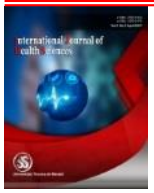

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Media Accessibility and Use-Patterns on the Occurrence of Mental Health Conditions Among Youths in Nairobi City County, Kenya

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Media accessibility;
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Mental health burden;
Mental health condition;
Young people;

Abstract

Aim: Globally, mental health problems affect 10 to 20% of adults and youngsters, with the onset age for 50% of cases being 14 years. In Kenya, estimates suggested that 1 in 10 individuals suffered from a known mental condition, with adult Kenyans having a 9.8% likelihood of experiencing depression. A study on social media use in Kenya revealed that the most active age group was 26-35 years, with a significant proportion using platforms like Facebook, WhatsApp, Snapchat, Instagram, and Twitter. The study assessed the impact of media accessibility and use patterns on the occurrence of mental health conditions among youths in Nairobi City County, Kenya. Methods: The study design was an analytical cross-sectional study with quantitative and qualitative methods. Data collection involved SSQs, KIIs, and FGDs, with 24 KIIs and 2 FGDs being conducted. A total of 385 participants were selected using a simple random sampling method, and data analysis was conducted using Advanced Excel, including descriptive statistics and regression analysis. Transcribing, coding, and classifying were employed to establish relationships and enable data summarization performance. Results: The results indicated a statistically significant difference in self-esteem scores between the two groups, $t(766) = -2.84$, $p = .0047$. Specifically, youths engaged in informal occupations ($M = 19.01$, $SD \approx 17.91$) reported higher self-esteem compared to those in formal occupations ($M = 15.42$, $SD \approx 17.14$). This suggested that employment type may influence how youths perceive their self-worth, possibly due to factors like increased autonomy or flexibility in informal settings. The regression analysis showed that media use-patterns were not a statistically significant predictor of self-esteem among youths in Nairobi City County, $\beta = -0.08$, $t(382) = 1.03$, $p = .30$. Media literacy had a positive and statistically significant effect on self-esteem, $\beta = 0.21$, $t(382) = 2.23$, $p = .03$. The regression model explained approximately 1.3% of the variance in self-esteem scores, $R^2 = .013$. Conclusion: Mental health issues are widespread, often fueled by digital exposure and compounded by structural limitations like poverty, stigma, and insufficient mental health infrastructure.

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Contents

1 Introduction

Mental health has become a critical concern globally, with increasing attention being paid to its impact on individuals, families, and societies (O'Higgins *et al.,* 2020). A US study performed on adolescents indicated that those who used social media in excess of 3 hours a day were more likely to have mental health-related problems, in particular, internalization problems (Riehm *et al.,* 2019; Cook *et al.,* 2021). In Ontario, a rise in moderate to serious mental distress was reported, with the proportions ranging from 24% in 2013, to 34% in 2015, and to 39% in 2017 amongst teenagers (Hamilton *et al.,* 2018; Cook *et al.,* 2021). This shows that teenagers and young adults form a large proportion of the media consumers, hence posing a rising risk to their mental health, which then requires attention.

Approximately 4.9 billion people have been reported to be engaging in social media usage, and the expectation is that it will shoot to some 5.85 billion users by 2027 (Wong, 2023). Facebook, as one of the topmost used applications, recorded an approximate of 1 billion active users, meaning 1 in 7 people used this source to connect with loved ones (BBC, 2015; Lee, 2021). Whilst media platforms offer avenues for social interaction, entertainment, and information consumption, there is a growing awareness of the potential psychosocial implications associated with excessive media exposure. It has been noted that prolonged exposure to unrealistic beauty standards, cyberbullying, and the constant barrage of information can lead to heightened stress, anxiety, and depressive symptoms among youths in New Zealand (Smith *et al.,* 2020; Or, 2024)

As per a study in SSA, 84% of the respondents stated that social media contributed to a rise in mental-health concerns amongst youngsters in South Africa (SA) and the Eastern Cape. Several people who responded mentioned that they spent in excess of 7 hours daily on social networks and average, 8-12 hours daily gazing at their devices' screens (Lukose *et al.,* 2023)

Recent studies showed the prevalence of mental health conditions among adolescents in SSA to be at 27% for depression, 30% for anxiety disorders, 21% for post-traumatic stress disorder (PTSD), and 12% for suicidal thoughts (Ma *et al.,* 2021). These rates were considerably higher than the global prevalence estimates for these conditions, which were 13% for depression, 7–10% for anxiety, 3–6% for PTSD, and 10% for suicidal thoughts (Vaivada *et al.,* 2022)

In Kenya, mental health remains a critical but often neglected aspect of public health, as evidenced by the mere 0.05% allocation of the annual budget to mental health services (Mutiso et al., 2018; Julia & Lumala, 2020). This inadequate funding reflected a broader issue of governmental oversight in addressing mental health needs. Despite the lack of precise data on the prevalence of mental health conditions in Kenya, various studies indicated a significant burden, with depression rates ranging from 19% in household surveys (Mutiso *et al.,* 2018; Julia & Lumala, 2020) to as high as 42% among individuals seeking healthcare services (Julia & Lumala, 2020; Ndetei, 2009)

Moreover, recent studies highlighted the impact of social media use on different age groups in Kenya, with the 26-35 age bracket emerging as the most active users across various platforms such as Facebook, WhatsApp, Instagram, and Twitter (USIU, 2019). Among young Kenyans, mental health challenges, including anxiety, conduct disorders, ADHD, and personality disorders, have been prevalent, often exacerbated by factors like substance abuse, aggression, and the effects of the COVID-19 pandemic (Memiah *et al.,* 2022).

Memiah *et al.,* (2022) further indicated that, recognizing the severity of these issues, former President Uhuru Kenyatta emphasized the importance of mental health as a national priority.

Within Nairobi City County, the situation was particularly concerning, with a notable concentration of mental health cases among adults. Recent data from the Kenya National Bureau of Statistics (KNBS) revealed over 20000 hospital visits related to mental disorders, with a significant portion involving individuals aged five years and above. Precisely, reported numbers were 20,353 cases of hospital visits because of mental health conditions. Of these, 18,846 were individuals aged above five years (Kajilwa, 2020). This study focused on Nairobi City County due to its alarming mental health statistics and aimed to shed light on the burden of media accessibility and usage patterns on the mental well-being of youths in this region.

2 Materials and Methods

The study was conducted on youths aged between 18-35 years in Nairobi City County in Kenya.

2.1 *Study Design:* The study design was an analytical cross-sectional study with quantitative and qualitative methods.

2.2 *Study location:* Nairobi City County's 17 sub-counties were engaged whilst collecting data. The sub-counties' target areas included a few institutions like churches and universities/colleges where youths engage while knowledge is being imparted, and this included mentions of the University of Nairobi, KMTC, and TUK. Estates within Nairobi County and vibrant social hubs where people gather for recreational activities. These organic meeting points span across the 17 sub-counties, with parks serving as serene spaces where individuals engage in sports, leisure, and relaxation, creating a unique blend of community and leisure.

2.3 *Sample size:* 431 participants, 385 participants took part in the quantitative part, and 46 respondents for the qualitative part, which was done purposively.

Sample size calculations: When the target population is > 10,000, use Fisher's (1998) formula to get the required sample.

n=(z^2 pq)/d^2

Where:

n = desired sample size where the study population is > 10,000

z = normal deviation standard, usually set at 1.96 (or simply at 2), which covers the 95% confidence level

p= overall population of the target population estimated to have a particular characteristic. If there is no reasonable estimate, use 35% (0.35)

q=1-p (1-0.35)=(0.65)

d=degree of error permissible, set as 0.05 (Fischer's, 1998; Mugenda & Mugenda, 1999)

(1.96*1.96)(0.35)(0.65)/(0.05*0.05)= 349.5856 thus approximately 350

Non-response rate= 10% of 350, resulting in 35

The sample size was 350+35=385

2.4 *Sampling techniques:* Nairobi City County was purposively sampled, with the sub-county division being used as a stratum. The basis of this is the fact that the mentioned County was termed as having the most mental health cases amongst adults. Reported numbers were 20,353 cases of hospital visits because of mental disorders. Of these, 18,846 were individuals aged above five years; all is still based on the KNBS data from 2018. (Kajilwa, 2020). The study targeted 385 youth participants from various sub-counties within Nairobi City County. Participants were selected using a simple random method by the use of computer-generated values. Efforts were made to engage diverse groups of youth, including those from formal and informal settlements, to capture a wide range of perspectives on media accessibility and mental health.

A total of 24 Key Informants were purposively selected based on their expertise and relevance to the study. These included parents/guardians with youths who have experienced mental health conditions or who have supported other parents in navigating similar challenges. Champions and leads, including

survivors and advocates, were engaged to provide real-time perspectives on mental health conditions and resilience strategies. Mental health professionals were also included, such as clinical psychologists from both private and public practice, including those working at national and sub-county levels within Nairobi. Youth counselors supporting informal settlements and engaging youths in mental health support initiatives were involved, along with psychology lecturers from universities and colleges in Nairobi, offering expert opinions on the psychological implications of media exposure. Additionally, media industry representatives were engaged, including medical doctors specializing in health journalism, national and sub-county communication experts across various ministries, advocacy officers, and TV/radio journalists. These participants contributed insights on the media's role, policies, and potential strategies for addressing mental health concerns tied to media use.

2 Focus Group Discussions (FGDs) were conducted, and participants were purposively selected to represent perspectives from formal and informal settlements. The Informal Settlement FGD included parents with youths affected by mental health conditions, youth counselors supporting families, a clinical officer engaging youths in community activities (youth representative), a community health worker (CHW), and peer educators. This group was comprised of 10 participants. The Formal Settlement FGD included youths, youth representatives and educators, mental health professionals, and media experts. This group was comprised of 12 participants (Lu, 2025).

2.5 Inclusion criteria: The study targeted residents aged 18-35 years who have lived in Nairobi County for at least six months. The said participants consented before being engaged. Not mentally incapacitated to answer survey questions.

2.6 Exclusion criteria: Mentally incapacitated youths (drunks, insane) or guests were excluded from participating in the study. Additionally, participants who had not resided in Nairobi City County for at least 6 months were exempted from participation.

2.7 Procedure methodology: Semi-structured questionnaires were used to collect quantitative data from primary respondents. Key informant interview schedules and focus group discussions were conducted to collect qualitative data from key informants and the discussions. *Statistical analysis:* Information was coded by the researcher before entering it into a spreadsheet, followed by analysis using Advanced Excel. Descriptive statistics for quantitative data were calculated and later presented in frequency tables, pie charts, and graphs. Inferential statistics were also calculated using ANOVA, t-tests were performed at a 95% confidence interval, and p-values less than 0.05 were considered statistically significant. This was used to show the association between independent and dependent variables. Qualitative data were analyzed using thematic analysis after a thorough reading of the transcripts.

2.8 Ethical Considerations: Research approval and authorization were sought from Kenyatta University graduate school, ethical clearance from KUERC, research permit from NACOSTI, permission from Nairobi county's health and education departments, and respondents' ICFs.

3 Results and Discussions

3.1 Response rate

The study administered 385 semi-structured questionnaires to selected youths in the 17 sub-counties within Nairobi City County, Kenya. Duly filled and returned questionnaires were taken into account and considered for analysis. After data checking and cleaning, 385 questionnaires were deemed fit for analysis, representing a response rate of 100%.

Table 1
Response Rate

Category	Frequency	Percentage
Successful	385	100%
Unsuccessful	0	0%
Total	385	100%

It is worth noting, however, that while all 385 participants responded, some questions—particularly those of a sensitive nature—were left unanswered by certain individuals. This reflects the ethical considerations upheld during the study, where respondents were encouraged to participate voluntarily and were given the freedom to omit responses to questions, they were uncomfortable answering. While this does not diminish the overall response rate, it underscores the importance of respecting participants' boundaries when addressing sensitive topics.

3.2 The types of mental health conditions among the youths accessing and using media in the Nairobi City County, Kenya

This study concentrated on identifying mental health disorders experienced by youths in Nairobi City County, with a specific focus on anxiety and stress-related symptoms. These disorders were selected due to their increasing prevalence among young people and their potential connection to digital media use. The assessment was conducted using the Spielberger State-Trait Anxiety and Rosenberg Self-Esteem Score.

3.2.1 Anxiety Levels

Table 1
Anxiety level scores

Score	Count	Percentage
High	30	8%
Moderate	315	82%
Low	40	10%
Total	385	100%

Analysis of total anxiety scores, using the Spielberger State-Trait Anxiety, demonstrated that high anxiety was absent among respondents, with 236 participants (61%) classified as experiencing low anxiety and 149 participants (39%) as experiencing moderate anxiety. The absence of high-anxiety cases suggests that severe anxiety may be less prevalent in this cohort; nonetheless, the sizeable proportion of youth reporting moderate anxiety underscores the importance of early identification and supportive measures to prevent progression to more debilitating levels of distress.

3.2.2 Depression

Table 2
Depression score

Score	Count	Percentage
High	22	6%
Moderate	155	40%
Low	208	54%
Total	385	100%

Table 3 indicates that more than half of the respondents (54%) reported low levels of the condition, while 40% exhibited moderate levels and 6% scored within the high category. This distribution suggests that while a majority of youth in Nairobi City County are not experiencing severe symptoms, a significant portion are grappling with moderate to high levels of distress. The presence of nearly half the respondents in the moderate and high categories highlights the importance of early mental health support and preventive interventions targeting emerging psychological vulnerabilities. Responses such as "There are times when I feel completely useless" and "Overall, I am inclined to believe that I am a failure" reflected the internalized negative self-perceptions contributing to the high depression scores.

3.2.3 Weak Emotional Intelligence

Table 3
Emotional intelligence score

Score	Count	Percentage
Low	67	17%
Moderate	297	77%
High	21	5%
Total	385	100%

As presented in Table 4, 77% of respondents scored within the moderate range for emotional intelligence, 17% were categorized as having low emotional intelligence, and only 5% had high emotional intelligence. These results suggest that while most youth possess some emotional regulation ability, a significant portion may struggle to manage emotions effectively, which could impact their resilience to media-related stressors. This was evident in responses such as "At times I doubt my abilities," "I can perform tasks on par with the majority of people," and "I believe I am a valuable person, at least on an equal footing with others," which provided insight into self-perceived emotional competence.

3.2.4 Suicidal Thoughts

Table 4
Suicidal thoughts

Score	Frequency	Percentage
High	19	5%
Moderate	161	42%
Low	205	53%
Total	383	100%

Table 5 shows that 53% of respondents reported low levels of suicidal thoughts, 42% indicated moderate levels, and 5% experienced high levels. Although the majority had low suicidal ideation, the presence of moderate to high levels in nearly half the sample reflects a concerning trend and the potential psychological toll of media exposure or related life stressors. Notably, the response "Overall, I am inclined to believe that I am a failure" served as a key indicator of suicidal ideation within the population.

3.2.5 Perceived social insecurity

Table 5
Perceived social insecurity

Score	Frequency	Percentage
High	7	2%
Moderate	194	50%
Low	184	48%
Total	385	100%

According to Table 6, 50% of respondents reported moderate levels of social insecurity, while 48% reported low levels and 2% high levels. The findings imply that while extreme social insecurity is rare, half the youth population still experiences a moderate sense of exclusion or lack of social safety, possibly influenced by online interactions and societal dynamics. The perception "I believe I am a valuable person, at least on an equal footing with others" highlighted varying levels of confidence in one's social standing and acceptance.

3.2.6 Low self-esteem

Table 6
Self-esteem score

Score	Frequency	Percentage
High	40	10%
Medium	218	57%
Low	127	33%
	385	100%

Table 7 reveals that 33% of respondents experienced low self-esteem, 57% had moderate self-esteem, and only 10% exhibited high self-esteem. This distribution is consistent with other mental health indicators in the study, suggesting that self-esteem issues are common among youth in Nairobi, potentially exacerbated by digital comparison, online criticism, and societal pressure. Self-assessments such as "Overall I am pleased with myself," "I don't think I have much to be proud of," and "Overall I am inclined to believe that I am a failure" underscored the varying degrees of self-worth experienced by the respondents.

3.3 Socio-demographic factors associated with the occurrence of mental health conditions due to media accessibility and use patterns

The study specifically examined how variables such as age, sex, marital status, religious affiliation, and duration of residence in Nairobi were related to the occurrence of mental health conditions. Questions such as "What is your sex?", "What is your age?", "What is your highest education level?", "What is your marital status?", "What is your religious affiliation?", and "How long have you been living in Nairobi City County?" were used to collect this information. These responses provided critical insights into how demographic characteristics shape mental health outcomes among the youth.

Table 7
Social demographic characteristics of respondents

Socio-demographic profile	**Frequency (n)**	**Percentage (%)**
Age (years)		
18-23	115	29.9%
24-29	199	51.7%
30-35	71	18.4%
TOTAL	385	100%
Sex		
Male	227	59%
Female	154	40%
Prefer not to say	4	1%
TOTAL	385	100%
Religious affiliation		
Christian	360	93.5%
Muslim	12	3.1%
Pagan	7	1.8%

Socio-demographic profile	Frequency (n)	Percentage (%)
African religion	5	1.3%
Blank	1	0.3%
TOTAL	385	100%
Marital status		
Single	308	80.0
Married	75	19.5
(Blank)	2	0.5
TOTAL	385	100
Length of stay (In Nairobi)		
< 1 year	29	7.5%
1-10 yrs.	210	54.5%
11-20 yrs.	92	23.9%
21-30 yrs.	44	11.4%
31years and over	10	2.6%
TOTAL	385	100%

3.3.1 Age profile of the respondents

The age distribution of the Nairobi City County residents shown by the findings, was that most of the respondents were aged 24-29 years, resulting in 199 respondents, hence 51.7%. The range was followed by 18-23 years respondents who were 115, thus 29.9% and finally 30-35 years who were 71, hence 18.4%. The age distribution was reflective of the younger population dynamics of Nairobi City County, where younger adults were more likely to actively engage in community and research activities. These age groups are important for the study as they represent the most economically and socially active demographics, influencing the study's findings. The inclusion of respondents across varying age groups ensured a balanced perspective.

3.3.2 Sex of the respondents

This characteristic presented the sex distribution of the respondents of the study who willingly participated. According to the results, more than half of the respondents captured in the study were males, whose number was 227, hence 59% while the rest, that is 40% hence 154, were males, with 1% hence 4 respondents preferring not to say their sex.

The distribution aligned with the study's aim to capture diverse perspectives across Nairobi City County residents. While the male majority may be indicative of easier accessibility and willingness to participate, it does not significantly skew the results, as both sexes were proportionally represented. The inclusion of the 'prefer not to say' category ensured inclusivity and respect for privacy.

3.3.3 Religious affiliation

For the religious affiliation, the findings presented in Nairobi City County showed that most residents were Christians, with a 93.5% output that represented 360 respondents, and it was followed by 3.1% of the residents who were Muslims, hence 12 respondents. Pagans had a 1.8% with 7 respondents, African religion had with 5 respondents 1.3% and lastly 1 person was not affiliated to either, hence did not pick a religion, thus making a 0.3%.

The distribution aligned with the religious demographics of Nairobi City County, where Christianity was/is the predominant faith. Including religious affiliation in the study allowed us to explore whether differing beliefs influenced perspectives or behaviors. While smaller groups like pagans and African religion practitioners were represented in smaller proportions, their inclusion ensured the study was comprehensive and inclusive of all viewpoints.

3.3.4 Marital status

The marital status section on Nairobi City County showed that most residents were single, based on the 80% score that represented 308 respondents, and it was followed by 19.5% of the residents who were married, hence 75 respondents.

The distribution mirrored the population trends in Nairobi City County, where a significant proportion of residents were younger and unmarried. The marital status variable was included to explore potential differences in responses/perspectives based on relationship status, as married individuals may have different priorities or experiences compared to single respondents. While the sample was predominantly single, this reflected the demographic reality and does not compromise the validity of the findings.

Marital Status and experience in mental health conditions

	Married	Prefer not to say	Single
Average	16.85	14.5	15.97

The analysis of mental health understanding scores across different marital status groups revealed slight variations. Participants who were married had the highest average score (M = 16.85), followed by those who were single (M = 15.97), while respondents who preferred not to disclose their marital status had the lowest average (M = 14.50). These differences, although observable, were relatively small and suggest that marital status may not be a strong determinant of understanding of mental health issues within the sampled population.

These findings were based on participants' responses on: *"I feel overwhelmed by the constant flow of information through various media channels", "Media accessibility contributes to heightened stress levels in my life.", "Overall, I am pleased with myself." / "I don't think I have much to be proud of."*, *"What would you say about feeling calm whilst accessing the media?", "What would you say about feeling worried whilst accessing the media?", "What would you say about feeling tense whilst accessing the media?", "What would you say about feeling safe whilst accessing the media?"*

3.3.5 Length of stay in Nairobi City County

The findings presented on Nairobi City County showed that 1-10years had the highest number with 210 residents, hence 54.5%, 11-20 years had 92 respondents, hence 23.9%, 21-20 years had 44 respondents, hence 11.4%, <1 year had 29 respondents, thus 7.5% and lastly, 31 years and over had 10 respondents with 2.6%.

The distribution reflected the transient yet stable nature of Nairobi's population, where many residents move to the city for work, education, or other opportunities and gradually establish long-term residency. The inclusion of length of stay as a variable helped to understand how familiarity with the city and its dynamics may influence perspectives. For example, longer-term residents had deeper insights into local issues compared to newer arrivals. The balanced representation across various durations ensures a diverse and nuanced view of the population.

Duration of residence and understanding of mental health issues

Source	df	SS	MS	F	Significance F
Regression	1	0.758	0.758	0.279	0.597
Residual	382	1036.302	2.713		
Total	383	1037.060			

The regression analysis yielded an F-statistic of 0.279 with a corresponding p-value of 0.597, indicating that the overall model is not statistically significant. Consequently, the duration of stay does not appear to be a significant predictor of participants' understanding.
These findings were based on participants' responses on: *"I am aware of the potential negative impact of excessive media use on mental health.", "Media accessibility plays a significant role in shaping my opinions and perceptions.", "Media content positively influences my overall mood and mental well-being."*

3.4 Socio-economic factors associated with the occurrence of mental health conditions due to media accessibility and use patterns

The socio-economic status of youths in Nairobi City County plays a pivotal role in shaping both the patterns of media engagement and the associated mental health outcomes. In this study, socio-economic variables such as income level, educational attainment, and employment status were assessed to determine how they interact with media use and mental health risks. These factors influenced not only the quantity of media consumed but also the ability to regulate consumption, curate content, and manage emotional responses to media accessibility. To establish socio-economic factors associated with increased risk of mental health conditions due to media use and accessibility among youths in Nairobi City County, Kenya, the following hypotheses were considered:

H_0: Socio-economic factors are not associated with increased risk of mental health conditions due to media use and accessibility among youths in Nairobi City County, Kenya.

H_1: Socio-economic factors are associated with increased risk of mental health conditions due to media use and accessibility among youths in Nairobi City County, Kenya.

The study also examined how socio-economic characteristics such as employment status and area of residence influence youth mental health. Respondents were asked: "What is your occupation?" and "What is your Sub-county/Area of residence?" A pie chart displayed the distribution of responses across Nairobi's sub-counties. These factors were analyzed alongside indicators of self-esteem and anxiety to explore whether economic engagement and living environments play a role in shaping mental health outcomes.

3.4.1 Employment Status of Respondents

Table 8
Employment Status of Respondents

Employment status	Frequency	Percentage
Informal	206	**53.5%**
Formal	177	**47.5%**
Blanks	3	**71.9%**
Total	385	**100%**

The findings indicate that most respondents from Nairobi City County were engaged in informal occupations, accounting for 206 individuals (53.5%). In comparison, 176 respondents (45.7%) were employed in formal occupations. Furthermore, 3 respondents (0.8%) left this section blank.

Table 9
Rosenberg Self-Esteem Score by Employment Status

Occupation type	Mean	Variance	n	t stat	p-value (two tail)	t critical (two tail)
Formal	15.42	293.95	385	-2.8356	0.0047	**1.963**
Informal	19.01	321.25	385			

An independent samples t-test was conducted to examine whether there were significant differences in self-esteem scores between youths in formal and informal occupations. The results indicated a statistically significant difference in self-esteem scores between the two groups, t(766) = -2.84, p = .0047. Specifically, youths engaged in informal occupations (M = 19.01, SD ≈ 17.91) reported higher self-esteem compared to those in formal occupations (M = 15.42, SD ≈ 17.14). These findings suggest that employment type may influence how youths perceive their self-worth, possibly due to factors like increased autonomy or flexibility in informal settings.

Table 10
Total Anxiety Score by Employment Status

Occupation Type	Mean	Variance	n	t Stat	p-value (two tail)	t critical (two tail)
Formal	8.818	96.759	385	-1.630	0.1036	**1.963**
Informal	9.951	89.193	385			

A second t-test was performed to determine if there was a significant difference in total anxiety scores between youths in formal and informal occupations. The results showed no statistically significant difference, t(767) = -1.63, p = .1036, indicating that occupation type may not have a substantial impact on anxiety levels. The following figure illustrates a comparison of the mean self-esteem score and total anxiety mean score by occupation:

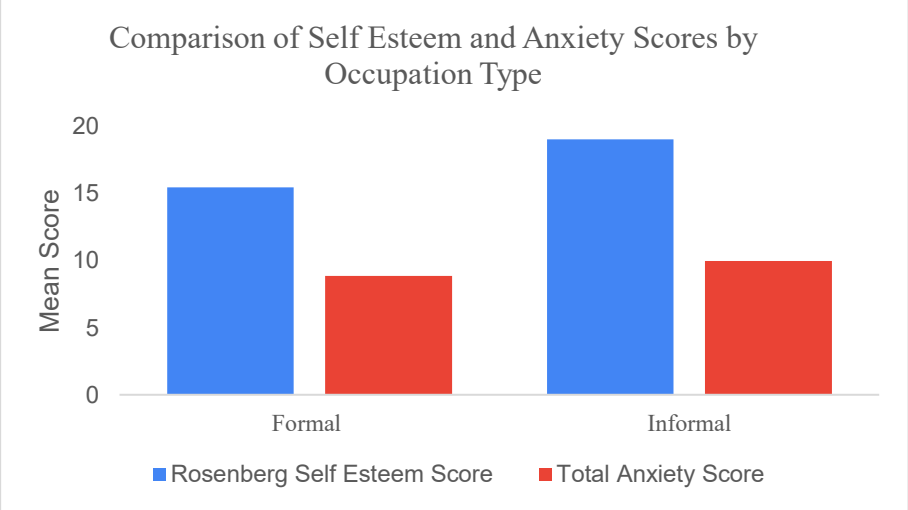

Figure 1. Comparison of Self-Esteem and Total Anxiety by Employment Status

3.4.2 Education level of respondents

Table 11
Education level of respondents

Education Level	Frequency	Percentage
Primary	8	**2.1%**
Secondary	100	**26%**
Tertiary	277	**71.9%**
Total	385	**100%**

The findings for Nairobi City County reveal that the majority of residents attended tertiary school, with 277 respondents (71.9%) falling into this category. This was followed by 26% of residents who completed

secondary school, representing 100 respondents. Only 2.1% of respondents, equating to 8 individuals, had attended primary school.

Table 12
Self-Esteem Score by Education Level

Source of Variation	SS	DF	MS	F Stat	p-value	F crit
Between Groups	111933.8	2	55966.91	316.2709	3.3E-110	**3.003536**
Within Groups	203856.5	1152	176.96			
Total	315790.3	1154				

A one-way ANOVA was conducted to examine the effect of education level on self-esteem scores among youths in Nairobi City County. The results revealed a statistically significant difference in self-esteem scores between the three education levels, $F(2, 1152) = 316.27$, $p < .001$. The effect size was large, indicating that education level accounts for a meaningful portion of the variance in self-esteem.

Table 13
Total Anxiety Score by Education Level

Source of Variation	SS	DF	MS	F Stat	p-value	F crit
Between Groups	35378.77	2	17689.38	345.41	3.46E-118	**3.00**
Within Groups	58842.50	1149	51.21			
Total	94221.27	1151				

An Analysis of Variance (ANOVA) was performed to assess whether total anxiety scores differed significantly across education levels. The results indicated a statistically significant effect of education on anxiety scores, with a between-groups sum of squares of 35,378.77 (df = 2) and a within-groups sum of squares of 58,842.50 (df = 1,149). The mean square between groups (17,689.38) was substantially greater than the mean square within groups (51.21), resulting in an F-statistic of 345.41, which exceeds the critical value of 3.00. The associated p-value (3.46×10^{-118}) was well below the conventional significance threshold, thereby rejecting the null hypothesis of equal means. These findings suggest that education level significantly influences total anxiety scores, highlighting the importance of educational attainment in understanding variations in anxiety within the population studied. The following figure illustrates a comparison of the mean self-esteem score and total anxiety mean score by education level:

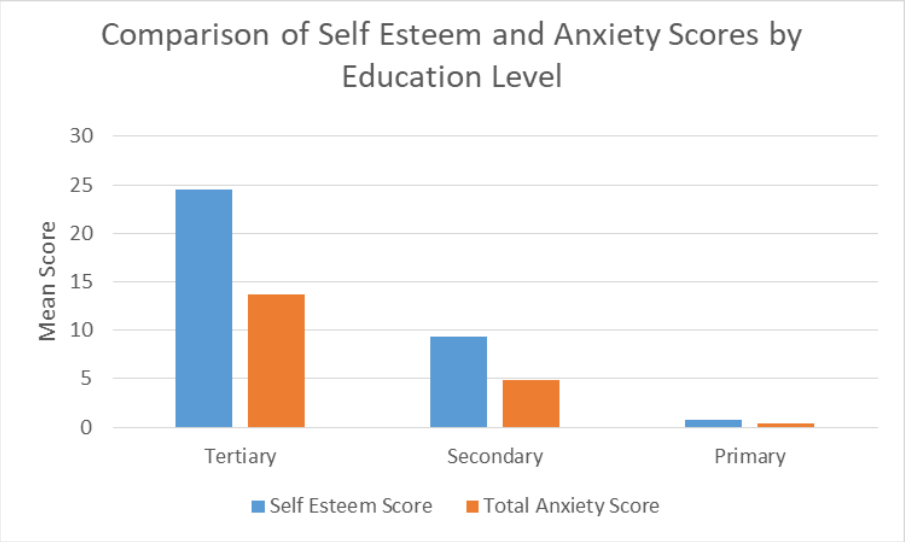

Figure 1. Comparison of Self-Esteem and Total Anxiety by Education Level

The analysis revealed that occupation type is significantly associated with self-esteem among youths in Nairobi City County. Youths engaged in informal occupations reported higher self-esteem than those in formal employment. However, no significant differences were observed in total anxiety levels between the two groups. These results suggest that while the nature of one's occupation may influence perceptions of self-worth, it does not appear to substantially affect anxiety levels. This underscores the importance of considering psychosocial dynamics within employment types when addressing youth mental health.

3.4.3 Respondents' sub-county of residence

Present the distribution of respondents by sub-county of residence across Nairobi County, drawn from a total of 390 participants across 17 sub-counties. The highest representation was from Starehe (7%), Embakasi North (7%), and Kasarani (7%), all of which are densely populated urban centers with significant youth populations and relatively high levels of media access. Sub-counties such as Roysambu, Makadara, and Kamukunji each accounted for 6% of respondents, reflecting areas with a blend of formal and informal settlements where youth often navigate socio-economic challenges alongside increasing exposure to digital platforms. Similarly, Embakasi Central, Mathare, Embakasi South, Westlands, Lang'ata, and Kibra each contributed 6% of the sample, reinforcing the study's emphasis on capturing diverse residential contexts, including those with informal housing and limited access to formal mental health services. Dagoretti North followed closely with 6% representation, while Embakasi East (5%), Embakasi West (5%), Dagoretti South (5%), and Ruaraka (5%) rounded out the distribution. The relatively balanced representation across sub-counties enhances the credibility and transferability of the findings, providing a robust basis for comparative analysis. It also ensures that the study reflects the voices of youth residing in both well-serviced neighborhoods and marginalized areas, particularly informal settlements such as Kibra, Mathare, and Ruaraka, where socio-economic vulnerability may intersect significantly with patterns of media use and mental health outcomes.

3.5 Relationship between media use-patterns and mental health conditions

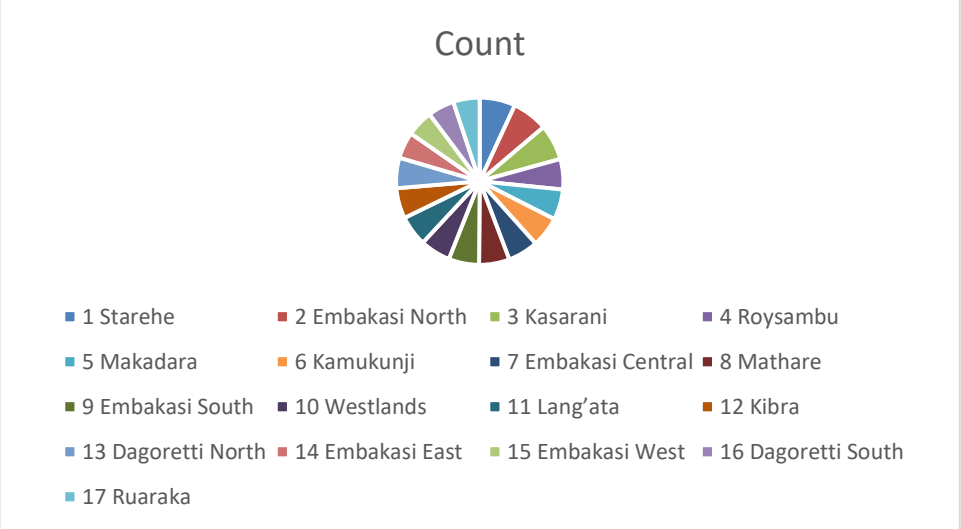

Figure 2. Sub-County of residence

This section explored how different types of media engagement relate to mental well-being. Participants responded to statements including: "Media content positively influences my overall mood and mental well-being," "Accessing media helps me stay connected with friends and community," "Media accessibility plays a significant role in shaping my opinions and perceptions," "I believe my mental health is positively influenced by carefully curating my media consumption," and "I actively seek out diverse and balanced media content to

support my mental well-being." These responses provided the foundation for regression analyses on media use patterns and their associations with self-esteem and anxiety.

Certain patterns of media use were found to contribute positively to the mental health status of youths. Participants who demonstrated intentional and mindful media engagement — such as curating their content and seeking diversity in information sources — were more likely to report beneficial effects on their mental well-being.

Table 14
Media Use Patterns and Self-Esteem Outcomes

Source of Variation	Coefficient	Std Error	t Stat	p-value	95% Confidence Interval
Intercept	33.25	1.42	23.49	3.99E-76	**[30.46,36.03]**
Media use-pattern Score	-0.08	0.07	1.03	0.30	**[-0.06,0.22]**

To determine the relationship between media use patterns and mental health outcomes of youths in Nairobi City County, Kenya, the following hypotheses were considered:
H0: Media use-patterns do not have a relation to mental health outcomes of youths in Nairobi City County, Kenya.
H1: Media use patterns have a relation to mental health outcomes of youths in Nairobi City County, Kenya.
To examine the relationship between media use-patterns and mental health outcomes—specifically self-esteem and total anxiety—simple linear regression analyses were conducted. Results of the regression analysis showed that media use-patterns were not a statistically significant predictor of self-esteem among youths in Nairobi City County, $\beta = -0.08$, $t(382) = 1.03$, $p = .30$. The model accounted for only 1.3% of the variance in self-esteem scores, $R^2 = .013$. This indicates that media use patterns, on their own, do not significantly influence the self-esteem of youths.

Table 15
Media Use Patterns and Total Anxiety Outcomes

Source of Variation	Coefficient	Std Error	t Stat	p-value	95% Confidence Interval
Intercept	19.16	0.90	21.41	2.19E-67	**[17.41,20.92]**
Media use-pattern Score	-0.02	0.04	-0.32	0.75	**[-0.11,0.08]**

Similarly, the regression model assessing the influence of media use-patterns on total anxiety levels (see Table 16) was not statistically significant, $\beta = -0.02$, $t(382) = -0.32$, $p = .75$, with the model explaining only 0.3% of the variance in total anxiety scores, $R^2 = .003$. This suggests a negligible relationship between media use patterns and anxiety among the sampled youths. The following figure illustrates a relationship between media use-pattern score and self-esteem score, and total anxiety mean score:

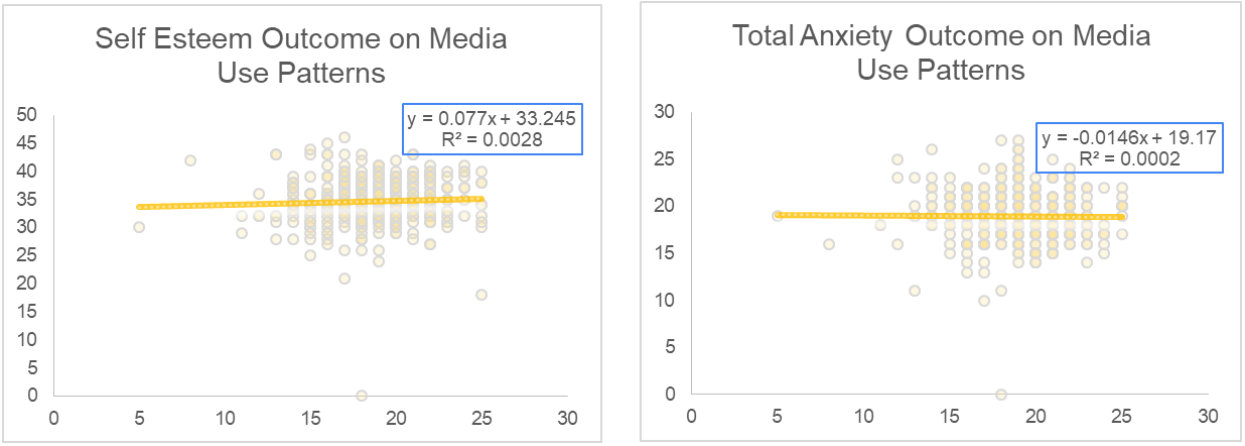

Figure 3. Relationship between media use patterns and mental health conditions

3.6 Role of media literacy in mitigating the negative effects of media exposure on mental health conditions

The findings of this study underscore the critical importance of media literacy in helping individuals, particularly youth, navigate the challenges associated with extensive media exposure. As the media landscape continues to expand, the ability to access, analyze, evaluate, and create media content becomes increasingly vital. Media literacy empowers individuals to exercise greater control over their media consumption, thereby mitigating the negative effects, such as stress, difficulty disengaging from media, and the potential for misinformation. This section examined whether awareness and critical engagement with media content can help reduce the negative impact of media on youth mental health. Respondents were asked to reflect on statements such as "I am aware of the potential negative impact of excessive media use on mental health." Their responses were analyzed in relation to both self-esteem and anxiety scores to evaluate the buffering role of media literacy.

Table 16
Role of media literacy on the self-esteem of youths in Nairobi City County

Source of Variation	Coefficient	Std Error	t Stat	p-value	95% Confidence Interval
Intercept	31.27	1.55	20.22	2.43E-62	**[28.23,34.32]**
Role of Media Literacy Score	0.21	0.09	2.23	0.03	**[0.03,0.40]**

To establish the role of media literacy in mitigating the negative effects of media exposure on the mental health of youths in Nairobi City County, Kenya, the following hypotheses were considered:

H_0: Media literacy does not play a role in mitigating the negative effects of media exposure on the mental health of youths in Nairobi City County, Kenya.

H_1: Media literacy plays a role in mitigating the negative effects of media exposure on the mental health of youths in Nairobi City County, Kenya.

To assess the role of media literacy in mitigating the negative effects of media exposure on mental health, linear regression analyses were conducted with media literacy scores predicting self-esteem and total anxiety outcomes. The results indicate that media literacy had a positive and statistically significant effect on self-esteem, $\beta = 0.21$, $t(382) = 2.23$, $p = .03$. The regression model explained approximately 1.3% of the variance in self-esteem scores, $R^2 = .013$. These findings suggest that higher awareness and regulation of media use may contribute to enhanced self-esteem among youth.

Table 17
Role of media literacy on total anxiety of youths in Nairobi City County

Source of Variation	Coefficient	Std Error	t Stat	p-value	95% Confidence Interval
Intercept	20.19	0.98	20.59	6.53E-64	**[18.27,22.12]**
Role of Media Literacy Score	-0.08	0.06	-1.35	0.18	**[-0.20,0.04]**

In contrast, media literacy did not significantly predict total anxiety scores. The regression coefficient was negative, β = -0.08, but not statistically significant, t(382) = -1.35, p = .18, indicating no meaningful association between media literacy and anxiety. This suggests that while media literacy may boost self-esteem, it may not sufficiently mitigate anxiety levels arising from media exposure. The figure below illustrates a relationship between media literacy and self-esteem and total anxiety mean:

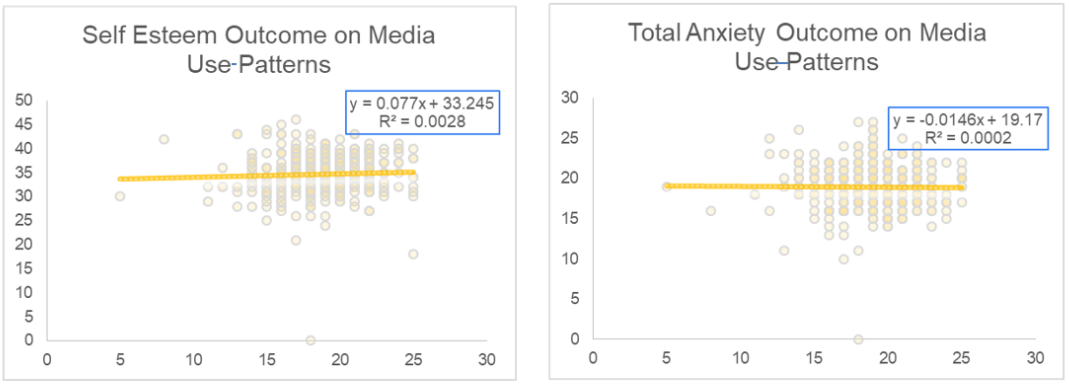

Figure 4. 4 Relationship between media use-pattern and mental health conditions
Figure 4. Relationship between media literacy and mental health

In summary, the findings suggest that media literacy may play a modest but meaningful role in promoting positive self-esteem among youths. However, its role in alleviating anxiety related to media exposure remains inconclusive based on the current data.

4. Discussions

4.1 Typologies of mental health conditions associated with media accessibility and use patterns

This study sought to examine the types of mental health conditions associated with digital media accessibility and use among youths in Nairobi City County, Kenya. The findings, based on both quantitative assessments and qualitative narratives, underscore the emergence of a variety of mental health challenges, including anxiety, depression, suicidal ideation, emotional dysregulation, perceived social insecurity, and low self-esteem. These psychological difficulties appear strongly linked to patterns of media consumption, influenced by socio-cultural expectations, peer dynamics, and digital environments that shape youths' self-perception and emotional regulation.

Anxiety emerged as a common issue, with the majority of respondents experiencing moderate levels. Although severe anxiety was not widely reported, the predominance of moderate anxiety indicates persistent stress among youths, particularly linked to the fear of missing out (FOMO) and social comparison on platforms like Instagram and TikTok. A participant in a Focus Group Discussion (FGD) noted, "Media is affecting mental health in a big way. Young people get anxious because they don't want to miss out. They're scrolling even at the dinner table". This addiction makes the brain stay active, leading to sleep deprivation. This was echoed by a psychologist, also in the FGD, who observed that "the addiction eventually causes a lot of brain activation and overload… young people rarely sleep… performance in class and social circles also go down."

Depression was also prominently reported, with a notable portion of youth experiencing moderate to high depressive symptoms. These feelings often stemmed from social media use, where idealized images and success narratives contribute to a sense of inadequacy. A chief executive officer of a youth organization noted in an interview: "As youths in Nairobi, we are living in difficult times, not due to lack of information but due to the abundance of it… Very many young people are getting into depression. Very many young people are having an identity crisis, and very many young people are going broke due to the kind of content that they have been consuming on social media." These findings are supported by self-reported statements such as, "There are times when I feel completely useless, and "Overall, I am inclined to believe that I am a failure," indicating deeply internalized feelings of hopelessness and inadequacy.

Suicidal ideation was present in a significant proportion of youth, with nearly half reporting moderate to high levels. This is deeply concerning and was directly associated with digital content, particularly on platforms where emotionally triggering videos and harmful trends are common. Participants directly linked such ideation to harmful or emotionally triggering digital content. A FGD participant observed, "There are people who committed suicide because of TikTok. Some people have committed suicide because of Facebook… because of betting… You see." Another participant, a parent from a KII, recounted, "Children are getting exposed to some games, and at the end of that game, you have to kill yourself… the daughter was just on her phone, every time there was a new challenge. And in the end, she took pressure medicines and died." With such a note from one of the clinical psychologists. "..you see right now suicide has been decriminalized. Initially, it was a crime to take your life by suicide in Kenya." Additionally, another clinical psychologist noted, "When you tend to look at a certain thing for a long time… for instance, someone has attempted suicide… it brings some of those things on how maybe to get your life out… it may act as a promoter." These narratives underscore the serious emotional toll of unfiltered and sensationalized content, which can normalize or glamorize harmful behavior.

Perceived social insecurity was found to be moderate in half of the sample, pointing to a widespread sense of social exclusion or inadequacy. Although severe social insecurity was rare, the large proportion experiencing moderate insecurity reveals ongoing feelings of exclusion or marginalization—often linked to online social dynamics. Digital metrics such as likes, shares, and comments were perceived as indicators of social value. A mental health advocate in the FGD remarked, "There's a lot of body shaming… it has brought about cases of low self-esteem, cases of anxiety and depression… the less likes you get, the more you start self-criticizing." Such digital feedback loops amplify doubts about one's social acceptance and identity.

Low self-esteem was another recurring concern. A significant portion of respondents reported difficulty with self-worth and confidence. The interviews and focus group discussions pointed to the role of social media in shaping these outcomes. Phrases like "Overall, I am pleased with myself" were less common than negative self-assessments such as "I don't think I have much to be proud of." Participants described frequent online comparison and constant exposure to idealized content as fueling these sentiments. A youth mental health advocate shared, "The less likes you get, the more you start self-criticizing," reinforcing how self-worth has become entangled with digital validation.

4.2 Socio-demographic factors associated with the occurrence of mental health conditions due to media accessibility and use patterns

The study revealed that Nairobi's youth, particularly those aged between 18 and 29 years, are deeply engaged in social media use. This age group aligns with a vulnerable developmental stage characterized by identity formation, social comparison, and heightened emotional sensitivity. The findings are consistent with global literature, including Riehm *et al.* (2019), which found that adolescents who used social media for over three hours daily were more likely to experience internalizing problems.

In the present study, youth of both genders reported mental health stressors linked to media use. However, qualitative data showed that females were more prone to body image anxiety, while males reported pressure related to financial performance and status. A young female participant in the FGD shared:
"I used to compare myself to others on social media. I had to quit Facebook after 10 years. It was too much pressure. Now I only use TikTok and YouTube, but even that can be overwhelming".
These insights confirm the role of sex in shaping media-related vulnerabilities and emphasize the need for gender-sensitive mental health interventions.

4.3 Socio-economic factors and the occurrence of mental health conditions due to media accessibility and use patterns

Socio-economic status plays a pivotal role in both access to media and its psychological consequences. Youths from lower-income backgrounds, especially those in informal settlements, are disproportionately affected. The constant exposure to aspirational content, coupled with financial limitations, contributes to mental health challenges such as stress, depression, substance use, and suicidal ideation. Media also shape harmful economic behaviors, such as betting and impulsive spending, which worsen economic distress (Dyrbye et al., 2017).

Unemployment and economic hardship emerged as powerful stress amplifiers. Youths from informal settlements or with limited financial means expressed a heightened sense of distress when confronted with media content that glamorized wealth, beauty, and success. A media expert interviewed during the study explained, "Even if you don't have food, you'll find a way to be online. You'll see others traveling, posting flashy lives, and you feel like a failure. That creates mental pressure". These socio-economic realities amplify the psychological burden of media consumption, particularly among youth who are economically marginalized. The findings support MCK (2021), which emphasized the role of structural inequality in shaping mental health outcomes.

The study also highlighted how media content fuels risky financial behavior. Youths are targeted with betting app advertisements and crypto scams. Exposure to betting advertisements and influencer content often leads to compulsive behaviors, such as gambling and unnecessary spending, which in turn trigger financial stress and related mental health concerns. A clinical psychologist lecturer noted: "Betting has become a way of coping for some youths. They see others win online, so they try their luck. When they lose, it breaks them. I know people who got depressed because of that". This finding aligns with the WHO (2022) data on the increasing link between digital gambling exposure and youth mental health decline.

The media creates a false sense of uniformity in lifestyle, ignoring the diverse socio-economic realities that exist in Nairobi. Youth in lower-income communities face greater emotional distress when trying to emulate lifestyles they cannot afford. A CEO interviewed during the study stated, "People from informal settlements are forced to adopt the majority of youths' views… but they're not living within the same realities…. They will go to protest because others are going, then return home to hunger… their day-to-day survival depends on doing odd jobs. So even mental health support becomes secondary." Similarly, an FGD participant explained that "Some of us are doing it just to survive… You go online, and you see your friends flaunting things, but you know at the end of the day, you can't afford food."

4.4 Relationship between media use-patterns and mental health outcomes

Quantitative analysis showed no statistically significant relationship between screen time and anxiety or self-esteem. However, the qualitative findings demonstrated that the media acts as a psychological trigger, not a direct cause. It intensifies already existing vulnerabilities. The data highlights a shift toward high-frequency consumption of emotionally charged, unfiltered, and performative content on platforms like TikTok, Instagram, and YouTube. This creates pressures to perform, alters behavior, fuels misinformation, and fosters emotional distress, especially among the most active users.

Narratives emerged showing that constant media consumption, particularly through short-form video platforms, leads to behavior shifts among youth, including unrealistic aspirations and the need to present a perfected online identity. These pressures often result in burnout, anxiety, and depressive symptoms. One story referenced by a parent during the KII was particularly disturbing: "There was a girl who followed a challenge online and died by suicide. She was always on her phone. Her mother didn't know what she was following." In such cases, the media served as a catalyst, especially when youth lacked social support or awareness. These observations support Smith et al. (2020), who found that unregulated media can amplify pre-existing psychological distress.

Additionally, participants noted how the media cultivates unrealistic expectations, often resulting in withdrawal from productive life goals. Trends and viral content, especially those tied to movements or influencers, significantly impact youth behavior. Many adopt attitudes or participate in actions (e.g., protests or challenges) not out of belief but because of social pressure and online visibility. As one FGD participant, a

youth counselor, explained in a comment, one of their clients stated: "Why should I finish school if influencers are making millions from dancing online?" This sentiment reflects the broader cultural shift where visibility has replaced value, and media-fueled success becomes the new benchmark, regardless of effort or ethics.

4.5 Role of media literacy in mitigating the negative effects of media exposure

Media literacy emerged as a weak buffer against anxiety, though it was moderately associated with higher self-esteem. However, many youths lack the tools to differentiate between credible and harmful content, often falling victim to misinformation, unrealistic standards, and digital manipulation. Participants highlighted the need for early, structured digital literacy education and emphasized stakeholder responsibility in promoting ethical media use and mental health awareness. A media expert warned: "We're all online, but nobody teaches us how to behave there. We share trauma, dead bodies, everything—without understanding the consequences". A clinical psychologist further reflected on the danger of self-diagnosis: "I've seen people say they have anxiety just because an influencer posted symptoms. They start skipping classes or isolating without seeing a doctor".

Participants called for early intervention through digital literacy training in schools, modelled similarly to previous HIV/AIDS awareness efforts. This would build resilience and decision-making capacity in media engagement among youth. A mental health expert explained that "Media literacy should be taught maybe in lower levels of education… not everyone reaches university to learn about defamation or libel." A psychologist and headteacher stated that "Putting in maybe a component of psych education on media within the life skills program… helps people learn and know what to look for, and how it will impact their mental health."

Experts and participants emphasized that policies and media programs must be co-created with youth and grounded in real experiences. Community-based safe spaces and counselling services were strongly recommended to provide immediate psychological support. A FGD participant explained, "Stakeholders should support short, engaging media clips with verified info. We can't sit through a lecture, but a catchy video? That works." In addition, a mental health champion stated that, "Most policies are being made for us… based on what they think we need. But if they came to the ground, they'd see we need human-centered approaches." For community-based approaches, one of the clinical psychologists stated, "There's an intervention called Friendship Bench. It's in Zimbabwe, I think. It's literally a bench. So, at a certain time, you could find the grandmas just chilling, talking to people. People hang around, sitting on the bench a few times a day and they're able to talk about issues that are affecting them and the older people can support the younger ones and it has gone a long way ... I saw some people are trying to replicate that as an intervention that has really worked too and it's low intensive you don't even need money for it"

These statements underscore the urgent need for early media education that focuses not only on consumption but also on ethical content creation and critical thinking. Despite this, digital platforms hold promise. Participants reported finding emotional relief, support communities, and mental health campaigns through media. The key, therefore, is regulated, informed, and purposeful use, not abstinence.

4 Conclusion

The study found that depression, anxiety, low self-esteem, suicidal thoughts, weak emotional intelligence, and perceived social insecurity were prevalent among youth with media access. While clinical disorders were not dominant, subclinical symptoms emerged as serious indicators of mental distress linked to media exposure.

Age and sex significantly influenced mental health outcomes. Youth aged 18–29 and females were especially vulnerable to media-related stressors such as body image concerns and digital social comparison. Employment status and area of residence were found to shape mental health outcomes. Financially disadvantaged youth, particularly those in informal employment or low-income sub-counties, reported greater susceptibility to media-driven anxiety and depressive symptoms. Quantitative analysis showed no significant relationship between media use patterns and mental health outcomes. However, qualitative responses revealed that media could amplify existing emotional vulnerabilities, contributing to psychological strain and emotional instability. Media literacy had a positive association with self-esteem but did not

significantly mitigate anxiety. This underlines the importance of structured media education that promotes critical thinking and healthier media consumption habits among young people.

Recommendations

The study recommends the following based on the findings of the study:

a) The Ministry of Health, in collaboration with youth-serving organizations, should design and implement gender-sensitive mental health programs that address the unique stressors faced by young adults, particularly issues related to social comparison and identity development exacerbated by social media use.
b) Government agencies and non-governmental organizations (NGOs) working in urban informal settlements should integrate economic empowerment initiatives with mental health awareness campaigns to help mitigate the psychological burden arising from media-fueled financial pressure and structural inequality.
c) The Kenya Film Classification Board and the Communications Authority of Kenya should develop and enforce guidelines for regulating harmful digital content, including online challenges and gambling advertisements, to reduce media-related psychological triggers among vulnerable youth.
d) The Ministry of Education should incorporate digital literacy and mental health education into the national curriculum at both secondary and tertiary levels to equip young people with critical thinking skills and ethical media practices that can buffer against anxiety and misinformation.

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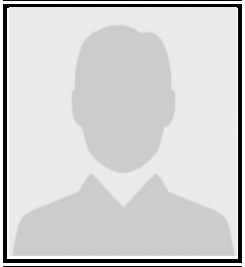
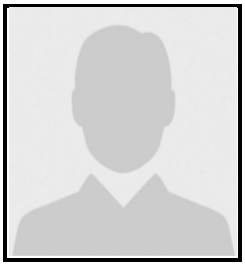
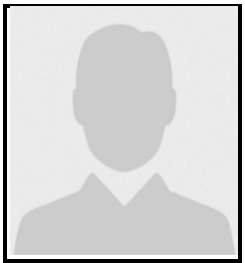
Biography of Authors

	**Akinyi Merab Stacy** Kenyatta University, Kenya *Email: staicemerab@gmail.com*
	**Prof. John Paul Oyore** Kenyatta University, Kenya
	**Prof. Alloys Stevens Sigar Orago** Kenyatta University, Kenya