



Perception of Parents of Children with Mental Health in Kisii County, Kenya

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Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

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ABSTRACT

Many studies done on families and hospitals have shown a high prevalence of children's mental illnesses. Due to discrimination and stigmatization connected to mental illness in children, few parents take their children to hospitals for complaints that are related to emotional and psychological problems despite the high cases of conduct disorders. This study sets out to identify and find out the perception of parents who have children with conduct disorders and what tends to contribute to the causation of these mental disorders and predictors of negative or positive perception. A sample of 179 children were used in the study. A cross-sectional study was carried out, and questionnaires were used to interview parents on the sociodemographic characteristics of children and family attachments. The study was done in Kisii Referral, Nyanchwa Mission, Nyangena, and Mediforte Hospitals. Child mental disorders were assessed using a Reporting Questionnaire for children, Parents' assessment of diagnostic statistical manual (DSM V) symptoms as being suggestive of childhood psychiatric disorders, and parents' assessment of contributory factors to the development of childhood psychiatric disorders. The results reveal that the majority of

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parents (87%) had poor perceptions about their children's conditions of conduct disorders. Only 27.4% of parents were willing to classify their children as having psychological problems, 10.6% had good knowledge while 77.7% had poor knowledge. Most of the symptoms, parents noticed as conduct disorders were epilepsy, abnormal behaviors, consistent indiscipline and much sleeping in children. In conclusion, most parents had negative perceptions towards their children. The study advocates for programs such as health education and enlightenment to enhance mental health and conduct disorder education for parents so that they can easily identify and recognize their children's health problems and take them for assessment and treatment which could lead to positive adversities.

Keywords: Mental illness; parents' perception; psychological problems; conduct disorders; family attachment; abnormal behaviors.

1. INTRODUCTION

A mental disorder is an undesirable or abnormal behavior that develops in an individual. An illness is categorized as social deviance which should be diagnosed as a medical [1]. And it can be biological or develop due to stress or environmental factors [2]. A mental disorder is any behavior that fails to meet standard norms expected in society or social groups [1]. According to Kulkarni, Joshi & Maliye [3], a mental disorder is an illness whose symptoms are considered violations of social norms such as sadness lasting two or more weeks, changes in social behavior or withdrawal, mood swings or outbursts, self-harm or talking about hurting oneself, talking about death or suicide, doing poorly in school, changes in eating habits and having outbursts or being very moody or testy) [4].

Predictors of mental health in children include Children's sociodemographic, such as family status factors like sibling count and separation, have an impact on mental disorder [5,6]. Social isolation, excessive use of social media and screen time, parental stress and strained parent-child relationships, low socioeconomic position, prior mental health disorders, and/or impairments are some of the variables that exacerbate the impacts [7].

Children with mental or disorder difficulties typically have parents who are more aware of their problems and who address them first. Among their responses are displays of humiliation, placing blame on the children, stigma, and bitterness toward their offspring [8]. Parents are enmeshed in their problems, such as pride and an incapacity to nurture their children gently, even though they frequently care for them. Proactive actions that could enhance behavioral outcomes are hindered by these.

More research is necessary, but it seems that parents' perceptions of their teenagers' personality flaws and how they respond to such actions have an impact [2].

Until undesirable traits in their children appear, parents believe they have done everything correctly. This might cause perplexity, rage, indifference, or action to correct the traits that bother them. Some parents believe that their children's undesirable traits are inherited, while others blame medical ailments or accidents for them [9]. It appears that these beliefs influence teenagers' presence and conduct, and it is crucial to acknowledge them for further understanding. Understanding parental prejudice about what makes an undesirable behavior appealing might help direct intervention more effectively and prevent these prejudices from being mistakenly attributed [10].

A child is said to have a mental disorder when the behavior or emotion in a child interferes with the child's social opportunities, and education or causes the child repeated distress which develops into mental problems that may be psychological, maturational, or organic [10]. Mental disorders among children are characterized by serious changes typically in learning, behavior, and handling emotions which causes day-to-day problems. Symptoms of mental disorders change over time as the child grows which can be noticed in how the child plays, acts, learns, speaks, and handles emotions [11]. Such symptoms usually start early, though some disorders develop during adolescence. Some diagnosis is often seen in schools, homes, and hospitals. However, some children may not be diagnosed or recognized with mental disorders as early as possible [8].

In Europe and America, a lot of people showed a rejecting perception towards children with mental

disorders and restricted social interaction with mentally ill individuals [9]. In Nigeria, educated Nigerians feel children with mental disorders are worthless, dangerous, dirty, cold, and unpredictable. Judgments were purely on behavioral observations. A study [1] showed that healthcare workers were not well enlightened about mental disorders problems and the majority had negative perceptions of mental illness. Knowledge will play a significant role in shaping the perception which in turn could determine the responses and reactions towards particular situations or circumstances.

Many studies in Nigeria have found the prevalence of child mental disorders to be between 10%-21.1% [2,10,12], in community studies. The studies done in hospitals reveal that most of the children with mental disorders have brain damage, epilepsy, severe mental retardation, psychosis, and conduct disorder [2,13]. In more recent studies, a prevalence of 37% of psychiatric morbidity in primary school children and 57.7% in Islamic education away from their parents [14].

In a study done by Kabir & Iliyasu [15], amongst 250 participants, almost half of the respondents had negative perceptions to mental illness. Literate people were 7 times more likely to accept mental illness as compared to non-literate people. In Kano, Nigeria [16], of the relatives of patients on admission with mental illness, 35% agreed that mentally ill persons should not be allowed to make decisions. Males significantly agreed more than females ($P=0.013$), over 65% of the relatives accepted that should continue with friendship with a mentally ill person, 27.1% agreed to marry a mentally ill person, and about 30% held an idea of not marrying a mentally ill person. Less literate strongly agreed they would hide their diagnosis of mental illness compared to more literate people ($p=0.001$). However, 35% plus of the interviewees stated that they would feel ashamed if one of the family members is diagnosed with mental illness.

The World Health Organization (WHO) [17], has described stigmatization as a mark of shame, disapproval, or disgrace that makes an individual shun or rejected by others [12]. Discrimination and stigma are associated with mental disorders which are strongly associated with disability, suffering, and poverty [17]. This situation lowers the access of victims to resources and opportunities like employment and housing leading to higher isolation, diminished self-

esteem, and hopelessness which influences helping-seeking behavior [18].

It is clear that despite the existence of evidence of children's mental disorders in communities, the presentation of children by parents because of mental illnesses is negligible. According to Abiodun [12], child mental disorders are common in hospital patients but exist in different patterns and types. The study emphasized the need to ensure early detection and treatment of mental disorders in children through screening hospital patients for morbidity. This is to focus on limiting the period of mental illness and reducing the risk of staying with the problems up to adulthood.

Nyaga [19] claims that behavior disorders are a significant problem for Kenyan children. Delinquent behaviors including absenteeism, destructive hobbies, and irregular eating patterns are associated with it. Negative interactions with parents and other kids are linked to these behaviors. According to Skinner, who was quoted by Siegel [20], a behavior will persist if it is rewarded and will stop or be extinguished if it is not. The taught behavioral responses are internalized as a pattern of conduct emerges over time. The quantity, frequency, and likelihood of reinforcement all directly affect how strong negative conduct is.

In Kenya, empirical research has examined the causes of mental health issues [21,19], whereas in Africa, the empirical literature that is currently available focuses on the general location of children's negative behaviors [22]. Studies have been conducted on the concept of mental behavior disorder [23,22] the factors that lead to mental disorders in children [24], and the psychosocial factors that influence mental health [25]. In a similar vein, Maleté (2007) concentrated on children's bad behaviors and aggression.

Objective: The study was carried out to determine and assess the prevalence of perception of parents to children's mental disorders.

Aims of the study:

1. Assess and determine parents' perceptions of children's mental disorders.
2. Find the types of symptoms that parents use to determine and recognize mental disorders in children.
3. Establish the predictors of know-how of parents to children disorders.

4. Determine the factors that parents feel contribute to children's mental disorders.

Significance of the study:

1. The study's primary significance is that it will further knowledge of how parents of children with mental disorders especially see their children, and consequently, how society as a whole views them.
2. The study will contribute to a renewed focus on children with the illness, as the majority of assistance providers view these children as deviant, uncooperative, social outcasts, or juvenile offenders.
3. The ultimate goal of care providers, counselors, and legislators will be defeated by the stigma attached to behavior problems until the way that children are now perceived is changed.

2. METHODOLOGY

A cross-sectional descriptive study was conducted in Kisii County, Nyanza region in Kenya. The study was carried out at Referral, Nyanhwa Mission, Nyangena, and Mediforte Hospital.

Sample size: The sample size required was calculated by using the formula below; [26].

$$S = Z^2 P (1 - P) / D^2$$

S= Sample size required at 95% confidence level
P= Prevalence of factor (Self-referrals to the institution, in this case, 5%); [13].

D= Allowance error (3%)

Sampling method: Random simple sampling was used to sample out the 179 children required. All children who were admitted to the pediatric wards and those who were brought by their parents to the pediatric outpatient department. Some children were excluded from the study:

- Those children whose parents refused the consent.
- Parents or caregivers did not have the required information.
- Children who were too ill.
- Parents were too young to understand some information.

Instruments/ Questionnaire:

1. The researcher designed a questionnaire to collect information on the sociodemographic

features of children such as the index of the child, his/her parents, and family.

2. "Reporting questionnaire for children (RQC): It is a ten-item questionnaire developed by the World Health Organization (WHO) where it identifies children with probable psychiatric morbidity. The response to each question is a "Yes" or "No". A minimum score of one identifies those with probable psychiatric disorders. The RQC has been found to have a sensitivity of between 73% and 97% and a specificity of between 61% - 81%" [13,11].
3. "Parents' assessment of diagnostic Statistical Manual (DSM V) symptoms as being suggestive of childhood psychiatric disorders: Thirty-six unambiguous phrases and sentences as presented in DSM V as symptoms and signs of childhood psychiatric disorders were presented for the parents to agree, disagree or indicate a not sure response to the phrase. A score of above two (i.e. agreeing) with the symptom was recorded as a positive perception and a score of less than two was a negative perception. A score of two is a 'not sure' perception" [27].
4. Parents' assessment of contributory factors to the development of childhood psychiatric disorders. Eleven factors identified in the literature [28] as contributors to the development of childhood psychiatric disorders were presented to the parents to comment as to whether they consider them contributory to the development of psychiatric disorders in children. They were also scored on a three-point scale. A score of two is a 'not sure' perception [29,30].

Data collection: The Research questionnaires were translated into Kiswahili language which is the local language. The Kiswahili questionnaire was back translated to English and a consensus of translation arrived at. The questionnaire was administered in Kiswahili to those parents who could not understand English. Three other trained assistants were used in data collection.

Statistical analysis was done using the statistical product and service solutions (IBM SPSS version 25) [31].

3. RESULTS

Sociodemographic features of index children and family features: There were one hundred and seventy-nine children aged between 7-15 years. 7-10 years comprising of large group

consisting of 103 (57.5%). About 92 (51.4%) children were in lower school, and 73 (40.7%) children in upper school. 14 (7.8%) children were not in any form of education. Most families had 3-5 children (61%) and those with more than 10 children were 21 (11.7%). Children with both

parents were 81 (45.3%) and those with single-parent families were 98 (54.7%). Economic status of parents, those who were employed were 36 (20.1%) and those who were not employed were 143 (79.9). This is shown in (Table 1).

Table 1. Sociodemographic features of index case and family features

Total N=179	
Variables	n (%)
Age (years)	
7-10	103 (57.5)
11-15	76 (42.5)
Educational level (Grade)	
0	14 (7.8)
1-2	59 (33)
3-4	33 (18.4)
5-6	52 (29)
7-8	21 (11.7)
Siblings	
0-2	48 (26.8)
3-5	61 (34.1)
6-8	49 (27.4)
10+	21 (11.7)
Both/without parents	
Both parents	81 (45.3)
Single parents	98 (54.7)
Economic status	
Employed	36 (20.1)
Unemployed	143 (79.9)

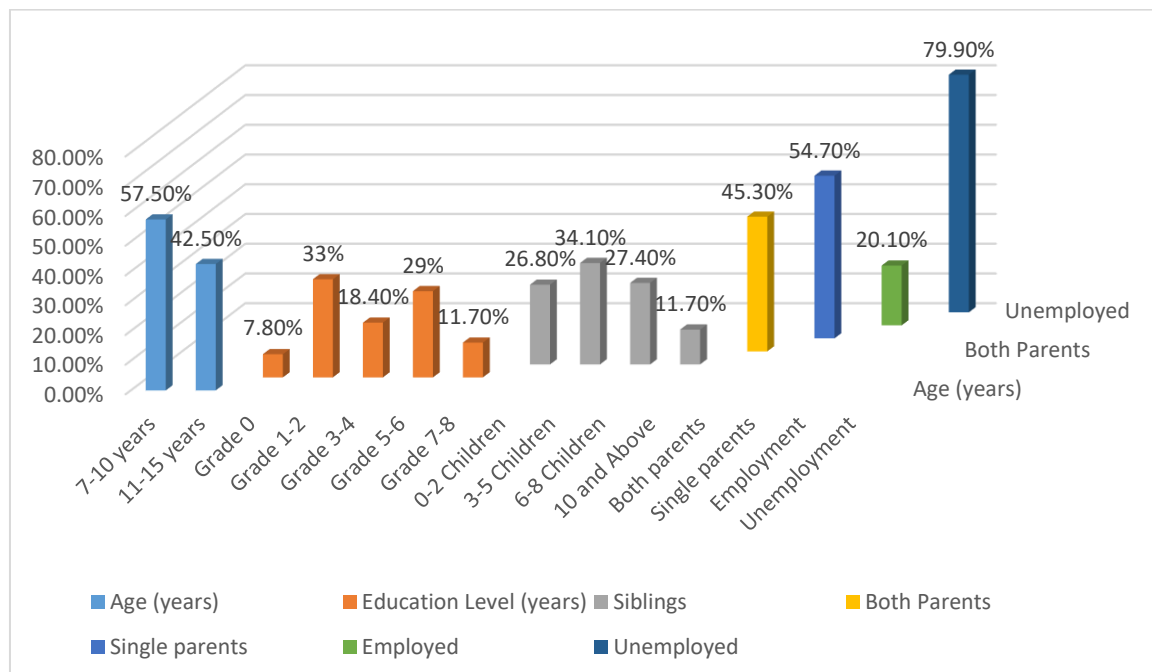


Fig. 1. Sociodemographic index case and family features. Vertical axis: Percentage; horizontal axis: Variables (items)

Table 2. Types of illnesses and hospital report

Total N=179	
Variables	n (%)
The gender of the parent accompanied.	
Mother	161 (90)
Father	18 (10)
Purpose of hospital consultation	
Malnutrition	29 (16.2)
Fever	41 (22.9)
Respiratory problems/Cough	34 (19)
Poor appetite/ Diarrhea/Stomach ache	17 (9.5)
Physical Injury	32 (17.9)
Other Complaints	26 (14.5)
Parents' classification of child's illness	
Psychological/Mental	49 (27.4)
Psychological/Mental and Physical	36 (20.1)
Physical	94 (52.5)

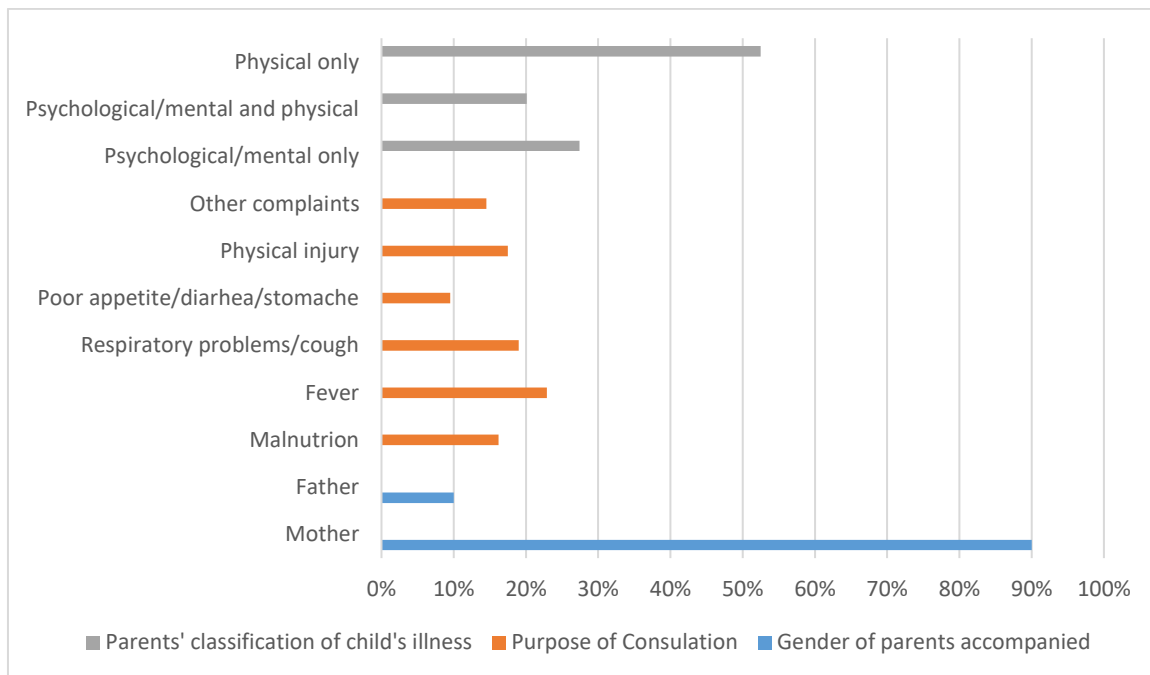


Fig. 2. Types of illness and hospital report. Vertical axis: Percentage; horizontal: variables (items)

Table 3. Index children's scores on the reporting questionnaire for children

Total N=179	
RQC Scores:	
Non-Probable Cases	136 (76)
Probable Cases	43 (24)
Total	179

Types of illnesses and hospital report: Most 161 (90%) children were accompanied by their mothers, while only 18 (10%) were accompanied by their fathers. Children with medical complaints; malnutrition 29 (16.2%), fever 41 (22.9%), respiratory problems and cough 34 (19%), poor appetite or diarrhea 17 (9.5%), physical injuries 32 (17.9), other complaints 26

(14.5%). Parents perceived 49 (27.4%) were having psychological problems, 36 (20.1%) psychological and physical problems, and 94 (52.5%) physical problems as reflected in Table 2.

Index children scores: The number of probable psychiatric cases was 43 (24%) based on RQC scores of one and above while non-probable psychiatric cases were 136 (76%). This information is presented in Table 3.

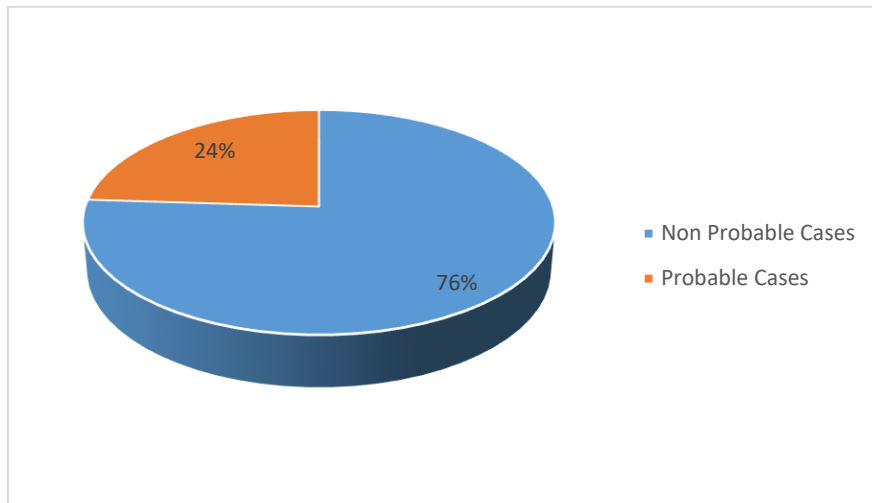


Fig. 3. A pie chart depicting index children score (RQC)

Table 4. Parents’ knowledge of DSM V symptoms suggestive of a child’s psychiatric disorders

Total N=179	
Variables	n (%)
Knowledge of Symptoms	
Good knowledge	19 (10.6)
Poor knowledge	139 (77.7)
Not Sure Knowledge	21 (11.7)

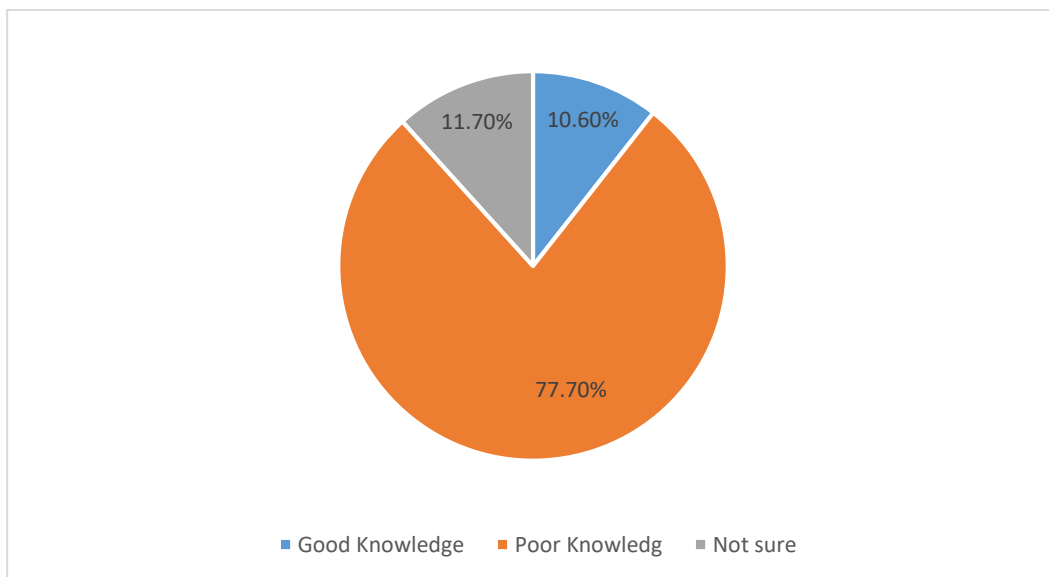


Fig. 4. A pie chart depicting Parents’ knowledge of symptoms suggestive of psychiatric (DSM)

Table 5. Parents’ knowledge of contributory factors to the development of a child’s psychiatric disorders

Total N=179	
Variables	n (%)
Knowledge of Factors	
Good Knowledge	6 (3.4)
Poor Knowledge	164 (91.6)
Not Sure Knowledge	9 (5)

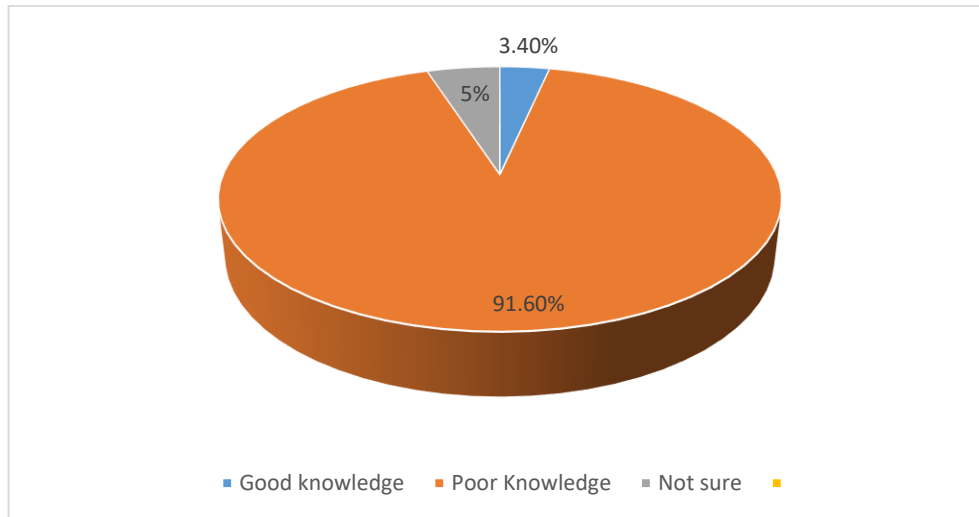


Fig. 5. A pie chart depicting Parents’ knowledge of contributory factors

Table 6. Parents' overall knowledge of their child’s psychiatric disorders

Total N=179	
Variables	n (%)
Good Knowledge	16 (8.9)
Poor Knowledge	152 (84.9)
Not Sure Knowledge	11 (6.2)

Parents’ knowledge of symptoms suggestive of psychiatric (DSM): The knowledge of parents on symptoms that were suggestive of psychiatric disorders in children differed. Only 19 (10.6%) parents had good knowledge of symptoms that were suggestive of children's psychiatric disorders as they had scored more than two. The symptoms parents were aware of were; repetitive behavior, eating anything, difficulties taking care of themselves, and preferred to be alone. While 139 (77.7%) had poor knowledge of symptoms. Only 21 (11.7%) parents were not sure of the symptoms. This is highlighted in Table 4.

Parents ‘knowledge of contributory factors: Of the parents’ knowledge of contributory factors in children's psychiatric disorders, only 6 (8.9%) parents had good knowledge of contributory factors, 164 (91.6%) parents had poor

knowledge, while 9 (5%) were not sure of the contributory factors. Many parents identified hereditary factors, indiscipline, physical injuries, epilepsy, and convulsions as contributory factors to children's psychiatric disorders. This is shown in Table 5.

Parents' overall knowledge of their child’s psychiatric disorders: When merging the two themes of contributory factors and identifying symptoms to give an overall knowledge, about 16 (8.9%) parents had good knowledge of children's psychiatric disorders, 152 (84.9%) had poor knowledge and 11 (6.2%) were not sure about overall knowledge. This is reflected in Table 6.

Knowledge of a child’s psychiatric disorders versus some variables: Further bivariable

analysis between the knowledge of parents and other variables reveals that; parents who identified their children as having a psychological component to their illness were more likely to have good than poor knowledge (65.9% vs 32.6%, $X^2=38.54$, $df=1$, $P=0.0001$). The gender of accompanying parents and family history of mental illnesses were not likely to affect the knowledge. According to the findings, a history of family psychiatric illnesses was not likely to affect the parents' classification of children's illnesses.

Children with a positive family history of psychiatric illnesses were more likely to be identified by the RQC as probable psychiatric cases. (65.9% vs 32.6%, $X^2=17.91$, $df=1$, $P=0.0002$). As shown in Table 7.

Logistic regression analysis on variables: Logistics regression analysis revealed that parents classified children as having only physical illness predicted poor knowledge ($r = 0.597$, $p = 0.004$). Reflected in Table 8.

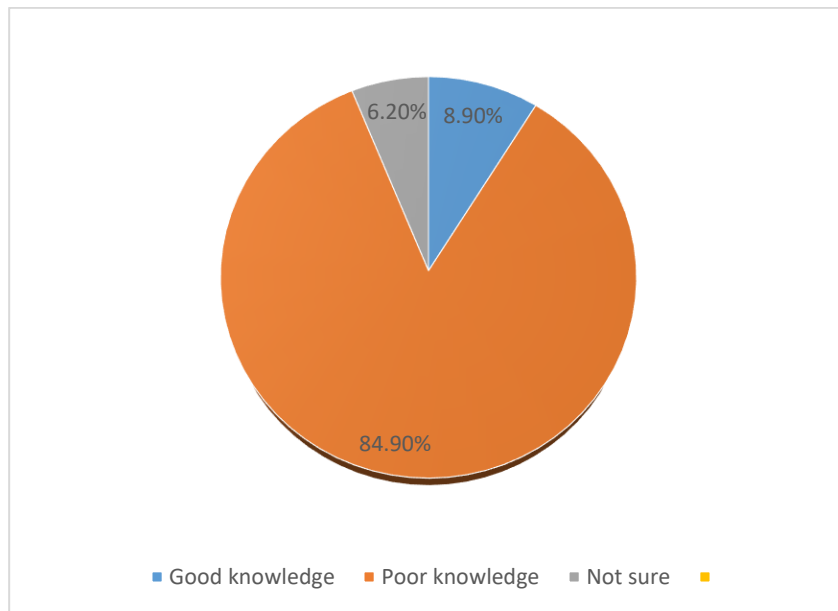


Fig. 6. A pie chart depicting Parents' overall knowledge of their child's psychiatric disorders

Table 7. Knowledge of a child's psychiatric disorders versus some variables

Variables	Knowledge		X ²	P Value	FET
	Good	Poor			
Parents' classification of child's health					
Psychological	4(32.6) (65.9)	2(1.2) (34.2)	38.54	0.0001	0.0001187
Physical	8(65.9) (3.9)	167(99.8) (96.7)			
Gender of accompanying parent					
Father	19(11.7) (80.67)	5(40.8) (80.67)	6.15	0.40186189	0.1575941
Mother	7(61.4) (4.4)	147(89.3) (97.2)			
Family history of psychiatric illnesses					
Yes	3(15.6) (20.3)	8(5.1) (79.9)	2.7	0.0775813	0.1311271
None	9(85.1) (5.1)	168(91.8) (92.7)			

Table 8. Logistic regression analysis on variables that predicted poor knowledge of childhood psychiatric disorders

Variables	coefficient	std error	T-ratio	P value
Poor Knowledge (constant)	1.11731	3.56879	0.28614	0.00001
Parents' classification of child's illnesses (physical)	-2.55973	0.89096	-2.7821	0.00278

$$X^2 = 23.80856. df = 1.$$

4. DISCUSSION

All children were middle age (below teens) and the majority were in lower school (51.4%) as compared to upper school (40.7%). Most children were brought by their mothers in the hospital (90%) as seen in other studies (6, 27); this might be because most roles are done by mothers, and as compared to fathers, mothers are more protective and nurturing. The majority of mothers took care of their children and accompanied them to the hospital. Most parents were unemployed (79.9%) making them to lower social class.

“Only 27.4% of parents were willing to classify their children as having psychological problems or mental illness. This might be because of poor knowledge of parents’ identifying psychological symptomology in children or a feeling of denial of parents to avoid classifying their children as psychiatric disorders due to the social stigma attached to psychiatric illness in society, despite the RQC identifying 24% of children as having probable psychiatric disorder. A study on Sub-Saharan Africa found that, rates of children's psychiatric disorders using screening questionnaires to be between 10.8%-20.7%” [13].

Parents’ knowledge of symptoms suggestive of children's psychiatric disorders was poor as only 10.6% had good knowledge while 77.7% had poor knowledge. The poor knowledge may be because of the perception of parents that the symptoms identified in their children do not conform to the cultural concept of psychiatric disorders of children. This was mentioned by Hackett and Hackett [32] who presented that culture affects the presentation of mental disorders in children, and may interfere with the parent's interpret their children’s behavior and their actions. Hackett and Hackett [32] also discovered that unlike physical disorders that may be identified using measurement

parameters, child psychiatric disorders use social constructs whose definitions depend not only on abnormal behavior but also on cultural values. It was obvious that in this study the findings suggest that the community has its ideas of abnormal behavior as the symptoms identified as suggestive of psychiatric disorders were generally those of overt gross abnormal behavior. Hackett and Hackett [32] also found that “a qualitative difference between ethnic groups in ideas of normal and deviant behavior exists. In a comparative study of English and Indian parents living in England. Fears (responding to a specific stimulus with severe anxiety) were far more common in the Indian children; it aroused much less concern in their parents compared to the English parents”.

“The symptoms that were identified in the present study are found mostly in those with mental retardation, brain damage, and epilepsy. These are the disorders found mostly in children in psychiatric hospital populations in Nigeria” [33,12]. “A study near where this study was carried out found a very high proportion of children and adolescents suffering from mental and neurological disorders not receiving any treatment at all for many years. Those who eventually receive treatment, four out of ten times would have presented to the traditional/religious healers before presenting at the mental health facility” [33]. The study also found the most common disorders to be epilepsy, mental retardation, and attention deficit hyperactivity disorder.

Wolff and Pathare [34], in his study, found that 78% of his respondents thought they would know if somebody was mentally ill by observing strange or odd behavior, odd speech, the way they dress, facial appearance, and aggression which are all overt behaviors. The present study also found that most (91.6%) of parents had poor knowledge about contributory factors to the development of childhood psychiatric disorders.

Factors identified by parents as contributory were inheritance, epilepsy, head injury, and lack of consistent constructive discipline by parental figures towards a child. The identification of inheritance was similar to the finding by Wolff [34] and Rutter [35] who in their studies found 73% of their respondents believed that mental illness could be passed down in families, this belief also seemed to be held by parents in this study. Epilepsy and head injury were possibly identified as they are viewed as affecting the brain directly. Lack of consistent discipline was identified because undisciplined children are susceptible to abuse drugs including cannabis which is viewed as causing mental illness as found in other studies [36].

Other family-related factors that the study found to have an impact on mental health were family conflict between parents, family history of problem behavior, and parental attitudes that support problem behavior. Furthermore, the majority of respondents stated that prostitution for profit was the result of antisocial behavior brought on by family-related causes, with other results including bullying, early sex, and confrontation with others [6].

“An almost similar study in Ethiopia found that 60.9% of parents perceived more Externalizing behavioral symptoms like “stealing from home, school or elsewhere” as signs of mental illness while only 38.2% viewed internalizing symptoms like “being nervous in new situations and easily losing confidence” as being features of mental illness in children. Even at this, the majority of parents in Ethiopia (92.7%) agreed that they would seek treatment either from religious or spiritual healers if their children developed mental illness” [37]. “Classification of a child’s illness as only physical predicted poor knowledge possibly failing to entertain psychological component to their child’s illness because of poor knowledge. It was found that patients with positive family history of psychiatric illness were more likely to be identified as having a probable psychiatric illness by the RQC, highlighting that genetic factors predispose them to psychiatric illness” [38,39].

The majority of respondents agreed with the study's findings that family-level counseling was infrequently provided. Additionally, the study indicated that students' economic backgrounds did not affect their antisocial behavior because most respondents believed that people from both rich and low economic backgrounds exhibited

antisocial behaviors and violent inclinations. The majority of respondents concurred that the family, led by parents, guardians, and other family members, was crucial in controlling behavior. These methods included keeping an eye on children's behavior, offering advice and counseling, and establishing regulations [40-45].

5. LIMITATIONS

The respondents were skewed with people from more of the lower social classes, which limits the generalization of the study.

6. CONCLUSION

There was a widespread lack of knowledge concerning childhood psychiatric disease, including symptoms of presentation and causal variables. Ebrahimi's statement is accurate and acceptable in this situation, as he states, "Cultural and social growth and development of human resources depend on societal health, and mental health is a key component of community health." Children are the future architects of every community, hence the health of human societies is based on their well-being. Mental disorders are among the most important risks threatening the health of children; hence, on-time recognition and appropriate actions by families to remedy the harmful effects of these disorders can decrease the harms” [46,47,48].

7. RECOMMENDATIONS

The study found that people with good knowledge were more likely to identify their children as having a psychological component to their illness. Therefore, it is important to enhance the knowledge of parents in the study area through health education.

Health education should aim to enlighten parents about the broadness of psychiatric symptoms in children; this should be the focus as the parents were only able to identify a few overt symptoms of abnormal behavior as being suggestive of childhood psychiatric disorders.

Health education can be administered through electronic media, special health talks, at special gatherings such as parent teachers' association meetings. There is a need to fully integrate mental health services for children in primary care.

Initiatives should be undertaken to enhance the ability of primary healthcare workers to diagnose childhood psychiatric disorders. Mental health

services for children should be prioritized based on the prevalence of the disorders, perceived community needs, available resources, and expected outcomes of intervention.

public health outreach should be emphasized to educate mothers and caregivers about the mental health of children, how they identify mental disorders in children and the way to manage mental conditions in the communities in Kisii county. Pushing them to engage in motivational of awareness of mental disorder where culture diversity, local beliefs and traditions on mental disorder are enlightened to the reality. Also, general preventive measures to prevent head injuries and brain infections through enhancing obstetric care, improving immunization care, and nutrition should be enhanced.

Further studies that further explore children's psychiatric disorder perception and knowledge by children, parents, teachers, and community should be carried out to provide a basis for best measures to employ towards prevention and management.

DISCLAIMER (ARTIFICIAL INTELLIGENCE)

Author(s) hereby declare that NO generative AI technologies such as Large Language Models (ChatGPT, COPILOT, etc).

CONSENT

As per international standards, parental written consent has been collected and preserved by the author(s).

ETHICAL APPROVAL

As per international standards or university standards written ethical approval has been collected and preserved by the author(s).

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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