s mind, in the message, in the decoding process and in the culture (Entman, 1993). In media framing, Angel and Kuypers (2009) see framing as the process by which an issue is portrayed in the news media. Journalists rely on media frames to decide what to include in a story; a process that may be conscious, instinctive or culture-bound. On the other hand, a media frame may draw a viewer’s attention to specific part of a news story, de-emphasize other parts, and leave out some aspects completely. Frames highlight some bits of information about an item that is the subject of a communication, thereby elevating them in salience. An increase in salience enhances the probability that receivers will perceive the information, discern meaning and thus process it, and store it in memory (Fiske & Taylor, 1991; Kahneman & Tversky’s as cited in Entman (1993).

Framing is based on the assumption that how an issue is characterized in news reports can have an influence on how it is understood or interpreted by audiences. Framing theory, therefore, postulates that in mass media frames provide boundaries around a news story and determine what is and is not newsworthy or notable. The process that the media uses to represent mental health issues is framing. On the other hand, a media frame may draw a viewer's attention to specific part of a news story, de-emphasize other parts, and leave out some aspects completely.

In giving news based on mental health issues, journalist frame reality through: the presence or absence of key words, stock phrases, stereotyped images, their choice of informants or sources, and by use of sentences that provide thematically reinforcing clusters of facts or judgment (Entman 1993). Other framing devices include: choices of language, quotations (Shah et al., 2002 as quoted by Vreese 2005) metaphors, catch phrases, exemplars, depictions and visual images (Gamson & Modiglian, 1989 as cited in De Vreese, 2005). These frames can be conceived on the individual level for instance through altered attitudes (on mental health) or on societal level political socialization or collective action (De Vreese, 2005).

Dorfman and Kransnow (2013) note that although media consumers have the capacity to hold diverse frames, including contradictory ones, the frames that get triggered and repeated often, have a higher probability of influencing the audience. It means that, in their analysis of how media represents mental health issues, the participants of this study discussed the common frames that were triggered in their memory.

Andersen et al. (2017) acknowledge that media stories framed according to public health framing, should consist of three critical components: information associating

the public health concern to other larger social and environmental contexts; description of risk factors and prevention information. This implies that when it comes to MH social and environmental contexts that trigger mental illnesses should not only be prominent but also relevant to policies to address the contextual factors. Additionally, risk factors associated with MH challenges like the psychosocial environment should be highlighted as well as prevention of MH challenges which are on the increase in Kenya and Africa.

Further attribution of responsibility is a critical factor as part of framing when it comes to public health issues. Andersen et al. (2017) add that public health issues are often contrasted within the individual rights versus community needs, which determines whether it is individual dispositional or environmental situations' causal attribution. However, to garner public support for a health policy, it is important that issues are framed as something that is universal or as environmental situations as opposed to solely the responsibility of the individual. The implications are that if MH issues are represented and ultimately framed as challenges affecting few individuals who are responsible for their disease, it means that although the MH challenges are on the rise, the stigma not only persists and review of MH policies may lack. Kiima and Jenkins (2015) observe that Kenya's MH care system operates under resource-restricted conditions as characterized by poor infrastructure and low manpower. If the environmental factors are downplayed, the sector is likely to continue being underfunded by the national and global level. Further, Marangu et al., (2014) and WHO (2010) point out that one of the reasons why MH challenges are on the rise is because mental illnesses often affect, and are affected by other non-communicable diseases such as diabetes, cancer, cardiovascular disease and HIV/AIDS. It is

therefore, important to find out the frames are used in media representation of MH issues in Kenya.

There are several factors that influence how the media influences issues. Angel and Kuypers (2009) comment that the media may be influenced by several social-structural or organizational variables and individual or ideological variables. Based on previous research, they point out five factors that may potentially influence how journalists frame a given issue: Social norms and values; Organizational pressure and constraints; Pressures of interest groups; Journalistic routines and ideological and political orientation of journalists.

## **2.5. Conclusion**

This chapter has progressively shown how mental health, as a branch of health communication, is in dire need of mental health advocacy and the role the mainstream media can play in that space. Consequently, the aspect of media representation was discussed while showing its link to media representation of mental health. Theories related to this study were also highlighted. The next chapter will look at methodology that was employed in the research, including the research approach, method, data generation techniques and data analysis.

**Table 2: Summary of Literature Review**

- |   |
|---|
| <ul style="list-style-type: none"><li>• Media representation has become an important field in health communication because of its influence on policy advocacy and public education</li></ul> |
|---|

- Media is an important tool for policy advocacy and public education on the stigmatized mental health
- This study is situated in the field of media studies and health communication. Media has become critical in health promotion, including mental health promotion
- Review of previous studies on media representation of mental health shows that there is a gap, which necessitated this study.
- Two theories, Social construction and framing theory, have been referred to in this study.



## **CHAPTER THREE: RESEARCH METHODOLOGY**

### **3. Introduction**

This chapter describes how the study was conducted and it outlines the procedures and rationale for the way the data was collected and analyzed. The chapter starts by describing the philosophical paradigm, followed by a discussion of the qualitative research approach that was employed and the case study design that was adopted. Consequently, methods of data collection and data analysis techniques are discussed. Multiple sources of data generation techniques, which were used in this study, namely, in-depth semi-structured interviews and document analysis are also discussed. The sample size and the justification for its choice are highlighted before concluding with a discussion on how the data collected was analyzed. The chapter concludes with a discussion on the trustworthiness and dependability of this research, and the key ethical considerations.

#### **3.1. Philosophical Paradigm of the Study**

In this study I adopted relativist-interpretivist philosophical paradigm. Jwan & Ong'ondo (2011) postulates that a paradigm is a broad view or a perspective of something. They argue that paradigms are patterns of beliefs and practices that regulate inquiry within a discipline by providing lenses, frames and processes through which investigation is accomplished. Taylor et al. (2007) further acknowledges that before explaining the specific methodologies utilized in a study, it is necessary for the researcher to provide an exploration of the research paradigm. This is necessary so as to clarify the researcher's structure of inquiry and methodological choices.

According to Johnson (2008) there are two main dimensions to consider in the research process. He argues that a research paradigm is an all-encompassing system of interrelated practice and thinking: ontology and epistemology and researcher's commitments to them are critical in the formation of a research process. Ontological and epistemological aspects concern what is commonly referred to as a person's worldview, which has significant influence on the perceived relative importance of the aspects of reality.

Ong'ondo and Jwan (2011) define ontological view as the nature of reality or the assumptions the researcher has about reality or knowledge. They, on the other hand, define epistemological view as the way reality or knowledge is studied. Epistemology is concerned with the question of how we can have valid knowledge about chosen domains while ontology is concerned with what we are studying. Carter and Little (2007) say that epistemology profoundly shapes the researcher's conceptualization of the participant in data collection and analysis. Further, Denzin and Lincoln (2005) give two extreme conceptualizations of ontological assumptions: into a continuum of realism and relativism.

The realist perspective looks at the world as an objective entity that has rules and regulations that govern behavior. But relativists take a subjective position that individuals have different views that are dependent on their personal perceptions and experiences; "and that there is no single viewpoint of the world and therefore reality is internal to and dependent on the individual's perceptions and experiences," (Jwan&Ong'ondo, 2011, p.20-21 as cited in Johnson, 2008). Qualitative research is mostly located in the social sciences and therefore is concerned with issues of a social nature where the existence of multiple viewpoints on most issues is always the norm.

In this study, I used the relativists approach and took a subjective position because I was interested in interrogating the understanding and interpretation that health journalists and mental health experts have towards the way the mainstream media in Kenya represents mental health issues while looking at the perspectives of those representations in light of the status of mental health sector in Kenya. It was important to see the different views and perceptions coming from both sets of participants and how their relative perceptions compare. Although my main objective was not to compare their perceptions, comparison was inevitable. It was also important to find out the perspectives of mental health experts on how the mainstream media representation of MH issues compare with the situation facing the sector. Further, the underpinning determinants that influence how mental health issues are covered were subjective and varied.

Yin (2009) says that understanding the process through which events and actions takes place is a major strength of qualitative studies due to the ability to understand the process that lead to the outcome of a certain phenomenon. It is in view of this, that it was not only critical to understand the perspectives of the participants on how the mainstream media represents mental health issues but also understand the process that influence that kind of representation. Citing Maxwell (1992, 2004a), Yin (2009) captures the importance of understanding participants in a phenomenon by saying, “the perspectives on events and actions held by the people (participants) involved are not simply their accounts of these events and actions, to be assessed in terms of truth or falsity; they are part of the reality that you are trying to understand, and a major influence on their behavior,” (p. 221). Indeed, this was applicable to me because the main purpose of the study was to understand the reality of media representation of

mental health and as I interacted with each participant, the reality was coming out. There was no right or wrong answer because the critical thing was to understand the perceptions and from the analysis, I drew the reality of how the mainstream media in Kenya represents MH and interesting viewpoints emerged as to how that reality can be reshaped in order for the Kenyan media to give a balanced representation of mental health.

The research was undertaken within the relativist/subjectivist ontology and constructivist framework. The question that follows under the ontological paradigm relates to the nature of reality and how that reality can be known while the epistemological question is about the nature of the relationship between the knower or and what can be known (Guba & Lincoln, 1994). According to Denzin and Lincoln (2005) and Carter and Little (2007), the most common epistemological paradigms are positivist and interpretivist-constructionist. They further explain that the ontological positions of realism and relativism are consistent with epistemological viewpoints of positivism and interpretivism-constructivism.

Consequently, this study was based on interpretivist-constructionepistemology, which seeks to “generate data from people themselves, aiming to get knowledge about how people perceive, interpret, and understand issues that affect them in their contexts” (Jwan&Ong’ondo, 2011, p. 22). Just like in subjectivism, on interpretivist-constructionist, epistemology assumes that knowledge can be created and understood from the point of view of individuals. The positivist epistemology, where quantitative approach is mainly used, presupposes that knowledge is achieved by following a rigid plan for gathering information. Therefore, the philosophical paradigm of this study was conceptualized under interpretive-constructive framework. This approach centres

on the way human beings make sense of their subjective reality and attach meaning to it.

From an ontological point of view, there are multiple realities or truths based on one's construction of reality; but that reality is socially constructed and therefore constantly changing (Sale, Lohfeld, & Brazil, 2002; Krauss, 2005). The issue of social construction was critical in this study since it formed one of the theories in terms of finding out different perspectives on how mental health messages are constructed and how they are re-presented by the media. Construction is critical in terms of informing how reality is made and how people develop subjective meanings of their experiences. "These meanings are varied and multiple, leading the researcher to look for the complexity of views rather than narrow the meanings into a few categories" (Creswell, 2013, p. 25). Rather than starting with a theory, the inquirer, using the social construct, generates a theory or a pattern of meaning (Lincoln & Guba, 2007) or refer to theory in analysis of data.

### **3.2. Qualitative Research Approach**

Following the philosophical paradigms, I used qualitative approach, which is a strategy of enquiry (Myers, 2009). At one level, qualitative and quantitative refer to distinctions about the nature of knowledge: how one understands the world and the ultimate purpose of the research. On another level of discourse, the terms refer to research methods, that is, the way in which data is collected and analyzed, and the type of generalizations and representations derived from the data. In comparison to quantitative research, qualitative inquiry employs different philosophical assumptions; strategies of inquiry; and methods of data collection, analysis and interpretation (Creswell, 2009). Such an approach emphasizes the 'qualities of entities, processes

and meanings that are not experimentally examined or measured in terms of quantity, amount, intensity or frequency,” (Denzin & Lincoln 2000, p.8). As is the case in this study, qualitative research approach, tends to answer the - what, how, when and where of research and facilitates the meaning-making process. Jwan and Ong’ondo (2011) posit that one of the features of the qualitative research is that it is interested in meanings, perspectives and understandings. Using multiple sources of information, this study looked at health journalists and mental health stakeholders attribute meaning on media representation of mental health while looking at their perspectives and their understandings on why the mainstream media in Kenya, represents mental health issues in the manner it does.

The focus of qualitative studies is not on the statistical representativeness of the study population, but rather the quality and depth of the findings hence this study focused on interviews that generated rich data that provided a detailed understanding of the phenomena that was under the study (Were, 2015). In view of this, qualitative approach was chosen in this study because of the desire to meet an intensive description (Silverman, 2013; Yin, 2014). My goal was not just to get the themes emerging from the representation, but a desire to understand how that representation compares with the reality as perceived by the mental health experts. Further, reasons of mental health issues being represented in the manner they are, was intriguing. Multiple cases are studied to build fuller understandings of participants’ perceptions in this study.

Qualitative research operates within the relativist tradition and constructivist framework, which also takes the stand that there exist multiple viewpoints on any subject under inquiry. Jwan and Ong’ondo (2011) define qualitative research as an

“approach to inquiry that emphasizes a naturalistic search for relativity in meaning, multiplicity of interpretations, particularity, detail and flexibility in studying a phenomenon or the aspect(s) of it that a researcher chooses to focus on at a given time,” (p. 3). Further, qualitative is concerned with looking at participant/s perspectives within the context of their lives and trying to gain access to their experiences and perceptions by listening to them and observing them. Creswell (2014) says that natural setting is critical in qualitative research where data is collected at the site where the participants related with the study. The act of talking directly to people in their context, seeing how they behave and act, is a major characteristic of qualitative.

In this study, the participants were interviewed in their natural setting where they work; the health journalists were interviewed in their respective media houses while the mental health experts were interviewed in their offices, which is within the context of their lives, and could easily relate with their day to day life. I was able to observe journalists and their demand for meeting deadlines while I observed the environment where the mental health stakeholders worked in. As part of qualitative research, as a researcher, I was also a key instrument in examining documents, observation and interviewing participants.

Another reason why qualitative research was used was the desire to have multiple sources of data: document analysis, observation and interviews. In qualitative research, as suggested by Creswell (2014) the focus is on learning the meanings that the participants hold about the problem or issue while they share their perspectives and shared experiences (Jwan and Ongondo, 2011). For example, mental health experts shared their experiences of working with those suffering from mental illnesses

and experiences working with media workers. On the other hand, health journalists shared their experiences of working with different health stakeholders and what works in different contexts. Examples that enriched the study were shared.

Realizing that the qualitative research calls for a thick description of the research process, the question ‘why’ becomes important because it unearths a number of ideas (Lincoln, 2010). However, the question ‘how’ and ‘what’ played the role of digging in to issues and giving thick description of issues, for example, one of the research questions was ‘what factors influence the way mental health issues are represented’; and divergent and deep views came from that question.

### **3.3. Case Study Method**

In this study I used case study method. The quantitative methods consist of the systematic empirical studies which involve quantifying through the assistance of mathematics and statistics (Bryman & Bell, 2007). Data is collected and transformed into numbers which are empirically tested to see if a relationship can be found in order to be able to draw conclusions from the results gained. In other words, quantitative methods are related to numerical interpretations. On the other hand, qualitative research does not rely on statistics or numbers. Qualitative methods often refer to case studies where the collection of information can be received from a few studying objects (Bryman & Bell, 2007). Research methods in qualitative research mainly use case study, ethnography, discourse analysis, narrative research and grounded theory. This study used case study as the research method.



The case study research method was used due to several reasons. One, although health journalists cover diverse types of diseases and health as a whole, this study singled out 'Mental Health' and interrogated how the case of mental health is represented by the mainstream media in Kenya. As proposed by Yin (2009), a case study entails the study of a phenomenon within a real-life context or setting. Further, the case of print and electronic media was singled out in view of studying media representation of mental health. Digital communication as a channel of communication was not involved in this study. Creswell (2013) takes it a step further by first acknowledging that case study falls under qualitative approach "in which the investigator explores a real life, contemporary bounded system (a case) or multiple bounded systems (cases) over time, through detailed, in-depth data collection involving multiple sources of information," (p. 97).

First, I explored a real-life case of mental health within the context of print and electronic media. Realizing the stigma facing MH issues, the contextual conditions of the event being studied are critical and where the researcher had no control over the events as they unfolded. Another reason for the case study method was the need for detailed in-depth data collection where both interviews, observation and document analysis were used as data collection methods. Further, multiple sources of information, consisting of health journalists from 6 TV stations and 4 daily newspapers and MH Experts coming from institutions offering diverse MH services was employed in this study.

Ritchie and Lewis (2003) argue that the primary defining features of a case study is the multiplicity of perspectives which are rooted in specific context. The context of this study was mental health and multiplicity of perspectives emerged from both Health

Journalists and mental health experts. For example, in this study, mental health experts had diverse perspectives on the role of ‘Scandal Frame’ in shaping policy issues surrounding health matters. Additionally, Yin (2003) contends that the case study approach makes use of multiple methods of data collection such as interviews, document reviews, archival records, and direct and participant observations and subsequently ‘thick descriptions’ of the phenomena under study. Such ‘thick descriptions’ give the researcher access to the subtleties of changing and multiple interpretations.

Another hallmark of qualitative case study is that it presents an in-depth understanding of the case (Creswell, 2013; Jwan & Ong’ondo, 2011; Yin 2009; Berg, 2001). One way to achieve that in-depth understanding of a case is through multiple sources which may include interviews, observations, documents, and audio-visual materials. That is in line with what Creswell mentions that relying on one source of data is not enough to develop in-depth understanding of the study. To gain deeper understanding of the case, multiple sources were used, including in depth interviews and document analysis. Multiple case studies were used consisting of journalists from both TV and daily newspapers who came from different media houses and there were also two editors. Besides that, mental health experts participated; also coming from different professions and institutions. It means there was deep information from different voices. The case study method was employed due to the enrichment nature it adds to a study while also it increased the trustworthiness of the study. Additionally, as multiple case studies were used, data source triangulation was achieved.

Although case studies are more interested in what can be learned from a single case (Yin 2003), through multiple case studies different phenomenon can be compared and also bring some form of generality (Silverman, 2013). Jwan and Ong'ondo (2011) bring out three types of case studies: which are intrinsic, instrumental and multiple or collective case study. Whereas the intrinsic case study is focused on a particular case due to the desire to gain better understanding of a particular case, the instrumental case study is concerned with the issue rather than the case itself. The latter is mainly "used if a particular case is examined mainly to provide insight into an issue or the redraw conclusions" (Jwan & Ong'ondo, 2011, p. 34). On the other hand, there is multiple case study that was more appropriate for the study. Whereas the case being investigated was 'mental health'; to understand how the mainstream media represents the case, media workers and mental health workers were interviewed in view of having thick description about the case being studies.

The method was instrumental in that the cases helped highlight health journalists and MH expert's perspectives on how the mainstream media in Kenya represents MH. This study benefitted from multiple cases and different phenomenon were compared and it was noticed that there were dominant themes that emerged from the participants. For example, mental health experts saw the Kenyan mainstream media focuses more on mental illnesses than mental health. According to Yin (2003), case studies arise out of the desire to understand complex social phenomena and allows "investigators to retain the holistic and meaningful characteristics of real-life events," (p.2) as it happened in this study.

### **3.4. Study Pre-planning and Sampling Procedure**

I commenced preparations for this study by seeking for research permit from National Council for Science and Technology (See Appendix 3). Sampling is the procedure a researcher uses to gather people, places or things to study. It is a process of selecting a number of individuals or objects from a population such that the selected group contains elements representative of the characteristics found in the entire group.

I conducted this study in Nairobi County, which is the capital city of Kenya and one of the forty-seven counties in the country. The county has a population estimate of 3.1 million in an area of sq.km:694.90s. The research site was chosen because majority of mental health institutions were based in Nairobi while the same case applied for the mainstream media houses.

The target population of the study were Health Journalists and MH Experts. Qualitative research includes purposive sampling, quota sampling and snowball sampling. While in purposive sampling groups participate according to preselected criteria relevant to a particular research question, in quota sampling, the number of people to be studied with which characteristics is decided at the stage of designing the study. Snowball sampling, considered type of purposive sampling, uses social networks of the selected participants. In this study I employed purposive sampling and snowball sampling in selecting the units that were involved in the study. Whereas probability sampling is common in quantitative research, purposive sampling techniques (sometimes referred as qualitative sampling) are mainly used in qualitative studies; they are “defined as selecting units (e.g., individuals, groups of individuals,

institutions) based on specific purposes associated with answering a research study's questions," (Teddlie & Yu, 2007, p.77).

Further, as Yin (2014) postulates, purposive sampling is a practical necessity that is shaped by researcher's availability of time, by his framework, by developing interests and by any restrictions placed upon his observations by his hosts. The framework of this study played a critical role in the selection of the population of study. Information-rich cases are those from which one can learn a great deal about issues of central importance to the purpose of the research, thus the term purposeful sampling. In this study, health journalists and mental health experts were chosen because of their central importance to the purpose of this research.

Onwuegbuzie and Leech (2007) suggest that after several observation visits to the sites, the researcher is normally in a better position to know whom to sample for the purpose of the study. Prior to selecting the population, I was familiarizing myself with the media to discover health journalists and the type of issues they were covering. Being a perception study, it was important that I chose a population that not only had interest but considered the topic under discussion close to them bearing in mind my aim was a critical analysis of the way the mainstream media in Kenya represents mental health issues. Health journalists and mental health experts were purposively chosen based on the aims of the research. Creswell (2014) says that the idea behind qualitative research is to purposefully select participants or sites that best help the researcher to understand the problem and the research question. Other categories that are considered in purposive sampling are age, gender, status, role or function in an organization, and in this study the role and function of the participants influenced the selection.

As warned by Silverman (2013), I had to consider the parameters of the population under study and sample cases to be chosen carefully. First, health journalists were purposively chosen in this study because they were considered as critical part of the gatekeepers of media health related messages. To get multiple views, health journalists came from both print and TV media with the highest readership and view ship as per GeoPoll's Media Measurement Service (2015). However, some of the leading print and TV stations did not have a designated Health Journalist, which disqualified those media houses and the following on the line were picked. In total, I chose 8 media houses because they gave me sufficient opportunity to explore my research questions. Some of the media houses produce both TV and print media products but with independent TV and print health journalists. However, for radio stations, there were no specific journalists designated as health journalists hence the focus on TV and print media.

In total, I interviewed 13 health journalists across the 8 media houses; 2 editors of newspapers involved in editing health magazines; 4 Print Media Health Journalists and 7 TV Health Journalists. The criteria I used in selection of the health journalists consisted of: experience and expertise in health reporting and the key role and position in their media houses in health related reporting and editing. I employed snowball sampling in selection of the participants for the study. As part of the study pre-orientation, I followed up on both print and TV reports and identified the by-lines of those who covered health issues and called them via phone. With the first interviews, the snowball sampling was employed as health journalists referred me to their colleagues in other media houses. Being a small group, the health journalists had their networks and associations that allowed them to know each other. They also

exchange information and share contacts of their sources of information. However, one of the health TV reporters was working with an international media house but she was highly recommended as a participant in this study because she had served as a health journalist for several years with one of the oldest private TV stations in Kenya. All the health journalists I interviewed had university level education and two of them were pursuing their post graduate degrees. They were all senior journalists and most of them had worked for multiple media organizations.

Being the experts and critical stakeholders in the field of mental health, the mental health experts were purposively selected due to their closeness to the subject under the inquiry; as a case in their context, which they interact with almost on a daily basis. In total, I interviewed 8 mental health experts who spread across 8 Mental Health institutions. It was my desire to have representative from different institutions and professions, which enriched my study as they all had different experiences and examples to share. I did not come across a list that had all the mental health institutions, facilities and rehabilitation centres. But using the networks within the Department of Mental Health under the Ministry of Health in Kenya, I received information about different types of mental health institutions. I purposely selected institutions that were cut across different fields in MH, including mental services like hospitals, Non-Government organizations (NGOs), Community Based Organizations (CBO), research institutions and mental health professional associations and rehabilitation centres.

The next phase of the sampling was to choose the actual participants that were going to be involved in the in-depth semi structured interviews. It was my intention to recruit participants at the top management level who were likely to have had an

experience with the Kenyan media. In regard to that, I identified the directors of those institutions and after that I looked for their contacts. I called them one by one and sought for appointments which were granted. Soon after that I started interviewing them and received a lot of cooperation. All the participants interviewed were directors of their respective institutions and associations, save for one participant whom I was referred to by her director due to her position and the role she played in that particular institution. Six of the participants had attained post-graduate degrees with the other two having a university level education. Most of the participants were professionals in the areas of psychiatry and psychology and all of them had interacted with the Kenyan media and their experiences with the media enriched the study.

In terms of the number of the participants that were involved in the study, the idea of saturation came into play. As suggested by Jwan & Ongondo (2011) and Creswell (2014), I stopped collecting data when I realized that I was not gathering fresh data with new insights.

### **3.5. Pilot Study**

Before I embarked on data collection for the main study, I conducted a pilot study in February 2015 where I tested the data collection tool, that is, the in-depth interview guides. I carried in-depth interviews with journalists working with radio station as a way to test my research instruments. It was critical in gauging the suitability of the research tool and it helped me gather some preliminary perspectives of the research tools and their appropriateness. The pilot study helped in revising and fine tuning the research instruments in line with the research questions. From the pilot study, I learnt that the instruments provided appropriate data; however, I needed to rephrase some



questions in order to capture the data I was looking for in terms of media representation and the factors influencing the same.

### **3.6. Data Generations Techniques**

I used in-depth interviews and document analysis as part of data generation techniques. Jwan and Ongondo (2011) note that qualitative research is strengthened when multiple data generation techniques are used as part of triangulation.

#### **3.6.1. In-depth interviews**

I used in-depth interviews as the principal technique of data generation in this study. The diversity of the health journalists and mental health experts, combined with all the participants coming from different institutions, provided an opportunity to explore whether the scope and nature of profession had any influence on their perception of how the mainstream media represents mental health issues and the reasons why the media represents them in the manner they do. In depth interviews are described as an extended conversation that aims at having profound information about a topic or subject and “through which a phenomenon could be interpreted in terms of meanings interviewees bring into it”(Alshenqeeti, 2014, p. 40). Interviews were instrumental in this study because in depth information was needed to understand how the mainstream media represents MH issues but also to understand how MH experts interpret those representations in light of what is facing the MH sector in the country. Realizing that MH issues are on the rise, and the media has been identified as a critical potential partner, it was important to interrogate the relevant stakeholders in view of understanding the factors that influence that kind of representation as a way to enrich MH stakeholders discourse in their desire to see the media play a proactive role in public education and promotion of relevant policies.

Another critical element of interviews is the desire for have them flow naturally while at the same time, rich details are captured. In view of that my role as an interviewer was to establish an appropriate atmosphere where the interviewees felt at ease and talk freely as suggested by Alshenqeeti (2014). Besides that, it is important to note that there are different types of interviews: structured, unstructured and semi-structured interviews (Jwan & Ongondo, 2011; Alshenqeeti, 2014). The structured is organized around a predetermined question that mainly require 'yes' or 'no' type responses; they are almost like questionnaires. On the other hand, unstructured interviews are like an open situation where both the interviewer and interviewee have greater flexibility and freedom in terms of the interview content and questions. In this study, the semi-structured interview style was adopted because it allowed deeper probing and exploring of emerging issues as much as I had developed an interview guide. Jwan and Ongondo (2011) argue that semi-structured interviewing helps researchers to develop a relationship with the participants and that was my experience as the participants expressed themselves freely and many issues emerged.

To conduct the semi-structured interview, I developed and used an interview protocol for asking questions and recording answers during the qualitative interviews as suggested by Creswell (2013). Two research guides, one of the health journalists and other one for the mental health stakeholders, were used only as a guide, "and departures from the guidelines are not seen as a problem" (Silverman, 2013, p. 121). The semi structured guides were ideal because they enabled deep investigation on participants' perceptions of media representation, in both, breadth and depth. The use of probes and follow up questions were critical in understanding how the participants viewed mainstream media representation of mental health issues, as well as

understanding the underpinning reasons that informs the representation of those issues by the media. The in-depth interviews were recorded using a digital voice recorder with the participants' consent. In addition, I took short notes in the course of the interviews as a back-up while I also noted down any issues that cropped up and needed further follow up. I had developed two interview guides: one for health journalists and the other one for mental health experts (See appendix 1 &2).

### **3.6.2. Document Analysis**

I also employed document analysis as a data technique in this study because I considered it critical in validating the data from the in-depth interviews. The review of documents is a process that involves the collection, review, interrogation, and analysis of various forms of documents as a primary source of research data. In many cases, this process involves the gathering and analysis of documents produced in the course of every day event(O'Leary, 2004; Silverman, 2013; Yin, 2014). As sources of data, documents in qualitative research enhance the credibility of a study, which is an important aspect of trustworthiness (Jwan & Ong'ondo, 2011).

Although in-depth interviews were used as the primary data collection tools, document analysis was used to complement interviews and for data triangulation. As suggested by Bowen (2009), in order to seek convergence and corroboration, different data sources and methods were used in this study. Apart from semi-structured interviews, document analysis was used to not only complement interviews but also for data triangulation.

Document analysis is a systematic procedure that requires data be examined and interpreted with a view "to elicit meaning, gain understanding, and develop empirical knowledge," (Bowen, 2009, p. 28). Documents could be printed or electronic, and in

this study newspapers articles and television programs that were placed just before the interviews commenced and soon after the interviews (January to September, 2015) were examined. About the number of documents that are to be analyzed, Bowen further points out whereas the number of documents to be analyzed is a legitimate question, the concern should be about “the quality of the documents and the evidence they contain, given the purpose and design of the study.... When documents are being used for verification or support, however, even a few can provide an effective means of completing the research” (Bowen, 2009, p. 29).

This study purposively selected media documents with a purpose of analyzing how MH issues were reported by the media with view of the first research question, which examined how the mainstream media represents MH issues. The media documents were considered authentic, credible, bearing accurate sample because they were the subjects of interrogation in the study.

Besides enriching the study, documents were also useful in pre- and post-interview situations because they helped in asking additional and probing questions. As suggested by Bowen (2009), documents in this study were reviewed, which involved reviewing line, phrase, sentence, paragraph and images, and they helped in identifying the language and how mental health issues are reported and what kind of images are used. Just like in the analysis of the interviews, inductive thematic approach was used that helped in identifying codes and categories of the documents. Creswell (2014) further says that documents enable a researcher to obtain the language and words used in an issue, which was true in this study.

In this study media documents were analyzed that consisted of media stories placed between February to September, 2015; that is slightly before I started collecting the data and soon after that. I collected the data from March to August, 2015. Some of the reviewed media documents were discussed by the participants during the interviews. These were the documents collected and analysed:

- a.) Abandoned and neglected, Kenya's mentally ill suffer in bitter silence; Daily Nation: 24th Feb. 2015 <http://www.nation.co.ke/lifestyle/>;
- b.) How do we get rid of terrible 'madness' that has taken our society hostage? Daily Nation –Monday, July 6 2015; <http://www.nation.co.ke/oped/Opinion/-How-do-we-get-rid-of-terrible/440808-2777494-y3pdh2z/index.html>
- c.) Let's treat the mentally ill as patients and stop thinking they are criminals: <https://www.nation.co.ke/oped/opinion/Lets-treat-the-mentally-ill-as-patients/440808-2634522-osugmn/index.html> Daily Nation, Feb. 24, 2015
- d.) Mentally challenged boy chained to a tree under 84 year old woman care: <https://www.youtube.com/watch?v=O1-bbKmpNvQ...KTN>.
- e.) Woman in Kisii chose to marry a mentally challenged man; <https://www.youtube.com/watch?v=7iXJhEjl0us> KTN News Kenya- Published on Mar 27, 2015
- f.) When a child is suicidal. <http://www.mediamaxnetwork.co.ke/people-daily/when-a-child-is-suicidal-170244/>. People Daily, September, 28, 2015

### 3.7. Data Analysis

Data analysis in qualitative research tends to be dense and rich, and as a result, Creswell (2014) says that in the analysis of the data, it is critical to 'winnow' the data; "a process of focusing in on some of the data and disregarding other parts of it...the impact of this process is to aggregate data into a small number of themes, something like five to seven themes," (p. 195). In light of the above, this study employed thematic analysis in analyzing the data collected through in-depth interviews and document analysis. The thematic analysis was adopted with a view of matching the

themes emerging from the data with the research questions. Jwan and Ong'ondo(2011) say that inductive thematic analysis is a common qualitative data analysis employed in the social, behavioral, and health sciences, where themes are allowed to emerge from the data. On the other hand, there is the deductive approach where themes are derived from pre-determined categories and referred to as a priori determined themes.

The process of thematic analysis that was used in the study consisted of reading through textual data, identifying themes in the data, coding those themes, and then interpreting the structure and content of the themes. Braun and Clarke (2013) mention 6 steps in data analysis and some are discussed here below, which include: familiarization with the data; coding; searching for themes; reviewing themes; refining and naming themes and writing up. A thematic analysis is one that looks across all the data to identify the common issues that recur and identify the main themes that summarize all the views you have collected.

Here below is a description of the steps I undertook:

### **3.7.1. Transcription of the data**

The first thing I did in the data analysis process was to transcribe all the data that I had recorded during the in-depth interviews, which was a process of turning data from the verbal to the written code. I ensured that the transcription captured everything like fillers, repetitions, laughter or anything else that was in the interviews.

### 3.7.2. Coding and Analysis

I re-familiarized myself through reading individual transcripts, which helped me to get a general overview of the whole data. Once I had gained a deeper understanding of the data, I started to analyze the data manually through coding, which involves labelling particular chunks of data and grouped as marking a particular point of view relevant to a study (Strauss & Corbin, 1990). I had two several set of participants, that is health journalists and mental health experts. I analyzed interviews from the health journalist's participants followed by mental health expert's participants. However, similar steps were followed in analyzing the interviews from the two sets of the participants.

There are three stages of coding (Jwan & Ongondo, 2011; Creswell, 2014) and I began with the first stage of coding called open coding where I went through each transcript and highlighted the chunks which were distinct in relation to the study (Cresswell, 2007). At this point I did not limit myself, and several codes emerged from the data and each was assigned phrases that captured a particular issue relevant to the study. During the first phase of coding of data coming from health journalists and mental health experts several codes emerged. For example, about 40 codes emerged from health journalist's interview data. By the end of the first coding I had cut different chunks of data and posted them under different codes identified; meaning that a new file had been opened.

In the second Phase coding referred as Axial Coding by Creswell (2007), I looked critically at the first level coding and merged several codes, "downgrading some codes and upgrading (promoting) others," Jwan&Ong'ondo,2011). At this point some

codes turned into categories whereby the data was cut and pasted again. The phase saw the codes reduce significantly according to the new categories. This process was quite iterative and involved going back and forth; including going back to the original data numerous times. In the third phase of coding, the categories were grouped into themes, which is referred as selective coding by Cresswell (2007). To a great extent, the themes corresponded to the research questions I had posed at the conceptualization stage of the study. At this phase of coding, the different categories and codes were cut and pasted and grouped into themes. I carefully read the final product of that phase, checking on whether it captured the focus of the study and I checked whether the categories, themes, codes, and data were all relevant and in line the original data.

The final stage involved producing a research report, (discussed in chapter 4) which is described as a narration that gives an explanation of the data in a cohesive and a manner that would make sense to the reader (Jwan& Ong'ondo,2011).

### **3.8. Trustworthiness of the Study**

Creswell (2014) says that there are multiple strategies to ensure that trustworthiness and dependability is achieved in qualitative research, which is an equivalent of validity and reliability in quantitative research. In this study, I applied a number of these strategies to ensure the research was trustworthy and dependable. There are four terminologies that were used to define trustworthiness in qualitative research: credulity, transferability, dependability and confirmability.



Credibility is the “extent to which the study investigates what it claims to investigate and reports what actually occurred in the field” s (Jwan& Ong’ondo, 2011, p. 131) as cited in (Yin, 2003; Nason, 2002; Creswell & Miller, 2000; Bassegy, 1999; Nunan, 1992). The question of credibility is demonstrated by looking at the key concepts in the study, exercising triangulation, providing a chain of evidence and member checking. As far as key concepts were concerned, there was operational definition of the terms that were used consistently and they were all defined in chapter 1 of this study. Shenton (2004) says that one way to increase credibility is through an early familiarity with the culture of the participants or their gatekeepers before the first data collection dialogues takes place and goes ahead to say that can also be achieved through consultation of appropriate documents. Prior to carrying out interviews, media reports on mental health were analyzed helping me to get familiar with mental health discussions in the media.

Creswell and Miller describe triangulation as a validity or credibility procedure where “researchers search for convergence among multiple and different sources of information to form themes or categories” (2007, p.126). Further, Creswell (2014) says it is important to triangulate different data sources of information through examining evidence from the sources and “using it to build a coherent justification for themes. If themes are established based on converging several sources of data or perspectives from participants, then this process can be claimed as adding to the validity of the study,” (p. 201). Triangulation involves the application and combination of several research approaches, methods, techniques and sources of data in one study (Taylor, Kermode, & Roberts, 2007; Creswell & Miller, 2007; Jwan&Ong’ondo, 2011). Triangulation provides corroborating evidence to locate

major and minor themes. Triangulation provides in-depth data, increases the confidence in the research results as well as enables different dimensions of the problem to be considered (Jones & Bugge, 2006). A combination of methods is thought by some to improve the consistency and accuracy of data by providing a more complete picture of the phenomenon (Halcomb & Andrew, 2005; Jones, 2006). In this study, multiple triangulation methods were employed.

One of the first triangulation methods I applied in this to increase credibility of the research, I spent a prolonged period in the field of 5 months, which helped me to gain in-depth understanding of the phenomena. During that period, I was also observing what the media was reporting about mental health. The prolonged interaction in the field helped in gathering in-depth information in a consistent manner from the participants, which ensured the credibility of the data. "It is not a process that is systematically established, but constructivists recognize that the longer they stay in the field, the more the pluralistic perspectives will be heard from participants and the better the understanding of the context of participant views (Creswell & Miller (2000, p.126).

Secondly, I used multiple sources of data in order to obtain differing views about the phenomenon under the single study. In this study, health journalists and mental health expert's perspectives were sought in establishing how the Kenyan mainstream media represents mental health issues and the reasons why those issues are represented in that manner. Multiple data sources helped validate the findings by exploring different views of the situation under investigation. Bearing in mind the sensitivity of the topic due to the stigmatization, person triangulation increased the authenticity of this research. Investigator triangulation, achieved by having many investigators was not

possible in this study; however, the research tools were checked by the supervisors of this study and other academic colleagues while the pre-test of tools amongst journalists helped in validating of the tools.

Additionally, there was triangulation of data generation techniques where in-depth interviews, observation and document analysis were used to generate detailed data about media representation. It was critical to employ triangulation of data generation techniques because a lot of information was collected and it helped in the corroboration of the information (Jwan&Ong'ondo, 2011).

Dependability is an aspect of trustworthiness of the research findings, which demonstrates that the operations of a study like data collection procedures can be repeated and yielding the same results (Yin, 2003). In view of that, dependability was achieved in this study through thick description of the setting, the participants, and the themes in rich detail. Creswell and Miller (2000, p. 128) as cited in Denzin (1989) who says, "Thick descriptions are deep, dense, detailed accounts. Thin descriptions, by contrast, lack detail, and simply report facts" (p.83).Elaborating the role of thick description, Creswell & Miller (2000) go further to say that such thick description "creates verisimilitude", which are accounts that make readers feel that they have experienced, or could experience, the events being described in the study. "Thus, credibility is established through the lens of readers who read a narrative account and are transported into a setting or situation," (p. 129).

Transferability is described as the extent to which the findings of the study can be 'generalized'. The presumed depth or universality of the phenomenon studied, and corroboration from other studies is one way of achieving transferability. In this study

health journalists from diverse media houses were interviewed, and there was presentation of print, TV reporters and editors. Additionally, mental health experts were from different mental health organizations and different professionals in the mental health sector were represented and therefore the issue of corroboration was critical towards ensuring transferability.

Researcher reflexivity is important in qualitative researcher where researchers disclose any assumptions, beliefs, and biases that may influence the inquiry. Researcher reflexivity has been described as critical because it is important to acknowledge such biases early in the research process and then to bracket or suspend those researcher biases as the study proceeds (Creswell & Miller, 2000). Besides being a communication specialist, I am also a counselling psychologist interested in mental health promotion, which is an area I have worked in. However, in this study my role was to get a balanced perspective of health journalist's perspective about the way the media represents mental health issues while checking on mental health expert's perspectives and seeking to understand what influences that kind of representation.

### **3.9. Ethical Considerations**

According to Fouka and Mantzorou, (2011) research ethics require the protection and dignity of subjects and the publication of the information in the research. According to the World Medical association (2014), ethical considerations must do the following: protect the rights and welfare of participants and minimize the risk of physical and mental discomfort harm and or danger from research procedures. Protect the right of the researcher to carry out any legitimate investigation as well as the reputation of the university for research conducted and or sponsored by it.

In keeping with the legal and ethical requirements, this study was vetted and approved by the National Council for Science and Technology (NACOSTI) and they issued me with a research permit. At the level of data collection, two critical issues, namely negotiated consent and confidentiality, were employed as discussed here below.

### **3.9.1. Informed Consent**

High standards of ethical consideration must be maintained and one of the critical ethical issue is informed consent when contacting in-depth interviews. As pointed out by Jwan and Ongondo (2011) informed consent entails voluntarism that the participants of a study understand the nature of the project, and with full knowledge about the research, they express consent before embarking on any research activity. In this study, I explained the important details of the study, including the purpose of the research, what was expected of a research participant, their role and duration of participation in the interview, and how I was going to use research data. Additionally, I explained that participation was voluntary and the participants could decline to answer any question they were uncomfortable: with or withdraw from the study at any time with no negative repercussions. I also asked their verbal consent to record all the interviews and they all agreed except one of the mental health experts where I had to write down the notes.

### **3.9.2. Confidentiality and Anonymity**

Confidentiality was maintained by not mentioning the names of the participants and specific settings anywhere in the research. Each participant was given a code and any information in the data that had possibility to reveal the participants' identity was removed or replaced with comparable information. The electronic data, the recorded interviews collected during the research phase was stored on the researcher's

computer with password protection, and all original hard copies are locked in a secure place.

### **3.9.3. Risk of Harm**

The research was guided by four basic ethical principles: Non-maleficence, which involves not harming participants; beneficence, which involved explaining the benefits of the research to the participants; while autonomy was adhered to through respecting participants' values and decisions, and justice was maintained where all the participants were treated equally (Christians, 2007; Murphy & Dingwall, 2001; Jwan & Ong'ondo, 2011).

### **3.10. Conclusion**

This chapter has looked at the research methodology that was used in this research while discussing research approach, methods, data generation techniques, sampling, and data analysis and issues of trustworthiness and ethical considerations. The next chapter I discuss data analysis and interpretation.

**Table 3: Summary of key issues from chapter 3**

- This study is situated within the relativist-interpretivist paradigm.
- It was a qualitative case study of 13 health journalists who came from both print and electronic media; consequently, the other participants constituted of 8 mental health experts coming from different mental health research organizations, NGO, CBO, head of different mental health bodies and also from the ministry in charge of health in Kenya
- I used semi-structured individual interviews, observations and documents to generate data from the participants, which later was analyzed thematically.
- I ensured the study's trustworthiness through triangulation, chain of evidence, thick description, and reflexivity.
- Ethical issues including informed consent, confidentiality, privacy and anonymity were considered during the study.

## **CHAPTER FOUR: DATA PRESENTATION, ANALYSIS AND FINDINGS**

### **4. Introduction**

In this chapter, I present findings based on my first research question, which was: how are mental health issues represented by the mainstream media? The scope of this question included: how are mental health issues represented as compared to other diseases; from your interpretation, what dominant themes emerge from the way the Kenyan media present mental health issues; and what kind of language is used in the representation of mental health issues. The findings, that emerged from document analysis and interviews with both health journalists and MH experts are presented as: 4.1 Representation of mental health issues as compared to other health issues; 4.2 Dominant themes of how mental health issues are represented; 4.3. the language used by the Kenyan media in mental health representation; 4.4. Summary

#### **4.1. Under representation of mental health issues**

Both the health journalists and mental health experts had a similar perspective to the effect that there is increased mental health representation in the media as compared to a few years ago. However, mental health representation is still low as compared to other health issues and also it is reactive and event based. In terms of increased representation, the mental health participants appreciated the slight increase of media representation of mental health issues saying that the increased representation has yielded positive results and slight increase of mental health knowledge in the public domain. They noted that they receive a lot of enquiries from the public after media coverage especially when the experts are invited in the media houses. One mental



health expert leading a Community Based Organization (CBO) involved in mental health said:

We had a lot of inquiries after a media show where I participated. People called asking, ‘you mean there are such services (mental health services) in this country where people can get help?’ We got calls from all over the country; from Mombasa, Malindi, Kisumu, Eldoret, North Eastern and some people travelled all the way to access our services. So media exposure is very crucial in this widely misunderstood field.

Mental health experts mentioned that, albeit unintentionally, the Kenya media contributes to mental health wellbeing through sports and other forms of entertainment, which are extensive but there lacks public education linking those activities to mental wellness. The findings showed that in the colonial days, social halls were strategically placed where different forms of entertainment like cinemas took place for mental wellness.

*“Media was used positively because the colonialists knew the link between positive mental health and increased productivity”,* said one of the participants.

Commenting on the role of the media in improving positive mental health outcomes, the participants said public education of mental health is important because the country is facing a mental health crisis and yet there exists stigma, misinformation and unhealthy beliefs about mental health illnesses that hinder people from seeking mental health services. Majority of the participants said that Kenya, like other African countries, is a ‘traumatized’ country that has been plagued by wars, terrorism, political upheavals, poverty, unemployment, and other psychosocial issues like Sexual and Gender Based Violence (SGBV), and drug and substance abuse which add to the mental health burden. The same sentiments had been shared in the analyzed document that traumatic events in case like accidents, disasters, violence and conflicts have

contributed to the growth of post-traumatic disorders, anxiety and depression in Kenya. In view of the above, it was pointed out that media is critical in public education. Besides, one of the psychiatrists said that bearing in mind the limited resources allocated to the mental health sector

*“the media can educate the masses to first recognize somebody with mental illness and educate them on how to provide supportive mechanisms. For example, ‘listening’ is one support needed because most of the time what these people need is just to be listened to.”*

It was also noted that through media, caregivers of mental health patients can be given forums to share their experiences and lessons learnt to enhance public education while those recovering from mental health conditions can also share tips on disease management.

However, as much as increased representation with good outcome was noted, all the participants concurred that mental health issues are underrepresented in the Kenyan media. When asked some of the mental health issues they had covered the previous year, majority of the health journalists mentioned HIV/AIDS, cancer, malaria, tuberculosis, diabetes, TB and cardiovascular diseases and only one of them mentioned depression. All the participants agreed that mental health issues are of low interest for the Kenyan media. One print health reporter described it this way:

*Mental health still has a stigma and the media is not left out. It is like those people out there who are helpless and there is nothing we can do about it. Although there are mental health stories from time to time, mental health has not generated enough attraction from the media (Print Reporter, Nairobi).*

Saying that the stigma in the public domain also exist amongst journalists hence low representation, one editor from one of the daily newspapers with the highest circulation, said the media perceives mental health issues as outrageous, which

*“belong in Mathare Hospital; let’s lock them in. I don’t think that mentality has changed at all even for us in the media”*. Further, it emerged that the mainstream media ostracizes mental health patients just like the society, and another editor put it this way:

*Like that’s how they (people with mental illness) are, there is nothing we can do about it. And also, the same apathy that makes the society to ostracize a person diagnosed with a mental illness, it is the same with media. We have ostracized mental health patients from the media (Print Media Editor, Nairobi).*

Describing the frequency of mental health coverage as minimal, one TV participant who had worked as a health reporter for 5 years asked, *“If I hardly cover the topic and I am the health reporter specialist, how about other journalists?”* It was apparent that health reporting struggle in the politics dominated media; with mental health representation emerging as the lowest in the ladder. It was noted that even health stories compete amongst themselves and pitching of such stories was considered critical, especially to editors. Explaining further, one of the editors said that there are a lot of ‘bars’ (interest) created around HIV and cancer but there lacks ‘bars’ created around mental health, and

*“although they might be there, they are not creating the kind of excitement that cancer and HIV is creating” (print editor, Nairobi).*

Besides underrepresentation of mental health, it was noted by the mental health participants the Kenyan mainstream media reinforces the misinformation about mental health that exists in the public domain by giving inaccurate information. One psychologist said,

*“I think journalists should educate themselves first on mental health before feeding us with information.”*

A case was given where in the previous year (before the interview) an inaccurate story appeared in one of the leading newspapers describing schizophrenia as a personality disorder.

In terms of the positioning of mental health stories, it came out that such stories are normally “tucked in corners” and rarely make it to the front pages while in TV stations they normally come as breakfast shows but not during the prime time. An example was given of a newspaper column in one of the newspapers with the highest circulation which tends to cover mental health related issues but the column was described as small and in the back pages of the newspaper.

*“It is hardly comparable to other columnists who have bigger columns to push their agenda”* said one of the mental health reporters.

Further, the participants said that the column is not restricted to mental health issues unlike a HIV/AIDs column in the same paper, which was given more prominence and positioned as a human interest story.

Mental health representation is more reactive and event based as opposed to being proactive. Both the health journalists and mental health experts agreed that issues surrounding mental health are extensively and frequently featured when a national disaster, ethnic conflict or terrorisms acts like the Westgate terrorist attack in 2014 and Garissa University Terrorist attack in 2015 occurred. During those times, it was noted, the media consults with psychologists and psychiatrists and they dominate the airwaves and media spaces but the issue is “shut until another crisis occurs. It is periodic in terms of coverage” said one participant. An example was given of the world mental day celebrations. Instead of the media covering the core issues related to

the special day, they seize the moment to ask the Cabinet Secretary for other health related issues.

Unlike most of the other Health Days, the World Mental Health Day does not attract media coverage and most of health journalists are not aware of the month when the day features. All the health reporters interviewed indicated that they did not attend the World mental health Day celebrations in the previous year (2014) but to the contrary they indicated that they knew the months that other Health days take place like the Cancer month, Malaria day, HIV/ AIDS world day and they consistently attend those events nor would their editors allow them to miss. The following excerpt depicts that:

**Interviewer:** If it was an AIDS World day and it fell on your off day, how would you go about it?

**Health Reporter:** They (editors) always call me! I would be told to prepare a package way before. But I tell you for the World Mental Health day, unless I take it upon myself as the reporter, and start looking for a story early enough and tell them this is what is coming up; I don't think it will be a big, big problem (Print Health Reporter, Nairobi).

Some of the participants noted that mental health conversations are alive in the social media platforms like twitter and Facebook, and some of the participants follow those conversations.

*"I have actually been following that debate on twitter and comment about it. But I am not bringing it into the mainstream media. The truth is we have buried our heads in the sand,"* (Print Editor, Nairobi).

In terms of how the mainstream media in Kenya represents mental health issues, three key themes emerged from the research findings as discussed here below:

#### **4.1.1. Focus on the 'ill' and visible symptoms of mental illnesses**

It was noted that the mainstream media equates mental illnesses to mental health while at the same time most media stories focus on the ill. However, the issue of

mental health that involves the causes, prevention, treatment and maintenance of good mental health hardly feature in the mainstream media. One psychiatrist had this to say:

The society, including the media, lacks understanding of the differences between mental illnesses and mental health. The latter deals with prevention, promotion of mental well-being and managing diseases, however, the media tends to focus on the ill person but not concerted efforts on prevention or maintaining of mental health (Psychiatrist, Nairobi).

Most of the mental health experts said that prevention of mental health is paramount bearing in mind that there are many environmental triggers of mental illnesses. For example, the mainstream media fails to show the connection between mental health and increased psychosocial crisis in the society triggered by economic, social, terrorism acts and ethnic conflicts in the country. An example is domestic violence, which was described as being on the increase in the country, and the media was accused of portraying it as a gender issue yet it is interrelated with mental health either as a trigger of violence or resulting from that kind of gender violence.

Cases of violence in families have increased sharply. The media highlights the incidents but they fail to inform the audience the triggers of such acts. They report and move on to the next agenda because for them it is business. Or the issue of drugs and alcoholism, victims are easily condemned and labelled without analyzing the problem critically. The issue of prevention of mental health is hardly covered yet majority of mental health cases are psychosocial in nature like parenting, gender based violence, poverty, trauma, substance abuse and alcoholism. (Director of a CBO, Nairobi)

The other dominant feature in mental health reporting is high representation of acute mental illnesses especially through the images and pictorial representation. Document analysis based on the selected media stories, including observation, showed that most of the pictorials used portrayed the outward symptoms like people walking half naked and being unkempt. The media images are of that dirty, rugged person in the street

collecting papers and looking confused. It was mentioned that they show images that reflect those mentally ill are non-entities and they are not like ‘normal’ people and by so doing they perpetuate that image at the community and at the policy level. Linking media pictorial presentation and policy, the mental health experts pointed out that the Kenyan constitution prohibits people with mental illnesses against voting or vying for political positions and the media contributes to that through the dominant images they use of the mentally ill.

*“For the policy makers the image they have about mental illnesses is the dramatic person who walks half naked in the streets and that view is perpetuated by the mainstream media,”* said one of the psychiatrists.

The same image created about mental health contribute to formation of laws like the *“recently introduced marriage law, where one can divorce their partner because of mental illness,”* said another mental health expert. It was felt that even when the media content had general stories on mental health, the images accompanying such stories are victims of mental health depicting outward visible symptoms. One psychiatrist put it this way:

For the media when they see a person who is mentally ill, they do not see the illness but a nude person walking or a violent person. They see the removed clothes rather than seeing it as medical emergency. What happens when someone faints by the road side? It becomes emergency; so even this is a psychiatric emergency but they capitalize on it to make news.

Concurring with that, the analyzed documents showed that images used are portrayal of the ‘drama’ of mental health. Below is an image used by one of the leading dailies of people with acute mental illnesses while the point of discussion was increase of mental health in Kenya.



It was pointed out that constant usage of ‘dramatic’ images and stories is making sensational news on medical matters without considering the consequences. For example, suicide reporting should be reported carefully because research shows that more suicides occur when detailed account of suicide are reported through media.

#### **4.1.2. Mental illnesses Represented as diseases linked to Crime, Violence and ‘Outrageous’ acts**

Both the mental health experts and health journalists were of the opinion that most of the stories and visual images to do with mental health are linked to crime and violence, which communicate that such people are dangerous and a security risk. Due to the nature of the media where controversy, conflict and violence sell, crime stories linked to mental health issues are prevalent in the mainstream media. Court reporting forms one of the segments of news making for the Kenyan media hence crime news linked to mental health are common in the media.



Besides court reporting, all the participants said that issues of violence in the community, which end up being linked to mental health issues attract the media. One print journalist put it this way: “*the ugly, the dark and the dramatic side of mental health attracts the Kenyan media*” while another participant had this to say:

**Interviewer:** What kind of mental health issues tend to attract the media?

**Respondent:** I think the biggest one is suicide and murder. I think that makes the biggest kind of impact. Unfortunately, media is always looking to sell stories. Most journalists will not go for the awareness bit; they will go for the fact that I want my story to sell out there (TV Health Journalist, Nairobi).

It emerged that the “awareness bit”, which involves educating or sensitizing the members of the public about mental is not considered as a priority but the critical thing is to attract the media audiences. Explaining it further, another TV reporter put it this way:

Unfortunately, media today is viewer-driven. So, at the end of the day, editors and reporters are looking for stories that will attract viewers to their station. For instance, a story of a violent person, may be somebody hacked another person... when such stories that are linked to mental illness run, there is a lot of response from the viewers. So, when any such stories come in, editors will say, definitely this is a good one. Like now the story yesterday about the vampire woman who was mistreating the house help, sucking their blood and even biting them. I mean, it was put number one in a couple of stations. We didn't explore further like why somebody would do this, so we are just telling people this is there. The other day we covered a woman who killed two children, the neighbor's child and what have you. We just link those stories to mental illness but we do not follow up (TV Health Reporter, Nairobi)

Document analysis also showed that MH is also linked to crime. For example, here below is an op-ed article in one of the leading newspapers which pointed out that 1 out of 4 people in Kenya are suffering from different forms of mental illnesses, but the image used is a person associate with terrorist attacks (The Daily Nation, Monday, July 6, 2015).



*(Photo caption) Thomas Evans, the 25-year-old British citizen who was one of the 11 terrorists shot dead by KDF soldiers when the militants raided a military camp. He grew up in Buckinghamshire, UK, but later changed his name to Abdul Hakim.*

As much as the story article was raising serious mental health issues, pointing out the increase of mental health challenges in the country, the story was linked to terrorism through the image that accompanied the story. In their explanation, the mental health experts described the Kenyan media as curios but lacking depth; where news are ‘splashed’ but hard questions are not asked to understand the issues. The media capitalizes on the assumption that Kenyans love controversy, and the more dramatic a story is, the more it sells; and mental health challenges are perceived as such by the media, just like at the societal level. The portrayal of drama that attracts the media audience, makes mental health facilities like Mathari National Teaching & Referral Hospital to be presented as organizations that are always in crisis. One psychiatrist had this to say:

A journalist sees me and all what they ask me is “how is Mathare Hospital?” ...is there a disconnect somewhere? They are just interested in sensational information that will make their stories to sell. ‘Mathari National Teaching & Referral Hospital’ was even rebranded but they still refer to it as Mathare Hospital in a derogatory way. It is okay to make news but it is also critical to understand issues for the development of this nation (Psychiatrist, Nairobi).

In terms of depiction of those suffering from mental illnesses as dangerous, it emerged that media representation mainly focuses on stories of the mentally ill who are either chained or locked up in houses. Some of the document analysis depicted the same, for example, one of the electronic documents, had a story entitled, *Mentally challenged boy chained to a tree under 84 year old woman care* (KTN News, Published on 20, 2015, <https://www.youtube.com/watch?v=O1-bbKmpNvQ>). Explaining their stand, some of the health journalists said that people with mental health are violent and they need to be chained; “*they are violent people or at some point they become violent,*” said an award-winning health journalist. However, one of the health journalists, the only one who had been exposed to Mental health reporting differed while on the other hand, as reported in the next chapter, the MH experts said that only 2% of people with mental health challenges tend to be violent, however, most of them are subjected to violence.

Both the health journalists and mental health experts were of the opinion that great representation of mental health issues linked to crime, violence and being dangerous, has made the media to commercialize mental health. The mental health experts perceived the Kenyan media as institutions that look for opportunities to ‘scandalize’ mental health issues. However, mental health experts differed amongst themselves in regard to what they called ‘media scandals’. Some of the participants were of the opinion that the media scandals have played a significant role in pushing relevant

policies and development of mental health sector in the country. *“When you report a scandal, it makes the government to wake up. The media sell their papers, it is a scoop for them, but at the same time it triggers reaction from policy makers* said of the psychiatrist, who was involved in mental health research. One such ‘media scandal’ that was viewed differently was a CNN documentary produced in 2010 called, ‘The Locked and forgotten’ which generated a lot of debate and media coverage from the local media stations. While some participants perceived the documentary as a wakeup call that saw human rights bodies calling on mental health reforms in Kenya, other participants felt the documentary was negative and was in bad taste. The latter said that some of the images were not taken from Mathari National Teaching & Referral Hospital like persons with mental illnesses being chained on trees. Secondly, the documentary was described as subjective because there was a feeling that it failed to recognize the contribution the hospital has made towards positive mental health outcomes in the country and in East Africa.

However, other narrations said that the CNN documentary triggered positive reactions, which resulted in the local media reporting on the issues which led to policy changes. In the absence of that media coverage, some of the participants argued the intervention from the Human Rights Commission and policy makers could not have been achieved.

Put it this way, Mathari Hospital was started in 1911, now it is about a hundred and three years old. We have just been writing a book on the history of mental health in the country. And we looked at major developments and milestones in the sector, and realized they were precipitated by scandals. Like if you go to Mathari National Teaching & Referral Hospital there is a new building called Maximum Unit and the building was built after 40 patients ran away from the hospital and it was a news splash all over the papers. So the news splash was done by the media and the government could not ignore it. So there are times when the media scandals catch the attention of the powers that be and they act,” (Psychiatrist, Nairobi).

The high representation of danger, violence and crime linked to mental health also makes mental illnesses to be portrayed as weird and outrageous diseases. All the participants said that just like the rest of the society, media attributes things that do not make sense to 'madness' or Mathare Hospital. As much as the health journalists concurred with mental health experts that such portrayal was negative, they agreed that it persists in the media and one TV journalist said "*It is wrong when we portray them as abnormal and victims. I have interviewed a couple of people with mental illness and they say they would like to be treated like everyone else.*" However, the findings showed that due to the disease being perceived as weird, prominent personalities in the society associated with mental health challenges are given prominence by the media "*because it is not expected of them*" said one of the print journalists.

It was noted that such news sell because a prominent person has been associated with an 'outrageous' disease. To illustrate that kind of representation, a number of examples were highlighted and one of them was the widespread media story of a former female Kenyan boxer who developed mental health challenges in 2012 and her story was highly publicized by the media. One of the health journalists' participants said that if the boxer had suffered from another disease, she could not have been accorded the extensive media coverage she received; "*it is like although she was a heroine, she broke down mentally and she is headed to the grave. It is like drawing public sympathy towards her,*" said a print reporter who had received several awards in health reporting. Other participants pointed out that the case of the female boxer

attracted the media because she had suffered from a “weird” disease, and it was going to popularize their media stories.

Another example was of a prominent Member of Parliament (2013-2017) whose mother was murdered by the MP's brother and the information was all over the media. Majority of health journalists were of the view that the story attracted the media because a prominent person was associated with the ‘outrageous mental health case’, and it was likely to attract the media audience. Another example shared was a case in 2013 when mental health patients admitted at Mathari National Teaching and Referral Hospital ran away complaining about poor services. Commenting on the way the media reported that case, TV journalist explained it this way:

The media made fun of that case and it became the joke of town. How can a mad person just get out of the hospital? People who are ‘mad’ are not taken seriously and so the assumption is that they don’t even have the capacity to stage-manage something like an escape or something like that. So, it becomes drama and definitely made news.

Both the mental health experts and health journalists said that the issue was trivialized and the media did not play its role of asking about policy issues that the patients were complaining about. But people were like; “oh they escaped. And that’s it!” said another participant. However, commenting on the same, the mental health experts questioned lack of empathy when it comes to mental health issues. *“When someone suffers from cancer, people empathize with them; the same empathy should be extended to those suffering from mental illnesses,”* said a psychologist. Commenting on that kind of representation, a psychiatrist said:

#### 4.1.3. A disease for the poor, rural and uneducated population

All the participants concurred and said that the Kenyan mainstream media represents mental health challenges as issues that mainly affect the poor, rural and uneducated population. *“Majority of Mental health stories are always about some poor people in a remote village suffering from mental illness,”* said a print health journalist. In terms of document analysis, two other TV documents, *mentally challenged boy chained to a tree under 84 year old woman care* (KTN News; Aug 20, 2015) was based in West Pokot, rural set-up of Kenya while the other story, entitled: *Woman in Kisii chose to marry a mentally challenged man* was also based in Kisii. However, one of the print documents, *Abandoned and neglected, Kenya's mentally ill suffer in bitter silence* (Kilonzo, The Daily Nation: 24th Feb. 2015) had 4 short human interest stories, two based in rural set ups and two based in the outskirts of an urban set up.

Explaining that kind of representation, one editor illustrated it this way:

We feel like mental health issues should have been left in 1980s. As in, if you are having mental health issues in this day and age, you know, it is weird. It is like mental health issue is a thing of our traditions. You get? That thing for this family that has mad people... So people don't know how to deal with young people who have mental health issues (Print Editor, Nairobi)

Further comment about the former popular female boxer, one health reporter had the following to say:

*...mental problems, it is something we expect with people, whom we don't know and who are uneducated and poor. But it was strange that this disease affected Kenya's biggest female boxer. And so the reason it attracted so much coverage was because it was a renowned person suffering from mental illness* (Print Editor, Nairobi)

Another editor said:

Like these mental health issues are for poor people. And it is like the community takes no responsibility completely. And so even in our reporting it

is not like we are telling people the responsibilities upon the community to support these people. It is mostly just a “woiyee story” (pity story) that will pull out people’s heartstrings but there is no action expected...media stays away from pity stories. We don’t want stories that just depress. And mental health is one of those” (Print Editor, Nairobi)

An interesting angle emerged from the media participants where, on one hand, they said that the media perceives mental health as something that

*“happens to ‘them’ and do not imagine ‘there’ are within our circles. We are not reporting that there are even people here in our newsrooms that are faced with mental health crisis,” said one of the participants.*

The findings showed although the media representation of mental health issues is someone out there in remote, poor rural areas, media personnel are also faced with mental health crises. Saying that in their institution they are required to seek psychosocial support, one print health journalist from one of the leading newspapers, had this to say:

While some journalists willingly seek psychosocial support, others perceive acceptance of seeking such services as a sign of weakness and they look for other coping mechanisms to deal with their stress but over time they suffer in silence and result in alcohol. Most journalists live pathetic lives especially when they retire from the profession” (Print Health Journalist, Nairobi).

It was noted that in an environment where journalists and newsroom managers paid little heed to their mental well-being, media representation of mental health is bound to be not only scarce, but biased. But further interrogation showed that editors face conflict when the desire to report sensitively is challenged by strong news values, such as public interest and the business aspect of media.

Consequently, the findings showed that people living productive lives in spite of mental challenges are hardly featured in the media. Saying that mental health media stories tend to be alarmist and the human element angle is scarce, one editor said: *“It*



*is not like what is the human face in this story? It is not, what has this person overcome. A lot of the stories are; 'oh my God this guy can't keep a job', making it as alarmist as possible,"* said one of the editors.

Whereas all the media participants saw the desire to humanize or share stories of people living productive lives despite mental health challenges in order to make the disease a day to day reality, a number of perspectives emerged in terms of giving the mentally ill a voice. Some of the media participants said that people with mental illnesses are unreliable and lack credibility as sources of information due to the nature of their illness. One editor equated such persons as interviewing children:

*You cannot interview them because their information cannot be trusted. It is like when you are reporting on children, and children might give you a very good quote but you don't want to go ahead and say the kid said this and this because legally that person is not supposed to be talking to the media (Print Editor, Nairobi).*

Other participants also perceived people with mental health conditions as mentally incapacitated and unpredictable.

*"Even when you sit down to talk, there are some things that person will say that might be true but you might not take them seriously because the person is legally and clinically, you might say, mentally incapacitated,"* said another editor

However, the print health journalist who had received training on mental health reporting, differed and argued that mental illnesses share common features with other diseases characterized by seasons where it is impossible to interview a patient depending on the severity of the disease at the time of the interview. Talking about her interviews and interaction with mental health patients, which saw her publish a number of articles, the trained print health journalist said:

I was also able to interact with persons with mental health conditions at Mathari Referral Teaching & National Hospital, and similar persons in communities in Nyeri, Nakuru and other places. I travelled to Kisumu as well and Nairobi and did stories. It was an enlightening point and I was able to influence how my stories were used in terms of the choice of words... I was able to understand them; you know directly asking such persons as, "How would you prefer to be referred to?" "What are some of the challenges you face as a person with mental illness?" (Print Health Reporter, Nairobi)

The trained print health journalist in mental health reporting said that her interactions with people with mental health challenges increased her knowledge and level of awareness about the right language and terms to use and as a result she had published several human interest stories, which attracted healthy public discourse about MH.

Both the mental health experts and health experts pointed out that self-stigmatization and stigmatization in the community makes those facing mental health challenges to shy away from media. *"Since these people are viewed as mad people, regardless of how educated or exposed, they fear talking about their experiences due to the stigma associated with the condition,"* said one of the editors. Comparing mental health to HIV/AIDS, which was also considered as a stigmatized disease, majority of the participants said that they have established networks, which helps them contact HIV patients easily. *"Right now, if I want to develop a HIV story, I will easily get a survivor to interview; but that is not the case with mental health,"* one of the print health journalist added.

Talking about self-stigmatization and societal stigma, the mental health stakeholders described it as a catch 22 situation because there is need for public education but the ill fear coming out publicly to share their experiences because of stigma. The fear of public declaration may include job loss, ridicule at work place and being judged harshly by society; seclusion in social gatherings and being perceived as unintelligent

person who cannot be trusted. One psychiatrist described the scenario this way: “*as long as one is taking their medicine and continuing with their work, nobody will bother with them but when they declare their mental health status, labelling sets in*”. Apparently, even mental health medics fear to publicly declare their status. One of the participants expressed their surprise when in the previous year the chairman of one of the mental health institutions went public about his struggle with depression. But the situation was described as different from the Western countries where prominent personalities like politicians and celebrities go public about their mental health status. However, the participants noted that the mainstream media has a significant role to play in shaping the public debate about mental health depending on how they represent mental health issues. One of the psychiatrists said:

*If the media is sensitive on how it reports, people suffering from these conditions will start coming out publicly and share how they have coped with conditions but as long as these conditions are linked to that dangerous man in the street, people will shy away from the media (Psychiatrist, Nairobi)*

Patients in rehabilitation centre also cover up mental health issues due to stigma. It was reported that sometimes they joke about it or abuse each other using the same terms like “wewe mwenda wazimu” (you mad person). When patients report in those rehabilitation centres, they prefer being diagnosed with substance disorder rather than being diagnosed with any kind of mental health condition. It was pointed out:

When they know they are suffering from schizophrenia, bipolar, depression or any other illness, they will keep it as a secret. I keep repeating that addiction is a mental disorder but they will not talk about it unless they trust each other. They will even insult each other “wewe ni mwenda wazimu”. You see, even in here it depicts what they have learnt out there so it is very hard to trust and open up to the media when they consider them as part of the society that stigmatizes them (Psychologist in a treatment rehabilitation facility).

Some participants said that people with mental health challenges do not trust media people because “*they represent them in unfriendly way*”.

The other challenge of humanizing mental health is that they are considered as ‘pity’ stories, and the media opted to keep off from pity stories, which just depress. However, majority of the participants said that due to its credibility and popularity, the Kenyan media is better positioned to change the mental health narrative through humanizing it, however, there lacked the will to do so as indicated by the following excerpt:

**Interviewer:** So in your own thinking, do you feel that the media would have a critical role to play in terms of humanizing mental health and if so, what role would that be?

**Interviewee:** Very, very powerful role to play. I think their role would be to give a human face to the people who have mental health issues. Tell the story of that person who does bead work, and yet they have severe disability so that people start seeing these are just people like us. I have a friend whose sister has Down syndrome, and she is selling mats.

**Interviewer:** But as an editor, you have this person with a successful story, how come it has not attracted media coverage?

**Interviewee:** I think it is just getting sucked into what our society thinks of mental health issues. It is just one of those things that you don’t talk about, because I have a lot of people whom I would do stories of; people with bipolar disorder, but I haven’t done them.

Some of the participants said that media stories of successful businessmen and or people who have made it in the society despite mental health challenges are rare. Further, it was noted, that the media hardly highlights stories of young people suffering from mental illnesses. One of the editors responded that:

...but we also want to see the stories of young people who are sometimes even considered ‘hip and trendy’. I once saw the most powerful HIV story I have ever watched about a twenty-six-year-old single lady, working class, in her own apartment and she had everything. And that was for me something I could relate to. So, a lot of our readers and viewers are not relating to the stories that we are sharing about mental health. The reason why that lady’s story captured me was that she lived a successful, productive life despite her health condition in a stigmatized disease like HIV. She used to play music with a popular band but later started her own band. I mean, you can tell this is somebody who is trying to make a living just like me (Editor, Nairobi)

#### 4.1.4. Demeaning language

All the participants pointed out that the Kenyan mainstream media use demeaning language in the description of mental health issues. Words like ‘mad’ are used to describe people suffering from mental illnesses. During the interviews, I observed that majority of the participants referred to people with mental challenges as ‘mad people’ and “wenda wazimu” (a common derogatory Kiswahili word used in the public domain to refer to persons with mental health challenges). Besides ‘mad’ people, another common word is ‘unstable’. “I use the word ‘unstable’ in describing someone who has a mental health challenge. Unstable in the sense that they are not in control of their actions because of their thinking,” said one of the print health journalists. Consequently, I noticed how an anchor of a vernacular TV health program introduced a mental health topic when a psychiatrist had been invited as a guest “do you recall that mad man in your village?” Then the anchor introduced the topic further saying “gute mbau” (a derogatory term used to describe the ‘lost’ in the community).

One of the documents analyzed, op-ed article, which was also referred by some of the research participants during the interviews, had the headline titled: ‘*How do we get rid of terrible ‘madness’ that has taken our society hostage?*’ The lead paragraph of the story read:

*I heard a statistic that shocked me that one in four people in this country are either mad now, have been mad in the past, or are likely to become mad before they die; that is 25% of Kenya current population of 44 million, which translates to over 10 million mad people (Kimura, The Daily Nation, 16<sup>th</sup> July 2015).*

The word ‘mad and madness’ were used to describe mental illnesses while another word used in reference to mental illnesses in the above article was “sanity”. The

sentence read, “*I recently saw a TV program on madness or, as it is called in polite company, insanity. It is a subject that most people prefer to ignore, believing that they are insulated against it or that it only happens to other people,*” (ibid). The word ‘madness’ was used in another analyzed media document entitled *Abandoned and Neglected, Kenya’s Mentally ill suffer in bitter silence* where in describing the story of a child suffering from one kind of mental illnesses, the report used the following words, “*His relatives said the family had never experienced any **madness**...*” (Kilonzo, The Daily Nation, February, 24, 2015).

The participants were of the opinion that casual language is used by mainstream media in description of mental health issues “*yet as reported in their media, 25% of the Kenyan population are suffering from it,*” said a psychologist. Saying that journalists are not sensitive of the language they use, a participant shared an example of the TV program they had watched in the previous week (before the interview) where the producer kept using the word ‘abnormal’ as much as the guest used a different term in reference to her child:

A case in hand is a (name of the TV station) interview I watched last week where a mother of a child with mental health challenges had been invited as a guest. The mum was keen to avoid stigmatizing words but the host of the show really struggled and kept referring to the child as ‘abnormal’. But the mother referred to her as a child with specialneeds (Psychologist based in a rehabilitation treatment facility, Nairobi).

It was reported that during the Alcoholism and Substance Abuse (ADA), which caught media’s attention, especially in 2015 when the President of Kenya issued a restraint against alcohol and drugs, the media disclosed the identities of the victims of ADA. Further, the media language used was demeaning. Referring to one of the TV shows, one of the mental health participants said that words like “kawara, bubuwazi,

wazimu wakupindukia” were used by journalists while reporting on ADA. *“I wondered, have we reduced the value of a person whom we can see their face just because he is an addict. Is there a better way to address the issue without belittling the victim?”* asked the psychologist. Just like in the public, it was noted that when things do not make sense or are weird, the media describes it as ‘madness’. *“I saw a cartoon which described the ‘madness’ of politicians and the need to have them locked up in Mathare Hospital because of salary increment demands. What do you think happens to those with mental illnesses when they hear such sentiments?”* asked one of the mental health experts.

Majority of journalists are ignorant about different types of mental illnesses and mostly they are all labelled under the term ‘madness’ while at the same time mental illnesses are depicted as a single ‘disorder’. Commenting on the same one psychiatrist said:

I have no idea what sickness is called ‘madness’. I wish people would tell us what it is because mental health conditions (illnesses) have names like depression, schizophrenia, bipolar, anxiety disorder and all that. How can the media in this century describe mental illnesses as madness? Madness is a term which is used to describe some sort of crazy behavior but majority of people suffer silently from mental health conditions (Psychiatrist, Nairobi).

It was pointed out that omitting specific diagnoses of mental illnesses by the media and describing it in broad strokes as “psychiatric patient,” “mentally ill” or just “crazy” or ‘mad’ people leave the media audiences continuing to generalize mental illnesses yet there are different types of mental illnesses and they all present differently and treatment differ. The participants agreed that such labels create a wall between the so called ‘mad people’ or the ‘mentally ill’ and the rest of the society. The media documents analyzed saw that the media tends to describe those suffering

from different types of mental illnesses as ‘mentally ill’. One document had the title: *Abandoned and neglected, Kenya’s **mentally ill** suffer in bitter silence* and the same document had the below image where the sick were described as ‘Mathari Patients’ as shown here below:



*(Photo caption) President Uhuru Kenyatta receives a gift of an art work done by **Mathari patients** on February 18, 2015.*

Besides labelling of mental illnesses as a single illness, journalists confuse mental health professional titles; for example, some journalists said they do not understand the differences between a psychiatrist and a psychologist. Further, professionals in the mental health sector are referred to as ‘mad people’s doctors’ and they are labelled as “madaktari wa wenda wazimu” (doctors of mad people). One participant narrated about a battle that ensued in the largest referral and teaching hospital in the country, Kenyatta National Hospital, when a strategic move was made to rebrand their department and be called ‘Mental Health Department’. Some staff members were



against the name due to the stereotypes and stigma associated with mental health. Although the department was rebranded, the members of staff from that department have to endure ridicule from other staff members in the hospital because of their association with persons considered ‘mentally ill’. Saying that the media sometimes shows the same stigma towards mental health personnel, one counseling psychologist reported of a journalist whom she had followed on Instagram, but immediately she commented on his post, her name was removed “*simply because he realized I am in a rehabilitation treatment facility and there is a lot of stigma around it. They are running away from knowledge*”, she concluded.

Although both the mental health experts and health journalists agreed that mainstream media trivializes mental health through their language, the issue of ‘economy of words’ emerged as a constraint that journalists face since newsrooms have stand-books and ways of writing. But there were diverse opinions between editors and health reporters over the ‘economy of words’ concept. The health reporters argued that in health reporting the principle should be applied sparingly due to ethical issues involved in reporting health related matter. The print health journalist who had received training in mental health reporting shared an incident where they clashed with an editor due to the same principle:

I remember there was a time in the newsroom that we had a very big debate with the editors. I wrote a story about albinism and I referred to them as ‘persons with albinism.’ But the editors replaced the statement with ‘albinos’ and he argued: “you know if we are going to qualify them as persons with albinism, then everybody else is going to say that they live with something...”. It went into a level where it became a joke in the newsroom. The editors did not realize that it was a serious issue, but I remember I stood my ground and I said “don’t call them albinos even if it was going to take longer words”. They listened to me and the words were retained (Print Health Reporter, Nairobi).

However, it was noted that the editors listened to the health reporter because she was a long serving journalist “*but unfortunately they do not listen to those journalists who are new in the profession*” the health reporter said.

Mental Health reporting guidelines, including suicide reporting by the World Health Organization (WHO), recognized by media especially in the West advocate for some certain terms to be used when reporting mental health related issues. For example, they do not advocate for words like the “mentally ill”. But in regard to those guidelines, besides the trained print health reporter in mental health reporting, none of the other participants were aware that such guidelines exist. However, the editors who participated in the study said that the media should not be expected to use the NGO language in its reporting and they criticized terms like “person with mental illness”. Such terms were dismissed as NGO language and terms like “mentally ill” were preferred; and they argued that when that debate is taken to the extreme end, it dehumanizes media stories.

*“I personally have a problem with political correctness especially when it is taken to the extreme end. This whole NGO language is robbing us of power...I don't like that language; I have a problem with it. I think it dehumanizes the story completely”* said one of the editors.

Moreover, some TV reporters described the TV medium “as a channel of few words”. Although no clear examples emerged, the editors maintained that there are other dignified ways of referring to people with mental health challenges or other diseases without necessarily using what they described as NGO language.

**Interviewer:** What kind of language should be used in describing people with mental illnesses?

**Interviewee:** You know, I don't know, maybe terms like ‘persons with Mental illnesses are good for organizational reports and all but not in the media. In the media we just want to give somebody a human face. Somebody with a mental

challenge is just somebody with a mental challenge and that is all. I also do have an issue with insensitive language like a mad person but not with mental illness.

In retrospect, health journalists recalled the emergence of HIV when the media had to make a deliberate decision to demote HIV/AIDS stigma language. Previously, terms like ‘HIV scourge, the malady, HIV carriers, and HIV pandemic’ were used but with exposure their language toned down and changed. Along the same lines of fighting labelling stigma, one participant said:

We changed the narrative and our objective was to show that one can be HIV positive and live a normal life. It was a deliberate plan to ensure we stopped publishing those gory images of people suffering from HIV. So we highlight somebody who is HIV positive but who looks healthy, they are successful, running a business and going on with their lives. But the image created about mental health is that it is a disease of the rugged, unkempt people in our society. The idea then is to change that image, that perception, and it can only come from good story telling and good subject. You must decide that I am not going to cover this... That way, you are able to fight stigma and you do not publish those Luanda photos anymore. ... The media is yet to get there, yeah. The media is just starting (Editor, Nairobi)

Mental health experts argued that language like ‘mad’ or ‘mwenda wazimu’ being used in the media and by politicians “creates a projection of societal behavior that all the negative and bad things emanate from those suffering from mental health challenges who cannot make good judgement and choices,” said one of the participants. Further, it was noted that lack of support and broader understanding from media and political class who have a lot of influence perpetuates stigma in a country where mental health challenges are on increase.

#### **4.2. Summary**

In this chapter the findings of the first question of the study, which is the perceptions of health journalists and mental health experts on media representation of mental health issues has been discussed. The diagram below summarizes the key findings:

**Table 4: Media representation of mental health issues**

Comparison to other health issues: Increased representation but underrepresented	<ol style="list-style-type: none"> <li>1. Positive results from increased representation</li> <li>2. Mental health under represented</li> <li>3. Back page and non-prime time stories</li> <li>4. Event based</li> </ol>
Themes emerging from media representation of mental health	<ol style="list-style-type: none"> <li>1. Predominant focus on the 'ill' and visible symptoms</li> <li>2. Mental health issues linked to crime, violence and the 'outrageous'</li> <li>3. A disease for the poor rural and uneducated</li> </ol>
Language	<ol style="list-style-type: none"> <li>1. Usage of labels; mad, madness, mwenda wazimu, shrink</li> <li>2. NGO language dehumanizes media stories and robs it powers</li> </ol>

## **CHAPTER FIVE: PERSPECTIVES OF HEALTH EXPERTS ON MEDIA REPRESENTATION OF MENTAL HEALTH**

### **5. Overview**

In this chapter, I present findings based on my second and third research questions, which were: What are the perspectives of mental health experts on mainstream media representation of mental health in light of the situation facing the sector? The scope of this question included: What is the status of mental health in Kenya? How does it compare with the media representation? The third research question was: What informs the way the media represent mental health issues? The scope of the question included: What is the place of culture in the way mental health issues are represented? What are the key factors that influence the way mental health issues are represented? What role have the mental health stakeholders played to influence the way mental health issues are represented by the mainstream media?

The findings are presented as 5.1 Media representation and the ‘reality’ as perceived by mental health experts; 5.2 Socio-Cultural orientation of journalists and its influence on media representation; 5.3. Media Routines and mental health representation; 5.4.Lack of Health reporting policies; 5.5.A Lack of investing on Mental Health Reporting; 5.6. Summary

### **5.1. Mainstream Media Representation and the reality of mental health as perceived by mental health experts**

The findings showed that there is a deviation between the way the mainstream media represents mental health issues and the reality as perceived by mental health stakeholders. As discussed here below the predominant issues in the media fail to represent the accurate picture about mental health:

### **5.1.1. Mental Health' illnesses' as a silent disease**

Only about 2 per cent of those who suffer from mental health challenges portray 'dramatic' visible 'abnormal' systems. Mental illnesses were described as silent killers where many suffer quietly; and sometimes the disease is not noticed until it is too late. "One person gets sick and is neglected by the society hence the case deteriorates and depending on the type of mental illness, they may portray visible symptoms which is a psychiatric emergency," explained one of the psychiatrists. It was noted that majority of Kenyans suffer from psychosomatic illnesses where a mental illness can manifest itself through physical symptoms like stomach/headaches.

Although low media representation of mental health exists as compared to other health issues, the findings showed that while other lifestyle diseases like diabetes, hypertension, HIV/AIDS, cancer and others receive high media coverage; the reality is that mental health is linked to those diseases either as a primary or a secondary disease. One psychiatrist put it this way:

Mental health illnesses, especially anxiety disorder and depression, are sometimes triggered by these lifestyles diseases that are on the increase. Think of a person with terminal cancer, almost sixty percent of them have depression. And depression can be more painful than the cancer itself. So to be looking at a physical condition on its own without looking at the psychological part, is to look at that person as if he didn't have a head; because what happens in the body affects the mind. (Psychiatrist & Director of a mental health Research institution; Nairobi).

Another reality that emerged is that, although the media stories and images portray mental health as an outrageous issue that is sometimes linked to witchcraft, majority of people suffer from mental illnesses due to increased psychosocial crisis in the society triggered by economic, social, terrorism acts and ethnic conflicts in the country. The mental health experts and a few health experts differed with the high media representation of people with mental illnesses being linked to crime and

violence and argued that in Kenya the mentally ill are subjected more to violence than vice versa. It was reported that only 2% tend to be violent. Describing the scenario, one psychiatrist asked: *“if majority are violent how come we do not tie patients in Mathari National Referral and Teaching Hospital; how can a ward with 60 patients have only two nurses? I have been seeing such patients this afternoon and some came on their own,”* said one of the psychiatrist. At the societal level people with mental health challenges are feared and are discriminated. *“Out there in the community people with mental health challenges are feared and people think they are dangerous, so if media portrays the same image, they reinforce those beliefs,”* said a psychologist.

The participants, mainly the mental health experts, shared examples of how the mentally ill are subjected to violence due to stigmatization. One example that was shared is to do with economic exploitation, which range from being underpaid to not being paid at all, interference of their enterprises, being denied family inheritance and opportunities to access loans by banks. In terms of business interference, an example was given of an organization that was involved in economic empowerment projects for people with mental illnesses but their businesses success rate ended up being low because other entrepreneurs used to sternly warn customers not to purchase from their shops saying *“usinunue hapo, huyo ni mwenda wazimu, ukikula hiyo matunda yake utakuwa mwenda wazimu (do not buy from that mad person, if you eat fruits from their stalls you will become mad). So you see this person wants to work but society’s negative stereotypes create barriers for them to live a productive and meaningful life,”* said the participant leading the NGO that was involved in the project.

Another example given was the issue of land where stigma leads to people with mental illnesses being disinherited on the assumption that other family members deserve land because the former are perceived as ‘abnormal’. It was noted that statements like the following are used to discriminate such people: “*Sasa huyo nani mwenda wazimu, mnampatia shamba afanye nayo nini?*” (*This is a mad person, what is the need of giving him a piece of land?*). In terms of accessing loans, the following excerpt shared by one of the participants explains some of the negative experiences that people with mental health conditions undergo due to stigma:

One of our members working with a Service Commission applied for a loan which was approved but in between he had a relapse. Somehow the bank learnt that he had a mental illness, and immediately they withdrew his bank loan papers. They said ‘oh, we didn’t know this about this particular person. We are not too sure this person is in a position to repay this loan’. Although this person was on the pay roll of a well-established government institution, the banks denied him a loan due to stereotypes and misinformation about mental health (Director of an NGO- Nairobi).

The discrimination and stereotypes surrounding mental health contributes to underfunding of the sector by the government, development partners and corporates. About the latter one of the participants shared how their mental health organization approached one of the leading banks in Kenya to partner with them in Corporate Social Responsibility (CSR) but they declined arguing that mental health challenges only affect a small percentage of the Kenyan population.

Unfortunately, the media is failing to show the public about the mental health crisis the country is in. It came out clearly from our conversation that mental health is equated to that dirty person who is walking around in tattered clothes, doesn’t take a shower, and he is speaking to himself. For them mental illness is something visible and an ‘ordinary’ person like a bank manager cannot suffer from mental illness. If misinformation about mental health is that high in such offices, what about at the grass root level? (Mental Health Expert leading – NGO)

Consequently, it was pointed out the people with mental illnesses face discrimination and abuse even in hospitals from health workers. One psychiatrist shared how nurses,



even in the private hospital where one would expect different treatment, discriminate his patients and refer to them as ‘Mathare case’ in a derogatory manner. He asked, *“Do we see ‘cases’ or people? Obviously with that kind of attitude they discriminate and stigmatize such patients”* he said. It was noted that some of the leading private hospitals in Kenya, where medical expertise is expected to be high, discriminate people with mental illnesses and refuse to admit them as in-patients *“yet by the time I send a patient to that hospital, I have assessed them and I know they do not need to be in a psychiatric ward!”* said one of the psychiatrists. Other form of violence subjected to such people is physical and sexual abuse. Sexual abuse was reported to be high and often goes unreported *“because the society does not care for the mentally ill,”* said a mental health expert working with an NGO. He further said that when the mainstream media link mental health issues to violence and crime, they perpetuate the cycle of violence that those with mental illnesses face:

Media legitimizes the stigma in the public domain leading to members of public being courageous to even interfere with one’s business calling them *‘mwenda wazimu na hawezi kuuzia watu, hawezi fanya biashara hapo’* (mad person who cannot engage in business and he cannot trade from here). It actually affects the way these people live in their day to day lives because the public has the right to say these people cannot go to school, these people cannot go to work or if they work they do not deserve equal pay *“juu hawa ni watu wagonjwa”* so let me pay them in kind by giving them maize and beans instead of giving them 300 shillings. Media legitimizes the perception and stereotypes that people hold in their own minds about persons with mental health and treat them accordingly. It is a human rights issue. The media speaks for the voiceless but that lacks when it comes to mental health issues. (Mental Health Expert- Director of an NGO)

It was reported that even the national administrators like the police force ‘have the right’ to beat those with mental illness but without anyone raising a finger. They were described as ‘voiceless’ people at the family, community, policy and administration level. From her experience, the health print journalist who had received mental health reporting training said that mental health patients are not violent. She had interacted

with them in different parts of the country including at Mathari National Teaching and Referral Hospital and held interviews with them, besides those who were severely down at the time of the interview.

Another reality that emerged from the findings is that there is a shortage of mental health personnel in the country yet mental health challenges are on increase. However, the mental health professions have not been appreciated in the society and few young people are not pursuing professions like psychiatry or psychology because such professions are linked to mental health and made fun of. The biased media language trivializes the whole mental health issue including the professions by calling them names like ‘a shrink’ ‘daktari wa wenda wazimu’ which worsens the situation reinforcing the belief that the profession is for the ‘mad people’. Sharing their experiences, some of the psychiatrists and psychologists who participated in the study shared how they sometimes receive negative reception when they introduce themselves. Here below are two experiences shared:

The first thing I see is a frown after people learn I am psychiatrist. Looking surprised, they nod their heads saying “you are a psychiatrist uuuh...how is it working as a psychiatrist... we heard that there are chances that you can also fall sick”. After that, they get into all kind of stereotypes they have heard about mental illnesses and persons suffering from the same (Psychiatrist, Nairobi).

Another psychologist shared their experience as:

*Immediately you introduce yourself people will always ask you, ‘how is it working with crazy people, are you not afraid that they are going to hurt you, what specifically makes you to work with those kind of people’ (Psychologist Nairobi).*

The ratio of psychiatrists to the Kenyan population was described as dismal with one psychiatrist serving about half a million people while shortage of psychiatric nurses, social workers and psychologists persist. “So, we need more young people training in

*different professions like psychiatry, clinical and counselling psychology but if the profession is stigmatized, then the problem of personnel persists in the country. The media should be at the forefront of that campaign,”* said the psychiatrist who was heading the mental health department in the Ministry of Health.

However, the participants acknowledged that in some aspects courtesy stigma directed to mental health personnel like psychiatrists had reduced as compared to early 90s. One of the psychiatrists running a private practice put it this way:

But the perception is changing slowly because in the past when I started practicing other doctors refused to go into group practice with psychiatrists fearing that it was a security issue as our patients needed to be restrained. But today we are sharing offices like now I share an office with a colleague who offers other medical services and there is no problem at all. My patients come and I see them. But the mass media has a role to educate the members of public so that we can see young people pursue psychiatry as there are very few psychiatrists in the country. (Psychiatrist, Nairobi)

Although mental health is underrepresented and skewed towards the ‘ill’, the findings showed that there is high need for public education on prevention of mental health due to the many stressors the country is going through. Alcoholism addiction were described as high in this country due to stress levels especially emanating from lack of employment, however, the issue, which is linked to mental health is handled casually. An example was given where the mental health stakeholders were not consulted in 2012 when there was a national battle directed towards alcoholism. The mental health experts said that a number of lives were lost because alcohol withdrawal management was not handled well. Even at the policy level, it was argued that mental health stakeholders are not appreciated and ignorance exists on the areas that are linked to mental health. “Media opportunities need to be created for the public to learn how to cope with all the economic and social issues being experienced in the country. It is time to change the way we have been doing things,” said one of the psychologists.

Just like the media do not pay attention to mental health issues, they are not paid attention to at the policy level either, but:

Unfortunately, people do not think mental illnesses is a major Non-Communicable Disease (NCD) yet it is becoming a major killer in the world. NCD effect may not be immediate but their outcome and impact are major to the social, health, economic and politics of a country. Mental health prevention is key but nobody is seeing that reality

### **5.1.2. Mental Health Challenges cut across status and age**

The predominant representation that mental health challenges affect the poor and uneducated differed from the reality facing the sector in the country. The findings showed that mental health challenges cut across people from different economic and educational backgrounds and that the Kenyan middle and upper class access mental health services quietly. Both the health journalist and mental health experts concurred saying that the Kenyan media workforce is faced with mental health crisis and while some are looking for coping mechanism like alcoholism; some have gone for in-patient treatment in rehabilitation facilities. One counselling psychologist had this to say:

...they have a lot of addiction and mental health issues within themselves and some of them have gone full blown and sought treatment. We who are in the industry know we have dealt with several cases and a number of them have sought treatment. So how come they are not destigmatizing mental health from inside and that will affect the way they report about the issue? (Psychologist based in a Rehabilitation treatment facility, Nairobi).

Concurring the health journalists said that due to exposure to trauma and other job triggered stress, majority media personnel suffer from mental illnesses; and most media houses provide psychological support services for their staff. However, a dismissive attitude exists amongst journalists where counselling services are not embraced. Saying that in their institution they are required to seek psychosocial

support, one print health journalist from one of the leading newspapers, had this to say:

While some journalists willingly seek psychosocial support, others perceive acceptance of seeking such services as a sign of weakness and they look for other coping mechanisms to deal with their stress but over time they suffer in silence and result in alcohol. Most journalists live pathetic lives especially when they retire from the profession” (Print Health Journalist, Nairobi).

It was noted that in an environment where journalists and newsroom managers paid little heed to their mental well-being, media representation of mental health is bound to be not only scarce, but biased.

Besides journalists, it was reported that politicians and other high professionals struggle with mental health issues but they are silent about it. And although there are many people with mental health challenges and living positively and productive lives, the media fails to depict that kind of story. Such kind of stories would create hope; however, it was pointed out that, predominant focus on the hopelessness of mental illness is counterproductive because the stigma continues to persist. In reference to that, some of the mental health experts disclosed that one of the biggest nightmares they encounter is when patients suffering from mental illnesses are discharged from mental health hospitals or other facilities like rehabilitation facilities. Although they make good progress in the facilities, there is failure by families and communities to integrate them back because they are expected to go ‘berserk’ anytime. Support for them to develop skills and get employment is lacking;

...their case is already decided. For the rich they employ a personal assistant to take care of that person; they are taken to hospital by their personal assistant while their parents or guardians just write cheques for their medical support. For the poor person, they are watched quietly as the community point out the home of the ‘mad person’. Nobody realizes they have potential and capabilities.

Unlike the depiction created of hopelessness and turmoil surrounding mental health issues, mental illnesses are just like any other diseases and they are treatable. “it is a brain disease and it is treatable and people recover while others learn to manage it,” said one of the psychiatrists.

Public education should include education that people recover from mental illnesses. The problem may recur but people recover and get back to their day to day business. Some may be on medication like persons with HIV-AIDs, cancer, or diabetes; do we discriminate them because they suffer from these chronic diseases (Psychiatrist)

Mental illness is a disease just like any other but some of the differences are that the former can be a silent disease and it presents differently. So the media needs to educate the public on the symptoms of different kinds of mental health conditions in order for them to go to hospital early before the diseases hits the acute stage. (Director of MH-CBO, Nairobi)

## **5.2. Factors Informing media representation of mental health issues**

The factors that inform the way mental health issues are represented include: socio-cultural orientation of journalists; media routines, lack of investing in mental health reporting by mental health stakeholders; and lack of health reporting policies in media houses.

### **5.2.1. Socio-Cultural Factors and their role on representation of mental health**

Social and cultural orientation of journalists contributes to how mental health issues are represented in the media. Both the mental health stakeholders and health journalists concurred and said that cultural lens see the media being more salient on some issues of mental health. One health journalist put it this way:

*And also because of our bigotry and cultural associations with people who are mentally ill as mad people, they don't tend to be taken seriously... the cultural associations with mental illness is always the dirty man in the streets (Print Health Reporter, Nairobi).*

A mental health expert said:

*They just report incidents informed by their own biases and cultural lenses. For example, in some cultures there are sayings like a 'mad person of the market' meaning such person loiters in the streets and around markets; and for journalists that is the same perception they have (Director- Mental Health CBO)*

It was critical to understand how health reporters and editors defined the term 'mental health' and it emerged that mental health was almost like an unexplainable phenomenon for most of the participants. On being asked about the images that came to their mind about a person with mental health challenges, the media participants had images of someone out there naked, who does not shower, homeless, collecting papers, violent and hidden in a dark, dingy place. *"When you say mental health the first thing that comes to mind is somebody who has trouble being him or herself (unpredictable). What come to my mind will be madness and all that"* said a print health journalist? Another participant described it this way:

*I imagine someone locked in a dingy place; a dirty person who cannot take care of themselves; or a person who is caged because they are violent. I even fear going close to that person (TV journalist)*

Some of the mental health stakeholders pointed out that in most African traditions, people with mental illnesses are not respected and valued; they are seen as useless people in the society. Often, they are blamed for the disease which is associated with witchcraft. Linking to the mainstream media, some of the participants said that journalists do not respect the rights of people suffering from mental illness. Below is an example shared by a counselling psychologist based in a rehabilitation treatment facility:

*A journalist called asking for an interview with our clients, and we agreed but we heard a clear agreement that they were not going to expose our clients. But it was very sad because when they aired the clip, they showed the faces of our clients. When the clients were watching the news, they clearly identified*

*themselves and it became a disaster. The clients almost rioted because they felt exposed without their consent or their families being informed (Counseling Psychologist based in a Rehabilitation Treatment Facility, Nairobi).*

From the majority of the participant, the most prevalent stereotype stemming from social and culture orientation is that people with mental illnesses are dangerous and can go ‘berserk’ anytime so they are feared. For most journalists, it is okay for such people to be chained and locked up and excluded from public gatherings due to their harmful nature. One print health reporter who had won health international awards said “*many mental health conditions are accompanied by violence, and at some point, people become violent. If it is not really violent, I think it is not something to be concerned about.*” Explaining some of the reasons why journalists do not pay attention to the Worlds Mental Health Day, the findings showed that fear of associating with people with mental health challenges is common. “*I believe our attitude is a mad person; we need to keep away from a mad person. They are dangerous,*” said another health journalist.

There was a belief that such people need to be isolated and one editor put it this way: “*guys who belong to Mathare; let’s lock them in. I don’t think that mentality has changed at all even for us in the media*”. The findings revealed that such kind of stereotypes evoke different emotions including apathy, shame, pity and disgust as exemplified by one of the editors here below:

*It is not hopelessness, it is apathy. Like that’s how they are, there is nothing we can do about it. And also, the same apathy that makes the society to ostracize a person diagnosed with a mental illness, it is the same with media. We have ostracized mental health patients from the media (Print Editor, Kijabe Street, Nairobi)*



Mental illnesses are perceived as not treatable and non-legitimate disease. Some of the health journalists were of the opinion that a well-known Female boxer in Kenya was headed to the grave because she was diagnosed with mental illness. As long as she was diagnosed with a mental illness, her life had come to an end. One of the participants explained it this way:

*If you tell somebody that at some point you had a mental problem, it is very difficult to think that it is gone. People think that it is somewhere and it will still come back. And so, people would not want to spend much time with you.* (TV Health Reporter, Nairobi)

Another reporter put it this way:

I think even now we (media workers) have tended to associate mental health problems with witchcraft and think that it is a condition that can never be treated. If someone gets a mental health problem, they get into all kinds of challenges like losing their jobs, family break up; they are neglected by their families because we tend to think that these conditions are untreatable. So, it is like we knew this person as a very good person, but right now everything is broken. So, people realize there is nothing that can be done about it (Print Health Reporter).

Due to its links to witchcraft, some participants perceived mental illnesses as something to be ashamed of: *“think about the image of the family, they don’t want to be known as this family which has a mad person”* said a print reporter while another TV reporter said; *“Mental health is not like any other disease... nobody wants to be associated with it. So it is difficult to get somebody who says, I have a mental health problem, and speaks out to let the world know”*.

On interrogation whether persons with mental health challenges ought to be pitied, the media participants had varied views. While some argued that they needed sympathy because *“they are tragic victims deserving sympathy”* (TV health reporter) others differed arguing that no one in society has feelings for mental health patients because

they “bring the disease upon themselves.” However, mental health issues are also neglected because they are “*pity stories with depressive information*” and media prefer staying away from such stories.

Majority of the participants had a belief that people suffering from mental illnesses are not normal human beings; “*what we know is that people with mental problems are mad people and that once you have that problem then you are not a normal human being anymore.*”

Another health reporter put it this way:

*Many of the cases we have covered of people with mental illness are people who are abnormal in the sense that they have become withdrawn and suddenly they can change their mood and become violent at some point, and really nobody likes violence (Print Reporter, Nairobi)*

Being an ‘abnormal condition’, some participants said that such people do not feel pain unlike physical illness; as one participant put it ‘*normal human beings feel pain*’. Journalists fear of associating with labelled diseases like mental illnesses contributes to the scarcity mental health issues. A few health reporters said that journalists who report on issues that the society stigmatizes end up being labelled and ridiculed in news room and by the public due to their link with the stigmatized issue. A scenario was given of a reporter who pushed for the human rights of homosexuals and he was labelled as a homosexual in the newsroom. Another TV health reporter narrated her personal experience when she was in the limelight covering HIV and the public had perception that she was HIV positive. She gave an incident of where she met one of her viewers who scolded her “*because I was pregnant yet from his perspective, I was HIV positive*”. So societal labels and ridicule make journalists to avoid stigmatized issues.

Saying that culture influence's journalist's judgment, the findings showed that the media cannot be solely blamed for the underrepresentation and skewed representation:

Mental health is greatly misunderstood both by the society and by the journalists who are part of society. You can't blame the journalist or the media houses without blaming society. We have stigmatized and labeled, and put these people in boxes because we do not understand them and because we are afraid of the unknown. Somebody removes his clothes and starts walking, and we don't want to touch because we don't understand what it is. So, we keep away (Psychologist).

### **5.2.2. Journalists Routines and their role in media representation of mental health**

Newsroom routines influence media representation of mental health issues and news value judgment of editors emerged as critical in determining the mainstream media content. Media gets attracted to controversy, conflict and that which is considered as “strange in the society”. As a result, crime reporting is one of the major areas of news source, and stories emerging from there linked to mental; end up being dominant in the media. Further, it was noted that editors face a dilemma between making news and social responsibility, however, media gets attracted to the ‘*non-ordinary activities like the sick being chained or a father molesting his mentally ill daughter or a mother kills her children. It is unfortunate but that is the way media works,*’ said one of the print reporters.

Majority of the participants described the Kenyan media as consumer oriented even in health messages and media is driven by high viewership and readership as a way to attract revenues. For example, advertising is critical for generating revenue. It was reported that the Kenyan media audiences portray lack of enthusiasm in interacting with mental health medics and experts. One TV health reporter narrated an occasion where she invited mental health professionals as guests in her TV health show

following the Garissa University Terrorism Act in 2015, but the audience engagement and feedback turned out to be so low as compared to other shows she had done.

I only received 10 short messages from the audience which was quite low for a show that attracts ninety plus sms from the audience! So, if I invite a psychiatrist, a psychologist, and the response is lower, definitely I will take some time before I call one. I will call doctors who bring viewership and response to my program. That's how we rate media. We rate it by viewership. How many people are texting me? how many people are calling in order to know people are actually watching this show. So, it holds us back from bringing specialists who can address that kind of issue, which is mental illness (TV Health Reporter).

Some of the media participants were of the opinion that mental health stakeholders were not attractive to their audiences and an example was given where a health reporter had invited an expert dealing with the issues of depression but during the live interview, they were limited on how to engage the audience. Usage of technical language by the practitioner is another limitation in mental health coverage when dealing with a media out to attract its audiences.

Mental health activities were described as “low key activities” for the media, for example, the World Mental Health Day activities were explained in that manner and one editor put it this way:

*But for mental health it's a no-go zone for media. There is a Mental Health Day celebrated annually but no one gives it even a little attention as other medical care areas... Tetanus is more prevalent. People know its cause and the campaign against it are so loud that it cannot be ignored even by the deaf (Editor, Nairobi).*

Examples of ‘high key’ news activities that attract the media were shared, like a campaign entitled “Bring Zack Back Home Campaign” in 2012 that was geared towards the construction of the first ever-spinal injury rehabilitation centre in Kenya. It was noted that the campaign attracted a lot of interest amongst the Kenyans who wanted to know more about spinal injury and issues surrounding that health issue.

Majority of the media participants said that the Kenyan media “*did not have a choice but to follow the campaign closely and inform its audiences about what was going on,*” said one of the participants.

### **5.2.3. A lack of investment in Mental Health Reporting**

Media houses hardly invest in health reporting because politics dominate the media. In view of that health stakeholders have to invest in media reporting to see coverage of their issues. However, the health journalists in this study noted that the mental health stakeholders have failed to invest in mental health reporting. But the mental health experts said that the media has ignored them and their efforts have yielded little success.

The media participants said the mental health stakeholders have not invested in training of journalists and editors, organizing media familiarization tours and round table meetings and budgets that would from time to time facilitate logistical issues of mental health coverage, especially for stories that are not easily accessible. One of the reporters had this to say in regard to media budgets:

If politicians can hire a helicopter for journalists to cover an event, what would hinder mental stakeholders to organize a van to take journalists to sites where they can enrich their stories? Health reporting is not like politics *utaenda kusema* (you will just report what was said). In mental health and any other health field, one must have facts and how do I get these facts? (TV health reporter, Nairobi).

Majority of the health journalists in Kenya land in health reporting out of interest as media training in the country is not specialized. However, they highly depend on health trainings to improve their reporting of health issues and most of those trainings are mainly sponsored by NGOs. It is important to note that the health journalist’s

participants were experienced in the field of health reporting with some having worked for ten years and received international awards for health reporting. Majority had a degree in journalism and mass communication, however, two of the participants were pursuing master's degree in public health and another one a post-graduate diploma in journalism. But majority said that they ended up in health reporting out of interest and health trainings that came their way. All the health reporters said that they had participated in health reporting training that had been offered by an organization called Intra-news which was sponsored by USAID. However, it emerged that the Intra-news media training centred on HIV/AIDS, maternal health, child health, and malaria reporting but mental health reporting never featured. The trainings were described as enriching in the field of health, which is considered technical. The participants said that unlike their western counterparts, specialized media training lacked in Kenya and it was learned while on the job. In terms of training or exposure to mental health, only one health print journalist had received training after she received a grant from an international organization which saw her travel to Kenya and Ethiopia to collect mental health related stories that were published by the local and international media. One other health TV journalist said she had attended a mental health conference in South Africa. It was clear that the trained journalist had some knowledge about mental health and had also published a number of stories including interviewing mental health patients like at Mathari National Teaching and Referral Hospital.

Emphasizing the need for journalists training, it was pointed out that journalists lack the most basic information about mental health and they are limited in the language to use when reporting about the issues. For example, they do not understand the different

types of mental illnesses and out of ignorance some dismiss diseases like bipolar. *“They (media) dismiss the conditions arguing that they are stylish terms found in the West because they have not been given facts portraying the current situation in the country,”* said the print health reporter who had gone through the training. Another TV reporter said, *“We have received training in HIV/AIDS reporting, cancer, reproductive, malaria reporting but I have never heard of mental health reporting or even an exposure seminar on the same”*. It was pointed out that health trainings increase knowledge of health-related issues and increases journalists’ capacity to pitch for health stories in newsrooms. One participant put it this way:

Pitching is when you go to your editor and tell them, I have this story. But you see, with mental health unless you have a lot of knowledge, you may not be able to pitch because it is like you are selling a product to a buyer but without accurate knowledge about the product. If I am not comfortable and confident about covering a topic, I will not touch it. Why not empower journalists on mental health? For example, I slipped into health reporting because of the frequent trainings that came along that line. Media houses no longer take people for trainings save for just a few refresher courses due to budgetary issues (TV Health Reporter, Nairobi).

Referring to the emergence of HIV/AIDs, the media participants said that through training, media houses changed their style of reporting. One health reporter narrated how their TV station ran a HIV/AIDs media campaign for a whole year once they were sensitized about the prevalence of the disease and the stigma surrounding it. *“Once the media is highly sensitized about an issue and information is made easily accessible, they engage in advocacy as part of their educational role”* said the TV health reporter.

Besides the training, majority of the participants pointed out that mental health stakeholders fail in media relations. *“I have never heard of any communication guy in mental health call me; so, where are they?”* asked one of the TV Health Reporters.

Establishment of relationships with journalists and editors was pointed out as important and editors were described as critical decision makers in media representation of issues:

If you had come here five years ago and asked me about cancer day, I would have been blank and asked you, ‘is there anything like that?’ But because there are major campaigns going on and the relevant stakeholders are making a lot of noise and reaching out to us, then it becomes something that is on my fingertips. (Print Editor, Nairobi).

It was pointed out that NGOs lead the conversation in health-related issues “*NGO world is really a partner when it comes to health issues. And the more they invite the media, the more the media gets information,*” said one of the TV health reporters.

Commenting on the power of stakeholder engagement, one print health reporter gave the following example:

Media- Stakeholders engagement plays a critical role. I am an award-winning journalist in the area of reproductive health in 2013 and 2014, and I was able to carry away awards every year because I was initiated to reproductive health by organizations such as UNFPA, UNICEF, UNFPA-United Nations Population Fund, Kenya Media Network on Development, and National Council on Population Development. These are institutions that are involved in reproductive health issues and they have trained us and the necessary networks have been established (Print Health Reporter, Nairobi)

The media health stakeholders must “*be at the forefront of mental health conversation and keep it alive. They should not just discuss it in boardrooms but bring it out to the fore so that they gain the interest of the media,*” said another health reporter.

Describing other diseases like HIV, malaria and cancer, the participants explained that they receive media attention because specific organizations involve the media in their activities and organize round table meetings, media tours and train journalists. One print journalist had this to say:

It was the stakeholders involved in HIV/AIDS campaign that created an enabling environment or platform for the media to raise awareness and educate the public through TV, radios, promotional materials, special events



like world's AIDS day. You find similar events being organized at the district and grassroots levels. So, the message is taken down to the community. That awareness assisted this country to contain the spread and deaths of HIV. It should be the same thing with mental health (Print Health Reporter).

The following excerpt also explains the role the media played as they partnered with the stakeholders in fighting HIV/AIDS labelling stigma:

And the idea was simple. It was a deliberate plan to ensure that all these gory images we used to publish of people living with HIV we don't. So if we get somebody who looks healthy, is successful, is running a business, is going on about his life, and has HIV, that's the person to highlight to show that there is life beyond HIV. The image that has been created about mental health is that you have these rugged people who are unkempt and all that... The idea then is to change that image, that perception, and it can only come from good story telling and good subject... For that to be achieved, mental health stakeholders have to partner with media (Editor, Nairobi).

It is important for mental health stakeholders to set up a budget and one health reporter added:

Media budget is critical in health reporting because if you have an activity out of Nairobi and you don't provide transport, unless it is something that will bring direct revenue to the company, the media houses may not invest because they are also in businesses; journalists will not come because it is difficult for media houses to keep on spending money for activities. So usually, and especially for health reporting it is really the organizers who provide transport and other necessities for journalists (Print Health Reporter, Nairobi).

However, a number of the mental health stakeholders said they had engaged the media, but with low turnout. In reference to pushing mental health policies through the media, some participants said that they had tried to reach out to the media unsuccessfully. One of the participants shared an example of a letter he had written to some of the media houses challenging the Kenyan constitution (2010) for describing people with mental health as:

People of unsound mind who cannot vote, register or be elected in a national office. The constitution does not even recognize that such persons may be under treatment and are productive members of society. Or even ask for approval letters from their doctors. They are treated as non-entities and so the communities treat them the same way. That is serious, I have written two

articles to the media and tried to engage them protesting against this, but have not been published” (Mental Health Expert, leading a CBO)).

Letters were also sent to the media criticizing the Marriage Law (2014) but they were not published. The law was criticized for allowing divorce on the basis of mental illnesses. The psychiatrist who was involved in mental health research said: “*We have tried to bring this information to the press but many journalists are not interested. They are interested in a scoop and what sells. There is a lot of research that is going on*”. In reference to a newspaper column that touches on mental health issues maintained by a psychiatrist and an Associate Professor of Psychiatry and Dean of School of Medicine in one of the Kenyan Universities, some participants wondered whether journalists read what is published. One psychologist said:

From time to time the negative consequences of stigma towards mental health patients are mentioned in that column in one of the leading newspapers in this country. Is it that journalists ignore what is in their publications? They form the editorial team that edits those articles so they interact with that material but they seem not to internalize it or take it seriously (Psychologist, Nairobi).

Further, the research findings revealed the frustrations faced by mental health stakeholders due to unsuccessful media efforts they had tried to initiate. One participant leading a Non-Governmental organization pointed out that he had tried to train journalists but the turnout was not only low but characterized by newly hired journalists while journalists from big media houses failed to attend those trainings. they trained journalists in mental health reporting but the media responsiveness was described as low. The participant with the NGO said that he had held those trainings for several years without yielding any positive report in terms of balanced representation of mental health issues in the mainstream media; and he was at the verge of giving up on media training as narrated here below:

I have organized for several media trainings and roundtable meetings but journalists seem to have no interest in mental health and the ethical issues involved in reporting on the subject. I am not sure whether it is the media editorial processes or whether mental health is perceived as a non-issue or something which does not elicit public interest. From my experience those media engagements have achieved very little and in the next projects we are not planning for media training. We will use the media to highlight our projects like showcasing economic empowerment programs and by so doing journalists will avoid focusing so much on the illness but show that people with mental health conditions can live productive lives (Director of MH-NGO, Nairobi).

However, a few of the participants said that people suffering from mental health conditions need preparation before speaking to journalists because some of their diseases originate from sensitive psychosocial issues which are considered private.

One participant put it this way:

For example, I expect journalists to send me a set of questions and then I sit down with the people who are going to be interviewed and decide what is relevant. One patient whom I had linked to a journalist shared how his childhood was characterized by fights between the parents and how that could have triggered mental health challenges and then the journalist shared all that information and it caused trouble at home. It becomes a sensitive issue (Director of MH-NGO, Nairobi).

One of the psychiatrists who had previously worked as a member of staff at the Ministry of Health narrated his frustration of engaging media to cover events like the World Mental Health Day. However, other stories took the lead and mental health was “tucked somewhere in a corner.” An example was given of the previous year (2014) when a few journalists attended the World mental health day “*but they focused on a controversy that surrounded Tetanus vaccine and mental health was just touched as a by-the-way,*” said one of the psychiatrists.

Although the mental health stakeholders said that a lot of research exists, the health journalists said that there lacks a systematic database where journalists can easily access mental health information easily. “*I don’t even know whether they have a*

*website or a data portal that one can easily click and find all the information. With easy access of information, we (media) do not need to call experts all the time,”* said one of the TV Health Reporters. Some of the media participants described mental health reporting as *“trial and error reporting, where we (journalists) have learnt from our mistakes,”* added a print reporter from one of the newspapers with the highest circulation.

However, the mental health experts differed with the health journalists and argued that information is accessible but the media is not interested. One of the experts involved in research said there is current research but journalists are not interested in technical information. They argued that majority of the Kenyan journalists lack capacity to research, interrogate and write on technical subjects. Their reporting was described as *‘expository but lacking responsiveness’* because there is failure to research and interrogate issues. One of the psychiatrists said: *“Journalists should interrogate mental health issues and get involved in advocating for relevant policies. Should we have patients being chained in the 21<sup>st</sup> century when mental illnesses can be treated?”* It was added that when stories of children being chained or locked up appear in the media, the public tends to condemn and make harsh judgement of caregivers of those with mental illnesses yet the sector is struggling with outdated policy issues, which the media is not addressing in their stories. One mental health expert explained further:

But journalists do not go a step further to connect those messages with the need to build healthy public policies around mental health. When incidents are reported of people suffering mental illness abandoning or killing their children; or images are shown of a mother who locks or chains their son, they appear gruesome and we are quick to condemn the ill or their caregivers but the media does not dig deeper for its audience to understand the challenges of personnel and infrastructure facing the mental health sector (Director- Mental Health NGO, Nairobi).

Concurring with mental health experts, the health journalists were of the opinion that Kenyan journalists dislike technical writing:

*...they have no passion for health journalism. They hate stories where they are expected to do research and dig into issues. They just want to go after politicians where they will report incidents as they occur in the field (Print health journalist).*

Consequently, they have not embraced the culture of reading widely and their reporting tends to be shallow. And it was also emphasized that politics sell more than environment and health journalism.

Although majority of the media participants acknowledged that doctors are more accommodative of journalists than some years back, it was noted that a few of mental health stakeholders treat journalists with suspicion like they are out to give them bad publicity. Commenting on the turnaround of information from some of the mental health professionals, the trained health reporter said:

So, if you are chasing an expert since morning and he tells you call me at 8pm, that is way past your deadline, and that day is gone. You will not call him tomorrow. You want to call an expert who understands details, who is friendly, who will be able to put out the words in non-technical terms. And I know one in the mental health field who promptly responds to the media and gets back to us when he promises. He respects deadline because he knows by 4 pm you need to have your story out. And he will link you up to other experts if he isn't able to answer the question (Print Reporter, Nairobi).

However, majority of the media participants acknowledged that some journalists fail to carry out prior research before interviews and health stakeholders also get frustrated. *“For a long time, journalists used to do bad stories, where experts comments were used wrongly or taken out of context. Doctors also complained about having to teach journalists basics about health” (Print Health Reporter).*

Prominent public figures and celebrities' involvement in a health issue attracts the media. However, it was noted mental health campaigns and outreaches lack

prominent public figures and celebrities, who would attract the media and by so doing increase its representation in the media. An outstanding member of society like a politician, would command attention as a champion of “*the unknown and misunderstood mental health issues,*” said one of the editors. It was also pointed out that Kenyan media tends to follow politicians and celebrities since they attract their audience. For the mainstream media to get involved in pushing for public policy issues like mental health policies, a prominent politician needs to be at the forefront in pushing the issue. Further, it was noted that public figures declaration of their health status attracts media attention resulting in policy improvement and funding of those health issues. An example was shared of a former Public Health Minister in Kenya (2008-2012) who disclosed her diagnosis of breast cancer and because she was a public figure “*there was a spotlight on the disease that was silently killing Kenyans*” said one of the TV reporters.

Besides public figures and celebrities, the critical role of internal newsroom champions was shared. The trained health reporter in mental health did say that she had played that role, and some mileage had been gained in mental health reporting. “I have played the role of *sensitizing editors and explaining the danger of sensationalizing issues like mental health conditions,*” said the print media reporter. It was also pointed out that newsroom champions play the role of verifying language and how stories are framed especially coming from freelance journalists.

Most of the media participants said that they belong to professional networks of journalists; with one of them saying she was the chairperson of a network of media writers called Media for Environment Science, Health and Agriculture with more than

100 members in Kenya. Such interactive forums provide good network for journalists to connect with potential sources of information, however, it was noted that there lacked mental health stakeholder's presence in such '*news creating forums*'.

In terms of media space constraint, there was a different perspective amongst the participants. Some of the TV health reporters felt like the print media covered mental health issues more "*because they have a lot of space and time to explore. For a TV story is only given about three or four minutes. But print you can do a full centre spread*" said one of the TV health reporters. But some of the other participants differed saying that TV stations also had health segments but they have chosen to side-line mental health issues.

#### **5.2.4. Disjointed and uncoordinated media efforts by mental health stakeholders**

The findings brought out that although the mental health stakeholders make efforts to engage the media, the initiatives fail because there is no strong, unified voice to put pressure on the media. Differences exist amongst the mental health professionals, who offer different services in field, while also it was noted that the institutions work in a disjointed manner. The mental health stakeholders said that the mental health sector is underfunded with only 0.01% of the national health budget being allocated to the sector under Ministry of Health. The development partners show little interest in funding the sector since they normally work with national governments priority areas. With little funding, the mental institutions fight for the little fund while at the same time the differences emanate from diverse views of management of mental health issues like treatment of patients. One mental health expert said:

Another challenge is that as mental health stakeholder we are disunited. We are working in a very disorganized and scattered way and there lacks a coordinated or integrated approach. There is a lot of infighting between the

different bodies and we are all caught up in fighting for the little resources allocated to the sector. We should even have a charter for mental health practitioners in Kenya. To be listened to by the media we need a strong, unified voice (Counseling Psychologist and Chairperson of a Mental Health professional body)

Another participant said:

So, at the end of the day everyone is doing their own small disjointed things. We fault the stakeholders in terms of how they approach mental health in Kenya. Even there are differences about the treatment models used. For us we say we use the human rights model, the doctors will use the medical model and suddenly there's a huge conflict between what a human rights person would say and what a doctor would say. (Director of mental health - NGO, Nairobi).

The need for having a unifying mental health national body like National Council of Aids Control (NCAC) was described as important. It is the kind of body that would house all bodies dealing with mental health, just like the NCAC, where all bodies are brought under one umbrella and jointly look for funding and push for the relevant policies.

Some participants were of the opinion that mental health expert's voice is never heard during national crises due to internal conflicts within themselves. For example, mental health stakeholder's presence was not felt in shaping the public discourse around substance abuse and mental health in 2015 when the President of Kenya issued restraints about alcoholism in the country.

*“The strategy was not thought through leading to high deaths as there lacked alcohol withdrawal management. The mental health experts should have contributed in the debate by issuing press statements and calling for media conferences when the campaign was going on,”* said one of the psychologists.



### **5.2.5. Lack of Media Policy in Health reporting**

Results from the field revealed that Kenyan mainstream media houses lack health reporting policies. Majority of the participants, besides the trained print reporter, were not aware of the Mental Health and suicide reporting guidelines endorsed by the World Health Organization (WHO). The participants pointed out that such guidelines and policies are received during health trainings. For instance, majority of the participants said that they received guidelines on Cancer reporting when they attended a Cancer Reporting Training. Further, it emerged that the Kenyan media houses have no policy specifically to do with health reporting. One journalist said:

Besides the general editorial policy, media houses do not have health reporting policies. It's actually in the process of being developed. I am in a team that is working on health reporting policy, which was pioneered by Inter-news in conjunction with the Media Council of Kenya, but that hasn't come out yet and it has a long way to go; so for now health stakeholders have to expose journalists to such guidelines where they exist (Trained Print Health Reporter, Nairobi).

### **5.3. Conclusion**

In this section, I have provided the research findings of how health journalists and mental health experts perceive the way the mainstream media represents mental health issues and the reasons underpinning that representation. The findings have illustrated that the mainstream media represents mental health in an inaccurate and biased way, while it emerged as one of the most underreported health issues. Some of the reasons cited by the health journalists that underpin the way mental health issues are represented include newsroom routines and processes, journalists social-cultural orientation, lack of investing in mental health reporting by mental health stakeholders and lack of health reporting policies in the Kenyan media houses. On the other hand, the mental health experts' reasons for the way mental health issues are represented

include journalists' cultural orientations but characterized by lack of interest of mental health issues by the Kenyan media, disjointed mental health Stakeholders leading to uncoordinated media efforts, and majority of Kenyan journalists lack interrogative and research skills in Technical Reporting. The next chapter consists of discussions, conclusions and recommendations drawn from the study.

**Table 5: Reality of mental health in Kenya & Factors informing the media representation**

<p>1. Mainstream media representation and the reality as perceived by mental health experts</p>	<p>a) Mental health 'illnesses' is a silent disease</p> <p>b) People with MH challenges are subjected more to violence than vice versa</p> <p>c) Mental health challenges cut across status and age</p>
<p>2. Factors informing mainstream media representation of mental health</p>	<p>a) Socio-cultural orientation of journalists</p> <p>b) Journalistic routines</p> <p>c) A lack of investment in mental health reporting</p> <p>d) Disjointed and uncoordinated media efforts by mental health stakeholders</p> <p>e) Lack of Media Policy in Health Reporting</p>

## CHAPTER 6: DISCUSSIONS AND CONCLUSIONS

### 6. Overview

In this chapter, I present a summary of key findings and a discussion with reference to the literature presented in Chapter Two. I also present my conclusions, the contribution of the study and implications for policy and practice. Finally, I reflect on my experience during the PhD study process.

#### 6.1. Summary of key findings

This study was based on three research questions, which were: How are mental health issues represented by the mainstream media in Kenya? What are the perspectives of mental health experts on media representation? What informs the way mental health issues are represented in the mainstream media? The key findings are summarized in the table below

**Table 6: Summary of key findings**

#### **Q1. How are mental health issues represented by the mainstream media in Kenya?**

- Mental health issues are underrepresented but the representation has increased as compared to a few years ago. Mental health issues hardly feature during prime time and the reporting is reactive and incident oriented.
- Three themes emerge from the media representation of mental health issues: i) Focus on the ‘ill’ and visible symptoms of mental illnesses; ii) Mental health challenges linked to crime and violence and ‘the Outrageous’ iii) A disease for the poor and uneducated in the society.
- The language used in media representation of mental health issues is biased, which legitimizes the language used in the public and ‘NGO’ language is dismissed as language that dehumanizes media stories and robs media of its power.

**Q2. What are the perspectives of mental health experts on media representation?**

- A representation that deviates from the situation that is facing the sector
- Mental health is a ‘silent’ disease, characterized with misinformation and stereotypes.
- The mentally ill are subjected more to emotional, physical, economic and sexual violence than vice versa.
- Mental health challenges affect all regardless of the economic status and economic background. Mental illnesses are like other diseases which are treatable and there are people, including media workers, living productive lives despite mental health challenges.

**Q3. What informs the way mental health issues are represented in the mainstream media?**

- The socio-cultural lens influence journalists in the way they represent mental health issues in the mainstream media. Social and culturally based beliefs including that people with mental health challenges are dirty people in the streets and dangerous hence feared; they portray visible ‘abnormal’ behaviour and they are people who need to be isolated.
- Media routines where controversy, conflict and ‘abnormal’ define news, see crime and violence linked to mental health issues feature more prominently. Media houses in Kenya have become viewer-driven and commercial and what attracts the media audience sells. Kenyans also love drama and mental health is viewed from that perspective
- A lack of investment in mental health reporting by mental health stakeholders contribute to the way mental health issues are represented. Health reporting is not prioritized in the media houses; however, mental health stakeholders do not have a media budget. As a result, capacity building of journalists has not been executed; there lacks mental health information database, no editors round table meetings, and there are no public figures and celebrities identified as brand ambassadors for mental health. Logistical support for journalists, and access to networks on mental health issues are rare. Disjointed media efforts by mental health stakeholders lead to lack of a strong unified voice than can lobby effectively.
- Health reporting in media houses is insufficient, and the language used is not appropriate in order to positively influence ethical issues

## **6.2. Discussion**

Overall, the following are the key findings of this study based on the research questions:skewed media representation of mental health issues;presentation that deviates from the reality of mental health; weak media advocacy on mental health issues; and lack of health reporting policies. These findings are discussed in the subsequent sections as 6.2.1, 6.2.2, and 6.2.3 and 6.2.4

### **6.2.1. Skewed Media representation of mental health issues**

The mainstream media in Kenya has increased representation of mental health issues but it still remains a low priority area as compared to other health issues. The representation is skewed to the ‘ill’ person and linked to the visible ‘abnormal’ symptoms such as crime and violence. It is more associated with the poor and uneducated. However, there is appreciation of the slight increase in media representation by mental health stakeholders. The slightly increased representation has played a significant role in creating awareness about mental health and more people have been able to access mental health services. In Sub-Saharan Africa the mental health practitioners have pointed out that they are not in a position to solely advance public knowledge about mental health and the media industry has been singled out as a critical partner in mental health literacy. “Being the information hub of most civilized societies, the mass media reflects and also shapes public knowledge in relation to issues of life, including mental ill-health,” said Andu et al. (2013, p. 2). Both the mental health experts and health journalists perceive the Kenyan mainstream media as a powerful vehicle in sensitization and policy advocacy. Affirming that role, one psychiatrist said:

They (media) have the muscles to build pressure and hold government accountable to allocate reasonable resources to mental health while pushing for relevant policies. The media should also hold County governments accountable and ensure that mental health is included at the primary level. History has shown the power of media in Kenya whenever they apply their muscles to an issue and put a lot of pressure to the government or other parties. (Psychiatrist & Director, Nairobi).

However, as much as the increased representation has played a role, this study shows that the Kenyan mainstream media ignore mental health issues as compared to other health related issues. Lack of government commitment to mental health is also reflected in the media, and among policy makers and donors. Research shows that 75% of Kenyans consider the mainstream media as a source of credible information, with the Daily Nation being the largest newspaper not only in Kenya but in the whole of East Africa (Mogambi, Kiai, & Ndati, 2013). However, the Kenyan media not only underrepresents mental health issues but it also ostracizes those with mental illness through their representation: *“the same apathy that makes the society to ostracize a person diagnosed with a mental illness, it is the same with media. We have ostracized mental health issues from the media,”* one of the newspaper editors commented. In comparison to other health issues like HIV/AIDS, cancer, tetanus, and diabetes, and heart disease, mental health has not generated a lot of attention.

This information corroborates with a study entitled *Media and Mental Health in Uganda*, which showed that the Ugandan media is actively involved in health initiatives, but with little attention devoted to mental health issues (Kigozi et al., 2010). The lack of interest in mental health by mainstream media is a mirror of what happens in society.

Leask et al. (2010) argue that mass media communications struggle with communication of scientifically accurate information about health, as framing makes them prone to sensationalism, sins of omission and even sheer inaccuracy. The latter, in terms of sheer inaccuracy, is reflected in this study where mainstream media confuse different type of mental illnesses and use wrong terminologies. “The media should first educate itself before educating others on mental health,” a mental health expert said.

In terms of framing it is episodic, sensational, conflict and controversy frames that dominate media representation of mental health issues whereas thematic, consequential, contextual and economic frames are rare. Brunner et al. (2011) observe that effective framing is imperative in using media to advance public health agenda. “Framing provides the context that shapes how the message is understood and how the facts and science presented are interpreted” (Brunner et al.2011, p. 9).Additionally, Boykoff (2007) comments that the news media, through framing practices, set the parameters of public discourse. So, when episodic frames feature, the media audiences fail to see the big picture in mental health and instead they focus on the ‘ill’.

The episodic framing predominance is reflected by the way mental health representation is event based, where more stories feature in the mainstream when the ‘abnormal’ occurrence happens like national disasters occur like the Westgate Terrorist act in Nairobi in 2014, when there are ethnic or political conflicts or when the ‘abnormal ill’ linked to mental health commit an outrageous act. During the crises there is high media consultation with the mental health stakeholders but as soon as the

disaster is over, the mental health issues are closed until the next episode of similar nature.

Further, episodes of those suffering from mental illnesses dominate the media and the contextual frames reflecting the whole spectrum of mental health, involving presentation, causes, diagnoses and treatment hardly feature. Other studies show that media opt to focus on illness rather than wellbeing. A study on the portrayal of mental health in Australian daily newspapers, showed that the newspapers favored stories about illness over wellbeing (Kenez, O'Halloran, & Liamputtong, 2015). Along the same line, heavy emphasis on episodic framing see mental health institutions like Mathari National Teaching & Referral Hospital being depicted as systems that are always in crisis as media interest is just to highlight the incidents going on in the hospital without showing the contribution it has made in the region. One mental health expert said:

A journalist sees me and all what they ask me is “how is Mathare Hospital?” ...is there a disconnect somewhere? They are just interested in sensational information that will make their stories to sell. ‘Mathari National Teaching & Referral Hospital’ was even rebranded but they still refer to it as Mathare Hospital in a derogatory way. It is okay to make news but it is also critical to understand issues for the development of this nation (Psychiatrist, Nairobi).

This study has shown that kind of representation has contributed to people, even from disadvantaged background, avoiding the hospital where other diverse medical services are given beyond mental services. Kjærgaard, Morsing and Ravasi (2010) point out that media representation emphasizing socially undesirable features not only destroys the image of the organization, but also the very self-concepts of its members. This study shows that those who work in mental health institutions face the same stigma that their organizations face. It is unfortunate bearing in mind that this study showed



that young people shy away from joining mental health professions due to the stigma associated with it; yet there is shortage of mental health manpower in the country (Kiima & Jenkins, 2015).

Leask et al. (2010) argue that 'Sins of omission' characterize media communication of health and scientific issues, and this study shows that the mainstream media downplays some aspects of mental health while being salient on other topics. Besides the emphasis on the 'ill', the other salient themes are high representation of "visible abnormal symptoms", of mental illnesses. The depiction, especially through images, that mental illness is associated with those who are half naked, unkempt and loitering in the streets. Further, the media predominant stories on mental health are linked to crime and violence and the dangerousness that accompanies the mental health challenges. In description of that, this study shows that both the perspectives of mental health stakeholders and health journalists agree in that they see mainstream media in Kenya as commercializing and sensationalizing mental health issues. Sensationalism characterizes media representation of mental health, as shown by the following excerpts:

...editors and reporters are looking for stories that will attract viewers to their station, for instance a story of a violent person linked to mental illness run; such stories draw a lot of response from the viewers. (TV health journalist) Mental health is not only neglected but only highlighted when there are ... sensational stories (Print health journalist)

With a perception that mental health issues are outrageous, when the prominent in the country are linked to mental illness, the media highly features those incidents. For example, the incident of the female Kenya boxer who developed mental health challenges featured highly in the media because, "*we did not expect her to suffer from such a disease*" said one of the media participants. This sensationalism in mental health

reporting while downplaying the media's role in public education (referred to as the 'awareness' bit) has been identified in other research (Nawkova, Nakwa, & Adamkova, 2011). Sensational news tends to sell, and the Kenyan mainstream media is consumer oriented, even when it comes to health issues. "*Unfortunately, media today is viewer-driven. So, at the end of the day, editors and reporters are looking for stories that will attract viewers to their station,*" said a TV health journalist. The media images, headlines and content often depict the 'dramatic' side of mental health in view of attracting media consumers, who are described as people who love drama. Such sensational framing suggests a norm of dangerousness, violent and unpredictable behavior by people struggling with mental health challenges. However, just like other scholars (Otten, 1992), some mental health stakeholders are of the opinion that sometimes media scandals propel governments to act.

This sensationalism in mental health reporting criminalizes mental health issues and those affected by them. In an op-ed carried by one of the Kenyan newspapers, *The Daily Nation*, Kaberia (February, 2015) wrote an article titled "Let's treat the mentally ill as patients and stop thinking they are criminals" (Kaberia, 2015). He argued that dealing with mental health is a collective undertaking and "citizens need to be sensitized that these are sick people, not criminals," (p.15). However, this study shows that the Kenyan mainstream media contributes in that criminalization as the dominant stories link such people to crime and violence. Other studies have shown that the recurring theme of extreme violence at the hands of mentally ill characters is the norm in mass media portrayals (Edney, 2004; Beachum, 2010; Smith, 2015).

A study examining the modes of framing mental illness in the Yoruba genre of Nigerian movies showed that psychotic symptoms were the most commonly depicted,

while treatments of the ill were mostly depicted as taking place in “unorthodox settings. The most commonly depicted etiology of mental illness was sorcery and enchantment by witches and wizards, as well as other supernatural forces,” (Olayinka & Olayiwola, 2013, p.1). Commenting on that kind of representation, which also features in the Kenyan mainstream media, Atilola (2015) notes that the media portrayal of mental health issues solely from cultural explanatory models tends to provide an incomplete representation of the issue. Such kind of representation often translates to some completely disheveled, dirty, poorly clad person, with a lot of other culturally sanctioned stereotypes about causation and treatment. This study shows that journalists use their social and cultural lens in their representation of mental health issues. Such content fails to inform the public about symptoms, assessments, interventions and treatment for mental illnesses yet that public education is critically needed in view of destigmatizing mental health issues. Makanyengo (2014) points out although there are many people suffering from mental illnesses in Kenya, they shun professional medical services due to the stigma associated with mental problems. So, when the Kenyan mass media stigmatizes mental health issues, it strengthens the stereotypes types in the public domain. Indeed, stigma influence “how a psychiatric diagnosis is accepted, whether treatment will be adhered to and how people with mental illness function in the world,” (Dinos, et al., 2004, p. 176).

Besides commercialization that leads to sensationalism, media need for a ‘news peg’ upon which they would hinge their stories, contribute to dominant representation of violence and crime linked to mental health. Ileri (2013) points out that conflict and controversy frames attract the media hence representation of violence, unpredictability, outrageous and people incapable of taking care of themselves are

themes that attract the media and mental health issues tend to be skewed that way (Ritterfeld & Jin, 2006; Shon & Arrigo, 2006; Adhikari, 2007, Goulden et al., 2011; Birch, 2012). Those issues are considered to hit the threshold of news value as determined by the media gatekeepers while at the same time journalism favors stories that blaze with novelty and drama (Boykoff, 2006).

One of the tenets of social construction theory is that language plays a critical role in socialization “through significant others who mediate the objective reality of society, render it meaningful and in this way, it is internalized by individuals,” says Andrew (2012) as cited in Berger and Luckmann (1996). The media language and representation render meaningful meaning to issues and they influence the way they are internalized. By using words ‘mad, madness, insanity, mwenda wazimu, shrink’, this study exposes that media legitimizes the language used in the public domain in description of those mentally ill, the mental health institutions and personnel serving in those institutions.

This study corroborates with other studies where language has been identified as another key element in media where labelling people with mental health is done in abusive and demeaning way (Adhikari, 2007; Goulden, et al., 2011; Birch, 2012). According to Smith (2007), societies affix labels to stigmatized groups to bring attention to the group’s stigma. Labelling of persons suffering from mental health challenges is one of the most salient stigma communications that exist in most of the health journalists. The labels are ‘mad people, mwenda wazimu, and unstable’ while the terms are also used to describe any anti-social behaviour in the community.

As part of construction, representation has been described as the production of meaning through language. “People and events are correlated with a set of concepts or mental representations which we carry around in our heads. Without them we could not interpret the world meaningfully”(Hall, 1997, p.18). The constructionist approach emphasizes the ability to create realities through language, in its varied forms of presentation, and stimulating a process of continuous creation (Gilban, 2014). It means that when the media uses the word ‘madness’ in description of the mentally ill, it is reinforcing the socio-cultural mental representation of mental health, where ‘madness’ may conjure the image of half dressed, psychotic person out in the streets yet the reality as shown by this study is that mental health challenges cuts across age, social economic status and even professionals, like media personnel, are affected by the same challenges.

A study done by Nyakundi (2015) amongst secondary school students in Nairobi showed that amongst other barriers, the fear of being labelled ‘mwenda wazimu’ or ‘mad person’ was top on the list for not seeking mental health ailments treatment. In its skewed representation, the mainstream media perpetuates the societal beliefs and stigma; and contributes to patients not seeking for medical help. Corroborating with other studies which implicates media in perpetuating stereotypes and promoting stigmatization in the public domain (Wahl, 2001; Ritterfeld & Jin, 2006; Shon and Arrigo, 2006; Adhikari, 2007; Goulden, et al., 2011; Birch, 2012), the Kenyan mainstream media perpetuates stigmatization and legitimizes the stereotypes in the public domain about people with mental health challenges and the institutions and personnel that serve them. As pointed out, it is important for the media to reframe the mental health public debate since media’s choice of words, images and messages can

determine perceptions, attitudes and behaviours amongst its target audience (Inmah, Mukulu, & Muthooka, 2012).

Recent studies continue to indicate the negative effect of negative editorial framing on persons with mental illness. A study carried and published by a Psychiatric bulletin called "*Changing media representations of mental health*", indicates:

...most powerful negative effect is in the area of self-definition and the stigma developed and reinforced by media portrayals... as one interviewee put it, "You see a program and it shows a very bad image of what it feels like yourself and then you think 'what are my neighbors going to think about it'," (Philo, 2014, p. 172).

In the same research another interviewee confessed that as soon as they were told that they were schizophrenic, the thoughts going through their minds were: "*I will never get a job, you'll never get a sick line, and you'll have nowhere to live. It was just going through my head, kill yourself*" (Philo, 2014 p.173). The research respondent attributed their attitude to a movie watched in childhood where one of the characters was an individual suffering from a mental health condition and was running around screaming and shouting.

### **6.2.2. A representation that deviates from the reality**

The mainstream media representation of mental health issues deviates from the 'reality' in the country as perceived by the MH Experts. This study shows that there exists high media representation of mental health issues linked to violence while that is not typically the case. People with mental illnesses are more subjected to violence and they face a lot of danger from their families, community and administration like the police force. Those with mental health challenges are denied access to loans; their income generating enterprises are interfered with; and in some cases, denied job

opportunities and equal remuneration due to the societal stereotypes. In addition, the study showed that mental health issues fail to attract Corporate Social Responsibility (CSR) from corporates like banks because there is a perception that only the few people in the streets suffer from mental health challenges. Corroborating with this study, Kilonzo (2015) mentions that in Kenya those with mental health challenges are subjected to untold violence. She further says that at Luanda Market, in Maseno those suffering from mental illnesses are not only ridiculed but subjected to sexual assault before being fed or clothed and some food vendors ask them to dance in exchange for food. When the mainstream media, which is considered credible in Kenya, perpetuates the societal beliefs, it reinforces those beliefs. In view of that the mental health experts are of the opinion that the media through its representation, endorses the violence subjected to those faced by mental health challenges. Besides being subjected to violence at the family and community level, those with mental health challenges also face violence from the administration police. In line with that Mungai (2013) says that stigmatization in Kenya contributes to the harsh conditions that persons with mental illnesses find themselves in like social exclusion, discrimination, violence, rape, low employment rate, castration, contraction of diseases like HIV/AIDS (Mungai, 2013).

Secondly, media representation is dominated by images portraying outward visible 'abnormal' explicit symptoms of those suffering from mental illnesses, however, the mental health is a 'silent' disease and majority suffer quietly. Only about 2% of those struggling with mental health challenges portray those visible symptoms. The study shows that the media depicts the common perception at the societal level; that it is easy to recognize those suffering from mental illness while majority suffer in silence. The sick or their family member cover up the disease because of the stigma associated

with it while others are ignorant of other ways that mental illnesses manifest themselves like through somatization (physical symptoms linked to mental health challenges). In one of the local Kenyan newspapers, Sunday Nation, Atwoli, who runs a column entitled 'Barometer' warns against a misconception that the "*mentally ill individuals are very easy to identify. It is as if mental illness gets inscribed on the patient's forehead! Most of them suffer in silence without anyone knowing about it,*" (2013, p. 32). The most common mental health illnesses in Kenya are depression, anxiety disorder and somatization (Kiarie, 2014). However, when the mainstream media emphasizes on symptoms that only affect 2% of the population, it creates the impression that mental illnesses affects just a few people while it is linked to witchcraft as shown by this study.

Commenting about media role in constructing reality, Ibroscheva and Ramaprasad (2008) as cited in Bar-Tal (1997) argue that as sources of information, media have the potential to serve as models and legitimize formed stereotypes and institutionalize views about objects. The emphasis of violence and dangerousness frame has the potential to enhance public fear and signify that persons with mental health challenges are people to be avoided at any cost yet this study shows that isolation of such people, worsens their conditions.

A study published in Australia showed that 6 out of 23 schizophrenia patients at a particular clinic had reported carrying a weapon during a psychotic episode; however, the following day the local newspaper ran the story with a headline: "Armed and Dangerous: Public at Risk as Mental Patients Escape the Care Net" (Ferriman, 2003). In May, 2013, patients from Mathari National Teaching & Referral Hospital ran away from the hospital complaining that their medicine did not work. One of the newspaper



headlines about the story that was received with a lot of humor were: “*Police hunt forty mentally ill patients after they break out of hospital in Kenya*”. The word “hunt” gives a connotation of criminals while there was also clear indication that dangerous people were out to harm the civilians and police. In his book, *Mediating Mental Health: Contexts, Debates and Analysis*, Birch (2012) says that “stereotypical meanings derogate and discriminate...these meanings mobilize knowledge content about people with conditions as potential killers, or as part of an outlaw culture,” (p.16).

This study further shows that although underrepresented in comparison to other diseases like cancer, diabetes, HIV/AIDS, there is a high link between mental illnesses and those diseases; either as a primary or secondary disease. Other studies have shown similar correlation like a study entitled, *Common Mental Disorders among HIV-Infected Individuals in South Africa: Prevalence, Predictors, and Validation of Brief Psychiatric Rating Scales*, Myer et al.,(2008), which demonstrated that there are high levels of depression, Post-Traumatic Stress Disorder (PTSD) and alcohol dependence/abuse among HIV-infected individuals. Media representation of mental health is dominated by stories to do with mental illnesses but not mental health which is the whole spectrum and involves causes, prevention, recognition and treatment; including policy issues, as also depicted in other studies (O’Neil, Mikulak, Morgan & Kendall-Taylor, 2009). The lack of media contextual frames fails to show the critical link between mental health and other diseases like cancer, heart disease, diabetes amongst other diseases.

Although the Kenyan mainstream media portrays mental health challenges as illnesses for the poor, mental illnesses in Kenya are not only on increase but affect the middle

and upper urban class. Media workers are also affected with majority accessing the mental health services quietly while others look for other stress coping mechanisms like alcoholism;

*While a few journalists willingly seek psychosocial support, others perceive acceptance of seeking such services as a sign of weakness and they look for other coping mechanisms to deal with their stress but over time they suffer in silence and result in alcohol. Most journalists live pathetic lives especially when they retire from the profession” (Print Health Journalist, Nairobi).*

Like other studies have shown, this study shows that individuals with mental illnesses or their families hardly appear as media’s source of information (Nawkova, Nawka, & Adamkoya, 2011). However, other studies show that when such affected people are accorded opportunities to express themselves, it improves their positive image and accentuates their ability to overcome stigma. However, as much as self-stigma emerged as an inhibition to public disclosure of mental illness, the study also shows that such people suffering from mental illness are good potential sources of information. The media must, however, refrain from using stigmatizing language and terminology.

Limited media voices from those who suffer from mental health challenges in topics that concern them, coupled with depiction as a disease that would not allow one to live a productive live, creates the impression that it is not treatable. Further, the study shows, it is likely to strengthen the policy makers position that mental health is not a priority issue and continues being underfunded.

Unfortunately, people do not think mental illnesses is a major Non-communicable Disease (NCD) yet it is becoming a major killer in the world... their outcome and impact are major to the social, health, economic and politics of a country. Mental health prevention is key but nobody is seeing that reality (Psychiatrist)

Believing that mental illnesses are treatable can encourage mentally ill people to seek early treatment or seek for help, thus resulting into better outcome (Khan, Hassali, Tahir, & Khan, 2011). Consequently, Semetko and Valkenburg (2000) talk of economic consequence frames used by media to report on events, problems or issues reflecting the economic consequences that issues bear on individuals, groups, institutions, region or a country. Although useful in making an issue relevant to the public or policy makers Gamson (1992) as cited in Ireri (2013), shows that the economic consequences frames are rare in media representation of mental health issues. For example, this study shows that depression cost the country a lot of resources and is one of the top ten causes of Daily Adjusted Life Years (DALYS) in Kenya. Corroborating with that, a study done in 2003 by Jose Kirigia, the Regional Adviser for Health Economics at the WHO, reported that Kenya's economic loss associated with the institutionalization of mental health challenges was about Sh. 1.1 billion per year (Okeya & Kilonzo, 2015).

The Kenya Mental Health Policy 2015 – 2030 indicates that if untreated, mental illnesses create an enormous amount of suffering, disability and economic loss. An economic framing would contribute in influencing policy agenda especially in an area that is underfunded like mental health. Kiima and Jenkins (2010) say that unlike the large scale investments in vertical communicable disease programs, limited investments have been made in mental health and it operates under extremely resource-restricted conditions, in terms of infrastructure, manpower and finances.

According to McCombs and Shaw (1972), Frames invite people to think in a certain way so deviation of media from the reality facing mental health in the country, invites the citizen to incorrect information. Muga and Jenkin (2008) point out that the

utilization and improvement of the mental health services in the country is heavily dependent on policymakers and public's views and perceptions about the prevention, recognition and treatment of mental health; and if the media perpetuates and legitimizes the stereotypes in the public domain, it has the potential to contribute to the increase of chronic mental illnesses in the Kenya. This study has already shown avoidance of mental health facilities by the sick due to the stigma associated with hospitals like Mathari National Teaching and Referral Hospital with some of the reasons being the way the mainstream media represents those facilities as institutions that are always in crisis.

Commenting about media and its influence in creating reality amongst its audience, Galbin (2014) differentiates the environment into two; that is, the world out there and the pseudo-environment, with the latter describing the media depictions of the world or social construction of reality. He argues that when constructing a reality of an issue, individuals will have a portion made up from the environment (i.e., direct experience) and a portion made up from the media-environment, as much as the degree to which each of these will influence one's pseudo-environment will depend on the interest, involvement, or salience of the issue or subject to the individual. Further, studies show that in the environment or African communities like Kenya, negative perception about mental health issues still exist that contribute to chronic mental illnesses as people fail to access medical treatment early (Kabiret al., 2004; Abboet al., 2008; Teferra & Shibe, 2012; Auduet al., 2011; Marangu et al., 2015; Kiima & Jenkins, 2015). Further, this study shows how mental illness patients are even discriminated in hospitals and by nurses, and sometimes refused admission. So, if the environment stigmatizes mental health issues; when that stigma is combined

with the pseudo-environment, the chances of media reinforcing the reality out there is high. Ultimately, mental health public education focusing on improving public and policymakers' knowledge on recognition, prevention and treatment may be slow to recognized.

#### **6.2.2.1. Journalists Social & Cultural Orientation and mental health**

Journalists mainly use their cultural lens in their perception of mental health issues, which ultimately influences the representation of those issues. Discussing 'Cultural Health Attributions, Beliefs, and Practices: Effects on Healthcare and Medical Education', Vaughn, Jacquez and Baker (2009) assert that cultural influences on health attributions and beliefs and practices contribute to how illnesses, health, disease, symptoms and treatment are constructed. However, Galbin (2014) argues that the way people understand the world is a product of a historical process of interaction and negotiation between groups of people, which explains journalist's belief as part of historical interaction emerging from their socio-cultural orientation.

This study brings to the fore that Kenyan journalists view 'mental health' as unexplainable phenomenon and the images that come to their mind about a person with mental health challenges is "naked, who does not shower, homeless, collecting papers, violent and hidden in a dark, dingy place. *"When you say mental health the first thing that comes to mind is somebody who is unpredictable. What come to my mind will be madness and all that"* said one of the participants while another one said: *"I imagine someone locked in a dingy place; a dirty person who cannot take care of themselves; or a person who is caged because they are violent. I even fear going close*

*to that person*” while another one said; “*Yes. I mean, it is like hii mambo ya wenda wazimu*” (these mad people).

Mental image is a powerful force influencing how the world is seen. Ibroscheva and Ramaprasad (2008) argue that the mass media have a significant role in providing a cognitive map to the social environment for media audiences. They further share the example of the Palestinians, whom the Western media depicted as terrorists while their intellectual and cultural lives were hardly featured and consequently, they were perceived as violent people. In terms of constructing reality, the media shares more than just information but it “takes elements of culture, magnifies them, frames them and feeds them back to an audience, thus, imposing their logic in creating a symbolic environment” (Ibroscheva & Ramaprasad, 2008, p.4).

Apparently, despite their role of increasing public knowledge, journalists’ perceptions are in line with other Kenyans’ beliefs where “many people believe that mentally ill people are the only ones who are dirty collecting rubbish on the streets and some being locked in houses” (Kinyua & Njagi, 2013). Further this study corroborates a study carried out in Kenya to determine the knowledge, attitude, beliefs and practice of mental illness among staff in general medical facilities, which showed that despite the staff’s knowledge on mental health issues, they still maintained their cultural views of mental illness as worthless, dirty, senseless, dangerous and unpredictable (Ndetei, Khasakhala, Mutiso, & Mbwayo, 2011).

Journalists mental images of mental health influence their framing of mental health messages and SterIbroscheva and Ramaprasad (2008) warn against the role of the media in producing and sharing stories and images with the potential to become

stereotypes. Bearing in mind that stereotypes are mental concepts or pictures in our heads, which govern perception; the Kenyan media reinforces stereotypes about mental health through the representation.

The public's cultural model of mental health encompasses the understanding that mental illness has to be controlled rather than fixed (Ndetei, 2010). The attribution of responsibility where blame and responsibility are bestowed upon the mentally ill and their families came up in the study. That corroborates with other studies which indicate that at the social level people with mental health challenges are made fun of, blamed and criticized for their sickness (Beaudoin, 2007; Kinyua & Njagi, 2013).

In the African traditions, mental health challenges were attributed to either ancestral effect or the evil machinations and the sick were seen as people responsible for their conditions (Nyamongo, 2013). Similarly, in this study journalists perceive mental health challenges as illegitimate diseases where people do not feel pain and they are to blame for it. The causes of mental health challenges are linked to personal or family blame, but not biological and environment causes. Further, such people are not respected and tolerated just like this study shows that journalists are intolerant of those associated with mental health and fail to respect the non-disclosure agreements with such patients. Ultimately, stigma sets and as this study shows an attitude exists even amongst the media workers of 'them' and not within "our circles". Stigmas are built from stereotypes (Smith, 2007, 2011) and stigmas that exist around health conditions, like mental health, are considered as leading barrier to health promotion, treatment, and support (Ma, 2017). "A supernatural view of the origin of mental illness may imply that orthodox medical care would be futile and that help would more likely be obtained from spiritualists and traditional healers" (Abbo, 2008, p.142)

The construction of mental health by the Kenyan journalists is viewed as a dynamic and circular model whereby selective media representations “constantly feed into and are themselves fed by the make-up and character of society” (Hodkinson, 2011, p. 6). As demonstrated by this study, Hodkinson, further argues that media representations hardly exist in isolation, however, depend significantly on their readers and the highly-fluid socio-cultural context. It means that media workers are socialized within communities where stereotypes of mental health are formed; and, unless unlearned, the same stereotypes are likely to be represented in the media regardless of the facts. However, it is key to note that stigma is one of the key factors in under-utilization of existing mental medical services (Mukolo, Heflinger, & Wallston, 2010). Further, such stigma may lead to greater risk for those already sick and may likely impair their self-esteem, help-seeking behaviors, medication adherence and overall recovery (Li, Stanton, Fang & Lin, 2006; Mukolo, Heflinger, & Wallston, 2010).

### **6.2.3. Weak Media Advocacy on mental health issues**

This study shows that weak media advocacy of mental health issues exists and is attributed to a low investment in mental health reporting while the study also shows disjointed media efforts by the stakeholders. Scholars have attempted to understand why the media represent issues in certain ways, however, the part of the reality that media chooses to focus on depends on media routines and pressure of interest groups, organizational pressure and constraints, economic factors, and socio-cultural orientation of media workers, amongst others (Shoemaker & Reese, 1996; Scheufele, 1999; Dimitrova & Strömbäck, 2005; Angel & Kuypers, 2009).



Limited pressure from interest groups contributes to weak advocacy of mental health issues in Kenya. The mainstream media uses the marketing approach in health issues and health stakeholders have to compete amongst themselves in order to gain media attention. Along the same lines, Kozel et al. (2006) point out that competition exists about coverage of health issues due to an undocumented agenda-setting process to gain the attention of media, public, and policy makers. This study shows that the health stories face stiff competition amongst themselves while also competing with politics; and that kind of competition see media playing an advocacy role in some health issues while ignoring others.

Framing of health issues occurs at two levels: one, framing the issue by the pressure groups in order to get better access to the media and secondly, framing the issue for content (Dorfmanetal, 2005; Wallack et al., 2006). However, a gap exists in terms of framing of mental health issues to get better access to the media by the mental health stakeholders in Kenya. For the first level of framing to be effective, the need for strong collaboration between media houses and the stakeholders must be attained, however, that lacks when it comes to mental health. “*We do not know who are behind the mental health initiatives and we have no networks,*” said one of the health journalists who added that he had established several networks with HIV/AIDS, Cancer, Reproductive health networks. Media-mental health stakeholder engagement that would forge partnership to build, foster, and advocate for the public agenda is scarce, however this study shows that such partnerships are initiated by health stakeholders.

Interest groups, also referred to as pressure groups, influence news media representation of issues; however, as noted by Binderkrantz and Christiansen (2011) not all interest groups are successful in their media-directed efforts due to various reasons like lack of resources or actors without high status and power. Corroborating with that, this study shows that the mental health sector lacks powerful pressure/interest groups to advocate for mental health issues both within the media; and for the media to influence policy. To the contrary, the mental health stakeholders push their agenda to the media as single entities; either as individuals or institutions, Further, the different professions within mental health stakeholders have differences that hinder them from having a unified pressure group to collectively influence media advocacy for health issues.

Consequently, there lacks high placed champions like politicians to ‘make noise about mental health’ whom the media would get attracted to. Shoemaker and Reese (1996) say that media content is influenced by the ideology of those in power in society however, this study demonstrated that journalist do not prioritize mental health since it is not prioritized by policy makers and development partners. This study shows that another way to attract the media in view of media advocacy is to position public figures health disclosures and celebrity advocacy (Brockington & Henson, 2014). It emerged that two Kenyan politicians, Beth Mugo and Anyang’ Nyong’o; aided the cancer campaign by disclosing their cancer status, which resulted in increased and balanced media representation of cancer, which ultimately led to favorable policies.

Speaking in a First Ladies meeting in 2015, the former Health Minister (Mugo, as cited in Muchangi, 2015), confessed how she desperately struggled to hide news of her cancer diagnosis from the media; however, she reported that the public disclosure

reduced stigma in the society. Mugo was the second public figure, after the former Medical Services Minister Prof. Anyang Nyong'o, to make their cancer diagnosis public. The study shows that such declaration from public figures and celebrities, which lack in the mental health sector, attract the media and they set an agenda around an issue, which leads to public and policy agenda setting (Kozel et al., 2006). Celebrity advocacy emerged as a strategy that leads to adoption of certain health prevention behaviors but also attracts media agenda because of their capacity to attract audiences. "Celebrities can serve as agents of positive social change, erasing stigma associated with disease and prompting information-seeking and preventive behaviors," says Hoffman et al. (2017, p.1).

Journalists capacity building is critical bearing in mind that most health journalists are not trained in their area of specialty but learn it on the job. Consequently, this study shows that capacity building of journalists in mental health issues reduces stigma and misunderstanding of mental health as evidenced by the report of the only health print reporter who had received training in mental health. Further, she plays the role of an internal champion, which has increased representation of mental health issues in the newspapers she has worked for. Capacity building of journalists who lack skills in technical writing is fundamental when it comes to mental health reporting. Further, unlike in the West, health journalists are not trained in their area of specialty but learn it on the job, and also benefit from health training that come their way. However, mental health stakeholder's failure to invest in capacity building leaves journalists with little knowledge of terminologies to use and they engage in a 'trial and error' reporting. The role of capacity building is demonstrated by the outstanding knowledge

that the trained health journalist portrayed as compared to the other journalists and editors.

Attainment of mental health database and organization of media tours and round table meetings with editors is critical in shaping media advocacy while it is important to note that media budget to cover journalistic logistical costs must be put into consideration. Health issues receive little attention from media houses and the relevant stakeholders must have media budgets as a critical part of their media strategy to see positive results. This study concurred with other studies that show that the Kenyan media is profit driven and uses a market approach in its messaging where audiences are given what they want for commercial purposes even when these are health issues (Oriare, Okello-Orlale, & Ugangu, 2010). However, it was imperative to note that when health stakeholders package or frame issues in a way that attracts the media, the Kenyan media embrace the social responsibility approach and “*give their audiences what they need rather than what they want*” as one TV reporter who had been involved in HIV/AIDS media advocacy mentioned.

As other studies have shown, the findings of this study demonstrated the need for mental health professionals having a closer relationship with journalists and a better appreciation of media priorities and practices, and ultimately such an approach yields positive effect on how media represent mental health issues (Nairn, 2009). But on the other hand, this study showed that mental health stakeholders were operating in one of the most underfunded subsectors yet they were faced with major mental health crises. Although WHO (2010) equated depression to Malaria in terms of affecting Africa and low-income countries population, it also emerged that depression was hardly acknowledged nor funded.

#### **6.2.4. Lack of Health reporting policies and impact to mental health representation**

Lack of media health reporting policies and guidelines influence the way health issues like mental health are represented by the media. Although this study shows that such policies and guidelines are being considered for development and implementation, none are in existent at the moment. Being the custodian of health, this study shows the need for the mainstream media to develop health reporting policies as a guideline on terminologies to use in health reporting and the kind of images to use.

Although the study shows that editors face the dilemma of balancing viable news and the ‘awareness bit’- the public education of health and other issues - it emerged that the ‘economy of words’ principle influence the media content. Describing mass media as a channel of few words, the study reveals a conflict that exists between health reporters and editors in terms of ethically sounding language in reference to the sick. Whereas some health reporters view terms like the ‘mentally ill’ and ‘madness’ stigmatizing and opted for terms like ‘persons with mental illness’ or ‘person with albinism’; editors perceived those terms as ‘NGO’ language, which lack sensational aspect in media reporting.

Link and Phelan (2001) as quoted in Smith (2015) note that in discussion of illnesses, they can be discussed as either conditions or labels.

*For example, syntactically, the statement “John has schizophrenia” signals that schizophrenia is separate from the person and is a condition that could happen to anyone; as opposed to “I saw a schizophrenic in town today”; which applies a label and suggests that John is a member of a category of people called “schizophrenics,” who are different from most people in the society (p.7).*

Along the same lines, media images disclosing details of patients are questioned. For example, this study shows that the former female box health status was disclosed by the media because she was suffering from ‘weird mental illness’; however, if she suffered from another disease, health status disclosure was going to be absent. Further, some images called as ‘Luanda images’ emerged as discriminatory for those suffering from mental illnesses hence the need for health policy. Luanda is based in Western Kenya and it is associated with high rate of mental illness. In 2013, one of the Kenya dailies had this headline: “Each market has its own mad man but Luanda has one too many” (Lungai, 2013). Just like the media has policy on different issues, this research shows the need for health reporting policy.

### **6.3. Conclusions**

This study sought to examine how the mainstream media in Kenya represents mental health issues. Specifically, the study sought to answer the following questions; What are the perceptions of health journalists and mental health experts towards the way the mainstream media in Kenya represent mental health issues? What is the reality facing the mental health issues in Kenya as perceived by mental health experts? What informs the way mental health issues are represented by the media?

Using a multiple case study, I held interviews with 13 health journalists and 8 mental health experts and used direct observation to supplement the interview data, which I analyzed and presented thematically.

Overall, the study reveals that skewed representation of mental health exists in the Kenyan mainstream media. Although there is increased representation, mental health issues are still given low priority in the mainstream media and they are skewed towards the ‘mentally ill’ who can be easily be identified and who are linked to violence while at the same time it is portrayed as a disease for the poor. However, the media representation deviates from the reality faced in the mental health sector, which shows that people with mental illnesses are more subjected to violence while at the same time mental health challenges in Kenya are faced by all classes of people regardless of the age and education.

Although hardly featured in the media, success stories of people with mental health challenges living productive lives upon treatment, hardly feature in the mainstream media. But to bridge the gap between the mainstream media representation and the reality facing the mental health sector, media advocacy needs to be prioritized. However, for a successful media advocacy to be actualized, capacity building of journalists in mental health reporting is important to address the cultural and social construction of mental health issues. Media health policy needs to be developed and implemented. Key champions constituting of politicians, celebrities and internal champions within the media need to be identified to lead in the lobbying for mental health issues. The critical need for media advocacy is informed by the dire need for public education and the need for current mental health policies, including pursuing funding for the underfunded mental health subsector in Kenya.

### **6.3.1. Contributions of this study**

This study contributes to the body of research on media representation of health issues especially the stigmatized and less understood illnesses. It responds to the need of mental stakeholders' discourse on how the media can be strategically used to demystify mental health issues and increase public education with a view of prevention and more people seeking professional services like the psychiatric and counseling interventions.

Secondly, the study highlights the challenges that are encountered in pursuit of balanced representation of mental health issues and offers suggestion to mental health stakeholders on how they can collaborate with the Kenyan media while at the same time providing insights to media practitioners on how their representation of mental health deviates from the situation on the ground.

Thirdly, most studies on media representation of mental health have focused on content analysis, mainly using the quantitative approach but this study is qualitative in nature and is based on perceptions of the health journalists who have interest in health matters and also mental health experts who are critical stakeholder in mental health issues. This study brings out perspectives of the insiders of mental health issues and their representation in the mainstream media.

Finally, this study contributes to the body of knowledge by highlighting how the mainstream media in Kenya represents mental health issues and how that representation compares with the situation faced in the sector. From a framing theory point of view, the study adds knowledge that shows that episodic, sensational,



conflict/controversy conflict dominate mainstream media representation of mental health issues while thematic and contextual frames are underutilized. Although sensational framing hinders promotion of health issues, this study contributes to the body of knowledge by showing that there are times when sensational frame (or media scandal) propels policy makers to act on health issues. However, in the least understood mental health, characterized with stereotypes, thematic and contextual frames need to be incorporated in media representation to depict the whole spectrum of mental health from causes, prevention, diagnosis, treatment and intervention.

### **6.3.2. Implications for policy and practice**

This study sought to shed light on the status of mainstream media representation of mental health in Kenya with the aim of providing an account of how media represents mental health issues and what can be done for the media to engage in public education and advocacy of mental health issues. I would like to end by highlighting the possible implications of the study for policy makers and media practitioners – what may be needed to improve mainstream media representation of mental health issues in Kenya. These implications arise from what I have identified in my analysis as possible constraints that influence how the media represents mental health issues in Kenya.

#### **6.3.2.1. Capacity building for health journalists as media custodians of health issues**

With the realization that there lacks specialized journalism training in Kenya, to see balanced representation of mental health, journalists; starting with health journalists need to be trained and exposed to mental health issues. A need exists for stakeholders, like universities and colleges to include health reporting in their curricula and develop

short courses on health reporting, with emphasis on reporting on illnesses like mental health challenges, affecting huge segments of population. This will ensure that when students graduate, they have technical writing skills.

#### **6.3.2.2.Unified mental health stakeholders to form strong collaborations with media houses**

There is need for mental health stakeholders to be united in their collaboration with the media stakeholders for effective pitching of mental health issues. At the same time the mental health stakeholders need to be at the forefront in leading that collaboration while ensuring that the threshold of media advocacy is met like identifying key politicians and celebrities who take the role of mental health brand ambassadors.

#### **6.3.2.3.Media Health Reporting policy**

There's a need for health reporting policies in media houses which will govern ethical issues while ensuring there are guiding principles on several issues like the type of language or terminologies in reference to the sick and their institutions and the depiction of images of the ill.

#### **6.3.2.4.Funding for mental health**

With the increase of mental health challenges, there is need for policy makers to increase the funding of mental health especially given the dire needed public education. Policy makers interest and prioritization of mental health, will see development agencies fund the area. That kind of funding will propel media advocacy and ultimately contribute to better mental health outcomes.

### **6.3.2.5. Diversification of channels of mental health public education**

The rise of social media and the high consumption of the same need to be considered by mental health educators as this study shows, the need to consider blogging and other social media channels and taking advantage of journalist's social networking and forums.

### **6.3.3. My Thesis**

Therefore, my Thesis is that although in Sub-Saharan Africa media has been recognized as a critical partner in public education of mental health and influence of policy, it is imperative that Kenyan journalists are trained in mental health and reporting of the same in view of having a balanced representation of mental health issues in the mainstream media.

## **6.4. Further Research**

1. Social media representation of mental health because this study shows that some mainstream journalists follow mental health discourse on social media
2. Perception of mental health patients towards the way the Kenyan media represent mental health issues
3. Investigation on how specific mental health illnesses like depression, schizophrenia, personality disorder, substance abuse disorders are represented by the mainstream media in Kenya.

## REFERENCES

- Abbo, C., Ekblad, S., Waako, P., Okello E., Muhwezi W., and Musisi, S. (2008) Psychological distress and Associated Factors among the Attendees of Traditional Healing Practices in Jinja and Iganga districts, Eastern Uganda: A Cross-sectional Study. *International Journal of Health Systems*,2(16), DOI: 10.1186/1752-4458-2-16.
- Abbo, C., Okello, E., Ekblad, S., Waako, P. & Musisi.S. (2008). Lay concepts of psychosis in Busoga, Eastern Uganda: A pilot study. *Journal of World Association of Cultural Psychiatry*:132-145
- Adamkova, L., Nawka, A., & Adamkova, T. (2012).The picture of mental health/illness in the printed media in three central European countries.*J Health Communication*, 17(1):22-40. doi: 10.1080/10810730.2011.571341.
- Ahmed, R. and Bates, B. (Eds).(2013). *Health Communication and Mass Media.An Integrated Approach to Policy and Practice*. Surrey, UK. Gower Publishing Ltd.
- Alshenqeeti, H. (2014). Interviewing as a Data Collection Method: A Critical Review.*English Linguistics Research*, 3 (1). doi:10.5430/elr.v3n1p39
- Allern, S. (2004).*The Construction of Frames in News Journalism*.University of Oslo/Volda University Lecture Notes
- Allison, D., & Wallace, S. (2007).*Media Studies:Key Concepts by Steve Baker Adapted for Sandringham by edition*.<http://www.adamranson.plus.com/Representation.pdf>
- Andersen, J., Wylie, L.& Brank, E. (2017). Public health framing and attribution: Analysis of the first lady's remarks and news coverage on childhood obesity. *Cogent Social Sciences*,3: 1268748,doi.org/10.1080/23311886.2016.1268748
- Amineh, J.&Davatgari, H. (2015).Review of Constructivism and Social Constructivism; *Journal of Social Sciences, Literature and Languages*.1(1), 9-16.
- Atilola, O. (2016). Mental Health service utilization in sub-Saharan Africa: is public mental health literacy the problem? Setting the Perspectives right. *Global Health Promotion*, 23 (2), doi.org/10.1177/17579759145867179
- Audu, I., Idris, S., Olisah, V. & Sheikh, T.(2013).*Stigmatization of people with mental illnesses among inhabitants of Rural Community in Northern Nigeria*,59,55-60
- Background Information (2013).*A Guide for Reporting on Mental Illness*.[www.mentalhealthreporting.org](http://www.mentalhealthreporting.org)
- Baxter, P. &Jack, S. (2008). Qualitative Case Study Methodology: Study Design and Implementation for Novice Researchers. *The Qualitative Report* 13(4),544-559.

- Beachum, L. (2010). The psychopathology of Cinema: How mental Illness and Psychotherapy Are Portrayed in Film. *Honors Projects*, 56. <https://scholarworks.gvsu.edu/cgi/viewcontent.cgi?article>
- Benjamin, D. (2007). *Episodic and Thematic Framing*. Frameworks Institute <http://www.frameworkinstitute.org>
- Ben-Zeev, D., Young M., & Corrigan P. (2010). DSM-V and the Stigma of Mental Illness. *Journal of Mental Health*, 19(4), 318-327.
- Berger, P. & Luckmann, T. (1991). *The Social Construction of Reality* (e-books). Clays Ltd., England.
- Binderkrantz A., & Christiansen P. (2011). *Making it to the News: Interest groups in the media* <http://www.interarena.dk>
- Birch, M. (2012). *Mediating Mental Health: Contexts, Debates and Analysis*. Ashgate Publishing Limited, England (e-book) Retrieved August 8, 2014 from [books.google.co.ke](http://books.google.co.ke)
- Bowen, G. (2009). Document Analysis as a Qualitative Research Method. *Qualitative Research Journal*, 9 (2), pp. 27-40. DOI 10.3316/QRJ0902027.
- Brokington, D., & Henson S. (2014). Signifying the Public Celebrity: Celebrity Advocacy and Post Democratic Politics. *International Journal of Cultural Studies*, 18(4), 431-448.
- Bryant, J., & Zillmann, D. (2008). *Media Effects: Advances in Theory and Research*. Lawrence Erlbaum Associates, Inc., Publishers: New Jersey, NJ.
- Brunner, W., Fowlie, K., Freestone, J. (2011). Using Media to Advance Public Health Agendas. Article sponsored by Contra Costa Health Services (CCHS). [https://cchealth.org/healthservices/pdf/media\\_paper.pdf](https://cchealth.org/healthservices/pdf/media_paper.pdf)
- Carter, S. & Little, M. (2007). Justifying Knowledge, Justifying Method, Taking Action: Epistemologies, Methodologies, and Methods in Qualitative Research. *Qualitative Health Research* 17(10):1316-28; DOI: 10.1177/1049732307306927
- Chong, D. & Druckman, J. (2007) Theory of Framing and Opinion Formation in Competitive Elite Environments. *Journal of Communication*, 0021-9966, doi:10.1111/j.1460-2466.2006.00331.x
- Claire Hooker, C. & Pols, H. (2006). Health, Medicine and the Media, *Health and History* 8 (2), pp. 1-13; DOI: 10.2307/40111540
- Clarke, V. and Braun, V. (2013) Teaching thematic analysis: Overcoming challenges and developing strategies for effective learning. *The Psychologist*, 26 (2). pp. 120-123. 0952-8229
- Charlotte H., & Robert, M. (2005). Vygotsky's philosophy: Constructivism and its criticisms examined. *International Educational Journal*, 6(3), 386-399.

- Clement, S., & Foster, N. (2008). Newspaper reporting on schizophrenia: a content analysis of five national newspapers at two time points. *Schizophrenia Research*, 98(1-3), 178-183.
- Coppock V., & Dunn B. (2010). *Understanding Social Work Practice in Mental Health*. Sage Publications Ltd: London. England.
- Corrigan, P., & Watson, A. (2004). *Stop the Stigma: Call Mental Illness a Brain Disease*. *Schizophrenia Bulletin*, 30(3).  
<http://schizophreniabulletin.oxfordjournals.org/content/30/3/477.full.pdf>
- Coyne I. (1997). Sampling in qualitative research: Purposeful and theoretical sampling; merging or clear boundaries. *Journal of Advanced Nursing*, 26, 623-630.
- Creswell, J. (2014). *Research Design Qualitative, Quantitative, and Mixed Methods Approaches* (4<sup>th</sup>ed.). Los Angeles, Sage Publications Ltd.
- Dinos, S., Stevens, S., Serfaty, M., Weich, S. & King, M. (2004). Stigma: the feelings and experiences of 46 people with mental illness: Qualitative study: *The British Journal of Psychiatry*, 184(2), 176-181.  
<https://doi.org/10.1192/bjp.184.2.176>
- Dorfman, L., & Kransnow, I. (2014). Public Health and Media Advocacy. *Annu Rev Public Health*, 35, 293-306. 10.1146/annurev-publhealth-032013-182503
- Edney, D. (2004). Mass media and mental illness. *A literature Review-Canadian Mental Health Association*. [www.ontario.cmha.ca](http://www.ontario.cmha.ca)
- El-Jardali, F., Karroum, L., Kdouh, L., El-Sayed F., Rachidi, H., Makki, M. (2015) Health Reporting in Print Media in Lebanon: Evidence, Quality and Role in Informing Policymaking PLoS ONE 10(8): e0136435. doi.org/10.1371/journal.pone.0136435
- Entman, R. (1993). Framing: Toward clarification of a fractured paradigm. *Journal of Communication*, 43 (4); ABI/INFORM Global
- Fiske, J. (1987). *Television Culture*. Routledge: London, England.
- Foerschner, A. M. (2010). The history of mental illness: from "skull drills" to "happy pills". *Journal of Psychiatry*, 2(9), 1-4.
- Francis, C., Pirkis, J., Blood, R.W., Dunt, D., Burgess, P., Morley, B., Stewart, A. & Putnis, P. (2004). The portrayal of mental health and illness in Australian non-fiction media. *Australian and New Zealand Journal of Psychiatry*, 38, 541-546. DOI: 10.1080/j.1440-1614.2004.01407.x
- Fursich, E. (2010) Media and the representation of Others. *International Social Science Journal*, 61 (199), <https://doi.org/10.1111/j.1468-2451.2010.01751.x>

- Galbin, A. (2014). An Introduction to Social Constructionism. Social Research Reports: 2066-6861 (print), 2067-5941 (electronic). Retrieved, October 13, 2015 from <https://www.researchgate.net/publication/283547838>
- Gathura, G. (2013, August 29). *Broken homes raise suicide levels among the youth*: Standard Newspaper.
- Gerbner, G., Gross, L., Morgan, M., & Signorielli, N. (1986). *Living with television: The dynamics of the cultivation process*. In J. Bryant & D. Zillmann (Eds.), *Perspectives on media effects*, Hillsdale, NJ: Lawrence Erlbaum.
- Girma, E., Tesfaye, M., Froeschl, G., Leimkühler, A., Dehning S. & Muller, N. (2013). Facility based cross-sectional study of self-stigma among people with mental illness: towards patient empowerment approach *International Journal of Mental Health Systems*, ISSN: 1752-4458
- Goulden, R., Corker, E., Evans-Lackio, S., Rose, D., Thornicroft, G., & Henderson, C. (2011). Newspaper coverage of mental illness in the UK, 1992-2008. *BMC Public Health*, 11(796), 1-8.
- Happer, C. & Philo, G. (2013). The Role of the Media in the Construction of Public Belief and Social Change. *Journal of Social and Political Psychology*, 1 (1). doi:10.5964/jspp.v1i1.96
- Hall, S. (1997). *Representation: Cultural Representations and Signifying Practices*. Sage Publications Ltd. California
- Hanusch, F. (2013). Cultural Forces in Journalism; the Impact of Cultural Values on Maori Journalists Professional Views. *Journalism Studies*, 1469-9699, doi:10.1080/1461670X.2013.859864
- Hawkins R., & Pingree, S. (1990). *Divergent psychological processes in constructing social reality from mass media content*. Newbury park CA Sage: California, USA.
- Hsieh H., & Shannon S. (2005). Three Approaches to Qualitative Content Analysis. *Qualitative Health Research*. Sage Journals. doi.org/10.1177/1049732305276687
- Ibrahim, M., & Morrow, M. (2015). Weaning off Colonial Psychiatry in Kenya *Journal of Ethics in Mental Health* 1, 1916-2405.
- Ibrahim, M. (2014) Mental Health in Kenya. *Disability and the Global South*, 1(2), 393-400.
- Ibroscheva, E & Ramaprasad, J. (2008). A social construction model of stereotypes of foreigners. *Journal of Intercultural Communication*, 1404-1634 (16).
- Interlandi, J. (2012, June 24). A madman in our midst. *The New York Times*.

- International Institute for legislative affairs (2011) Mental Health in Kenya: Unpacking the Issues. *Legislative Digest*, 2
- Ileri, K. (2013). A study of newspaper Columnist's Framing of Kenyan Politics in Post 2007 Election Violence. *Ecquid Novi: African Journalism Studies*, 34(2), 109-127.
- Jennings B., Dolf, Z. & Oliver, M. (Eds.) (2008). *Media Effects: Advances in Theory and Research* (2<sup>nd</sup> Ed). (e-book). Mahwah, New Jersey.
- Joanna, E. M., Sale., Lynne, H. L., & Kevin (2002). Revisiting the Quantitative-Qualitative Debate: Implications for Mixed-Methods Research, *Quality & Quantity* 36, 43-53.
- Jorm. A. F. (2000). Mental health literacy: Public knowledge and beliefs about mental disorders. *The British Journal of Psychiatry*, 177(396), Doi: 10.1192/bjp.177.5.396
- Jorm A., Barney L., Christensen H., Highet, J., Kelly, C., & Kitchener B. (2006). Research on mental health literacy: what we know and what we still need to know. *Aust N Z J Psychiatry*, 40, 3-5.
- Jorm A., Korten A., Jacomb P., Christensen H., Rodgers B. & Pollitt, P. (1997) "Mental health literacy"; a survey of the public's ability to recognize mental disorders and their beliefs about the effectiveness of treatment. *Med J Aust*, 166, 182-186.
- Jwan, J. & Ong'ondo, C. (2011) *Qualitative Research: An Introduction to Principles and Techniques*. Moi University Press, Eldoret.
- Kaberia, G. (2015, February, 24). Let's treat the mentally ill as patients and stop thinking they are criminals. *The Daily Nation*, 15
- Kabir M., Iliyasu Z., Abubakar I. & Aliyu, M. (2004). Perception and beliefs about mental illness among adults in Karfi Village, North Nigeria; *BMC International Health and Human Rights* 4, 3(2004).
- Kakuma, R., Kleintjes, S., Lund, C., Drew, N., Green, A., & Flisher, A. (2010). Mental Health Stigma: What is being done to raise awareness and reduce stigma in South Africa? *African Journal of Psychiatry*, 78(2), 42-48.
- Kakuma, R., Kleintjes, S., Lund, C., Drew, N., Green, A., & Flisher, A. (2010). Mental Health Stigma: What is being done to raise awareness and reduce stigma in South Africa? *African Journal of Psychiatry*, 78(2), 42-48.
- Kariuki, T. (2015, January, 30). High Court Releases a man who killed his father. *The Daily Nation*, p. 3.
- Kenez S.; O'Halloran, P.; & Liamputtong, P. (2015). The portrayal of mental health in Australian daily newspapers. *Australian and New Zealand Journal of Public Health* 513, 39(6).



- Kiarie, J. (2014, April, 15). Million Kenyans Suffer Mental Disorders as Harsh Life Pushes Them over the Cliff. *Standard Newspaper*, p.14
- Kilonzo, E. (2015, February, 24). Abandoned and neglected, Kenya's mentally ill suffer in bitter silence. *The Daily Nation*, p. 13
- Kimotho, S., Miller, A., & Ngure P. (2015) Managing Communication Surrounding Tungiasis in Kenya, *Communication*, 41(4), 523-542.
- Kimura, J. (2015, July, 6). How do we get rid of terrible 'madness' that has taken our society hostage? *The Daily Nation*, p.15
- Kigozi, F., Kizaa, D., Ssebunnya, J. & Ndyabangi, S. Media and Mental Health in Uganda. *African Journal of Psychiatry* 13(2):125-7. DOI: 10.4314/ajpsy.v13i2.54358
- Kiima, D. & Jenkins, R. (2010). Mental health policy in Kenya -an integrated approach to scaling up equitable care for poor populations. *International Journal of Mental Health Systems*. 4:19, <https://doi.org/10.1186/1752-4458-4-19>
- Knapp, M., Beecham, J., McDaid, D., Matosevic, T., & Smith, M. (2011). The economic consequences of deinstitutionalization of mental health services: lessons from a systematic review of European experience. *Health and Social Care in the Community*, 19(2), 113-125.
- Kobau, R., Seligman, M., Peterson, C., Zack, M., Chapman, D., & Thompson, W. (2011). Mental Health Promotion in Public Health: Perspectives and Strategies from Positive Psychology. *Am J Public Health*. 101(8): e1-e9. doi: 10.2105/AJPH.2010.300083
- Kothari, C. (2013). *Research Methodology Methods and Techniques* (2<sup>nd</sup> revised edition). New Age Techno Press, New Delhi.
- Kozel C., Kane W., Hatcher M., H. A., Dearing J., Foster-cox S., Thompson S., Perez F. & Goodman M. (2006). Introducing Health Promotion Agenda Setting for Health Education Practitioners. *Californian Journal of Health Promotion*, 4(1), 32-40.
- Lamb, H., & Weinberger, L. (2005). The shift of psychiatric inpatient care from hospitals to jails and prisons. *Journal of American Academy Psychiatry Law*, 33, 529-534.
- Lauber, C., Nordt, C., Falcató L, & Rössler W. (2003). Do people recognize mental illness? Factors influencing mental health literacy. *Eur Arch Psychiatry ClinNeurosci*, 253, 248-251
- Leonard, I. (2007). The Watchdog Role of the Media - Media as the Fourth Estate. *Rrezan Journal*. <http://rrezja.blogspot.com/2007/01/watchdog-role-of-media.html>
- Leupo, K. (2010). The history of mental illness. *Journal of Psychiatry*, 2(9), 1-4.

- Lincoln, Y. (2010). *History of Qualitative Research* www.qix.sagepub.com
- Litchman, M. (2014) *Qualitative Research for the Social Sciences*. London: Sage
- Littlejohn, S. W., & Foss, K. A. (2008). *Theories of Human Communication* http://books.google.co.ke/books
- Lyons, C. (2000). Examining media representations: benefits for health psychology. *J Health Psychol.* 5(3):349-58. doi: 10.1177/135910530000500307.
- Marangu E, Sands N, Rolley J, Ndeti D, Mansouri F. (2014). Mental healthcare in Care Fam Med. 6(1), doi.org/10.4102/phcfm.v6i1.682
- Maxwell, J. (2008). Designing a Qualitative Study. *Applied Research Designs*, 214-253.
- Maxwell, J. (2012). Qualitative Research Design: An Interactive Approach. *Applied Research Designs*. 214-250 https://www.researchgate.net/profile
- McGorry, P. (2005). "Every me and every you": responding to the hidden challenge of mental illness in Australia. *Austr Psychiatry*, 13, 3-15.
- Mental health Global Action Programme. (2002). *Close the Gap, Dare to Care*; Copyright World Health Organization. from http://www.who.int/mental\_health/media/en/265.pdf
- Minkler, M. (2012). *Community Organizing and Community Building for Health*. Edited by Meredith, http://books.google.co.ke/books
- Mooney, D. (2013). The Journal Read, Share and Shape the news: Does Hollywood's portrayal of mental illness help or hinder awareness. http://www.thejournal.
- Mogambi, H., Kiai, W., & Ndati, N. (2013) Priming HIV Messages in Kenyan Print Media: Patterns, Trends, and Issues. Sage Open, DOI: 10.1177/2158244013504935, sgo.sagepub.co
- Muga, F. & Jenkins, R. (2010). Health care models guiding mental health policy in Kenya 1965 – 1997. *International Journal of Mental Health Systems*. 4:9 doi.org/10.1186/1752-4458-4-9
- Muga, F. & Jenkins, R. (2008). Public perceptions, explanatory models and service utilization regarding mental illness and mental health care in Kenya. *Social Psychiatry and Psychiatric Epidemiology*: 43:469
- Myers, D. G. (2007). *Psychology* (8th ed.). New York, NY: Worth Publishers.
- National Union of Journalist (2015). *The Reporting of Mental Health and Suicide by the Media; a Practical Guide for Journalists*. from www.nuj.org.uk

- Naveena, N. (2015). Importance of Mass Media in Communicating Health Messages: An Analysis. *Journal of Humanities and Social Science (IOSR-JHSS)*, 20(2), pp 36-41: 2279-0837
- Nyakundi, A. (2015). The Impact of Communication Campaigns on Mental Health Behaviour among Secondary School Students in Nairobi County.(Doctoral Dissertation, Jomo Kenyatta University of Agriculture and Technology, Nairobi, Kenya).<http://ir.jkuat.ac.ke/handle/123456789/1755>
- Ndetei, D., Khasakhala L., Mutiso, V. & Mbwayo, (2011). A. Knowledge, attitude and practice (KAP) of mental illness among staff in general medical facilities in Kenya: practice and policy implications. *African Journal of Psychiatry*, 14:225-235
- Onwuegbuzie, A., & Leech, N. (2007). Sampling Designs in Qualitative research: Making the Sampling Process More Public. *The Qualitative Report*,12(2), 238-254.
- Organization, W. (2011, October). *Mental health: a state of well-being*.  
www.who.int: [http://www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/)
- Oriare, P., Ugangu, W., Okello-Orale R.(2010). The Media We Want: The Kenya Media Vulnerabilities Study. Nairobi: Friedrich Ebert Stiftung (FES).
- Osborne, H. (2013). *Health Literacy from A to Z: Practical Ways to Communicate Your Health Messages*, (2<sup>nd</sup>ed.). <http://books.google.co.ke/books>
- Parker, J., & Thorson, E. (2009).*Health Communication the New Media Landscape*.New York, NY: Springer Publishing Company.<http://books.google.co.ke/books>
- Paykel, E., Hart D., & Priest R. (1998). Changes in public attitudes to depression during the defeat depression campaign.*British Journal Psychiatry*, 173, 519–522.
- Peter, B.,& Thomas L. (1966).*The social construction of reality, a treatise in the sociology of knowledge*. New York, NY: Garden City.
- Pfister,R. (2014) Teenagers’ media consumption and Perception of Mental Illness (Masters’ thesis. Moi University
- Republic of Kenya (2007). Media Act, *Kenya Gazette supplement*. Nairobi, Kenya: Government Press.
- Ritchie, J.,&Lewis, J. (Eds) (2003). *Qualitative Research Practice; A Guide for Social Science Students and Researchers*. London, England: Sage Publications.
- Robin, L.,Nabi.,&Mary, B. O. (Eds). (2009).*The SAGE Handbook of Media Processes and Effects*<http://books.google.co.ke>

- Saraf, R. & Balamurugan, J. (2018). The Role of Mass Media in Health Care Development: A Review Article. *Journal of Advanced Research in Journalism and Mass Communication*, 5 (1&2): 39-43.
- Seale, C. (2003). Health and media: an overview. *Sociology of Health & Illness*, 25 (6) 0141–9889, pp. 513–531
- Schiavo, R. (2007). *Health Communication: From Theory to Practice*. (e-book). Jossey-Bass, San Francisco
- Schuck, A., and Vrees, C. (2006). Between Risk and Opportunity; News Framing and its Effects on Public Support for EU Enlargement. *European Journal of Communication*, 21(5).
- Shakeel, M. (2013). The role of media on today's world. *Society and Culture*, 67(2). .
- Sharma, S. & Gupta, Y. (2017). Mass Media for Health Education (A study in the state of Rajasthan). *Multidisciplinary International Journal*. DOI. www.globalresearchacademy.uk
- Shenton, A. (2004). Strategies for Ensuring Trustworthiness in Qualitative Research Projects. *Education for Information*, 2, 63-75
- Sheufele, D. (1999) Framing as a Theory of Media Effects; *Journal of Communication*, 49(1), 103-122.
- Shoemaker, P., & Reese, S. (1996). *Mediating the Message: Theories of Influences on Mass Media Content*, (2<sup>nd</sup> ed.). USA: Longman Publishers.
- Smith, B. (2015). Mental illness Stigma in the Media. *The Review: A journal of undergraduate Student Research*. 16, 50-63.
- Somasundaram, O. (2013). Literary de-stigmatization of mental illness: A study of the writings of Jayakanthan. *Indian Journal of psychiatry*, 55, 295-299.
- Stephen, W., & Karen, A. (2008). *Theories of Human Communication* <http://books.google.co.ke>
- Stake, R.E. (2014) *Case Study Research: Design and Methods* 5ed. California: Sage Publications
- Stake, R. E. (2005). Qualitative case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *The Sage handbook of qualitative research* (3 ed.). Thousand Oak, CA: Sage Publications.
- Stuart H. (Ed) (1997). *Representation: Cultural Representations and signifying Practices*. London, England, Sage Publications.

- Teddlie, C., & Yu, F. (2007). Mixed Methods Sampling. *Journal of Mixed Methods Research*, 1, 77.
- Tefarra, 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 (2012)
- Thompson A, Hunt C, & Issakidis C. (2004). Why wait? Reasons for delay and prompts to seek help for mental health problems in an Australian clinical sample. *Soc Psychiatry Epidemiol*, 39, 810–817.
- Today, M. (2013, March 7). What is mental health? What is mental disorder? *Medical News Today* .
- Tom, A. (2012). What is Social Constructionism? *The Grounded Theory Review*, 11(1), 39 University College Cork.
- Vaughan, M. (1991). *Curing Their Ills: Colonial Power and African Illness*. Cambridge: Polity Press.
- Vaughn, L., Jacquez, F. & Baker R. (2009). Cultural Health Attributions, Beliefs and Practices: Effects on Healthcare and Medical Education. *The Open Medical Education Journal* 2, 64-74.
- Ventevogel, P., Jordans, M., Reis R and Jong, J. (2013); Madness or sadness? Local concepts of mental illness in four conflict-affected African communities: *Conflict and Health*, 7:3, doi: 10.1186/1752-1505-7-3
- Vreese, C. H. (2005). News Framing: Theory and Typology. *Information design journal+ Document design*, 13(1), 51-62.
- Wahl, O. (2003.) News Media Portrayal of Mental Illness; implications for Public Policy *American Behavioral Scientist*, 46.
- Wallack, L., & Dorfman, L. (1996). *Media Advocacy: A Strategy for Advancing Policy and Promoting Health*. <http://heb.sagepub.com/content/23/3/293.short>
- Weber, S. (2002). *Media and the Construction of Reality*. from [www.mediamanual.at](http://www.mediamanual.at).
- Wells, J., Robins, L., Bushnell J., & Jarosz, D. (1994). Perceived barriers to care in St Louis (USA) and Christchurch (NZ): Reasons for not Seeking Professional Help for Psychological Distress. *Social Psychiatry Epidemiol*, 29, 155–164.
- William A., Gamson, D., William H., & Theodore S. (1992). Media Images and the Social Construction of Reality. *Annual Review of Sociology*, 18, 373-393.
- Wilson, C., Nairn, R., Coverdale, J., & Panapa, A. (1999). Psychiatry and the media: Mental illness depictions in prime-time drama: identifying the discursive resources. *Australian and New Zealand Journal of Psychiatry* 33, 232-239.

- World Economic Forum.(2011). The situation faced by young people in Kenya *The Harvard School of Public Health. The global economic burden of non-communicable diseases.Geneva*.<http://siteresources.worldbank.org>
- World Health Organization. (2010). Mental health and development: Targeting people with mental health conditions as a vulnerable group. <http://whqlibdoc.who.int/publications.pdf>
- World Health Organization. (2013). Mental Health Action Plan 2013-2020 - 66th World Health Assembly, consisting of Ministers of Health of 194 Member States, adopted the WHO's Comprehensive Mental Health Action Plan 2013-2020 in May 2013. from [https://www.who.int/mental\\_health/publications/action\\_plan/en/](https://www.who.int/mental_health/publications/action_plan/en/)
- World Health Organization. (2002). Mental health Global Action Program (mhGAP): Close the Gap, Dare to Care; Retrieved November 7, 2013from [http://www.who.int/mental\\_health/media/en/265.pdf](http://www.who.int/mental_health/media/en/265.pdf)
- World Health Organization. (2003). Investing in Mental Health.*WHO 2003 Report*[www.who.int](http://www.who.int)
- Yazan, B. (2015). Three Approaches to Case Study Methods in Education: Yin, Merriam, and Stake. *The Qualitative Report*, 20(2), 134-152.
- Yin, R.K. (2014). *Case study research: Design and methods*. (5th Ed.) Thousand Oaks, CA: Sage
- Yin, R.K. (2009).*Case study research design and methods*.(3rd Ed.). Thousand Oaks, CA: Sage.
- Yu, C. (2007). Mixed Methods Sampling: A Typology *Journal of Mixed Methods Research*, 1(77)
- Zarcadoolas, C., Pleasant, A, & Greer, D. (2006).*Advancing Health Literacy: A Framework for Understanding and action*.San Francisco: John Wiley & Sons. <http://books.google.co.ke>
- Zhang, Y., & Jin, Y. (2017). Thematic and Episodic Framing of Depression: How Chinese and American Newspapers Framed a Major Public Health Threat. *Athens Journal of Mass Media and Communication*, 3(291-106).

## APPENDICES

### Appendix 1: In-depth Interview Guide for Health Journalists

1. How does the mainstream media in Kenya represent mental health issues?
  - a) Briefly tell us how long you have held this position and education background
  - b) What health issues have been predominant in the mainstream media in the last one year?
  - c) What kind of health issues have you covered in the last one year?
  - d) From your perspective what mental health issues attract the media?
  - e) How are mental health issues represented or portrayed by the Kenyan media?
  - f) What kinds of images are mainly used in mental health representation?
  - g) What kind of language is mainly used by journalists when reporting on mental health issues?
2. From your perspective, what influences the way MH issues are covered by the mainstream media?
  - a) *What makes some diseases to receive high representation by the media than others?*
  - b) *What are some of the diseases that have received high representation and why?*
  - c) *What makes MH issues to receive the kind of representation they receive from the mainstream media?*
  - d) *What kind of images come to your mind when you think about people with mental health challenges?*
  - e) *What triggers that kind of image?*
  - f) *What is your attitude towards mental health institutions?*
  - g) *What role does culture play in media representation of mental health issues?*

## **Appendix II: In-Depth Interview Guide for Mental Health Experts**

1. How are mental health issues represented by the Kenyan mainstream media?
  - a) *What is your position in the organization and briefly what does your job entail?*
  - b) *What do you think about the Kenyan media as a platform to enlighten the public and policy makers about mental health issues?*
  - c) *How does MH media coverage compare with the coverage of other diseases?*
  - d) *What is your opinion about the way the mainstream media represents mental health issues?*
  - e) *From your view, what are the dominant angles that the mainstream media take in representation of mental health issues?*
  - f) *How do those predominant angles play out in the public domain?*
  - g) *What kind of images is mainly used by the media in its representation of MH issues?*
  - h) *What has been your experience and mental health stakeholders experience in relating to the media?*
2. From your perspective, how does the media representation of mental health issues compare with the situation facing the mental health sector in?
  - a. How is the media representation a reflection of what is facing the mental health sector in the country?



- b. How different is the media representation in comparison to the issues facing the mental health sector?
3. Why informs the way mental health issues are represented by the mainstream media?
    - a) *From your perspective, what informs the way mental health issues are represented by the media?*
    - b) *What role does culture play in media representation of mental health issues?*
    - c) *How do mental health stakeholders relate with the mainstream media?*

## Appendix III: Media Documents that were Analysed

### 1. Kenya's mentally ill suffer in bitter silence

Tuesday February 24 2015



People living with some kind of a mental disorder roam in the streets in various parts of the country. In Africa, five per cent of the population suffers from mental illnesses.

PHOTO | FILE

In Summary

- Mathari National Teaching and Referral Hospital, Kenya's main specialized facility for mental health cases, attends to an average of 1,500 patients a day, against a stipulated maximum capacity of 622.
- At least 80 patients are attended by one health staff on a regular basis, but these are the lucky ones.
- Many more others are tethered to bed posts or trees in households across the country, made to suffer for being "different" and "abnormal"

ADVERTISEMENT

By

By EUNICE KILONZO

In a suburban home in Oyani, Migori County, Ben Odhiambo, 11, eats his lunch while coiled inside a dark room, safely away from the family dining table.

He seems to be enjoying the porridge and boiled cassava meal, and also somehow acquainted with the semi-darkness that surrounds him. He begs us to taste the cassava, which now reflects the few rays of sunshine that penetrate the small room, courtesy of the salivary dribble he has bestowed upon it.

His body is etched with bruises and scalds, which are an enduring, indelible evidence of the many seizures and falls he has had throughout his 11 years on earth. Ben is epileptic, and because that makes him "abnormal" and different from the rest of his family, he spends his days and nights inside this small room.

It does not take a medical degree to see that the playful boy is in dire need of medical attention, but his parents do not think so. It is not epilepsy, they say, but some sort of black magic cast upon their child. A maternal relative used the boy in a money-making ritual, they argue.

### CHASING DEMONS

According to a nurse in the area, Ben has been to a *laktar* — Dholuo for a female religious leader — for prayers. Conversely, seldom has the boy stepped inside a hospital. The prayer rituals involve beatings “to chase away demons”, which explains some of the scars on Ben’s body. He is deprived of social contact and locked up when the rest of the family goes for prayers at the local Adventist church.

In Mbale, Vihiga, another family is facing the ugly face of mental health as Noel Sishihali reels from the loss of a pregnancy. Her husband, whom she had always known as a quiet and doting man, one day slipped into unexplained rage, kicked her in the belly and caused her to lose the baby she was expecting.

A doctor at the Vihiga District Hospital had thrice recommended psychiatric attention to the troubled man, but he sailed off the cliff before he could be attended to. His relatives said the family had never experienced any madness and instead blamed Noel for being a “nagging wife” who had pushed her husband to the wall.

Ben and Noel are having it rough, but they are not alone. Their stories and experiences are never told, either because they are never afforded the opportunity, or because they do not know they need to tell share their agonies and tribulations in the first place. Maybe this is life as designed by nature, they probably reason.

Statistics show that one per cent of Kenya’s population — or about 500,000 people — has a mental disorder. Dr Rachel Jenkins of the Institute of Psychiatry of Kings College in London and Kenya’s Dr David Kiima agrees that is a huge number, and that it needs urgent government attention.

Their views are supported by the World Health Organisation, which states that about one in four people seeking outpatient services and four in ten patients admitted in hospital suffer from some form of mental condition. Interestingly, only one case out of every 100 is detected and treated.

The most frequent diagnosis of mental illnesses is depression, drugs and substance abuse, and neurotic, stress-related anxiety disorders.

### DEPLORABLE PICTURE

Traumatic events such as accidents, disasters as well as violence and conflicts, such as the 2007 post-election skirmishes, have contributed significantly to the growth of post-traumatic disorders, anxiety and depression in Kenyans. These spur hopelessness and desperation that precipitate mental disorders.

Paediatric psychiatrist Dr Josephine Omondi says rising cases of suicide, homicide and domestic violence have also given rise to mental disorders. However, even with such diagnosis, treatment and proper management of mental ailments remains elusive in Kenya.

A study by the Kenya National Commission on Human Rights (KNCHR) in 2012, dubbed *Silenced Minds: The Systemic Neglect of the Mental Health System in Kenya*, paints a deplorable picture of the mental health of the nation.

It shows that Mathari National Teaching and Referral Hospital, Kenya's main specialized facility for mental health cases, attends to an average of 1,500 patients a day, against a stipulated maximum capacity of 700. At least 80 patients are attended by one health staff on a regular basis, researchers found out. Other major public hospitals with mental health units, such as Port Reitz in Mombasa, Rift Valley Provincial General Hospital in Nakuru, and Moi Teaching and Referral Hospital Eldoret, also suffer the consequences of overcrowding and overworked staff.

Dr Lukoye Atwoli, a psychiatrist, thinks more attention should be directed to this health sector: "If the government does not pay attention to its people's health, then all of these economic milestones that we are gaining will come to naught," says Dr Atwoli. "No one is going to enjoy the multi-million-dollar railway if they are disturbed, no one is going to work to achieve Vision 2030 if they are weighed down mentally."

Indeed, studies in and out of the continent link a mentally unhealthy populace with a declining economy. In a 2003 study, Joses Kirigia, the Regional Adviser for Health Economics at the World Health Organization's regional office for Africa, reported that Kenya's economic loss associated with the institutionalization of mental and behavioral disorders was about Sh1.1 billion.

Dr Atwoli is concerned that some of the laws adopted by the government have a mental impact to the citizenry. Members of Parliament, governors and other leaders, he says, "do not care about how much distress the financial burdens they place on the economy" drive Kenyans over the edge.

Sadly, when people are diagnosed and/or admitted for mental health treatment, they have to grapple with lack of qualified staff to handle their condition properly.

#### REFUSING HELP

By 2012, there were only 46 psychiatrists in public service, and 28 of these were in Nairobi while the north eastern region did not have any trained nurse or psychiatrist. According to the Ministry of Health, there are currently 87 psychiatrists in the country.

To add to their misery, those with mental diseases face stigma, ignorance, and neglect from the society and their care givers. Last year, Beth Nduta, 15, was kicked out of school in Nakuru for poor performance despite a licensed psychiatrist diagnosing her with dyslexia, a reading disability that occurs when the brain does not properly recognize and process symbols.

Unwittingly or otherwise, some Kenyans consider such mental difficulties as some form of divine punishment; read witchcraft or bad luck. As such, Nairobi-based counselling psychologist Ken Munyua says psychiatrists and psychologists are caught in the middle of the ideological divide: on one side are people who are very distressed and in need of help, while on the other stand sceptics who act as an impediment to that help.

“Kenyans have refused to accept help,” says Munyua. “Not all of these mental conditions are biological; sometimes all we need to do is teach people how to emote in the face of adversity, such as grief over the loss of a loved one, unemployment, abuse and all this complex mix of social and psychological issues.”

His sentiments are echoed by Dr Omondi, who says that, in her work with mentally sick children, she often discovers that her professional opinion keeps being substituted for prayers or a visit to a traditional healer, as was the case with Ben, the young boy at the start of this story in Migori.

“When I meet those children later they have worsened, yet sometimes all that was needed was sharing with the parents about non-biological causes of their children’s disorder,” she said.

Apart from the apathetic attitude the public has on mental illness, the mentally sick are subjected to untold violence. At Luanda Market, near Maseno University, the mentally ill are ridiculed or sexually assaulted before being fed or clothed. Some food vendors are even known to ask the mentally ill to dance in exchange for food.

In Nakuru’s Pipeline Estate, Simon Mureithi, 20, has been in chains for 10 years. His father, Charles Mureithi, keeps his son tethered to stop him from destroying any more property and hurting people in the rental house they live in with three other siblings. The father told DN2: “We tie him to keep him from running away from home.... It is hard to cope. I am appealing to well-wishers to help me secure medication.”

## THE GRIM NUMBERS

1 in 4

Number of people seeking outpatient services, and four in ten patients admitted in hospital, who suffer from some form of mental condition. Interestingly, only one case out of every 100 is detected and treated

450,000,000

Number of people worldwide, according to the World Health Organisation, living with some kind of a mental disorder. In Africa, five per cent of the population suffers from mental illnesses

Sh50,000,000

Amount of money Safaricom Foundation donated for the refurbishment of Kenya’s largest mental referral hospital, Mathari. In addition, President Uhuru Kenyatta promised that Treasury would set aside another Sh50 million to aid the hospital

87

Number of psychiatrists in the country today, according to the Ministry of Health. Even though that is still a desperately low figure, it is much better from that of 2012, when there were only 46 psychiatrists in public service, 28 of these were in Nairobi while the north eastern region did not have any trained nurse or psychiatrist

---

## HELP IS AT HAND

Treasury, Safaricom Foundation in aid of Mathari Hospital



President Uhuru Kenyatta receives a gift of an art work done by Mathari patients on February 18, 2015. President Kenyatta further said the Treasury would provide another Sh50 million to renovate 11 other wards and staff quarters at Mathari in addition to the project funded and implemented by Safaricom Foundation. PHOTO | JEFF ANGOTE | FILE

IN EFFORTS to address mental health, President Uhuru Kenyatta on February 18 commissioned three refurbished wards and a laundry unit at Mathari Hospital. The project, just one of several other Kenya@50 legacy undertakings, was funded by the Safaricom Foundation to a tune of Sh50 million.

President Kenyatta further said the Treasury would provide another Sh50 million to renovate 11 other wards and staff quarters at Mathari. The hospital has a 622-bed capacity and records 60,000 out-patient visits annually.

Cabinet Secretary for Health, James Macharia, said negative stereotypes and stigma associated with mental health disorders discouraged patients from seeking timely interventions.

He echoed President Uhuru's remarks that "empathy and compassion, critical ingredients of all help and treatment, are scarce for those suffering from mental illness".

## 2. Article 2

**Let's treat the mentally ill as patients and stop thinking they are criminals**

TUESDAY FEBRUARY 24 2015



Students take part in a Mental Health Awareness walk in Nyeri on October 5, 2013.

FILE PHOTO | JOSEPH KANYI | NATION MEDIA GROUP

In Summary

Our young minds also deemed it appropriate to stone Mr Theuri and chase him around like a wild dog. Years later, my mother would tell me that he had died of pneumonia. Such is the fate of many mentally ill people in Kenya.

We ostracized Mr Theuri. Like numerous other mentally sick Kenyans, he eventually succumbed to decades of rejection, neglect and physical injuries that could easily have been prevented.

As the government embarks on a workable mental health strategy, the drafters should prioritise preventive care. Many studies suggest that an increase in mental illness is a reflection of a sick society

My memories of Maua Primary School revolve around three things. One, was the mean-spirited but loving principal, who would always “motivate” us by saying that even the Paralympics produce winners. The other was soccer. The third was a Mr Theuri.

Mr Theuri, a mentally ill but athletic man in his late 20s, loved to hang outside the school gate where he performed free nude shows for pupils. We cheered him on and got a kick out of it.

Our young minds also deemed it appropriate to stone Mr. Theuri and chase him around like a wild dog. Years later, my mother would tell me that he had died of pneumonia. Such is the fate of many mentally ill people in Kenya.

Last week's launch of President Kenyatta's mental health initiative and his call on Kenyans to address mental health seriously is spot on. The call brought back memories of those days when I would join other boys to happily hurl rocks at Mr. Theuri.

I remembered how Mr. Theuri would run for dear life or how he would grab a banana or whatever he could from passers-by.

Adults would beat him up for grabbing a morsel of bread, handcuff him and frog march him to the police station, where he would be thrown into the cells with murder suspects and robbers who would continue beating him for no rhyme or reason.

Children and adults alike treated this man like a criminal instead of a patient. None of us reasoned that he grabbed food from people because he was starving. Nobody bothered to understand why he liked to hang around the school gate.

Did he feel safer amongst children? Perhaps. Was he there because he desired education and his sick mind told him that the surest way to get educated would be by hanging around a school?

### SUCCUMBED TO REJECTION`

We ostracized Mr. Theuri. Like numerous other mentally sick Kenyans, he eventually succumbed to decades of rejection, neglect and physical injuries that could easily have been prevented.

The mental health challenge in Kenya is slowly but surely getting out of control. Both the lawyer who sacrificed his entire family, the Nyeri man who hacked his mother to death and the woman who recently killed her children in Korogocho were mentally ill.

Unethical utterances and public spats among leaders are another indicator that the society is sick and getting sicker. Unless we approach this issue soberly, we will continue losing productive people.

Apart from the emotional toll on the families, mental illness could pose serious national security challenges. In a paper titled, "Managing Public Mental Health: Locally and Globally", Lisa Burton, a sergeant with the Washington, DC Metropolitan Police, argues that across borders, prisons are disproportionately filled with people suffering from mental disorder.

In the US alone, 16 per cent of the nearly two million prisoners suffer from mental illnesses. In Kenya the situation is equally bad. Mathari Hospital, whose renovation the President has ordered, has a 620-bed capacity, yet it receives 60,000 outpatients annually.

It is logical to assume that majority of these outpatients are released simply because the hospital has nowhere to accommodate them. Once released, such patients become a danger to themselves, relatives and other members of the society.

As the government embarks on a workable mental health strategy, the drafters should prioritise preventive care. Many studies suggest that an increase in mental illness is a reflection of a sick society.

The poorer people become, the more likely they are to sink into depression and eventually, a mental breakdown.



The widening gap between those who have and those who do not, creates a situation where the downtrodden lose their minds. On the other hand, some rich folks overindulge themselves in risky behavior that could impair their mental stability.

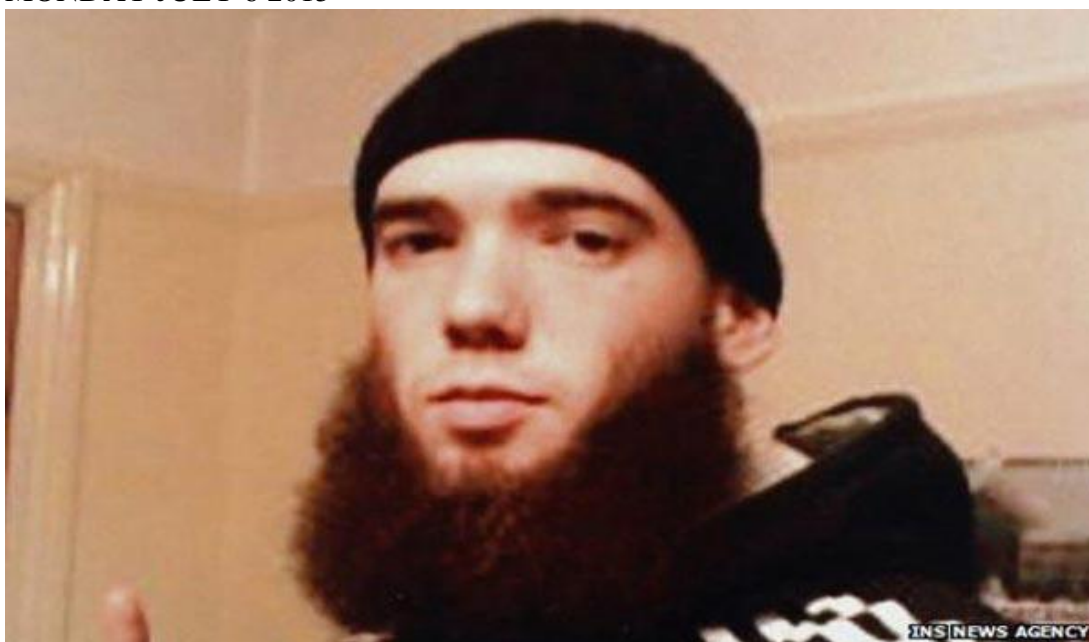
Dealing with mental health is a collective undertaking. Citizens need to be sensitized that these are sick people, not criminals. County governors, including Kwale's Salim Mvurya, who has had first-hand experience of the wrath of a mentally ill man should rethink the vanity of grandstanding on the provision of health equipment.

Mr Kaberia is an assistant director of international programmes at the University of the District of Columbia, Washington DC

### 3. Article 3

#### **How do we get rid of terrible 'madness' that has taken our society hostage?**

MONDAY JULY 6 2015



Thomas Evans, the 25-year-old British citizen who was one of the 11 terrorists shot dead by KDF soldiers when the militants raided a military camp. He grew up in Buckinghamshire, UK, but later changed his name to Abdul Hakim.

#### In Summary

- I heard a statistic that shocked me into alertness: that one in four people in this country are either mad now, have been mad in the past, or are likely to become mad before they die.
- There is also the case of 22-year-old shy "good boy" Seifedinne Rezgui, who cold-bloodedly killed at least 30 British tourists on a Tunisian beach last week.
- I hold the view that a child goes to school to learn, yes, but also to grow up, to learn to live with other people and, most important, to get help to discover their natural talent.

I recently saw a TV programme on madness or, as it is called in polite company, insanity. It is a subject that most people prefer to ignore, believing that they are insulated against it or that it only happens to other people. I heard a statistic that

shocked me into alertness: that one in four people in this country are either mad now, have been mad in the past, or are likely to become mad before they die.

That is 25 per cent of Kenya's current population of 44 million, which translates to over 10 million mad people. Is this a credible statistic or is it the fertile imagination of an over-enthusiastic clinical psychiatrist?

I was about to dismiss it until I recalled certain things that have happened in the recent past. One is the brutal massacre of 148 people at Garissa University College on April 2. It might have been understandable if it had been done by your ordinary fanatical heretic.

In this case, however, the leader of the gang of murderers was a 27-year-old brilliant university law graduate called Abdirahim Abdullahi.

Then here is the case of the 25-year-old Briton, Thomas Evans, who was killed as he led an attempted attack on an army camp in Lamu.

There is also the case of 22-year-old shy "good boy" Seifedinne Rezgui, who cold-bloodedly killed at least 30 British tourists on a Tunisian beach last week.

Then there is 21-year-old Dylann Roof, the American who killed nine worshippers in a church. And many other such cases.

The tragedy of these "isolated" incidents and many others that are not as attention-grabbing is that they are committed by relatively young people.

Which raises a disturbing question: Are these psychotic youngsters the product of a misguided educational system, victims of inappropriate religious indoctrination, or, God forbid, an unacknowledged widespread medical condition called "madness"? I have come to the conclusion that the first two possible explanations are largely to blame for exploiting an unfortunate human weakness, that is, a fundamentally insecure human mind.

On education, I think that we have over the years been giving our children the "wrong" type. By concentrating on the three traditional Rs — reading, (w)riting, and (a)rithmetic, we forget that a child is much more than the sum total of these components of normal education. I hold the view that a child goes to school to learn, yes, but also to grow up, to learn to live with other people and, most important, to get help to discover their natural talent. This could be art, music, football, athletics, mountain climbing — whatever else their creator programmed into their genetic bank. Do our teachers give these children a chance to discover these talents?

The second one is our religious training. I hold the view that too much emphasis has been placed on religious training or indoctrination. While I have no quarrel with the inculcation of the values embedded in religion, I believe too much emphasis is placed on dogmatic acceptance of the tenets of religion without allowing the young mind to question the validity of some of the basic assumptions of their faith.

When, in later years, the youth ask themselves these questions and recognise the fallacy of what has been drilled into their minds as the truth, the results can be calamitous. It was Albert Einstein who made the famous statement on madness: "The true definition of madness is repeating the same action over and over, hoping for a different result." In essence, this means that if we keep repeating something in our head, we come to believe that it is true, even when our intellect tells us it is manifest nonsense.

The tragedy of mankind is that we usually learn to convert belief into irrefutable truth despite evidence to the contrary. So, is there any hope for mankind? Unfortunately, we are in so deep that the only recourse left may be madness. Society must pay the terrible price and the worst part is that, with modernity, it is getting worse by the year. Just look at what is happening around you every day.

I hope that I am wrong, but what I know is that we have work to do.

Prof Kimura is an accountant and [educationist.joseph.kimura@crakenya.org](mailto:educationist.joseph.kimura@crakenya.org).

#### 4. Article 4

When a child is suicidal

(People Daily September 28, 2015)



Early this month, a 10-year-old boy killed himself over homework. His death continues to evoke debate and concerns regarding mental health among minors Down in Rititi Village in Mathira Nyeri County, the mound on 10-year-old Andrew Kuria's grave is slowly receding. On the cross where his dates of birth and death are written, nothing betrays the circumstances the Class Five pupil died in. The young boy committed suicide after an alleged quarrel with his mother over homework.

Described as a quiet and obedient boy, who also served as an altar boy, Kuria's suicide still evokes endless questions on how such a young mind would have conceived the idea to hang himself on the avocado tree outside their compound. So, why would a child commit suicide? Consultant child psychiatrist with Ministry of Health, Dr Judy Kamau, says suicide is a symptom of a mental illness under the surface.

She says about 90 per cent of people who attempt suicide have a mental problem or disorder and for each completed suicide, 20 have already been attempted once or more times. Dr Kamau terms the homework issue in Kuria's death as a trigger and not the real cause. "It is possible the stress of homework only activated the situation at hand, rather than being its cause. Parents' sometimes have unrealistic expectations when it comes to their children's performance. School stress becomes a trigger when for example, a child gets an E in mock exams, yet a parent beats them up, expecting an A in the final exams," she says.

She believes this to be especially so since some of the teachers say the pupil had told some of his mates that they would not see him again. Despite being taken for counselling, Kuria killed himself, leaving millions of Kenyans stunned. The doctor expounds why suicide in a child is so dumbfounding. “First, in many people’s minds, a child does not know how to and thus cannot commit suicide.

It therefore serves as a great shocker when a child turns to suicide. Such unbelief causes people to ignore its possibility and dismiss a child with terms such as: “He is angry now but will be okay.” A child’s brain is not fully developed while an adult thinks through options. Thus, you will hear one saying: “I’d rather die than my friends know I was dumped by my girlfriend.”

Adults, even teachers sometimes publicly shame children in school not knowing the effects and even label them ‘useless’. This, the doctor says, can maim their self-esteem leading to suicidal thoughts. Separation and divorce; poverty are also contributing factors. There can be telltale signs like withdrawal and lack of interest in previously like activities. When a child retreats from norm, parents should take note.

The child may be depressed or going through a hard time. Depression, a mental disorder mainly associated with suicide is distinguished by extreme sadness or feeling of emptiness, because it has an impairing effect, making a person unproductive. Just as with an adult, a young person keeps to him or herself withdrawing from friends especially as a social person and fails to carry out daily activities such as bathing. Depression is the most common mental disorder characterised by a child or adult becoming sad without an actual cause. Then there is Schizophrenia, which is a brain disorder in which people interpret reality abnormally.

Parents need to be aware that teens sometimes rebel because they are depressed and act out to mask inner problems. Sudden deterioration in school performance and getting into trouble without a care for punishment is a sign to worry about. Dr Kamau says resilience is necessary in life since not everyone who has had a bad life gets depressed. In 2003 while studying her Masters’ programme, Dr Kamau sampled 166 adolescents in Kenyatta National Hospital who came to the child and adolescent mental health clinic with various situations.

Out of these, 14 per cent were reported to be suicidal and seven per cent had attempted more than once to kill themselves. “A great number did not report to the facility. What happened to them?”, she poses. World Health Organisation says suicide is the second leading cause of death in the world, for those aged between 15 and 24 years. Yet, the world body says, the mental health of this age bracket is ignored.

### **Electronic Media Documents**

5. Mentally challenged boy chained to a tree under 84 year old woman care <https://www.youtube.com/watch?v=O1-bbKmpNvQ>; KTN News, Published on Aug 20, 2015

## Appendix IV: Research Permit



### NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,  
2241349, 310571, 2219420  
Fax: +254-20-318245, 318249  
Email: secretary@nacosti.go.ke  
Website: www.nacosti.go.ke  
When replying please quote

9<sup>th</sup> Floor, Utalii House  
Uhuru Highway  
P.O. Box 30623-00100  
NAIROBI-KENYA

Ref. No.

Date:  
16<sup>th</sup> March, 2015

NACOSTI/P/15/4844/4729

Julia Wanjiku Kagunda  
Moi University  
P.O. Box 3900-30100  
ELDORET.

#### RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*Media representation of mental health in Kenya*," I am pleased to inform you that you have been authorized to undertake research in **Nairobi County** for a period ending **31<sup>st</sup> August, 2015**.

You are advised to report to **the County Commissioner and the County Director of Education, Nairobi County** before embarking on the research project.

On completion of the research, you are required to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

  
DR. S. K. LANGAT, OGW  
FOR: DIRECTOR GENERAL/CEO

Copy to:

The County Commissioner  
Nairobi County.

The County Director of Education  
Nairobi County.

**CONDITIONS**

- 1. You must report to the County Commissioner and the County Education Officer of the area before embarking on your research. Failure to do that may lead to the cancellation of your permit.**
- 2. Government Officers will not be interviewed without prior appointment.**
- 3. No questionnaire will be used unless it has been approved.**
- 4. Excavation, filming and collection of biological specimens are subject to further permission from the relevant Government Ministries.**
- 5. You are required to submit at least two(2) hard copies and one(1) soft copy of your final report.**
- 6. The Government of Kenya reserves the right to modify the conditions of this permit including its cancellation without notice.**

**REPUBLIC OF KENYA**

**NACOSTI**

**National Commission for Science, Technology and Innovation**

**RESEARCH CLEARANCE PERMIT**

Serial No: **A/4408**

**CONDITIONS: see back page**

**THIS IS TO CERTIFY THAT:**

**MS. JULIA WANJIKU KAGUNDA**  
**of MOI UNIVERSITY, 0-606 Nairobi, has**  
**been permitted to conduct research in**  
**Nairobi County**  
**on the topic: MEDIA REPRESENTATION**  
**OF MENTAL HEALTH IN KENYA**  
**for the period ending:**  
**31st August, 2015**

Permit No: **NACOSTI/P/15/4844/4729**  
 Date Of Issue: **16th March, 2015**  
 Fee Received: **Ksh. 2000**

*[Signature]*  
**Director General**  
**National Commission for Science, Technology & Innovation**

## **Appendix V: SAMPLE INFORMED CONSENT FORM**

**Title of study:** Media Representation of Mental Health issues in Kenya: Health Experts Perspectives

**Investigator:** Julia Kagunda

**Institution:** School of Communication, Languages and Music: Daystar University

### **Introduction:**

I am Julia Kagunda, a Doctor of Philosophy student from the Department of Communication Studies of Moi University and doing a research on how the mainstream media in Kenya represent mental health issues.

### **Purpose of this research study**

The purpose of the study is to establish how mental health issues are represented in the mainstream media; what informs that kind of representation while investigating the perspectives of Mental Health experts in regard to that representation in light of the situation facing the mental health sector in Kenya.

### **Procedures**

I am inviting you to participate in this research project. The interview will take an average of forty-five minutes to one hour at your place of work or any other place suitable to you. With your permission, I will record our interviews. However, you will be free not to answer any question during the interview.

### **Possible risks or benefits**

There is no risk involved nor any benefit as you participate in this study however, the results of this study will help improve the way mental health issues are represented in the mainstream media, which ultimately will lead to positive mental health outcome.

### **Right of refusal to participate and withdrawal**

You are free to choose to participate in the study or not. You may also withdraw at any time from the study.

### **Confidentiality**

Kindly note that the information recorded is confidential, and no one else will have access to the information. Your name and identity will also not be disclosed at any time. However, the data may be seen by an Ethical review committee and may be published in a journal and elsewhere without giving your name or disclosing your identity.

### **Available Sources of Information**

If you have questions you may contact me on 0721213930.

### **AUTHORIZATION:**

I have read and understand this consent form, and I voluntarily choose to participate in this research study. I understand that my consent does not take away any legal rights in the case of negligence or other legal fault of anyone who is involved in this study.

Participant's Name:

Signature :

Date :

Investigator's Name :

Signature :

Date :