

Prevalence of Internalized Stigma and Associated Sociodemographic Factors among Adult Psychiatric Outpatients in Bomet County, Kenya

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Article History: Submitted: 30th July; Accepted: 9th October 2026; Published (online): 16th October 2026

Abstract

Internalized stigma is a major barrier to recovery among people living with mental illness, contributing to poor treatment adherence, reduced self-esteem, social isolation, and impaired quality of life. Evidence among psychiatric outpatients in Kenya remains limited. The objective was to determine the prevalence of internalized stigma and identify sociodemographic factors associated with internalized stigma among adult psychiatric outpatients attending AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital in Bomet County, Kenya. A hospital-based analytical cross-sectional study was conducted among 371 adult psychiatric outpatients between June and July 2026. Data were collected using a structured questionnaire incorporating the 29-item Internalized Stigma of Mental Illness (ISMI-29) Scale and sociodemographic characteristics. Descriptive statistics summarized participant characteristics and stigma prevalence. Independent-samples *t*-tests, one-way analysis of variance (ANOVA), and multiple linear regression were performed to identify factors associated with internalized stigma. The prevalence of high internalized stigma was 66.6%. Social Withdrawal had the highest mean score, followed by discrimination experience, alienation stereotype endorsement while stigma resistance had the lowest. Age, education level, and duration of mental illness were significantly associated with internalized stigma in bivariate analyses. After adjustment, age and education level remained independent predictors. Internalized stigma was highly prevalent among psychiatric outpatients. Routine stigma screening and targeted psychosocial interventions should be integrated into outpatient mental health services to improve recovery outcomes.

Keywords

Adult psychiatric outpatients; internalized stigma; Kenya; mental illness; sociodemographic factors.

Introduction

Mental disorders are among the leading causes of disability worldwide and contribute substantially to the global burden of disease. Although advances in mental health services have improved the diagnosis and treatment of psychiatric disorders, many individuals continue to experience stigma and discrimination, which adversely affect recovery and quality of life. Internalized stigma, also referred to as self-stigma, occurs when individuals living with mental illness internalize negative societal stereotypes and apply them to themselves, resulting in diminished self-esteem, reduced self-efficacy, hopelessness, social withdrawal, and impaired recovery (Dubreucq et al., 2021; Gärtner et al., 2022; Thornicroft et al., 2022). Internalized stigma is also associated with poor treatment engagement, impaired social and occupational functioning, and poorer recovery outcomes (Dubreucq et al., 2021).

Internalized stigma affects individuals across a wide range of mental disorders and remains an important barrier to recovery-oriented mental healthcare. Evidence from Africa demonstrates a substantial burden of internalized stigma among people living with mental illness. A systematic review and meta-analysis estimated that approximately 29% of individuals with mental illness in Africa experienced elevated internalized stigma, with considerable variation across countries and populations (Alemu et al., 2023). Studies from sub-Saharan Africa have also identified sociodemographic and illness-related characteristics associated with internalized stigma. In Ethiopia, internalized stigma has been associated with educational attainment, medication adherence, and other sociodemographic characteristics (Abdisa et al., 2020; Asrat et al., 2018; Sori et al., 2022). Studies from Nigeria and other African settings have further demonstrated that cultural beliefs and explanations of mental illness can influence experiences of stigma (Makanjuola et al., 2016; Ibrahim et al., 2016).

The relationship between sociodemographic characteristics and internalized stigma has not been consistent across settings. Factors such as age, educational attainment, employment status, marital status, and duration of illness have been reported in previous studies, although the direction and strength of these associations vary between populations (Abdisa et al., 2020; Sori et al., 2022; Zarbah et al., 2023). These inconsistencies suggest that contextual and sociocultural factors may influence experiences of internalized stigma and highlight the importance of setting-specific research.

In Kenya, mental health has increasingly been recognized as a public health priority; however, evidence on internalized stigma among people receiving psychiatric care remains limited. Earlier Kenyan research documented substantial internalized stigma among psychiatric patients (Makanjuola et al., 2016). More recent Kenyan studies have focused largely on public stigma, community attitudes, stigma reduction, and the measurement of mental health-related stigma, with relatively limited research specifically examining internalized stigma and its sociodemographic correlates among adult psychiatric outpatients (Mutiso et al., 2018; Bitta et al., 2022; Bitta et al., 2023; Kiilu et al., 2024). Cultural and geographical differences may also influence experiences of mental illness stigma across Kenya, particularly between rural and urban settings (Kwobah et al., 2023; Wakoli, 2024).

Bomet County provides an important rural setting for examining internalized stigma among people receiving psychiatric care. AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital provide healthcare services within different faith-based and government healthcare contexts and serve patients from Bomet County and neighbouring areas (County Government of Bomet, 2025). However, there is limited evidence on the prevalence of internalized stigma and its associated sociodemographic factors among psychiatric outpatients in this setting. Therefore, this study aimed to determine the prevalence of internalized stigma and identify the sociodemographic factors associated with internalized stigma among adult psychiatric outpatients attending AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital in Bomet County, Kenya.

Materials and Methods

Study Design

A hospital-based analytical cross-sectional study was conducted between June and July 2026 to determine the prevalence of internalized stigma and its association with selected sociodemographic factors among adult psychiatric outpatients attending AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital in Bomet County, Kenya.

Study Setting

The study was conducted at the psychiatric outpatient clinics of AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital, the two major referral facilities providing specialist outpatient mental health services in Bomet County, Kenya. AGC Tenwek Teaching and Referral Hospital is a faith-based tertiary Teaching and Referral hospital serving patients from western Kenya and neighbouring regions, whereas Longisa County Referral Hospital is the principal public referral hospital in Bomet County. Both hospitals provide outpatient psychiatric assessment, treatment, counselling, and follow-up services for individuals with a wide range of mental disorders.

Study Population

The study population comprised adult psychiatric outpatients attending the psychiatric clinics of AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital during the study period. Participants were eligible if they were aged 18 years or older, had a confirmed psychiatric diagnosis, were clinically stable with a Clinical Global Impression (CGI) score of 1–3, and were able to provide written informed consent. Patients with severe psychiatric symptoms, significant cognitive impairment, or those unable or unwilling to provide informed consent were excluded.

Sample Size and Sampling

The sample size was determined using the single population proportion formula, assuming a prevalence of 37.5% for internalized stigma among psychiatric patients reported by Makanjuola

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et al. (2016), with a 95% confidence level and a 5% margin of error. An allowance for anticipated non-response was incorporated into the sample size determination. Based on these assumptions, the minimum required sample size was 371 participants. Eligible participants were recruited consecutively from the psychiatric outpatient clinics until the required sample size was attained.

Data Collection Procedures

Data were collected by four trained research assistants who were not involved in the clinical management of the participants. Prior to data collection, the research assistants underwent two consecutive days of training conducted by the principal investigator on the study objectives, informed consent procedures, ethical considerations, interviewing techniques, and quality assurance.

During routine outpatient care, attending clinicians screened patients using the Clinical Global Impression (CGI) scale. Patients meeting the eligibility criteria (CGI score 1–3) were referred to the research team. Eligible participants received a detailed explanation of the study in a private setting and provided written informed consent before enrolment.

Data were collected using a structured questionnaire. Participants who were able to read and write completed the questionnaire independently, whereas trained research assistants assisted participants with limited literacy by reading the questions verbatim in a neutral, non-leading manner. Completed questionnaires were reviewed daily for completeness and consistency before data entry.

Study Instruments

Internalized stigma was assessed using the 29-item Internalized Stigma of Mental Illness Scale (ISMI-29), which measures five domains: alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance. Each item is scored on a four-point Likert scale ranging from 1 (strongly disagree) to 4 (strongly agree). Negatively worded items in the stigma resistance domain were reverse coded before calculating domain and total scores, with higher scores indicating greater internalized stigma.

The questionnaire was available in English, Kiswahili, and Kipsigis, according to participants' language preference. The Kipsigis version was translated and back-translated to ensure conceptual equivalence with the original instrument. A pilot study involving 18 psychiatric outpatients (5% of the calculated sample size) was conducted at AIC Litein Hospital to evaluate clarity, comprehensibility, and feasibility before the main study. Data from the pilot study were excluded from the final analysis.

Statistical Analysis

Data were entered into Microsoft Excel for cleaning and coding before being exported to IBM SPSS Statistics version 25 (IBM Corp., Armonk, NY, USA) for analysis. Descriptive statistics were used to summarize participant characteristics and the prevalence of internalized stigma. Continuous variables were summarized using means and standard deviations, whereas categorical variables were presented as frequencies and percentages.

Independent-samples *t*-tests were used to compare mean internalized stigma scores between dichotomous variables, while one-way analysis of variance (ANOVA) was used for variables with more than two categories. Variables with statistically significant ANOVA results were further examined using post hoc multiple comparisons. Variables with a *p*-value < 0.20 in the bivariate analysis, together with clinically important variables, were entered into a multiple linear regression model to identify independent sociodemographic predictors of internalized stigma. Regression coefficients (β), 95% confidence intervals (CI), and *p*-values were reported. Statistical significance was set at *p* < 0.05.

Ethical Considerations

Ethical approval for this study was obtained from the AGC Tenwek Teaching and Referral Hospital Institutional Scientific and Ethics Review Committee (ISERC) prior to the commencement of the study. Academic approval was subsequently obtained from the Kabarak University Institute of Postgraduate Studies. In addition, a research permit was obtained from the National Commission for Science, Technology and Innovation (NACOSTI) (Licence No. NACOSTI/P/26/4189591). Administrative permission to conduct the study was granted by both AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital.

Informed consent was obtained from all participants before enrolment. Participants were informed about the purpose of the study, the voluntary nature of participation, their right to withdraw at any time without affecting their care, and the measures taken to protect confidentiality. Unique identification codes were used in place of personal identifiers, and all study data were stored securely with access restricted to the principal investigator and authorized research personnel.

Results

A. Participant Characteristics

A total of 371 adult psychiatric outpatients participated in the study, yielding a 100% response rate. Participants were recruited from the psychiatric outpatient clinics of AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital between June and July 2026. The sociodemographic characteristics of the participants are summarized in Table 1. Overall, the study population consisted predominantly of male, married, rural-dwelling participants, with primary education being the most common educational level. Approximately 70 percent of the participants had previous psychiatric admission

Table 1

Sociodemographic Characteristics of the Study Participants (N = 371)

Characteristic	Category	N	%
Age group (years)	18–24	62	16.7
	25–34	97	26.1
	35–44	119	32.1
	45–54	74	19.9
	≥55	19	5.1

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	Total	371	100
Sex	Male	196	52.8
	Female	175	47.2
	Subtotal	371	100
Marital status	Married	188	50.7
	Single	90	24.3
Education level	Divorced/Separated	67	18.1
	Widowed	26	7
	Total	371	100
	No formal education	86	23.2
	Primary	162	43.7
Employment status	Secondary	94	25.3
	Tertiary	29	7.8
	Total	371	100
	Casual work	117	31.5
	Self-employed	89	24
Residence	Unemployed	75	20.2
	Formal employment	55	14.8
	Farmer	20	5.4
	Student	14	3.8
	Other	1	0.3
	Total	371	100
	Rural	282	76
Living arrangement	Urban	89	24
	Total	371	100
	With family	246	66.3
	Alone	73	19.7
	With friends/others	52	14
Duration of mental illness	Total	371	100
	Less than 1 year	70	18.9
	1–5 years	154	41.5

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	6–10 years	119	32.1
	More than 10 years	28	7.5
	Total	371	100
Previous psychiatric admission	Yes	261	70.4
	No	110	29.6
	Total	371	100

B. Prevalence of Internalized Stigma

The mean overall ISMI score was 2.68 ± 0.31 . Based on the recommended cut-off score of 2.50, 247 participants (66.6%) were classified as having high internalized stigma, whereas 124 (33.4%) had low internalized stigma.

Analysis of the ISMI domains demonstrated varying levels of internalized stigma. Social withdrawal recorded the highest prevalence of high stigma, followed by discrimination experience, Alienation and stereotype endorsement and whereas stigma resistance showed the lowest prevalence of high stigma. The prevalence of overall internalized stigma and domain-specific scores is presented in Table 2.

Table 2

Prevalence of internalized stigma among adult psychiatric outpatients (N = 371)

ISMI Domain	Low Stigma n (%)	High Stigma n (%)
Overall ISMI	124 (33.4)	247 (66.6)
Social Withdrawal	135 (36.4)	236 (63.6)
Discrimination Experience	140 (37.7)	231 (62.3)
Alienation	145 (39.1)	226 (60.9)
Stereotype Endorsement	184 (49.6)	187 (50.4)
Stigma Resistance	232 (62.5)	139 (37.5)

C. Bivariate Association Between Sociodemographic Factors and Internalized Stigma

Independent samples *t*-tests showed no statistically significant differences in mean internalized stigma scores according to sex ($t = 0.637$, $p = 0.525$), residence ($t = -1.485$, $p = 0.138$), or previous psychiatric admission ($t = -0.327$, $p = 0.744$).

One-way analysis of variance (ANOVA) demonstrated statistically significant differences in mean internalized stigma scores across age group ($F(4, 366) = 2.824, p = 0.016$), education level ($F(3, 367) = 3.415, p = 0.018$), and duration of mental illness ($F(3, 367) = 4.484, p = 0.004$). Marital status, employment status, and living arrangement were not statistically significantly associated with internalized stigma at the 5% significance level, although employment status ($p = 0.090$) and living arrangement ($p = 0.067$) met the predefined criterion ($p < 0.20$) for inclusion in the multivariable analysis.

Post hoc pairwise comparisons were performed only for variables with statistically significant ANOVA results. Games–Howell analysis for age group identified significant differences between participants aged 18–24 years and 35–44 years (mean difference = -0.154 , 95% CI: -0.295 to -0.013 , $p = 0.025$), and between participants aged 18–24 years and 45–54 years (mean difference = -0.156 , 95% CI: -0.311 to -0.001 , $p = 0.048$). Tukey HSD analyses showed no statistically significant pairwise differences for education level or duration of mental illness after adjustment for multiple comparisons. These findings are presented in Table 3.

Table 3

Summary of Post Hoc Analyses for Variables with Significant One-Way ANOVA

Variable	Levene's test (p-value)	Post hoc test	Significant pairwise comparison(s)	p-value
Age group	0.04	Games–Howell	18–24 vs 35–44	0.025
			18–24 vs 45–54	0.048
Education level	0.9	Tukey HSD	No significant pairwise comparisons after adjustment	—
Duration of mental illness	0.34	Tukey HSD	No significant pairwise comparisons after adjustment	—

D. Multivariable Analysis of Sociodemographic Factors Associated with Internalized Stigma

Variables meeting the inclusion criterion in the bivariate analysis ($p < 0.20$), together with clinically relevant covariates, were entered into the multiple linear regression model. After adjustment, age group ($\beta = 0.139$, $B = 0.036$, 95% CI: 0.009 – 0.063 , $p = 0.009$) and education level ($\beta = 0.123$, $B = 0.041$, 95% CI: 0.006 – 0.077 , $p = 0.023$) remained independently associated with internalized stigma.

In contrast, duration of mental illness, employment status, sex, residence, living arrangement, marital status, previous psychiatric admission, and total perceived social support score (MSPSS)

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were not independently associated with internalized stigma after adjustment for potential confounding variables (Table 4).

Table 4

Multiple Linear Regression Coefficients for Factors Associated with Internalized Stigma

Variable	β (Standardized)	B	95% CI for B	p-value	Interpretation
Age group	0.139	0.036	0.009 to 0.063	0.009	Significant independent predictor
Education level	0.123	0.041	0.006 to 0.077	0.023	Significant independent predictor
Total MSPSS score	0.099	0.029	-0.003 to 0.061	0.071	Not significant
Duration of mental illness	-0.082	-0.025	-0.056 to 0.006	0.11	Not significant
Employment status	-0.077	-0.012	-0.028 to 0.004	0.142	Not significant
Sex	-0.048	-0.028	-0.088 to 0.032	0.355	Not significant
Residence	0.046	0.031	-0.040 to 0.102	0.388	Not significant
Living arrangement	-0.045	-0.023	-0.075 to 0.029	0.383	Not significant
Marital status	-0.034	-0.012	-0.049 to 0.024	0.503	Not significant
Previous psychiatric admission	-0.004	-0.002	-0.067 to 0.062	0.94	Not significant

Discussion

A. Prevalence of Internalized Stigma

The present study found that 66.6% of adult psychiatric outpatients experienced high internalized stigma, indicating that self-stigma remains a major challenge among people receiving outpatient mental health services in Bomet County, Kenya. This finding suggests that despite ongoing psychiatric treatment, many individuals continue to internalize negative societal attitudes towards mental illness, potentially affecting recovery, treatment adherence, and social participation.

The prevalence observed in this study is substantially higher than the 37.5% reported by Makanjuola et al. (2016) among psychiatric patients in Nairobi, Kenya, whose findings informed the sample size estimation for the present study. It is also higher than the prevalence reported among psychiatric outpatients in Ethiopia by Sori et al. (2022) and among mental health service users in Saudi Arabia by Zarbah et al. (2023). Differences in sociocultural beliefs, study settings, diagnostic profiles, mental health service accessibility, and methods used to classify internalized stigma may partly explain these variations.

The high prevalence observed is consistent with global evidence indicating that internalized stigma remains a persistent barrier to recovery among people living with mental illness. The World Mental Health Report emphasizes that stigma continues to undermine treatment engagement, social inclusion, and quality of life despite improvements in mental healthcare (WHO, 2022). Similarly, the Lancet Commission on Ending Stigma and Discrimination in Mental Health concluded that self-stigma continues to restrict recovery opportunities and remains a major public health concern across both high- and low-income settings (Thornicroft et al., 2022).

The findings highlight the need for routine assessment of internalized stigma within outpatient psychiatric services. Integrating psychoeducation, recovery-oriented counselling, and stigma-reduction interventions into routine mental healthcare may help improve treatment engagement and psychosocial recovery among psychiatric outpatients.

B. Sociodemographic Factors Associated with Internalized Stigma

Age and Internalized Stigma

The present study identified age group as an independent predictor of internalized stigma, with increasing age categories being associated with higher internalized stigma scores after adjustment for other sociodemographic characteristics. This finding suggests that age continues to influence how individuals internalize negative societal attitudes towards mental illness, independent of educational level, employment status, duration of illness, and other measured factors.

The observed association differs from findings reported in Ethiopia by Sori et al. (2022) and Alemu et al (2023), where younger adults experienced greater internalized stigma than older individuals. Similarly, Fekadu et al. (2016) reported higher self-stigma among younger psychiatric patients, attributing this to concerns regarding education, employment, and social relationships. In contrast, the present study demonstrated higher internalized stigma among older age categories after multivariable adjustment, suggesting that the relationship between age and self-stigma may vary across populations and healthcare settings.

One possible explanation is that older adults often live with mental illness for prolonged periods and may experience cumulative exposure to stigma, repeated discrimination, social exclusion, and functional limitations over time. These experiences may reinforce negative self-perceptions even while receiving ongoing psychiatric care. Differences in cultural expectations, family responsibilities, and social roles among older adults within the Kenyan context may also contribute to greater internalization of stigma. However, because this study was cross-sectional, causal relationships cannot be established, and further longitudinal studies are needed to clarify the mechanisms through which age influences internalized stigma.

The finding highlights the importance of incorporating age-sensitive psychosocial interventions into outpatient psychiatric services. Recovery-oriented counselling and stigma-reduction programmes should recognize that internalized stigma may persist across the lifespan and may

require different approaches according to patients' developmental stage and psychosocial circumstances.

Education Level and Internalized Stigma

The present study found that educational level was an independent predictor of internalized stigma, even after adjustment for age and other sociodemographic variables. This finding suggests that educational attainment plays an important role in shaping individuals' perceptions and responses to mental illness. Participants with different levels of education experienced significantly different levels of internalized stigma, indicating that education influences vulnerability to self-stigmatizing beliefs.

The present finding is consistent with previous studies conducted in Ethiopia by Sori et al. (2022) which reported that educational attainment was significantly associated with internalized stigma among people receiving psychiatric care. Similarly, Fekadu et al. (2016) observed that individuals with lower educational attainment experienced greater self-stigma than those with higher levels of education. Comparable findings have also been reported in Saudi Arabia by Zarbah et al. (2023) and Oti-Boadi et al. (2024), who suggested that education enhances mental health literacy and reduces the likelihood of internalizing negative societal stereotypes.

Higher educational attainment may improve understanding of the biological and psychosocial causes of mental illness, reduce misconceptions, and increase access to accurate health information. Individuals with more education may also possess stronger problem-solving skills, greater self-efficacy, and improved access to social and economic resources that promote resilience against stigmatizing experiences. Conversely, limited education may increase susceptibility to traditional misconceptions, self-blame, and negative community attitudes, thereby reinforcing internalized stigma.

The finding supports the recommendations of the World Mental Health Report, which identifies mental health literacy as an essential component of stigma reduction and recovery-oriented care (WHO, 2022). Likewise, the Lancet Commission on Ending Stigma and Discrimination in Mental Health emphasized that improving public understanding of mental illness through education is fundamental to reducing both public and self-stigma (Thornicroft et al., 2022). Integrating culturally appropriate psychoeducation into routine outpatient mental health services may therefore help reduce internalized stigma, particularly among patients with lower educational attainment.

Duration of Mental Illness and Other Sociodemographic Factors

Although duration of mental illness was significantly associated with internalized stigma in the bivariate analysis ($F = 4.484$, $p = 0.004$), it did not remain an independent predictor after adjustment for other sociodemographic characteristics ($p = 0.110$). Likewise, employment status, which approached statistical significance in the bivariate analysis ($p = 0.090$), was not independently associated with internalized stigma in the multivariable model ($p = 0.142$). These findings suggest that the observed associations were largely explained by other factors, particularly age and educational level, which remained significant after adjustment.

The finding regarding duration of mental illness is comparable to that reported by Abraham et al. (2025), who observed that several clinical and sociodemographic variables lost statistical significance after multivariable adjustment, highlighting the importance of controlling for potential confounding factors when identifying independent predictors of internalized stigma. Similarly, Ma et al. (2024) found that although illness-related characteristics influenced psychosocial outcomes in unadjusted analyses, their effects were substantially reduced after accounting for broader psychosocial determinants, including social support and functional status. These findings suggest that internalized stigma is a multifactorial phenomenon that cannot be explained solely by illness duration.

In contrast, Assefa et al. (2012) reported that longer duration of schizophrenia was associated with greater internalized stigma, while Manghani et al. (2025) observed that chronic mental illness contributed to persistent self-stigmatizing beliefs among individuals with common mental disorders. Differences in diagnostic composition, study design, healthcare systems, and cultural contexts may explain these discrepancies. Unlike those studies, the present study included adult psychiatric outpatients with diverse psychiatric diagnoses receiving ongoing follow-up care, which may have reduced the independent influence of illness duration after adjustment for other characteristics.

Employment status was likewise not independently associated with internalized stigma after adjustment. Although unemployment has frequently been associated with poorer psychosocial outcomes among people living with mental illness, evidence regarding its relationship with self-stigma remains inconsistent. Görmez et al. (2025) reported no significant difference in internalized stigma after accounting for clinical characteristics among psychiatric service users, while Hosseini et al. (2024) demonstrated that psychological factors such as self-esteem, hope, and self-efficacy were more strongly associated with internalized stigma than socioeconomic characteristics alone. The present findings therefore suggest that interventions aimed at reducing internalized stigma should extend beyond employment or illness duration and instead focus on strengthening psychosocial resilience and recovery-oriented care.

Similarly, sex, marital status, residence, living arrangement, and previous psychiatric admission were not significantly associated with internalized stigma in either the bivariate or multivariable analyses. Comparable findings have been reported by Abraham et al. (2025) and Zarbah et al. (2023), who found that these demographic characteristics were not consistent predictors of self-stigma after adjustment for other variables. These findings support the growing body of evidence suggesting that internalized stigma is influenced more by individual psychological processes, mental health literacy, and social experiences than by demographic characteristics alone.

Conclusion

This study demonstrated that internalized stigma remains highly prevalent among adult psychiatric outpatients attending AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital, with approximately two-thirds of participants experiencing high levels of self-stigma.

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Among the sociodemographic characteristics examined, age and educational level were identified as independent predictors of internalized stigma, whereas duration of mental illness, employment status, sex, marital status, residence, living arrangement, and previous psychiatric admission were not independently associated after multivariable adjustment. These findings highlight the persistent burden of internalized stigma among psychiatric outpatients and underscore the importance of incorporating stigma assessment and recovery-oriented interventions into routine mental health services. Addressing internalized stigma, particularly among vulnerable population groups, may contribute to improved treatment engagement, psychosocial recovery, and overall quality of life for people living with mental illness.

Recommendations

The findings of this study support strengthening implementation of the Kenya Mental Health Action Plan (2021–2025) by integrating routine assessment of internalized stigma into outpatient mental health services and expanding evidence-based anti-stigma interventions at both national and county levels. Mental health professionals should routinely screen for internalized stigma and incorporate recovery-oriented interventions, including psychoeducation, family education, and peer-support programmes, particularly for patients in middle age groups and those with higher educational attainment who were identified as having a higher risk of internalized stigma. Community leaders, faith-based organizations, civil society organizations, and the media should collaborate to deliver culturally appropriate mental health awareness programmes that reduce stigma, promote early help-seeking, and support the social inclusion of people living with mental illness.

Acknowledgments

The authors sincerely thank the management and staff of AGC Tenwek Teaching and Referral Hospital and Longisa County Referral Hospital for facilitating this study. We are grateful to the research assistants and all study participants for their time and valuable contributions. We also acknowledge Kabarak University for academic support throughout this research.

Authorship Statement

Atnafu Alemayehu Asha: Conceptualization, Methodology, Investigation, Data curation, Formal analysis, Writing – original draft. Jonathan Steen and Leon Gakuo: Supervision, Validation, Writing – review & editing. All authors read and approved the final manuscript.

Funding

This study received no external funding. It was self-sponsored by the authors.

Competing Interests

The authors declare that they have no competing interests.

Ethics Approval

Ethical approval for this study was obtained from the AGC Tenwek Hospital Institutional Research and Ethics Committee (ISREC) prior to commencement of the study. Administrative permission

was subsequently obtained from Kabarak University Institute of Post graduate studies(IPGS), the management of AGC Tenwek Hospital and Longisa County Referral Hospital. Research authorization was granted by the National Commission for Science, Technology and Innovation (NACOSTI), Kenya (License No. NACOSTI/P/26/4189591). Informed consent was obtained from all participants before enrolment, and confidentiality and anonymity were maintained throughout the study.

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