

**Lived Experiences of Mothers of Children with Mental Illnesses: A Case Study of
Mukuru Kwa Ruben Center in Nairobi, Kenya**

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DECLARATION

I, Esther Omwamba, do declare that this Thesis is a product of my initiative and research that has not been published or presented in any other institution for academic purposes. Any literature source utilized in this work has been duly cited and acknowledged.

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DEDICATION

This Thesis is dedicated to my family members for their love and continued support. May God Almighty bless each one of you.

ACKNOWLEDGEMENT

My gratitude goes to my academic supervisors, Dr Anne Mbwanyo and Dr Daniel Kitonga, for their guidance, treasured assistance and encouragement while I was undertaking this work. I also appreciate Tangaza University, Institute of Youth Studies, and all my lecturers for their contributions to my achievement of this Thesis. Finally, I acknowledge my family members for their psychological, emotional and financial support towards my academic journey in pursuing a master's degree at Tangaza University College.

ABSTRACT

This study analysed the experiences of mothers with children diagnosed with mental illnesses at the Mukuru Kwa Ruben Centre in Nairobi, Kenya. The study aimed to understand mothers' views on the causes of mental health disorders, their preferred treatment methods, and the coping strategies they employ. The study employs the social constructivism theoretical framework, utilizing the Health Belief Model (HBM) to examine health perceptions and beliefs, alongside the Family Systems Theory (FST) to explore the impact of family dynamics on caregiving. A qualitative phenomenological methodology was employed, involving semi-structured interviews with eight mothers of children experiencing mental health challenges, such as autism spectrum disorder, ADHD, foetal alcohol spectrum disorder, and cerebral palsy. The mothers were deliberately selected from those in attendance at the centre. The data were collected in English and Kiswahili and then analysed thematically. The findings indicate that mothers possess varying perspectives on mental illness, significantly influenced by their cultural and spiritual beliefs. Some individuals believe that mental health issues stem from supernatural influences, ancestral curses, or moral shortcomings. This notion influences their caregiving approach and the treatment options they select. Many mothers acknowledge the importance of professional mental health services, even though accessibility remains a challenge. These findings emphasize the need for culturally sensitive mental health interventions that integrate traditional beliefs with evidence-based practices, improve access to affordable professional care, and promote community education to address stigma and misconceptions. The research offers helpful suggestions for policymakers, mental health professionals, and support organizations to improve support systems for families affected by mental illnesses.

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ABBREVIATIONS/ACRONYMS

ADHD: Attention-deficit hyperactivity disorder

ASD: Autism Spectrum Disorder

BAS: Beck Anxiety Scale

CD: Conduct Disorder

CP: Cerebral Palsy

DD: Developmental Disorder

DSM – 5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition

EU: European Union

FST: Family Systems Theory

GAD: Generalized Anxiety Disorder

GP: General Practitioner

HBM: Health Belief Model

KCPE: Kenya Certificate of Primary Education

KCSE: Kenya Certificate of Secondary Education

KISE: Kenya Institute of Special Education

MDD: Major Depressive Disorder

ODD: Oppositional Defiant Disorder

SCMHE: School Children Mental Health in Europe

SHG: Self Help Group

WHO: World Health Organization

OPERATIONAL DEFINITION OF KEY TERMS

Children: In this study, "children" refers to persons under the age of 18 who are undergoing mental health treatment at the Mukuru Kwa Ruben Center in Nairobi, Kenya.

Mental illness: This refers to a broad spectrum of mental health problems that influence emotion, thinking, and behavior. This includes, but is not limited to, cerebral palsy (CP), bipolar disorder, schizophrenia, and attention-deficit/hyperactivity disorder (ADHD).

Mothers: "Mothers" refers to the female caregivers, including biological, adoptive, or stepmothers, who are the primary caregivers for children diagnosed with a mental illness at the Mukuru Kwa Ruben Center.

Lived experiences: The personal, subjective experiences, perceptions, beliefs, and understandings that mothers have regarding their children's mental illnesses, including how these experiences shape their caregiving practices and treatment decisions.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter will include the background to the Study, statement of the problem, research objectives and questions, purpose, assumptions, justification, scope/delimitation, significance and a summary of chapter one.

1.2 Background to the Study

Mental illness has consistently been a major public health concern worldwide throughout recorded history (Hubert and Aujoulat, 2018). Mental illness in children represents a significant public health concern, carrying substantial implications for those impacted and their families. The World Health Organization (WHO, 2018) reports that 10% to 20% of children and adolescents globally face mental health conditions. These conditions are on the rise, yet they continue to be underdiagnosed and undertreated. Patel et al. (2018) highlight that mental health conditions represent 16% of the global burden of disease and injury among individuals aged 10-19 years.

Sheehan (2017) states that childhood is a vital phase for developmental potential, marked by important physical growth, mastery of motor skills, language acquisition, cognitive development, and psychosocial milestones, such as the establishment of trust and security through parental care. Gould (2022) categorizes children's mental health issues into behavioral disorders, developmental disorders, and emotional disorders. The terms 'normative' and 'non-normative' development are utilized to evaluate if a child is undergoing a healthy and suitable condition for their age. Describing development as non-normative indicates that the child's experiences are atypical or unusual, which may lead to deficits in functioning and subsequent impairments; this compromised health can impact the child's emotional and social well-being.

The DSM-5, released by the American Psychiatric Association in 2013, details a range of mental disorders and illnesses that may impact children. These encompass neurodevelopmental disorders like autism spectrum disorder (ASD) and attention-deficit/hyperactivity disorder (ADHD), marked by developmental deficits that lead to impairments in personal, social, academic, or occupational functioning. Behavioral disorders like Oppositional Defiant Disorder (ODD) and Conduct Disorder (CD) are emphasized, characterized by patterns of negative, hostile, and defiant behavior. The DSM-5 encompasses mood disorders, including Major Depressive Disorder (MDD), as well as anxiety disorders such as Separation Anxiety Disorder and Generalized Anxiety Disorder (GAD), which can greatly affect a child's emotional and social well-being. These classifications offer a clear framework for diagnosing and treating mental health issues in children (Lolk, 2013).

Ravens-Sieberer and Ottová-Jordan (2016) underscore that developed countries currently view mental illness as their primary health concern for children and adolescents. Mental health problems among young people are a significant global public health challenge of the twenty-first century. While there have been advancements in the physical health of children and adolescents, they are encountering more social, emotional, and behavioral challenges associated with mental health.

Kovess et al.'s 2015 study on School Children Mental Health in Europe (SCMHE) aimed to establish indicators for monitoring children's mental health across seven EU countries. The research involved parents, teachers, and children. The Dominic Interactive questionnaire was completed by 9084 children from seven countries, and 6563 teachers and 6031 parents completed questionnaires. Interviews with informants revealed that teachers reported higher incidences of externalized problems and lower incidences of internalized problems. Children reported more internalized problems than both parents and teachers. Boys had a higher frequency of externalized problems than girls, who exhibited a greater tendency towards

internalized problems. After considering impairment levels, it was found that about 9.9% of children needed mental health care. However, 76% had not sought help from any mental health professional, increasing to 78.7% in Eastern countries and 63.1% in Western Europe.

Abera et al. (2015) emphasize that grasping mothers' perceptions of their children's mental illness is essential, as their beliefs and attitudes greatly affect their readiness to pursue and follow through with treatment. The emotional and psychological well-being of both the mother and the child can be influenced by these perceptions. Byrne (2020) states that knowledgeable and supportive caregivers can improve treatment outcomes for children facing mental health challenges. This study aimed to contribute to the broader discourse on mental health care in Kenya by examining the perceptions of mothers at the Mukuru Kwa Ruben Center. The aim was to pinpoint particular challenges and requirements encountered by these mothers and improve assistance for families managing childhood mental illness.

Research utilizing screening questionnaires indicated elevated prevalence rates in comparison to studies employing clinical diagnostic tools. The evidence shows high levels of mental health issues among children and adolescents in sub-Saharan Africa, with one in seven facing significant challenges and 9.5% diagnosed with a specific psychiatric disorder. Abubakar et al. (2022) observed that mental health disorders in children and adolescents in sub-Saharan Africa are still insufficiently addressed, with prevalence rates between 10% and 20%, aligning with global estimates.

In African contexts, spiritual and cultural explanations are prevalent. Gona et al. (2015) carried out a study in Kenya's coastal region investigating perceptions of parents and professionals regarding causes and treatment of autism spectrum disorders (ASD). The study identified two main perceived causes: preternatural and biomedical. Preternatural causes included witchcraft, evil spirits, and curses. Many participants believed that evil spirits could invade a child's mind either before birth or during early childhood, leading to ASD. Some

believed ASD could result from curses brought upon parents due to transgressions such as infidelity or marrying a relative. On the biomedical side, participants mentioned exposures and hereditary factors as potential causes, including infections and drug use during pregnancy.

Mkabile and Swartz (2020) conducted research in Cape Town, South Africa, focusing on primary caregivers and parents of children with intellectual disabilities. Participants provided explanations attributing their child's condition to life experiences and biological or spiritual factors. Some parents believed intellectual disability resulted from physical and emotional abuse they endured during pregnancy, while others considered genetic factors. Beyond these explanations, some respondents believed their child's intellectual disability could be due to witchcraft or displeased ancestors.

Cultural beliefs, economic factors, and healthcare accessibility influence the wide range of treatment preferences for children's mental illnesses. Abera et al. (2015) conducted a study in Ethiopia among parents of children with mental illnesses. The findings revealed that 69.2% of parents believed modern mental health care for children was only available in major cities, while 92.7% acknowledged the availability of religious and spiritual healers in their localities. Less educated parents were nearly six times more likely to prefer traditional treatments compared to their better-educated counterparts. Those endorsing supernatural causes of mental illness were approximately ten times more likely to prefer traditional treatments.

Mothers caring for children with mental illnesses employ various coping strategies to manage the demands of caregiving. Mahmood et al. (2015) conducted a qualitative study in India investigating coping strategies employed by mothers of children with autism spectrum disorders (ASD). The study involved in-depth interviews with ten mothers. Employment status and education level significantly influenced coping mechanisms. Employed and educated mothers exhibited lower stress levels and adopted more positive coping strategies. Positive strategies included integration (normalizing the presence of the ASD child within the family),

networking (socializing and educating themselves and other parents about ASD), and reliance on religion for comfort. Negative coping strategies included avoidance, ignorance, and isolation.

Oti-Boadi (2017) conducted a study in Ghana exploring the lived experiences of mothers with children with intellectual disabilities. The study revealed that coping strategies such as spiritual beliefs, hope, and support from family and community played crucial roles in providing meaning and purpose in their lives. Approximately 95% of mothers highlighted the significance of their spiritual beliefs, which helped them understand why God gave them a child with an intellectual disability and led them to rely heavily on prayer. Around 80% remained hopeful for their children's future despite recognizing their limitations. All mothers reported that the presence or absence of support from others significantly impacted their coping mechanisms.

Gona et al. (2016) conducted a study exploring challenges and coping strategies of parents of children with autism on the Kenyan coast. The study identified two primary coping strategies: problem-focused and emotion-focused. Problem-focused strategies aimed to manage or alter the source of distress, such as modifying the child's diet or seeking respite care through boarding schools. Emotion-focused strategies, particularly spiritual coping, were also prevalent. Many parents accepted their child's condition as part of a divine plan, finding comfort in prayers and seeking spiritual healing.

The presence of a child with mental illness profoundly impacts family dynamics. Manyara (2020) reports that in Kenya, mothers of children with autism and other developmental disabilities endure significant caregiving strain, which adversely impacts their physical and mental health. These mothers experience exhaustion and fatigue, leading to physical illnesses, and suffer from stress, anxiety, and depression. The demand for constant care isolates them from social interactions. Additionally, extreme poverty makes it challenging

for many mothers of children with mental disorders to access rehabilitation and treatment services.

Despite the growing recognition of childhood mental illness as a significant public health concern, there remains limited research specifically addressing the lived experiences of mothers of children with mental illness in informal settlements in Kenya, particularly in Nairobi. This research sought to fill this gap by exploring the lived experiences of mothers whose children have been diagnosed with mental illnesses at Mukuru Kwa Ruben Center, Nairobi, examining their beliefs about causes, preferred treatment options, coping strategies, and the impact on family dynamics. Addressing the problem of this study is crucial in contributing to the implementation of the Kenya Mental Health Policy 2015-2030, which provides a framework for interventions securing mental health systems reforms in Kenya, in line with the Constitution of Kenya 2010, Vision 2030, the Kenya Health Policy (2014-2030), and global commitments.

1.3 Statement of the Problem

Mental illness among children is a significant and growing public health issue. Despite advancements in physical health care, mental health services remain underfunded and overlooked, particularly for children. Patel et al. (2018) report that around 20% of children and adolescents globally suffer from mental health issues, which represent 16% of the worldwide burden of disease and injury among individuals aged 10 to 19 years.

In Kenya, mothers of children with autism and other developmental disabilities experience considerable caregiving strain that negatively affects their physical and mental health. They report exhaustion, fatigue, and associated physical illnesses, as well as heightened levels of stress, anxiety, and depression (Manyara, 2020). The constant care required isolates these mothers from social interactions, and extreme poverty exacerbates their inability to access necessary rehabilitation and treatment services.

Investigating mothers' lived experiences concerning their children's mental illnesses is essential, as these experiences affect their readiness to pursue treatment and comply with prescribed interventions, thereby influencing the overall well-being of both mother and child (Abera et al., 2015). According to the Kenyan National Commission of Human Rights, it is estimated that between 25% and 40% of outpatients and inpatients at general hospitals are children suffering from mental illness.

There is a significant gap in the literature concerning the lived experiences of mothers with children with mental illnesses in the Mukuru Kwa Ruben Center in Nairobi. While studies have examined mothers' experiences in rural and coastal regions of Kenya (Gona et al., 2015; Gona et al., 2016), limited research has focused on urban informal settlements where poverty, limited access to healthcare, and cultural beliefs intersect to create unique challenges.

This study filled this gap by looking into the lives of mothers whose children have mental illnesses at Mukuru Kwa Ruben Center. Specifically, the study examined mothers' beliefs about the causes of their children's mental illnesses, their preferred treatment options, the coping strategies they employ, and the impact on family dynamics and challenges they face. This research is essential for informing culturally relevant interventions and policies that can enhance mental health care for children and provide better support for their families in Kenya.

1.4 Purpose of the Study

This study aims to explore the lived experiences of mothers regarding mental illnesses of their children at Mukuru Kwa Ruben Center in Nairobi, Kenya.

1.5. Research Objectives

The Study was guided by one general objective and four specific objectives.

1.5.1. General Objective

To explore the lived experiences of mothers regarding mental illnesses of their children at Mukuru Kwa Ruben Center in Nairobi, Kenya.

1.5.2 Specific Objectives

The study was anchored on the following specific objectives:

1. To investigate mothers' beliefs about the causes of their children's mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya.
2. To identify mothers' preferred treatment options for their children with mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya.
3. To determine coping strategies employed by mothers of children with mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya.
4. To examine the impact on family dynamics and challenges experienced by mothers of children with mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya.

1.6 Research Questions

The study endeavored to answer the following four research questions:

1. What beliefs do mothers hold about the causes of their children's mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya?
2. What are mothers' preferred treatment options for their children with mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya?
3. What coping strategies do mothers employ in managing their children's mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya?
4. What is the impact on family dynamics and what challenges do mothers of children with mental illnesses experience at Mukuru Kwa Ruben Center in Nairobi, Kenya?

1.7 Significance of the Study

This study aimed to provide insights into the lived experiences of mothers with children diagnosed with mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya. The findings of this study have several significant benefits for various stakeholders:

Mothers of Children with Mental Illness: The study empowers mothers by giving voice to their experiences and challenges in managing their children's mental illnesses. Understanding their lived experiences, beliefs about causes, treatment preferences, and coping strategies can lead to the development of targeted support programs and interventions that address their specific needs, ultimately improving their well-being and their ability to care for their children effectively.

Management and Staff of Mukuru Kwa Ruben Center: By understanding mothers' lived experiences and the barriers they face, these centers can improve their service delivery, making it more responsive and empathetic to the needs of such families. Enhanced training for staff based on these findings can also lead to better caregiver support and more effective therapeutic outcomes for children.

Researchers: This study contributes to the existing body of knowledge about caregiver experiences of children with mental illnesses in Kenya and similar contexts. It lays the groundwork for additional investigation into culturally pertinent mental health interventions and support frameworks.

Counseling Psychologists: Counseling psychologists benefit from a more profound understanding of the unique challenges faced by mothers of children with mental illness. The study provides evidence-based insights that can inform the development of tailored therapeutic approaches and interventions. This enhances their ability to support both children and their caregivers, promoting better mental health outcomes and resilience in families dealing with mental illnesses.

Policy Makers: The study benefits policymakers by providing evidence to inform policies that support families with children affected by mental illnesses, particularly regarding holistic health, educational support, and accessible mental health services. The findings can guide resource allocation and development of culturally sensitive interventions aligned with the Kenya Mental Health Policy 2015-2030.

1.8 Scope/Delimitation of the Study

The scope of this study encompassed mothers at Mukuru Kwa Ruben Center in Nairobi, Kenya, whose children had been diagnosed with mental illnesses. This qualitative research conducted in-depth interviews exploring the lived experiences, beliefs about causes, preferred treatment options, coping mechanisms, and impact on family dynamics and challenges faced by these mothers.

Delimitation is the process by which the researcher sets limits on the study's scope to make it more manageable and focused. This study did not include mothers of children with mental illnesses who were not part of Mukuru Kwa Ruben Center. A clear explanation was given to respondents about the importance of the study before conducting semi-structured interviews that were used to explore their lived experiences. The study focused specifically on mothers as primary caregivers and did not include fathers or other family members, though their influence was acknowledged in mothers' narratives.

1.9 Assumptions of the Study

Assumptions are unexplained beliefs that are not always true, but researchers take them to be true without any verification, which remains a realistic expectation to them (Mugenda & Mugenda, 2019). The following were the assumptions of this Study:

1. The researcher assumed that mothers at Mukuru Kwa Ruben Center would be willing to participate in the study.

2. The participants will be able to provide the required data honestly for free without monetary compensation.
3. Sufficient rapport and trust would be established between the researcher and participants to facilitate open sharing.

1.10 Chapter Summary

Chapter One presents an overview of the thesis, detailing the study's background, research problem, objectives, research questions, purpose, significance, assumptions, and scope and delimitation. The following chapter centered on the literature review.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter provides a theoretical literature review and empirical literature based on the research objectives. This study was anchored on two theories: the Health Belief Model (HBM) and Family Systems Theory. A conceptual framework for the study is also presented, followed by a chapter summary.

2.2 Theoretical Framework

This research employed the Health Belief Model (HBM) and Family Systems Theory (FST) to elucidate mothers' experiences concerning their children's mental illnesses at the Mukuru Kwa Ruben Center in Nairobi, Kenya. Using both HBM and FST provided a comprehensive framework that addressed both individual and familial aspects, resulting in a more holistic understanding of mothers' challenges and how to best support them. This integrated method enabled the study to capture both personal perspectives and family dynamics, providing insights into mothers' experiences managing their children's mental illnesses at the Mukuru Kwa Ruben Center in Nairobi, Kenya.

2.2.1 The Health Belief Model

The Health Belief Model (HBM) was established in the 1950s by social psychologists Hochbaum, Rosenstock, and Kegels while working for the United States Public Health Service. It was designed to help explain why people did not use disease prevention techniques or screening tests for early illness diagnosis. The model has since been expanded and is frequently used to comprehend various health behaviors.

The HBM contends that multiple elements influence an individual's decision to engage in a health behavior. The HBM posits that six fundamental beliefs shape health behaviors:

perceived susceptibility (the belief in one's vulnerability to a health issue), perceived severity (the belief in the serious consequences of the health issue), perceived benefits (the belief that a specific action would mitigate susceptibility or severity), perceived barriers (the belief that the costs of the action exceed the benefits), cues to action (triggers that incite action), and self-efficacy (confidence in one's capacity to successfully execute the action).

This model's emphasis on individual perceptions and readiness to change is especially useful for developing individualized health education and intervention programs. Studies have shown that HBM-based interventions can effectively modify health behaviors by addressing these beliefs. Rosenstock et al. (1988) discovered that emphasizing perceived susceptibility and severity in health communications can significantly increase motivation to adopt preventive behaviors.

The HBM is useful in this study because it allowed the researcher to investigate how mothers perceive their children's mental illness, including their thoughts about the causes, severity, and probable outcomes. It aided in understanding the barriers to treatment and the factors that inspire or dissuade them from seeking mental health services for their children. The HBM insights can be used to inform interventions that target specific beliefs and barriers, resulting in increased use of mental health services (Henshaw & Freedman-Doan, 2009).

Nonetheless, despite its merits, the HBM has been criticized for various shortcomings. Ghazi (2020) explains that the Health Belief Model has gained widespread popularity; however, very little is known about its effectiveness when it comes to health behavior intervention. Green et al. (2008) contend that the model fails to account for habitual behaviors, social acceptability, and economic and environmental factors that may influence health behaviors. Davidhizar (2008) further points out that the HBM implies a high level of rationality in decision-making, which may not necessarily represent real-world behaviors, especially in settings involving emotions and social pressures.

According to the aforementioned assessment by Green et al. (2008), it is critical to evaluate the larger family context in which these behaviors occur. These limitations are particularly relevant when examining mothers' beliefs about their children's mental illnesses, where emotional factors, cultural beliefs, and socioeconomic constraints may override rational decision-making processes. To address these limitations, this study incorporated Family Systems Theory to provide a more comprehensive understanding of how family dynamics and social contexts influence mothers' experiences and decision-making.

2.2.2 Family Systems Theory

Family Systems Theory, developed by Murray Bowen, posits that individuals cannot be understood in isolation from their family unit, as families are complex, interconnected systems (Titelman, 2012). Bowen's theory emphasizes the role of family dynamics and interaction patterns in shaping individual behaviors and emotions. According to Bowen, the family is an emotional unit, and changes in one member's emotional functioning can affect the entire family system (Titelman, 2014).

Triangles, self-differentiation, nuclear family emotional system, family projection process, intergenerational transmission process, emotional cutoff, sibling position, and societal emotional process are all significant elements in this theory (Kerr, 1981). A central tenet of Family Systems Theory is the concept of triangles, which are the smallest stable relationship systems within a family. Triangles emerge when a two-person relationship becomes unstable or overly intense, and a third person is brought in to relieve tension (Titelman, 2012).

These scenarios can result in cycles of conflict and alliance, which reinforce emotional processes within the family. Differentiation of self is an individual's ability to distinguish their intellectual and emotional functioning from that of their family (Titelman, 2014). Individuals with stronger differentiation can preserve a sense of self while remaining connected to their

family, whereas those with weaker differentiation are more likely to become overwhelmed by familial dynamics.

Family Systems Theory is important to this study because it provides a framework for studying how mothers perceive and manage their children's mental illnesses in light of their family dynamics. Mothers, as primary caregivers, often play a critical role in ensuring the emotional stability of the family while handling the complex requirements of a child with mental illness. This theory aids in understanding how family relationships and interactions influence mothers' beliefs, coping strategies, and decision-making processes surrounding their children's mental health care. Researchers can gain insights into the broader social and emotional context that influences mental health care by looking at the family as a whole, rather than just the individual child (Crittenden & Dallos, 2009).

However, FST has its limitations. One criticism is that it may be unduly focused on family dynamics at the expense of external factors such as socioeconomic status, cultural influences, and broader social determinants of health (Prest & Protinsky, 1993). Furthermore, the theory's emphasis on the family unit may overlook individual family members' experiences and needs, especially when individual mental health concerns are prevalent. The theory may also place excessive emphasis on intergenerational patterns without adequately accounting for how families can break cycles of dysfunction through external interventions or individual agency.

Despite its shortcomings, Family Systems Theory remains a useful tool for understanding the relational context of mental health concerns. In the context of this study, these limitations were addressed by including additional theoretical perspectives, such as the Health Belief Model, to capture mothers' individual beliefs and perceptions about their children's mental health. The study's integration of these theories yielded a comprehensive understanding of the individual and familial factors that impact mental health treatment.

This integrated approach not only considered family dynamics but also addressed the individual experiences and needs of mothers and their children. Ultimately, Family Systems Theory offered a robust framework for exploring the complexities of family interactions and their impact on mental health. Its application to this study helped in identifying patterns of behavior and emotional processes that affect how mothers perceive and manage their children's mental illnesses.

2.3 Empirical Literature Review

This section focuses on reviewing literature that offers explanations for the research objectives. The researcher used research publications from peer-reviewed academic journals as well as university digital repositories to explore mothers' lived experiences regarding their children with mental illnesses.

2.3.1 Beliefs About Causes of Children's Mental Illnesses

Thabet et al. (2006) carried out a study in Palestine to investigate Palestinian mothers' perceptions regarding child mental illnesses and their causes. The study included checklists completed by 249 mothers living in refugee camps in the Gaza Strip. The results revealed that mothers identified multiple causes for child mental health issues. A substantial proportion of mothers, 221 (89.1%), identified family issues as the cause of these problems, while 212 (85.5%) attributed them to parental mental illness as a contributing factor. Additionally, 208 (83.9%) cited socio-economic difficulties as a cause, 164 (66.1%) pointed to accidents, and 157 (63.3%) mentioned genetic disorders. Furthermore, 152 (61.3%) believed organic brain lesions were a cause, and 86 (34.7%) thought their children were "possessed." These findings highlight the diverse range of factors that Palestinian mothers associate with child mental health problems.

Yeh et al. (2004) carried out a study in the United States to investigate parental beliefs regarding the causes of child mental health problems across different racial and ethnic groups. The research indicated that parental beliefs exhibited considerable variation across racial and ethnic groups. Latino and Asian American parents were more likely to endorse beliefs that situational stress and family problems were the primary causes of child mental health issues. African American parents, on the other hand, were more likely to attribute these problems to external factors such as racism and societal disadvantage. Caucasian parents tended to endorse biomedical explanations, such as chemical imbalances and genetic factors, more than other groups. These results indicate that cultural background profoundly affects parental perceptions of the origins of their children's mental health issues.

Hebert and Koulouglioti (2010) reviewed literature on parental beliefs about the causes and progression of autism in their children. The review underscored that parents possess varied beliefs concerning the etiology of autism, encompassing genetic determinants, perinatal occurrences, and early childhood environmental factors. Despite declining frequencies, some parents still attribute their child's autism to immunizations. Parental outlooks on their children's futures varied, with some parents expressing pessimism while others remained hopeful for the development of new strategies and societal acceptance of their children's unique behaviors. These beliefs significantly influence parents' decisions about future healthcare, family planning, and maternal mental health.

Felnhofer et al. (2020) conducted a study in Austria to investigate potential differences between mothers' and fathers' beliefs regarding the causes of their child's illness. Findings revealed distinct perspectives from mothers and fathers on the causes of their child's disorder. Mothers tended to emphasize psychological and environmental factors, such as stress during pregnancy and early childhood experiences. They also frequently considered genetic predispositions and complications during childbirth. Fathers, on the other hand, were more

likely to attribute the child's disorder to genetic factors and less often to environmental influences. Both parents expressed concerns over potential hereditary elements, but mothers showed a greater inclination to consider a broad range of potential causes, including immunizations and other external factors. Mothers frequently pursued holistic healthcare solutions encompassing both medical and psychological interventions, whereas fathers preferred genetic counseling and medical treatment alternatives.

Mkabile and Swartz (2020) conducted research in Cape Town, South Africa, focusing on primary caregivers and parents of children with intellectual disabilities. Participants provided a range of explanations for their child's condition, primarily attributing it to life experiences and biological or spiritual factors. Some parents believed that the intellectual disability resulted from physical and emotional abuse they endured during pregnancy, suggesting that the stress and trauma from such abuse affected the fetus and led to the child's developmental issues. Additionally, some participants considered genetic factors, attributing the condition to the presence of intellectual disability in other family members. Beyond these life events and biological reasons, other respondents believed that their child's intellectual disability could be due to witchcraft or displeased ancestors. This diversity of beliefs underscores the complex and multifaceted perceptions held by caregivers regarding the causes of intellectual disabilities.

A study by Gona et al. (2015) in Kenya's coastal region identified two main causes of autism spectrum disorders (ASD): preternatural and biomedical. Preternatural causes included witchcraft, evil spirits, and curses, with many believing that evil spirits could invade a child's mind before birth or during early childhood. Witchcraft was also considered a direct result of sorcery, while some participants believed that ASD could result from curses brought upon parents due to transgressions or sins. Biomedical causes included exposures and hereditary factors, with infections and drug use during pregnancy being significant concerns. Brain

damage from infections and the inappropriate use of medications, such as malaria drugs and family planning pills, was also cited as a possible contributor to ASD development. This study provides context for understanding beliefs in the Kenyan coastal region but does not address beliefs in urban informal settlements like Mukuru in Nairobi.

Imbwaga (2015) conducted a study in Endebes sub-county, Trans-Nzoia County, Kenya, involving 381 parents and guardians of children with mental illness. The findings revealed that 265 respondents (84%) identified various causes of mental illness, while 52 respondents (16%) admitted to not knowing any causes. Among those who provided explanations, 44 respondents (14%) attributed mental illness to witchcraft and curses. Furthermore, 221 respondents (70%) cited a range of causes, including family inheritance, accidents, drug abuse and alcoholism, illnesses, and traumatic experiences such as abuse. Overall, the study concluded that 30% of the respondents were either misinformed or unaware of the causes of mental illness, whereas 70% were knowledgeable about the actual causes. While this study provides valuable insights from a rural Kenyan context, it does not address the specific beliefs held by mothers in urban informal settlements.

Kariuki et al. (2021) conducted a more recent study in Kenya examining community perceptions of mental illness among children and adolescents in Kilifi County. The research revealed that community members, including parents, frequently ascribed mental illness to supernatural factors such as witchcraft and curses, in addition to substance abuse. There was limited awareness of biological and psychological causes of mental illness. The study highlighted that these perceptions significantly influenced help-seeking behaviors, with many families initially consulting traditional healers before seeking formal medical care. This recent study confirms that traditional beliefs about mental illness persist in Kenyan communities and significantly impact treatment-seeking behaviors.

Ndetei et al. (2016) examined mental health knowledge, attitudes, and practices among primary healthcare workers in Kenya. The study found that even healthcare providers often held stigmatizing attitudes toward mental illness and had limited training in mental health care. Many attributed mental illness to spiritual causes or moral failings. This study underscores that misconceptions regarding mental illness are prevalent not only in lay communities but also among healthcare providers, thereby exacerbating obstacles to suitable care.

Research indicates diverse beliefs about mental illnesses among different populations, such as witchcraft, curses, family inheritance, accidents, drug abuse, illnesses, and traumatic experiences. However, there is a knowledge gap in Nairobi regarding mothers' beliefs about their children's mental illnesses, especially in informal settlements. This study aims to fill this gap by examining the beliefs of mothers at the Mukuru Kwa Ruben Center in Nairobi, Kenya. By addressing this gap, the research provides a clearer understanding of the cultural and contextual factors influencing these beliefs, which can inform more effective mental health interventions and support strategies tailored to urban informal settlement contexts.

2.3.2 Preferred Treatment Options for Children with Mental Illnesses

Thabet et al. (2006) investigated Palestinian mothers' awareness of available services and sources of help for their children's mental illnesses. The study found that 42.6% of the mothers were aware of child mental health centers and services, and a significant majority (92.7%) recognized the necessity for these services. When considering action for mental health concerns, 70% of the mothers indicated they would visit a primary health care center, 63.2% would consult a psychologist or psychiatrist, and 52.4% would see a social worker. Only a small number (4%) said they had used cauterization, which is a traditional Arab treatment. In terms of preferred treatments, 84.7% favored psychotherapy, 63.1% opted for medication, 61% preferred treatment through reciting the Quran, and 15.3% chose traditional smoking methods for their children to inhale.

Boulter and Rickwood (2013) conducted a study in Australia to investigate parents' experiences in obtaining assistance for their children with mental health issues. The study delineated two distinct pathways for the initiation of mental health services: a parent-initiated pathway, which was predominant (N = 10), and a teacher-initiated pathway, which was less prevalent (N = 5). Children with primarily emotional problems entered the mental health system through both pathways, whereas children with primarily behavioral problems entered through the parent-initiated pathway. Participants reported contacting multiple services, including psychiatrists, pediatricians, general practitioners (GPs), psychologists, teachers, and counselors. A typical parent-initiated pathway might begin with a nurse, followed by visits to a family doctor, social worker, pediatrician, and finally a psychologist. A teacher-initiated pathway may encompass the teacher, school psychologist, family physician, pediatrician, and ultimately a youth mental health service, frequently involving multiple referrals to prior professionals.

Ogun et al. (2009) conducted a study in Nigeria to explore factors influencing the pathway to child and adolescent mental health care. They recruited parents and guardians of children and adolescents attending the Child and Adolescent Centre at the Federal Neuropsychiatric Hospital in Yaba, Lagos. Out of 253 patients, 232 parents or guardians consented to participate. Only 23% of the children were brought to the hospital on the parents' initiative, while 39% were advised by neighbors, relatives, or friends. Referrals from health institutions accounted for 25.4%, schools for 6.9%, and religious organizations for 4.3%. In terms of pathways to care, 33.6% had consulted orthodox treatment services alone, 6.0% had consulted herbalists or traditional healers alone, and 16.4% had consulted Christian or Muslim spiritual healers alone. More than a third (37.1%) of caregivers had consulted multiple sources before seeking help at the mental health facility. The majority of patients (63.4%) were brought to the unit more than six months after the onset of their illness.

Abera et al. (2015) conducted a study in Ethiopia among parents of children with mental illnesses. The findings revealed that 69.2% of parents believed that modern mental health care for children was only available in major cities like Addis Ababa, while 92.7% acknowledged the availability of religious and spiritual healers in their localities for treating psychiatric problems. Commonly mentioned treatments included holy water, Rukiya (Quran-based treatment), and prayers at home or in religious settings. The study's bivariate logistic regression analysis indicated that less educated parents were nearly six times more likely to prefer traditional treatments compared to their better-educated counterparts. Housewives and farmers were 1.5 times more likely to favor traditional options than merchants and other employed individuals. Conversely, never-married parents were 65% less likely to choose traditional treatments compared to married parents. Coptic Christians were twice as likely to prefer traditional treatments over Muslims. Those endorsing supernatural causes of mental illness were approximately ten times more likely to prefer traditional treatments.

Skylstad et al. (2019) conducted a study in Uganda to explore the help-seeking behaviors of parents with children under the age of 10 who have mental illnesses. Parents considered various help providers, including doctors, religious leaders, elders, traditional healers, witch doctors, teachers, peers, and legal authorities. Most parents believed that incorporating a spiritual component was crucial for effective treatment, as it addressed the perceived underlying causes of the symptoms. Elders, religious leaders, and traditional healers were often consulted alongside or before medical professionals. Common practices included rituals, animal sacrifices, or prayers, depending on the perceived cause of the illness. Health facilities were mainly expected to diagnose the patient, alleviate symptoms medically, provide advice, and create reports for other help providers. Only one participant mentioned therapeutic counseling by medical personnel as a viable treatment.

Gona et al. (2015) conducted a study in Kenya's coastal region to examine parents' and professionals' perceptions regarding the causes and treatment of autism spectrum disorders (ASD). Two main types of treatment were identified: traditional and modern. Traditional treatment involved consulting traditional healers and offering spiritual prayers, often concurrently with medical consultations or after unsuccessful visits to health facilities. Modern treatment, preferred by most participants, involved utilizing available health facilities in the counties. Parents primarily hoped for a cure, believing that ASD would bring disasters or bad omens to their families and the wider community. This study highlighted the coastal region's treatment preferences but did not address urban informal settlements.

Ndetei et al. (2015) conducted a study in Kenya examining pathways to mental health care there. The study found that most individuals with mental health problems first sought help from traditional and faith healers before accessing formal mental health services. Barriers to accessing formal care included cost, distance to facilities, lack of awareness about mental health services, and stigma. The study recommended integrating traditional and formal mental health care systems to improve access and outcomes. While this study provides valuable national-level data, it does not specifically focus on mothers of children with mental illness in urban informal settlements.

Kigamwa et al. (2020) examined mental health service delivery in primary health care settings in Kenya. The study found that mental health services were often inadequately integrated into primary care, with limited availability of trained personnel and psychotropic medications. Many facilities lacked basic resources for mental health care. This study highlights systemic barriers to accessing professional mental health care in Kenya, which likely influences treatment preferences among mothers.

There is limited research on the preferred treatment options for children with mental illnesses in Nairobi's urban informal settlements. A study by Gona et al. (2015) in Kenya's

coastal region revealed a mixed approach to treatment, combining traditional and modern methods. Participants used consultations with healers, spiritual prayers, and health facilities. However, there is limited information on whether mothers in Nairobi, specifically at Mukuru Kwa Ruben Center, share similar preferences or if their choices differ due to varying cultural, social, and economic contexts. This study aimed to investigate the preferred treatment options of mothers for their children with mental illness in Nairobi, offering suggestions for factors influencing these preferences and understanding potential differences or similarities with those observed in the coastal region.

2.3.3 Coping Strategies Employed by Mothers of Children with Mental Illnesses

Mahmood et al. (2015) conducted a qualitative study in India to investigate the coping strategies employed by mothers of children with autism spectrum disorder (ASD). The study involved in-depth interviews with ten mothers, of whom four were employed and six were housewives. The employment status and education level of the mothers significantly influenced their coping mechanisms. Employed and educated mothers exhibited lower stress levels and adopted more positive coping strategies. Positive strategies included integration, where mothers normalized the presence of the ASD child within the family; networking, which involved socializing and educating themselves and other parents about ASD; and reliance on religion for comfort. Negative coping strategies identified were avoidance, where mothers avoided thinking or talking about ASD; ignorance, which entailed neglecting the child's needs and priorities; and isolation, leading to social withdrawal and detachment from the child, affecting the entire family. The study points out the importance of education, employment, and social support in enhancing the coping capacities of mothers dealing with ASD.

Deepak et al. (2016) carried out a study in India to evaluate the quality of life and coping strategies among caregivers of children with physical and mental disabilities. The primary coping style identified was active emotional coping. Parents of children with learning

disabilities, epilepsy, and cerebral palsy predominantly used this coping strategy. On the contrary, parents of children with Down syndrome mainly employed problem-focused coping, while those with children diagnosed with attention-deficit/hyperactivity disorder (ADHD) resorted to avoidant emotional coping. Parents of mentally retarded children employed both problem-focused and active emotional coping strategies with equal frequency. The findings suggest that all three coping mechanisms are pertinent for parents of children with developmental disabilities. The study indicates that problem-focused coping and active emotional coping are linked to a better quality of life, highlighting the clear distinction between emotion-focused and problem-focused coping strategies commonly found in stress and coping research.

Durukan et al. (2008) conducted a study in Turkey to evaluate the depression and anxiety levels, as well as the coping strategies, among mothers of children with ADHD. The study found that the ADHD group had significantly higher scores on the subscales for repression, focusing on the problem, expression of emotions, denial, and dysfunctional coping behavior when assessed with the Scale for Evaluation of Coping Behavior (COPE). Additionally, there was a significant positive correlation between the Beck Anxiety Scale (BAS) scores and the substance use subscale of the COPE. This suggests that overanxious mothers may resort to substance use to alleviate their stress, forget stressful situations, and cope with their anxiety.

Oti-Boadi (2017) conducted a study in Ghana to explore the lived experiences of mothers of children with intellectual disabilities. The study revealed that coping strategies such as spiritual beliefs, hope, and support from family and community played crucial roles in providing meaning and purpose in their lives, helping them adapt to their new circumstances. Approximately 95% of the mothers talked about their spiritual beliefs, which helped them understand why God gave them a child with an intellectual disability and led them to rely

heavily on prayer. Despite recognizing their children's limitations, around 80% of the mothers remained hopeful for their children's future. Additionally, all mothers reported that the presence or absence of support from others significantly impacted their coping mechanisms. About 70% of the mothers indicated that support from husbands, family members, friends, church, and healthcare professionals was essential for maintaining their mental health.

Masulani-Mwale et al. (2016) conducted a study in Malawi to investigate the psychological experiences of parents caring for children with intellectual disabilities and to understand their coping mechanisms. The study revealed that parents employed various coping methods, with spirituality being the predominant one. Many parents reported that their spiritual beliefs provided significant support, helping them to accept their child's condition as part of God's plan. However, some parents turned away from their faith due to difficulties in coping and negative attitudes from the community. Likewise, parents expressed the need for education, rehabilitation, respite services, material support, counseling, and support groups to better manage their caregiving responsibilities.

Gona et al. (2016) conducted a study to explore the challenges and coping strategies of parents of children with autism on the Kenyan coast. The research delineated two principal coping strategies: problem-focused and emotion-focused. Problem-focused strategies aimed to manage or alter the source of distress, such as modifying the child's diet, which some parents believed could control autistic behaviors. Professionals also advised parents on dietary issues. Another problem-focused strategy was respite care, with some parents opting to place their children in boarding schools for better support. Emotion-focused strategies, particularly spiritual coping, were also prevalent. Many parents accepted their child's condition as part of a divine plan, finding comfort in prayers and seeking spiritual healing. The conviction that God had predestined their child's autism instilled in them a sense of acceptance and resilience. Prayers were considered a powerful means of strengthening their relationship with God and

coping with the challenges of raising a child with autism. This spiritual approach was a significant coping mechanism for many parents in the region, reflecting deep-rooted cultural and religious values.

Mbwayo et al. (2020) conducted a study in Kenya examining mental health literacy and stigma among caregivers of children with mental health problems. The study revealed that caregivers frequently possessed insufficient knowledge regarding mental health conditions and available treatments, thereby impairing their coping capabilities. Stigma was a significant barrier to seeking help and discussing mental health challenges openly. Caregivers who participated in psychoeducation programs and support groups reported improved coping and reduced feelings of isolation. This research paper emphasizes the value of education and social support in enhancing coping among caregivers.

Kathomi et al. (2021) examined resilience among mothers of children with autism spectrum disorder in Nairobi, Kenya. The study found that mothers employed various resilience strategies, including seeking social support, maintaining positive attitudes, and engaging in religious practices. However, many mothers reported feeling overwhelmed by caregiving demands and expressed a need for more structured support services. Financial constraints and limited access to specialized services were significant stressors. While this study provides insights into mothers' experiences in Nairobi, it focused specifically on autism and did not examine a broader range of mental illnesses.

This study aims to fill a knowledge gap in understanding coping strategies used by mothers in urban informal settlements in Nairobi, Kenya. Despite extensive research on coping mechanisms in other regions, such as the Kenyan coast, there is a lack of understanding of coping strategies specific to mothers in urban centers like Nairobi, where poverty, limited healthcare access, and unique cultural dynamics converge. The research will help develop

targeted support programs and interventions tailored to the unique challenges faced by these families in Nairobi's urban informal settlement context.

2.3.4 Impact on Family Dynamics

A study by Lautenbach et al. (2012) in the US found that mothers perceive their child's mental illness as more severe and impactful than other complex disorders. The study found that serious mental illness has more significant emotional, financial, and practical repercussions than other conditions like cancer, diabetes, or heart disease. Stigma was also a significant factor contributing to these differing perceptions. Mothers expressed feelings of guilt and mourned their child's pre-illness personality, highlighting the profound challenges faced by families dealing with serious mental illness. The study points out that there is greater support and understanding for families dealing with such conditions.

A study by Oz et al. (2019) in Turkey found that mothers of 69 children diagnosed with autism spectrum disorder (ASD) experienced moderate levels of internalized stigma, depression, and anxiety symptoms. Their quality of life and life satisfaction scores were low. The study found a significant positive correlation between internalized stigma perception and anxiety and depression symptoms. Mothers with severe autism-related difficulties reported higher levels of depression and anxiety, leading to reduced quality of life and satisfaction. The research highlights the significant impact of internalized stigma on the mental health and overall well-being of mothers of children with mental illnesses.

Scharer et al. (2009) conducted a study in the US on mothers of children with serious mental illnesses. The study's participants came from child psychiatric units where their children received hospitalization. The study identified three primary themes: the emotional burdens faced by mothers, the mother's role as an advocate for her child, and the function of mental

health nurses in augmenting mothers' advocacy skills. Mothers experienced emotional reactions like fear, frustration, concern, and guilt, which complicated their parenting efforts. Despite these challenges, most mothers maintained optimistic views of their children, identifying positive characteristics. The study underscored the critical role of mental health nurses in supporting mothers by enhancing their advocacy abilities.

Gona et al. (2011) conducted a study on caregivers' experiences caring for children with disabilities in Kilifi, Kenya. The study found that caregivers experience significant stress when their child's disability prevents them from fulfilling their future dreams and expectations. This stress shows up as not having enough time for other duties and being cut off from community events. The study also highlighted the complex causes of severe disabilities, combined with cultural beliefs and superstitions, leading to rumor-mongering. Carers are often associated with evil spirits, punishment from God, or witchcraft. Poverty further handicaps carers in providing optimal care, as it reduces the availability of external resources needed for efficient caregiving practices. Carers face difficulties in meeting basic needs such as food, clothing, school fees, and medication. Most caregivers believed that medical staff would provide clear information about their child's condition, but their expectation was often not the case.

Manyara (2020) reports that in Kenya, mothers of children with autism and other developmental disabilities endure significant caregiving strain, which adversely impacts their physical and mental health. These mothers experience exhaustion and fatigue, leading to physical illnesses, and suffer from stress, anxiety, and depression. The demand for constant care isolates them from social interactions. Additionally, extreme poverty makes it challenging for many mothers of children with mental disorders to access rehabilitation and treatment services.

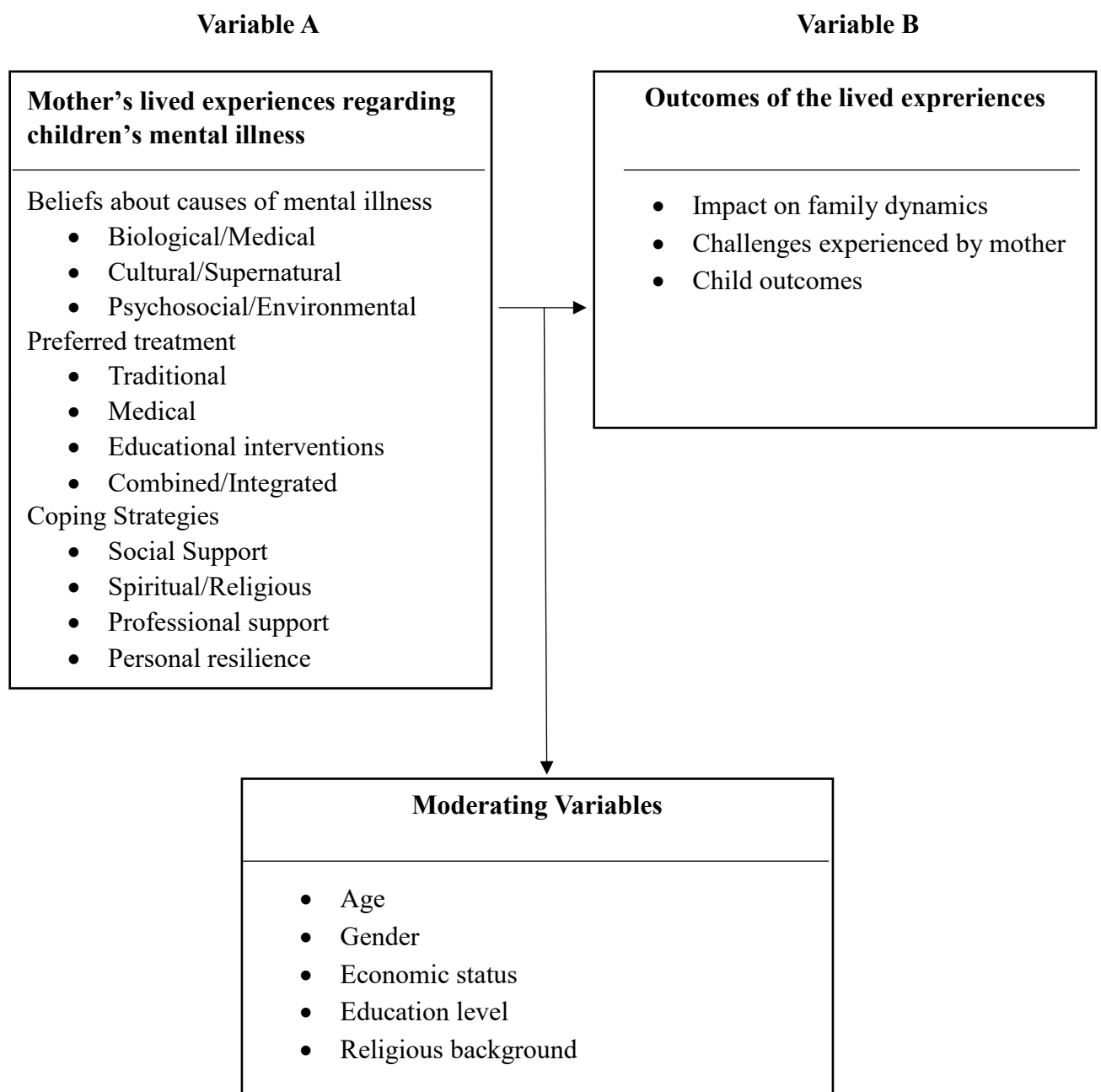
Although the study by Gona et al. (2011) offers beneficial information regarding the experiences of carers of children with disabilities in Kilifi, there is a notable gap in the literature

concerning the impact on family dynamics experienced by mothers of children with mental illness in informal settlements in Nairobi, Kenya. The Kilifi study elucidates the emotional, social, and economic challenges encountered by caregivers; however, it does not specifically examine the distinct experiences of mothers managing their children's mental illness within urban informal settlement contexts. Given the distinct cultural, social, and economic dynamics of Nairobi's informal settlements, this study aimed to fill this gap by exploring the impact on family dynamics and challenges experienced by mothers of children with mental illness at Mukuru Kwa Ruben Center in Nairobi, Kenya. This research offered a comprehensive understanding of their challenges, contributing to more effective mental health interventions and policies in urban Kenyan settings.

2.4 Conceptual Framework

The conceptual framework outlines the connections between the study variables as they pertain to the research objectives and questions. It provides a structured approach to understanding how different elements such as mental illness, lived experiences, beliefs about causes, preferred treatments, and coping strategies, interact with each other. The framework employs a diagram to visually represent these relationships and illustrate the flow from one variable to another (Selvam, 2017).

Figure 1: Conceptual Framework



Source: *Researcher, 2025*

Figure 1 distinguishes between independent variables (A), representing mothers' lived experiences and actions, and dependent variables (B), representing the outcomes of those experiences. The independent variables (A) encompass three key dimensions of mothers' lived experiences. First, beliefs about causes of mental illnesses include biological/medical, cultural/spiritual beliefs, and psychosocial/environmental factors. Second, preferred treatment options range from traditional healing approaches to professional medical treatment and

educational interventions. Third, coping strategies employed by mothers include social support networks, spiritual/religious coping, professional support services, and personal resilience strategies (problem-solving, advocacy, and hope).

These independent variables influence the dependent variables (B), which represent outcomes and impacts across multiple dimensions. These independent variables have an impact on family dynamics, the challenges faced by the mothers, and the outcomes for the children. The framework thus serves not only as an analytical tool for understanding mothers' experiences but also as a practical guide for developing comprehensive, multi-level interventions to support families affected by childhood mental illness in Nairobi's informal settlements and similar contexts.

2.5 Chapter Summary

This chapter discusses the theoretical framework, literature review, and conceptual framework of a study on mothers' experiences of the mental illness of their children. It provides a foundation for understanding the variables, discusses the diverse perceptions and beliefs of parents regarding mental illness causes, and reviews studies on preferred treatment options, including traditional, spiritual, and biomedical approaches. The chapter also looks at how parents deal with problems and puts them into three groups: problem-focused, emotion-focused, and avoidant. The conceptual framework visually represents the relationships between study variables, providing a structured approach to understanding the interaction of different elements. The next chapter presents the research methodology.

CHAPTER THREE

METHODOLOGY

3.1 Introduction

The chapter discusses the research methodology that was employed in the Study. It presents the Epistemology of the Study, research design and location of the Study, target population, sampling techniques and sample size. It also describes research instruments, pre-testing of tools, validity and reliability of the instruments, data collection and analysis procedures, ethical considerations, envisaged impact of the study, and chapter summary.

3.2 Epistemology of the Study

This research study adopted a Social Constructivism approach, which is appropriate because it focuses on the lived experiences and attitudes of individuals. The conclusions drawn from this study regarding the coping strategies of mothers of children with mental illnesses were based on their interpretations of the phenomena. This means that the research relied on interviewing participants to capture their views, opinions, and lived experiences, which served as the truth for the phenomena under study. This approach allowed for a deep understanding of the mothers' experiences, beliefs about the causes of mental illness, preferred treatment options, and coping strategies (Mvumbi & Ngumbi, 2015).

3.3 Study Design

This study used a qualitative research design to capture the lived experiences of mothers with children suffering from mental illnesses in Nairobi. Specifically, the research uncovered the lived experiences, challenges, and coping strategies these mothers employ in their daily lives. The study relied on the phenomenological approach, which is suitable for exploring the phenomena of mothers' lived experiences regarding their children's mental illnesses as experienced at the Mukuru Kwa Ruben Center in Nairobi. This approach focused on understanding the essence of their experiences and the meanings they attach to them. Due to

time constraints, the study employed a cross-sectional approach in data collection, capturing a snapshot of the mothers' experiences at a specific point. This method allowed for a comprehensive understanding of current beliefs, treatment preferences, coping strategies, and their effectiveness (Mugenda & Mugenda, 2019).

3.4 Location of the Study

The study was conducted at Mukuru Kwa Ruben Center, situated within the Mukuru informal settlement in Nairobi, Kenya. Mukuru is one of Nairobi's largest informal settlements. According to the 2019 census projections, Mukuru kwa Ruben has a population of 527,526. The Ruben Center, managed by the Christian Brothers African Province, is a faith-based charitable organization committed to empowering the Mukuru community through the provision of quality education, healthcare, and social services.

The center serves as a crucial hub for community development, offering a range of programs aimed at improving the living standards of the residents. These programs include educational initiatives, health services, economic empowerment projects, and advocacy efforts. The Curt Fearnley Self Help Group (SHG) at the center helps families with children who are having mental health problems. The Ruben Center's holistic approach and its pivotal role in the community make it an ideal setting for exploring the lived experiences of mothers with children suffering from mental illness (Ruben Center, n.d.).

3.5 Target Population

According to Mvumbi and Ngumbi (2015), the population can consist of people, objects, cases, or items that usually share similar characteristics. The study also involved selecting a significant group that shares a common trait as the sample. The target population for this study consisted of 39 mothers whose children have been diagnosed with mental illness (autism spectrum disorder, ADHD, fetal alcohol spectrum disorder, and cerebral palsy) and are receiving support at the Ruben Center in Mukuru Kwa Ruben, Nairobi. These mothers are

members of the Curt Fearnley Self Help Group at the center. These mothers are a crucial demographic for understanding the challenges, beliefs, treatment preferences, and coping strategies employed in managing their children's mental health conditions. By focusing on this group, the study gathered in-depth insights into their experiences and the effectiveness of the support systems available to them.

3.6 Sample Design

This study employed a purposive sampling technique to select participants from a defined population. Mothers whose children received mental illness diagnoses at the Mukuru Kwa Ruben Center in Nairobi made up the target group. Purposive sampling was appropriate for this qualitative phenomenological study, as it allowed the researcher to intentionally select participants who had direct experience with the phenomenon under investigation—namely, caring for children with mental illnesses. This sampling approach ensured that participants could provide rich, relevant information about their lived experiences, beliefs, treatment preferences, and coping strategies. According to Palinkas et al. (2015) and Selvam (2017), the use of purposive sampling enhances the credibility and depth of qualitative data while maintaining ethical standards in participant selection.

3.6.1 Sampling Technique

This study employed the purposive sampling technique, specifically criterion sampling, where participants were selected based on predetermined criteria of importance to the study. The inclusion criteria were (1) being a mother or primary female caregiver of a child diagnosed with mental illness, (2) the child receiving support services at Mukuru Kwa Ruben Center, (3) membership in the Curt Fearnley Self Help Group, and (4) willingness to participate and provide informed consent. Purposive sampling was chosen because it is appropriate for qualitative phenomenological research where the goal is to gain deep understanding of lived

experiences rather than statistical generalization (Palinkas et al., 2015). This approach allowed the researcher to select information-rich cases that could offer comprehensive explanations for the phenomenon of interest. Additionally, it was a practical approach for studying a specific population at a particular center, ensuring that all participants had relevant experiences to share (Patton, 2015).

3.6.2 Sample Size

Selvam (2017) defines a sample size as a meticulously chosen subset that accurately reflects the target population. The study involved 39 mothers from the Curt Fearnley Self Help Group at Mukuru Kwa Ruben Center, whose children had been diagnosed with mental illnesses. The researcher introduced and explained the study's nature, purpose, procedures, voluntary participation, confidentiality provisions, and the right to withdraw at any time. Each mother received a written consent form in either English or Kiswahili based on preference.

At the follow-up meeting, 28 mothers out of the 39 members signed informed consent forms, forming the sampling frame for the final sample. The researcher initially planned to conduct individual interviews with up to 10 participants to ensure comprehensive and in-depth exploration of the study's objectives. This number was determined based on qualitative research guidelines suggesting that 8-25 in-depth interviews are typically sufficient for phenomenological studies (Creswell, 2013).

Purposive selection criteria were developed to capture variation across key characteristics: age diversity, educational background diversity, marital status diversity, and type of mental illness diversity. From the pool of 28 consenting mothers, the researcher purposively selected 10 participants who collectively represented and met the criteria of the study. The researcher reviewed demographic information collected during the consent process and systematically selected participants to ensure representation across age ranges, educational levels, marital statuses, and children's diagnostic categories.

The 10 selected participants were contacted individually to schedule interview appointments at times convenient for them. Interviews were scheduled sequentially over approximately four to five weeks, with two mothers interviewed per week on different days. This sequential approach allowed the researcher to begin preliminary analysis after each interview, remaining alert to emerging patterns and the approach of data saturation. Data saturation was achieved after conducting in-depth interviews with 8 respondents.

The researcher made the evidence-based decision to conclude data collection after 8 interviews, which was discussed with and approved by the research supervisors. The remaining 2 participants from the original 10 selected were not interviewed, as the quality and completeness of data from 8 participants adequately addressed all research objectives. The researcher documented the decision-making process, including evidence of data saturation, supervisory consultations confirming saturation, justification that 8 participants provided sufficient depth and breadth of data, and acknowledging that this approach aligns with qualitative research best practices prioritizing data quality and saturation over predetermined sample sizes.

3.7 Research Instruments

Turale (2020) defines research instruments as tools used to collect data pertinent to the study's topic, determined by the research type undertaken. For this study, the researcher used semi-structured interview questions to obtain information on mothers' beliefs about the causes of their children's mental illnesses, their preferred treatment options, the coping strategies they employ, and the impact on family dynamics and challenges they face. Semi-structured interviews were preferred because they provided the researcher with the flexibility to ask open-ended questions and follow up with probe questions to analyze the participants' responses (Melnikovas, 2018).

This approach allowed the researcher to explore the participants' thoughts, beliefs, and lived experiences comprehensively. The interview guide was organized according to the four research objectives, with main questions and follow-up probes for each area of inquiry. The researcher conducted face-to-face interviews after seeking consent from participants to audio record the conversations. Interviews were facilitated in both English and Kiswahili, the official languages of Kenya, based on the participant's preference and comfort. The conversations were audio recorded, and simultaneously the researcher took field notes to complement the recordings, capturing nonverbal cues, emotional reactions, and contextual information that audio recordings might not capture.

3.7.1 Pre-Testing of Research Instrument

Pre-testing is undertaken to evaluate the practicality, accuracy, and consistency of the study instruments in obtaining the required data (McLaughlin, 2020). For this study, the interview guide was piloted with five mothers of children diagnosed with mental illnesses at a nearby center in Nairobi County, Kenya (not the Mukuru Kwa Ruben Center). These mothers had similar characteristics to the target population but were not part of the study sample.

This pre-testing process served several purposes: (1) it allowed the researcher to assess whether the questions were clear and understandable, (2) it helped identify any ambiguous or leading questions that needed revision, (3) it provided an opportunity to practice interview techniques and timing, and (4) it ensured the interview guide would elicit the depth and type of information needed to address the research objectives. Based on feedback from the pilot interviews, the researcher made minor adjustments to the wording of some questions and added additional probes to ensure comprehensive data collection. This pre-testing process enhanced the credibility and confirmability of the research instruments.

3.8 Data Collection Procedure

Data collection was carried out at the Mukuru Kwa Ruben Center in Nairobi County. The researcher adhered to relevant procedures throughout the data collection process. First, an Ethical Clearance Letter was obtained from the Tangaza University Research Ethics Committee. With this clearance, the researcher applied for and received a research license from the National Commission for Science, Technology, and Innovation (NACOSTI). With these approvals, the researcher sought written permission from the administration of the Mukuru Kwa Ruben Center.

Subsequently, the researcher met with the center's administration, who facilitated her introduction to the mothers in the Curt Fearnley Self Help Group (SHG) during a scheduled group meeting. During this initial meeting, the researcher introduced herself, explained her background and interest in the research topic, and described the nature, purpose, and procedures of the study in clear, simple language. She addressed questions and concerns from the mothers, clarifying issues related to confidentiality, voluntary participation, and the right to withdraw. This interaction contributed greatly to the process of building rapport and trust with potential participants.

The informed consent process was initiated during this session. Each mother received a written consent form in either English or Kiswahili (based on preference) and was given adequate time to review it. The researcher read through the consent form with the group, explaining each section and ensuring understanding. Mothers were encouraged to ask questions and were informed they could take the form home to review before deciding. The researcher scheduled a follow-up meeting one week later to collect signed consent forms from those willing to participate. A total of 28 mothers out of the 39 members of the SHG signed the informed consent forms, indicating their willingness to participate in the study.

From the pool of 28 consenting mothers, the researcher purposively selected 10 participants for potential in-depth interviews, consistent with the study's initial sample size projection. Selection considered ensuring diversity in terms of age, educational level, marital status, and types of mental illnesses affecting their children, to capture a range of experiences. However, as is appropriate in qualitative research, data collection concluded after eight face-to-face interviews, as data saturation had been reached—meaning no new themes or information were emerging from additional interviews.

Interviews were conducted over a period of four weeks, with two mothers interviewed per week on different days. Each interview was scheduled at a time convenient for the participant, with most interviews conducted during mid-morning or early afternoon when mothers were available after completing morning household tasks but before afternoon responsibilities. Interviews were conducted in a private and quiet room within the Ruben Center to ensure privacy, confidentiality, and comfort. The room was arranged to be welcoming, with comfortable seating and minimal distractions.

Prior to commencing each interview, the researcher welcomed the participant and reaffirmed the purpose of the study and what participation would involve. reviewed the signed informed consent form, reminding the participant of her rights, obtaining verbal consent to audio-record the session, ensuring the participant's confidentiality, explaining how the data would be used, and encouraging the participant to speak freely and honestly, emphasizing that there were no right or wrong answers.

Each interview lasted approximately 45 minutes to one hour, though the researcher remained flexible to allow participants adequate time to express themselves fully. Interviews were conducted in the language preferred by each participant—either English, Kiswahili, or a mixture of both. The researcher used the semi-structured interview guide but remained flexible to follow interesting leads and probe deeper into areas of significance to participants.

Throughout interviews, the researcher was attentive to participants' emotional states, offering breaks when needed and ensuring counseling support was available if any participant became distressed.

The researcher maintained an empathetic, non-judgmental stance throughout, using active listening skills, maintaining appropriate eye contact, and showing genuine interest in participants' stories. At the conclusion of each interview, the researcher thanked the participant for her time and willingness to share, asked if the participant had any questions or anything else to add, and reminded the participant of available support services at the center. Provided contact information for follow-up questions or concerns, briefly summarized key points to ensure accuracy (member checking). This approach ensured a thorough and respectful data collection process, capturing the rich insights and lived experiences of the participants in an ethically guarded environment.

3.9 Data Analysis

Thematic analysis was employed to analyze the descriptive data collected. This method involved categorizing data into words and concepts to identify recurring themes related to the study's objectives (Williams & Moser, 2019). The researcher used this approach to discern patterns in the respondents' experiences, forming coherent themes relevant to the research topic. The process included four steps: familiarizing with the transcribed data, establishing and coding themes, harmonizing and classifying sub-themes, and categorizing them into major themes.

Initially, the researcher thoroughly reviewed the raw textual data to identify phrases and sentences that aligned with the coding template. These codes were refined into sub-themes, which were subsequently grouped into major themes. This systematic approach ensured that the findings report accurately reflected the participants' perspectives on the topic under investigation. On the other hand, qualitative data analysis entailed the examination and

interpretation of figures and numbers, followed by a conclusion based on the rationale for the emergence of discoveries.

3.10 Ethical Considerations

Ethics must be integral to research from the initial design phase to data analysis and reporting (Ritchie et al., 2014). Hence, permission and clearance were sought from relevant authorities, including the Tangaza University College Ethics Committee, the National Commission for Science, Technology, and Innovation, and the Kwa Ruben Mukuru Center Management Committee.

According to Mugenda and Mugenda (2019), an ethical study is one that affords participants freedom of purpose while also protecting their rights to voluntary participation, anonymity, informed permission, and confidentiality. Respondents were being asked if they are OK with the interviews, if they would like to take a short break, if they would like to reschedule the remainder of the interview for later, and/or any other relevant question that kept building rapport. Through these interactions the researcher respectfully observed facial expressions of actions or reactions to emotions, such as eye movements, voice tone, or gestures, without invading their space.

The non-maleficence principle in ethics states that research should not purposely cause harm; thus, the research participants were not subjected to intentional risk of harm, as their participation was essential to achieving the study's aims. Therefore, any risks that were of a physical or emotional nature were explained to the respondents before engaging in the research process by signing the consent form. Psychological or emotional risks that may be triggered due to past experiences, like fear, anxiety, stress, confusion, guilt, and loss of self-esteem, among others, were to be handled with counselors who were on standby at the center. The research was conducted in a room away from the noisy areas in the compound to avoid physical

hazards caused by high noise levels that could cause pain, discomfort, and fatigue (Mugenda, 2008).

The principle of beneficence states that persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Consequently, the research procedures included, firstly, obtaining informed consent after clearly explaining risks that could be physical, emotional, or psychological. Secondly, the researcher prioritized safety by monitoring participants closely for adverse effects. Thirdly, the researcher provided support by offering counseling resources for emotional well-being and/or medical services to participants during and after data collection. Fourthly, respect for autonomy was followed by allowing participants to withdraw at any time without penalty (Ritchie et al., 2014).

Confidentiality signifies the obligation to keep personal information private and secure in accordance with legal and ethical principles. Hence, it is crucial to respect and protect interviewees' rights to privacy and ensure the confidentiality of their shared information. On the same note, a core ethical principle of justice in relation to research is fairness. Fairness is the ability to apply principles in a way that will remove bias and help create an equal playing field for all respondents. It includes adhering to the principle of autonomy, which entails giving persons independence in their decisions and actions to the extent to which they do not harm themselves or others or do not violate others' rights.

Consequently, the researcher was guided by the ethical principle of fidelity to build trusting relationships by being truthful in keeping promises made to those taking part in the research process through actions that aligned with high standards and values as a researcher (Williams & Moser, 2019). The study acknowledges other authors' works used in the dissertation, avoiding any bias, exaggeration, or distortion regarding the objectives of the study. Moreover, the study findings show anonymity, the option to opt out, voluntary

participation as per their informed consent forms, privacy, and confidentiality as ethical considerations observed by the researcher. Thus, when reporting the research findings, pseudonyms were used to further protect participant identities (Mugenda & Mugenda, 2019).

Guided by integrity, transparency, and accountability, the researcher honestly reported data, results, methods and procedures, and publication status in an open and transparent way such that the information and communication are easily accessible and easy to understand by use of plain language. The study also acknowledges other authors' works used in the dissertation, avoiding any bias, exaggeration, or distortion regarding the objectives of the study (Ritchie et al., 2014).

3.11 Worthiness and Trustworthiness

To establish the trustworthiness of the study, the researcher ensured the credibility, transferability, confirmability, and dependability of the findings as outlined by Turale (2020).

3.11.1 Credibility

To enhance the credibility of the research findings, the researcher employed participant validation, also referred to as member checking, a quality control approach described by Yin (2016) where respondents verify research findings. The researcher achieved those objectives by reviewing interview notes with participants to validate their responses, ensuring accuracy and credibility in the study's final results.

3.11.2 Transferability

Transferability refers to the researcher's ability to demonstrate that the study findings can be applied to different contexts and are beneficial to other researchers (Scott et al., 2016). The researcher achieved this outcome by providing a detailed description of the data collection process, including contextual factors, timing, methodology, and other relevant details that enhanced understanding of the study settings, thereby supporting transferable conclusions.

3.11.3 Confirmability

Confirmability, according to Carcary (2020), refers to the degree of objectivity in research findings, ensuring they are derived from participant responses rather than researcher biases. To achieve confirmability, the researcher implemented an audit trail method where she documented each phase of the research, including data collection and analysis, to validate the objectivity of findings (Yin, 2016). Transparency throughout the study process was maintained to openly acknowledge any potential biases or preconceptions that could influence results, thereby enhancing the credibility of the study outcomes.

3.11.4 Dependability

Dependability, as defined by Scott et al. (2016), measures the extent to which other researchers can replicate a similar study and obtain consistent results. The task involved evaluating the thoroughness of the research process and the reliability of its findings. To ensure dependability, the researcher conducted an inquiry audit, where external scrutiny of study data and relevant documents occurred. Detailed documentation of all research processes has been maintained to enable future reviews, and the researcher will make collected data accessible to facilitate evaluation.

3.12 Data Management

Ritchie et al. (2014) clarify that diverse forms of qualitative research data collection necessitate management and organization for effective access and analysis. The researcher secured the raw data, including audio recordings and interview notes, by locking physical copies in storage cabinets. To protect against loss or theft, copies of both raw and processed data were made. This too was done in accordance with the right to privacy as enshrined in the

Kenyan Constitution under Article 31 and the subsequent enactment of the Data Protection Act, 2019 (Act No. 24 of 2019.)

3.13 Chapter Summary

Chapter Three provided an overview of the methodological framework that guided this study. The chapter detailed the study's population and outlined the study design. The sampling design was detailed, including the reasons for choosing the sample size and the method used to choose the sample. The chapter also described the research instruments employed in data collection as well as outlining the data collection procedures and analysis methods. The next chapter presents the findings of the study.

CHAPTER FOUR

RESEARCH FINDINGS

4.1 Introduction

This chapter dives into what the data collected from mothers at Mukuru Kwa Ruben Center revealed about their children's mental illnesses. The chapter presents the analysis thematically, looking at each point through the lens of the four main questions this study aimed to answer all while keeping the real-life experiences of these mothers at the center of the discussion.

4.2 Demographic Characteristics of Respondents

Table 1 presents the demographic details of the study's participants.

Table 1: Demographic details of the participants

Respondent	Age	Marital Status	Level of Education	Religious Background
Respondent 1	36	Married	Form 4	Christian
Respondent 2	38	Married	Form 4	Christian
Respondent 3	44	Widowed/Single	Form 4	Christian
Respondent 4	28	Single	Class 8	Christian
Respondent 5	30	Married	Form 4	Christian
Respondent 6	47	Single	Class 6	Christian
Respondent 7	42	Separated	Form 4	Christian
Respondent 8	35	Married	Form 4	Christian

Table 4.1 presents the demographic characteristics of the eight participants who took part in this study. The participants' ages ranged from 28 to 47 years, with a mean age of approximately 38 years. Four participants (Respondents 1, 2, 5, and 8) were married, one was widowed (Respondent 3), two were single (Respondents 4 and 6), and one was separated (Respondent 7). Regarding educational attainment, six participants (Respondents 1, 2, 3, 5, 7, and 8) had completed secondary education up to Form 4 and obtained the Kenya Certificate of

Secondary Education (KCSE), while two participants had primary education—Respondent 6 completing up to Class 6 and Respondent 4 completing up to Class 8 with the Kenya Certificate of Primary Education (KCPE). All eight participants identified as Christian, reflecting a shared religious background.

4.3 Mothers' Beliefs About Causes of Their Children's Mental Illnesses

The first research objective sought to investigate mothers' beliefs about the causes of their children's mental illnesses. Participants held diverse and complex beliefs regarding what brought about mental health issues in their children. Analysis revealed that these beliefs generally fell under three primary categories: biological and medical explanations, cultural and superstitious beliefs, and psychosocial and environmental factors.

4.3.1 Biological and Medical Explanations

Some mothers demonstrated understanding of mental illness that aligned with biological and medical frameworks. These mothers attributed their children's mental illnesses to factors such as neurological imbalances, brain chemistry problems, genetic predispositions, and physical trauma. This perspective reflected exposure to mental health education and information from healthcare professionals.

Respondent 1 specifically identified brain chemistry and neurological imbalances as potential contributors to mental illness, rejecting more traditional or superstitious beliefs:

"It is through the scientific knowledge that I have gained in and out of this center on mental illnesses that I can explain how brain chemistry or neurological imbalance can be a cause of mental illness."

This response indicated an understanding that mental illness is not inherently connected to external factors like curses or witchcraft but can arise from medical conditions that affect brain function.

Similarly, Respondents 3 and 5 viewed mental illness as a brain disorder resulting from physical events that damaged brain structure or function:

"If the brain structure is tampered with, it stops being okay. My child had normal development of milestones until she had convulsions at nine months as a result of high temperatures due to severe malaria. The outcome is what caused my child's mental illness." (Respondent 3)

"After giving birth to my child, the doctor bluntly informed me that my child would not lead a normal life." He was diagnosed with cerebral palsy as a result of prolonged labor and its effects. It was so traumatizing." (Respondent 5)

These narratives demonstrated mothers' understanding that specific medical events—severe illness with high fever, birth complications—could result in neurological damage leading to mental health conditions.

The influence of mental health education in transforming mothers' understanding was apparent in the response from Respondent 8, who initially subscribed to superstitious beliefs but subsequently altered her viewpoint after acquiring knowledge:

"My attitude changed after I gained knowledge and understanding about mental health. I now know it is an illness just like any other sickness that needs attention, medication, and care. Similarly, I have learned to be loving and caring to my child, unlike before when I wished him death. "God forgive me."

This transformation highlights the crucial role of awareness and mental health literacy in confronting firmly entrenched misconceptions and empowering mothers to pursue appropriate care for their children.

Another aspect of biological explanations was acknowledgment of hereditary influences. Respondent 2 conceded the potential for mental illness to be transmitted across generations:

“It is not something I can run away from. I am told it runs in the family where I am married; thus, there is a possibility of a member of the family getting affected. Fortunately, I can affirm that not everyone suffers from it; my first two children remain mentally healthy.”

This response demonstrated awareness of genetic predisposition, consistent with scientific understanding that points to hereditary factors in certain mental health conditions.

Overall, responses indicated that some mothers held a more medical and biological view of mental illness, especially following exposure to mental health education through the Ruben Center and healthcare providers. Their acknowledgment of neurological, genetic, and physiological factors as potential contributors to their children's conditions suggested a more informed and evidence-based understanding of mental health.

.3.2 Cultural and Superstitious Beliefs

Despite exposure to medical explanations, several mothers still understood their children's mental illnesses through the lens of cultural and superstitious beliefs. These beliefs often involved attributing conditions to forces like witchcraft, curses, black magic, and supernatural influences, revealing deeply ingrained cultural perspectives on mental well-being.

Respondent 4 firmly held that mental illness was intertwined with superstition and black magic, suggesting that invisible spiritual entities could be influencing a child's mental state:

“I have never heard of mental illness that is not brought about by witchcraft and/or superstition. None, none at all. My husband's stepmother and her team of witches are feared for causing calamities and disasters in the community at large. What I have

heard and known about mentally ill people since I was a child is that mental illness is caused by different types of witches tied to superstitions or black magic, period."

(Spoken with raised voice and anger).

This observation highlighted the extent to which cultural beliefs regarding the impact of supernatural forces were embedded within the community—beliefs that often-perpetuated anxieties and misunderstandings surrounding mental illness.

Likewise, Respondent 8 initially attributed her child's condition to witchcraft, a perspective widespread in areas where mental illness is commonly connected to spiritual activity:

"I am super glad I was introduced and joined this group. Before I joined this great group of Curt Fearnley SHG here at Mukuru Kwa Ruben Center, nobody or nothing would convince me that my child's cause of mental illness was not witchcraft. I strongly believed my child was bewitched. In short, personally, I always associated any mentally ill person with being bewitched. But as of here and now, the knowledge I have has driven me to believe otherwise."

This viewpoint highlighted dependence on conventional beliefs, where those thought to harbor harmful intentions or possess supernatural powers were frequently held responsible for causing misfortune to others.

Extending beyond witchcraft, some mothers linked mental illness to curses, especially those stemming from familial discord. Respondent 7 shared that mental illness might stem from marital conflict and family rejection:

"I was married where my mother-in-law hated me. To date I view the rejection as a curse, since our union with her son lacked her blessing. Moreover, I had so much anxiety about my fate and that of my unborn child based on what the other family members and neighbors told me about her ill motives. Though I managed to run away

from that home, the curses caught up with me, and here I am with this mentally ill child who has their flesh and blood."

This statement illustrated the extent to which interpersonal conflicts and familial stressors could be interpreted as factors in a child's mental health, adding another layer of complexity to mothers' understanding of the illness.

Some mothers believed that certain actions during pregnancy could invoke curses.

Respondent 2 explained:

"Mental illness can occur as a curse when a pregnant woman laughs at a person, especially a child suffering from it."

Respondent 5 connected her child's condition to a past abortion, viewing it as ancestral punishment:

"When I was in school in Form 3, I became pregnant, and we decided with the teacher who was my boyfriend that getting rid of it was the way to go, as I could not face my parents. Later on, I got married and my second child is mentally ill. Though I had prolonged labor in the village before going to the hospital, at the back of my mind I have no doubt it is a curse from my ancestors for shedding blood, though I kept it a secret."

These responses reflected superstitious beliefs surrounding pregnancy, where expectant mothers felt they must act with extreme care to avoid inviting misfortune upon their unborn children.

Additionally, some mothers believed that inadequate self-care during pregnancy, as dictated by cultural norms, could result in mental illness. Respondent 3 stated:

"In my culture, a pregnant woman should be well taken care of so that her unborn child can be healthy. If this doesn't happen, mental illness can occur."

Respondent 7 also connected cultural violations to her child's condition:

"I keep telling myself I am paying for a cultural curse. I was married to a man whose culture dictates that if there is any divorce or separation, the children must remain with the father. However, because I did not believe in the same, coming from a different culture, I ran away with my pregnancy, abused drugs and alcohol to reduce stress levels, and did not take the child back after delivery. Actually, I am not even sure which is which here."

Collectively, these responses highlighted the influence of cultural and superstitious beliefs on mothers' understanding of mental illness. These beliefs frequently caused mothers to attribute their children's conditions to external spiritual forces rather than to medical causes.

4.3.3 Psychosocial and Environmental Causes

Beyond biological and cultural factors, some mothers linked their children's mental health issues to psychosocial and environmental influences. These mothers suspected that maternal stress during pregnancy, unhealthy behaviors during pregnancy such as substance and alcohol abuse, and physical harm experienced by children contributed to the onset of mental health problems.

Respondent 6 specifically pointed to the mother's lifestyle and health during pregnancy as possible factors:

"The fetus feeds on what the mother feeds on while in the womb; hence, the lifestyle of a mother determines their nutritive value. "For instance, abusing alcohol and having a poor diet can be contributing factors to the malformation of the fetus."

This response indicated awareness of how substance abuse and inadequate nutrition during pregnancy could impact the fetus's development, potentially resulting in neurological or developmental issues.

Several mothers acknowledged that physical harm could play a role in mental health disorders, especially when children experienced head injuries. Respondent 3 shared her experience:

"When a child falls, the brain's damage can lead to mental illness, whether it is frequent falling or a single accidental fall. I found myself as a mother of a mentally ill child. My house help did not explain how it happened, though we suspect she dropped the baby and the baby fell while she was carrying the child. A fall that was not accompanied by the baby's cry because of the damage that took place then."

Respondent 5 echoed this concern:

"Physical causes like head injury and falling can damage the brain. That is what affected my child. Our brain is fragile, more so that of a child, hence should be handled with a lot of care. Hitting the head or falling is a risky factor for anyone, even us adults. Really dangerous."

Respondent 7 described how childhood accidents during play could cause harm:

"Children can accidentally hurt their heads when playing. Never take it lightly, as it can be a cause of mental illness. It is important to check on them as they play and never take any bit of complaint they make for granted. Maybe if I had taken what the siblings reported to me seriously and sought medical attention, maybe I would not be here. However, I cannot keep blaming myself; it was due to ignorance. How I wish others would learn from my experience and be more careful to avoid such regrets."

These responses revealed understanding that external environmental influences—maternal stress, inadequate prenatal health, childhood injuries—have the potential to impact mental health outcomes. Although some mothers retained superstitious or spiritual beliefs, others embraced scientifically based explanations, especially concerning brain injuries and maternal health during pregnancy. This growing comprehension indicated a progressive shift

towards medical and environmental perspectives on mental illness, particularly among mothers who had received education through the Ruben Center.

4.4 Mothers' Preferred Treatment Options for Their Children with Mental Illnesses

The second research objective sought to identify mothers' preferred treatment options for their children with mental illnesses. Mothers detailed a range of strategies they employed to address their children's mental health challenges. Cultural beliefs, economic limitations, service availability, and personal experiences frequently influenced their decisions. The analysis uncovered preferences for traditional healing, professional medical and psychiatric treatment, educational interventions, and frequently a blend of these methods.

4.4.1 Traditional Healing and Herbal Remedies

Some mothers prioritized traditional healing methods, especially as initial treatment approaches. These included utilizing herbal concoctions, spiritual ceremonies, and guidance from traditional healers. People perceived these practices, strongly tied to indigenous knowledge and traditions, as more readily available, affordable, and culturally appropriate than formal healthcare services.

Respondent 6 explained her initial reliance on traditional healing:

"In our community, traditional healers have been treating illnesses for generations. When I noticed my child's condition, I first consulted a local healer who gave me herbal medicine and spiritual cleansing rituals to remove any bad spirits."

Some mothers attributed mental illness to spiritual imbalances or ancestral influences, prompting them to seek guidance from religious figures or spiritual healers. Respondent 4 elaborated on her approach:

"I took my child to a pastor for prayers and deliverance. I believed that spiritual forces caused the illness, which meant I needed divine intervention before anything else."

Participants also viewed religious practices like prayer, fasting, and church attendance as crucial treatment methods. Respondent 1 described her initial approach:

"Before considering the hospital, I prayed and fasted, asking God to heal my child, but it did not work as I expected, as the condition was not improving. What saved my child was a community outreach conducted by these mothers of mentally ill children from this group at our shopping center, informing the community on matters pertaining to mental illness."

Despite initial reliance on traditional and spiritual methods, some mothers later sought medical intervention when symptoms persisted or worsened. This progression from traditional to medical care emerged as a common pattern, particularly after mothers received education about mental health through the Ruben Center's programs.

4.4.2 Psychological and Psychiatric Treatment

Although traditional healing practices were prevalent as initial approaches, some mothers sought psychological or psychiatric assistance, particularly when their children's symptoms reached unmanageable levels or when they received education about available professional services. However, the availability of qualified mental health professionals was limited, and financial constraints often made regular therapy challenging.

Respondent 2 described her journey to professional care:

"At first, I thought mental illness could only be treated with prayers, but when my child's condition worsened, with the help of a social worker, I had to take him to the hospital for screening, assessment, diagnosis, and treatment. I am glad my child gets professional treatment that is appropriate for him."

Several mothers recognized the value of therapeutic approaches but faced significant barriers. Respondent 7 explained:

"Therapeutic approaches such as counseling, cognitive behavioral therapy (CBT), and play therapy are recommended. However, it is an uphill task to take my child for therapy sessions because I cannot afford them regularly as required. They are expensive and not widely available. So, majorly, I rely on the financial support of good friends or well-wishers who I believe are God-sent to help me out."

Medication presented another treatment option, though mothers frequently approached it with hesitation, primarily due to concerns regarding potential side effects and initial skepticism. Respondent 5 shared her experience:

"The first time the doctor prescribed medication, I hid it. I was scared it would make my child's condition worse based on my beliefs. However, I had no clue that my child's condition was worsening. Fortunately, I got timely psychoeducation from social workers and CHWs [Community Health Workers] that made me quit ignorance and join the right path of medication, therapy, and nutrition."

Some mothers discovered that a combination of therapy and medication constituted the most effective treatment approach. Respondent 8 noted:

"Counseling helped my child with emotional struggles, and medication managed the severe symptoms. When used together, they made a difference."

Others explored alternative medical treatments such as nutritional supplements alongside psychiatric care. Respondent 3 explained:

"Though my child's treatment is majorly therapy and medication, she takes omega-3 supplements, which help with brain functioning. The combination's results are commendable."

4.4.3 Frequency of Traditional or Alternative Medicine Use

The utilization of traditional and alternative medicine was influenced by social, cultural, and economic factors. Mothers frequently employed these methods either as standalone

treatment or in conjunction with conventional medical care. Some mothers continued using traditional healing practices even after accessing medical intervention, convinced of their holistic benefits.

Respondent 6 described her continued use of traditional remedies:

"I still use herbal remedies, which my family has used for generations, even though I take my child to the hospital. I utilize a combination of special leaves from my rural home that are fried and cooled, and pig fat to massage my child's weak body before I put him out in the sun to acquire vitamin D."

This response highlighted firmly entrenched cultural conviction in the holistic advantages of traditional medicine, viewed as a complement to rather than a substitute for conventional hospital care.

Accessibility and affordability influenced mothers' ongoing use of traditional healers.

Respondent 1 explained:

"It was easier to go to the local healer first because I didn't have to wait in long hospital lines or pay expensive consultation fees."

Family and community dynamics significantly influenced treatment choices, with elders often advising mothers to explore traditional remedies. Respondent 2 offered the following insight:

"In our culture, the transmission of our ancestral/traditional medicine from one generation to the next brings us contentment. Hence, I had no objection when my mother-in-law took me and my child to see a traditional healer as our first treatment option before we later went to the hospital."

For many mothers, the cost and availability of medical care played crucial roles in their ongoing use of traditional remedies. Respondent 7 explained:

"Most of us in the informal settlements have economic hardships. Getting ourselves the basic needs has never been easy; hence, this translates to the fact that we cannot afford hospital treatment. Therefore, clearly, we are left with only one way out—that is herbal treatment, which costs less. The reason why I keep using them is I comfortably negotiate and pay what I have or make a pledge and pay later."

Beyond monetary issues, the stigma associated with mental health care additionally deterred some mothers from pursuing professional medical help. Respondent 4 expressed:

"I smell social stigma here, there, and everywhere around me. I cannot imagine how 'people' will laugh at me as a failed mother if I take my child to a psychiatrist. It's easier to use traditional medicine because it's more acceptable in the community, just to play safe and avoid further rejection, discrimination, and isolation, among others."

Although traditional treatments remained firmly established, some mothers recognized the value of medical intervention but encountered obstacles such as financial limitations and lack of access to professional mental health services.

4.4.4 Role of Educational Interventions

At Mukuru Kwa Ruben Center, educational interventions played vital roles in aiding children with mental health difficulties. Numerous mothers acknowledged the significance of specialized learning initiatives and support services provided within schools, observing that these interventions empowered their children to better manage emotions, enhance social skills, and boost academic achievements.

For children with learning disabilities or developmental problems, Individualized Education Plans (IEPs) offered carefully structured and customized instruction. Respondent 8 highlighted beneficial effects:

"My child is in a special program where teachers help him learn at his pace."

The center incorporated behavioral modification initiatives to assist children in managing emotions and cultivating self-control. Respondent 3 elaborated:

"The school uses reward systems and clear routines to help my child with their behavior."

This approach emphasized positive reinforcement and well-defined discipline, proving especially advantageous for children with difficulties in impulse management or emotional outbursts.

Mothers highly valued Social-Emotional Learning (SEL) initiatives designed to assist children in developing emotional intelligence and relationship abilities. Respondent 5 highlighted positive impacts:

"My child has learned how to manage their emotions better through school activities that teach social skills."

This showed how SEL programs encouraged emotional regulation and peer interactions, helping children navigate social challenges more effectively.

School-based counseling services proved particularly valuable for families unable to afford private therapy. Respondents 1 and 7 expressed appreciations:

"My child attends a community program that helps him interact with others. He is building his self-esteem as well and gaining confidence." (Respondent 1)

"The school counselor is helping my child learn anger management skills to stop his aggressiveness. I appreciate it a lot because honestly I can't afford private therapy."
(Respondent 7)

These responses illustrated the vital role that readily available counseling in schools played in bridging gaps for families who couldn't afford professional mental health care.

4.5 Coping Strategies Employed by Mothers

The third research objective sought to determine coping strategies employed by mothers in caring for their children with mental illnesses. Mothers employed diverse strategies to manage the demands of caregiving, including social support networks, spiritual and religious beliefs, professional support services, and personal resilience strategies.

4.5.1 Role of Social Support Networks

Social support networks proved vital for mothers as they tackled complex emotional, financial, and physical hurdles associated with raising children struggling with mental health issues. Various resources were utilized, including peer support groups, extended family, religious communities, non-governmental organizations, and community-based programs, all providing essential aid.

Peer Support Groups: Many mothers discovered that peer support groups were highly effective coping mechanisms. The Curt Fearnley Self Help Group at the Ruben Center offered a safe environment where mothers could share experiences, receive encouragement, and learn from others facing similar challenges. Respondent 5 highlighted the importance of this support:

"The use of community and peer support networks is a central coping strategy for us mothers at the Curt Fearnley Self-Help Group. They provide us with a non-judgmental supportive environment where we as mothers share our experiences, exchange coping strategies, and find emotional comfort among ourselves. In a nutshell, it is being in an ideal safe space."

Similarly, Respondent 1 described how connecting with others helped her feel less alone:

"It is said a problem shared is a problem half-solved; therefore, as a mother with a mentally ill child, I feel encouraged to seek my own mental wellness through mental

health support systems. This includes counseling services, support groups, or just talking to a trusted friend or family member."

Beyond emotional comfort, peer support groups also provided valuable knowledge about mental health care. Respondent 6 explained:

"The Curt Fearnley Self-Help Group provides us mothers with information on the right steps to take in the professional treatment processes for our mentally ill children. What we learn changes our mindset, hence changing our misinformation from our schemas in which we have built our belief systems. We also learn self-care strategies in dealing with stress-related issues and burnout."

This indicated that educational support within these groups enabled mothers to make informed decisions regarding their children's well-being and to better manage their own mental health.

Extended Family Support: While peer support groups were crucial, some mothers also leaned on extended families, especially grandparents, for emotional support and help with childcare. Respondent 4 explained her family's role:

"I often rely on my extended family. My parents and other relatives who live around me make a strong support system for me. They provide emotional support, help with childcare, or offer advice based on their own life experiences. Our bond unites us all. It has no boundaries or discrimination."

Community Support: The support network extended beyond family, as community members actively participated in caregiving. Respondent 7 recounted:

"I am lucky to be in a tight-knit informal settlement where neighbors and local community groups often step in to help each other. No social stigma, no isolation. Hence, these support systems offer emotional reassurance, advice, or practical help such as providing meals or assisting with household chores."

Another crucial coping mechanism involved emotional validation received from family and peers. Respondent 3 highlighted the significance of having safe spaces to express feelings:

"Social support networks, including family, friends, and fellow members of support groups, allow mothers to express their feelings and experiences in a safe, non-judgmental environment. Honestly, with this support system I feel validated in my emotions, whether it's frustration, guilt, sadness, or hope, among others."

These responses demonstrated that mothers who had strong family or community support were better able to manage stress and caregiving responsibilities.

NGO Programs and Community Health Workers: In addition to informal support systems, numerous mothers found structured assistance programs run by non-governmental organizations, community groups, and healthcare professionals to be advantageous. Respondent 7 highlighted the crucial role of NGO-initiated mental health services:

"Many NGOs offer programs specifically designed to support families of children with mental illnesses. These programs often provide free or low-cost mental health services, educational materials, workshops, and counseling."

Community Health Workers (CHWs) also played crucial roles in providing home-based support. Respondent 6 elaborated:

"CHWs help in managing chronic conditions like mental illness, which is indeed a big relief for me. They are my major support system because they often visit me and my mentally ill child at home, conduct health assessments, and offer medical care at no cost. When nobody else may visit my home, CHWs will do. They tirelessly visit homes, conduct health assessments, and offer support with basic medical care, including managing chronic conditions like mental illness. In case any child needs attention they are unable to provide—thus anything beyond their competence—they refer to more qualified ranked personnel."

Some mothers found that group therapy sessions provided by these institutions were instrumental in helping them acquire practical coping approaches. Respondent 3 articulated the advantages:

"For me, our sharing about the similar challenges we face because of our mentally ill children as mothers in group therapy comes with emotional relief, practical advice, and a sense of community."

These structured programs helped bridge gaps where formal mental health care was inaccessible, making it easier for mothers to manage their own stress and their children's needs.

4.5.2 Influence of Spiritual or Religious Beliefs

Mothers found that their spiritual and religious beliefs were integral to managing the multifaceted challenges of parenting children with mental illness. Faith served as a compass, offering solace, fortitude, a sense of purpose, and a lens through which to interpret their experiences.

Some mothers discovered solace and guidance in religious counseling, with faith leaders offering blends of spiritual insight and actionable suggestions. Respondent 5 articulated how religious counseling reshaped her comprehension:

"I no longer believe in witchcraft in connection to mental illness. My pastor offers me spiritual wisdom and practical advice on how to handle my child's mental illness. This guidance provides me with reassurance that I am on the right path, even if the road is difficult."

This highlighted the significant roles faith leaders played in questioning damaging traditional beliefs and substituting them with hope, knowledge, and a sense of purpose.

Religious teachings also shaped mothers' attitudes toward caregiving, encouraging them to approach their children with compassion, patience, and unconditional love. Respondent 4 shared how these values helped her manage emotional burdens:

"Religious and spiritual teachings often emphasize values like patience, compassion, and unconditional love, all of which are essential in caregiving for children with mental illness. These values have shaped how I manage the emotional toll of caregiving."

For many mothers, faith furnished foundations for acceptance, enabling them to approach their child's condition with understanding instead of frustration.

For some mothers, challenges associated with raising children with mental illness could be perceived as divine trials, moments for spiritual development, or even routes to salvation. Respondents 6 and 7 articulated this viewpoint:

"A child is a child; hence, the task of caring for a child fosters a sense of purpose. I mean any child, including the one with mental illness, is a sacred duty or an act of service to God that one is assigned by God." (Respondent 6).

"The challenges of caregiving, including dealing with a child's mental illness, are seen as tests of faith, opportunities for personal growth, or pathways to spiritual redemption." (Respondent 7).

By viewing caregiving responsibilities as parts of divine missions, mothers felt greater senses of fulfillment and strength, reducing feelings of despair.

Faith served as a source of emotional strength, enabling mothers to cultivate mindsets of endurance and perseverance when confronted with adversity. Respondents 2 and 3 reflected on how religion fortified their resolve:

"Religion and spirituality often encourage me with an approach of endurance and perseverance in the face of adversity." (Respondent 2).

"The sense of hope that comes from the love of God is a powerful motivator, especially in difficult times when other avenues of support are unavailable." (Respondent 3).

4.5.3 Professional Support Services

Despite encountering obstacles to formal healthcare access, mothers acknowledged the significance of professional assistance in addressing their children's mental illnesses. Various forms of professional support were utilized, including community health workers (CHWs), social workers, therapy programs, specialized educational services, and psychiatric treatment.

Community Health Workers (CHWs): Community health workers were often vital to mothers, especially in delivering home-based healthcare, educating them about mental health, and referring them to specialists when needed. Respondent 1 highlighted how CHWs simplified accessing healthcare:

"The CHWs visit my home, check on my child's progress, and guide me on how to manage their medication. Without them, I would not know what to do or where to go for help."

Similarly, Respondent 6 emphasized how CHWs helped mothers understand their child's condition:

"After realizing that my child was not a 'normal child,' I moved to another place where I would be comfortable hiding the child. Unfortunately for me, the secret was out as my children shared about the sibling who is kept inside the house."

The story made rounds. Finally, with the help of a non-judgmental attitude, the CHWs made me understand that my child needed medical attention, not just prayers or herbal treatments as I was rationalizing."

Respondent 8 also appreciated how CHWs offered emotional and practical support:

"There are situations I do not know what to do about my child's condition. In such moments I feel overwhelmed and hopeless. However, when CHWs come to my rescue, I

talk to them, and they help me in finding solutions. For instance, they refer me to hospitals when my child is in a state they cannot handle or when the child needs more professional attention than they can give."

For these mothers, community health workers served as crucial links between traditional beliefs and contemporary mental healthcare, facilitating their willingness to accept medical treatment without experiencing fear or stigma.

Social Workers and Case Managers: Beyond community health workers, some mothers discovered that social workers and case managers were valuable assets in navigating the healthcare system, educational resources, and various community support services. These skilled professionals helped connect them with financial aid, advocacy initiatives, and support groups. Respondent 3 was particularly thankful for direction given by social workers:

"They help us find schools for our children, assist in getting medical referrals, and connect us to support groups where we meet other mothers like us."

Similarly, Respondent 7 highlighted the importance of social workers in advocating for mental health resources:

"Without their help, I wouldn't know where to start. They fight for our children's needs and help us get access to services that we didn't even know existed."

For Respondent 2, the community and sense of belonging created by support groups facilitated by social workers made a significant difference:

"Social workers search for us from the different corners of the informal settlement and bring us together to form a group of mothers of children with mental illness. They purpose not only to offer advice to us but also to give us any required help. Their attention is focused on making sure we feel heard, understood, and supported in the treatment journey of our children."

Through these experiences, it became evident that social workers were vital in assisting mothers as they navigated bureaucratic hurdles, gained access to crucial resources, and enhanced their confidence in caregiving.

Therapy and Integrative Mental Health Support: Some mothers found that therapy programs and holistic approaches were beneficial for managing their children's mental health conditions. These included individual counseling, play therapy, occupational therapy, and group therapy. Respondent 4 valued the benefits of therapy:

"My child struggles with expressing emotions, but after attending play therapy sessions, which help her calm down and communicate better."

Respondent 5 described how group therapy provided both emotional relief and practical advice:

"Meeting with other mothers in therapy helps me feel less alone. I too learn different ways to handle my children's struggles."

For some, occupational therapy and structured interventions made noticeable differences. Respondent 7 explained:

"My child has trouble focusing, but therapy has helped with their attention span and behavior management."

Despite the efficacy of these treatments, numerous mothers encountered financial barriers to consistent access, highlighting the critical need for accessible, community-oriented mental health services.

Specialized Education Programs: Numerous mothers actively sought specialized educational programs tailored for children diagnosed with learning disabilities, autism spectrum disorder (ASD), or attention-deficit/hyperactivity disorder (ADHD). Such programs offered structured educational settings and expert assessments, guaranteeing that each child

received personalized support. Respondent 6 elaborated on positive impacts of educational psychologists:

"The school psychologist, together with the team from the Kenya Institute of Special Education (KISE), assessed my child and recommended special learning programs that match his needs."

Similarly, Respondent 8 emphasized how special education programs created supportive learning environments:

"My child is no longer in an integrated school or class like before. After joining the special school, she too joined a special class where she gets specialized attention and support. The difference between the two schools has shown a huge positive change in her academic pathways."

For Respondent 2, access to specialized education services was a turning point:

"Before getting professional support, my child struggled a lot. But with the right school program, he is improving, and I feel more hopeful."

These responses highlighted vital functions that specialized educational support played in facilitating academic and social flourishing of children grappling with mental health issues.

4.6 Impact on Family Dynamics and Challenges Experienced by Mothers

The fourth research objective sought to examine the impact on family dynamics and challenges experienced by mothers of children with mental illnesses. Analysis revealed that families were profoundly impacted by the presence of a child with mental illness, affecting their structure, relationships, and overall dynamics. Three main themes emerged: financial burdens, emotional toll on siblings, and social isolation and loneliness. Additionally, mothers experienced significant personal challenges, including stress and overwhelm, and stigma and discrimination.

4.6.1 Financial Burden

A prominent difficulty encountered by mothers was financial hardship linked to raising children with mental health issues. Expenses related to healthcare, therapy appointments, specific dietary requirements, and additional support services imposed substantial weight on families, many already navigating meager financial means. In some instances, this monetary strain precipitated family dissolutions.

Respondent 6 described how financial burden led to the breakdown of her marriage:

"My marriage broke up majorly due to financial constraints. Life turned out to be unbearable for us. My husband thought he would be safe to run away and indeed he did. He even moved to another town, promising to support us but we have never seen or heard from him for three years now."

This response highlighted the difficult reality that some fathers, either incapable or reluctant to handle the financial and emotional burdens of childcare, decided to abandon their families. In these situations, mothers were forced to carry the weight of providing for their children single-handedly, often with little to no assistance.

For those who stayed in marriages, financial pressure frequently pushed fathers to take on multiple jobs, resulting in extensive work hours and greater physical absence from households. Respondent 5 stated:

"My husband has to hustle here and there, thus engaging in many casual jobs so as to provide for us as his family. He is more of an absent father; we miss him a lot."

This statement highlighted the strain that monetary limitations imposed on both mothers and fathers, compelling the latter to undertake strenuous labor to provide for their households. Although their efforts contributed to meeting families' financial needs, resulting extended periods away from home often led to a sense of emotional detachment within family units.

Respondent 6 elaborated on how steep expenses associated with healthcare and specialized diets further intensified these monetary challenges:

"Family resources are drained because of catering to the needs of the mentally ill child, like medical bills and special diets. It is not easy providing for this child who cannot eat anything outside the doctor's advice. No doubt, I can borrow or beg for his sake when ends do not meet. Therefore, struggle or no struggle, he always comes as our first priority whatsoever, such that even when there is no food for the rest of us in the family, he gets his medication and food on time."

This response highlighted persistent and frequently burdensome financial obligations tied to caring for children with mental health issues, particularly when access to cost-effective medical care and support services was constrained. Numerous families were compelled to place their child's requirements ahead of other indispensable expenditures, occasionally compromising their own health or that of their other children.

4.6.2 Emotional Toll on Siblings

The presence of children with mental health conditions extended influence beyond parents, significantly touching the emotional lives of siblings. Numerous mothers shared accounts of their other children grappling with difficulties inherent in cohabiting with siblings suffering from mental illness. These siblings frequently experienced sentiments of being overlooked, jealousy, apprehension, and a heightened sense of responsibility.

Respondent 8 illuminated how her other children struggled to comprehend their sibling's condition, often succumbing to fear during moments of aggression:

"It is so sad that my other two children do not understand the nature of their sibling's mental illness at all, at all. They express fear, especially of the unknown, when their sick sibling experiences aggressive episodes. An expression of traumatic scenarios that disrupts their daily routines, like playing, eating, and sleeping most of the days."

This response highlighted the role that the family's limited awareness and comprehension of mental illness played in exacerbating fear and emotional turmoil for siblings. These siblings often struggled to make sense of or logically explain their sibling's erratic actions.

In a similar vein, Respondent 3 disclosed that her children frequently experienced feelings of jealousy and being overlooked, as she was compelled to allocate more of her time and attention to the child coping with mental illness:

"My other children feel angry, jealous, frustrated, and neglected because I prioritize their sick sibling consciously and at times unconsciously. For now, there is nothing I can do. I am looking forward to that day my children will grow up to understand why I do what I do and know that I am not doing it because I do not love or value them."

Parents of children with special needs frequently encountered the difficult and emotionally draining task of fairly distributing their attention among all their children. It was not uncommon for siblings to harbor feelings of resentment and jealousy, often rooted in the belief that their mother's affection and care were not shared equally.

This situation extended beyond emotional hardship, with some siblings taking on greater responsibilities, including assisting with the care of their special needs brothers or sisters and managing more household tasks. Respondent 5 spoke about how her other children had to step up and assume extra duties:

"If the other children wait for me to do what I have been doing for them as their mother before their sibling's problem emerged, they will suffer, as I will not meet their expectations. As a result, they chip in, handling some chores and assisting with the daily routines. This is helpful to us all as a family since I am either out of home or busy with their sister most of the time, as she needs my assistance here and there."

This response highlighted how caregiving duties were sometimes unintentionally transferred to siblings, forcing them to grow up faster and take on adult-like responsibilities at young ages.

Respondent 1 echoed this concern, acknowledging that her children were burdened with added household responsibilities due to demands of caregiving:

"It is unfortunate my other children cannot stop complaining about helping in adult responsibilities with a lot of anger and bitterness. It is not that I like it; it is due to the unavoidable circumstances since we have been sidelined by even our relatives, like my siblings and my in-laws, who should offer us the needed assistance and support."

These highlighted challenges faced by mothers, who, despite their dedicated efforts, frequently found it difficult to juggle demands of caregiving and managing household responsibilities. This imbalance often resulted in frustration among siblings who felt coerced into adopting roles they did not select for themselves.

4.6.3 Social Isolation and Loneliness

Mothers responsible for children with mental health challenges frequently experienced social isolation and significant loneliness. Social stigma attached to mental illness, combined with the demanding nature of caregiving, created obstacles for these mothers in sustaining social connections, attending family events, or engaging in community life.

Respondent 8 illustrated this struggle, explaining that her caregiving commitments took up the vast majority of her time, leaving little room for social interaction:

"It is impossible for me to be socially active because I have so much in my family to handle. For sure this is not by choice; it is a reality dictated by the situation I am in. I just don't have that resource, the time."

This response highlighted the heavy burden that mothers often carried when caring for children with mental illness. Constant demands of this role frequently led to narrowing of their personal and social lives, ultimately causing a sense of disconnection from the wider world.

It was not just about time commitment; some mothers experienced profound emotional loneliness, feeling ostracized or scrutinized by their own families and communities. Respondent 4 eloquently captured this feeling:

"Of course, my child comes first. I realized I am no longer attached to friends and family. I even forgo crucial family gatherings purposely to take care of my mentally ill child, a child who is less human to them, yes, a child they do not value. To be honest, due to the stigma around me, I feel like I am rejected, discriminated against, and isolated, and not only alone but also feeling lonely day in and day out."

Her statement highlighted how societal misconceptions and poor grasps of mental illness frequently resulted in social marginalization, making mothers feel unwelcome in both family and community settings. The specter of gossip, judgment, or simple misunderstanding further deterred them from engaging in social events.

For some, social isolation was compounded by physical dislocation, as family squabbles and financial hardships compelled them to live on their own. Respondent 7 recounted her personal journey of repeatedly relocating due to difficulties inherent in raising a child with mental illness:

"I thought running away to my parents from my husband's harsh home after my second born was diagnosed with a mental illness was a good idea in reducing my stress levels and my feelings of hopelessness. Unfortunately, it increased my pain, as my parents and siblings never welcomed me. I then relocated to start a new life on my own. Here I am, a single mother taking care of my two children and the only family that I have is this Curt Fearnley Self Help group."

This response highlighted how lack of support from partners and extended families sometimes led to single parenthood, compounding feelings of loneliness and stress.

4.6.4 Stress and Overwhelm

A significant majority of mothers surveyed reported experiencing profound levels of mental, emotional, and physical fatigue. This exhaustion stemmed from intense and often overwhelming challenges associated with caring for children battling mental illness. Their struggles were frequently compounded by financial hardship, scarcity of emotional support, and a sense of social detachment.

A particularly potent source of stress was the dual pressure mothers faced as both primary caregiver and sole financial pillar for their families. Respondent 7 emotionally articulated this difficult reality:

"Life without a support system is not easy. It is like being alone in the wilderness, more so as the primary caregiver and a breadwinner. No wonder, with no one to talk to or someone to listen to me as I share what I am going through, I feel hopeless and overwhelmed. How I wish they would come by and get to know the extent to which I need their emotional support more than any other thing in this world."

Her experience was echoed by others who found it difficult to balance childcare, medical expenses, and household responsibilities without sufficient financial or emotional support.

Beyond financial stress, many mothers felt abandoned by their extended families, further deepening their emotional distress. Respondents 2 and 5 shared:

"Rejection and discrimination out of nowhere. It pains me a lot that people who I need around me teamed up to reject, discriminate against, and isolate me. Due to myths and the stigma around them, none of them wants to be associated with me." (Respondent 2)

"I lack support from my relatives or the extended family. Myths based on cultures and lack of knowledge about mental illness have made me less human in the eyes of 'my people,' who no longer count on me and vice versa. The people who were there for each other in my other life." (Respondent 5)

Without robust networks of support, burdens of caregiving became significantly heavier, exacerbating feelings of isolation and emotional depletion.

The combined impact of social seclusion, the weight of societal stigma, and the inherent stress of caregiving resulted in what Respondent 7 termed "cognitive overload"—a state of mental exhaustion due to the relentless demands of caregiving. Furthermore, this state of exhaustion was amplified by sorrow associated with unmet expectations. Respondent 6 articulated her grief over the loss of the child she had imagined:

"I grieve for the child I expected to have as my second born, yes, that mentally healthy baby boy. Apart from this support group, I have no other shoulder to lean on when grieving the 'ideal' child. During pregnancy as a mother-to-be, I was looking forward to having a 'normal child,' a child who will undertake 'the normal' milestones for children, which never turned out to be."

This statement highlighted the profound emotional weight that mothers often carried when confronting a reality that deviated from their initial expectations, a struggle frequently borne in silence.

A number of mothers articulated a desire for respite and escape, if only momentarily. Respondents 3 and 4 eloquently voiced their sentiment:

"I feel emotionally drained and mentally overwhelmed, yet the only option left is pushing on." (Respondent 3)

"I too am tired and only wish I could get a break, just to rest a bit." (Respondent 4)

These responses highlighted pervasive fatigue experienced by numerous mothers, whose caregiving responsibilities often left little room for personal time.

4.6.5 Stigma and Discrimination

Mothers encountered considerable social stigma and discrimination. This prejudice emanated not only from the broader community but, in certain instances, also from within their own extended familial networks. The pervasive influence of misconceptions and culturally ingrained beliefs regarding mental health conditions fostered judgmental attitudes, social exclusion, and dehumanization.

Respondent 8 illustrated the dehumanizing impact of this stigma:

"People with mental illness and their families are not recognized as fully human based on social stigma attached to societal ideologies. People treat us as if we are beggars who always go out there to seek help because we must need help. The society are always ready with coins to offer us, only for them to be ashamed when realizing that their offers are turned down."

This statement highlighted social exclusion and patronizing attitudes encountered by numerous families, who were frequently met with pity or contempt instead of authentic support and empathy.

Linking of mental illness to misdeeds, curses, or mystical punishment exacerbated this stigma. Respondent 7 highlighted how entire families bore the brunt of this stigmatization due to these prevailing beliefs:

"My family of origin chased me, claiming that my child's mental illness was brought by wrongdoing or a curse in the family I was married into. It is a serious accusation stemming from my culturally accepted beliefs/myths leading to social stigma. Hence, clearly, without the scientific knowledge that I have, my people do associate mental

illness with a wrongdoing and this has caused me rejection and discrimination, among others."

This reply highlighted how cultural misunderstandings impacted not just the child but also the whole family, resulting in their social isolation and exclusion from the wider community.

A major obstacle to acceptance and assistance was the prevalence of misinformation and lack of understanding surrounding mental health issues. Respondent 1 stressed that destructive myths perpetuated stigma:

"Myths! Myths! Myths! The greatest barriers that children with mental illness and their families face begin with people's attitudes. Attitudes that are often rooted in misinformation and misunderstandings about what it's like to have and live with mental illness."

This observation highlighted how a deficiency in understanding mental health could foster inaccurate assumptions, resulting in individuals scrutinizing, being apprehensive of, or steering clear of families whose members were experiencing mental health challenges.

4.7 Chapter Summary

This chapter examined the findings of the research concerning the ways in which mothers at the Mukuru Kwa Ruben Center comprehend and address their children's mental health challenges. The results revealed a combination of biological, spiritual, and cultural views, with many mothers initially associating mental health issues with curses, divine punishment, or supernatural factors before gradually accepting clinical explanations. Mental health challenges significantly affected family life, leading to financial strain, social isolation, and emotional distress. Due to social stigma and limited access to healthcare services, many mothers first turned to faith healers, traditional remedies, or family guidance, seeking psychiatric help only when symptoms intensified. Treatment preferences differed, with some

opting for medical interventions like therapy, medication, and specialized education programs, while affordability continued to pose a challenge.

CHAPTER FIVE

DISCUSSION

5.1 Introduction

This chapter provides detailed discussion of study findings, exploring how mothers experience their children's mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya. The discussion is structured around the four research objectives, drawing on the Health Belief Model (HBM) and Family Systems Theory to illuminate mothers' lived experiences. This discussion also compares study findings with other research in the field, noting both common threads and fresh perspectives that emerged from this investigation.

5.2 Mothers' Beliefs About Causes of Children's Mental Illnesses

Research findings indicate that mothers at Mukuru Kwa Ruben Center varied beliefs regarding causes of their children's mental illnesses. These beliefs are shaped by combination of cultural traditions, individual experiences, and information they access regarding mental health. While some mothers connected mental illness to biological factors like brain chemistry imbalances and inherited traits, others gravitated towards cultural or supernatural explanations, citing curses or witchcraft as potential causes. Furthermore, number of participants recognized role of psychosocial and environmental factors, such as maternal stress during pregnancy, in contributing to these challenges.

Similar to findings presented by Thabet et al. (2006) in Palestine, this study underscores diverse range of factors that mothers associate with child mental health problems. Both studies found that mothers attributed mental illness to multiple causes including family problems, socio-economic difficulties, genetic factors, and supernatural explanations. However, this current research in Nairobi Mukuru Kwa Ruben, revealed particularly strong emphasis on witchcraft and curses, potentially reflecting specific cultural dynamics of Mukuru community.

Yeh et al. (2004) offer further insight into how cultural background influences parental beliefs about causes of mental illness. Their US-based study found significant variation across racial and ethnic groups, with Latino and Asian American parents emphasizing situational stress and family problems, African American parents citing external factors like racism, and Caucasian parents endorsing biomedical explanations. This resonates with current study's findings, as mothers at Mukuru demonstrated similar diversity—some embracing biomedical explanations while others maintained cultural and spiritual attributions. However, unlike Yeh et al.'s study, this research revealed more fluid movement between belief systems, with some mothers initially holding supernatural beliefs but shifting toward biomedical understanding after mental health education.

Gona et al. (2015) and Mkabile and Swartz (2020) provide particularly relevant comparisons from African contexts. Both studies found that parents held mixed beliefs about causes, attributing conditions to both biomedical factors (genetics, pregnancy complications) and preternatural causes (witchcraft, ancestral displeasure). Current study confirms these patterns exist in urban informal settlements, not just rural or coastal areas. However, this research provides additional insight by documenting how mental health education through programs like Curt Fearnley Self Help Group can facilitate belief transformation without entirely displacing cultural explanations, suggesting that mothers often hold multiple explanatory frameworks simultaneously.

More recent Kenyan studies by Kariuki et al. (2021) and Ndeti et al. (2016) confirm the persistence of supernatural attributions and limited awareness of biological causes in Kenyan communities. However, the current study's findings suggest that targeted, culturally sensitive mental health education in community settings can effectively increase biomedical understanding, as evidenced by Respondent 8's transformation from exclusively believing in witchcraft to recognizing mental illness as a treatable medical condition.

Imbwaga's (2015) study in rural Trans-Nzoia County found that 30% of respondents were misinformed about causes of mental illness, while 70% were knowledgeable. The current study suggests potentially higher rates of mixed beliefs in urban informal settlements, where traditional rural beliefs intersect with urban exposure to biomedical information, creating complex hybrid belief systems rather than clear distinctions between "informed" and "misinformed."

These findings become even more insightful when viewed through the lens of this study's theoretical framework. The Health Belief Model (HBM) sheds light on how a mother's actions regarding the health of her child are influenced by her perceptions of susceptibility, severity, and barriers. A clear example of this is the internal struggle some mothers experienced between understanding illnesses have biological roots and believing they stem from supernatural forces. This conflict highlights differences in how they perceive the threat of illness and what triggers their decision to seek help. For instance, mothers who attributed mental illness to curses (Respondents 4, 7) perceived barriers to biomedical treatment as irrelevant since treatment wouldn't address the "real" cause. Conversely, mothers who accepted biomedical explanations (Respondents 1, 2, 3, 5, and 8) perceived benefits of professional treatment as high, motivating help-seeking despite financial barriers.

Family systems theory offers a way to understand the broader impact these beliefs have on the family as a whole. It shows that family relationships, emotional ties that bind them, and beliefs passed down through generations significantly affect how mental illness is dealt with within a family. For example, Respondent 7's belief that her child's condition resulted from a curse by her mother-in-law reflected intergenerational transmission of beliefs and family projection processes described by Bowen. By combining these two theories, this study shows that a mother's personal beliefs are intricately connected to her family's cultural and emotional

context, ultimately influencing her choices about seeking professional medical care and psychosocial support.

A critical finding from this research is that beliefs about causes directly influenced treatment-seeking behaviors and coping strategies. Mothers attributing mental illness to supernatural causes initially sought traditional or spiritual healers, delaying or avoiding biomedical treatment. However, mental health education provided through the Ruben Center appeared to create cognitive dissonance that eventually motivated some mothers to try biomedical approaches, though without entirely abandoning cultural frameworks. This suggests that effective mental health interventions in similar contexts must acknowledge and respectfully engage with cultural beliefs rather than dismissing them, creating space for multiple explanatory frameworks to coexist.

5.3 Preferred Treatment Options for Children with Mental Illnesses

This study's findings reveal that mothers at the Mukuru Kwa Ruben Center use a range of strategies to address their children's mental illnesses, influenced by cultural beliefs, financial limitations, and available services. Many mothers preferred traditional healing practices, such as using herbs, participating in spiritual rituals, and consulting traditional healers. Others sought clinical care, counseling, or a combination of both traditional and modern methods. Research also highlights the importance of educational efforts, especially support services provided in schools.

These findings align with earlier research emphasizing the major role traditional healing plays in mental illness management across African contexts. Research by Ogun et al. (2009) in Nigeria, Skylstad et al. (2019) in Uganda, and Abera et al. (2015) in Ethiopia has demonstrated that traditional healing methods remain widely used due to cultural acceptance, accessibility, and belief in holistic benefits. The current study confirms these patterns exist in Kenyan urban informal settlements.

However, current research provides several unique contributions. Unlike Ogun et al. (2009), who found only 6% consulted traditional healers alone, this study found much higher rates of initial consultation with traditional healers, suggesting that in informal settlements with limited healthcare access, traditional healing may be an even more prominent first-line approach. Additionally, while Skylstad et al. (2019) noted an evolving trend toward formal clinical services, the current study reveals a more nuanced picture: mothers often maintained traditional approaches alongside biomedical treatment rather than replacing one with the other, suggesting an integrative rather than a replacement model.

Abera et al.'s (2015) finding that less educated parents were six times more likely to prefer traditional treatments was partially supported, as this study's two mothers with only primary education (Respondents 4 and 6) did show strong initial preferences for traditional healing. However, educational level alone did not fully predict treatment preferences; exposure to mental health education through the Curt Fearnley group appeared more influential than formal educational attainment in shifting treatment preferences.

This study's emphasis on educational interventions represents a significant contribution beyond existing literature. Unlike past studies that largely concentrated on traditional and clinical treatment methods, this investigation highlights the critical role of school-based assistance programs like Individualized Education Plans (IEPs), Social-Emotional Learning (SEL), and behavioral modification programs. Thabet et al. (2006) highlighted the necessity of accessible mental health resources, and Boulter and Rickwood (2013) explored pathways through schools, but neither examined educational interventions as a treatment modality itself. Current research demonstrates that in resource-constrained settings, schools function as alternative therapeutic spaces, especially for households unable to afford professional psychological services.

Kenyan studies by Ndetei et al. (2015) and Kigamwa et al. (2020) documented significant barriers to accessing formal mental health care, including cost, distance, lack of trained personnel, and inadequate integration of mental health into primary care. The current study confirms these barriers profoundly influence treatment preferences in informal settlements. However, findings also reveal that despite these barriers, mothers who received mental health education increasingly valued professional treatment and actively sought creative ways to access it, including relying on well-wishers, negotiating payment plans, and utilizing free services through NGO programs and CHWs.

Gona et al.'s (2015) study in coastal Kenya revealed a mixed approach to ASD treatment, combining traditional and modern methods. Current research in Nairobi's informal settlement found similar patterns but with important contextual differences. While the coastal study emphasized parents' hope for a "cure" driving treatment choices, the current study found that Mukuru mothers, through ongoing education and peer support, developed more realistic expectations focused on management and improvement rather than a cure, potentially reflecting the impact of sustained engagement with the Curt Fearnley Self Help Group.

The Health Belief Model (HBM) effectively illuminates treatment preference patterns. Mothers' choices regarding traditional, medical, or educational assistance reflected their understanding of causes (perceived susceptibility), severity perceptions, and beliefs about treatment effectiveness (perceived benefits). Mothers believing in supernatural causes perceived traditional/spiritual treatments as most beneficial since these addressed the "root cause." Financial constraints represented a major perceived barrier, leading mothers to prefer more affordable traditional options or free educational interventions. Cues to action—such as worsening symptoms, advice from CHWs or social workers, or testimonies from other mothers in support groups—prompted transitions from traditional to biomedical treatments.

Family systems theory helps explain why extended family often influenced treatment decisions. Respondent 2's acquiescence to her mother-in-law's insistence on consulting a traditional healer first exemplifies how family hierarchies and intergenerational patterns shape treatment pathways. Respondent 7's isolation from family due to cultural violations meant she had greater autonomy in treatment decisions but also lacked family support, illustrating how differentiation of self within a family system affects healthcare navigation.

A critical insight from this research is the documentation of treatment preference evolution over time. Rather than static preferences, mothers demonstrated dynamic treatment-seeking trajectories, typically progressing from traditional/spiritual to biomedical approaches, often maintaining elements of both. This progression appeared facilitated by (1) persistent or worsening symptoms despite traditional treatment, (2) mental health education reducing stigma and increasing biomedical understanding, (3) peer testimonies about treatment effectiveness, and (4) practical support from CHWs and social workers in navigating healthcare systems.

Findings also revealed the important role of educational interventions as a bridge between traditional and formal mental healthcare. School-based programs provided an acceptable entry point for families hesitant about psychiatric services, gradually normalizing professional mental health support. This suggests that in stigmatized contexts, educational interventions may serve as a crucial gateway to more comprehensive mental health treatment.

5.4 Coping Strategies Employed by Mothers

This study's findings demonstrate that mothers caring for children with mental illnesses at Mukuru Kwa Ruben Center employ variety of coping strategies including social support networks, spirituality, professional mental health services, and personal resilience strategies. Peer support groups offered safe spaces for sharing experiences, extended family provided emotional and practical help, and many mothers found support in structured programs run by

NGOs and healthcare professionals. Spirituality proved important, with religious beliefs and faith leaders providing comfort and helping reduce stigma.

Findings align with earlier studies underscoring crucial role of social support for caregivers. Mahmood et al. (2015) in India highlighted vital function of social networks in furnishing emotional solace and tangible aid, central theme reaffirmed by current investigation. Their distinction between positive coping strategies (integration, networking, religious reliance) and negative strategies (avoidance, ignorance, isolation) was partially reflected in current study, though Mukuru mothers demonstrated predominantly positive strategies, possibly due to structured support through Curt Fearnley group reducing isolation and providing networking opportunities.

Deepak et al. (2016) identified active emotional coping, problem-focused coping, and avoidant emotional coping as primary strategies among Indian caregivers. Current study found similar patterns: mothers employed emotion-focused strategies (spiritual coping, peer support for emotional validation) and problem-focused strategies (seeking professional services, educational interventions). However, unlike Deepak et al.'s findings, avoidant coping was notably absent in current study, possibly because the structured support group environment discouraged avoidance by normalizing discussion of challenges and providing practical solutions.

Durukan et al.'s (2008) Turkish study found correlation between anxiety and substance use as coping mechanism among mothers of children with ADHD. Notably, current study found no evidence of substance use as coping strategy. This may reflect cultural and religious factors (all participants identified as Christian and emphasized spiritual coping), poverty limiting access to substances, or social desirability bias in reporting. Instead, mothers in current study channeled stress through spiritual practices, peer support, and, for some, prescribed medications for their own mental health.

Oti-Boadi's (2017) Ghanaian study and Masulani-Mwale et al.'s (2016) Malawian research both emphasized spirituality as predominant coping mechanism, with approximately 95% and majority of participants respectively highlighting spiritual beliefs' significance. Current study strongly confirms this pattern, with all eight participants discussing faith as central to coping. However, current research provides additional nuance: mothers distinguished between spirituality providing emotional comfort versus religious leaders providing practical guidance and mental health education, suggesting that effective faith-based coping involved both emotional/spiritual dimensions and practical problem-solving support.

Gona et al.'s (2016) Kenyan coastal study identified problem-focused strategies (dietary modifications, respite through boarding schools) and emotion-focused strategies (spiritual coping, acceptance). Current study in Nairobi's informal settlement found similar spiritual coping but different problem-focused strategies. Rather than dietary modifications or boarding schools (which mothers mentioned as financially inaccessible), Mukuru mothers employed problem-focused strategies including: actively seeking free CHW services, negotiating with traditional healers for payment plans, connecting children to special education programs, and utilizing peer networks to share childcare. This suggests that specific problem-focused strategies reflect available resources in particular contexts.

Recent Kenyan studies provide valuable comparisons. Mbwayo et al. (2020) found that caregivers participating in psychoeducation programs and support groups reported improved coping and reduced isolation. Current study strongly confirms this, with all participants crediting Curt Fearnley Self Help Group as transformative in their coping abilities. Participants specifically described how group provided: emotional validation reducing feelings of isolation, practical information improving problem-solving, peer modeling demonstrating effective strategies, and collective advocacy increasing access to resources.

Kathomi et al.'s (2021) Nairobi study examining resilience among mothers of children with autism found mothers employed strategies including seeking social support, maintaining positive attitudes, and engaging in religious practices, while reporting feeling overwhelmed by caregiving demands. Current study with broader range of mental illnesses confirms these patterns while revealing that structured, ongoing peer support (rather than informal support alone) appeared particularly effective in sustaining coping over time.

What distinguishes current study from previous research is comprehensive documentation of professional support systems' role in coping. While earlier studies like Gona et al. (2016) and Masulani-Mwale et al. (2016) mainly examined informal support and spiritual coping, current research highlights critical functions of Community Health Workers, social workers, therapy programs, and specialized educational services. CHWs emerged as particularly crucial, serving multiple roles: providing home-based medical support, offering mental health education, facilitating referrals, and crucially, serving as non-judgmental bridges between communities and formal healthcare systems. This bridge function appeared essential in helping mothers overcome stigma-related barriers to seeking professional help.

The Health Belief Model (HBM) illuminates coping strategy selection. Mothers who perceived high severity of their children's conditions and believed professional interventions offered benefits (perceived benefits outweighing barriers) actively sought professional support despite financial obstacles. Cues to action—such as visible improvement in other mothers' children, encouragement from CHWs, or crisis situations—prompted mothers to try new coping strategies. Self-efficacy, enhanced through peer support group where mothers learned from each other's successes, increased confidence in employing various coping strategies.

Family Systems Theory explains how coping strategies functioned within broader family contexts. Mothers with supportive extended families (like Respondent 4) could employ wider range of coping strategies including practical help with childcare, while isolated mothers

(like Respondent 7) relied more heavily on external support systems like Curt Fearnley group and CHWs. This illustrates how family emotional system and support availability within family unit profoundly affected individual coping capacity. Additionally, mothers' coping influenced entire family system—when mothers coped effectively (through peer support and professional help), family functioning improved, while maternal overwhelm cascaded through family creating distress in siblings and marital strain.

Particularly important finding is synergistic effect of multiple support sources. Mothers employing combination of peer support, spiritual coping, and professional services reported feeling more supported than those relying on single strategy. This suggests that effective support for mothers in similar contexts requires multi-layered approach addressing emotional, spiritual, practical, and clinical needs simultaneously.

Critical insight emerging from this research is that coping strategies were not merely reactive responses to stress but proactive strategies for improving situations. Mothers didn't just cope with circumstances; they actively worked to change them through advocacy (seeking better services), education (learning about mental health), community building (strengthening peer networks), and problem-solving (finding creative ways to access resources). This active, transformative approach to coping appeared facilitated by structured support group environment that modeled advocacy and provided collective efficacy.

Finally, research revealed important temporal dimension to coping. Mothers described different coping needs and strategies at different stages of caregiving journey. Initial diagnosis periods required primarily emotional support and information; ongoing caregiving required practical assistance and respite; crisis periods required immediate professional intervention. Curt Fearnley Self Help Group's effectiveness appeared partly due to its ability to provide appropriate support across these different phases.

5.5 Impact on Family Dynamics and Challenges Experienced by Mothers

Study findings reveal that children's mental illnesses profoundly impacted family dynamics and created significant challenges for mothers at the Mukuru Kwa Ruben Center. Impacts included substantial financial burdens, emotional tolls on siblings, severe social isolation for mothers, overwhelming stress and exhaustion, and pervasive stigma and discrimination.

Lautenbach et al.'s (2012) US study found that mothers perceived serious mental illness as more severe and having a greater family impact than other complex disorders like cancer or diabetes. The current study strongly confirms this pattern while providing additional insights specific to resource-poor urban informal settlement contexts. Mukuru mothers described financial burdens that were not merely stressful but existential—threatening family survival, leading to marital dissolution, and forcing impossible choices between a child's treatment needs and the family's basic needs like food. This represents a more severe impact than typically reported in higher-resource contexts, suggesting that poverty amplifies mental illness's family impact.

Oz et al.'s (2019) Turkish study found moderate levels of internalized stigma among mothers of children with ASD, with significant correlations between stigma and depression/anxiety symptoms. The current study confirms these patterns but reveals even more severe stigma impacts in the Mukuru context. Mothers described not just internalized stigma but enacted stigma—actual discrimination, rejection by extended families, abandonment by spouses, and social ostracism. This suggests that in contexts where mental health literacy is low and resources are scarce, stigma may manifest more overtly and harmfully.

Scharer et al.'s (2009) US study identified three primary themes: emotional strains experienced by mothers, mothers' roles as advocates, and mental health nurses as facilitators. The current study confirms emotional strains but reveals these were compounded in the

informal settlement context by a lack of basic resources and formal support systems. While Scharer et al.'s participants had access to mental health nurses and psychiatric units, Mukuru mothers often lacked access to even basic mental health services, making advocacy more challenging. However, the current study found that CHWs and social workers at the Ruben Center fulfilled similar facilitator roles to mental health nurses in Scharer et al.'s study, helping mothers develop advocacy skills.

Regarding sibling impacts, the current study provides rich detail often missing in previous literature. While existing studies mention siblings are affected, current research documents specific manifestations: younger siblings' fear and trauma from witnessing aggressive episodes, school-aged siblings' jealousy and feelings of neglect, older siblings' resentment about premature adult responsibilities, and all siblings' confusion and lack of understanding about their brother's/sister's condition. This granular understanding can inform targeted sibling support interventions.

Gona et al.'s (2011) Kilifi study documented stress experienced by carers of children with disabilities, including insufficient time for other responsibilities, isolation from community activities, and association with supernatural evil. A current study in Nairobi's informal settlement confirms all these impacts while revealing additional urban-specific challenges: navigating complex healthcare bureaucracies, managing multiple small income-generating activities while caregiving, and living in extremely close quarters with neighbors amplifying visibility of stigma.

The financial burden theme in the current study is particularly striking compared to existing literature. While many studies mention financial challenges, current research documents specific mechanisms through which poverty and mental illness interact: fathers abandoning families specifically due to financial stress, mothers borrowing money for a child's special diet while the family goes hungry, children dropping out of school because fees are

used for medical care, and families becoming homeless due to the inability to afford rent while meeting medical expenses. This document shows how mental illness can perpetuate or deepen poverty, creating vicious cycles.

The social isolation theme in the current study reveals important gender and cultural dimensions. Mothers described how caregiving responsibilities, combined with stigma, systematically excluded them from women's social networks that are culturally important sources of identity and support. Loss of these networks represented not just loneliness but loss of social capital, information networks, and collective problem-solving resources that women in these communities typically rely on. Some mothers, like Respondent 7, described the Curt Fearnley group as "only family," highlighting the profound social rupture caused by the child's mental illness and the subsequent group's critical role in rebuilding social connections.

Regarding marital impacts, the current study documents a range of responses from supportive husbands who took multiple jobs (though becoming physically/emotionally distant) to complete abandonment. Notably, even in intact marriages, mothers described bearing the primary emotional labor of caregiving while husbands focused on income generation, reflecting gendered caregiving patterns. This suggests that even when marriages survive, burden distribution often remains highly gendered, leaving mothers carrying disproportionate emotional and practical caregiving responsibilities.

From a theoretical perspective, Family Systems Theory powerfully illuminates findings. Bowen's concept of family as an emotional unit where changes in one member's functioning affect the entire system is clearly manifested in the current study. Child's mental illness created triangles (particularly when siblings became parentified or when extended family blamed mothers), emotional cutoffs (family members abandoning or rejecting mothers), and transmission of anxiety throughout the system (mothers' stress affecting siblings' well-being, marital relationships, and even extended family relationships).

The family projection process was evident in how some mothers (like Respondent 3) felt they were "paying for" past mistakes through their child's condition and how some extended families projected blame onto mothers. These projection processes, rooted in cultural beliefs about mental illnesses causes, intensified mothers' emotional burdens and family dysfunction.

Differentiation of self-concept helps explain variation in how mothers coped with family impacts. Mothers with stronger differentiation (like Respondent 1, who clearly articulated boundaries between her responsibilities and extended family's obligations) managed family pressures more effectively than those with weaker differentiation, who became overwhelmed by family expectations and criticism.

The Health Belief Model helps understand how mothers' perceptions of severity influenced family dynamics. Mothers perceiving their children's conditions as severe but manageable (rather than hopeless) were more likely to maintain family functioning and seek help. Conversely, mothers perceiving conditions as curses or punishments (severe and unmanageable) experienced more family dysfunction, possibly because these beliefs offered no path toward improvement.

Important insight from current research is the interconnected nature of challenges. Financial burden led to social isolation (couldn't afford to maintain social relationships); social isolation increased stress; stress affected ability to parent other children; siblings' distress created additional family tension; family tension sometimes led to marital problems; marital problems exacerbated financial difficulties. These vicious cycles meant that a single intervention addressing one challenge (e.g., financial assistance) might have cascading positive effects, while a single stressor could trigger multiple problems.

A critical finding is that the Curt Fearnley Self Help Group appeared to interrupt some vicious cycles. By providing peer support, the group reduced isolation; mental health education reduced some stigma; practical information improved access to resources; and collective

advocacy improved service availability. This suggests that structured peer support groups in similar contexts could be powerful interventions for mitigating multiple family impacts simultaneously.

Finally, research revealed resilience alongside challenges. Despite profound difficulties, mothers demonstrated remarkable persistence, creativity in problem-solving, and commitment to children's well-being. Many explicitly articulated growths through challenges, describing how experiences made them stronger, more compassionate, or more aware. This resilience, often supported by spirituality and peer networks, represents an important strength-based finding suggesting that interventions should build on existing resilience rather than focusing solely on deficits.

5.6 Revisited Conceptual Framework

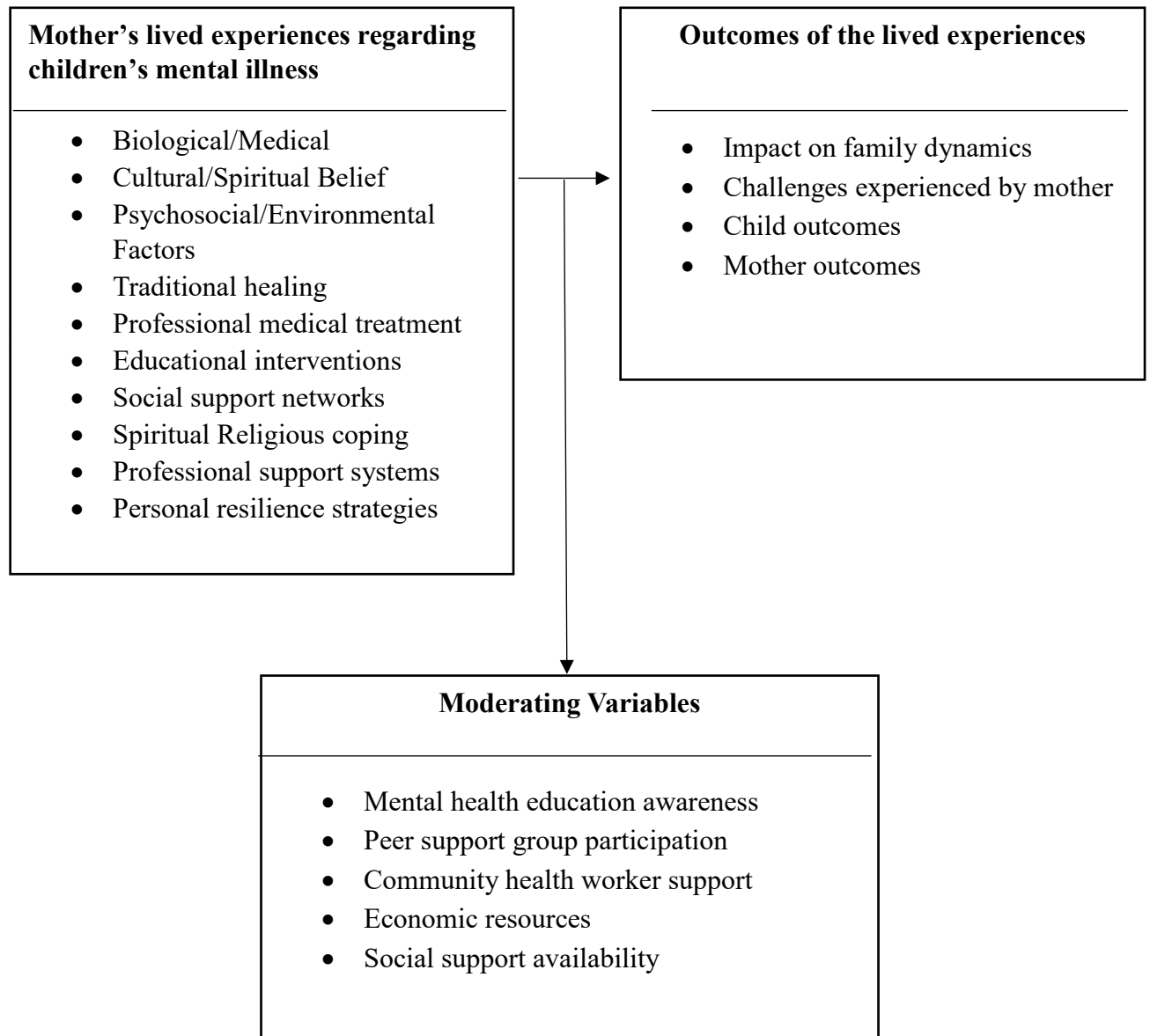
Having analyzed the study's findings and situated them within existing literature and theoretical frameworks, it is essential to revisit and refine the initial conceptual framework to better reflect the findings of the current study.

The original conceptual framework (Figure 2.1) presented relationships between independent variables (mothers' beliefs, treatment preferences, and coping strategies) and dependent variables (impacts on family dynamics and challenges experienced). The research findings, however, indicated significantly more intricate, bidirectional, and interrelated relationships among these elements than initially expected. Additionally, several important factors emerged from data that were not adequately represented in the original framework, particularly the transformative role of mental health education and the interconnected nature of challenges.

Figure 2: Revisited Conceptual Framework

Variable A

Variable B



Source: *Researcher,2025*

Figure 2 illustrates the revised conceptual framework at Mukuru Kwa Ruben Center offers a more comprehensive understanding of mothers' experiences with their children's mental illnesses. It identifies independent variables such as mothers' beliefs about causes, preferred treatment options, and coping strategies, which are influenced by factors like extreme poverty, limited healthcare access, cultural beliefs, and stigma. The framework also highlights the impact on family dynamics, which are more severe and interconnected than initially

understood. It also highlights five mediating factors: mental health education, peer support group participation, community health workers, economic resources, and social support availability. The revised framework integrates the Health Belief Model and Family Systems Theory, providing a comprehensive map for understanding change and identifying high-impact intervention points.

5.7 Chapter Summary

This chapter has explored the main findings of the research and their implications for understanding mothers' perceptions and responses to their children's mental illness. The results supported the theoretical framework and the main parts of the original conceptual model, emphasizing how mothers' opinions and beliefs regarding mental illness shape their decisions about treatment and how they manage the situation. This chapter illustrates how the study's results provided a deeper understanding of the factors influencing mothers' coping strategies and treatment decisions, leading to a more comprehensive conceptual framework. The following chapter provides the summary, conclusions, and recommendations.

CHAPTER SIX

SUMMARY, CONCLUSION AND RECOMMENDATIONS

6.1 Introduction

Chapter six offers a thorough integration of the research's findings, presenting a summary of the key findings in line with the four objectives, and deriving conclusions from these findings. Also, the chapter provides conclusion based on the findings and identify recommendations for future investigation.

6.2 Summary of Key Findings

This study explored the lived experiences of mothers regarding their children's mental illnesses at Mukuru Kwa Ruben Center in Nairobi, Kenya. Eight participants with diverse caregiving experiences took part in the research.

Participants ranged from 28 to 47 years of age. Younger mothers (28-35 years) were adapting to caregiving roles for younger children; middle-aged mothers (36-42 years) managed complex intersections of family responsibilities and financial pressures; older mothers (44-47 years) brought perspectives shaped by longer-term caregiving experiences. Half of participants were married though facing relationship and financial difficulties, while the others were single, widowed, or separated, navigating caregiving responsibilities largely alone. All participants identified as Christian. Most had completed secondary education (Form 4), while two had only primary education, representing diverse levels of formal education exposure.

Mothers held diverse and complex beliefs about causes of their children's mental illnesses, falling into three main categories. First, biological and medical explanations including brain chemistry imbalances, neurological factors, genetic predisposition, birth complications, and illness-related brain damage. Second, cultural and superstitious beliefs including witchcraft, curses, ancestral punishment, moral failings, and violations of cultural norms during pregnancy. Third, psychosocial and environmental factors including maternal

stress during pregnancy, substance abuse, poor nutrition, and physical injuries to children. Many mothers held beliefs spanning multiple categories, reflecting complex interplay between traditional cultural worldviews and exposure to biomedical education through Ruben Center. Mental health education appeared to shift some mothers' understanding toward more medical explanations, though cultural beliefs remained influential for many.

Mothers' preferred treatment options were diverse and often involved multiple approaches. Traditional healing methods including herbal remedies, spiritual rituals, and consultations with traditional healers were commonly preferred as initial treatments, influenced by cultural beliefs, accessibility, and affordability. Professional medical and psychiatric treatments including medication, therapy, and counseling were increasingly recognized as valuable, though financial constraints and limited availability posed significant barriers. Educational interventions including special education programs, Individualized Education Plans (IEPs), behavioral modification programs, Social-Emotional Learning (SEL), and school-based counseling played crucial roles in supporting children's development and managing symptoms. Many mothers employed combined approaches, utilizing both traditional and professional treatments, reflecting pragmatic responses to limited resources and influence of both cultural beliefs and mental health education. Ruben Center's educational programs facilitated gradual shifts from exclusive reliance on traditional healing toward more integrated treatment approaches.

Mothers employed multiple coping strategies to manage demands of caregiving. Social support networks, including peer support groups (particularly Curt Fearnley Self Help Group), extended family, community members, and NGO programs, provided emotional comfort, practical assistance, and valuable information. The peer support group emerged as particularly significant, offering safe spaces for sharing experiences, exchanging coping strategies, and accessing mental health education. Spiritual and religious beliefs played central roles in coping,

providing comfort, sense of purpose, frameworks for acceptance, and emotional strength. Faith leaders offered both spiritual guidance and practical advice, helping some mothers shift away from harmful traditional beliefs. Professional support services, including Community Health Workers, social workers, therapists, and specialized education programs, were recognized as valuable despite barriers to access. CHWs in particular served as crucial bridges between communities and formal healthcare systems. Many mothers employed multiple coping strategies simultaneously, demonstrating resilience and resourcefulness in managing caregiving demands while navigating financial constraints and systemic barriers.

Children's mental illnesses profoundly impacted family dynamics and created significant challenges for mothers. Financial burdens were substantial, including healthcare costs, therapy, special diets, and support services, often leading to marital strain or dissolution, with some fathers abandoning families while others worked multiple jobs and became physically absent. Siblings experienced emotional tolls including feelings of neglect, jealousy, fear of aggressive episodes, and increased responsibilities, often taking on caregiving roles and household tasks beyond their developmental stages. Mothers experienced severe social isolation and loneliness due to time constraints of caregiving, stigma from communities, and rejection from extended families, with some mothers physically relocating to escape judgment. Mothers faced overwhelming stress and emotional exhaustion from dual roles as caregivers and breadwinners, compounded by lack of support, grief over unmet expectations for their children, and relentless caregiving demands. Pervasive stigma and discrimination came from both communities and sometimes extended families, rooted in misconceptions and cultural beliefs about mental illness, leading to social exclusion, judgmental attitudes, and dehumanizing treatment. These challenges were interconnected and mutually reinforcing, creating complex webs of difficulty that mothers navigated daily while striving to provide care for their children.

Throughout findings, critical role of Curt Fearnley Self Help Group and Ruben Center's programs emerged as pivotal in providing education, reducing stigma, facilitating access to services, and offering crucial peer support that helped mothers navigate these complex challenges. Mental health education appeared to be transformative force, gradually shifting beliefs, reducing stigma, improving treatment access, and enhancing coping capacities. Community Health Workers served vital bridging function between communities and formal healthcare systems, providing home-based support, education, and non-judgmental assistance. Mothers demonstrated remarkable resilience despite profound difficulties, showing persistence, creativity in problem-solving, and commitment to children's wellbeing, often supported by spirituality and peer networks.

6.3 Conclusion of the Study

This study examined lived experiences of mothers regarding mental illnesses of their children at the Mukuru Kwa Ruben Center in Nairobi, Kenya. The following conclusions were drawn.

Beliefs about causes of children's mental illnesses are complex and multifaceted.

Mothers at the Mukuru Kwa Ruben Center hold diverse beliefs about causes spanning biomedical, cultural/spiritual, and psychosocial/environmental explanations. These beliefs are not mutually exclusive but often coexist, creating hybrid explanatory frameworks. Importantly, beliefs are not static but can evolve through exposure to mental health education, though cultural beliefs remain influential even after biomedical understanding increases. This complexity suggests that effective mental health interventions must engage respectfully with multiple belief systems rather than attempting to replace traditional beliefs with biomedical models.

Treatment preferences reflect pragmatic navigation of constraints and opportunities. Rather than simple choices between traditional or modern treatments, mothers

employ sequential or combined approaches based on accessibility, affordability, perceived effectiveness, and cultural acceptability. Traditional healing is often the first choice because it is easy to get to and fits with the culture. However, as mothers learn more and see good results, professional treatments are becoming more popular. Educational interventions in schools serve as important bridges, providing acceptable entry points for families hesitant about psychiatric services. Effective mental health service delivery in similar contexts must therefore be flexible, integrated, and multi-modal rather than requiring exclusive commitment to a single treatment approach.

Coping effectiveness depends on multiple, layered support systems. Mothers who cope most effectively employ multiple strategies simultaneously—combining peer support, spiritual resources, professional services, and personal resilience. Single interventions addressing isolated needs prove insufficient. Particularly crucial is structured peer support creating safe, non-judgmental spaces for sharing experiences, learning practical strategies, and accessing mental health education. Professional support from CHWs and social workers is valued not just for technical services but for bridging function—connecting mothers to resources, advocating with systems, and providing non-stigmatizing support. This suggests that effective interventions should facilitate multiple, interconnected support systems rather than single-focus programs.

Family impacts are profound, interconnected, and extend beyond immediate caregiving challenges. Mental illness in children doesn't simply create a caregiving burden for mothers; it triggers cascading effects throughout family systems, including financial crises potentially leading to family dissolution, emotional impacts on siblings affecting their development, social isolation severing mothers from crucial support networks, and pervasive stigma creating barriers to help-seeking. These impacts are mutually reinforcing, creating vicious cycles where financial stress exacerbates social isolation, which increases maternal

stress, which affects sibling well-being, which creates additional family tension. Breaking these cycles requires comprehensive, family-centered interventions addressing multiple impacts simultaneously rather than targeting individual symptoms or needs in isolation.

Stigma remains the most pervasive and harmful barrier. While financial constraints and healthcare access limitations create obvious barriers, stigma emerged as perhaps the most insidious obstacle. Stigma prevents help-seeking even when services are available and affordable, isolates families from support networks, compounds maternal stress through shame and blame, and perpetuates harmful beliefs about mental illness. Critically, stigma operates at multiple levels—internalized (mothers' own shame), interpersonal (rejection by families and communities), and structural (healthcare systems' inadequate response). Reducing stigma, therefore, requires multi-level interventions: education to change beliefs, peer support to reduce shame, community engagement to shift attitudes, and healthcare system reforms to provide respectful, accessible care.

Mental health education is a transformative force facilitating positive change across multiple domains. Throughout the findings, mothers who received mental health education through the Ruben Center showed shifts toward more biomedical understanding, greater willingness to seek professional treatment, reduced self-blame and shame, improved coping capacities, and better outcomes for their children. Education didn't simply provide information; it challenged harmful beliefs, normalized help-seeking, built mothers' confidence as caregivers and advocates, and created communities of support. This suggests that mental health education, particularly delivered through trusted community organizations and peer networks, should be the cornerstone of mental health interventions in similar contexts.

Poverty and mental illness interact in mutually reinforcing ways. Findings revealed that poverty doesn't merely make mental illness harder to manage; it fundamentally shapes every aspect of lived experience. Poverty limits treatment options, forcing reliance on

traditional healers or untreated conditions. It creates impossible choices between a child's medical needs and a family's basic survival. It prevents mothers from accessing support groups or services due to transportation costs or inability to leave work. It increases stress that exacerbates both children's symptoms and mothers' well-being. Conversely, children's mental illness deepens poverty through direct costs, reduced maternal earning capacity, and sometimes father's abandonment of family. This bidirectional relationship means that mental health interventions without addressing economic dimensions will have limited effectiveness, and poverty alleviation programs without considering mental health needs will fail to reach most vulnerable families.

Mothers demonstrate remarkable resilience despite overwhelming challenges.

While the study documented profound difficulties, it also revealed mothers' extraordinary strength, creativity, and commitment. Mothers found ingenious ways to access resources, navigated complex systems with minimal formal support, maintained hope despite discouragement, and advocated persistently for their children. This resilience was not simply an individual trait but was cultivated through social connections, spiritual beliefs, small successes, and supportive relationships with professionals like CHWs. This strength-based conclusion suggests that interventions should build on existing resilience rather than viewing mothers solely through a deficit lens. Supporting mothers' agency, acknowledging their expertise about their children, and facilitating their natural support-seeking and problem-solving capacities may be more effective than approaches that position mothers as passive recipients of services.

Formal healthcare systems remain largely inaccessible and unresponsive to the needs of families in informal settlements. Despite Kenya's mental health policy framework and global commitments, mothers at the Mukuru Kwa Ruben Center faced enormous barriers accessing formal mental health services: geographic distance to facilities, unaffordable costs,

long wait times, shortage of trained professionals, and often stigmatizing attitudes from healthcare providers. As a result, informal systems—traditional healers, CHWs, peer support groups, NGO programs, and community networks—carried the primary burden of mental health support. While these informal systems provided valuable assistance, they operated with limited resources and often without integration with formal healthcare. This gap between policy commitments and ground realities reveals an urgent need for healthcare system reforms that genuinely reach marginalized communities.

Gender dimensions of caregiving create specific vulnerabilities for mothers.

Throughout the finding's, gendered patterns were evident: mothers bore primary emotional and physical caregiving responsibilities even in intact marriages; mothers were blamed for children's conditions more than fathers; mothers experienced social isolation while fathers often remained socially integrated; and mothers made impossible sacrifices while managing households and often generating income. When marriages dissolved, mothers were left with full caregiving responsibilities while fathers disappeared. This gendered burden reflects broader societal patterns but is intensified in the context of childhood mental illness. Effective interventions must therefore address gender dimensions, supporting mothers' wellbeing, engaging fathers in caregiving, and challenging cultural patterns that place disproportionate burdens on mothers.

In conclusion, this study reveals that lived experiences of mothers of children with mental illnesses in Nairobi's Mukuru informal settlement are characterized by a complex interplay of cultural beliefs, economic constraints, systemic barriers, and profound family impacts. However, experiences are also marked by resilience, transformation through education, and the power of peer support. Addressing the mental health needs of children and the support needs of their families requires comprehensive, culturally sensitive, economically

realistic, and family-centered approaches that build on existing strengths while addressing multiple interconnected challenges simultaneously.

6.4 Recommendation

Based on study conclusions, following recommendations are proposed for different stakeholders:

Mothers of Children with Mental Illness: Engage in peer support groups like the Curt Fearnley Self Help Group for emotional support, practical information, and advocacy opportunities. Seek mental health education about children's mental health conditions through workshops, health talks, and discussions with healthcare professionals. Utilize available support services like CHWs, NGOs, and Ruben Center programs to supplement family resources and provide professional guidance. Practice self-care, seek counseling when overwhelmed, maintain spiritual practices, and ask for help from support networks. Advocate for your children's needs within schools, healthcare facilities, and communities, using knowledge from support groups and professionals. Collective advocacy through support groups can be particularly powerful.

Mukuru Kwa Ruben Center and Similar Organizations: Other communities should replicate the model of the Curt Fearnley Self Help Group, which has had a transformative impact. To achieve this, resources should be allocated to strengthen peer support programs, including training for facilitators and adequate meeting spaces. Mental health education should be integrated into all programs, using various formats to reach diverse audiences. Services that focus on the whole family, not just the kids, should be created. Economic empowerment opportunities should be established, and access to professional services should be improved through strengthened referral networks, reduced fees, transportation support, and advocacy with healthcare facilities. It can also be beneficial to partner with other faith leaders.

Mental Health Professionals and Healthcare Providers: The study emphasizes the importance of culturally sensitive care, offering flexible, integrated services, training in family-centered approaches, actively addressing stigma, collaborating with Community Health Workers (CHWs), and reducing financial barriers. It suggests acknowledging mothers' cultural and spiritual beliefs about mental illness, offering flexible treatment options, and training healthcare workers in family-centered approaches. It also suggests collaborating with CHWs to bridge communities and formal healthcare and advocating for free or subsidized mental health services for low-income families. The text also suggests offering sliding scale fees where possible.

Policymakers and Government Officials: The Kenya Mental Health Policy 2015–2030 aims to implement accessible services, integrate mental health into primary healthcare, establish community mental health programs, and include mental health in Universal Health Coverage. It also supports economic empowerment, mandates mental health education, strengthens specialized education, and establishes accountability mechanisms. These measures aim to address underserved areas, ensure mental health services are covered under the National Health Insurance Fund, and promote economic empowerment. They also strive to enhance specialized education and guarantee fair access to mental health services.

6.5 Recommendations for Future Research

This study aimed to examine the lived experiences of mothers regarding the mental illnesses of their children at the Mukuru Kwa Ruben Center in Nairobi, Kenya. Future research should delve into fathers' lived experiences when it comes to comprehending and addressing their children's mental health challenges. Although this current research centers on mothers, acquiring an understanding of fathers' roles, convictions, and ways of dealing with children's mental illnesses could yield a more comprehensive perspective on parental caregiving. Exploring how fathers interact with mental health support systems, or understanding the

potential reasons behind their lesser involvement as cited by the mothers, can help develop approaches to promote their engagement in the abovementioned children's care.

Furthermore, there is a need to investigate the effectiveness of culturally adapted mental health interventions. Many mothers depend on spiritual and traditional ways of healing, but we do not have much research on combining these methods with standard mental health services. Down the line, researchers should look into whether therapy approaches that are mindful of a person's culture help engage and benefit caregivers who have strong cultural and spiritual convictions.

Lastly, it is vital to conduct long-term research into the effects of caregiving on mothers' mental health. Numerous mothers face emotional burdens stemming from financial, social, and systemic obstacles, but there is a scarcity of data examining how these stressors influence their holistic well-being. A longitudinal study that monitors the psychological and emotional health of these caregivers could offer valuable insights into the potential for burnout and the necessity of specialized mental health support programs.

6.6 Reflexivity

Reflexivity is a critical aspect of research, requiring researchers to critically examine their role in the process. In this study, the researcher, a Kenyan woman, brought both insider and outsider perspectives to the research. The researcher's background in counseling psychology positioned her as an outsider to participants' lived experiences.

The researcher initially held certain assumptions about mothers' beliefs about mental illness, but reflexive engagement helped the researcher to recognize the complexity of their experiences. Data collection reflections, recognizing the strength and creativity of mothers despite challenges and the frustration of systemic failures were documented. Analytical reflections revealed that the researcher's psychology training led her to focus heavily on individual coping and resilience, potentially underemphasizing structural barriers.

The researcher also addressed power dynamics by conducting interviews in both English and Kiswahili, allowing mothers to communicate in the language most comfortable for them. However, she acknowledged her position as a researcher from the university and her association with the Ruben Center, which may have influenced what mothers chose to share.

Bias management strategies included member checking, peer debriefing, maintaining a detailed audit trail, and actively searching for disconfirming evidence. The research profoundly affected the researcher personally and professionally, intensifying her commitment to advocating for mental health system reforms and accessible, culturally appropriate services. The study has shaped the researcher future clinical and research directions, orienting her toward community-engaged, strength-based, and systems-level approaches to mental health promotion.

REFERENCE

- Amuyunzu-Nyamongo, M. (2013). The social and cultural aspects of mental health in African societies. *Commonwealth health partnerships*, 2013, 59-63.
- Boulter, E., & Rickwood, D. (2013). Parents' experience of seeking help for children with mental health problems. *Advances in mental health*, 11(2), 131-142.
- Byrne, S. (2020). *An exploration of caregivers' and peers' support-giving responses to adolescents showing signs of depression* (Doctoral dissertation, Trinity College Dublin).
- Chabra, A. N. A. N. D., Chávez, G. F., & Harris, E. S. (1999). Mental illness in elementary-school-aged children. *Western journal of medicine*, 170(1), 28.
- Champion, V. L., & Skinner, C. S. (2008). The health belief model. *Health behavior and health education: Theory, research, and practice*, 4, 45-65.
- Cortina, M. A., Sodha, A., Fazel, M., & Ramchandani, P. G. (2012). Prevalence of child mental health problems in sub-Saharan Africa: a systematic review. *Archives of pediatrics & adolescent medicine*, 166(3), 276-281.
- Crittenden, P. M., & Dallos, R. (2009). All in the family: Integrating attachment and family systems theories. *Clinical Child Psychology and Psychiatry*, 14(3), 389-409.
- Davidhizar, R. (1983). Critique of the health-belief model. *Journal of advanced nursing*, 8(6), 467-472.
- Durukan, I., Erdem, M., Tufan, A. E., Congologlu, A., Yorbik, O., & Turkbay, T. (2008). Depression and anxiety levels and coping strategies used by mothers of children with ADHD: a preliminary study. *Anatolian Journal of Psychiatry*, 9(1), 217-223.
- Felnhofer, A., Bussek, T., Goreis, A., Kafka, J. X., König, D., Klier, C., ... & Kothgassner, O. D. (2020). Mothers' and fathers' perspectives on the causes of their child's disorder. *Journal of Pediatric Psychology*, 45(7), 803-811.
- Gona, J. K., Newton, C. R., Rimba, K. K., Mapenzi, R., Kihara, M., Vijver, F. V., & Abubakar, A. (2016). Challenges and coping strategies of parents of children with autism on the Kenyan coast. *Rural and remote health*, 16(2), 3517.
- Gona, J. K., Newton, C. R., Rimba, K., Mapenzi, R., Kihara, M., Van de Vijver, F. J., & Abubakar, A. (2015). Parents' and professionals' perceptions on causes and treatment options for autism spectrum disorders (ASD) in a multicultural context on the Kenyan coast. *PloS one*, 10(8), e0132729.

- Gona, J. K., Mung'ala-Odera, V., Newton, C. R., & Hartley, S. (2011). Caring for children with disabilities in Kilifi, Kenya: what is the carer's experience?. *Child: care, health and development*, 37(2), 175-183.
- Gould, N. (2022). *Mental health social work in context*. Routledge.
- Green, E. C., Murphy, E. M., & Gryboski, K. (2020). The health belief model. *The Wiley encyclopedia of health psychology*, 211-214.
- Guest, G., Bunce, A., & Johnson, L. (2006). How many interviews are enough? An experiment with data saturation and variability. *Field methods*, 18(1), 59-82.
- Hebert, E. B., & Koulouglioti, C. (2010). Parental beliefs about cause and course of their child's autism and outcomes of their beliefs: A review of the literature. *Issues in comprehensive pediatric nursing*, 33(3), 149-163.
- Henshaw, E. J., & Freedman-Doan, C. R. (2009). Conceptualizing mental health care utilization using the health belief model. *Clinical Psychology: Science and Practice*, 16(4), 420.
- Hubert, S., & Aujoulat, I. (2018). Parental burnout: When exhausted mothers open up. *Frontiers in Psychology*, 9. <https://doi.org/10.3389/fpsyg.2018.01021>
- Imbwaga, E. A. (2015). *Factors influencing access to health care services among children with mental illness: a case of Endebess sub-county, Trans-nzoia county-kenya* (Doctoral dissertation, University of Nairobi).
- Kerr, M. E. (1981). Family systems theory and therapy. *Handbook of family therapy*, 1, 226-264.
- Lautenbach, D. M., Hiraki, S., Champion, M. W., & Austin, J. C. (2012). Mothers' perspectives on their child's mental illness as compared to other complex disorders in their family: Insights to inform genetic counseling practice. *Journal of genetic counseling*, 21, 564-572.
- Liu, M., Lambert, C. E., & Lambert, V. A. (2007). Caregiver burden and coping patterns of Chinese parents of a child with a mental illness. *International journal of mental health nursing*, 16(2), 86-95.
- Lolk, A. (2013). Neurokognitive lidelser. In *Diagnostic and statistical manual of mental disorders*. American Psychiatric Association.
- McLaughlin, E. (2020, October) data collection. Retrieved from searchcio.techtarget.com: <https://searchcio.techtarget.com/definition/data-collection>>

- Manyara, N. K. (2020). Exploring the Lived Experiences of Mothers of Children with Intellectual Disabilities in Rural Kenya. *Journal of Humanities and Social Sciences Studies*, 2(3), 01-13.
- Mahmood, H., Saleemi, M., Riaz, H., Hassan, Y., & Khan, F. (2015). Coping Strategies Of Mothers With ASD Children: Coping Strategies Of Mothers With ASD Children. *The professional medical journal*, 22(11), 1454-1463.
- Masuda, A., Anderson, P. L., & Edmonds, J. (2012). Help-Seeking Attitudes, Mental Health Stigma, and Self-Concealment Among African American College Students. *Journal of Black Studies*, 43(7), 773–786. <http://www.jstor.org/stable/23414696>
- Melnikovas, A., 2018. Towards an explicit research methodology: Adapting research model for future studies. *Journal of Future Studies*, 23(2), pp. 29-44
- Mkabile, S., & Swartz, L. (2020). Caregivers' and parents' explanatory models of intellectual disability in Khayelitsha, Cape Town, South Africa. *Journal of Applied Research in Intellectual Disabilities*, 33(5), 1026-1037.
- Mvumbi, F., & Ngumbi, E. K. (2015). *Companion to research methodology. Focus on humanities, education and social sciences*. CUEA Press.
- Ndetei, D. M., Khasakhala, L. I., Kuria, M. W., Mutiso, V. N., Ongecha-Owuor, F. A., & Kokonya, D. A. (2009). The prevalence of mental disorders in adults in different level general medical facilities in Kenya: a cross-sectional study. *Annals of general psychiatry*, 8, 1-8.
- Ngui, E. M., Khasakhala, L., Ndetei, D., & Roberts, L. W. (2010). Mental disorders, health inequalities and ethics: A global perspective. *International review of psychiatry*, 22(3), 235-244.
- Ogun, O. C., Owwoeye, O. A., Dada, M. U., & Okewole, A. O. (2009). Factors influencing pathway to child and adolescent mental health care in Lagos, Nigeria. *Niger J Psychiatry*, 7(1), 16-20.
- Öz, B., Yüksel, T., & Nasiroğlu, S. (2019). Depression-Anxiety Symptoms and Stigma Perception in Mothers of Children with Autism Spectrum Disorder. *Noro psikiyatri arsivi*, 57(1), 50–55. <https://doi.org/10.29399/npa.23655>
- Prest, L. A., & Protinsky, H. (1993). Family systems theory: A unifying framework for codependence. *American Journal of Family Therapy*, 21(4), 352-360.

- Ravens-Sieberer, U., Ottová-Jordan, V., Matthes, M., Pulkkinen, L., Heys, B., Clouder, C., & Pinto, L. (2016). Improving the Quality of Childhood in Europe. 6.
- Ritchie, J, Lewis, J, Nicholis, C, Ormston, R. (2014). *Qualitative Research Practice: A Guide for Social Science Students & Researchers*. Los Angeles, USA: Sage Publishers.
- Rosenstock, I. M., Strecher, V. J., & Becker, M. H. (1988). Social learning theory and the health belief model. *Health education quarterly*, 15(2), 175-183.
- Ruben Centre. (n.d.). About us. Ruben Centre. Retrieved July 10, 2024, from <https://www.rubencentre.org/>
- Scharer, K., Colon, E., Moneyham, L., Hussey, J., Tavakoli, A., & Shugart, M. (2009). A comparison of two types of social support for mothers of mentally ill children. *Journal of Child and Adolescent Psychiatric Nursing*, 22(2), 86-98.
- Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation. *Qualitative Health Research*, 26(13), 1802– 1811. <https://doi.org/https://doi.org/10.1177/1049732316654870>
- Selvam, S. G. (2017). *Empirical research: A study guide*. Paulines Publications Africa.
- Shaheen, M., & Pradhan, S. (2018). Sampling in qualitative research. In M. Gupta & K. Reddy (Eds.), *Qualitative techniques for workplace data analysis* (p. 27). IGI Global.
- Sheehan, R. (2017). Mental illness in children: Childhood illness and supporting the family. *Brain sciences*, 7(8), 97.
- Skylstad, V., Akol, A., Ndeezi, G., Nalugya, J., Moland, K. M., Tumwine, J. K., & Engebretsen, I. M. S. (2019). Child mental illness and the help-seeking process: a qualitative study among parents in a Ugandan community. *Child and adolescent psychiatry and mental health*, 13, 1-13.
- Tekola, B., Kinfu, M., Girma, F., Hanlon, C., & Hoekstra, R. A. (2020). Perceptions and experiences of stigma among parents of children with developmental disorders in Ethiopia: A qualitative study. *Social science & medicine*, 256, 113034.
- Titelman, P. (2014). *Clinical applications of Bowen family systems theory*. Routledge.
- Titelman, P. (2012). *Triangles: Bowen family systems theory perspectives*. Routledge.
- Thabet, A. A., El Gammal, H., & Vostanis, P. (2006). Palestinian mothers' perceptions of child mental health problems and services. *World Psychiatry*, 5(2), 108.
- Turale, S. (2020). A brief introduction to qualitative description: A research design worth using. *Pacific Rim International Journal of Nursing Research*, 24(3), 289-291.

- Vera, E. M., & Conner, W. (2007). Latina mothers' perceptions of mental health and mental health promotion. *Journal of Multicultural Counseling and Development*, 35(4), 230-242.
- Williams, M. & Moser, T. (2019) The art of coding and thematic exploration in qualitative research. *International Management Review*, 15(1), pp.45-55.
- Yeh, M., Hough, R. L., McCabe, K., Lau, A., & Garland, A. (2004). Parental beliefs about the causes of child problems: Exploring racial/ethnic patterns. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(5), 605-612.
- Yin, R. K. (2016). *Qualitative research from start to finish* (Second Edi). The Guilford Press.

APPENDICES

Appendix A: Participant Consent Form

Tangaza University
Title of Research: Exploring the perceptions of mothers regarding the mental illness of their children at the Mukuru Kwa Ruben Center in Nairobi, Kenya
<ul style="list-style-type: none"> • This study is being conducted as the requirement for MA Proposal in Counselling Psychology at Tangaza University College. It has been approved by the supervisors (contact: iysba@tangaza.org) <p>This study involves no known risk to participants and contains no deception. It takes approximately 45-60 minutes to take part in the present phase of the study.</p> <ul style="list-style-type: none"> • The task requires a participant to answer a series of questions. • All respondents are treated as strictly confidential. No participant's results will be presented individually but only in aggregate form. • Participation in this study is voluntary and there is no monetary or any other kind of compensation. Withdrawal from participation in the study will not lead to any penalization in any way, and all participants have the right to withdraw themselves and their data from the study at any time.
Name of the researcher: Esther Omwamba
Position of the researcher: Student, MA Counselling Psychology
Address of the University College: Tangaza University College, Langata, Nairobi, Kenya, 15055-00509,
Signed by researcher.....Date.....
Statement to be signed by the participant
<p>I confirm that the organizer has explained fully the nature of the project and the range of activities which I am asked to undertake and that I have received an information sheet. I confirm that I have had adequate opportunity to ask questions about this project.</p> <ul style="list-style-type: none"> • In understand that my participation is voluntary and that I may withdraw at any time during the project, without having to give a reason • I agree to take part in this project, by participating in the interviews
Signed by participant.....Date.....

Appendix B: Interview Guide for Mothers of Children with Mental Illness

This interview guide has two parts; part A has demographic information of the participants while part B has in-depth questions on the phenomenon under investigation

Part A: Demographic Information of Participants

1. Participant's age:

2. Participant's Gender (M/F):

3. Participant's Educational Level completed:

Primary school.....

Form IV.....

Diploma/Bachelor

PG Diploma/Masters

4. Participant's Religious background:

Christians

Muslim.....

Other religions

No religious affiliation

5. Where have you lived most of your life:

Village.....

Town.....

Nairobi city.....

6. Participant's marital status:

Married.....

Not Married.....

Separated/divorced.....

Part B: Interview Questions

1. How do mothers at Mukuru Kwa Ruben Center perceive their children's mental illnesses?
 - What beliefs do mothers hold about the causes of their children's mental illnesses?
 - How do mothers describe the impact of their children's mental illnesses on family dynamics?
 - What are the emotional and psychological challenges faced by these mothers?

2. What are the prevalent beliefs among mothers at Mukuru Kwa Ruben Center regarding the causes of their children's mental illnesses?
 - To what extent do cultural, spiritual, and traditional beliefs influence these perceptions?
 - How do these beliefs affect the mothers' approach to seeking treatment and care for their children?

3. What are the most common treatment options preferred by mothers for their children with mental illness at Mukuru Kwa Ruben Center?
 - Which medical treatments (e.g., medications, therapy sessions) do mothers prefer for their children's mental illnesses?
 - How frequently do mothers utilize traditional or alternative medicine in treating their children's mental illnesses?
 - What role do educational interventions (e.g., special education programs) play in the preferred treatment options?

4. What coping strategies do mothers at Mukuru Kwa Ruben Center use in caring for their children with mental illnesses?
 - What role do social support networks play in the mothers' coping mechanisms?
 - How do spiritual or religious beliefs influence their coping strategies?
 - What types of professional support (e.g., counseling, medical treatment) do the mothers find most helpful?

(Fomu ya Ridhaa ya Mshiriki)

Chuo Kikuu cha Tangaza

Kuchunguza mitazamo ya akina mama kuhusu magonjwa ya akili ya watoto wao katika Kituo cha Mukuru Kwa Ruben kilichopo Nairobi, Kenya

- Utafiti huu unafanywa kama sharti la pendekezo la MA katika Saikolojia ya Ushauri katika Chuo Kikuu cha Tangaza. Umeidhinishwa na wasimamizi (mawasiliano: iysba@tangaza.org)
Utafiti huu hauna hatari yoyote inayojulikana kwa washiriki na hauna udanganyifu wowote. Inachukua takriban dakika 45-60 kushiriki katika awamu ya sasa ya utafiti huu.
- Kazi inahitaji mshiriki kujibu mfululizo wa maswali.
- Majibu yote ya washiriki yanashughulikiwa kwa siri kabisa. Matokeo ya mshiriki hayatawasilishwa mmoja mmoja bali kwa njia ya jumla.
- Ushiriki katika utafiti huu ni wa hiari na hakuna fidia ya pesa au aina nyingine yoyote. Kujiondoa kushiriki katika utafiti hakutasababisha adhabu yoyote kwa njia yoyote, na washiriki wote wana haki ya kujiondoa wao wenyewe na data zao kutoka kwenye utafiti wakati wowote.

Jina la mtafiti: Esther Omwamba

Nafasi ya mtafiti: Mwanafunzi, MA Saikolojia ya Ushauri

Anwani ya Chuo Kikuu:
Chuo Kikuu cha Tangaza, Lang'ata, Nairobi, Kenya, 15055-00509

Sahihi ya mtafiti: Tarehe:

Taarifa ya kusainiwa na mshiriki

Ninakubali kwamba mratibu ameeleza kikamilifu asili ya mradi na shughuli mbalimbali ambazo nimeombwa kushiriki na kwamba nimepokea karatasi ya taarifa. Ninathibitisha kuwa nimepata nafasi ya kutosha kuuliza maswali kuhusu mradi huu.

- Ninaelewa kuwa ushiriki wangu ni wa hiari na kwamba naweza kujiondoa wakati wowote katika mradi bila kutoa sababu yoyote.
- Nakubali kushiriki katika mradi huu kwa kushiriki katika mahojiano.

Sahihi ya mshiriki: Tarehe

Kiambatisho B

Mwongozo wa Mahojiano kwa Akina Mama wa Watoto Wenye Magonjwa ya Akili

Mwongozo huu wa mahojiano una sehemu mbili; sehemu A inahusu taarifa za demografia za washiriki, wakati sehemu B inajumuisha maswali ya kina kuhusu jambo linalochunguzwa.

Sehemu A: Taarifa za Demografia za Washiriki

2. Umri wa mshiriki:

2. Jinsia ya mshiriki (M/F):

3 Kiwango cha Elimu kilichokamilika:

Shule ya Msingi

Kidato cha Nne

Diploma/Bachelor

Diploma ya Uzamili/Masters

5. Mahali ambapo umekaa sehemu kubwa ya maisha yako:

Kijiji

Mji

Jiji la Nairobi

4. Dini ya mshiriki:

Wakristo.....

Waislamu

Dini nyingine

Haina uhusiano wa kidini

6. Hali ya ndoa ya mshiriki:

Ameoa/Ameolewa

Hajaolewa/Hajaowa

Wametengana/Wameachana

Sehemu B: Maswali ya Mahojiano

1. Akina mama katika Kituo cha Mukuru Kwa Ruben wanaonaje magonjwa ya akili ya watoto wao?
 - Ni imani zipi ambazo akina mama wanaamini kuhusu sababu za magonjwa ya akili ya watoto wao?
 - Akina mama wanaelezeaje athari za magonjwa ya akili ya watoto wao kwenye mienendo ya familia?
 - Ni changamoto gani za kihisia na kisaikolojia ambazo akina mama hawa wanakabiliana nazo?

2. Imani gani zilizopo miongoni mwa akina mama katika Kituo cha Mukuru Kwa Ruben kuhusu sababu za magonjwa ya akili ya watoto wao?
 - Imani za kiutamaduni, kiroho, na za kitamaduni zinaathiri vipi mitazamo hii?
 - Imani hizi zinaathiri vipi njia ya akina mama kutafuta matibabu na huduma kwa watoto wao?
 - Je, kuna dhana au imani potofu za kawaida kuhusu magonjwa ya akili miongoni mwa akina mama hawa?

3. Ni chaguo gani za matibabu zinazopendelewa na akina mama kwa watoto wao wenye magonjwa ya akili katika Kituo cha Mukuru Kwa Ruben?
 - Ni matibabu gani ya kitabibu (km. dawa, vikao vya tiba) ambavyo akina mama wanapendelea kwa watoto wao wenye magonjwa ya akili?
 - Akina mama wanatumia mara ngapi dawa za kitamaduni au mbadala kutibu magonjwa ya akili ya watoto wao?
 - Jukumu gani elimu maalum (km. programu za elimu maalum) linachukua katika chaguo la matibabu linalopendelewa?

4. Ni mikakati gani ya kukabiliana inayotumiwa na akina mama katika Kituo cha Kwa Ruben katika kuwahudumia watoto wao wenye magonjwa ya akili?
 - Mitandao ya msaada wa kijamii inachukua jukumu gani katika mikakati ya akina mama ya kukabiliana na hali?
 - Imani za kiroho au za kidini zinaathiri vipi mikakati yao ya kukabiliana?
 - Ni aina gani za msaada wa kitaalamu (km. ushauri, matibabu ya kitabibu) ambao akina mama wanapata kuwa wenye msaada zaidi?

APPENDIX C: TU-ISERC Research Permit



TANGAZA UNIVERSITY

Teaching Minds / Touching Hearts / Transforming Lives

REF: TU/ISERC2024/01/0036

13th November 2024

To: Esther Omwamba, **Reg. No.** 19/00563

Dear Esther,

Re: "*Perspectives of Mothers on Mental Health of Their Children at Dwa Informal Settlement Makueni County, Kenya*"

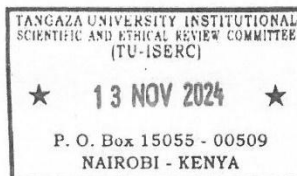
This is to inform you that TU-ISERC has reviewed and approved your above research proposal. Your application approval number is *TU/ISERC2024/01/0036*. The approval period is **13th November 2024 – 14th November 2025**. This approval is subject to compliance with the following requirements;

1. Only approved documents including (informed consents, study instruments, MTA) will be used
2. All changes including (amendments, deviations, and violations) are submitted for review and approval by TU-ISERC.
3. Death and life-threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to TU-ISERC within 72 hours of notification.
4. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to TU-ISERC within 72 hours
5. Clearance for export of biological specimens must be obtained from relevant institutions.
6. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
7. Submission of an executive summary report within 90 days upon completion of the study to TU-ISERC.

Prior to commencing your study, you will be expected to obtain a research license from National Commission for Science, Technology and Innovation (NACOSTI) <https://research-portal.nacosti.go.ke> and also obtain other clearances needed.

Yours sincerely

Dr. Daniel M. Kitonga (Ph.D., MBA)
Chair, TU - ISERC





TANGAZA UNIVERSITY

Teaching Minds / Touching Hearts / Transforming Lives

**OFFICE OF THE CHAIRMAN
TANGAZA UNIVERSITY INSTITUTIONAL SCIENTIFIC AND ETHICS
REVIEW COMMITTEE**

E-mail: iserc@tangaza.ac.ke Website: www.tangaza.ac.ke

OUR Ref: TU/ISERC2024/01/0036

Date: 13th November 2024

The Commission Secretary,
National Commission for Science, Technology and Innovation
P.O. Box 30623,
Nairobi – Kenya.

Dear Sir/Madam,

Re: Recommendation for Research Permit – Esther Omwamba

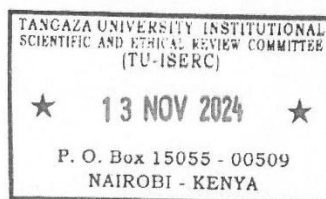
This is to confirm that Esther Omwamba is a PI in a researcher protocol which was submitted to TU-ISERC for review. The protocol was reviewed and approved for research permit.

Esther wishes to carry out research under the title "*Perspectives of Mothers on Mental Health of Their Children at Dwa Informal Settlement Makueni County, Kenya*".


I strongly recommend Esther Omwamba to the Kenya National Commission for Science, Technology and Innovation for issuance of a research permit. The permit will enable her to proceed to data collection for her study. Thanking you in advance for your cooperation.

Yours sincerely,

Dr. Daniel M. Kitonga (Ph.D., MBA)
Chairperson, TU-ISERC




Appendix D: NACOSTI Research License



REPUBLIC OF KENYA


Ref No: **215574**



**NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY & INNOVATION.**

Date of Issue: **30/December/2024**

RESEARCH LICENSE




This is to Certify that Ms. Esther Magara Omwamba of Tangaza University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nairobi on the topic: PERCEPTION OF MOTHERS ON MENTAL HEALTH OF THEIR CHILDREN AT MUKURU KWA REUBEN CENTER IN NAIROBI KENYA for the period ending : 30/December2025.

License No: **NACOSTI/P/24/414718**

Applicant Identification Number


215574



Director General

**NATIONAL COMMISSION FOR
SCIENCE, TECHNOLOGY &
INNOVATION**

Verification QR Code



NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

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Appendix E: Authorization Letter from Ruben Centre



RUBEN CENTRE

P.O BOX 20094 - 00200 NAIROBI- KENYA

OFFICE : 0703771035/ 0717788801

WEBSITE: www.rubencentre.org

EMAIL: info@rubencentre.org

9TH JAN 2025

RE: LETTER OF AUTHORIZATION TO CONDUCT RESEARCH AT RUBEN CENTRE

Based on my review of the proposed research by Esther Magara Omwamba from Tangaza University with admission number 19/00563, I give permission for the researcher to conduct the study entitled 'THE PERCEPTION OF MOTHERS REGARDING MENTAL ILLNESS OF THEIR CHILDREN AT THE MUKURU KWA RUBEN CENTRE IN NAIROBI, KENYA' from 9th Jan to 20th Feb 2025.

Within Ruben Center, the researcher will do among others; psycho education on the importance of self-care, reaching out for individual therapy and group therapy/social support networks for mothers who are the primary care givers.

The individual's participation will be voluntary and at their own discretion therefore the researcher will have to obtain informed consent prior to subjects participation.

We will provide the researcher needed support including personnel and meeting room to make the data collection process success.

We understand that the data collection will remain entirely confidential and may not be provided to anyone outside the research team without permission from Ruben Center.

Please feel free to contact us if you have any concerns or request additional information.

Sincerely,

Elisha Mutsotso

OT, Ruben Center

Contact: 0707265747



Appendix F: Plagiarism Report

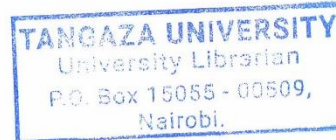


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Oliver

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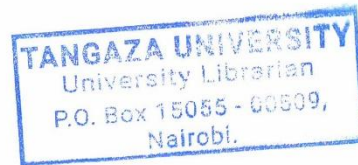
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Omwamba Esther

**Lived Experiences of Mothers of Children with Mental Illnesses:
A Case Study of Mukuru Kwa Ruben Center in Nairobi, Kenya**

 Quick Submit

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 Tangaza University

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Appendix G: Research Map

Study area

