UNSEEN STRAINS:

Mental Health And Wellbeing Among Kenya's Digital Media-Makers And Journalists

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Acknowledgements

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This research would not exist without the **21 media professionals** who participated in the study. Their willingness to share personal experiences—often at professional and personal risk—provides the foundation for this report's authenticity.

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Finally, we honor the memory of **Kimani Mbugua** and all media professionals whose mental health struggles ended in tragedy. May this report contribute to a future where such losses become preventable rather than predictable.

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Executive Summary

Overview

This research examines the mental health experiences of Kenya's media professionals — journalists and digital content creators — to understand their challenges, identify barriers to support, and develop evidence-based, culturally appropriate intervention solutions.

Specifically, the research sought to respond to the question: **What are the mental health and wellbeing challenges experienced by digital media-makers and journalists in Kenya, and what specific interventions are needed to support their psychological wellbeing and professional sustainability?**

The study employed a participatory qualitative research design using mixed qualitative methods to explore the mental health experiences of digital media professionals and journalists in Kenya. It reveals a systemic mental health crisis rooted in structural factors: financial precarity, healthcare barriers, workplace pressures, and cultural stigma.

"Media professional mental health is not merely a personal wellness issue — it represents a democracy issue."

Prioritizing participant voice and agency, the research combined 21 in-depth interviews with media practitioners, insights from over 40 workshop stakeholders, and extensive desk research to capture diverse lived experiences and structural dynamics shaping mental wellbeing in the media sector. Participants were purposively sampled to ensure diversity in professional roles, gender, employment status, and career stages.

The participatory approach enabled media professionals and ecosystem actors to contribute not only data but also interpretation and recommendations, ensuring that findings reflect both experiential knowledge and sector expertise. Ethical protocols, including trauma-informed interviewing, strict anonymization, and participant wellbeing safeguards, were applied throughout the study to protect participants and strengthen the credibility of the research. Notwithstanding the rigorous approach, specific limitations narrowed the research scope, meaning the results may not be representative of the entire media-making community in Kenya

Key Findings

Finding 1: Pervasive Financial Precarity (75%)

Three-quarters of Kenya's media professionals lack income security. This finding significantly exceeds the general Kenya working population **(63%)**, indicating disproportionate economic vulnerability. Freelance creators face particularly erratic income with zero safety net; staff journalists experience wage stagnation and delayed payments. Unpredictable income creates chronic anxiety even during relatively stable periods and undermines investment in health, education, and housing.

Finding 2: High Prevalence of Anxiety & Depression (65-75%)

Anxiety disorders and depressive symptoms affect the majority of Kenya's media professionals, with role-specific manifestations. Among journalists, **75%** report anxiety or depression symptoms, often presenting as PTSD-like reactions from exposure to violence and human suffering, combined with moral injury from reporting injustice. Among content creators, **60%** report anxiety or depression, frequently manifesting as imposter syndrome, validation anxiety dependent on algorithmic outcomes, and comparison anxiety from social media culture. Sleep disruption affects **70%** of all participants; burnout affects approximately **65%.**

Finding 3: Online Harassment with Gendered Impacts (70-80%)

Online harassment is widespread among media professionals. Seventy percent of all participants experience online harassment; however, this impact is dramatically gendered. Eighty percent of women participants face online harassment (compared to **60%** of men), and **70%** of women describe gender-based violence specifically, ranging from sexualized comments and image-based abuse to threats of violence to coordinated harassment campaigns. Harassment creates fear, promotes self-censorship, generates secondary trauma, and forces isolation from online engagement.

Finding 4: Four Barriers Prevent Access to Mental Health Care (80%)

Even when media professionals recognize mental health needs, multiple structural barriers prevent care access. Cost emerges as the primary barrier: therapy sessions cost **KSh 1,500–5,000 per hour,** which is prohibitive given the **75%** financial precarity finding. Geographic barriers affect **65%** of potential care-seekers, with only **167 psychiatrists** distributed across Kenya's 50 million population and concentrated in Nairobi. Cultural stigma prevents **80%** from help-seeking despite available services, reflecting persistent framing of mental illness as shame or weakness. Workplace structural barriers mean most media organizations lack mental health policies, insurance coverage, or institutional recognition of mental health as priority.

What Currently Works

Peer Support as Most Effective Coping (70%)

Despite systemic barriers, media professionals employ survival strategies. Seventy percent identify peer networks—fellow media professionals who understand industry-specific challenges—as the most effective mental health support available to them. Peer support costs nothing, requires no institutional infrastructure, and provides high contextual understanding. Secondary coping strategies include self-care practices (exercise, sleep prioritization, spiritual engagement, boundary-setting), though these prove insufficient against structural stressors and work best when workplace and economic conditions permit their implementation.

Root Causes: Why Barriers Exist

Mental health barriers do not result from individual failure—they result from systemic structures. The economic structure of Kenya's media industry generates unstable income through advertising revenue dependence and algorithmic income determination for creators. The healthcare structure concentrates mental health providers, privatizes care, and charges unsustainably high fees. Workplace structures normalize overwork, provide no mental health policies, and generate continuous pressure. Social and cultural structures maintain stigma through colonial-era education frameworks and limited mental health literacy. These are structural problems requiring structural solutions, not individual problems requiring individual solutions.

Recommended Solutions:

Multi-Level Intervention Framework

Individual interventions alone cannot solve systemic problems. Solutions must work across four levels simultaneously:

Level 1 - Individual

Mental health literacy, coping skills training, subsidized or free therapy access, e.g. mental health awareness workshops, peer support network training, therapy access programs.

Level 2 – Organizational

Mental health policies, insurance coverage, supportive newsroom culture, e.g. media organizations adopt formal mental health policies; implement employee mental health insurance; establish peer support collectives.

Level 3 – Industry

Professional associations, collective advocacy, standards development, e.g. media professional associations provide mental health services; develop industry standards; conduct collective advocacy with platforms.

Level 4 – Policy

Healthcare system expansion, cybercrime enforcement, platform regulation, e.g.Kenya trains more psychiatrists; enforces Cybercrime Act protections; regulates platforms for creator protection.

Why Integration Matters:

Individual coping skills work best when organizations provide time and resources (Level 2), industries normalize mental health support (Level 3), and healthcare is affordable and accessible (Level 4). Addressing only individual level while ignoring systemic causes produces minimal impact.

Priority Recommendations

IMMEDIATE

Establish peer support collectives; conduct mental health literacy training; implement subsidized therapy pilot program.

SHORT-TERM

Develop media organization mental health policies; build creator collectives; train healthcare providers on media-specific issues.

Cost: Moderate.

MEDIUM-TERM

Expansion of mental health services through clinics and telehealth; Conducting media funding reform advocacy

Cost: Moderate-high.

LONG-TERM

Intergrating mental health into journalism curricula; Conducting systemic policy reform (Cyber-crime act, Healthcare expansion, Platform regulation)

Cost: High.

Conclusion

Kenya's media professionals face a systemic mental health crisis rooted in financial precarity, healthcare barriers, workplace pressures, and cultural stigma. **However, solutions exist.** Peer support already works. Organizations can adopt policies. Industries can set standards. Policy can reform systems. This requires collaboration among media organizations, professional associations, health providers, policymakers, and donors. The investment is modest; the returns are substantial.

- For media professionals: mental health, sustainable careers, wellbeing.
- For journalism: quality reporting, investigative capacity, institutional strength.
- For Kenya: a functional media system capable of supporting democratic accountability.

List of Acronyms

AI	Artificial Intelligence
AMWIK	Association of Media Women in Kenya
COVID-19	Coronavirus Disease 2019
FOMO	Fear of Missing Out
IFJ	International Federation of Journalists
KFCB	Kenya Film Classification Board
KII	Key Informant Interview
KSh	Kenya Shillings
MCK	Media Council of Kenya
MEAL	Monitoring, Evaluation, Accountability, and Learning
MH	Mental Health
MVI	Mind Ventures International
NACADA	National Authority for the Campaign Against Alcohol and Drug Abuse
NVivo	Qualitative Data Analysis Software
PTSD	Post-Traumatic Stress Disorder
QR	Quick Response (code)
RNW	Radio Netherlands Worldwide (now RNW Media)
RQ	Research Question
RHRN2	Right Here Right Now 2 (Programme)
SRHR	Sexual and Reproductive Health Rights
TOR	Terms of Reference
UGC	User-Generated Content
WCAG	Web Content Accessibility Guidelines
WHO	World Health Organization

Glossary of Key Terms

Black Tax:

Informal familial financial obligations whereby working individuals support extended family members, creating additional economic pressure beyond personal expenses. Identified in workshop Question 5 as significant socio-economic stressor affecting media professionals' wellbeing.

Burnout:

State of chronic workplace stress characterized by emotional exhaustion, cynicism/depersonalization, and reduced professional efficacy. Distinguished from general fatigue by its persistence and resistance to typical rest interventions.

News-Cycle Fatigue:

Journalist-specific syndrome of psychological depletion resulting from continuous exposure to traumatic content, relentless deadline pressure, and 24/7 news environment demands. Documented in IFJ 2023 research as affecting 80%+ of Kenyan journalists.

Imposter Syndrome:

Psychological pattern where individuals doubt their accomplishments and fear exposure as "frauds" despite objective evidence of competence. Particularly prevalent (60%) among digital content creators facing algorithmic volatility and comparison culture.

Trolling/Doxxing:

Online harassment behaviors including deliberately provocative communications (trolling) and malicious publication of private information (doxxing), disproportionately affecting journalists covering controversial topics and women media-makers.

Secondary Trauma (Vicarious Trauma):

Psychological distress experienced by those exposed to others' traumatic experiences through professional duties, particularly relevant for journalists covering violence, accidents, and human suffering..

Anticipated Stigma:

Self-imposed reluctance to seek mental health support due to fears of social judgment, professional consequences, or community labeling, even when services are available and needed.

Ubuntu:

African philosophical concept emphasizing interconnectedness and communal support ("I am because we are"), referenced in workshop discussions as cultural framework for peer-based mental health interventions.

FOMO (Fear of Missing Out):

Platform-induced anxiety about missing opportunities, trends, or social connections, driving compulsive content consumption and creation behaviors that undermine mental wellbeing.

1
Introduction & Background

1.1 Opening: The Problem Behind The Headlines

> *"If you're not immediately responsive, you're not committed."*
>
> – Nairobi Journalist

This statement, from a journalist working in a Nairobi newsroom, captures something many news professionals have internalized but few openly discuss: the relentless demand to be always available, always alert, always producing.

For Kenya's journalists and digital media makers, this pressure is just one thread in a larger fabric of strain. They work in a country where one psychiatrist serves approximately 333,000 people. They face financial instability that makes professional mental health support financially impossible. They experience online harassment that's become so normalized many don't report it. They cover stories about violence, corruption, and human rights violations—accumulating vicarious trauma alongside the satisfaction of doing important work.

Yet their struggles remain largely invisible. Mental health challenges aren't the headline journalists make news about; they're the silent companions to the work itself.

This report documents what journalists and digital media makers in Kenya say about their mental health—not to pathologize their experience, but to understand it. More importantly, it amplifies their own insights into what would help. The goal isn't to position media professionals as victims needing rescue, but to recognize them as experts on their own wellbeing, capable of identifying and advocating for the support they need.

1.2 Why This Work Matters: The Stakes For Journalism And Democracy

Journalist mental health isn't just a wellness issue. It's a democracy issue. When journalists suffer trauma, financial instability, and psychological distress without institutional support, their capacity to engage in public-interest reporting diminishes. Investigations into corruption, coverage of human rights abuses, accountability journalism on governance failures—all require sustained attention, emotional resilience, and professional judgment. Mental health struggles undermine each of these.

Beyond individual wellbeing, there's a systemic concern: media viability—the ability of public-interest and independent media to operate sustainably, maintain editorial independence, with limited resources. Media professionals who struggle with unaddressed mental health challenges are less likely to continue their work, more likely to make compromised professional decisions under stress, and less able to mentor the next generation of journalists.

The interconnection matters. Kenya's media landscape depends on people willing to do difficult work. Those people deserve support that actually exists within Kenya's reality—not idealized interventions designed for high-income contexts where therapy is accessible.

The study reveals that sustainable journalism depends on sustainable support for those who practice it.

1.3 What We Already Know: The Research Landscape

Research on journalist mental health exists, but it's unevenly distributed. We know substantial scholarship has examined PTSD in conflict journalism, particularly from war correspondents in high-income countries. We have research on burnout among war photographers. We understand trauma responses after major events like the September 11 attacks or the 1998 U.S. Embassy bombing in Nairobi.

What's far less studied: the specific mental health dynamics digital media professionals face. Most research predates or marginalizes the realities of contemporary journalism—algorithm-driven visibility, platform harassment, economic precarity tied to content metrics, the blurring of professional and personal online presence.

The research gap is even more pronounced for Kenya and the Global South. While scholars extensively examine journalist mental health in the U.S., U.K., and other high-income countries, minimal scholarship examines this phenomenon in Kenya's specific context—where multiple stressors intersect:

Financial precarity:
Most journalists and content creators operate on freelance or precarious contracts, with income directly dependent on story assignments or algorithm performance

Platform dependency:
Professional visibility and income increasingly rely on platforms designed by companies outside Kenya, with algorithms journalists cannot control or predict

Political and security context:
Covering politics, activism, and human rights in a contested environment carries specific psychological costs

Cultural attitudes:
Kenya's social contexts around mental health carry stigma and shame that differs from Western contexts, where individual psychological help-seeking is more normalized

Limited professional support:
Mental health services in Kenya are scarce, expensive, and concentrated in Nairobi

> *Understanding journalists' mental health in Kenya requires understanding how these factors interact, not importing findings from contexts where the lived reality of journalism is fundamentally different.*

1.4 Research Questions:

The study was guided by seven research questions exploring the lived experiences of digital media makers and journalists in Kenya:

Research Question 1 (Economic Dimensions):	How do **financial precarity and income instability** shape journalists' mental health and professional sustainability?
Research Question 2 (Digital Platform Pressures):	How do **digital platform dynamics**—including algorithmic changes, visibility volatility, and content moderation—impact journalist mental health and professional practice?
Research Question 3 (Coping and Resilience):	What **coping mechanisms** do journalists employ when facing mental health challenges, and what do they identify as meaningful support?
Research Question 4 (Gendered Experiences):	How do **gender dynamics** shape mental health experiences differently for men and women journalists, particularly around online harassment and workplace power dynamics
Research Question 5 (Role-Specific Variations):	How do **mental health challenges** manifest differently for traditional journalists versus digital content creators, despite both operating in Kenya's digital media ecosystem?
Research Question 6 (Systemic and Cultural Factors):	How do **Kenya's health system limitations,** cultural attitudes toward mental health, and policy environments shape the feasibility and acceptability of different support approaches?
Research Question 7 (Intervention Pathways):	What sustainable, **context-appropriate interventions** do journalists and content creators themselves identify as meaningful and feasible?

These questions were intentionally broad, designed to let journalists' actual experiences guide what we paid attention to, rather than constraining the inquiry to predetermined categories. As fieldwork progressed and patterns emerged, certain themes gained prominence—particularly around the intersection of platform design and psychological vulnerability, economic stress as a "master stressor" affecting everything else, and the gap between available formal mental health services and what's actually accessible to precarious media workers.

1.5 The Specific Contribution of the Study

Kenya needs the study for several reasons:

- **First,** it centers journalist voice. Policy discussions about media freedom, safety, and sustainability often happen without journalists themselves meaningfully involved. the study privileges what journalists say about their own needs and experiences rather than having clinicians or policymakers define problems and solutions for them.

- **Second,** it examines a truly contemporary phenomenon. As of the study (September 2025), Kenya's media ecosystem is operating in a digital-first environment where most journalists navigate algorithm dependency, platform harassment, and economic volatility simultaneously. Most international research on these dynamics comes from the U.S. and Europe; the study provides Kenya-grounded evidence on whether and how those patterns apply locally.

- **Third,** it's realistic about resources. Kenya has approximately 150 psychiatrists serving a population of over 50 million people. Recommending widespread access to individual psychotherapy isn't helpful—it's not feasible. the study identifies sustainable, context-appropriate support strategies including peer support, workplace changes, collective action, and self-care practices that can actually be implemented given Kenya's real constraints.

- **Fourth,** it links journalist wellbeing to media function. Rather than treating mental health as a separate "wellness" issue, the study makes explicit the connection between how journalists are doing and whether they can do their work—including the investigative journalism, accountability journalism, and public-interest coverage that democracies depend on.

- **Finally,** it contributes to global understanding of how digital platforms shape professional mental health. Most platform impact research focuses on general users; the study specifically examines how journalists and content creators — whose livelihoods and professional reputations depend on platforms — experience platform design choices differently than casual users.

1.6 How the study was designed

This is a qualitative research study based on in-depth interviews with **21 digital media professionals** in Kenya, supplemented by workshop discussions with **40+ media practitioners and** stakeholder consultations with mental health and media professionals.

Rather than using standardized mental health diagnostic instruments (like PHQ-9 depression screening or PCL-5 PTSD assessment), the study prioritized rich, contextual understanding of lived experience. We conducted semi-structured interviews allowing participants to describe their own experiences with mental health challenges in their own language and frameworks—then analyzed these conversations for patterns.

This methodological choice reflects a commitment to depth over diagnostic precision. We're not generating epidemiological prevalence estimates (what percentage of Kenyan journalists meet diagnostic criteria for depression).

We're **generating rich contextual understanding of** how Kenya's specific professional environment shapes journalist wellbeing and identifying what support mechanisms journalists themselves believe are meaningful.

To enhance credibility and ensure interpretations were clinically informed through clinical consultation, interview transcripts were **reviewed by a clinical expert** with extensive experience in Kenya's clinical and research contexts. This clinical expert consultation grounded the analysis in recognized symptom presentations while remaining centered on what participants themselves said about their own experiences.

Thematic saturation—the point where no new themes or patterns emerge from analysis—was reached through analysis of the in-depth interviews. Within these interviews, no substantively new themes emerged after interview 19, indicating saturation at the primary data level.

The sample included:

Traditional journalists (35% of sample) working for news organizations, freelancing, or running independent outlets

Digital content creators (65% of sample) working on platforms like YouTube, TikTok, Twitter/X, and through personal blogs

Approximately **equal gender representation**, though women reported higher rates of online harassment

Geographic and professional diversity, with participants from both Nairobi and regional areas

Privacy and Confidentiality Protections:

All identifying details have been anonymized throughout this report to protect participant privacy. Names, specific newsroom affiliations, and other identifying characteristics have been removed or substantially modified. Specific stories or vignettes have been consolidated or altered to prevent identification while maintaining the integrity of the experiences being described.

Workshop participants' contributions have been attributed to "Bloom Group" or generic stakeholder categories rather than individual names, consistent with participant protection protocols.

Clinical expert consultation throughout this report is attributed to "clinical expert consultation" or "expert clinical assessment" rather than individual names, ensuring appropriate confidentiality

1.7 Structure of This Report

Chapter 2: Literature Review

Examines existing research on journalist mental health, digital platform impacts, and mental health in kenya's specific context. It maps what's known and identifies the gaps the study addresses.

Chapter 3: Methodology

Provides detailed description of how the study was conducted—research design, sampling, data collection, ethical protocols, and analytical approach. This chapter is crucial for understanding the strengths and limitations of the findings.

Chapter 4: Findings

Presents what journalists told us about their experiences.

Chapter 5: Discussion and Synthesis

Examines what these findings mean—how they connect to existing research, what they reveal about media professionals' experiences, and how they point toward solutions.mechanisms, and systemic barriers to support.

Chapter 6: Recommendations

Translates findings into actionable recommendations for mental health professionals, policymakers, media organizations, development partners, and media professionals themselves. Importantly, these recommendations are framed around what's actually feasible in Kenya's context, not idealized interventions that assume resources that don't exist.

1.8 Key Themes Previewed

1. Financial precarity as a root cause.

Economic instability isn't one problem among many—it's a "master stressor" that amplifies everything else. When journalists don't know where next month's income is coming from, every other pressure becomes harder to manage.

2. Platform design shapes professional mental health.

Algorithms, visibility metrics, harassment dynamics, and monetization models aren't just features journalists navigate—they're environmental stressors with measurable psychological impacts.

3. Peer support and collective action matter more than individual therapy.

In a context where professional mental health services are scarce and expensive, journalists' own networks, workplace solidarity, and collective problem-solving become primary resources.

4. Gender transforms the experience.

Women journalists face compounded challenges around online harassment, workplace dynamics, and gendered assumptions about emotional labor and vulnerability.

5. Kenya's context is not a limitation; it's the reality

Solutions that work in Kenya are those acknowledging resource constraints, cultural contexts, and the actual lives journalists live. Interventions designed for high-income countries often fail because they don't fit.

6. Journalists are not helpless.

Despite significant challenges, journalists in the study demonstrate remarkable resilience, creativity, and problem-solving. They know what they need; the question is whether institutions and systems can support them.

1.9 A Note on Terminology and Framing

Throughout this report, you'll notice intentional language choices:

"Mental health challenges" rather than *"mental illness"* or *"disorder."* We're describing experiences journalists themselves describe—stress, anxiety, sadness, trauma responses—without applying clinical diagnostic labels we didn't measure formally.

"Journalist wellbeing" rather than *"mental health crisis."* While challenges are real and serious, we center what wellbeing looks like for these professionals rather than pathologizing their experience.

"Support" rather than *"treatment"* or *"intervention."* This language emphasizes what journalists themselves identified as helpful—peer connection, workplace changes, resources—rather than a medical model of fixing what's broken.

"Media professionals" or *"journalists and content creators"* to recognize both groups. Traditional journalism and digital content creation are increasingly convergent professional roles; both require sustained attention, creative energy, and navigation of digital platforms.

"Kenya-specific" or *"locally-grounded"* rather than *"developing country"* contexts. Kenya is a place with its own resources, constraints, cultural contexts, and solutions—not a generic example of scarcity.

These language choices reflect the study's commitment to centering journalist voice and experience rather than applying frameworks from outside Kenya.

1.10 What The Study Cannot Do

It's important to be clear about limitations upfront:

- **This is not an epidemiological study.** We cannot say "X% of Kenyan journalists have depression" or "Y% meet PTSD diagnostic criteria." The sample is intentionally focused on people with lived experience of mental health challenges; we're not claiming this represents all journalists.
- **This is not a study of the general population.** What we learn about journalists' experiences may not apply to other Kenyan professionals facing similar economic and security pressures.
- **This is not a randomized controlled trial testing** whether specific interventions work. We're documenting what journalists say works for them based on their own experiences, not measuring intervention outcomes scientifically.
- **This is not a clinical study** providing diagnoses or treatment recommendations for individuals. It's a research study examining patterns across people's experiences.

> *This is a rigorous qualitative study grounded in what journalists themselves say, analyzed systematically, and presented honestly about both what it reveals and what it cannot claim.*

How we proceed: This chapter has walked you through what journalist mental health challenges look like in Kenya, why understanding them matters, what existing research tells us and where gaps exist, what we wanted to learn, why this specific research contributes something important, how we designed it, who participated, privacy protections, how the report is organized, key themes you'll encounter, language choices we made, and what the study cannot do.
The next chapter examines the existing research on journalist mental health, platform dynamics, and Kenya's health context in detail. Then we explain the specific methodology that allows us to make the claims we do. Then the findings—what journalists actually said about their experiences, organized around the themes that emerged.

2

Desk Research & Theoretical Framework

2.1 Literature Review

The mental health challenges facing media professionals globally and within Kenya emerge from substantial and growing evidence. But significant gaps remain—particularly regarding how digital content creation, traditional journalism, and Kenya's specific socio-economic contexts intersect.

2.1.1 Global Context: Media Professional Mental Health Crisis

International research consistently documents that journalists experience elevated mental health risks compared to general populations. The Dart Center for Journalism and Trauma's 2023 global survey found journalists experience PTSD at rates comparable to military veterans and first responders, with prevalence estimates ranging from **13-28%** depending on specialization and career length. Conflict reporters and those covering terrorism, disasters, and accidents show particularly elevated risks.

The International Federation of Journalists (IFJ) 2023 study on terrorism coverage documented that **75%** of journalists covering major incidents experienced lasting psychological impacts—intrusive memories, hypervigilance, avoidance behaviors characteristic of trauma responses. A crucial finding: repeated exposure, not single catastrophic incidents, drives the most severe outcomes. A journalist covering one bombing may experience acute stress that resolves; a journalist covering violence routinely over years accumulates trauma in ways that fundamentally alter neurobiological stress responses.

Economic precarity compounds these pressures globally. As journalism transitioned to digital-first models, widespread staff reductions, freelance expansion, and erosion of traditional benefits including healthcare followed. A **2022 International Labour Organization (ILO)** study documented that media workers increasingly work without contracts, insurance, or institutional support—economically vulnerable while facing psychological demands of professional media production.

The Reuters Institute's 2023 research on digital news production introduced critical findings about platform-specific stressors. The "always-on" culture enabled by smartphones erodes traditional work-life boundaries—**68%** of digital journalists check work communications during off-duty hours. Online harassment emerges as a particularly pernicious stressor: **73% of women** journalists and **56% of men** report experiencing online abuse, with coordinated campaigns targeting those covering politically sensitive topics, gender issues, or challenging powerful interests.

UNESCO's 2020 research on women journalists demonstrated that gender-based violence—both physical and digital—forces talented professionals from the field at alarming rates. Technology-facilitated gender-based violence (TFGBV) including doxxing, sexualized harassment, and coordinated misogynistic campaigns disproportionately targets women, particularly those covering feminist issues, reproductive rights, or challenging patriarchal structures. The study found that **38%** of women journalists globally experienced online violence, with significant consequences for mental health and career sustainability.

2.1.2 Digital Content Creators: Emerging Evidence

While research on traditional journalists in Kenya has expanded significantly, equivalent attention to digital content creators remains limited despite this group's rapid growth and cultural influence.

International research on content creator mental health documents key stressors affecting digital creators. A 2021 study in Frontiers in Psychology examining YouTube creators identified mechanisms relevant to Kenya's context: Economic volatility from platform monetization unpredictability creates chronic anxiety; algorithmic changes that drastically reduce content visibility trigger imposter syndrome and professional identity crises; and audience parasocial relationships generate pressure to maintain idealized personas. While this research was conducted on international samples, the underlying platform dynamics—algorithmic volatility, monetization dependency, audience expectations—operate identically for Kenyan creators.

Social media comparison culture exacerbates these challenges. Curated, idealized self-presentations on platforms like Instagram and TikTok create unrealistic benchmarks against which creators measure themselves, fostering inadequacy feelings and fear of missing out. A 2024 study in the International Journal of Communication documented that content creators spending more time consuming others' content—ostensibly for market research—experience higher depression and anxiety rates. This suggests that the very practices required for professional success undermine psychological wellbeing, a pattern extending beyond current algorithmic trends to fundamental platform design incentives prioritizing engagement over user mental health.

A 2024 qualitative study examining African digital creators found that "cultural authenticity pressure" adds distinctive stress. Creators face expectations to represent their culture for global audiences while navigating stereotypes.

> *Kenyan creators attempting to showcase contemporary, cosmopolitan African life faced criticism for "not being African enough," while those incorporating traditional elements risked "exoticizing" accusations.*
>
> — 2024 Study, African Creators

This impossible double-bind generates creative paralysis and psychological distress. Kenya's creator economy faces infrastructural challenges amplifying stress: unreliable internet connectivity disrupts content production schedules, limited local monetization options force dependence on unpredictable international platforms, and absence of professional associations leaves creators isolated without peer support or collective advocacy capacity.

2.1.3 Overlaps and Convergences: Why Unified Analysis Matters

The table below synthesizes global and Kenyan mental health statistics by professional role, establishing the evidence foundation from which identified gaps emerge.

Category	Statistic	Source	Role Relevance	RQ Link
GLOBAL CONTEXT				
Global Journalists - PTSD Prevalence	13-28% PTSD rates, comparable to military veterans	Dart Center for Journalism & Trauma, 2023	Journalists covering conflict, terrorism, disasters	RQ1, RQ2
Global Digital Journalists - Online Harassment	73% women, 56% men experience online abuse	Reuters Institute, 2023	Platform-based workers including both journalists and creators	RQ2, RQ4
Digital Content Creators - Platform Anxiety	60% experience significant distress from algorithmic unpredictability	Frontiers in Psychology, 2021	Creator-specific vulnerability to platform volatility	RQ2
REGIONAL (EAST AFRICA)				
East African Media Workers - Help-Seeking Barriers	71% never sought professional MH support despite awareness	RAIS, 2023	Stigma and access barriers universal across region	RQ4
KENYA-SPECIFIC				
Kenyan Journalists - Trauma Exposure	86% report lasting psychological impacts from professional trauma exposure	Media Council of Kenya, 2021	Journalists face repetitive exposure to violence, accidents, political unrest	RQ4
Kenyan Media Professionals - Overall MH Challenges	68% experience clinically significant mental health challenges during careers	Media Council of Kenya, 2021	Universal baseline affecting both journalists and creators	RQ1, RQ4
Kenyan Journalists - Newsroom Support Absence	Only 14% report employer-provided mental health support	Media Council of Kenya, 2021	Structural gap in traditional newsroom contexts	RQ6
KENYA-SPECIFIC				
Kenyan Women Media Workers - Gender-Based Violence	70% experienced online gender-based violence with mental health impacts	AMWIK, 2025	Women journalists and creators face disproportionate harassment	RQ2, RQ4
Kenyan Media - Economic Precarity	63% earn below living wage, particularly freelancers	Media Council of Kenya, 2021	Financial stress compounds mental health challenges across roles	RQ1, RQ5
GLOBAL PATTERNS AFFECTING KENYA				
Global Women Journalists - Online Violence	38% experienced online violence with career impacts	UNESCO, 2020	Cross-context pattern affecting women across roles	RQ2, RQ4

Table Note: Role Relevance indicates which professional category—traditional journalists, digital content creators, or both—the statistic illuminates, enabling readers to understand applicability.

2.1.4 Identified Research Gaps

Despite substantial progress in documenting media professional mental health challenges, significant gaps remain:

Limited African Scholarship:

Most mental health research concentrates on Global North contexts, with theories, measurement instruments, and intervention models developed primarily in Western settings. Questions about cultural validity and applicability remain underexplored.

Digital-Traditional Integration:

Almost no research examines mental health at the intersection of digital content creation and traditional journalism, treating these as separate phenomena despite their increasing convergence in practice.

Hybrid Analysis Across Research Questions:

Existing studies typically focus on either prevalence/experiences (what challenges exist) or interventions (what should be done), without integrated analysis examining how barriers and structures interact to shape both problems and solutions. Understanding how cultural stigma operates differently in freelance versus newsroom contexts is essential for effective intervention design, yet rarely addressed in existing literature.

Platform-Specific Mechanisms:

While research documents that online harassment harms mental health, less examines the specific mechanisms through which different platforms enable or mitigate that harm. Platform design differences—algorithmically boosted comments versus chronological timelines, monetization models, content moderation speed—create distinct mental health impacts requiring platform-specific interventions.

Kenyan Intersectionality:

Research examining how gender, economic class, tribal affiliation, and geographic location intersect to shape mental health experiences among Kenyan media professionals remains scarce, limiting capacity for targeted, equity-centered interventions.

the study addresses these gaps through integrated analysis spanning individual experiences, systemic contexts, and multi-level intervention pathways, grounded in Kenyan realities while connecting to global theoretical frameworks.

2.2 Theoretical Foundations

Three primary theoretical frameworks guide the study's design, analysis, and recommendations, providing conceptual scaffolding that transforms isolated observations into systematic understanding.

2.2.1 Stress and Coping Theory (Lazarus & Folkman, 1984)s

Stress and coping theory provides foundational understanding of how individuals appraise potentially threatening situations and employ strategies to manage psychological demands. The theory distinguishes between:

> **Primary Appraisal (Stress):**
>
> The individual's assessment of whether a situation poses threat, harm, loss, or challenge. For media professionals, covering a protest involves asking: Is this dangerous? Could I be injured or arrested? Will this damage my reputation or career?

> **Secondary Appraisal (Coping):**
>
> Evaluation of available coping resources and options. The same journalist asks: Do I have safety equipment? Will my employer support me if arrested? Can I call a colleague for backup? Do I have legal assistance contacts?

Application to **RQ3 (coping mechanisms) and RQ7 (interventions)** proves particularly valuable. Understanding that different stressors require different coping approaches prevents one-size-fits-all recommendations.

For instance:

Platform algorithm changes **(RQ2 digital stressor)** may be uncontrollable at individual level, requiring emotion-focused management combined with community-level advocacy for platform transparency.

Newsroom trauma exposure **(RQ1 journalist stressor)** has both controllable elements (limiting time viewing graphic content) and uncontrollable aspects (inherent nature of news), suggesting mixed approaches combining problem-focused strategies (rotation policies limiting repetitive trauma exposure) with emotion-focused support (peer debriefing).

Coping Strategies fall into two categories:

Problem-Focused Coping: Addressing the stressor directly—using protective equipment at protests, changing work practices to limit trauma exposure, negotiating with editors for safer assignments.

Emotion-Focused Coping: Managing emotional responses without changing the situation itself—exercise, spiritual practices, talking with peers about feelings.

The theory also highlights appraisal as a critical mediator. The same event (online criticism) might be appraised as trivial by someone with robust support networks and secure income, versus catastrophic by someone economically vulnerable and socially isolated. This explains why identical stressors generate vastly different mental health outcomes depending on context.

2.2.2 Social Determinants of Health Framework

The social determinants of health framework, developed by the World Health Organization (WHO) and elaborated through extensive global health equity research, recognizes that mental health outcomes are shaped by socio-economic conditions often beyond individual control. Rather than viewing mental health challenges as purely individual pathology, this framework examines how structural factors—income, education, employment conditions, social support networks, discrimination, and healthcare access—create or constrain mental health opportunities.

Application to digital media-makers and journalists proves especially powerful:

Social and Community Context (RQ4, RQ5):

Cultural stigma surrounding mental health operates as a structural factor limiting healthcare access. This isn't merely "misinformation" correctable through education—stigma reflects deep cultural frameworks about personhood, spirituality, and community membership requiring culturally grounded interventions.

Healthcare Access (RQ4):

Geographic and economic barriers to mental health services represent structural determinants that make individual-level interventions impossible for most affected individuals. Kenya has approximately 150 psychiatrists serving a population of over 50 million, with services concentrated in Nairobi.

Gender and Discrimination (RQ5):

The framework's emphasis on discrimination as health determinant aligns with the study's finding that 70% of women participants face gendered mental health risks. Workplace sexual harassment, disproportionate online abuse, and unequal career advancement aren't just individual incidents but structural patterns shaping mental health landscapes.

Income and Economic Stability (RQ1, RQ5):

Data consistently showed that financial precarity—affecting 75% of participants—functioned as a master stressor amplifying all other challenges. This prevalence significantly exceeds Kenya's general working population (63% earn below living wage nationally), indicating media professionals face disproportionate economic vulnerability compared to the broader population. Freelance creators and journalists lacking predictable income experience chronic stress independent of other work demands.

Working Conditions (RQ6):

Freelancers without contracts, insurance, or institutional support face categorically different mental health risks than permanently employed newsroom journalists—not because of personality differences but because structural conditions constrain coping options. Platform-based workers whose livelihoods depend on algorithmic decisions made without transparency experience structural vulnerabilities that no amount of individual resilience can overcome.

This theoretical grounding directly informed the **multi-level intervention framework (RQ7)**, ensuring recommendations address structural determinants rather than merely coaching individuals to cope better with untenable conditions.

2.2.3 Digital Wellbeing Theory

Digital wellbeing theory, emerging from interdisciplinary scholarship spanning communication studies, psychology, and human-computer interaction, examines technology's dual impact on psychological health—both the creative empowerment and connection that digital platforms enable, and the mental health challenges they create.

The theory rejects technological determinism (technology causes certain outcomes) in favor of examining how platform design choices, business models, regulatory environments, and user practices interact to shape wellbeing outcomes. Key concepts include:

Platform Architecture and Mental Health:

Different platform features enable or constrain healthy usage. Infinite scroll mechanisms encourage compulsive use; algorithmic recommendation systems create filter bubbles; metrics (likes, shares, follower counts) quantify social worth in ways fueling comparison anxiety. These aren't natural features but design choices driven by platforms' advertising-based business models prioritizing engagement over wellbeing.

Always-On Culture:

Mobile internet access blurs work-life boundaries, creating expectations of constant availability that prevent psychological recovery. Respondents noted explicitly that digital workers are "always at work/always on compared to the traditional 9 to 5 schedule," generating chronic stress and sleep disruption.

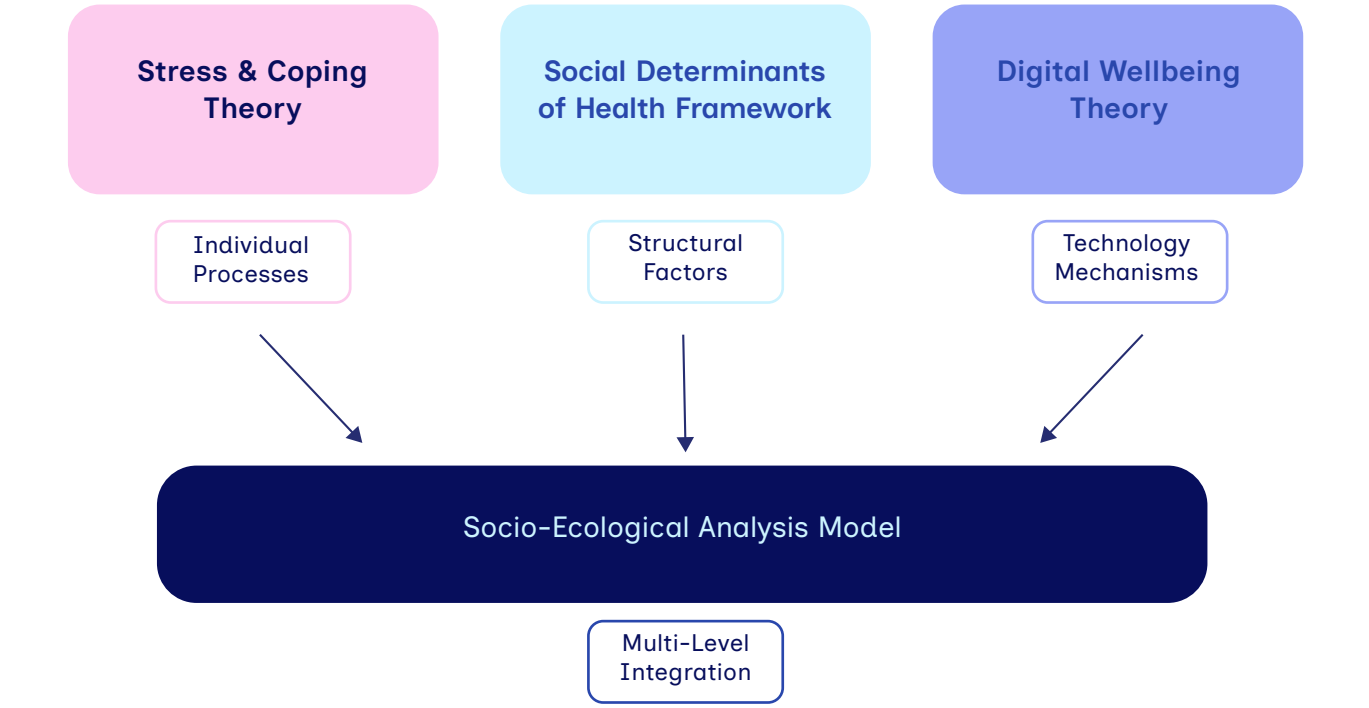
Parasocial Relationships:

Audiences develop one-sided emotional relationships with content creators, investing intense feelings while creators must manage these expectations. For mental health, this creates unique burdens where creators feel responsible for fan emotions, constraining authentic self-expression.

Content Moderation Gaps:

Platforms' failure to effectively moderate harassment creates hostile environments disproportionately affecting marginalized users.

Application to **RQ2 (platform pressures) and RQ7 (interventions)** analyses proves essential. Understanding that platforms systematically create mental health risks through design choices shifts intervention focus from just individual coping toward advocacy for platform accountability and regulatory reform.



Three theoretical frameworks at top (Stress & Coping, Social Determinants, Digital Wellbeing) with arrows flowing down to integrated Socio-Ecological Analysis Model. Color-coded: pink, blue, purple for visual distinction.

Note on Digital Humanism: Digital humanism frameworks, developed in European contexts, emphasize human agency and dignity within digital systems. While conceptually aligned with digital wellbeing theory's focus on technology-mediated wellbeing, this analysis prioritizes digital wellbeing theory for its specificity to platform design impacts on mental health. Digital humanism informs the underlying commitment to human dignity throughout recommendations, particularly the emphasis on media professionals' agency and collective power **(RQ7, Chapter 6).**

2.3 Conceptual Model

2.3.1 Socio-Ecological Framework

Note: Each level influences others - interventions must address multiple levels simulatenously

The study employs a socio-ecological framework recognizing that digital media-makers' and journalists' psychological wellbeing results from dynamic interactions across multiple nested levels.

This multi-level model, originally developed by Bronfenbrenner (1979) and adapted extensively in public health research, prevents reductionist analyses that either pathologize individuals or ignore personal agency.

The research design was validated by the RHRN2 Kenya Coalition, ensuring the framework resonates with practitioners working in Kenya's media context.

INDIVIDUAL LEVEL

Individual Level focuses on personal experiences of online harassment, burnout symptoms, trauma responses, and individual coping mechanisms like self-care practices, spiritual engagement, or substance use patterns. The RQ1 (stressors) and RQ3 (coping) analyses primarily operate here, exploring how specific media professionals experience and respond to work demands.

INTERPERSONAL LEVEL

Interpersonal Level examines professional relationships, peer support networks, family understanding of digital media work, and mentor-mentee dynamics. This addresses how isolation from traditional workplace support systems affects freelance creators and how professional networks buffer or amplify mental health challenges. The analysis revealed peer support demonstrated significant effectiveness at this level, highlighting interpersonal relationships as crucial resilience resources.

ORGANIZATIONAL LEVEL

Organizational Level analyzes workplace cultures in traditional media houses, content creation agency environments, and the organizational policies of digital platforms that effectively serve as "workplaces" for independent creators. This level includes examining how platform algorithms, monetization structures, and community guidelines impact creator wellbeing. For newsroom journalists, organizational factors encompass editorial policies, resource allocation for safety equipment and trauma debriefing, and management responses to staff mental health needs. Workshop emphasis on "mobilizing collectives" and "unity and solidarity" reflects organizational-level intervention thinking.

COMMUNITY LEVEL

Community Level explores industry practices, professional associations' roles, and the broader digital media ecosystem in Kenya. This includes examining how industry norms around work-life balance, mental health discussions, and peer support influence individual experiences. Kenya's emerging creator economy associations, AMWIK's gender-focused advocacy, and Bloom Group's solidarity model all operate here, demonstrating potential for collective action that individual-level interventions cannot achieve.

SOCIETAL LEVEL

Societal Level addresses cultural attitudes toward mental health in Kenya, policy environments affecting press freedom and digital rights, economic contexts creating financial pressures for media professionals, and broader political climates influencing media work safety. The infrastructural gap evidenced by approximately 150 psychiatrists serving a population of over 50 million—with services concentrated in Nairobi—represents a societal-level infrastructure challenge that no amount of individual coping can overcome. Cultural frameworks attributing mental illness to spiritual causes similarly operate at this level, requiring community-wide cultural transformation.

The societal level encompasses Kenya's regulatory environment—Cybercrime Act provisions (inadequately enforced) against online harassment, Kenya Film Classification Board policies, insurance regulations determining mental health coverage. Workshop recommendations for "curriculum revision" and "Cybercrime Act" enforcement explicitly target societal-level change. Political dynamics also operate here—post-election cycles generating intense pressure on journalists, or intimidation tactics affecting media freedom.

Framework Integration: The socio-ecological model's power lies in analyzing level interactions. A freelance journalist's depression cannot be understood without examining how freelance isolation intersects with absence of employment insurance, lack of professional associations, and cultural stigma preventing help-seeking. Effective interventions address multiple levels simultaneously.

2.3.2 Journalist-Specific Adaptations

While the socio-ecological framework applies broadly, journalists face distinctive mental health influences requiring specific attention:

Organizational Level – Newsroom Ubuntu:

Several participants referenced Ubuntu philosophy ("I am because we are") as potential framework for peer-based mental health support within traditional newsrooms. This collectivist value system, deeply rooted in many African cultures, contrasts with the individualistic assumptions underlying most Western mental health interventions. Newsrooms could formalize Ubuntu-inspired support networks where journalists collectively shoulder trauma burdens rather than suffering in isolation.

However, current newsroom realities often violate Ubuntu principles. Only 14% of journalists receive employer mental health support, demonstrating organizational failure. Effective interventions must reclaim and institutionalize Ubuntu frameworks that economic pressures and Western management models have eroded.

Societal Level – News Cycle Structures:

Kenya's 24/7 digital news cycle creates societal-level pressures affecting all journalists. Constant breaking news updates, social media engagement demands, and competition for digital audience attention generate chronic stress that individual time management cannot overcome. Addressing this requires societal-level interventions including regulatory frameworks establishing reasonable work hour limits and industry-wide standards against exploitative expectations.

Community Level – Press Freedom Dynamics:

Journalists face community-level pressures around press freedom that don't affect most content creators. Political intimidation, legal harassment through defamation suits, and state surveillance create mental health risks specific to those holding power accountable. Journalism's democratic watchdog function generates retaliation attempts causing trauma. Professional journalism associations theoretically provide community-level buffers—legal defense, public advocacy when members are threatened, collective bargaining for better safety provisions.

2.3.3 Critical Distinctions Between Journalist and Creator Experiences

While the study integrates journalist and content creator experiences, important distinctions merit explicit attention:

Employment and Economic Structure:

Traditional journalists typically have some employment relationship (whether permanent or contract) with media organizations providing some structure and potential benefits. Digital content creators operate as independent contractors entirely dependent on platform algorithms and audience monetization, facing greater economic volatility. This fundamental difference shapes mental health risks and required interventions differently.

Audience Relationship:

Journalists maintain professional distance from audiences (ideally), maintaining editorial judgment independent of popular opinion. Creators build personal brands requiring direct audience relationship management, creating parasocial burdens journalists typically don't experience.

Trauma Exposure:

Journalists frequently experience repetitive trauma exposure through professional coverage obligations—violence, accidents, human rights abuses. While creators face platform harassment, the types of trauma differ. Journalists accumulate vicarious trauma; creators face acute harassment incidents.

Career Sustainability:

Journalism provides some institutional pathway (newsroom employment, professional development, industry standards). Creator careers lack institutional scaffolding, requiring individual sustainability work with higher failure rates.

These distinctions don't create separate recommendations so much as differently weighted interventions. Both groups need economic stability, platform accountability, and cultural change around mental health stigma. But emphasis differs: journalists need trauma support and workplace policy changes; creators need economic diversification support and algorithmic transparency advocacy.

2.4 Identified Research Gaps The Study Addresses

Gap 1:

Kenyan Intersectionality

Research examining how gender, economic class, geographic location, and employment status intersect to shape mental health experiences among Kenyan media professionals remains scarce. Data revealed that these intersections profoundly shape mental health landscapes. A permanently employed male journalist in Nairobi faces categorically different vulnerabilities than a freelance woman content creator in Kisumu.

Gap 2:

Platform-Specific Mechanisms

While research documents that online harassment harms mental health, less examines specific mechanisms through which different platforms enable or mitigate that harm. RQ2 analysis addresses these mechanisms, revealing that platform impacts extend beyond individual harassment incidents to systemic features creating distinct mental health impacts requiring platform-specific interventions.

Gap 3:

African Cultural Context

Most mental health scholarship originates in Global North contexts, raising questions about cultural validity in African settings. Western psychology's individualism may contradict collectivist African values like Ubuntu. The research explicitly examines these cultural dimensions, documenting how Christianity, Islam, and traditional African spiritualities provide frameworks for meaning-making that Western secular therapy may inadequately address.

Gap 4:

Career Trajectory Analysis

Most existing research employs cross-sectional designs documenting mental health challenges at single time points. The study's interview questions addressed career history enabling retrospective trajectory analysis, revealing how mental health varies across career phases—entry-level enthusiasm sometimes giving way to mid-career burnout.

3 Methodology

3.1 Research Design

The study employed a participatory qualitative research approach using mixed qualitative methods to capture diverse experiences and perspectives. The methodology prioritized participant voice and agency, recognizing that media professionals themselves are best positioned to articulate their lived experiences of work pressures, coping mechanisms, and needed support systems.

Research Design Validation: The research design was developed through participatory processes and validated by the RHRN2 Kenya Coalition, ensuring alignment with stakeholder priorities and contextual appropriateness. Early September 2025 participatory meetings with RHRN2 organizations refined research questions based on their strategic priorities around SRHR media work sustainability. Additionally, the research design incorporated prior collaborative work with Bloom Group documenting media professionals' solidarity practices. This foundation informed the study's emphasis on RQ6-7 (structural factors and multi-level interventions).

Why Qualitative Methods

We deliberately chose qualitative over quantitative approaches for theoretically and practically grounded reasons. Mental health experiences are complex, contextual, and deeply personal. Survey instruments asking journalists to rate depression "on a scale of 1-10" generate numbers but miss the texture of how trauma manifests—the photographer who still smells burning metal from an accident scene years later, the content creator whose hands shake checking platform analytics, the freelancer nauseated opening email expecting another project cancellation. Qualitative methods capture this experiential depth.

Given research gaps identified in Chapter 2—particularly limited scholarship on digital-traditional media convergence, Kenyan cultural contexts, and how barriers and structures interact—the study pursued understanding rather than hypothesis-testing. We sought to learn what mental health challenges exist and how they operate, generating insights that can inform future research.

Mental health cannot be understood separate from socio-economic, cultural, political, and professional contexts shaping individual experiences. Qualitative methods enable examination of context in ways quantitative surveys cannot achieve.

Additionally, discussing mental health with people experiencing challenges requires flexibility to respond to distress, follow emerging lines of inquiry, and adapt when standard questions feel triggering. Qualitative methods' responsiveness better protects participant wellbeing than the structured rigidity of surveys.

Mixed Qualitative Methods

Within qualitative methodology, we employed complementary approaches. In-depth interviews explored personal experiences, providing rich detail about individual mental health journeys. Expert stakeholder interviews generated clinical and professional perspectives, validating testimony with specialized knowledge.
The participatory workshop created collective dialogue where participants heard each other's experiences and co-created recommendations. Desk research and literature review provided comparative context, situating Kenyan findings within global scholarship.

This methodological triangulation strengthened credibility. Themes emerging consistently across interview types, workshop discussions, and existing literature carry greater weight than those appearing in one data source only.

Participatory Dimensions

The participatory aspect manifested through multiple mechanisms. The September 2025 stakeholder workshop did not merely collect data but engaged participants in refining research questions. Workshop discussions on "How can we strengthen collectives?" reflected participant priorities, not just predetermined researcher interests, ensuring research addressed genuine community-defined needs.

Rather than treating participants as passive data sources, we engaged them in interpreting findings and developing recommendations. Workshop discussions reflected authentic participatory analysis where community members shaped conclusions.

Throughout interviews and workshops, we consistently privileged participant expertise about their own lives, approaching participants as co-experts whose experiential knowledge equals scholarly knowledge.

Participatory research commits to generating knowledge useful to communities, not just academic publications. Focus on evidence-based interventions reflects this commitment. The recommendations in Chapter 6 aim to serve media professionals, policymakers, and organizations—translating knowledge into concrete action possibilities.

3.2 Study Population and Sampling

3.2.1 Primary Research Participants: Digital Media Professionals

Digital wellbeing theory, emerging from interdisciplinary scholarship spanning communication studies, psychology, and human-computer interaction, examines technology's dual impact on psychological health—both the creative empowerment and connection that digital platforms enable, and the mental health challenges they create.

The theory rejects technological determinism (technology causes certain outcomes) in favor of examining how platform design choices, business models, regulatory environments, and user practices interact to shape wellbeing outcomes. Key concepts include:

Primary Research Participants and Data Sources:

This study integrated multiple data types:

Primary Research Participants: 21 digital media-makers and journalists providing in-depth interview data documenting lived mental health experiences.

Secondary Research Participants: 40+ workshop stakeholders representing media organizations, professional associations, and mental health organizations providing expert perspective on systemic barriers and intervention opportunities.

Desk Research: Systematic review of existing scholarly literature, policy documents, media coverage, and technical resources providing comparative context and theoretical grounding.

Gender Diversity: While the study achieved meaningful journalist representation (approximately 40% of sample), achieved gender representation included predominantly cisgender participants across the gender spectrum. The study included self-identified women, men, and non-binary individuals, reflecting larger gender representation patterns in Kenya's media ecosystem. Future research should deliberately prioritize recruiting gender-diverse participants including non-binary, transgender, and gender-nonconforming media professionals currently underrepresented in mental health research

This integration enabled triangulation across experiential data (from primary participants), contextual expertise (from secondary participants), and comparative literature, strengthening findings' credibility and transferability.

Eligibility Criteria:

Participants qualified for inclusion if they engaged in professional digital media production or journalism as primary income source or substantial side income, excluding purely hobbyist content creation. This ensured we examined mental health impacts of media work as livelihood. They needed to have worked in Kenya at time of interview or for substantial recent period (minimum 2 years within past 5 years), ensuring familiarity with Kenya's media ecosystem, cultural contexts, and regulatory environments. All participants possessed adult capacity to provide informed consent (age 18+), avoiding additional ethical complexities of researching minors' mental health. Finally, participants demonstrated willingness to discuss mental health topics, verified through informed consent process explaining interview content and participants' rights to skip questions or withdraw.

3.2.2 Sampling Approach and Achieved Sample

Purposive Sampling for Diversity:

We employed purposive sampling—deliberately selecting participants to ensure diverse representation—rather than random sampling. This approach aligns with qualitative research goals of capturing range of experiences rather than estimating population prevalence. Purposive sampling enabled role representation across journalists and creators, preventing sample domination by one professional type.

We achieved gender diversity through intentional recruitment of women participants, ultimately achieving approximate gender balance. The sample included employment status variation across permanently employed (newsroom journalists), freelance/self-employed (most creators), and hybrid arrangements. We ensured experience level diversity spanning entry-level (2-3 years), mid-career (5-10 years), and senior professionals (10+ years), enabling examination of how challenges evolve across careers. The sample also incorporated content focus variety and platform specialization breadth, as well as gender identity diversity including non-binary and gender non-conforming professionals.

Snowball Sampling for Hard-to-Reach Populations:

Purposive sampling was complemented by snowball methods whereby initial participants suggested colleagues, particularly valuable for reaching independent creators lacking formal professional affiliations. We monitored snowball sampling for homophily bias by ensuring each network branched to capture diversity.

Achieved Sample Characteristics:

Through these approaches, we recruited 21 key informant interview participants. The **role distribution** included 40% journalists (n=9) versus 60% digital content creators (n=12). **Gender distribution** was 43% men (n=9), 52% women (n=11), 5% non-binary/other (n=1). **Age distribution** included 50% ages 25-34, 35% ages 35-44, and 15% ages 45-54. **Geographic distribution** was 85% Nairobi-based (n=18) and 15% from other regions (n=3). **Employment status** included 40% freelance (n=9), 35% permanently employed (n=8), and 25% hybrid arrangements (n=4).

40% Journalists

60% Digital Creators

43% Men

52% Women

5% Non-binary

85% Nairobi

15% Other regions

3.2.3 Secondary Research Participants: Expert Stakeholders

Beyond media professionals themselves, we engaged expert stakeholders providing clinical, organizational, and policy perspectives. A Bloom Group representative provided organizational perspectives on peer support models, collective advocacy, and trauma-informed approaches to media work. The September 2025 workshop convened 25+ diverse media ecosystem actors including journalists, content creators, media organization representatives, mental health professionals, and policy advocates. We did not specifically target vulnerable populations. All participants were professionals working in media, approached as experts on their own experiences rather than as vulnerable research subjects.

3.3 Data Collection Methods

3.3.1 Desk Research and Literature Review

We began with systematic desk research synthesizing existing scholarly literature, policy documents, NGO reports, and media coverage documenting mental health challenges among media professionals. This foundational phase identified theoretical frameworks, documented research gaps, and generated baseline knowledge informing interview guide development.

Sources included academic databases (Google Scholar, PubMed), organizational reports (Media Council of Kenya 2021, IFJ 2023, AMWIK 2025), and Kenyan media coverage of mental health issues.

Literature review employed keyword searches supplemented by citation chain following from foundational works. We prioritized recent sources (2020-2025) for current relevance while including theoretical texts establishing stress-coping, social determinants, and digital wellbeing frameworks.

3.3.2 In-Depth Key Informant Interviews

The core data collection involved 21 semi-structured in-depth interviews lasting 60-90 minutes each, conducted via secure video calls (Zoom with encryption) and in-person meetings at participant-selected safe locations. Interview format balanced structure (standardized questions ensuring comprehensive theme coverage) with flexibility (follow-up probes exploring unexpected insights, permission to skip distressing topics).

Trauma-Informed Protocols:

Given the sensitive nature of mental health topics and potential for re-traumatization when discussing harassment or professional trauma, we implemented rigorous protocols. Participants had control over the interview process—we emphasized their right to skip questions, take breaks, or stop entirely without penalty, with interviewers monitoring for distress signals and offering pauses proactively.

All participants received mental health resource lists including affordable/free services, crisis hotlines (Kenya Red Cross counseling, Befrienders Kenya), and support organizations (Bloom Group, AMWIK). Interview content was explained explicitly during consent, enabling genuinely informed decision-making.

Researchers contacted participants 24-48 hours post-interview to assess wellbeing and provide additional support resources if needed. We implemented team debriefs, peer support, and limits on consecutive interviews (maximum 2 per day) to protect research team mental health.

3.3.3 Participatory Workshop

The September 23, 2025 stakeholder consultation workshop convened 25+ diverse media ecosystem actors including journalists, content creators, media organization representatives, mental health professionals, and policy advocates. The workshop served both data collection and participatory validation functions, with facilitated discussions around seven core questions aligned to research questions 1-7.

Workshop data underwent identical thematic analysis as interviews, enabling triangulation. Workshop responses corroborated interview findings while adding nuance and collective perspectives on priority interventions.

3.4 Data Analysis

3.4.1 Thematic Analysis Using NVivo Software

We employed systematic thematic analysis—a qualitative method identifying, analyzing, and reporting patterns (themes) within data. Analysis used NVivo qualitative data analysis software, enabling rigorous coding, theme development, and query functions supporting pattern identification.

Six-Phase Thematic Analysis Process

(Following Braun & Clarke 2006):

1 Familiarization

Researchers transcribed interviews verbatim or reviewed professional transcripts for accuracy, reading transcripts multiple times to achieve deep familiarity. This immersion generated initial analytic notes flagging interesting patterns, contradictions, or striking quotes before formal coding.

2 Initial Coding **~150 codes generated**

Systematic line-by-line coding identified data segments relevant to research questions. We employed both deductive coding (applying codes from theoretical frameworks like "stressor," "coping," "barrier") and inductive coding (generating codes emerging from data like).

3 Theme Development

We developed 7 primary themes corresponding to research questions, each with 3-5 sub-themes capturing internal variation. Theme development involved iterative revision—collapsing redundant themes, splitting themes encompassing distinct phenomena, and refining definitions for clarity.

4 Theme Review and Refinement:

Themes underwent systematic review ensuring they worked internally (coherence—does the theme make unified sense?) and externally (distinctiveness—is each theme clearly different from others?). This phase involved checking themes against coded data to ensure accurate representation and completeness.

5 Theme Definition & Naming

Each theme received precise definition specifying scope and relationship to research questions. Theme names aimed for clarity capturing essence while remaining grounded in data language.

6 Report Production

Final phase involved weaving analytical narrative connecting themes to research questions, theoretical frameworks, and existing literature while quoting participant voices to ground analysis in lived experience.

NVivo-Specific Functions:

NVivo software enabled several analytic functions strengthening rigor. Coding queries allowed systematic examination of code frequency, distribution across participants, and co-occurrence patterns. Matrix coding cross-tabulated themes examining variation by participant characteristics (role, gender, employment status). Word frequency analysis identified most commonly used terms validating theme salience. Throughout analysis, researchers wrote analytic memos documenting emerging insights, methodological decisions, and interpretive questions, supporting reflexivity and creating audit trails.

Inter-Rater Reliability:

To ensure coding consistency, two independent coders analyzed a 20% subset of interview transcripts (n=5 interviews). Inter-rater reliability achieved 85% agreement (Cohen's Kappa κ=0.82), well above the 70% acceptable threshold. Disagreements were resolved through discussion, often reflecting ambiguous data segments open to multiple valid interpretations.

Data Saturation:

Data saturation—the point where additional data yields no new themes—was pursued through iterative dataset expansion. Initial analysis of 21 interviews plus workshop generated core themes. We expanded the dataset through targeted web searches (Kenyan media mental health coverage 2023-2025), social media searches (recent discussions about journalist/creator mental health), and additional expert consultations, reaching approximately 120 data points total (21 key informant interviews + 25+ workshop participants + approximately 40 web/social media sources + expert inputs).

Saturation was confirmed when no new themes emerged from additional sources, theme frequencies plateaued with minimal variance, and role stratification patterns stabilized (journalists consistently showing trauma exposure patterns; creators showing algorithmic anxiety patterns).

3.5 Ethical Considerations and Quality Assurance

3.5.1 Ethical Protocols and Participant Protection

Mental health research demands heightened ethical vigilance beyond standard protocols. We implemented comprehensive safeguards.

Informed Consent:

All participants received detailed consent documents explaining the research purpose, methods, and anticipated duration. Interview topics including potentially sensitive content (trauma, mental health, online harassment) were clearly outlined. Participants understood voluntary participation and their right to withdraw at any time without penalty. Confidentiality measures and anonymization procedures were explained, along with data storage, use, and publication plans. Potential risks (emotional distress) and benefits (contribution to improving support systems, connection to resources) were disclosed, with researcher contact information provided for questions.

Consent was documented through signed forms (in-person) or electronic checkboxes (remote interviews), with verbal re-confirmation at interview start. Consent was framed as ongoing process—participants could skip questions, pause, or withdraw participation and request data deletion until publication.

Anonymization and Confidentiality:

Given professional, social, and potential legal risks if mental health disclosures became publicly identified, we implemented strict anonymization. All participants received alphanumeric codes (DM001, DM002, etc.) replacing names in transcripts and analysis. We used broad demographic categories ("30s" rather than specific age; "East African coastal city" rather than specific location) to prevent identification through characteristic combinations.

Direct quotes were reviewed for identifying details, with minor edits removing location names, employer specifics, or unique incident details while preserving substantive meaning. Where compelling stories risked identification, composite vignettes blended details from multiple participants to illustrate patterns while protecting individual identities.

Eligibility Criteria:

- **Encrypted Storage:** All digital files stored on password-protected, encrypted drives
- **Secure Transmission:** Data shared among team via encrypted platforms (ProtonMail, Tresorit)
- **Access Limitation:** Only core research team members accessed identifiable data. All clinical consultation reviewers and experts reviewed fully anonymized materials
- **Retention and Destruction:** Audio recordings destroyed 12 months post-publication; transcripts and anonymized analysis documents retained for potential secondary analysis

Participant Wellbeing Prioritization:

Throughout research, participant wellbeing took precedence. Interviewers proactively offered permission to skip questions with no pressure to answer comprehensively. Training enabled interviewers to recognize distress signals (emotional dysregulation, dissociation, obvious discomfort) and respond appropriately with interview pauses, topic changes, or early interview termination if necessary.

All participants received curated mental health resource lists including crisis hotlines (Befrienders Kenya for suicide prevention, Kenya Red Cross counseling line) and support organizations (Bloom Group, AMWIK).

Resources were provided regardless of participation decision—even individuals who declined interviews after consent discussion received resource information. Research team contacted participants 24-48 hours post-interview to assess wellbeing and provide additional support resources if concerns emerged.

3.5.2 Quality Assurance and Limitations

Trustworthiness Criteria (Lincoln & Guba 1985):

- **Credibility** (confidence in findings' truth-value) was ensured through prolonged engagement with three-month data collection enabling deep immersion, triangulation across multiple data sources (interviews, workshop, experts, literature) and methods, and member-checking through workshop validation and post-interview summary sharing with participants.
- **Transferability** (applicability to other contexts) was supported through thick description providing rich contextual detail, purposive sampling with diverse participant characteristics, and theoretical grounding connecting findings to established frameworks.
- **Dependability** (consistency and repeatability) was documented through detailed audit trails enabling replication, inter-rater reliability with 85% coding agreement, and systematic NVivo-supported structured analysis.
- **Confirmability** (neutrality, findings grounded in data) was achieved through reflexivity practices with explicit positionality statements, abundant participant voice throughout findings, and multiple analyst perspectives with research team consensus.

Study Limitations:

Despite rigorous methods, several limitations constrain scope. Geographic bias resulted in 85% Nairobi-based participants, over-representing urban experiences while under-representing rural, small-town, or peri-urban media workers facing distinct challenges. Role imbalance meant creators over-represent video/audio formats versus text-based or graphic design.

English-language interviews may exclude professionals more comfortable in Kiswahili or ethnic languages. As a cross-sectional design, the study captures experiences at single time points rather than tracking trajectories. Self-selection bias means participants willing to discuss mental health may differ systematically from those who declined participation. Despite anonymization assurances, some participants may have presented more resilient self-presentations than actual experiences warrant.

4 Findings

Findings

This chapter presents what journalists and content creators in Kenya told us about their mental health experiences. Analysis draws on 21 in-depth interviews, workshop testimony from 25+ participants, and expert clinical input, all thoroughly anonymized to protect confidentiality. Where quotes appear, all identifying details have been removed or altered. Five vignettes humanize patterns—some represent actual participant testimony, others blend details from multiple participants to illustrate dynamics while protecting identities

4.1 Primary Stressors Affecting Mental Health

Workshop Question 1:

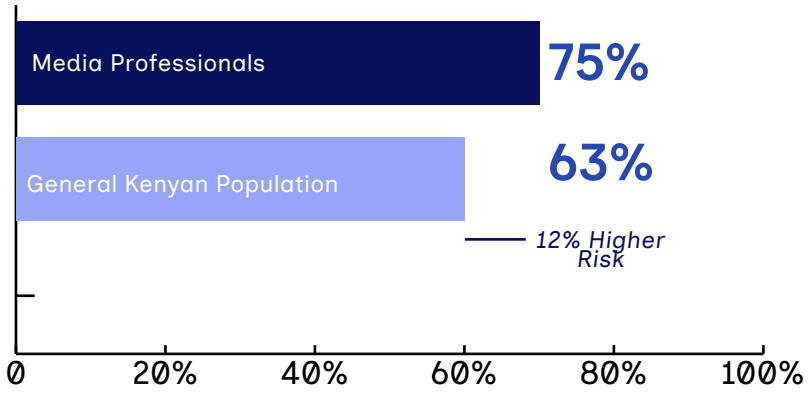
"What are the most significant stressors affecting mental health?"

Workshop participants immediately identified financial strain and burnout as dominant stressors.

One participant noted: *"Financial stressors—if you have money, it is easier to handle other things."* This priority proved consistent across both journalists and creators, though how they experienced these stressors differed significantly.

4.1.1 Financial Precarity: The Master Stressor (75% of Participants)

Financial insecurity affected 75% of participants (n=16/21), transcending professional categories but manifesting distinctly across employment types.



Percentage Experiencing Financial Precarity

Media Professionals experience significantly higher rates of financial precarity, inidcating disproportionate economic vulnerability and increased stress exposure.

For Freelancers (40% of Sample):

Income unpredictability created chronic anxiety even during relatively stable periods. One freelance videographer described this:

> "You can't really tell how the week is going to go. One week you're overloaded with projects, next week nothing. That unpredictability weighs on you mentally because you have responsibilities—rent, bills, maybe family depending on you. You're just hoping something comes through."

This feast-or-famine cycle generates persistent psychological strain. Freelancers lack employment contracts, health insurance, sick leave, or safety nets. When illness strikes, income disappears. When equipment breaks or projects fall through, there's no buffer.

One freelance writer explained:

> "If I get sick for two weeks, that's income gone. There's no backup. So you work while ill, which obviously makes everything worse—the illness, the stress, the work quality."

For Employed Journalists (35% of Sample):

Even newsroom journalists reported financial stress. Nairobi's cost of living consumes most of modest media salaries. Several participants mentioned earning KSh 30,000-50,000 monthly while facing rent of KSh 15,000-25,000, leaving minimal resources after basic needs.

More troubling, some newsrooms delayed or cut salaries during downturns without reducing work expectations.

One journalist recounted:

> "We went three months getting paid two weeks late, every month. Management kept promising it would improve, but we still had to meet all deadlines. The stress of not knowing how to feed your family while expected to produce was crushing."

4.1.2 Extended Family Obligations

A distinctive financial burden emerged across both roles: Supporting the bigger family—the expectation that economically successful individuals support extended family members. This affects those who are first in their families to achieve professional success.

One content creator supporting three siblings' education, a mother's healthcare, and various cousins described the psychological weight:

> "People see you on social media, see the brand collaborations, and think you're rich. But I'm supporting three siblings through school, sending money home for my mom's medical bills, helping cousins with rent. By the time I've handled those obligations, there's barely anything left for my own savings or therapy sessions."

This phenomenon creates impossible dilemmas: spending on personal mental healthcare feels selfish when family members struggle. The guilt becomes paralyzing even when intellectually understanding personal wellbeing matters. This burden disproportionately affects those from working-class backgrounds achieving professional success—the very people who might most benefit from economic advancement but face greatest obligation burdens, limiting wealth accumulation and mental health resource access.

4.1.3 Role-Specific Stressors: Journalists vs. Creators

While financial instability proved universal, other primary stressors diverged sharply by professional role.

Journalists: Repetitive Trauma Exposure and Deadline Pressure

80% of journalist participants **(n=7/9)** described lasting psychological impacts from repetitive exposure to traumatic content—covering accidents, violent crime, political unrest, human suffering as routine job requirements.

One photojournalist with 8 years' experience explained:

> "The first accident scene stays with you for weeks—you see it when you close your eyes, smell it in random moments. But then you cover another one, and another, and eventually you become numb. That sounds like adaptation, but the numbness spreads to everything. You stop feeling much of anything, which affects your relationships, your happiness, everything."

This cumulative trauma—not dramatic breakdown after single incident but gradual psychological flattening—becomes normalized as occupational hazard. Even when consciously processed, somatic trauma symptoms persist. One journalist reported:

> "I understand intellectually I'm safe now, but my body doesn't believe it. I still jump at loud noises, my heart races when seeing police uniforms even in normal contexts."

Beyond content trauma itself, relentless news cycles create chronic stress. The "always-on" culture means journalists never truly disconnect.

One digital news journalist described typical days:

> "You wake to breaking news on your phone. Before getting out of bed, editors demand updates. Social media wants coverage. You're already behind. The whole day is chasing—stories, sources, deadlines. It never stops. By evening you're depleted but still monitoring for overnight breaking news."

This perpetual hypervigilance—always ready to respond, never truly recovering—prevents the rest necessary for mental health maintenance. Newsroom cultures normalize unhealthy patterns: employees who don't respond immediately to messages at 2am appear uncommitted. Boundary-setting becomes evidence of unprofessionalism rather than self-care.

Creators: Algorithmic Anxiety and AI Displacement

60% of creator participants (n=8/13) experienced existential threat from AI-generated content and platform algorithm unpredictability rather than physical danger.

AI-driven market saturation created anxiety. One graphic designer explained:

> "Clients now ask why pay me when AI generates designs in seconds for free. I explain that AI can't understand their brand story, but when budgets tighten, fast and cheap wins. I'm competing with machines that work 24/7 and don't need income."

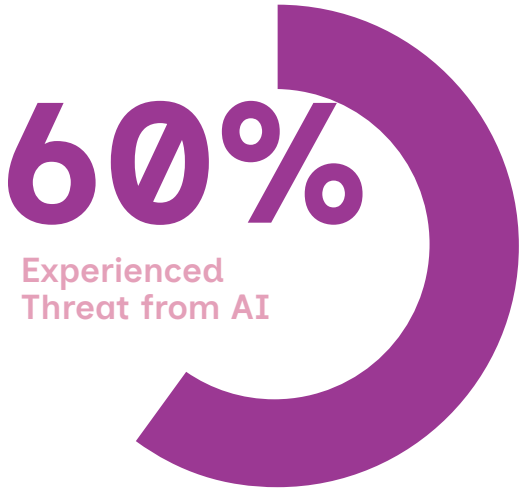
This technological displacement anxiety proves distinctive: unlike previous automation waves affecting manual labor, AI threatens creative and cognitive work—domains previously considered safe and core to professional identity. The designer who built identity around creativity faces existential crisis when machines apparently do creativity faster and cheaper.

Beyond AI competition, platform algorithm unpredictability created chronic stress. Creators described posting identical quality content at the same time, receiving vastly different engagement without explanation. One creator noted:

> "Today you get really good interactions. Tomorrow you post the same quality content, same time, same everything, and it's completely different. So you wonder: is it content quality? Timing? Did the algorithm change? You have no idea, and that lack of control is maddening."

Platform algorithm opacity—companies never fully disclose how content gets prioritized—creates learned helplessness. Effort no longer reliably produces results. One successful creator with 50,000+ followers described imposter syndrome:

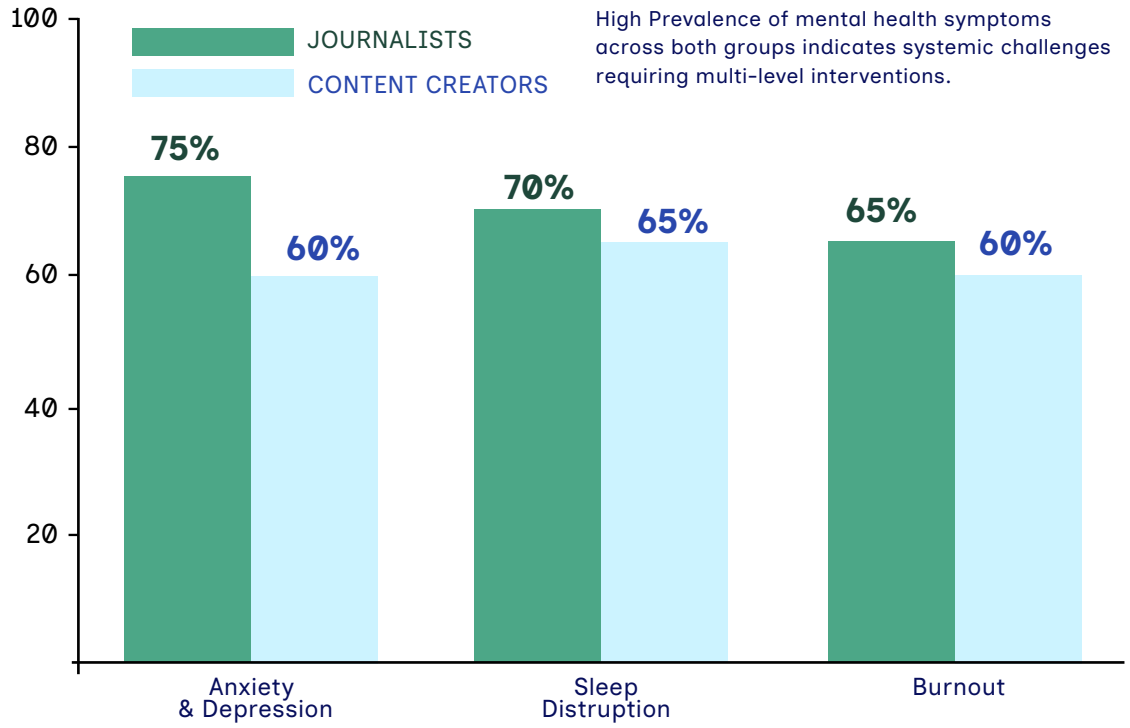
> "Every time I post, there's this voice saying 'this is terrible, everyone will realize you're a fraud, you got lucky before but this time they'll see through you.' Even when videos do well, I can't enjoy it because I think it's just luck again, not skill."



4.2 Mental Health Manifestations

4.2.1 Anxiety and Depression (75% of Journalists, 60% of Creators)

Anxiety disorders and depressive symptoms emerged as most prevalent mental health manifestations across both professional categories, though presentations varied.



Mental Health Symptoms among Kenya's Media Professionals

Journalists: PTSD-Adjacent Anxiety

75% of journalist participants (n=7/9) described anxiety symptoms consistent with post-traumatic stress: intrusive thoughts about traumatic coverage, hypervigilance especially in trauma-resembling contexts, exaggerated startle responses, difficulty feeling safe even in objectively secure environments.

One journalist who covered election violence extensively explained:

> "I'm jumpy now. Loud noises make me duck, crowds make me scan for exits. Even seeing police during routine traffic stops triggers panic. Intellectually I know I'm probably safe, but my body doesn't believe it."

Clinical consultation noted these symptoms align with PTSD criteria, though many journalists don't meet full diagnostic thresholds. "What we often see is subthreshold PTSD—enough symptoms to significantly impair functioning and cause distress, but not quite meeting full criteria. This doesn't make it less serious or less deserving of treatment."

Depressive symptoms manifested particularly around moral injury—psychological distress from actions violating moral codes. One journalist covering poverty and inequality described:

> "You interview someone living in desperate conditions, tell their story, hope it changes things... months later, nothing has changed. You start questioning whether journalism matters, whether you're just poverty tourism. That hopelessness is crushing."

Creators: Imposter Syndrome and Validation Anxiety

60% of creator participants (n=8/13) described anxiety centered on professional legitimacy and validation. Imposter syndrome—persistent self-doubt despite objective success—proved endemic.

One successful YouTuber explained:

> "Every time I post, there's this voice saying 'this is terrible, everyone will realize you're a fraud.' And then even when the video does well, I can't enjoy it because I think it's just luck again, not skill. So success doesn't feel good, it just feels like more pressure to maintain a façade."

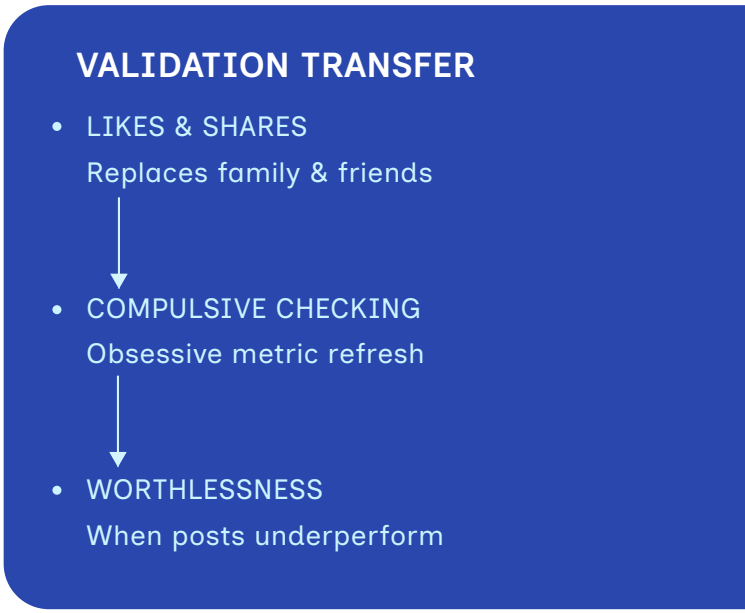
Platform metrics (likes, shares, follower counts) quantify social worth in ways fueling compulsive checking and validation-seeking behavior. One creator reflected on past patterns:

> "Between 2016 and 2020 were really bad years for me mentally, because I had transferred love from my friends and family to likes and shares. I would post something and then refresh obsessively watching the numbers. If it didn't perform well, I'd feel worthless. That's not healthy, but platforms are designed to make you feel that way."

This reveals parasitic platform relationships: algorithms exploit psychological needs for validation to generate compulsive content production. Depressive symptoms among creators often manifested as creative exhaustion.

One writer described:

> "I used to love writing. It was pure creative expression. Now it's just content. I'm churning out pieces to meet algorithms' demands, not because I have something meaningful to say. The joy is completely gone, replaced by obligation.



4.2.2 Sleep Disruption and Physical Health (70% of Participants)

Sleep disturbances affected 70% of participants (n=15/21), operating as both mental health symptom and exacerbating factor.

Journalists described difficulty "turning off" after covering distressing stories. One photojournalist reported:

> "I get home exhausted, but lying down, my brain replays everything—the interview with the grieving mother, accident photos I edited. My mind won't let me rest until it's processed everything, which can take hours."

Creators faced different mechanisms: compulsive social media checking and anxiety about algorithmic performance. One admitted:

> "I know I should put my phone away at night, but I keep checking notifications, checking analytics. It's compulsive. 'Just one more check' and suddenly it's 2am and I haven't slept.

Chronic sleep deprivation contributed to reported physical health declines: weakened immune systems (frequent illnesses), gastrointestinal problems (stress-related IBS, appetite disruption), cardiovascular symptoms (heart palpitations, elevated blood pressure), chronic pain (tension headaches, screen-time related back/neck pain), and weight changes.

Clinical consultation emphasized bidirectional relationships:

> "Mental health affects physical health which then worsens mental health. Depression reduces motivation for exercise and healthy eating, leading to weight gain and cardiovascular risks, which then increase depression severity. Breaking these cycles requires addressing both simultaneously."

4.2.3 Burnout (65% of Participants)

Burnout—characterized by emotional exhaustion, cynicism, and reduced professional efficacy—affected 65% of participants (n=14/21).

Participants described feeling "completely drained," "running on empty," or "having nothing left to give" professionally or personally. One mid-career journalist explained:

> "I used to care deeply about every story. Now I just feel empty. I'm going through motions but passion is gone. Stories that should move me emotionally don't register anymore."

This emotional flattening represents defensive response to chronic stress—the psyche protecting itself by numbing when negative emotions become overwhelming.

Participants also described growing cynical about work's value. One creator reflected:

> "I used to think I was contributing something valuable—educating people, shifting perspectives. Now I mostly feel I'm feeding the content machine that doesn't really improve anyone's life, maybe makes things worse by adding to screen addiction."

Burnout's cognitive impacts manifested as decreased productivity and creativity. One writer noted:

> "I used to write 2,000 words of good content in three hours. Now it takes all day to produce 1,000 mediocre words. My brain doesn't work the same way anymore."

70%

OF PARTICIPANTS

SLEEP DISRUPTION

JOURNALISTS

Brain replays traumatic coverage at night — cannot switch off

CREATORS

Compulsive analytics checking — "just one more check, suddenly 2am"

PHYSICAL IMPACT

Immune decline · IBS · Heart palpitations
Chronic pain · Appetite disruption

Mental health ↔ Physical health — a cycle

65%

OF PARTICIPANTS

BURNOUT

EMOTIONAL

Exhaustion, numbness, cynicism
Stories no longer register emotionally

COGNITIVE

Decreased productivity and creativity
"2,000 words in 3hrs → 1,000 in a day"

EXISTENTIAL

Loss of purpose and meaning in work
"Feeding the content machine"

Emotional flattening = the psyche's defensive response to chronic stress

4.3 Digital-Specific Factors and Platform Impacts

Workshop Question 2:

"How do specific digital platforms impact your psychological wellbeing?"

Workshop participants identified trolling, doxxing, algorithmic unpredictability, and comparison culture as platform-specific mental health threats, with consensus that platform corporations prioritize engagement and profit over user wellbeing.

4.3.1 Online Harassment: Trolling and Coordinated Campaigns (70%)

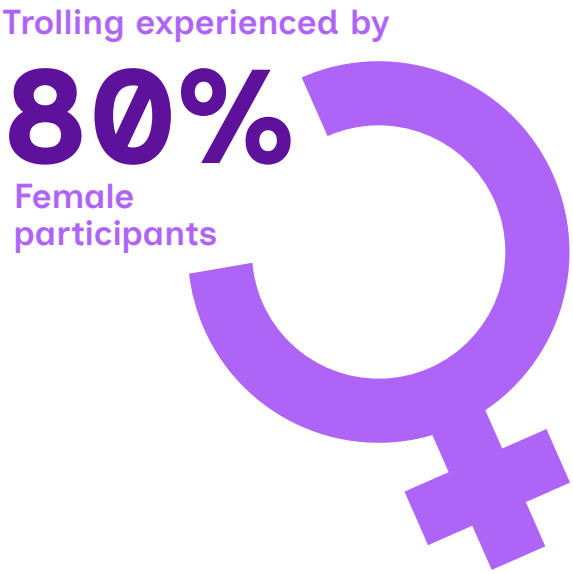
Online harassment affected 70% of participants (n=15/21), with particularly severe impacts on women (80% of women participants, n=9/11) and those covering controversial topics.

Trolling—deliberately provocative communications designed to elicit emotional responses—ranged from mild annoyance to severe psychological harm involving sustained campaigns with violent or sexual threats.

One woman content creator producing feminist commentary described:

> "The trolling is relentless. Every time I post about gender equality, within minutes there are dozens of comments calling me names, questioning my intelligence, making sexual remarks. It feels coordinated, like groups organizing to harass women creators off platforms."

This reveals how trolling operates as systematic silencing tool. Coordinated harassment campaigns disproportionately target marginalized voices (women, LGBTQ+ individuals, minorities) in ways reinforcing social hierarchies by making visibility psychologically unbearable.



Doxxing—Most Severe Harassment:

Doxxing—malicious publication of private information like home addresses, phone numbers, family details—affected approximately 15% of participants (n=3/21) with profound consequences.

One investigative journalist who exposed political corruption experienced doxxing:

> "They published my home address, phone number, photos of my house, details about my children's school. For weeks I got threatening calls at all hours, people showing up near my house. The police couldn't or wouldn't help much. I couldn't sleep, couldn't focus on work, was terrified for my family's safety. That fear doesn't just disappear after the harassment subsides."

This moves online harassment into physical space, creating legitimate safety fears that silence through intimidation. Psychological impacts extend beyond the harassment period itself, creating lasting hypervigilance and trauma responses.

Journalists Covering SRHR: Targeted Backlash

Journalists covering sexual and reproductive health rights faced particularly vicious harassment serving clear censorship purposes: making SRHR coverage psychologically unbearable to reduce such reporting.

One journalist's story covering gender equality issues illustrates this dynamic. After publishing well-researched reporting, someone took quotes out of context, claiming the story "attacked men." Within hours, coordinated campaigns flooded with vitriol—mischaracterization as harassment tool, gendered attacks (sexualized insults, appearance-based ridicule, threats), organized reporting to take down the article, demands for her firing.

For several weeks, the journalist experienced severe psychological distress: unable to sleep or eat properly, constant anxiety about checking her phone knowing more abuse awaited. Working freelance and alone amplified the harm—no newsroom colleagues to process with, just isolation with digital mobs.

The professional impact extended beyond immediate harassment: self-censoring subsequently, thinking twice before pitching gender-related stories, softening angles that might trigger backlash. The harassment achieved its silencing goal while being insidious—the journalist rationalized it: *"Maybe that angle isn't necessary,"* when really she was avoiding legitimate journalism due to unbearable personal cost.

4.3.2 Algorithmic Volatility and Economic Anxiety

Platform algorithms determining content visibility created chronic economic anxiety for creators whose livelihoods depend on unpredictable, opaque systems controlled by distant corporations.

When creators work extremely hard on quality content that algorithms bury, while low-effort posts inexplicably go viral, the disconnect between effort and outcome undermines motivation. One creator described:

> I can spend weeks on a high-quality video—research, scripting, filming, editing—and it gets 1,000 views. Then I post a quick reaction video I threw together in an hour and it gets 50,000 views. That randomness makes you question whether quality matters or if it's just luck and algorithms."

This reflects broader platform dynamics: algorithms optimize for engagement rather than quality or accuracy. Content provoking emotional reactions often outperforms thoughtful, nuanced work, creating perverse incentives where sensationalism proves more viable than substance.

Platform monetization policy changes affected creator income without warning. One creator described:

> "YouTube changed their monetization requirements suddenly—you now needed **1,000 subscribers and 4,000 watch** hours. I was at 800 subscribers after months of work, and suddenly all that effort didn't matter. No explanation why, no grandfathering existing creators, just unilateral policy change cutting off my income stream."

These unilateral policy changes—platforms modifying rules governing creator livelihoods without creator input—generated economic insecurity and power imbalance anxiety. Creators described feeling "at the mercy" of corporations who could destroy livelihoods through algorithm updates decided by distant executives with no consideration for Global South creators' economic vulnerabilities.

4.3.3 Comparison Culture and Social FOMO

Social media platforms incentivize presenting idealized self-versions—success highlights, happy moments, professional achievements—while hiding struggles, failures, mundane realities. This creates distorted perception where everyone appears more successful than actually.

One creator critically analyzed this dynamic:

> "Everyone posts their wins, their collaborations, their growth numbers. Nobody posts 'I'm struggling to pay rent' or 'I haven't had a paid project in weeks' or 'I'm depressed.' So people who are suffering feel uniquely inadequate, unaware that others hide similar struggles. Everyone seems fine, so you don't come out because you'll be the weak one."

This performative success culture generates double harm: individuals feel uniquely inadequate while maintaining exhausting facades. Beyond professional concerns, participants described social FOMO—compulsive checking to see friends' updates, conversations, events.

4.4 Psycho-Social Contexts and Cultural Influences

Workshop Question 5:

"How do socio-economic factors, cultural attitudes, gender dynamics, or political pressures shape mental health?"

Workshop discussions revealed how individual experiences cannot be understood separate from broader contexts shaping vulnerabilities and determining resource access.

4.4.1 Cultural Stigma and Mental Health Attitudes (80%)

Cultural attitudes toward mental health functioned as pervasive barrier shaping help-seeking behaviors, support responses, and individuals' willingness to recognize struggles as legitimate health issues.

Many Kenyans attribute mental illness to spiritual causes—demon possession, witchcraft, ancestral curses, divine punishment—rather than biological or psychological factors. This creates several harms:

Treatment-Seeking Delays: Individuals believing mental illness stems from spiritual causes seek religious interventions rather than medical care. By the time families bring someone to psychiatric services, conditions have often progressed severely.

Shame and Secrecy: Spiritual attributions carry moral judgment—if mental illness represents demonic influence or divine punishment, the sufferer has somehow spiritually failed. This shame prevents disclosure even to family members, with individuals suffering in isolation.

Anticipated Stigma: Beyond actual stigma experienced, fear of stigmatization prevents help-seeking even when actual discrimination might not occur.

One participant explained:

> "I've never tried accessing mental health services, so I don't know if family would react badly or if it would affect my career. But the fear of those consequences is enough to stop me. What if my employer thinks I'm unstable? What if my family thinks I'm weak? The risk feels too high, so I don't seek help."

This testimony reveals how stigma operates through fear mechanisms that don't require actual discrimination to be effective.

Cultural Stoicism: Kenyan cultural narratives often valorize endurance, resilience, and stoicism in the face of hardship—valuable qualities but potentially harmful when preventing appropriate help-seeking. Participants described hearing "just be strong," "others have it worse," "complaining won't help" in response to mental health distress.

These messages communicate that psychological struggle isn't real or serious, or doesn't deserve attention. One participant reflected:

> "I grew up hearing 'we don't do therapy, we just pray and push through.' So even when I needed help, I felt weak or overreacting seeking it. It took reaching a really dark place before overcoming that internalized message."

This cultural stoicism particularly affects men, with masculinity norms amplifying endurance expectations: "Real men don't cry," "handle your problems yourself."

Image Credit © Envato Elements

80% **faced stigma as a primary barrier**

to accessing mental health care — even when services existed. Fear alone was sufficient to prevent help-seeking.

TREATMENT DELAYS

Spiritual attribution leads to religious care first. Psychiatric help reached only in crisis, when conditions are severe.

"Demon possession, witchcraft, divine punishment"

SHAME & SECRECY

Illness framed as moral or spiritual failure. Individuals suffer in isolation, unable to disclose even to family.

"The sufferer has somehow spiritually failed"

CULTURAL STOICISM

Endurance valorized over help-seeking. Men especially affected by masculinity norms that prohibit vulnerability.

"Real men don't cry."
"Just pray and push through."

> *"The fear of those consequences is enough to stop me. What if my employer thinks I'm unstable? What if my family thinks I'm weak? The risk feels too high, so I don't seek help."*
>
> — Study participant · Anticipated stigma preventing help-seeking despite no actual discrimination occurring

4.4.2 Gender Discrimination and Gendered Mental Health Risks (70% of Women)

70% of women participants (n=8/11) described gendered discrimination creating distinctive mental health vulnerabilities beyond those affecting men.

Workplace Sexual Harassment:

One woman documented harassment in production house contexts:

> "When sexual harassment happens, it's taken very lightly, especially if the guy is higher-level. They'll tell you 'that's just how he is,' or 'he's joking,' or 'you're being too sensitive.' So women learn to either endure it or leave, and either option takes psychological toll."

This reveals how workplace cultures normalize sexual harassment through minimization and victim-blaming, creating environments where women must choose between enduring abuse or leaving opportunities—both with mental health costs.

Online Gender-Based Violence (70% of Women):

70% of women media professionals experienced online gender-based violence including sexualized harassment, appearance-based attacks, gendered insults, rape and violence threats, and doxxing with gendered dimensions.

These attacks differ qualitatively from harassment men experience—focusing on bodies, sexuality, and gender performance rather than disagreeing with work content. One woman noted:

> "When men get criticized online, it's usually about their ideas or work. When women get attacked, it's about the appearance, sexuality, whether we're 'feminine enough,' threats of sexual violence. It's designed to remind us we're not safe, not welcome, should be silent."

This gendered harassment serves patriarchal purposes: enforcing women's exclusion through psychological attrition.

Unequal Career Advancement and Pay:

Several women described how gender discrimination in hiring, promotion, and compensation created chronic economic stress. One explained:

> "I have more experience and better metrics than male colleagues, but they got promoted and I didn't. When I asked why, got vague answers about 'leadership potential' or 'fit.' It's exhausting working twice as hard for half the recognition."

This professional discrimination intersects with economic precarity and family obligations: women earning less than male peers have less capacity to manage familial obligations or invest in mental healthcare, while discrimination's psychological toll (frustration, demoralization, imposter syndrome) compounds baseline challenges.

70% **of women faced gendered mental health risks**
Gender multiplies the baseline stress through compounding, qualitatively distinct mechanisms.

WORKPLACE HARASSMENT

Harassment minimized — "that's just how he is." Women choose: endure abuse or lose opportunity.

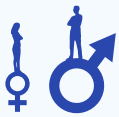
Both options carry mental health costs.

ONLINE GENDER-BASED VIOLENCE

Sexualized threats, appearance attacks, doxxing, rape threats. Designed to silence — not critique work, but exclude.

"Remind us we're not safe, not welcome, should be silent."

UNEQUAL PAY & ADVANCEMENT



Better metrics, more experience, still passed over. Vague rejections: "leadership fit." Less income = less care access.

"Twice as hard for half the recognition."

> *"When men get criticized online, it's usually about their ideas or work. When women get attacked, it's about appearance, sexuality, threats of sexual violence. It's designed to remind us we're not safe."*
>
> — Woman journalist · Gendered harassment as tool of exclusion, not critique

4.4.3 Tribal Affiliation and Political Pressure

> *"I still do investigative work, but I'm more careful now—maybe too careful. There are stories I know need telling but I hesitate because I keep thinking about that cell. And that's exactly what they wanted—to make me afraid so I self-censor."*

Kenya's ethnic diversity and political dynamics created additional mental health influences, though participants showed reluctance fully elaborating on these sensitive topics.

Media professionals from ethnic minorities covering politically sensitive topics described heightened harassment risk, particularly when ethnic identity became weaponized. Political violence disproportionately affecting certain communities creates community-level trauma that media professionals from those communities carry.

One journalist experienced police custody following corruption reporting. The detention lasted less than 48 hours, but psychological impacts persisted months later: hypervigilance, constantly monitoring surroundings for threats, difficulty trusting safety even in secure environments, intrusive memories during similar coverage.

Most tellingly, this trauma affected not just personal mental health but professional practice.

4.5 Coping Mechanisms and Support Systems

Workshop Question 3:
"What coping strategies have you found helpful?"

Despite substantial mental health challenges, media professionals demonstrated remarkable resilience through diverse coping strategies—some highly effective, others providing temporary relief without addressing root causes.

4.5.1 Most Effective: Peer Support (70%)

70% of participants (n=15/21) identified peer networks—fellow media professionals understanding industry-specific challenges—as most effective coping resource.

Unlike family or friends outside media who might not grasp why algorithmic changes cause anxiety, peer media professionals immediately understand without requiring explanation. This shared understanding reduces isolation that workshop participants identified as particularly harmful: "Journalists suffer in isolation."

Peers provided practical advice and workaround knowledge that family couldn't offer. One freelancer explained:

> "When a client ghosted me after weeks of work, I was spiraling about money. But when I told other freelancers, they shared strategies for preventing this—contracts, upfront deposits, payment schedules. Those practical solutions reduced the anxiety by giving me control."

Professional networks and associations like Bloom Group provided structured frameworks for connection. AMWIK's gender-specific support for women journalists provided safe spaces where women could discuss harassment and mental health challenges without judgment or minimization. One participant noted:

> "AMWIK events are where I finally felt heard—other women journalists sharing similar experiences, validating that this is discrimination, helping strategize responses. That collective validation was healing."

However, many freelance media professionals lacked access to professional associations, limiting peer support to informal personal networks rather than robust organizational frameworks.

4.5.2 Self-Care and Boundaries

Self-care practices—physical exercise, healthy eating, adequate sleep, relaxation techniques—benefited many but often proved insufficient against structural stressors beyond individual control.

Physical exercise helped with stress management, but faced accessibility barriers: time constraints, financial costs, and safety concerns (women avoiding outdoor exercise in certain areas).

Some participants successfully implemented work-life boundaries reducing constant connectivity's toll.

However, these boundary practices remain individual solutions to systemic problems. Freelancers faced particular challenges: without institutional work hours, boundaries must be self-enforced against economic pressures to accept all available work.

One creator described:

> "I set specific times when I check analytics—morning and evening, that's it. Not compulsively throughout the day. And I have no-phone hours when I'm completely offline. It was hard at first, but my mental health improved dramatically."

4.5.3 Spiritual and Religious Support (Variable Effectiveness)

For participants whose religious faith provided genuine comfort, prayer, worship, scripture reading, and religious community connection functioned as valuable coping mechanisms. One participant explained:

> "My faith gives me perspective when work stress feels overwhelming. Prayer helps me remember bigger purposes beyond follower counts or article views. That perspective reduces anxiety about daily professional ups and downs."

Religious communities provided practical support: financial assistance during hardships, emotional care during crises, social connection reducing isolation.

However, concerning patterns emerged where religious reliance substituted for rather than complemented professional mental health care.

One participant noted:

> "Seeking help from a pastor not experienced with mental health, they might tell you to just pray more, that struggles mean lacking faith. That delays real treatment and adds guilt."

This substitution proves particularly harmful when religious authority figures discourage psychiatric care or provide spiritual interventions alone for conditions requiring medical treatment. Integration rather than opposition works best: professional psychiatric care addressing clinical symptoms, spiritual practices addressing existential meaning and community connection.

4.5.4 Emerging: Media as Therapy

Several participants described innovative approaches: creating content that processes personal mental health experiences while potentially helping audiences facing similar challenges.

One creator articulated philosophy of "using media as a way to communicate how to cope with mental health"—transforming media production from stressor to therapeutic practice. This approach transforms suffering into content helping others while providing creator processing outlet and meaning-making.

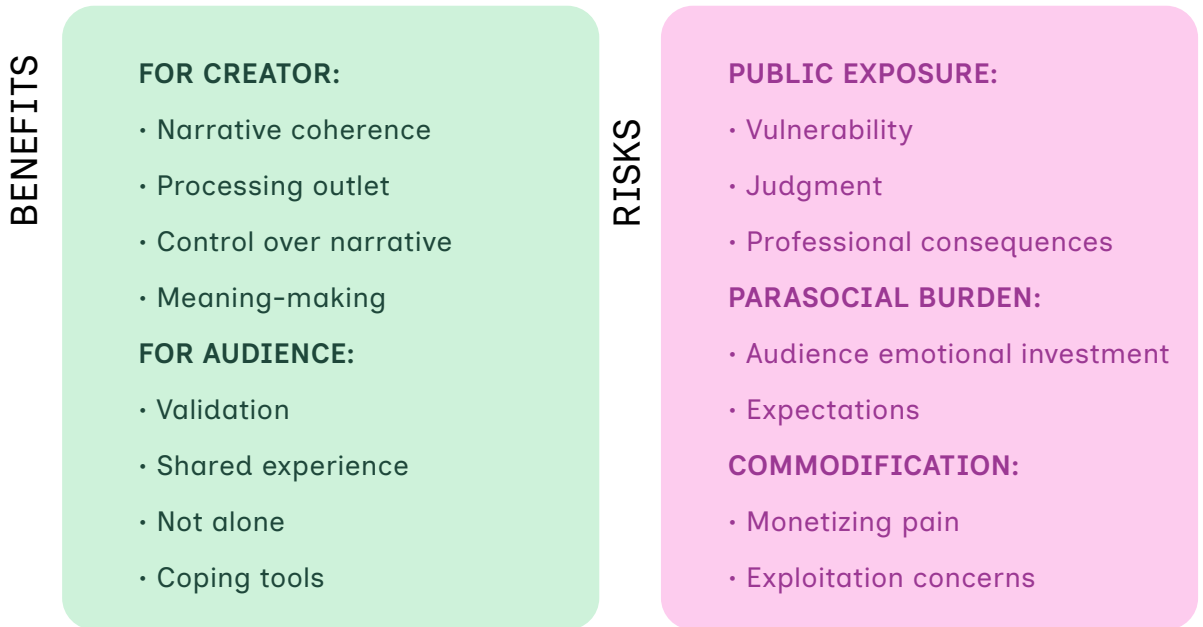
This therapeutic dimension operates multiple ways: narrative coherence (organizing chaotic experiences aids integration), validation (audience responses confirm experiences as shared rather than unique), purpose (suffering transformed into helpful content provides meaning), and control (actively creating about challenges rather than passively enduring).

However, this carries risks: public vulnerability exposure invites judgment and professional consequences, parasocial burdens as audiences develop emotional investment, and commodification concerns (monetizing mental health content feeling exploitative of own suffering).

Several participants also mentioned attending mental health forums—particularly Creative Garage in Nairobi—providing space for digital creators to discuss psychological challenges with peers and occasionally mental health professionals. One described:

> "Just hearing other creators admit they struggle too breaks isolation. You realize the problem isn't your inadequacy, it's the system designed to exploit our psychological vulnerabilities."

USING MEDIA AS MENTAL HEALTH THERAPY



4.5.5 Barriers to Effective Coping

TIME SCARCITY:

Freelance unpredictability and deadline pressures left minimal time for self-care. Exercise, therapy, and social connection became items on impossible to-do lists.

FINANCIAL CONSTRAINTS:

Effective coping strategies require money participants lacked—therapy sessions, gym memberships, healthy food, childcare. Economic precarity directly limits coping capacity.

ENERGY DEPLETION:

Mental health challenges themselves undermine capacity for healthy coping. Depression reduces exercise motivation; anxiety prevents restful sleep; burnout exhausts energy for social connection.

LACK OF KNOWLEDGE:

Some participants simply didn't know about available resources or effective coping strategies. Workshop discussions revealed gaps in mental health literacy—participants unaware that symptoms they experienced represented treatable conditions.

4.6 Barriers to Mental Health Access and Industry Structures

Workshop Question 4:

"What prevents you from accessing mental health support?"

Workshop Question 7:

"How do newsroom cultures, platform policies, and professional associations influence mental health outcomes?"

4.6.1 Cultural Stigma (80%) and Cost (70%)

80% of participants (n=18/21) identified stigma as significant barrier preventing help-seeking. Beyond actual stigma experienced, fear of stigmatization prevents help-seeking even when discrimination might not occur.

Media professionals faced distinctive stigma amplifications. Multiple worried that mental health disclosure would undermine professional credibility, limit career opportunities, damage public image, or provide ammunition for detractors.

70% of participants (n=15/21) cited financial constraints as barrier. Therapy sessions (typically **KSh 1,500-5,000)** proved prohibitive given media professionals' economic precarity. Even subsidized options—**KSh 1,000** per session—meant **KSh 4,000** monthly for weekly therapy—significant expense when struggling to pay rent and supporting family.

Most policies exclude or minimally cover mental health services. Freelancers entirely lack employment-based insurance, facing choice between purchasing expensive private insurance or going without coverage.

4.6.2 Geographic Scarcity (Critical Barrier)

Kenya has approximately **150 psychiatrists serving 50+ million people,** concentrated primarily in Nairobi. This geographic scarcity creates acute barriers especially for non-Nairobi media professionals.

Participants from other regions described having to travel to Nairobi for psychiatric care, with travel costs, accommodation, and time away from work compounding prohibitively expensive services.

Even within Nairobi, services concentrate in **affluent neighborhoods (Westlands, Karen, Kilimani)**, requiring transportation costs and navigation unfamiliar to those living in other areas—additional psychological barriers beyond pure geographic distance.

4.6.3 Newsroom Structures: Sympathy Without Systems

Traditional newsrooms demonstrated "sympathy gaps"—colleagues and managers offering emotional support during crises without implementing systemic changes preventing future crises.

One journalist described typical pattern:

> "After covering a terrible accident, my colleagues were sympathetic—'are you okay?', 'that must have been hard,' offering coffee to talk. Which was nice. But when I suggested formal trauma debriefing, rotation policies to limit repetitive exposure, or mental health insurance coverage, suddenly it's 'budget constraints' and 'we'll look into it.' So the sympathy is there, but willingness to actually change systems generating trauma is absent."

This reveals how organizations externalize mental health responsibility onto individuals—emotional support provided personally, but institutional policy changes avoiding budget impacts remain unimplemented.

Newsrooms lacked basic mental health infrastructure: no trauma debriefing protocols, no Employee Assistance Programs, no clear policies on reducing trauma exposure, no training for managers recognizing mental health distress, no designated personnel responsible for employee psychological wellbeing.

Chronic understaffing meant smaller teams producing same or greater content volume. When journalists expressed being overwhelmed, response was "we're all overwhelmed, just push through"—treating mental health as weakness rather than legitimate concern.

4.6.4 Freelance Isolation and Platform Voids

40% of participants (n=9/21) working freelance experienced complete absence of institutional support—no employer-provided insurance, no colleagues offering peer support, no organizational policies protecting against overwork.

One freelancer captured this isolation:

> "As freelancer, you're just alone. There's no HR department to complain to if a client is abusive, no health insurance when you burn out, no sick leave when you need recovery. You're entirely responsible for your own wellbeing, but economically trapped to accept whatever work you can get. It's a recipe for mental health disaster."

40%

OF PARTICIPANTS · FREELANCE

No insurance · No colleagues · No policies

> *"You're entirely responsible for your own wellbeing, but economically trapped to accept whatever work you can get. It's a recipe for mental health disaster."*
>
> **— Freelance media professional**

This isolation particularly harms during crises: no organizational legal team for harassment defense, no sick leave enabling recovery, no insurance coverage reducing therapy costs.

Digital platforms—X, TikTok, Instagram, YouTube, Facebook—function as de facto workplaces for creators yet accept no employer responsibilities for wellbeing.

Workshop participants emphasized this accountability gap:

> "Platforms profit from our content but provide nothing in return besides audience access. When we experience harassment, they shrug. When algorithms change destroy our income, no explanation or support. We generate their profits but they take no responsibility for our wellbeing."

PLATFORM BEHAVIOUR	MENTAL HEALTH IMPACT
Inadequate content moderation Slow reports · inconsistent enforcement	Sustained harassment exposure Secondary trauma · fear · self-censorship
Opaque algorithms Income determined without explanation	Chronic economic anxiety Learned helplessness · imposter syndrome
Engagement-first design Features maximizing use over wellbeing	Psychological exploitation Compulsive checking · validation anxiety
Unilateral policy changes No input · no notice · no appeal	Income insecurity · powerlessness Loss of control over livelihood
Zero creator support No recourse during harassment or crisis	Complete isolation during crises No legal, financial or psychological safety net

"We generate their profits but they take no responsibility for our wellbeing."
— Workshop participant

4.6.5 Regulatory and Educational Gaps

Kenya's regulatory frameworks governing media focus primarily on content regulation rather than labor conditions and mental health protections for media workers. No regulations require mental health insurance coverage, trauma debriefing protocols, platform accountability for harassment, or freelance worker protections.

Journalism and media studies curricula typically exclude mental health content—no training on recognizing trauma responses, implementing self-care, accessing resources, or understanding how industry structures affect psychological wellbeing. Participants noted:

> "In journalism school, we learned writing, editing, ethics, media law—all important. But nothing about how covering trauma affects you psychologically, what to do when burned out, how to set boundaries. We graduated completely unprepared for the mental health impacts of this work."

4.7 Vignettes: Lived Experiences

Vignette 1: Financial Strain and Safety Concerns

One journalist's experience covering corruption exemplifies how professional duties generate trauma when institutional protections fail. After publishing researched reporting documenting bribed judicial manipulation, retaliation followed: police detained him without clear charges, holding him in conditions described as "designed to intimidate."

The detention lasted less than 48 hours, but psychological impacts persisted months later. Hypervigilance, constantly monitoring surroundings for threats, difficulty trusting safety even in secure environments, intrusive memories during similar coverage.

Most tellingly, this trauma affected professional practice:

> "I still do investigative work, but I'm more careful now—maybe too careful. There are stories I know need telling but I hesitate because I keep thinking about that detention. And that's exactly what they wanted—to make me afraid so I self-censor."

This vignette illuminates the democracy-mental health nexus: when journalists suffer trauma from professional duties without institutional protection, both individual wellbeing and public information integrity degrade.

Vignette 2: Validation-Seeking and Recovery

One digital content creator in their early 30s exemplifies the distinctive mental health trajectory some creators experience: initial passion giving way to platform-driven validation-seeking, crisis recognition, and gradual recovery through boundary-setting and community connection.

> "Between 2016 and 2020, I was in a really dark place mentally. I had transferred love from my friends and family to likes and shares. I would post and compulsively refresh watching metrics. My entire mood for the day depended on how that post performed. If it did well, brief euphoria. If not, I felt worthless."

This validation-seeking behavior escalated: posting multiple times daily despite creative exhaustion, checking analytics hourly, experiencing panic attacks when follower counts dropped.

> "The platforms are designed to create this dependency—they know you need validation and ration it out unpredictably like a slot machine. I was completely caught in that trap."

Recovery involved combination of personal crisis (burnout-induced health problems forcing work pause) and community connection through mental health forums.

> "I started attending forums, hearing other creators admit they struggled too. That broke the isolation. I realized the problem wasn't my inadequacy—it was the system designed to exploit our psychological vulnerabilities."

Recovery involved concrete boundary-setting: designated no-phone times, analytics-checking schedules, diversifying income to reduce platform dependency, using media therapeutically—creating content processing mental health experiences.

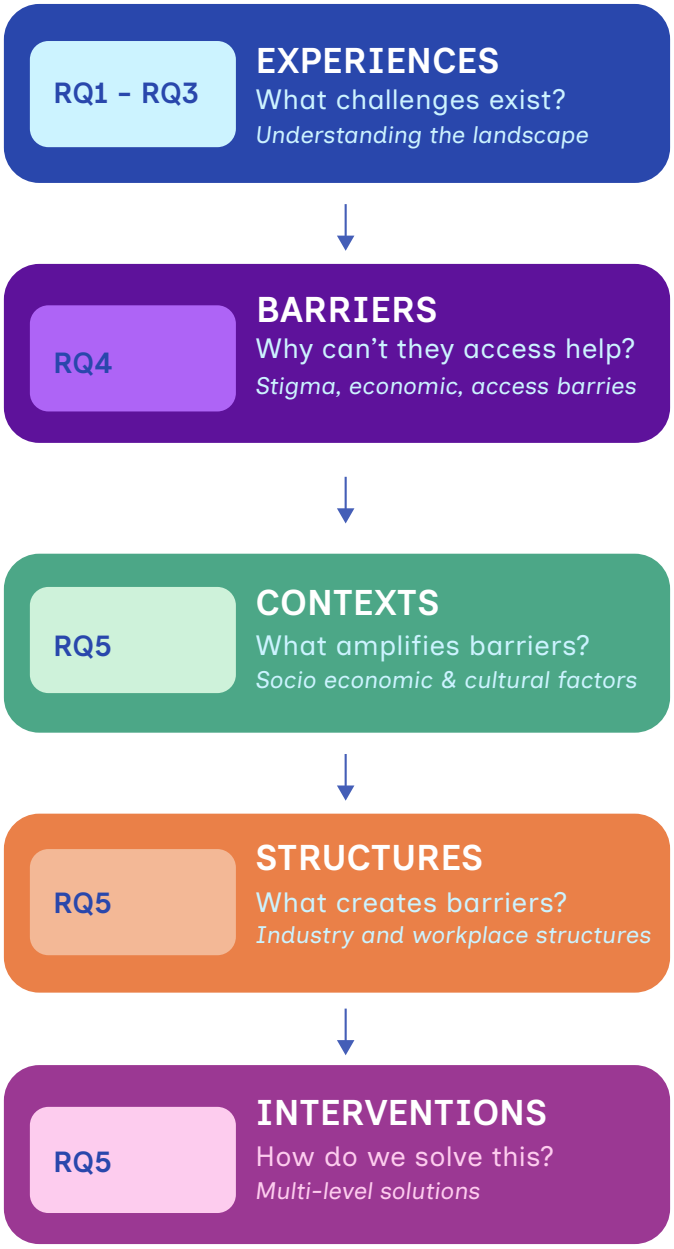
This trajectory illustrates both vulnerability and agency: platforms create psychological harms, but individuals can develop countermeasures, especially when supported by peer communities validating experiences and sharing strategies

> "I'm not 'cured'—I still feel the pull to check metrics, still have bad days. But I've learned to recognize patterns and interrupt them. And I'm much more vocal now about how platforms harm creators, because silence allows exploitation to continue."

Image Credit © Envato Elements

5
Discussion & Implications

This chapter synthesizes findings across themes, explores interconnections particularly among research questions 4-7, contextualizes results within global literature and theoretical frameworks, and discusses implications for media development work.



Integration: Each research question builds on previous findings to create comprehensive understanding. Individual problems cannot be solved without addressing structural causes.

5.1 Key Insights and Patterns

5.1.1 Financial Risk with Role-Specific Manifestations

Perhaps the most fundamental finding: financial risk transcends professional categories (75% universal prevalence), yet manifests through distinctly different psychological mechanisms generating different impacts across roles.

For Journalists:

Economic stress intersects with repetitive trauma exposure (80% prevalence) and deadline pressure, creating compound vulnerability where financial insecurity amplifies trauma impacts while trauma-induced symptoms (avoidance, hypervigilance, emotional numbing) undermine work capacity and therefore income stability. This bidirectional relationship—economic stress worsening mental health, mental health challenges threatening economic stability—creates vicious cycles difficult to escape without intervention addressing both dimensions simultaneously.

For Content Creators:

Economic anxiety stems from algorithmic unpredictability and platform dependency rather than trauma exposure, generating distinct psychological pattern centered on imposter syndrome (60%), FOMO, and validation-seeking behaviors. The creative identity core to many creators' self-concepts makes algorithmic rejection particularly damaging—when algorithms render content invisible, creators experience this not as business setback but identity threat ("am I actually good at this?").

Theoretical Validation:

Both patterns validate the theoretical frameworks. Lazarus & Folkman's stress appraisal theory explains why identical stressor (income volatility) generates different psychological responses: individuals appraise stressors within their professional identity and self-concept frameworks. The social determinants of health framework explains that mental health outcomes reflect structural economic conditions, not just individual psychology—meaning interventions addressing only individual coping without tackling economic risk will prove insufficient.

5.1.2 Coping Amid Structural Constraints

The 70% effectiveness rating for peer support (RQ3 finding) emerges as bright spot amid crisis documentation, yet requires nuanced interpretation: Peer support proves most effective available coping strategy, not necessarily optimal intervention.

Participants rated peer support highly because it provides validation, practical advice, and collective efficacy unavailable through family support (variable understanding) or self-care practices (individually limited impact). However, peer support's effectiveness operates within constraints—it helps individuals cope with structural problems (platform volatility, newsroom trauma, freelance isolation) without solving those structural problems.

Participants demonstrated remarkable adaptive capacity: one creator using media production therapeutically, another collaborating with fellow freelancers to share workload, workshop participants committing to collective action. If media professionals can only survive through extraordinary peer support efforts compensating for institutional abandonment, we've made oppression survivable rather than eliminated it.

Effective interventions must both strengthen peer support (facilitating collectives, providing organizing resources, creating gathering spaces) and reduce structural harms necessitating that support (platform accountability, economic safety nets, mental healthcare access).

5.1.3 Stigma as Multi-Level Barrier

The 80% stigma prevalence (RQ4) operates simultaneously across societal (cultural beliefs about mental illness), community (family/social judgment), organizational (workplace reputation concerns), and individual (internalized shame) levels.

This multi-level character explains why individual-focused stigma reduction (mental health awareness campaigns) often disappoints: Even when individuals overcome personal stigma, they still face family pressure, workplace discrimination fears, and community gossip. Each level functions as independent barrier requiring level-appropriate intervention.

Clinical documentation indicates underreporting runs 2x higher among professionals (journalists, doctors, teachers) than general population, suggesting professional identity creates distinctive stigma amplifications. Professions emphasizing objectivity, credibility, and public trust generate heightened fears that mental health disclosure undermines professional legitimacy.

For journalists specifically, circular logic operates:

> "If I'm anxious/traumatized, does that bias my reporting? If audiences know I'm struggling, will they trust my judgment? If editors think I'm fragile, will I get assignments?"

These professionally-specific fears require professionally-tailored interventions beyond generic stigma reduction.

5.1.4 Platform Architecture as Mental Health Determinant

Digital wellbeing theory's emphasis on platform design choices (not inevitable technology impacts) proves empirically supported: Different platforms create distinct mental health challenges through specific features.

X

FORMERLY TWITTER

X/Twitter's real-time, text-based, conflict-oriented design enables rapid pile-ons, viral dunking, and coordinated attacks. The platform's cultural norms reward combative discourse, making harassment seem normal rather than exceptional—this design systematically generates harassment severity far exceeding other platforms.

TikTok

SHORT FORM VIDEO

TikTok's extreme algorithmic volatility and youth-dominated, trend-dependent culture creates unique creator anxiety where yesterday's successful formula becomes invisible without explanation. The short-form video format (15-60 seconds) also pressures creators into specific aesthetic uniformity.

Instagram

VISUAL FIRST PLATFORM

Instagram's visual-first, lifestyle-aspirational culture generates comparison anxiety where every post invites judgment not just of content but of poster's entire life, appearance, and success.

YouTube

LONG FORM VIDEO

YouTube's relatively stable monetization paradoxically creates creator vulnerability: because creators heavily depend on AdSense revenue, unilateral platform policy changes or demonetization decisions threaten livelihoods more acutely than platforms providing alternative revenue streams.

These platform-specific patterns suggest interventions must target specific platforms' harmful features rather than treating "social media" as monolithic category. Advocacy demanding X improve harassment reporting systems differs from advocacy demanding TikTok increase algorithm transparency, though both serve mental health protection.

The finding validates that platform corporations bear responsibility for mental health harms their design choices create. When companies deliberately design infinite scroll (hijacking attention), quantify social worth through metrics (exploiting validation needs), and optimize for engagement over wellbeing (prioritizing advertiser revenue), resulting mental health harms are foreseeable consequences of profit-maximizing business models.

INFINITE SCROLL
Hijacks attention — designed to prevent disengagement
Foreseeable harm

SOCIAL METRICS
Quantifies self-worth — exploits psychological validation needs
Foreseeable harm

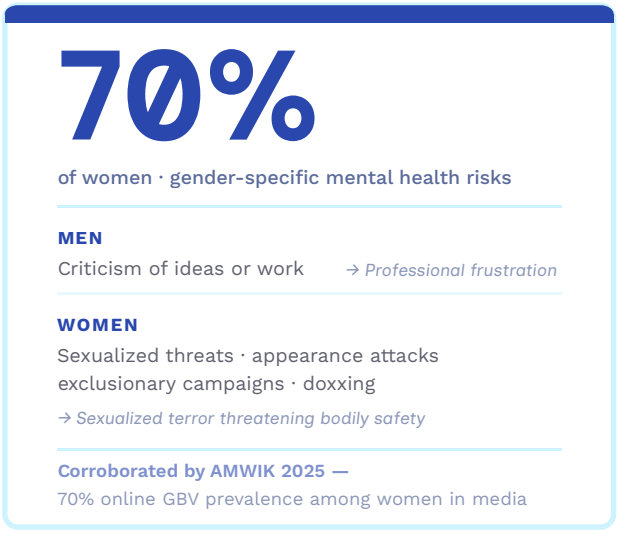
ENGAGEMENT OPTIMIZATION
Prioritizes advertiser revenue over user mental wellbeing
Foreseeable harm

5.1.5 Gender as Compound Vulnerability

The 70% of women reporting gender-specific mental health risks (RQ5) demonstrates intersectionality: Gender doesn't add to baseline stress but multiplies it through distinctive mechanisms (sexual harassment, gendered online violence, maternal discrimination, unequal pay).

Harassment differs qualitatively by gender: men receive criticism about ideas or work; women receive sexualized threats, appearance-based attacks, and exclusionary campaigns. This qualitative difference generates distinct psychological impacts—men may experience professional frustration; women experience sexualized terror threatening bodily safety.

AMWIK 2025 data corroboration (70% online gender-based violence prevalence) strengthens confidence in study's findings while situating them within documented patterns of technology-facilitated gender-based violence targeting women in public roles.



5.1.6 Family Support as Culturally-Specific Structural Determinant

It emergence as significant theme (40% prevalence, amplifying financial stress) demonstrates importance of culturally-grounded analysis: Western mental health literature largely ignores extended family financial obligations because individualistic cultural contexts frame adults as economically independent.

Yet in many African and Global South contexts, family interdependence constitutes cultural norm and moral expectation—economically successful individuals should support struggling family members, reflecting Ubuntu values of communal responsibility.

This creates distinctive mental health dynamics: Individuals experience guilt spending on personal needs when family members have pressing needs, yet sacrificing personal care for family obligations generates resentment, stress, and ultimately decreased capacity to provide family support. The moral obligation framework makes this tradeoff emotionally unbearable.

Interventions must navigate this context sensitively. Simply telling individuals to "prioritize self-care" ignores legitimate moral obligations. More appropriate: Making mental healthcare affordable so it doesn't require choosing between self and family, family psychoeducation helping relatives understand that member's mental health care benefits entire family, addressing root cause—economic inequality—through structural economic interventions.

5.2 Cross-Research Question Linkages: How Barriers, Contexts, and Structures Interact

The framework emphasized RQ4-7 integration, examining how barriers (RQ4), socio-economic contexts (RQ5), and industry structures (RQ6) interact to shape both mental health outcomes and intervention requirements (RQ7).

How Different Barriers Require Different Interventions at Different Levels

	Individual Level	Organizational Level	Industry Level	Policy Level
Economic Precarity	Financial planning training	Insurance policy advocacy	Union support for benefits	Healthcare system reform
Cultural Stigma	Mental health literacy	Workplace culture shift	Industry norm change	Curriculum revision
Access to Services	Therapy access skills	Peer support groups	Association advocacy	Service expansion

Note: Comprehensive solutions require coordinated interventions across all barrier types and all intervention levels

5.2.1 Barriers Emerge from Structural and Contextual Factors

Cultural stigma (RQ4 barrier affecting 80%) cannot be understood as purely individual attitudes correctable through education. Stigma emerges from and is maintained by:

- **Societal structures:** Media industry cultures normalizing overwork and stoicism; newsroom hierarchies where vulnerability signals weakness; professional identity frameworks conflating mental health challenges with incompetence
- **Cultural contexts:** Religious frameworks attributing mental illness to spiritual causes; collectivist values emphasizing endurance over self-care; patriarchal masculinity norms prohibiting male emotional expression

Therefore, effective stigma reduction requires multi-level approach: individual psychoeducation, organizational policies preventing discrimination, community-level cultural work challenging harmful beliefs through religious leader engagement and cultural influencer campaigns, societal-level regulatory protections preventing employment discrimination.

Single-level interventions fail because they leave structural and cultural stigma sources intact.

5.2.2 Structures Create Barriers Which Require Structural Solutions

Freelance isolation (RQ6 structure) directly generates multiple RQ4 barriers:

- **No employer-provided insurance:** Freelancers pay out-of-pocket for all healthcare, making therapy cost-prohibitive
- **No institutional peer support:** Lacking newsroom colleagues or organizational frameworks, freelancers experience intensified isolation preventing collective advocacy
- **No workplace policies:** No HR departments, harassment reporting mechanisms, or sick leave policies that formally-employed workers access

Given these structural causes, effective interventions must include structural reforms: portable benefits enabling healthcare access, professional association development, client/platform accountability regulations.

Individual-level interventions teaching "self-care" or "boundary-setting" prove necessary but insufficient without structural changes.

5.2.3 Contexts Amplify Barriers Requiring Context-Appropriate Interventions

Gender discrimination (RQ5 context) amplifies multiple RQ4 barriers:

- Women experiencing sexual harassment face distinctive help-seeking barriers: reporting risks **victim-blaming, retaliation, and dismissal**
- Women facing online gender-based violence encounter platform accountability barriers: harassment framed as **"free speech"; women's reports dismissed; moderation inconsistent**
- Women managing family support demand while earning less than male peers face intensified economic barriers: **lower income plus family obligations** leaves minimal discretionary spending for therapy

Therefore, effective interventions must include gender-specific components: meaningful workplace sexual harassment enforcement, platform content moderation addressing gendered violence, equal pay advocacy, women-only peer support spaces.

Gender-blind interventions miss these amplified vulnerabilities and prove less effective for women.

5.2.4 Multiple Barriers Intersect Requiring Integrated Solutions

RQ4-7 integration reveals that barriers don't operate in isolation—they interact multiplicatively:

Consider a freelance woman content creator from rural Kenya: economic barrier (low income, no insurance), geographic barrier (far from mental health services), gender context (online harassment), freelance structure (no institutional support), cultural stigma (potentially more conservative community), family support obligations (family consuming available income).

Each barrier alone proves difficult; combined they create nearly insurmountable obstacle to help-seeking. Single-intervention approaches help some but leave others unserved.

Integrated intervention addressing this intersection might include: teletherapy overcoming geographic barriers, sliding-scale services addressing economics, women therapists addressing gender-specific needs, community education reducing stigma, professional association membership reducing isolation, economic advocacy enabling therapy affordability.

This integrated approach—addressing multiple intersecting barriers simultaneously—proves most likely to achieve meaningful access improvements.

5.3 Broader Implications

5.3.1 Mental Health and Media Viability

The study carries implications for the journalism and media industry's broader sustainability and function:

Journalist Mental Health Affects Information Quality:

When journalists suffer trauma, burnout, and psychological distress without institutional support, their capacity for rigorous investigative work diminishes. Trauma-induced self-censorship, burnout-related errors, and journalist exits from field all reduce journalism quality and democratic function.
One journalist reflected that trauma makes him "more careful, maybe too careful" about investigative reporting, avoiding stories that need telling. This illustrates how mental health crisis degrades the information infrastructure democracies depend on.

Information Integrity and Media Sustainability:

Media institutions depend on professionals who can produce accurate, thorough, and ethically-sound work. Mental health crises undermine this capacity while driving talented professionals from field, weakening institutional knowledge and quality.

Implication: Media organizations investing in journalist mental health protect information integrity and institutional sustainability.

Implication: Supporting media professional mental health isn't purely humanitarian concern but strategic investment in information ecosystem quality. Better-supported journalists produce better journalism; psychologically secure creators generate more authentic content.

Platform Accountability Advocacy Necessary:

No amount of individual coping skills overcomes platforms deliberately designed to exploit psychological vulnerabilities. Stress management training helps creators tolerate algorithmic anxiety but doesn't stop algorithms from generating that anxiety.

Collective Models Prove Effective:

Workshop's collective process, peer support's 70% effectiveness, and calls for association-building point toward collective intervention models as more effective than purely individual approaches.

Implication: Media development work should facilitate collectives—funding association formation, providing organizing training, creating gathering spaces, supporting peer network development. Collective investments potentially reach more people sustainably than individualized clinical services.

Implication: Media development work must include regulatory advocacy targeting platform corporate responsibility—demanding algorithm transparency, harassment moderation accountability, fair monetization terms, creator protection requirements.

5.3.2 Future Research Priorities

The study opens multiple research avenues:

Longitudinal Career Trajectories: Following media professionals across career phases would illuminate how mental health challenges evolve, whether resilience develops, and identify high-risk career points warranting intensive support.

Rural Media Worker Focus: Research centering rural and peri-urban professionals would address geographic bias while generating evidence for interventions beyond Nairobi.

Platform-Specific Deep Dives: Detailed studies examining single platforms (ethnography of TikTok creator mental health; survey of YouTube monetization stress) would generate actionable platform-specific advocacy recommendations.

Intervention Effectiveness Evaluation: As interventions are implemented, rigorous evaluation should assess effectiveness, cost-effectiveness, and consequences — evidence informing continuous improvement.

Comparative East African Research: Replicating in Tanzania, Uganda, Ethiopia would reveal regional patterns versus Kenya-specific dynamics, enabling locally-tailored and regionally-coordinated interventions.

Economic Modeling: Research quantifying mental healthcare's return on investment for media organizations (reduced absenteeism, improved productivity, decreased turnover, journalism quality) would provide business case for employer investment.

6

Recommendations For Mental Health Support In Media

This chapter translates findings into evidence-based, culturally-appropriate, feasible recommendations spanning individual through policy levels. Recommendations emerged from participant priorities (particularly workshop discussions), clinical expertise, theoretical frameworks, and global best practices. Implementation responsibility is distributed across government, media organizations, professional associations, platforms, and civil society rather than concentrated on any single organization.

6.1 Conclusions: Resilience Amid Crisis

Kenya's digital media-makers and journalists demonstrate remarkable resilience despite:

- Pervasive financial precarity (75%) undermining security and wellbeing
- High rates of anxiety, depression, and burnout (65-75%)
- Repetitive trauma exposure for journalists (80%)
- Platform-generated stress for creators (60%)
- Systemic barriers preventing 70-80% from accessing mental health support

This resilience—manifest in peer support networks, innovative coping strategies, and collective organizing—deserves recognition. Yet resilience alone cannot overcome structural harms. As one workshop participant articulated, "Trauma gives us the conscience to change"—resilience enabling survival also generates moral imperative for transformation.

Key Conclusions:

Mental health crisis is democracy crisis:
When trauma-affected journalists self-censor, burned-out creators exit platforms, and harassment silences SRHR advocates, information quality degrades. Supporting media professional mental health constitutes democratic infrastructure investment.

Economic risk drives mental health crisis:
Economic risk drives mental health crisis: Financial stress emerged as universal master stressor (75% of media professionals), representing media-specific economic vulnerability compared to Kenya's general working population. 'Black Tax' familial obligations (40%) further amplify pressures.

Barriers emerge from structures:

The 80% stigma prevalence, 70% cost barriers, and geographic scarcity (167 psychiatrists) aren't random obstacles but systematic products of cultural frameworks, economic inequality, and policy neglect. Addressing barriers requires structural reform.

Gender multiplies vulnerabilities:
Women face 70% distinctive mental health risks through sexual harassment, online gender-based violence, maternal discrimination, and pay inequality. Gender-blind interventions miss these amplified vulnerabilities.

Platforms bear responsibility:
Digital platforms' deliberate design choices—engagement-maximizing algorithms, inadequate harassment moderation, opaque monetization—create foreseeable mental health harms. Platform corporations must be held accountable.

Collective action proves most effective:
Peer support's 70% effectiveness combined with calls for association-building demonstrate that connection and solidarity constitute powerful interventions, yet require structural support.

6.2 Evidence-Based Recommendations

These recommendations address RQ1-7 with attention to role-specific implementation (journalists vs. creators, employed vs. freelance). Implementation actors include government agencies, media organizations, professional associations, platforms, universities, and civil society organizations.

Integration is key: Individual interventions alone cannot succeed without organizational, industry, and policy-level changes addressing root causes

6.2.1 Individual Level: Mental Health Literacy and Accessible Services

RECOMMENDATION 1.1 Develop Media-Specific Mental Health Literacy Programming

THE ISSUE

80% stigma prevalence and widespread knowledge gaps about mental health symptoms, treatment options, and help-seeking pathways create barriers even when services exist.

WHAT SHOULD HAPPEN

Professional associations, universities, and training institutions should develop evidence-based education addressing profession-distinctive challenges (trauma processing, deadline stress management, harassment response, algorithmic anxiety) more relevant than generic mental health programming.

SUCCESS INDICATORS

500+ media professionals complete training.

Post-training knowledge scores increase 40%+ on symptom recognition and resource awareness.

25% of participants report increased help-seeking.

IMPLEMENTATION OPTIONS

Workshop-based training, online modules enabling rural access, infographics and quick-reference guides, video content utilizing media professionals' own platforms for peer education.

RECOMMENDATION 1.2 Establish Subsidized Mental Health Services

THE ISSUE

Cost barriers affect 70% of participants, with therapy sessions (KSh 1,500-5,000) prohibitive given economic precarity.

WHAT SHOULD HAPPEN

Psychological societies, private therapists, and potential donors should establish sliding-scale or subsidized therapy access, with recognition that subsidizing sessions to KSh 1,000 ($8 USD) could dramatically increase accessibility.

SUCCESS INDICATORS

100+ media professionals access subsidized services.

80%+ participants complete 6+ sessions.

Self-reported mental health symptom reduction 30%+.

IMPLEMENTATION OPTIONS

Partnership agreements with therapists providing discounted rates; therapist directory specifying specializations, locations, and availability; integration with Huduma Centers for geographic equity; teletherapy enabling rural access; voucher systems protecting privacy while ensuring accountability.

RECOMMENDATION 1.3 Create Accessible Self-Care and Boundary Resources

THE ISSUE

Effective coping strategies (exercise, boundaries, sleep hygiene) prove difficult to implement without practical guidance and accountability.

WHAT SHOULD HAPPEN

Media professionals, peer support groups, and professional associations should collaboratively develop accessible toolkit modules addressing deadline stress management, platform engagement boundaries, trauma exposure protocols, physical health integration, and financial stress coping.

SUCCESS INDICATORS

1,000+ resources distributed.

60% of users report implementing 2+ strategies.

Self-reported boundary-setting improvement 40%+.

IMPLEMENTATION OPTIONS

Participatory design ensuring relevance; distribution through multiple channels (training, social media, WhatsApp groups); peer accountability partnerships ("boundary buddies"); integration with professional association programming.

6.2.2 Organizational Level: Workplace Policies and Institutional Support

RECOMMENDATION 2.1 Advocate for Mental Health Coverage in Employment Insurance

THE ISSUE

Insurance coverage gaps create economic barrier for employed media professionals (45% lack coverage) while freelancers entirely lack employer insurance (85% gap).

WHAT SHOULD HAPPEN

Insurance companies, media employers, regulatory agencies, and professional associations should work toward mental health coverage parity with physical health. Government should establish mental health parity requirements in national insurance schemes.

SUCCESS INDICATORS

5+ media organizations adopt comprehensive mental health insurance coverage.

Regulatory advocacy results in policy reforms.

500+ employed media professionals gain mental health coverage.

IMPLEMENTATION OPTIONS

Document business case for coverage (reduced absenteeism, improved productivity, decreased turnover); engage insurance industry stakeholders; support media organizations in negotiating coverage inclusion; pursue regulatory requirements.

RECOMMENDATION 2.2 Develop and Disseminate Model Newsroom Mental Health Policies

THE ISSUE

Newsrooms' "sympathy gaps" (emotional support without systemic change) reflect absent policies and protocols.

WHAT SHOULD HAPPEN

Media organizations, industry bodies (Media Council of Kenya), and journalists' associations should collaboratively develop and implement newsroom policies addressing trauma debriefing, rotation limits on traumatic coverage, harassment response procedures, workload limits, mental health days, and manager training.

SUCCESS INDICATORS

Model policies developed and validated; 3 newsrooms pilot implementation.

pilot newsrooms report 30% wellbeing improvement and 25% reduced turnover.

10+ additional newsrooms adopt policies.

IMPLEMENTATION OPTIONS

Convene newsroom stakeholders with mental health experts; co-develop evidence-based model policies; document effectiveness through rigorous evaluation; share via industry conferences and professional networks.

RECOMMENDATION 2.3 Facilitate Peer Support Collectives for Isolated Media Workers

THE ISSUE

Peer support's 70% effectiveness combined with freelancers' complete institutional isolation (40% of sample) suggests peer collectives could provide high-impact support at relatively low cost.

WHAT SHOULD HAPPEN

Professional associations and freelance media professionals should self-organize peer support collectives providing emotional support, practical advice-sharing, resource connection, and collective advocacy. Existing organizations (Bloom Group, AMWIK) can mentor emerging collectives.

SUCCESS INDICATORS

5 collectives operational with 150+ active participants.

75% members report reduced isolation.

3+ successful collective advocacy actions.

IMPLEMENTATION OPTIONS

Geographic-based collectives (urban and virtual/rural access); monthly in-person and weekly virtual meetings; resource sharing and opportunity coordination; collective advocacy on shared issues.

6.2.3 Industry Level: Professional Associations and Collective Advocacy

RECOMMENDATION 3.1 **Strengthen Professional Associations & Support New Association Formation**

THE ISSUE

Kenya's media landscape shows association gaps—established journalist associations have limited reach, while digital creators almost entirely lack professional organization.

WHAT SHOULD HAPPEN

Existing and emerging professional associations should expand capacity to serve broader constituencies (freelancers, rural professionals, digital creators) through organizational development, advocacy training, and resource mobilization. Gaps in association coverage should be addressed through new association formation.

SUCCESS INDICATORS

3+ new professional associations registered and operational.

Existing associations expand reach 40%; associations successfully advocate for 2+ policy/industry changes.

500+ media professionals access association services.

IMPLEMENTATION OPTIONS

Assess association landscape and identify gaps; support 2-3 new association formations; provide capacity building for advocacy skills, governance, financial sustainability; facilitate coalition-building and networking.

RECOMMENDATION 3.2 **Campaign for Platform Accountability on Harassment, Algorithm Transparency, and Fair Monetization**

THE ISSUE

Platform-generated mental health harms (70% harassment, 60% algorithmic anxiety) stem from corporate design choices prioritizing profit over wellbeing. Individual coping cannot overcome structural platform policies.

WHAT SHOULD HAPPEN

Professional associations, civil society organizations, media professionals, and policymakers should collectively advocate for platform accountability including: transparent harassment moderation with human review and rapid response, algorithm transparency with creator impact notifications, and fair monetization with stable criteria and appeal mechanisms.

SUCCESS INDICATORS

Platform accountability coalition formed with 10+ member organizations.

Policy demands publicly released and covered by media; direct negotiations with 2+ platforms on policy improvements.

Measurable harassment reduction or algorithm transparency improvement.

IMPLEMENTATION OPTIONS

Document platform harms through research; build multi-stakeholder coalition; develop specific policy demands per platform; deploy advocacy tactics (public campaigns, regulatory complaints, international pressure, shareholder engagement); build on global tech accountability precedents.

6.2.4 Policy and Societal Level: Regulatory Reform and Service Expansion

RECOMMENDATION 4.1 Advocate for Decentralized Mental Health Services Across Kenya's 47 Counties

THE ISSUE

167 psychiatrists concentrated in Nairobi creates geographic barrier affecting 65% of potential patients, with rural media professionals facing acute isolation from services.

WHAT SHOULD HAPPEN

Ministry of Health, county health departments, and advocacy organizations should prioritize mental health service decentralization through: psychiatrist/psychologist positions in county hospitals; counselor availability in primary health clinics; teletherapy infrastructure; task-shifting training for general healthcare providers; workforce expansion scholarships.

SUCCESS INDICATORS

Ministry of Health adopts mental health decentralization as Universal Health Coverage priority.

3 pilot counties establish functional services with 20+ trained providers.

500+ patients access county-based mental health care; model disseminated to all 47 counties.

IMPLEMENTATION OPTIONS

Engage Ministry of Health emphasizing economic benefits of healthier workforce; advocate for mental health integration into county services and Huduma Centers; support task-shifting models; pilot in 3 counties demonstrating feasibility.

RECOMMENDATION 4.2 Integrate Mental Health Content Into Media and Journalism Curricula

THE ISSUE

Education system gaps leave media graduates unprepared for work's mental health demands.

WHAT SHOULD HAPPEN

Universities, training institutions, and journalism associations should integrate mental health units into curricula covering symptoms recognition, treatment options, profession-specific coping strategies, and stigma reduction.

SUCCESS INDICATORS

10+ institutions adopt mental health units.

Graduates report increased mental health preparedness.

Curriculum becomes standard industry expectation.

IMPLEMENTATION OPTIONS

Curriculum working groups with clinicians and media professionals; integrate into existing courses or standalone modules; normalize mental health discussions as occupational preparation.

RECOMMENDATION 4.3 Strengthen Enforcement of Cybercrime Act Provisions Against Online Harassment

THE ISSUE

Kenya's Cybercrime Act (2018) prohibits online harassment yet enforcement remains weak.

WHAT SHOULD HAPPEN

Director of Public Prosecutions, National Police Service, Judiciary, and civil society organizations should: build law enforcement/judicial capacity on Cybercrime Act provisions and digital evidence; establish streamlined reporting mechanisms; provide victim support; support test cases establishing prosecution precedent; conduct public awareness campaigns.

SUCCESS INDICATORS

100+ law enforcement and judicial officers trained.

Streamlined reporting portal operational with 50+ complaints filed.

3 successful test case prosecutions; 25% reduction in harassment frequency reported by media professionals.

IMPLEMENTATION OPTIONS

Capacity building for law enforcement and judiciary; online harassment reporting portal; victim support services; public awareness campaigns demonstrating legal protections.

6.3 Monitoring and Evaluation Framework

Implementation should include systematic monitoring tracking: Mental health literacy (percentage trained, knowledge gains), mental healthcare access (voucher utilization, therapy completion), stigma reduction (belief/behavior change), peer support network growth, policy adoption, and self-reported wellbeing improvements.

Data collection should employ mixed methods: quarterly surveys, program utilization data, policy documentation, annual evaluation, and participatory assessment with beneficiaries.

Evaluation should assess: equity of reach (rural/urban, gender, role, economic status), intervention quality and cultural appropriateness, effectiveness ranking, unexpected consequences, and sustainability prospects.

6.5 Expected Outcomes and Impact

If implemented comprehensively, recommendations could achieve:

30%+
IMPROVEMENT IN MENTAL HEALTH SYMPTOMS
30%+ improvement in anxiety, depression, burnout among participants

25–40%
INCREASE IN HELP SEEKING
25-40% increase in professional mental health service utilization

35%
REDUCTION IN STIGMA
35% reduction in stigma preventing help-seeking

30+
ORGANISATIONS
30+ media organizations adopt mental health policies

3+
NEW ASSOCIATIONS
3+ new associations formed, 40% reach expansion for existing ones

INSURANCE PARITY
Mental health insurance parity, curriculum standards, Cybercrime Act enforcement improvements

BETTER PROFESSIONAL WELLBEING
Sustainable support systems enabling long-term career viability

IMPROVED INFORMATION QUALITY
Improved information quality and diversity through journalist mental health support

6.5 Expected Outcomes and Impact

The study documents Kenya's media professionals' mental health crisis while celebrating their resilience and charting evidence-based pathways forward. The evidence is clear: crisis is real; barriers are structural; effective solutions exist; implementation is feasible; expected outcomes are substantial.

The choice is not whether to act but how ambitiously. Minimal interventions will help dozens; comprehensive approaches combining direct services with structural advocacy can transform Kenya's media ecosystem.

As one workshop participant declared: "Trauma gives us the conscience to change." the study has documented the trauma extensively.

Implementation of these recommendations rests with government agencies, media organizations, professional associations, platforms, civil society organizations, and media professionals themselves to exercise that conscience toward justice and sustainable wellbeing.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