

**DISCLOSURE AS AN INTERPERSONAL
COMMUNICATION STRATEGY IN DEPRESSION
MANAGEMENT AMONG UNIVERSITY STUDENTS IN
KENYA**

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**DOCTOR OF PHILOSOPHY IN
MASS COMMUNICATION**

**JOMO KENYATTA UNIVERSITY
OF
AGRICULTURE AND TECHNOLOGY**

2026

**Disclosure as an Interpersonal Communication Strategy in
Depression Management among University Students in Kenya**

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**A Thesis Submitted in Partial Fulfilment of the Requirements for
the Degree of Doctor of Philosophy in Mass Communication of the
Jomo Kenyatta University of Agriculture and Technology**

2026

DECLARATION

This thesis is my original work and has not been presented for a degree in any other university.

Signature..... Date.....

Lilian Wamuyu Mwangi

This thesis has been submitted for examination with my approval as the University Supervisor

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DEDICATION

This work is dedicated to my children: Lindsay, Leslie, and Jakes, whose precious playtime was sacrificed to support the completion of this project.

ACKNOWLEDGEMENT

I am grateful to the Almighty God for granting me the strength, wisdom, and grace to complete this research. His guidance has been a constant source of inspiration and resilience throughout this journey.

I would like to express my sincere appreciation to my supervisors, Prof. Hellen K. Mberia and Dr. John Ndavula, for their unwavering support, dedication, and intellectual insights, which were invaluable in shaping this thesis. I am fortunate to have had the privilege of working with such esteemed mentors, whose guidance and encouragement were instrumental in my academic development. Special gratitude to Prof. Fr. Lawrence Njoroge for his consistent encouragement and prayers throughout the journey.

To my family: Dad, Mum, Esther and Shad, your unwavering moral and spiritual support provided me with the strength and stability required to navigate this journey. To my friends, Timothy Muchiri, Mary Mbirua, and Elijah Mbirua, your moral support, and constant push to finish this work was pivotal in keeping me focused and motivated. I am truly blessed to have such an amazing system.

I also wish to acknowledge my colleagues: John Wandaga, Asmahan, Dr. Mary Wachira, and Dr. Rosana, for their insightful assistance and support in refining this work. To Nge'ndo and Roselyne for always willingly assisting to print and bind my documents whenever I needed that kind of support. Special thanks to Steve Buist for his meticulous review of the thesis and guidance in the data collection procedure; and to the office of the Dean of Students; Prof. John Githiri, Counselor Joseph Mwangi and his team of counselors including Monica, for their assisting with the data collection.

Finally, I extend my gratitude to all those who supported me, whether through kind words, encouragement, or their belief in my abilities. Your contributions have made this achievement possible, and I am deeply thankful for your support throughout this journey.

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ABBREVIATIONS AND ACRONYMS

ACHA	American College Health Association
APA	American Psychological Association
COVID-19	Coronavirus Disease of 2019.
CPM	Communication Privacy Model
CPM	Communication privacy management theory
DDM	Disclosure-Decision Model
DSMMD	Diagnostic and Statistical Manual of Mental Disorders
HHS	Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act
IPT	Interpersonal psychotherapy
LMICs	Low- and Middle-Income Countries
MOH	Ministry of Health
NACOSTI	National Commission of Science, Technology and Innovation
OSNs	Online Social Networks
SPT	Social Penetration Theory
WHO	World Health Organization

DEFINITION OF OPERATIONAL TERMS

- Anhedonia** The inability to experience pleasure or enjoyment from activities that are typically found enjoyable or rewarding. This term is often used in psychological and psychiatric contexts to describe a symptom of various mental health conditions, particularly depression. (Merriam-Webster, 2024)
- Anxiety** According to the Diagnostic and Statistical Manual of Mental Disorders DSMMD (1980), Anxiety may be defined as apprehension, tension, or uneasiness that stems from the anticipation of danger, which may be internal or external. According to the American Psychological Association [APA], (2022), Anxiety is an emotion characterized by feelings of tension, worried thoughts, and physical changes like increased blood pressure
- Depression** Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. The common features of all the depressive disorders are sadness, emptiness, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function (World Health Organization, 2017)
- Interpersonal communication** Interpersonal communication is the process of exchange of information, ideas and feelings between two or more people through verbal or non-verbal methods. (Hartley, 2002).
- Interpersonal psychotherapy** Interpersonal psychotherapy (IPT) is a time-limited, focused, evidence-based approach to treat mood

disorders. The main goal of IPT is to improve the quality of a client's interpersonal relationships and social functioning to help reduce their distress (Bleiberg & Markowitz, 2019).

Self-disclosure

Self-disclosure is an aspect of communication that involves intentionally sharing personal information about ourselves with another person—information that others generally could not know without us sharing it (Robinson, 2017)

Therapist self- disclosure

Therapist Self-Disclosure is the revealing of a therapist's feelings, thoughts or personal information to a client (Johnsen & Ding, 2021).

ABSTRACT

Depression and anxiety are pervasive issues affecting college students globally. Over the past decade, media coverage has spotlighted the psychological struggles of this demographic, highlighting tragic events such as school shootings, suicides, alcohol abuse, and sexual assaults. In Kenya, studies indicate that over 40% of university students exhibit depressive symptoms, underscoring the urgency of addressing this issue. Depression significantly contributes to the global burden of disease, impacting communities worldwide at social, economic, and clinical levels. Despite the existence of evidence-based strategies, such as interpersonal psychotherapy, which relies heavily on communication between therapists and patients, the prevalence of depression and associated suicides among students continues to rise. This study explored the role of disclosure as an interpersonal communication strategy in managing depression among university students in Kenya. Specifically, it examined the effects of self-disclosure, disclosure by others, and therapist disclosure on depression management, while also considering the moderating influence of socio-demographic factors. Employing a mixed-methods research design, the study combined quantitative and qualitative approaches. A sample of 384 students was systematically selected from a population of 44,000 students at JKUAT (Jomo Kenyatta University of Agriculture and Technology), focusing on those who had attended counseling sessions. Additionally, four counselors from the university were conveniently selected to provide qualitative insights. The study found that self-disclosure significantly contributed to better depression management, with students reporting improved emotional well-being through open communication about their struggles. Furthermore, disclosure by others and reciprocal sharing of personal experiences also played a crucial role in providing emotional support and fostering a culture of openness. Socio-demographic factors, such as gender and socio-economic status, were found to moderate the effectiveness of these disclosure strategies, with female students being more likely to engage in self-disclosure than their male counterparts. Based on the findings of this study, several recommendations are made to improve the management of depression among university students, with a focus on disclosure practices and the role of social demographic factors. Universities should promote environments that encourage self-disclosure, offer peer counseling programs

to facilitate therapist disclosure, and develop personalized mental health support systems tailored to the diverse needs of students, considering factors like age, gender, culture, religion, and personality. These strategies would help students manage depression more effectively through open, reciprocal sharing in safe and supportive environments. Additionally, areas for further research include exploring other interpersonal communication strategies such as emotional expression, active listening, and support-seeking behaviors. Future studies should also examine the role of social support networks, including family, peers, and counselors, in shaping depression management strategies. Comparative studies across different student populations and cultural contexts could provide a broader understanding of how contextual factors influence the effectiveness of disclosure practices. Longitudinal research could further explore the long-term impact of disclosure practices on mental health and coping strategies.

CHAPTER ONE

INTRODUCTION

1.1 Introduction

This chapter includes the background of the study, highlighting the global, regional and local perspectives of depression management among university students. It also entails the statement of the problem, objectives, research questions, significance of the study, scope and limitations of the study.

1.2 Background of the Study

Depression is a prevalent and debilitating mental health condition that affects millions of individuals worldwide, contributing significantly to emotional, cognitive, and physical impairment. It is not merely a transient feeling of sadness but a complex disorder that interferes with daily functioning and overall well-being. According to the World Health Organization (WHO, 2021), approximately 280 million people globally are affected by depression, making it one of the leading causes of disability. Among university students, depression is particularly concerning due to the unique stressors associated with this critical developmental stage, including academic pressures, financial instability, social isolation, and uncertainty about the future (Dyrbye, Thomas, & Shanafelt, 2006). Depression is a pervasive and debilitating mental health disorder that impairs emotional, cognitive, and physical functioning, significantly reducing quality of life. It is characterized by persistent sadness, loss of interest or pleasure in most activities, fatigue, difficulty concentrating, and disturbances in sleep and appetite (American Psychiatric Association [APA], 2013). Globally, depression remains a leading cause of disability, affecting an estimated 280 million people, with a disproportionate burden in low- and middle-income countries (World Health Organization [WHO], 2021).

Among university students, depression presents a critical concern due to the complex interplay of psychosocial stressors typical of this transitional life stage. These stressors include academic demands, financial instability, separation from familial

support structures, social isolation, and uncertainty about future career prospects (Dyrbye, et al., 2006; Ibrahim, Kelly, Adams, & Glazebrook, 2013). The university context, while developmentally enriching, often poses heightened psychological risks, making students vulnerable to mental health disorders, particularly depression.

Increased academic competitiveness, performance pressures, and identity formation challenges have led to elevated rates of depressive symptoms within university populations globally. Numerous studies have documented a growing trend of mental health concerns in tertiary institutions, including rising levels of stress, anxiety, and depressive disorders (Eisenberg, et al., 2013). Despite the growing prevalence of these issues, many students do not seek help due to stigma, fear of social judgment, or limited access to mental health services; barriers that highlight the importance of effective interpersonal communication and supportive disclosure environments in facilitating care and intervention.

Disclosure, which is defined as the voluntary sharing of personal, often sensitive information, is central to mental health recovery, as it mediates access to social support and professional care. Within interpersonal communication theory, particularly Communication Privacy Management (CPM) theory, disclosure is seen as a negotiated process influenced by perceived risks and benefits (Petronio, 2010). For students experiencing depression, disclosure to peers, family, or professionals may serve as a pivotal step toward coping, therapeutic engagement, and psychological relief.

However, in many cultural contexts, especially within sub-Saharan Africa, social norms and stigma inhibit open conversations about mental health. This cultural silencing, coupled with institutional inadequacies, creates a significant gap in early identification and management of depression among university students. Understanding the role of disclosure in such environments, and how it functions as an interpersonal communication strategy, is thus imperative to designing responsive mental health interventions.

1.1.1 Global Perspective

Across the globe, depression and anxiety disorders have emerged as critical challenges in higher education, with universities reporting an alarming surge in mental health concerns among students. A global synthesis of empirical data confirms a significant and growing prevalence of depressive symptoms among university students, with meta-analyses indicating rates ranging from 20% to over 30% in various contexts (Ibrahim, et al., 2013; Rotenstein et al., 2016). This upward trend has raised substantial concern among educators, mental health practitioners, and policy-makers alike, prompting calls for more systemic approaches to student mental health support.

University counseling centers across North America and Europe have reported a marked increase in both the volume and severity of student mental health cases since the 1980s (Gallagher, 2014; Xiao, Carney, Youn, Janis, Castonguay, Hayes, & Locke, 2017). Common concerns include chronic depression, suicide ideation, self-harm, substance abuse, and interpersonal difficulties. The American College Health Association (ACHA, 2021) has observed that more than 40% of college students report feeling so depressed that it is difficult to function, with suicide remaining a leading cause of death among university-aged individuals in many parts of the world (WHO, 2021).

This mental health crisis has also attracted widespread media and institutional attention, particularly in relation to catastrophic events such as campus suicides, substance-related deaths, and violence, events often linked to untreated or undiagnosed mental illnesses (Kadison & DiGeronimo, 2004; Schwartz, 2006). A longitudinal analysis by the National Survey of Counseling Center Directors in the United States documented over 1,400 student suicides over a 14-year period, with the majority of these cases linked to depressive disorders (Schwartz, 2006).

The psychosocial challenges faced by university students are intensified during the transition from adolescence to early adulthood. This life phase is characterized by identity formation, increased autonomy, and exposure to new cultural and academic environments (Arnett, 2000). For many students, this transition is fraught with

anxiety and emotional vulnerability, especially when accompanied by academic pressures, financial strain, and weakened support systems. Jones, Park, & Lefevor, (2018), note that such developmental disruptions can significantly impair emotional regulation, interpersonal relationships, and academic functioning, thereby increasing the risk of depression.

Despite the global nature of this phenomenon, students' willingness and ability to disclose mental health struggles remains inconsistent, largely due to stigma, lack of trust, and cultural inhibitions. Research has emphasized the need for safe interpersonal environments where students can disclose psychological distress without fear of judgment or reprisal (Rickwood, Deane, Wilson, & Ciarrochi, 2005). In this regard, interpersonal communication, particularly supportive disclosure, is increasingly recognized as a critical mechanism for early intervention and emotional support.

As such, the global mental health crisis among university students necessitates not only structural interventions such as access to therapy and institutional support, but also an enhanced understanding of how communication strategies like disclosure can facilitate help-seeking and resilience in academic settings.

1.1.2 Regional Perspective

Depression among university students in sub-Saharan Africa presents a growing but under-addressed public health concern. The region is characterized by limited mental health infrastructure, widespread cultural stigma, and a paucity of research specific to student populations in higher education (WHO, 2017; Othieno, Okoth, Peltzer, Pengpid, & Malla, 2014). Recent meta-analyses indicate that approximately 26–27% of university students in Africa report symptoms of depression, with significant variation across national contexts (Asante & Andoh-Arthur, 2015; Peltzer & Pengpid, 2015).

Cultural beliefs play a substantial role in shaping attitudes towards mental health in the region. In many African societies, psychological distress is often attributed to spiritual or moral failure rather than being understood as a medical or psychological

condition. For example, in Nigeria, beliefs associating mental illness with witchcraft or divine punishment have been shown to influence public attitudes, contributing to stigma and the marginalization of affected individuals (Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005). Similarly, in Tanzania, studies have found that over 80% of respondents were unwilling to associate with people who have mental illnesses, revealing deep-rooted prejudices that deter disclosure and help-seeking (Sambasivan, Maharaj, & Ndlovu, 2022).

This sociocultural environment discourages emotional expression and often leads students to suffer in silence. Disclosure of depressive symptoms is widely perceived as a sign of weakness, particularly in communities that place high value on resilience and stoicism (Atilola, 2015). As a result, students may avoid seeking help, fearing judgment, social exclusion, or being labeled as mentally unstable. This pattern is observed across several African countries, including Ghana, Malawi, Uganda, and Kenya, where cultural taboos around mental illness persist despite increasing awareness (Musisi & Kinyanda, 2020; Othieno et al., 2014).

Resource limitations further worsen the situation. Sub-Saharan Africa has some of the lowest ratios of mental health professionals per capita globally. For instance, Malawi is reported to have only one psychiatrist for every two million people (World Health Organization, 2017). In Uganda and Nigeria, although mental health policies exist, implementation is fragmented, and mental health services are largely centralized in urban hospitals, limiting accessibility for students in rural or peri-urban university campuses (Kaggwa, Mamun, Najjuka, Kaoma, Sserunkuma, Kajjimu, Muwanguzi, Malinga, Rukundo, & Bongomin, 2022). University counseling services, where they exist, are typically understaffed and lack adequate funding to meet student needs (Asante & Andoh-Arthur, 2015).

In South Africa, a relatively more developed context, mental health support structures such as university counseling centers have been established, but these still face high demand and limited capacity. A study conducted by Herman et al. (2019) revealed that nearly one in four university students in South Africa experiences symptoms of depression, yet the majority do not access formal mental health services

due to stigma and logistical barriers. Similar trends have been documented in Ghana and Nigeria, where students often turn to informal support systems such as religious leaders, family members, or traditional healers rather than mental health professionals (Asante, & Andoh-Arthur, 2015; Atilola, 2015).

This regional context reveals a confluence of cultural, structural, and institutional barriers that limit effective identification and management of depression among university students. These conditions present a unique challenge for mental health interventions and point to the need for culturally sensitive strategies that promote disclosure, reduce stigma, and improve access to care. Within this framework, disclosure as an interpersonal communication strategy holds particular relevance, as it intersects with the cultural and social dynamics that shape how mental health is experienced and managed in African settings.

1.1.3 Local Perspective

In Kenya, depression among university students has emerged as a significant public health concern, particularly affecting academic functioning and psychological well-being. A cross-sectional study conducted at the University of Nairobi, involving 923 undergraduate students, found that 35.7% reported moderate depressive symptoms and 5.6% reported severe symptoms. These symptoms were notably higher among first-year students, those experiencing financial hardship, and students residing off-campus (Othieno et al., 2014).

Suicidal behaviors among Kenyan university students compound the severity of the local mental health burden. A recent study in two Kenyan universities reported a 17.1% prevalence of suicidal ideation, with 5.9% having made suicide plans and 7.8% having attempted suicide (Mutwiri, Wambugu, Kinuthia, & Gachenia, 2023). Risk factors included depression, financial difficulties, academic stress, hopelessness, and loneliness (Mutwiri et al., 2023). These findings align with other investigations that have identified depression as the leading psychological driver of suicidal ideation and attempts in Kenyan universities (Wanyoike, 2015).

Despite the alarmingly high rates of psychological distress and suicidal behaviors, efforts to address them within Kenyan higher education remain inadequate. Surveys suggest that upwards of 60% of university students experience mental health issues, yet the majority rely on informal coping mechanisms rather than professional counseling (Nyagwencha & Ojuade, 2021; Sibanda, Muturi, & Ng'ang'a, 2023). Mental health services remain under-resourced; for instance, Mathari National Teaching, Referral and Teaching Hospital serves as the country's only major psychiatric hospital indicating severe service scarcity for student populations.

Cultural stigma and legal frameworks further hinder students' willingness to seek help. Until recently, attempted suicide was criminalized under Kenyan law, perpetuating social censorship and discouraging open discussion. However, the High Court's January 2025 ruling decriminalizing attempted suicide marks a critical shift towards destigmatization and may improve disclosure and help-seeking behavior (The Guardian, 2025). Despite this progress, university counseling infrastructure remains limited, and awareness campaigns, while present, do not always provide sustained psychosocial support or training to help peers recognize and respond to distress effectively (Othieno et al., 2014; Sibanda et al., 2023).

These data illustrate a pressing need for comprehensive mental health strategies within Kenyan universities, ones that prioritize safe interpersonal disclosure, responsive counseling services, and targeted interventions. This study's focus on disclosure as an interpersonal communication strategy is therefore especially pertinent: facilitating structured and culturally affirming disclosure could play a vital role in bridging the gap between students experiencing distress and access to professional support.

A study by Othieno, et al. (2014) revealed high levels of depression and anxiety among Kenyan university students, with academic pressures, financial instability, and social isolation cited as primary stressors. The Kenya Mental Health Taskforce (Republic of Kenya, 2020), highlighted similar findings, emphasizing the pervasive societal stigma surrounding mental health issues and the inadequacy of counseling services within universities (Munyua, 2018). While recent efforts have introduced

mental health awareness campaigns and limited counseling programs, these initiatives remain insufficient to address the rising demand for mental health support (Muthoni, 2020).

Factors such as academic stress, financial instability, and social isolation significantly contribute to depression among university students. Academic stress arises from the pressure to excel academically while balancing multiple responsibilities. The transition from high school to university amplifies this stress, as students face increased academic demands and diminished support structures (Dyrbye et al., 2006). Financial instability further exacerbates the issue, with many Kenyan students relying on loans or family support to finance their education.

Social isolation is another critical factor influencing depression among university students. The disconnection from family support networks, difficulties in forming meaningful peer relationships, and feelings of loneliness are common during university life. Studies in African contexts, such as those by Musisi et al. (2014), highlight the crucial role of social support in mitigating depressive symptoms, underscoring the detrimental effects of isolation. These challenges are often magnified by societal expectations that students should independently manage their emotional well-being, discouraging them from seeking help (Pritchard, Wilson & Yamnitz, 2007).

Symptoms of depression among university students manifest in emotional, cognitive, and physical domains. Emotionally, students may experience persistent sadness, hopelessness, and a lack of interest in previously enjoyable activities. Cognitive impairments, including difficulties with concentration and decision-making, can hinder academic performance and exacerbate feelings of failure (Muthoni, 2020). Physical symptoms such as fatigue, sleep disturbances, and changes in appetite are also common, further disrupting students' daily functioning (American Psychiatric Association, 2013).

1.1.4 Depression Management: The Role of Interpersonal Communication

Depression is a complex and pervasive mental health condition that demands multifaceted management strategies. Across global and local contexts, the approaches to managing depression vary widely, shaped by cultural, institutional, and resource-based factors. Various approaches have been developed to manage depression, ranging from pharmacological treatments to psychological interventions and community-based strategies. Cognitive-behavioral therapy (CBT), antidepressant medication, mindfulness-based interventions, and psycho-education remain widely used, particularly in high-income countries with well-developed health systems (Cuijpers, Karyotaki, Weitz, Andersson, Hollon, van Straten, & Ebert, 2013; National Institute for Health and Care Excellence [NICE], 2009). Increasingly, task-shifting models and low-intensity psychological interventions are being employed in low- and middle-income countries (LMICs), where mental health specialists are scarce (Patel, Chowdhary, Rahman, & Verdeli, 2011; Van Ginneken, Tharyan, Lewin, Rao, Meera, Pian, & Patel, 2013).

Peer support programs, university counseling centers, online therapy platforms, and helplines have also been introduced as flexible and scalable interventions for students. For example, many universities across Africa have begun implementing mental health awareness campaigns and limited counseling services (Muthoni, 2020). However, despite these efforts, access remains inconsistent, and the quality of services often falls short of meeting the growing demand, especially among young adults navigating the high-stress university environment.

One evidence-based psychological intervention that has shown promise in the management of depression is interpersonal psychotherapy (IPT). IPT is a time-limited, structured form of talk therapy that focuses on resolving interpersonal problems and building social skills to reduce depressive symptoms (Norcross & Lambert, 2011). The therapy is grounded in the idea that interpersonal relationships and life events significantly impact mood and that improving these relationships can relieve symptoms of depression.

IPT typically targets one or more problem areas, such as grief, role transitions, interpersonal disputes, or social deficits. It has been effectively adapted for diverse populations, including adolescents, university students, and individuals in LMICs. By enhancing communication patterns and social support networks, IPT aims to foster emotional resilience and promote functional coping strategies, making it especially relevant for university students who face multiple psychosocial stressors.

A central mechanism within IPT, and in broader depression management, is disclosure, the act of sharing personal, emotionally salient information with others. According to Communication Privacy Management (CPM) theory, disclosure is not merely about revealing the self, but about negotiating boundaries and co-managing private information with others (Petronio, 2010). This process plays a fundamental role in both diagnosis and treatment, as individuals must articulate their internal states to access help and receive appropriate support.

Disclosure enhances therapeutic relationships, encourages social support, and promotes self-awareness. In peer and family contexts, open disclosure facilitates empathy, validation, and the reduction of social isolation, which are protective factors against depression (Derlega, Winstead, Mathews, & Braitman, 2001; Vogel, Wade, & Hackler, 2007). Yet, disclosure is a complex process influenced by cultural norms, perceived stigma, and relational dynamics (Petronio, 2010). Where supportive relationships exist, disclosure tends to foster healing; in unsupportive or judgmental environments, it may result in emotional withdrawal or further distress (Chaudoir & Fisher, 2010).

The role of interpersonal communication more broadly cannot be overstated. Thompson and Parrott (1994) argue that effective interpersonal communication in health contexts affects a range of outcomes, from immediate responses such as satisfaction and understanding, to long-term effects like treatment adherence and symptom reduction. Communication is inherently transactional, shaping not only the content of health encounters but also the emotional tone and relationship dynamics that sustain mental health recovery.

Despite the existence of effective interventions, significant barriers continue to undermine the management of depression, especially in LMICs. As highlighted by the World Health Organization (WHO, 2017), key impediments include a lack of trained healthcare providers, inadequate funding for mental health services, and pervasive societal stigma surrounding mental illness. These structural deficits result in a lack of access to early diagnosis and timely care.

Diagnostic inaccuracies remain a serious issue: individuals suffering from depression are often misdiagnosed, while others who do not meet diagnostic criteria are prescribed medication unnecessarily. This misalignment not only delays recovery but also reduces trust in mental health services. Furthermore, the cultural reluctance to discuss emotional issues openly impedes the use of interpersonal strategies such as disclosure, which are central to both IPT and general mental health communication.

In light of the multifaceted nature of depression and its profound effects on university students, it is evident that effective management must go beyond pharmacological treatments and incorporate psychosocial approaches rooted in interpersonal dynamics. Interpersonal communication, particularly through strategic disclosure within therapeutic and social contexts, plays a vital role in enhancing mental health outcomes. However, the success of such strategies is often mediated by cultural attitudes, stigma, and availability of supportive relationships or systems. Understanding how disclosure functions as a tool within interpersonal communication frameworks, especially in the context of student populations in low- and middle-income countries, therefore remains a critical area of inquiry. This study investigated this intersection, with a focus on university students navigating depression within such environments.

1.3 Statement of the Problem

Depression is a prevalent mental health concern among university students in Kenya, significantly impacting academic performance, social relationships, and overall well-being. A study conducted at the University of Nairobi revealed that 35.7% of students exhibited moderate depressive symptoms, while 5.6% experienced severe depression. First-year students, those who were economically disadvantaged, and

students living off-campus were particularly vulnerable (Othieno et al., 2014). Further research at the Technical University of Mombasa indicated an even higher prevalence, with 57.7% of students reporting depressive symptoms. Contributing factors included family dynamics, academic pressures, environmental stressors, and economic challenges (Otieno et al., 2024).

Among university students in Kenya, the interplay of academic pressures, social expectations, and limited access to mental health resources has created an environment conducive to depression. Studies show that young individuals with poor-quality interpersonal relationships experience heightened levels of social anxiety and depression (La Greca & Harrison, 2005). Furthermore, the gap between ideal and actual social connections, or loneliness, mediates the relationship between interpersonal relationships and depressive symptoms, often worsening mental health outcomes (Boivin & Hymel, 2006).

The severity of this issue is highlighted by the high rates of suicidal behavior among students. A web-based survey found that 60.9% of undergraduate students in Kenya exhibited suicide behaviors, including ideation, planning, and attempts. The prevalence was highest among students aged 20-22, females, and those attending public universities (Ambayo, Karume, & Kihara, 2021).

While peer support networks and professional interventions such as interpersonal psychotherapy show promise, little research has been done to evaluate the impact of self-disclosure and its reciprocity on depression management in this demographic. Understanding these dynamics is essential for developing culturally relevant interventions that can improve mental health outcomes and prevent further loss of life.

This study, therefore, sought to analyze the effect of disclosure as an interpersonal communication strategy in the management of depression among university students in Kenya. By examining the effect of self-disclosure, reciprocity, and the moderating role of demographic factors such as age, gender, and personality, the study aimed to provide actionable insights for improving mental health outcomes and mitigating the alarming rise in suicide cases within this population.

1.4 Objectives

1.3.1 General Objective

To determine the effect of disclosure as an interpersonal communication strategy in depression management in university students in Kenya.

1.3.2 Specific Objectives

1. To evaluate the effect of self-disclosure on managing depression in university students in Kenya.
2. To determine the effect of disclosure-by-others on depression management in university students in Kenya.
3. To examine the effect of therapist disclosure on depression management in university students in Kenya.
4. To analyze the moderating effect of socio-demographic factors on the relationship between disclosure and depression management among university students in Kenya.

1.5 Research Questions

- 1 What is the effect of self-disclosure on managing depression in university students in Kenya?
- 2 What is the effect of disclosure by others on depression management in university students in Kenya?
- 3 What is the effect of therapist disclosure on depression management in university students in Kenya?
- 4 What are the moderating effect of socio-demographic factors on the relationship between disclosure and depression management in university students in Kenya?

1.6 Significance of the study

This study was motivated by the alarming rise in cases of depression and its adverse effects, including increasing suicide rates, particularly among university students.

These issues have become a critical public health challenge requiring targeted interventions.

Addressing the Burden of Depression and Suicide

The study responds to the global and national demand for actionable solutions to combat depression and its severe outcomes, such as suicide. Depression management aligns with global efforts such as the World Health Assembly's call for addressing mental health issues (WHO, 2012). The study will contribute to this agenda by providing insights and actionable recommendations to curb depression and enhance mental health management in Kenya, aligning with the Sustainable Development Goals (SDG) on health and well-being.

Testing Theoretical Frameworks on Interpersonal Relationships

This study sought to examine and test existing theories on interpersonal relationships, such as Communication Privacy Management (CPM) theory, to understand how attributes like self-disclosure influence relationships and contribute to depression management. By identifying how interpersonal communication strategies affect mental health outcomes, the study provides evidence-based approaches for addressing depression.

Benefits to Institutions of Higher Learning

Institutions of higher learning, particularly universities, will benefit significantly from this study. The findings will offer insights into effective strategies for managing depression among students, enabling universities to create conducive environments that eliminate stressors and reduce the stigma associated with seeking mental health help. The study will also inform the development of comprehensive mental health policies that promote collaboration among students, families, lecturers, and counselors to support students struggling with depression.

Empowering Students

University students, who are directly affected by depression, are key beneficiaries of this study. The findings will help them understand how self-disclosure and reciprocal communication can be used as effective strategies to manage depression. Students will also gain awareness of available resources and the importance of seeking help to improve their psychological well-being.

Enhancing Counseling Practices

Student counselors in universities will benefit from the study's findings by gaining deeper insights into how to establish meaningful relationships with their clients. By leveraging the power of self-disclosure and reciprocal communication, counselors can provide more effective support and contribute to better mental health outcomes among students.

Advancing Mental Health Policy and Universal Healthcare

This study's recommendations will contribute to mapping a path toward addressing mental health issues in Kenya. By proposing strategies that are culturally relevant and tailored to the university context, the findings will support the achievement of universal healthcare, particularly in mental health services, thus contributing to national and global health priorities.

The study's relevance spans academic, social, and policy dimensions, making it a vital contribution to understanding and managing depression among university students in Kenya.

1.7 Scope of Study

This study was geographically confined to Jomo Kenyatta University of Agriculture and Technology (JKUAT), a large public university in Kenya. JKUAT was purposively selected for two principal reasons. First, its proximity to the researcher offered logistical feasibility and consistent access to key stakeholders, which facilitated the data collection process. Second, and more significantly, the university

has been consistently highlighted in national media reports for recurrent cases of student suicides and mental health crises, particularly between 2020 and 2024. Such cases were attributed to academic stress, financial difficulties, and social isolation, making JKUAT a relevant site for exploring mental health dynamics within university settings. Although the study was limited to one institution, JKUAT's mental health landscape mirrors that of other public universities in Kenya. Recent studies, for example, indicate that approximately 60% of university students in Kenya report experiencing mental health problems, including depression (Mutwiri et al., 2023). At the Technical University of Mombasa, 57.7% of students screened positive for depressive symptoms, particularly among final-year students (Otieno et al., 2024). These findings underscore that JKUAT represents a broader mental health crisis affecting public institutions of higher learning in the country.

The theoretical scope of the study was grounded in four key frameworks that guided the conceptualization and interpretation of findings. Social Penetration Theory and the Disclosure Decision-Making Model were used to examine how individuals manage private information and make decisions to disclose. Communication Privacy Management (CPM) Theory helped explore how individuals regulate boundaries around personal information in therapeutic and social contexts. Finally, Hofstede's Cultural Dimensions Theory provided a lens for understanding how cultural values influence disclosure behaviours, particularly in collectivist societies like Kenya.

Methodologically, the study adopted a mixed methods design, combining both quantitative and qualitative approaches. Quantitative data were collected using structured questionnaires administered to students who had received psychological counselling services at the university. This allowed for statistical analysis of the relationship between disclosure and depression management. Qualitative data were gathered through in-depth interviews with university counsellors, providing deeper insights into the nuances of disclosure in therapeutic settings. This mixed approach ensured triangulation of data and enriched the understanding of disclosure as an interpersonal communication strategy in managing depression among university students.

1.8 Limitations of the Study

This study encountered several limitations that may have influenced its scope, methodology, and outcomes. A major challenge was related to accessing eligible respondents, as the inclusion criterion required participants to have attended counselling sessions with the university's student counsellors. Due to ethical and legal restrictions around mental health records, the researcher was not permitted to access patient files or identify participants directly, in line with confidentiality and privacy regulations.

To mitigate this, the study relied on student counsellors to identify and distribute research instruments to qualifying students. While this approach safeguarded respondent anonymity and adhered to ethical standards, it introduced potential bias in respondent selection. The researcher had no direct oversight of the recruitment process and could not independently verify whether all participants met the inclusion criteria. As such, the study was dependent on the integrity and professionalism of the counsellors, and no objective measures were available to control for selection bias. The researcher acknowledges this as a limitation but emphasizes that it was the only ethically viable method available for participant recruitment.

Because of this arrangement, data collection was significantly prolonged, taking approximately eight months to gather a sufficient sample size. This delay stemmed from the need to give counsellors ample time to identify, inform, and engage students in a manner that respected their privacy and availability.

Another limitation was the inability to conduct in-depth interviews with participants. Although such qualitative data could have enriched the study's findings, the sensitive nature of the subject matter and privacy considerations surrounding mental health disclosures rendered direct interviews impractical. This limitation constrained the study to predominantly quantitative data, which, while informative, may not fully capture the complexity of individual experiences with disclosure and depression management.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter consists of a detailed analysis of theories relevant to the study, review of existing literature, review of variables, and an expounded conceptual framework detailing the relationship between the disclosure and depression management.

2.2 Theoretical Framework

This study was informed by the Social Penetration Theory, The Disclosure- Decision Model, The Communication Privacy Management Theory and Hofstede's Cultural Dimensions Theory.

2.2.1 Social Penetration Theory

The Social Penetration Theory (SPT), developed by Altman and Taylor (1973), serves as a foundational framework for understanding the dynamics of relationship development, particularly through the process of self-disclosure. The theory posits that relationships progress systematically from superficial exchanges to deeper, more intimate communication. This progression is highly relevant in the context of depression management, where the gradual sharing of personal information plays a critical role in therapeutic and supportive relationships.

According to SPT, self-disclosure is the cornerstone of relationship development, enabling individuals to move beyond surface-level interactions toward deeper emotional connections (Altman & Taylor, 1973). This concept is particularly significant in therapy and peer support settings, where individuals initially disclose less sensitive information and gradually share intimate details about their emotional struggles as trust is established. The therapeutic alliance relies heavily on this progression, as it fosters mutual understanding and creates a safe space for emotional healing.

The theory further highlights the dual dimensions of breadth and depth in self-disclosure, which are instrumental in mental health interventions. Breadth refers to the range of topics discussed, often beginning with general life experiences or stressors, while depth involves exploring more intimate aspects, such as personal fears, traumas, and coping mechanisms. This duality aligns with therapeutic practices, where conversations initially focus on broader concerns before delving into core emotional issues (Carpenter & Greene, 2016).

The concept of reciprocity, central to SPT, is another critical element in therapeutic and interpersonal contexts. The norm of reciprocity, which suggests that disclosure by one party prompts a reciprocal response from the other, is often employed by therapists to encourage clients to open up. Limited self-disclosure by therapists can foster trust, while reciprocal sharing among peers enhances emotional bonding and reduces stigma. This reciprocity facilitates the creation of a supportive environment conducive to depression management (Sultan & Chaudhry, 2008).

SPT's assertion that relationships develop in a systematic and predictable manner is also relevant in structured therapeutic interventions. Therapy sessions, for instance, are designed to progress through distinct phases, starting with rapport building, advancing to the exploration of personal issues, and culminating in the development of coping strategies. This predictable trajectory provides a sense of security for clients, which is crucial for fostering consistent engagement (Altman & Taylor, 1973).

The theory's recognition of de-penetration, or the regression of relationships, offers valuable insights into potential challenges in therapeutic or supportive contexts. For instance, clients may withdraw from therapy if trust is compromised or if they perceive stigma or judgment. Understanding the potential for relational regression allows mental health practitioners to design interventions that sustain engagement and address relational breakdowns effectively.

The relevance of Social Penetration Theory to this study lies in its ability to explain the dynamics of self-disclosure and relationship development, particularly in the context of managing depression. By elucidating how self-disclosure facilitates trust

and intimacy, SPT provides a theoretical foundation for understanding how supportive interpersonal relationships can aid in the emotional well-being of individuals. The theory's insights into reciprocity, breadth, depth, and relational progression are instrumental in designing interventions that promote open communication and support among university students in Kenya, addressing the challenges of stigma and limited access to mental health resources.

2.2.2 Disclosure-Decision Model (DDM)

The Disclosure-Decision Model (DDM) was proposed by Omarzu (2000) to explain how individuals decide whether to disclose personal information. The model suggests that self-disclosure is not a spontaneous act but rather a deliberate decision-making process influenced by various factors, including motivation, expected outcomes, and situational considerations. According to this model, individuals carefully weigh the potential benefits and risks before choosing to disclose or withhold personal information (Omarzu, 2000).

At the core of the model is the idea that motivation drives disclosure. People choose to share personal information for different reasons, such as seeking emotional support, strengthening relationships, or gaining social validation. In some cases, disclosure serves as a way to express emotions and achieve psychological relief. However, before revealing personal details, individuals engage in a risk-benefit analysis, where they evaluate the potential advantages, such as receiving empathy and assistance, against possible drawbacks, including rejection, judgment, or loss of privacy (Omarzu, 2000).

Once the risks and benefits have been assessed, individuals select a disclosure strategy that best suits their situation. Some may opt for full disclosure, openly sharing all relevant information, while others might choose selective disclosure, revealing only parts of their story. In some cases, people decide on non-disclosure, keeping their information private when the risks seem too high. After disclosure occurs, the individual then evaluates the recipient's response. A positive reaction, such as understanding and support, encourages further disclosure in the future, while

a negative reaction, such as dismissal or criticism, discourages openness and may reinforce secrecy (Omarzu, 2000).

One of the strengths of the Disclosure-Decision Model is that it realistically captures the complexity of self-disclosure by emphasizing the role of rational decision-making. It also acknowledges the influence of social context, recognizing that disclosure decisions are shaped by the trustworthiness of the recipient, cultural norms, and the environment in which disclosure takes place. Additionally, the model is widely applicable in areas such as mental health, counseling, workplace communication, and healthcare, where self-disclosure plays a critical role in support-seeking and relationship-building (Omarzu, 2000).

Despite its strengths, the model has some limitations. It assumes that people always make rational decisions about disclosure, yet in reality, emotions often drive individuals to share personal information impulsively. Additionally, the model does not fully account for how cultural factors influence disclosure decisions, particularly in societies where discussing personal struggles is stigmatized. Furthermore, it primarily focuses on the immediate disclosure process rather than examining how repeated disclosure affects relationships and mental health over time (Omarzu, 2000).

The model is based on several key assumptions. First, it assumes that individuals are rational decision-makers who carefully weigh their options before sharing personal information. It also posits that disclosure is goal-driven, meaning individuals disclose information for specific reasons, such as emotional relief or social connection. Additionally, the model assumes that social context influences disclosure, as individuals consider factors like trust, confidentiality, and potential consequences before revealing personal details. Finally, it suggests that the outcomes of disclosure influence future behavior, meaning that a positive disclosure experience encourages more openness, while a negative experience discourages future disclosure (Omarzu, 2000).

The Disclosure-Decision Model is particularly relevant in mental health and therapy, where individuals may struggle with whether to disclose their emotional difficulties.

Many people hesitate to open up about depression or anxiety due to fear of stigma, yet the model explains how perceived support can increase their willingness to share. Similarly, in interpersonal relationships, disclosure plays a key role in trust-building, with individuals adjusting their level of openness based on the responses they receive. In workplace settings, employees often consider whether to disclose challenges, such as mental health struggles or work-related stress, depending on how supportive their environment is. In healthcare communication, the model helps explain why some patients withhold critical medical information from doctors due to concerns about confidentiality or negative judgment (Omarzu, 2000).

The Disclosure-Decision Model provides a structured and insightful framework for understanding self-disclosure as a strategic and context-dependent process. By highlighting the role of motivation, risk assessment, and environmental factors, the model sheds light on why individuals choose to share or withhold personal information. While it has some limitations, particularly in accounting for emotional and cultural influences, it remains a valuable tool for analyzing disclosure dynamics in mental health, relationships, workplace communication, and healthcare settings.

2.2.3 Communication Privacy Management Theory

Communication Privacy Management (CPM) theory explains one of the most important, yet challenging social processes in everyday life, that is, managing, disclosing and protecting private information. The theory explicates how people make decisions about revealing their own private information and any private information that is entrusted to them. The theory also considers the impact of serving as a confidant and the ramifications of privacy turbulence on relationships with others. The theory was created by Sandra Petronio in 1991. According to Petronio, the first iteration of CPM was developed over 20 years ago, and it was designed to create a theoretical framework for understanding and categorizing disclosure. CPM treats privacy as a metaphorical boundary and outlines three main components to manage private information: privacy ownership, privacy control, and privacy turbulence (Petronio, 2013). Privacy ownership means people believe they own their private information and can choose to whom they will deny or provide access to their

private information. People become “authorized co-owners” (Petronio, 2013.) when granted access and they have responsibilities to keep information private. Accordingly, privacy ownership (boundaries of private information), privacy control (privacy management engine), and privacy turbulence (privacy regulation breakdowns) are the key tenets of the CPM theory that allow for understanding how people regulate private information.

Privacy ownership predicts the way that people consider privacy ownership and how they regulate ownership issues for private information. It predicts that people believe they are the sole owners of their private information and they trust they have the right to protect their information or grant access (Petronio & Gaff, 2010). Accordingly, ownership can be restricted or shared with others. The theory predicts, that when these “original owners” grant others access to private information, they become “authorized co-owners” and are perceived by the “original owner” to have fiduciary responsibilities for the information (Tokic & Pecnik, 2011). Privacy ownership defines the boundaries surrounding the information, marking it private. The privacy boundaries help to delineate the context as well as the boundary lines of demarcation for information considered private.

Privacy control symbolizes the engine that regulates conditions of granting and denying access to private information. Because individuals believe they own rights to their private information, they also justifiably feel that they should be the ones controlling their privacy. This assumption stands true even after giving access to “authorized others”. According to CPM, predicting the way people control the flow of private information is done through the development and use of privacy rules. These rules are derived from decision criteria such as motivations, cultural values, and situational needs. This theory hinges upon the idea of weighing and comparing pros and cons in order to decide courses of action in communication when considering privacy boundaries in different relationships.

Privacy turbulence occurs when privacy rules break down for various reasons including purposeful violations and privacy rule mistakes allowing unprivileged parties’ access to the private information. Turbulence can function as a catalyst

criterion to adjust privacy rules and people may address turbulence by updating, correcting, or recalibrating privacy rules to restore the privacy management system (Petronio, 2002).

CPM theory allows for identifying process issues underlying the disclosing or protecting of information that is considered private. CPM argues that in considering the processes of disclosure, it is important to note that disclosure is not what is revealed; instead, disclosure represents the process of telling. Private information is what people disclose within CPM theory. What constitutes private information is defined as information that has the potential to yield vulnerabilities if shared with others. Private information, per se, is not further defined in CPM theory because everyone has a different sense of what is private (Petronio, 2012). Nevertheless, once people start to manage and regulate private information by having conditions for who can know, how much they can know, and how freely they can share the information with others, the establishment of these types of privacy rules signals that the information shared has potential vulnerability. As a result, the owners have expectations for managing their privacy boundaries when others are involved (Durham, 2008). Underpinning the CPM management system is the dialectical assumption that people need to be both social (through disclosing) and private (through protecting information) simultaneously leading to making choices about when to protect and when to tell. CPM provides a valuable perspective for understanding how others may disclose personal, sensitive information on behalf of an individual who is unable or unwilling to do so themselves, particularly in cases of depression. For instance, when an individual suffering from depression struggles to communicate their emotional or psychological distress, trusted friends, family members, or mental health professionals might disclose the individual's struggles to others. This sharing of information, while potentially violating the individual's privacy, can serve as an essential step in seeking support and facilitating interventions that can help manage the depression (Petronio, 2013). Thus, CPM offers critical insights into the process by which third parties navigate the delicate balance of disclosing private information and maintaining privacy boundaries, especially in the context of mental health management.

2.2.4 Hofstede's Cultural Dimensions Theory

This theory was developed by Dutch social psychologist Geert Hofstede in 1980, explains how cultural values influence behavior, communication styles, and social relationships. The theory emerged from Hofstede's research at IBM, where he analyzed how values in the workplace varied across national cultures. Hofstede originally identified four cultural dimensions, later expanded to six, which include: individualism vs. collectivism, power distance, uncertainty avoidance, masculinity vs. femininity, long-term vs. short-term orientation, and indulgence vs. restraint.

The central argument of Hofstede's theory is that culture profoundly shapes how individuals think, feel, and act especially in social contexts. For example, people from individualistic cultures tend to prioritize personal autonomy and self-expression, making them more likely to engage in open self-disclosure. In contrast, those from collectivist cultures may value group harmony over personal expression, thus being more reserved in sharing emotional struggles.

Power distance influences how students perceive authority figures such as counselors or lecturers; those from high power distance backgrounds may avoid seeking help or disclosing personal struggles to authority figures due to fear of disrespect or stigma. Similarly, masculinity versus femininity influences emotional expressiveness, with masculine cultures valuing toughness and emotional restraint, particularly among men, which may discourage disclosure.

One of the strengths of Hofstede's theory is its explanatory power in understanding cross-cultural differences in communication and social behavior. It has been widely applied in intercultural communication and organizational studies. However, its main limitation lies in the generalization of national cultures, which may overlook individual-level variations and the influence of subcultures within countries.

In the context of this study, Hofstede's theory is applied to explain how cultural dimensions act as moderating factors in the relationship between interpersonal disclosure and depression management among university students. Specifically, it helps understand how socio-demographic factors such as ethnicity, religion, and

gender norms, which are often shaped by broader cultural orientations, influence students' willingness to disclose emotional difficulties and seek help. These cultural factors can either facilitate or inhibit effective disclosure, thus affecting the success of depression management strategies.

2.3 Conceptual Framework

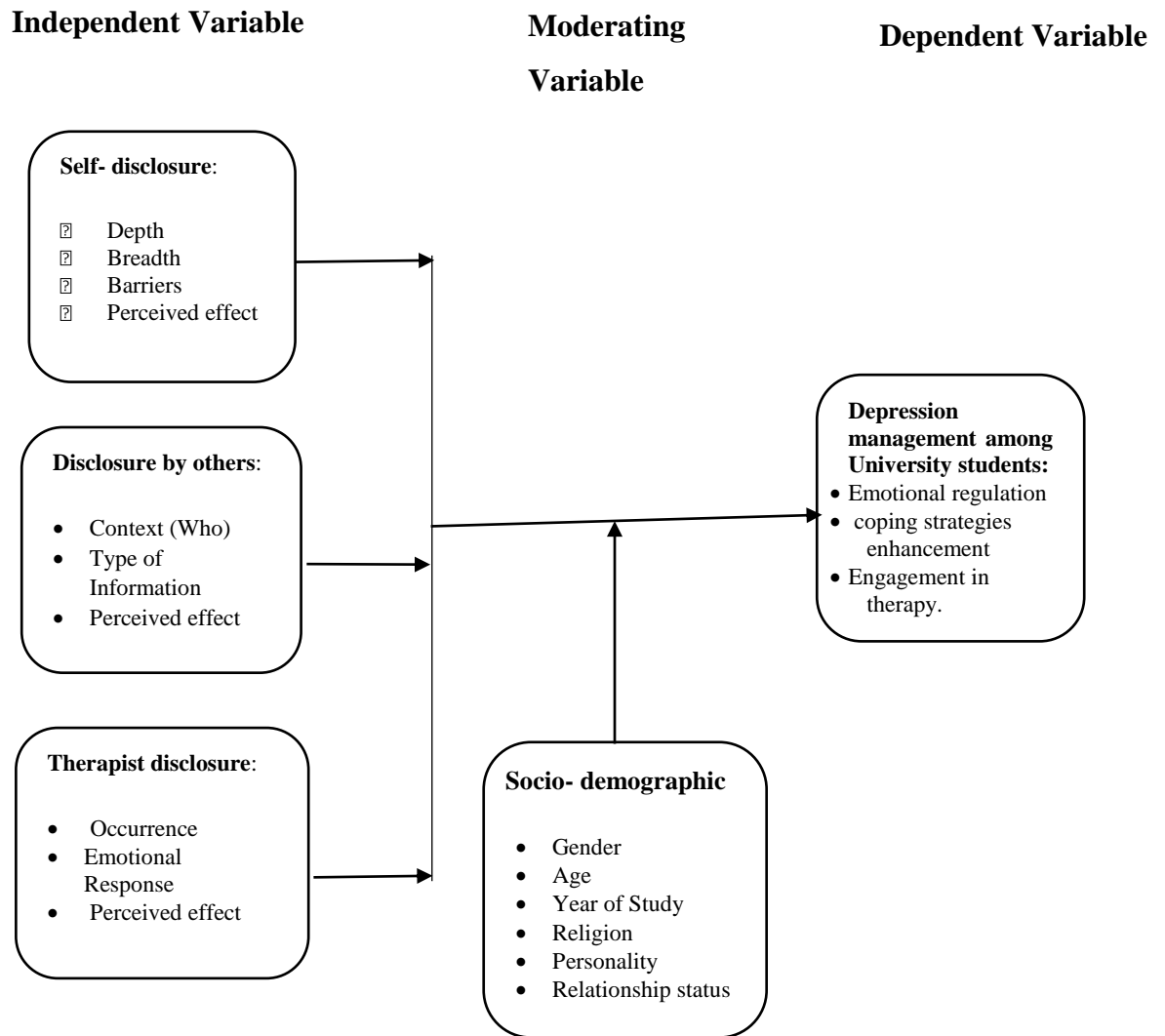


Figure 2.1: Conceptual Framework

In this conceptual framework, self-disclosure, disclosure by others, and therapist disclosure were identified as the independent variables, while depression management was the dependent variable. Social demographic factors, including age, year of study, gender, religion and personality, were considered moderating variables to the relationship between disclosure and depression management.

Self-disclosure refers to the process where an individual reveals their emotions, thoughts, beliefs, and attitudes (Vogel & Wester, 2003). It involves the disclosure of personally sensitive information, such as actions, thoughts, or feelings, by either the

client or counselor. Self-disclosure plays a critical role in the diagnosis and treatment of depression. This variable was assessed by having the participants report on the depth, and breadth of their disclosures, the perceived effect of this type of disclosure was also assessed with responses evaluated on a Likert scale

Disclosure by others occurs when individuals entrusted with private information become co-owners of it and may disclose it to others, especially when the original owner is not in a position to share it themselves (Petronio, 2013). This variable was measured by participants indicating if they ever shared their private information with any other person other than the counselor and if these people had shared their information with a third party in a bid to get them help. A tailored scale was used to capture perceptions of the appropriateness and consequences of such disclosures, as well as whether participants viewed this type of sharing as beneficial or harmful for managing depression.

Therapist disclosure describes a situation where the therapist and patient engage in a mutual exchange of personal information. This reciprocal process often strengthens the therapeutic alliance, normalizes the patient's experiences, and introduces alternative perspectives (Lane, Farber, & Geller, 2001). This variable was assessed through participant reports of their interactions in therapeutic or interpersonal settings where reciprocal disclosure occurs. A Likert scale was used to evaluate the effect of these exchanges on depression management.

Depression management, the dependent variable, encompasses the strategies and outcomes aimed at reducing depressive symptoms. Self-reported measures were used to examine coping strategies, perceived support, and improvements in daily functioning.

The social demographic factors considered as moderators between disclosure and depression management, in this study includes, age, gender, year of study, religion and personality, each of which had been shown to influence disclosure behaviors. Age was recorded as a continuous variable based on participants' reported chronological age. Gender was categorized based on participants' self-identification. Personality traits was measured using a questionnaire where participant indicated

their personality category among introverts, extroverts and ambiverts. Religion was assessed on the basis of self-reporting by the participants and so was the year of study.

2.4 Review of Variables

2.4.1 Effect of Self-Disclosure on Depression Management

Self-disclosure, the intentional act of revealing personal thoughts, emotions, and experiences, is a central element of interpersonal communication and psychological well-being. It serves multiple purposes, ranging from the formation of initial connections through casual exchanges to the deepening of relationships through intimate revelations. The complexity of self-disclosure lies not only in its functions but also in the various contexts, cultural influences, and individual differences that shape its practice.

The foundational work of Irwin Altman and Dalmas Taylor, encapsulated in their Social Penetration Theory, emphasizes the gradual nature of self-disclosure. According to the theory, interpersonal relationships develop through layers of disclosure, similar to peeling an onion, with initial conversations involving superficial topics and progressively advancing to more personal and intimate matters. Altman and Taylor emphasize that this progressive disclosure fosters trust and deepens emotional bonds, making it a cornerstone of relational development (Altman & Taylor, 1973).

Jourard (1971), was one of the earliest scholars to emphasize the role of self-disclosure in psychological health and interpersonal relationships. In his seminal work, *The Transparent Self*, He argued that individuals who share their inner worlds openly experience greater self-awareness and emotional relief. He posited that withholding personal information creates barriers to intimacy and can contribute to emotional distress. Jourard's insights laid the groundwork for understanding self-disclosure as a therapeutic tool and a mechanism for building meaningful connections.

Derlega, Winstead, Mathews, and Braitman (2001), expanded on Jourard's work by examining the interplay between self-disclosure and intimacy. Derlega and his colleagues identified key motivations for self-disclosure, including the need for emotional expression, social validation, and relationship enhancement. They highlighted the importance of privacy boundaries, emphasizing that excessive or premature disclosure can lead to discomfort and relational strain. Their contributions also shed light on the role of self-disclosure in coping with stress and navigating challenging interpersonal dynamics.

In therapeutic contexts, self-disclosure is pivotal for fostering a strong alliance between clients and therapists. Sigmund Freud's foundational principle that clients should reveal their innermost thoughts and feelings to their therapists remains a cornerstone of contemporary counseling approaches. Greene, Derlega, & Mathews (2006), emphasizes that trust and rapport between a client and a therapist are essential for effective self-disclosure. Without a secure and supportive therapeutic environment, clients may withhold information, limiting the potential benefits of therapy. Empirical studies, such as Youn, Sundquist, Hovey and Wang (2022), meta-analysis, confirm that structured self-disclosure interventions significantly reduce depressive symptoms, particularly among adolescents and young adults.

Cultural dimensions play a critical role in shaping self-disclosure practices. Triandis' (2018), research on individualism and collectivism demonstrates how cultural norms influence the extent and nature of disclosure. In individualistic cultures, where personal autonomy and self-expression are valued, individuals are more likely to engage in open self-disclosure. Conversely, collectivist cultures prioritize group harmony and often discourage direct expressions of personal thoughts or emotions, particularly those related to mental health. Alternatively, health stigma frameworks highlight how cultural emphasis on social harmony contributes to amplified stigma and diminished willingness to disclose mental health struggles (Stangl, Earnshaw, Logie, Van Brakel, Simbayi, Barré, & Dovidio, 2019). These cultural factors highlight the need for context-sensitive approaches when addressing self-disclosure in therapeutic and informal settings.

The Johari Window, originally introduced by Luft & Ingham (1955), offers a conceptual framework for understanding the interplay between self-disclosure, self-awareness, and relational dynamics. The model divides personal knowledge into four quadrants: the open self, hidden self, blind self, and unknown self, highlighting how interpersonal exchanges shape self-perception. By consciously engaging in self-disclosure, individuals expand their open self, thereby fostering mutual understanding and strengthening relationships. This dynamic emphasizes the importance of transparency and feedback in building therapeutic and peer support environments conducive to effective depression management.

Mark L. Knapp's model of relational development remains influential, but recent scholarship has expanded and refined his insights. An Oxford Research Encyclopedia of Communication entry (Derlega & Winstead, 2018) highlights that self-disclosure continues to be recognized as a key driver of intimacy, influencing both the breadth and depth of relationship formation, echoing and extending Knapp's original framework. Furthermore, a comprehensive review by Stafford and Canary (2021) in the *Personal Relationships* journal synthesizes the past two decades of relational maintenance literature, reaffirming the critical role of ongoing self-disclosure in sustaining meaningful connections over time.

Despite its potential benefits, self-disclosure carries significant risks when not accompanied by communication competence. A recent study by Werle and Byrd (2022) demonstrated that self-disclosure by a speaker with low communication competence can still positively influence listener perceptions, though it is the combination of disclosure and high communication competence that yields the most favourable outcomes. Additional research by Werle, Byrd, & Coalson (2023), reinforces this, showing that informational self-disclosure paired with high communication competence reduces perceived distraction and improves evaluations, whereas disclosure alone in low-competence contexts can detract from relational perceptions.

Chaudoir and Fisher (2010), emphasize the role of the audience in determining the effectiveness of self-disclosure. Their research indicates that disclosures to trusted

individuals, such as close friends or therapists, are more likely to yield positive outcomes than disclosures to acquaintances or on public platforms. This finding is particularly relevant in the context of social media, where the boundaries of privacy and trust are often blurred. Nesi, Choukas-Bradley & Prinstein, (2018), highlight the dual role of social media in self-disclosure, noting that while it can provide a platform for emotional relief and social support, it also exposes individuals to risks such as judgment and cyberbullying.

The phenomenon of spontaneous self-disclosure, often referred to as the "stranger-on-the-train" effect, illustrates the complexity of disclosure dynamics. Floyd (2011) describes this as verbal leakage, where individuals unintentionally reveal personal information to strangers. While this type of disclosure deviates from the calculated reciprocity outlined in Social Penetration Theory, it stresses the multifaceted nature of self-disclosure and its variability across contexts.

2.4.2 Effect of Disclosure by Others on Depression Management

Disclosure by others in the context of depression management involves a third party sharing an individual's mental health information, typically with healthcare providers, when the individual affected by depression is unable to do so themselves. This form of disclosure is often necessary to ensure that the individual receives the appropriate care and support, especially in cases where the individual's depression has impaired their ability to communicate effectively. However, this process introduces significant ethical and legal considerations regarding privacy, confidentiality, and the protections afforded to mental health information.

A central consideration in this context is the principle of duty of confidence, which under common law arises when an individual discloses private information to another with a reasonable expectation of confidentiality. According to NHS Digital (2022), this legal obligation prohibits further use or disclosure of the information unless authorized by the discloser or justified by exceptional circumstances, such as safeguarding the public interest.

This duty is particularly critical in mental healthcare, as it fosters trust between patients and providers. When third parties, such as family members or friends, are involved in disclosing a patient's mental health information, it is essential to ensure that confidentiality is maintained. Legal frameworks such as HIPAA in the United States permit certain disclosures to family members or others involved in care without explicit patient consent, provided that the information shared is limited in scope and aligned with the patient's best interests (U.S. Department of Health & Human Services, 2017). Meanwhile, studies have shown that mental health professionals often encounter ethical dilemmas when balancing confidentiality with the need for family involvement in care (Knutstad, Husum, Finset, & Natvig, 2023).

When individuals with depression become too severely impaired to articulate or uphold their healthcare preferences, alternative decision-making mechanisms are essential. One common solution is the use of advance directives, legal instruments that allow individuals to state their treatment preferences in the event they lose decisional capacity (American Bar Association, 2020). In situations where no advance directive exists, a surrogate decision-maker, often a close family member or legally recognized guardian, is appointed to make healthcare decisions on behalf of the patient (Merck Manuals, 2023). This surrogate may also bear responsibility for disclosing the patient's mental health status, thereby emphasizing how disclosure by others is critically involved in ensuring timely and appropriate treatment.

Surrogate decision-making demands careful preparation, both legally and emotionally. Research shows that surrogates lacking clear knowledge of the patient's wishes experience higher levels of anxiety and uncertainty, underscoring the importance of prior conversations or advance care planning (Fisher, Parrillo, Petchler, Kub, Hughes, Sulmasy, Baker & Nolan, 2023). Thus, advance directives not only empower patients by preserving autonomy but also improve the quality and timeliness of healthcare decisions, especially when patients can no longer speak for themselves.

The Health Insurance Portability and Accountability Act (HIPAA) provides a regulatory framework that governs the use and disclosure of protected health

information, including mental health records. Its Privacy Rule delineates the conditions under which personal health information may be shared, thereby safeguarding the confidentiality of sensitive data related to mental health conditions (U.S. Department of Health and Human Services, 2023). This legal framework is particularly crucial when managing depression, as individuals often feel vulnerable or stigmatized due to the social and cultural associations with mental health conditions (Corrigan, 2004). The application of HIPAA is designed to provide individuals with the necessary protections while allowing for the disclosure of information when it is required for treatment or when there are concerns for the individual's safety or the safety of others (U.S. Department of Health and Human Services, 2023).

Despite the general emphasis on confidentiality, HIPAA allows for exceptions, particularly in circumstances where disclosing mental health information is necessary to prevent harm or ensure the individual receives adequate care. For example, if a patient with depression is at risk of self-harm or poses a threat to others, healthcare providers are permitted to share relevant information to ensure safety. This provision demonstrates the balance that must be maintained between ensuring patient privacy and safeguarding the health and well-being of both the individual and the public (U.S. Department of Health and Human Services, 2023).

Another crucial aspect of mental health care under HIPAA is the special protection afforded to psychotherapy notes. These notes, documented by mental health professionals during counseling sessions, receive heightened confidentiality compared to other medical records. HIPAA treats psychotherapy notes as distinct from other health information, and their disclosure requires the patient's express consent (U.S. Department of Health and Human Services, 2013). This protection ensures that patients can freely discuss their mental health without fear that their private thoughts and emotions will be shared without their approval. However, when third parties disclose information about an individual's mental health to healthcare providers, it is critical that such disclosures are relevant and limited; notably, psychotherapy notes remain protected and not subject to general disclosure rules (Jaffee vs Redmond, 1996).

The legal and ethical dimensions of disclosure by others are also influenced by the societal stigma surrounding mental health conditions. Individuals with depression often face considerable stigma, which may discourage them from disclosing their condition to others (Corrigan, 2004). As such, third-party disclosures, particularly when made by family members or friends, must be handled with sensitivity. It is crucial that healthcare providers approach these disclosures with care, ensuring that they do not exacerbate the individual's feelings of shame or isolation. Additionally, healthcare providers must be mindful of the need to align any third-party disclosures with the individual's known preferences, as far as possible, in order to maintain respect for their autonomy (Friedman & Jones, 2023).

Disclosure by others in depression management presents both opportunities and challenges. While it is an essential mechanism for ensuring that individuals receive the care they need, it must be balanced carefully with considerations of confidentiality, privacy, and the ethical implications of sharing mental health information. Legal protections such as HIPAA help to safeguard individuals' rights, ensuring that disclosures are made only when necessary and appropriate. However, it is essential that healthcare providers navigate these disclosures with sensitivity, particularly in light of the stigma surrounding mental health, and that they always act in the best interest of the patient. By carefully balancing the need for disclosure with the protections offered by law, healthcare providers can ensure that individuals with depression receive the support they need while maintaining their dignity and privacy.

2.4.3 Effect of Therapist disclosure on Depression Management

Therapist disclosure, in the therapeutic context, refers to a mutual exchange where both the therapist and the client take turns revealing personal information of similar magnitude. This process is central to the development of the therapeutic alliance, which plays a critical role in managing depression. Client self-disclosure, in particular, is widely regarded as essential for successful counseling, as it fosters trust and allows for the exploration of personal issues (Hill & Knox, 2001). However, therapist self-disclosure remains a controversial but potentially powerful

intervention, influencing the dynamics of therapy and the outcomes of depression treatment.

Broadly, therapist self-disclosure refers to any statements or actions that reveal personal information about the therapist. This includes verbal disclosures of personal experiences or thoughts, as well as nonverbal communication such as body language, office decor, and even the therapist's attire and physical characteristics (Zur, 2007; Peterson, 2002). These disclosures can be intentional, accidental, or unavoidable, each carrying distinct implications for the therapeutic process. Deliberate self-disclosure refers to planned and intentional revelations by the therapist, aimed at enhancing the client's understanding or facilitating the therapeutic process. Accidental self-disclosure occurs when the therapist unintentionally reveals information, such as through unplanned encounters or spontaneous reactions. Unavoidable self-disclosure includes elements over which the therapist has limited control, such as tone of voice or emotional responses (Zur, 2007).

Therapist self-disclosure has long been a subject of debate within the psychotherapy community, with both proponents and critics discussing its impact on the therapeutic alliance (Audet, 2011). Sigmund Freud, one of the early pioneers in the field, strongly advised against therapist self-disclosure, believing that it could lead to increased resistance, complicate the transference process, and create unnecessary distractions, as clients might focus on analyzing the therapist instead of addressing their own issues (Freud, 1912/1958a). From a Freudian perspective, such disclosures risked undermining the authority of the therapist and skewing the focus of therapy away from the client's needs.

In contrast, other therapeutic orientations, particularly humanistic, feminist, and existential approaches, encourage the use of therapist self-disclosure as a means of fostering a more authentic and egalitarian therapeutic relationship (Horvath & Bedi, 2002). Advocates of self-disclosure argue that when used appropriately, it can normalize the client's experiences, reduce power imbalances, and promote emotional engagement, all of which are crucial for effective depression management (Barrett & Berman, 2001; Knox, Hess, Petersen, & Hill, 1997). This kind of disclosure can also

facilitate the client's self-expression, enabling them to gain new perspectives on their struggles and fostering a sense of connection and understanding between the therapist and client.

The literature on therapist self-disclosure has explored various dimensions, including the content and timing of disclosures. One distinction commonly made is between immediate and non-immediate self-disclosure. Immediate self-disclosure, also known as self-involving or interpersonal self-disclosure, focuses on the present moment and the therapist's reactions to the client, such as countertransference. This type of disclosure addresses the therapeutic relationship and aims to clarify how the therapist perceives the client's behaviors in the "here and now" (Audet, 2011). Despite its benefits, self-disclosure must be balanced with communication competence. Recent reviews indicate that therapist statements, especially those involving immediacy and supportive self-disclosure, are generally linked to stronger therapeutic alliances and better session quality (Kadur, Lüdemann, & Andreas, 2020). A qualitative meta-analysis found that therapist self-disclosure and immediacy consistently lead to enhanced therapy relationships, client insight, and perceived helpfulness across 21 studies (Alfi-Yogev, Kivity, Hasson-Ohayon, & Ziv-Beiman, 2018).

In contrast to immediate self-disclosure, which is carefully tailored to the client's current concerns, non-immediate self-disclosure involves sharing personal opinions, beliefs, or past experiences that are less directly connected to the therapeutic moment (Hill, Knox, & Pinto-Coelho, 2018). While non-immediate disclosure can sometimes offer value, such as normalizing client experiences or building rapport, it often carries greater inherent risk. Alfi-Yogev, Hasson-Ohayon, Lazarus, Ziv Beiman and Slonim (2020), found that the effectiveness of therapist self-disclosure is highly contingent upon factors such as client characteristics and the timing and relevance of the disclosure. When disclosures are not directly related to the client's immediate concerns, they may shift focus away from the therapeutic goals, potentially introducing role confusion or fostering dependency.

A critical aspect of therapist self-disclosure is ensuring that it remains appropriate to the context of the therapeutic relationship. The primary goal of therapist self-

disclosure is to enhance the client's therapeutic experience without overshadowing or detracting from the client's own course of self-disclosure. As such, therapist disclosures should be carefully timed and relevant to the client's therapeutic needs. It is inappropriate for therapists to share personal information if it does not serve a clear purpose in the treatment or if it disrupts the client's emotional safety or privacy (Zur, 2007).

When implemented appropriately, therapist disclosure; where both client and therapist share relevant personal information, can strengthen the therapeutic alliance, enhance trust, and create a space in which the client feels supported and understood. For individuals dealing with depression, a condition that often involves feelings of isolation, this sense of shared vulnerability can be particularly beneficial. By seeing the therapist as a more relatable and human figure, clients may feel more comfortable in disclosing their own struggles, leading to a more open and effective therapeutic process (Barrett & Berman, 2001). Ultimately, the mutual exchange of personal information, when conducted with care and ethical consideration, can help to promote emotional healing and greater self-awareness in clients battling depression.

2.4.4 Moderating Effect of Social Demographic Factors on the Relationship between Disclosure and Depression Management

The moderating effects of social demographic factors on self-disclosure significantly shape the process of depression management. Understanding when and how individuals choose to disclose personal information is crucial in therapeutic settings, as it can either facilitate or hinder the effectiveness of treatment. Several factors, including age, year of study, gender, relationship status, religion and personality traits, play a pivotal role in moderating this process, influencing the depth and timing of self-disclosure in both clients and therapists.

One of the crucial factor in the self-disclosure process is gender. Gendered expectations around emotional expression play a significant role in how individuals disclose personal information, particularly in relation to emotional experiences such as depression. Research has shown that women are generally more likely to disclose personal and emotional information than men, likely due to societal norms that

encourage women to be more emotionally expressive (Derlega et al., 2001). In contrast, men may experience social pressure to maintain emotional restraint, which can make it more challenging for them to openly discuss their feelings of depression (Tang, Oliffe, Galdas, Phinney, & Han, 2014). However, studies also suggest that men may be more inclined to disclose to female therapists, perhaps due to perceived safety and understanding associated with female therapists' emotional responsiveness (Liddon, Kinglerlee, & Barry, 2017). Women, on the other hand, are often more comfortable disclosing personal information to both male and female therapists, which highlights the gendered dynamics that influence the self-disclosure process (Derlega et al., 2001). The gender differences in self-disclosure are important to consider in therapeutic contexts, as they can impact the way individuals manage their depression and the therapist's ability to address those issues effectively.

Age plays a central role in shaping disclosure behavior. Younger students, particularly those in their late teens and early twenties, may lack the emotional maturity or confidence to openly articulate depressive symptoms. This age group may struggle with identity development and emotional regulation, which are essential for effective interpersonal communication (Arnett, 2000). Older students, on the other hand, may have more life experience, improved self-awareness, and stronger emotional coping mechanisms, all of which support healthier disclosure practices and more effective management of depressive symptoms (Tamres, Janicki, & Helgeson, 2002).

Similarly, the year of study influences the degree and quality of disclosure. First- and second-year students often experience transitional stress, academic pressure, and unfamiliar social environments, which can heighten vulnerability to depression while simultaneously inhibiting open communication due to fears of stigma or judgment (Barry, Clarke, Jenkins & Patel, 2013). By contrast, students in their third or fourth year are more likely to have established support networks and familiarity with campus resources, which encourages greater openness in discussing mental health issues (Ibrahim, et al., 2013).

Religion functions both as a source of support and as a potential barrier to disclosure. In some religious contexts, mental illness is stigmatized or attributed to spiritual weakness, discouraging individuals from seeking help or disclosing psychological struggles (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001). This can significantly inhibit depression management, particularly among students from conservative religious backgrounds. Conversely, religious coping, particularly when it involves supportive communities or spiritually grounded counseling, can facilitate disclosure and promote psychological well-being (Pargament et al., 1998). Religious leaders, in such cases, may serve as trusted figures with whom students feel comfortable sharing personal difficulties.

Personality, especially along the introversion-extraversion spectrum, profoundly influences self-disclosure behavior. Extraverted individuals; who are sociable, energetic, and comfortable with external stimulation, are more likely to engage in interpersonal communication and share emotional challenges, which can promote timely mental health support and intervention (McCrae & Costa, 2008; Schmit, 2012). In contrast, introverted individuals are more reserved and introspective, often preferring solitude and experiencing discomfort in social contexts. Empirical evidence shows that higher levels of introversion correlate with reduced emotional self-disclosure and lower levels of friendship intimacy, potentially delaying access to therapeutic resources and peer support (Ren, Zhang, & Li, 2024). Consequently, this dynamic can exacerbate symptoms of depression, where low extraversion is a recognized personality correlate (Kendler, Gatz, Gardner, & Pedersen, 2010). Furthermore, systematic reviews suggest that self-disclosure interventions such as sharing lived experiences of depression, can effectively reduce symptoms among adolescents and young adults, highlighting disclosure's therapeutic potential when adopted (Jones, Patel, & Green, 2023).

Ambiverts, who exhibit a balance between introversion and extroversion, may demonstrate flexible disclosure patterns depending on the context. They are generally capable of engaging in meaningful interpersonal exchanges while also maintaining boundaries around personal information. This adaptability can be beneficial in therapeutic settings, where comfort with controlled disclosure enhances the

effectiveness of counseling interventions. Ambiverts may be particularly well-positioned to manage depression effectively, as they can leverage both introspection and social connectedness (Grant, Gino, & Hofmann, 2011).

Relationship status also plays an important role in moderating self-disclosure in the context of depression management. Students in supportive romantic relationships may experience greater emotional security and encouragement to share personal struggles, thereby facilitating timely self-disclosure and psychological relief (Derlega et al., 2001). Conversely, individuals who are single, experiencing relationship strain, or have recently undergone a breakup may be more vulnerable to emotional distress and less likely to engage in open communication (Tamres, Janicki, & Helgeson, 2002). The absence of a secure interpersonal bond can intensify feelings of isolation, particularly among students who are already introverted or experiencing stigma due to mental health challenges (Ren, Zhang, & Li, 2024). This dynamic interacts closely with other social demographic factors, such as gender, age, and personality. For instance, introverted individuals or younger students in unstable relationships may find it even more difficult to articulate their emotional experiences (McCrae & Costa, 2008). In contrast, students who have developed mature coping strategies and supportive interpersonal ties, whether through long-term partners, peer networks, or religious communities, tend to exhibit more effective disclosure practices and, by extension, healthier approaches to depression management (Ibrahim et al., 2013).

The moderating effects of these social demographic factors; such as age, year of study, gender, religion, relationship status and personality, are critical to understanding the dynamics of self-disclosure in depression management. These factors not only affect when and how individuals disclose personal information, but they also shape the therapeutic relationship itself. A deeper understanding of these moderating influences enables therapists to adapt their approach to meet the unique needs of each client, thereby fostering a supportive environment where self-disclosure can occur more naturally. By addressing these factors, therapists can enhance the effectiveness of depression treatment and help clients navigate their emotional struggles more openly and constructively.

2.4.5 Depression Management among University Students

A considerable number of mental disorders have their onset between the ages of 18-24 (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005). Therefore, it is not surprising that the prevalence of certain mental illnesses is particularly high among college students. Academic pressures, irregular sleep patterns, and living away from home are aspects of college life that increase the risk of mental illness (Said, Kypri, & Bowman, 2013).

Depression is widely recognized as one of the most prevalent psychological disorders among university students. According to Ferizi, Mashhadi, Yazdi, and Noferesti (2015), it is a leading clinical issue that contributes significantly to referrals to psychiatric clinics and constitutes a substantial portion of students' medical concerns. Depression is a debilitating condition that affects nearly every aspect of an individual's life disrupting personal and familial relationships, impairing occupational functioning, and undermining overall public health. It is typically characterized by a persistent low mood, feelings of guilt, reduced energy, and loss of interest in daily activities, communication difficulties, and social withdrawal. In essence, depressive disorder stands out as one of the most influential factors contributing to inefficiency and diminished quality of life in human functioning.

According to projections by the World Health Organization, depression was expected to become the second leading cause of disability worldwide by 2020 (World Health Organization, 2001). Researchers have noted that this disorder, as a psychological factor, not only disrupts psychological structures but also alters the external environment and interpersonal relationships. A review of research literature on depression reveals several components adversely affected by the disorder, including an individual's social skills. A depressed person often loses the ability to perform socially and fails to attain effective interpersonal functioning (Nezafat, Mashhadi, Amin, & Noferesti, 2015).

The other component is quality of life, which, according to the World Health Organization (2011), is one of the most important pillars of human well-being, and addressing it is one of the main responsibilities of health authorities. The third

component is emotional expressiveness. Emotional expression is a key psychological construct that is strongly linked to mental health. Many theorists argue that individuals with depression often struggle with this component, and their limited ability to express emotions contributes to the severity and persistence of the disorder (Kring & Sloan, 2007).

Depression can be one of the greatest challenges in life, but there are many effective treatments available to help manage its symptoms. Depending on the severity, a treatment plan may include a combination of medication, psychotherapy, and complementary remedies. Research has shown that interpersonal psychotherapy (IPT) is one of the most effective approaches for treating depression. For instance, IPT has been associated with significant reductions in depressive symptoms and improvements in quality of life among adolescents and women from low socio-economic backgrounds (Mufson, Dorta, Moreau & Weissman, 2004; Li, Zhang, & Wang, 2015). These findings highlight the versatility and adaptability of IPT in addressing depression across diverse and vulnerable populations.

In the meta-analysis that was performed on interpersonal psychotherapy on depression, its effectiveness was demonstrated as a stand-alone therapy, and in combination with drug therapy too. Interpersonal psychotherapy (IPT) is a short-term psychotherapy with a focus on structure, context and interpersonal skills. The theoretical background of this treatment is Mayer's psycho-biological approach, Sullivan's interpersonal school and Bowlby's attachment theory. Therefore, its main emphasis is on the relationships between mood and interpersonal events. In interpersonal psychotherapy, it is assumed that several factors (genetic and environmental) are involved in prevalence of depression and that's why this type of treatment focuses on patient's psychosocial and interpersonal context (Nezafat, et al., 2015).

Of some interest is the fact that, despite a wealth of research that suggests an increase in psychopathology, most college students with mental health problems do not receive treatment (Blanco, Okuda, Wright, Hasin, Grant, Liu, & Olfson, 2008). Researchers have examined the correlations between help seeking and factors

regarded as barriers and as facilitators to treatment in order to understand the under-utilization of mental health services among university students (Eisenberg et al, 2012). These factors include: stigma, perceived need, access to services and close relationships with individuals who have used treatment, and cultural competence.

Stigma surrounding mental health can be broadly categorized into self-stigma, which involves internalized negative beliefs about oneself, and public stigma, which refers to negative societal perceptions. While some research suggests that public stigma may not directly deter individuals from seeking help, it can influence self-stigma, which in turn significantly affects help-seeking behavior (Vogel, et al., 2007). Self-stigma has been consistently linked to lower rates of therapy utilization, reluctance to take medication, and reduced engagement with both clinical and informal support systems. These effects are particularly pronounced among students from marginalized backgrounds, such as those from low-income households or certain cultural communities, where stigma remains a significant barrier to accessing mental health services (Eisenberg,et al., 2012).

Medical students and university students in general often cite various barriers to seeking mental health support. Common reasons include lack of time, fear of stigma or academic consequences, and a preference to handle problems independently. Many students question the severity of their symptoms, normalize stress as a typical part of university life, or believe their problems will resolve without intervention. In addition to these attitudinal barriers, pragmatic issues such as long waiting periods, financial constraints, and uncertainty about where to access services, and previous negative experiences with professional help also contribute to low help-seeking behavior (Eisenberg et al., 2011; Czyz et al., 2013).

2.5 Empirical Review of Relevant Studies

The empirical literature review involves examining original research works, including past studies, surveys, and scientific experiments. This section presents a review of empirical studies conducted on Disclosure and depression management. It is organized according to the study's objectives, which include the effects of self-disclosure on depression management, disclosure by others and depression

management, moderating effects of social demographic factors on depression management.

2.5.1 Self-Disclosure and Depression Management

Gonsalves, Nair, Roy, Pal and Michelson, (2023), conducted a systematic review examining the role of self-disclosure in interventions targeting depression and anxiety among adolescents and young adults. Their findings revealed that self-disclosure, especially when facilitated within therapeutic or peer-led settings, significantly contributes to the reduction of depressive symptoms. The process of openly sharing one's emotional struggles was shown to enhance emotional expression and strengthen perceived social support, both of which are crucial in managing depression. The study emphasized the importance of creating therapeutic environments that encourage safe and meaningful disclosure, highlighting its value as an active ingredient in effective mental health interventions.

While Gonsalves et al. (2023) provide valuable insights into the role of self-disclosure in managing depression and anxiety among adolescents and young adults, a key limitation of their review is its predominant focus on interventions in high-income and Western contexts. This limits the generalizability of the findings to regions like Kenya, where cultural perceptions of mental health and disclosure practices may differ significantly. Moreover, their conceptual scope primarily emphasizes individual self-disclosure, with limited attention to how disclosure by others such as therapists or peers, may also influence therapeutic outcomes. The present study addresses these gaps by examining both self-disclosure and other-directed disclosure within the Kenyan university context, thereby expanding the conceptual framework and enhancing the cultural relevance of disclosure-based interventions in depression management.

Keller, Valdez, Schwei and Jacobs, (2016), conducted a qualitative study in the U.S. examining how women disclose depression symptoms in primary care settings. Their findings revealed that women generally experienced emotional relief and a reduction in symptoms when they opened up to empathetic providers. Disclosure was facilitated when clinicians' demonstrated empathy, asked direct questions about

emotional well-being, and created a sense of psychological safety. However, the study also identified significant barriers particularly among women with high social anxiety or those from marginalized cultural backgrounds, who reported discomfort in disclosing their mental health struggles, which consequently limited the therapeutic benefits of disclosure.

A key gap in Keller et al. (2016), study lies in its restricted cultural context, focusing exclusively on the U.S. primary care environment. This context may not reflect the social norms or interpersonal dynamics that affect disclosure in different settings. Furthermore, the study did not investigate how demographic and personality differences such as age, gender identity, or personality traits, might moderate disclosure behaviors or outcomes. The current study will address these limitations by exploring how both self-disclosure and disclosure by others function in Kenya, while also examining how demographic and personality traits influence disclosure practices and depression management.

Al-Krenawi and Graham (2011) conducted a study in the Middle East to explore the relationship between cultural norms, mental health stigma, and disclosure practices. The research found that societal expectations often discouraged individuals from revealing emotional struggles, particularly in public or professional contexts, contributing to poorer mental health outcomes. Many individuals coped with depression in silence due to the fear of judgment or shame. However, the study also observed that in supportive environments, such as within therapeutic or counseling settings, disclosure led to improved emotional well-being and symptom relief.

The conceptual gap in Al-Krenawi and Graham's study lies in its emphasis on disclosure in formal or public spheres, with limited focus on how informal disclosures within peer or family networks influence depression management. Additionally, the contextual gap stems from its Middle Eastern focus, which may not reflect the socio-cultural landscape of Kenya. The current study aims to address these limitations by examining how disclosure across various settings (personal, familial, and therapeutic) affects depression management in the Kenyan context, while also accounting for social and demographic moderators.

Naslund, Aschbrenner, Marsch, and Bartels (2016) investigated the role of peer support and self-disclosure in managing depression, particularly among individuals with serious mental illness. Drawing on both qualitative and quantitative data, the study found that sharing personal experiences in peer support groups helped reduce depressive symptoms by fostering emotional connection and enhancing self-esteem. The researchers also noted that individuals with lower emotional expressiveness- often due to introversion or social anxiety- were less likely to benefit from these interventions, highlighting the importance of tailoring support strategies to individual personality traits.

A methodological gap in the study is its limited attention to the influence of social and demographic variables, such as age, gender, or cultural background, on the disclosure process. Contextually, the study was conducted in the United States, and its findings may not be entirely transferable to regions such as Kenya, where cultural attitudes toward mental illness and emotional expression differ. The present study seeks to address these gaps by examining not only self-disclosure but also disclosure by others in depression management within the Kenyan context.

A study by Shah, Laving, Okech-Helu, and Kumar, (2021) explored depression among medical students in Nairobi, highlighting that supportive relationships, including those involving friends or counselors, can significantly alleviate depressive symptoms. The research found that students who engaged in open conversations with trusted individuals reported better emotional well-being and reduced depression severity. However, the study did not examine how demographic characteristics such as age, gender, or personality traits might influence the benefits of such disclosure.

The contextual gap in Shah, et al., (2021), study stems from its focus on medical students, who may not reflect the broader population in Kenya. Conceptually, the study centered on peer and counselor support disclosures without exploring how professional disclosures, such as therapists sharing insights, might also impact depression management. To address these gaps, the current study will investigate both personal and professional forms of disclosure across diverse demographic profiles in Kenya.

2.5.2 Disclosure by Others and Depression Management

Naslund et al. (2017) explored the role of family and community-based support in managing mental illness in low- and middle-income countries. They found that when trusted individuals such as family members or close friends took initiative to disclose a loved one's mental health challenges to professionals or community support systems, it often reduced stigma and encouraged the individual to seek help. In many cases, this third-party disclosure allowed the affected person to feel understood and supported, especially when they were not ready to share their experiences directly. The effectiveness of such interventions, however, was largely dependent on the level of trust and safety felt by the individual, and on whether the third-party respected their emotional boundaries and consent.

The conceptual gap in this study lies in its limited focus on how individuals perceive being disclosed about by others, as the emphasis was placed more on caregiver or third-party perspectives. Additionally, the study was conducted across several low-income countries but did not provide in-depth cultural contextualization for each, including Kenya. The current study seeks to build on this by investigating how third-party disclosure functions specifically within the Kenyan context, accounting for cultural norms, social stigma, and community mental health awareness.

Ducharme, Davidson, Greene and Swartz, (2019), explored third-party disclosures in the context of severe mental health conditions, including depression, in the United Kingdom. Their study demonstrated that when individuals disclosed information about a loved one's mental health struggles, especially in healthcare settings, it often led to early interventions and better management of the condition. However, the effectiveness of such disclosures was contingent on the person making the disclosure. Disclosures by emotionally attuned and supportive individuals were linked to more positive outcomes, while disclosures made by individuals who were less empathetic or unaware of the person's emotional state could lead to negative consequences, including feelings of betrayal and resistance to treatment. Notably, the study did not consider the role of cultural differences in how third-party disclosures

are received or how these disclosures might be perceived differently depending on the gender or age of the individual experiencing depression.

A key conceptual gap in this study is its failure to explore the power dynamics inherent in third-party disclosures, particularly when family members or close friends disclose on behalf of the depressed individual without their consent. Additionally, the study did not examine the role of professional disclosures by healthcare providers, which may involve legal and ethical considerations. The study's contextual gap arises from its Western focus, where therapeutic practices and attitudes toward mental health differ significantly from those in Kenya. The present study intends to explore how third-party disclosures operate within both informal and formal settings in Kenyan communities and how these disclosures affect both the discloser and the individual receiving support.

Reupert, Maybery, and Kowalenko (2013), examined third-party disclosures in mental health contexts, particularly focusing on how family members disclose mental health issues on behalf of individuals who may be unwilling or unable to do so themselves. The study found that disclosures by trusted individuals, especially within supportive family relationships, can facilitate access to appropriate care and tailored interventions for individuals with depression. However, it also noted that disclosures made without consent can lead to unintended consequences, such as a sense of disempowerment, reduced autonomy, and hindered therapeutic engagement.

A conceptual gap in the study lies in its limited exploration of how the strength and quality of the relationship between the discloser and the depressed individual affect the outcomes of the disclosure. Furthermore, the study primarily focused on disclosures made to clinical professionals, with little attention to disclosures within informal support networks like peers or community groups. The current study seeks to address these gaps by investigating both professional and informal third-party disclosures and their influence on depression management in Kenya, where mental health stigma and cultural norms heavily shape disclosure dynamics.

Lauber, Carlos, and Wulf (2005), examined third-party disclosures within family contexts, particularly focusing on how lay beliefs about mental illness influence

help-seeking behaviors and stigma. Their study highlighted that when relatives disclosed information about a loved one's mental health struggles, particularly depression, to professionals or extended social networks, it often led to earlier interventions and greater communal understanding. However, in cultural settings where mental illness is heavily stigmatized, such disclosures were sometimes met with negative consequences, including family tension and social isolation of the affected individual.

The conceptual gap in their study lies in its concentration on family-based disclosures, overlooking the impact of disclosures by peers or healthcare providers. Contextually, the study was situated in a Western environment, limiting its applicability to African contexts such as Kenya, where social norms and beliefs about mental illness significantly influence disclosure dynamics. The current study addresses these gaps by investigating third-party disclosures across multiple actors; family, peers, and professionals, within Kenya's cultural framework, with the aim of understanding their implications for effective depression management.

Truong, Gallo, Roter, and Joo (2019) examined the role of self-disclosure by peer mentors in the context of depression care and found that sharing personal narratives helped establish trust and emotional resonance between mentors and individuals experiencing depression. Their study showed that when peer mentors disclosed their own struggles with mental health, it fostered therapeutic engagement, reduced stigma, and encouraged help-seeking behaviors among participants. This interpersonal strategy not only normalized mental health challenges but also empowered individuals to express their own emotions, thereby supporting effective depression management. The study underscores the potential of peer-based self-disclosure interventions in culturally diverse settings, where stigma may otherwise hinder open communication.

2.5.3 Therapist Disclosure and Depression Management

Therapist disclosure, the mutual exchange of personal information, plays a significant role in managing depression by fostering emotional connection, reducing isolation, and encouraging support. This concept has been explored in various

contexts, including therapeutic settings, peer groups, family dynamics, and workplace environments. Research on this topic highlights both the positive outcomes of reciprocal disclosure and the challenges it presents, often shaped by cultural and contextual factors.

Reciprocal disclosure in therapeutic contexts, where both clients and therapists share personal information has been shown to enhance emotional connection and trust within the therapeutic relationship. According to Hill and Knox (2001), therapist self-disclosure, when used appropriately, can promote client engagement and reduce feelings of isolation, especially for individuals dealing with depression. Such reciprocal interactions may help clients feel more understood and emotionally validated, thereby improving therapeutic outcomes. However, poorly timed or overly personal disclosures by therapists can lead to discomfort and may undermine the therapeutic alliance. While most studies on therapist disclosure focus on clinical settings in Western contexts, there remains a conceptual gap regarding how reciprocal disclosure functions in non-clinical relationships such as those with family or peers, and within cultural settings like Kenya, where norms around privacy and emotional expression may differ.

Byrom (2018) examined therapist disclosure within peer support interventions for university students and found that when students engaged in mutual sharing about their mental health, it fostered a sense of connection and emotional validation. This reciprocal communication reduced feelings of isolation and contributed to better mental health outcomes among students. However, the study also noted that factors such as fear of judgment, privacy concerns, and social anxiety often hindered students from participating in reciprocal disclosures. These barriers weakened the potential benefits of peer support in managing depression.

A key conceptual gap in Byrom's (2018), study is the limited consideration of how demographic characteristics such as age, gender, and personality traits, influence therapist disclosure. Additionally, the study focused on a Western university setting, which may not fully reflect the cultural and social dynamics affecting peer-based disclosure in contexts like Kenya. The current study aims to bridge these gaps by

exploring how social, demographic, and cultural variables affect therapist disclosure in depression management within Kenyan university populations.

Solomon (2004), examined therapist disclosure in close relationships, particularly within peer and family support systems, and found that when individuals shared mutual emotional experiences, it fostered a supportive environment conducive to managing depression. This reciprocal sharing helped reduce stigma, built trust, and promoted solidarity among family members, which in turn improved the individual's mental health outcomes.

However, the study also noted that such reciprocity was effective only in contexts where open communication and emotional safety existed. In families where mental health remained stigmatized or communication was strained, disclosure often led to conflict and misunderstanding. A conceptual gap in this study is its limited engagement with how cultural norms influence therapist disclosure. The current study addresses this by examining how reciprocal disclosure functions across various familial and social networks in Kenya, where cultural values heavily influence attitudes toward mental health.

Jones (2011) conducted a comprehensive review of mental health disclosure in workplace settings, highlighting that reciprocal sharing of emotional struggles among employees helped foster a culture of empathy and reduce mental health stigma. This atmosphere of mutual support encouraged emotional expression and improved psychological well-being. However, the review also identified significant barriers, including concerns over privacy, professional boundaries, and fear of discrimination, which often deterred individuals from disclosing their mental health challenges at work. These limitations undermined the potential benefits of therapist disclosure. A conceptual gap in Jones's work is its exclusive focus on workplace settings, without examining how therapist disclosure operates in other relational domains such as therapy or family environments. Additionally, the study did not explore how individual personality traits like introversion or social anxiety, might moderate disclosure behaviors. The current study seeks to address these gaps by examining

therapist disclosure across diverse social contexts within Kenya, while accounting for cultural and personality-based influences.

Mead, Hilton, and Curtis (2001) explored the therapeutic value of reciprocal disclosure within peer-led mental health support groups. Their study found that mutual sharing of personal experiences created a sense of connection and validation among participants, reducing feelings of isolation and encouraging help-seeking behavior. However, the study also noted that when group members felt judged or lacked trust in the group setting, reciprocal disclosures were limited, weakening the group's effectiveness. While the findings highlighted the value of supportive environments for depression management, the study did not examine how individual demographic characteristics such as age, gender, or personality traits, might influence one's willingness or capacity to engage in reciprocal disclosure. The current study seeks to address this gap by investigating how such demographic factors modify the relationship between disclosure (both self and third-party) and depression management outcomes within the Kenyan context.

2.5.4 Social Demographic Factors Moderation on the Relationship between Disclosure and Depression Management

Social demographic factors such as age, gender, religion, year of study, and personality significantly influence how individuals experience and manage depression. These variables affect not only the recognition of depressive symptoms but also the willingness to disclose emotional struggles, the contexts in which disclosure occurs, and the overall effectiveness of depression management strategies.

Age plays a crucial role in shaping mental health experiences. Younger university students are often more exposed to mental health education and peer discussions, which can encourage openness to disclosure and help-seeking (Eisenberg et al, 2013; Kessler et al., 2005). However, they may also experience higher social anxiety and uncertainty, which can hinder their ability to act on this awareness. Older students, particularly those balancing academic demands with work or family responsibilities, may suppress emotional distress due to perceived obligations or societal expectations of maturity (Mojtabai, Olfson, & Han, 2016).

Gender differences are also pronounced in depression management. Women are more likely to experience depression and are typically more open to seeking emotional support through interpersonal networks (Kuehner, 2017; Nolen-Hoeksema, 2012). Men, on the other hand, often face cultural expectations of emotional stoicism, leading to lower rates of disclosure and greater reliance on avoidant or self-destructive coping strategies (Addis & Mahalik, 2003).

Religion can function as both a support mechanism and a barrier to disclosure. In many cases, faith communities provide social and emotional support that encourages open discussions and resilience (Koenig, 2009; Loewenthal et al., 2001). However, in some religious contexts, depression is interpreted as a spiritual or moral failure, which may lead to shame, secrecy, and reluctance to seek help (Leavey, Loewenthal, & King, 2007; Mantovani, Pizzolati, & Edge, 2017).

Year of study affects students' experience and willingness to disclose emotional distress. First-year students are often in transitional phases, dealing with adaptation stress, limited knowledge of mental health services, and fragile peer networks, which can reduce their likelihood of disclosing distress (Beiter, Nash, McCrady, Rhoades, Linscomb, Clarahan, & Sammut, 2015; Dyson & Renk, 2006). In contrast, senior students may face stress from career uncertainty or academic overload but are generally more knowledgeable about available support systems and have greater confidence in accessing them (Bacchi & Licinio, 2017; Stallman, 2010).

Personality, especially along the introversion–extroversion continuum, plays a central role in disclosure behaviors. Extroverted individuals tend to engage more in interpersonal communication and are more likely to share emotional challenges, facilitating early intervention (McCrae & Costa, 2008; Swickert, Rosentreter, Hittner, & Mushrush, 2010). Introverts may experience discomfort in social exchanges, making them less likely to disclose, which can delay access to mental health support (Cain, 2012; Chapman & Goldberg, 2017). Ambiverts, who demonstrate flexible behavior between these poles, often adapt their disclosure according to situational demands, potentially enhancing the effectiveness of therapeutic relationships (Grant, et.al, 2011; Wilt & Revelle, 2009).

These social and personality-based moderators shape how disclosure functions as a tool in depression management. Accounting for these variables is essential in developing targeted and culturally responsive interventions for university students navigating mental health challenges.

2.6 Critique of Existing Literature

Although a wide range of studies have contributed to the understanding of disclosure as a strategy in depression management, several limitations emerge upon closer scrutiny. In the domain of self-disclosure, studies have emphasized its therapeutic value, particularly in structured interventions such as peer support and psycho-educational programs. For example, Truong, et al. (2019), affirmed the utility of peer-led self-disclosure in alleviating depressive symptoms, demonstrating that sharing personal narratives fosters empathy, reduces stigma, and enhances engagement in care. However, this line of inquiry is often grounded in Western or clinical contexts and tends to overgeneralize the benefits of disclosure without fully accounting for sociocultural environments where revealing personal vulnerabilities might invite judgment or social sanction. Moreover, many studies overlook how trust, relational dynamics, and emotional safety moderate the effectiveness of self-disclosure, especially in settings where stigma persists and emotional restraint is culturally valued.

Scholarly discourse on disclosure by others has predominantly emphasized its utility in facilitating early access to mental health care. For instance, studies such as that by Ducharme et al. (2019) highlight how disclosures made by family members, peers, or professionals on behalf of individuals with depression can lead to prompt therapeutic intervention and heightened awareness of the individual's condition. However, this literature tends to understate the ethical and emotional complexities that accompany such disclosures. When disclosure occurs without the explicit consent of the individual, it may infringe on their right to privacy, compromise their autonomy, and engender feelings of betrayal or social alienation. Samaritans (2020) underscore these concerns, noting that well-intentioned disclosures can sometimes result in disempowerment, especially when the discloser lacks emotional attunement or

contextual sensitivity. Moreover, much of this research is rooted in Western cultural paradigms that uphold individual agency and open expression, thereby limiting its applicability to collectivist societies such as Kenya, where disclosure decisions are often mediated by family hierarchies, communal norms, and the pervasive stigma surrounding mental illness. This study seeks to address these gaps by examining how disclosure by others functions within culturally specific networks of trust, obligation, and discretion in the Kenyan context.

In the therapeutic space, the concept of therapist disclosure and reciprocity has received considerable attention. While reciprocal disclosure may foster therapeutic alliance and emotional safety, this presumes that clients are culturally primed to accept therapist self-disclosure as supportive rather than intrusive (Derlega et al., 2008). In non-Western contexts such as Kenya, therapist disclosure may conflict with expectations of professional distance or hierarchical patient-provider relationships, particularly where cultural norms favor emotional restraint and privacy (Omar et al., 2020; Loewenthal et al., 2001). Moreover, few studies differentiate between appropriate and inappropriate therapist disclosures, or examine how these are interpreted across diverse cultural settings. Although broader self-disclosure theories highlight the role of mutual openness in fostering relational trust (Greene, 2009), these frameworks often fail to address how disclosure operates in settings where psychological distress is stigmatized and authority structures remain rigid.

The role of social demographic factors as moderators of the disclosure-depression relationship is Age and gender differences in disclosure remain similarly under-theorized in much of the existing literature. While Addis and Mahalik (2003) and Nolen-Hoeksema (2012) offer critical insights into how men and women navigate emotional expression differently, many studies continue to interpret male reluctance to disclose from a deficit perspective, pathologizing silence rather than situating it within broader constructions of masculinity. This tendency flattens complex social dynamics and obscures how disclosure behaviors may be socially reinforced or sanctioned. Moreover, even nuanced analyses often fail to consider how intersecting demographic variables such as religious affiliation or academic status, mediate the disclosure process. As Chaudoir and Fisher (2010) emphasize, disclosure is a

context-sensitive act shaped by anticipated stigma and perceived audience receptivity. Similarly, Loewenthal et al. (2001) highlight how religious beliefs can both inhibit and support help-seeking and emotional openness, illustrating the need for more intersectional approaches in disclosure research.

While educational attainment is often cited as a key predictor of mental health literacy and service utilization, many studies overlook the multifaceted differences within student populations by treating them as a monolithic group. In reality, university students' mental health experiences vary significantly across different academic years, reflecting distinct developmental, social, and academic stressors. Existing evidence shows that the year of study can significantly influence students' exposure to stress, degree of social integration, and awareness or use of campus mental health resources (Othieno et al., 2014; Peltzer & Pengpid, 2015). First-year students often grapple with transition stress, identity formation, and isolation, while final-year students report heightened anxiety related to academic pressure and future career uncertainty (Said et al., 2013; Sibanda, et al., 2023). These stage-specific stressors, in turn, affect students' willingness to engage in help-seeking and self-disclosure as coping strategies. Consequently, year of study emerges as a more immediate and contextually grounded moderator of depression management than the broader category of educational attainment.

Religion, too, plays a complex and sometimes contradictory role in shaping disclosure and coping behaviors. Loewenthal, et al., (2001) highlight how religious beliefs can serve as a coping mechanism, with many individuals turning to spiritual practices and community support during periods of psychological distress. However, the same religious environments can also propagate stigma, particularly when mental illness is framed as a lack of faith or a spiritual failing. Leavey, et al., (2007) further demonstrate that clergy, despite being trusted figures, may lack the training to respond effectively to mental health concerns, sometimes reinforcing silence and non-disclosure. In Kenya, where religion is a deeply embedded social institution, this dual influence of faith; as both a buffer and a barrier, requires more contextually grounded investigation.

Additionally, personality traits play a significant role in shaping disclosure practices, yet this area remains largely underexplored in culturally specific studies. For example, introverted individuals may be less likely to engage in self-disclosure due to heightened sensitivity to social judgment (Ren et al., 2024), while individuals high in openness may demonstrate greater willingness to share emotions. These personality-driven tendencies interact with cultural expectations of emotional restraint, suggesting that personality should be treated as a dynamic moderator in disclosure-related interventions.

While existing literature provides foundational insights into the role of disclosure in depression management, significant theoretical and contextual limitations persist. The prevailing focus on Western, individualistic frameworks often overlooks the sociocultural complexities that influence disclosure behaviors in collectivist societies such as Kenya. The tendency to universalize the benefits of self-disclosure, therapist reciprocity, or third-party intervention risks obscuring the nuanced ways in which disclosure is mediated by trust, relational norms, and perceived stigma. Furthermore, the limited theorization of social demographic variables particularly personality, religion, year of study, gender, and age, has hindered the development of culturally adaptive interventions. To enhance the applicability and effectiveness of disclosure-based strategies in depression care, future research must adopt intersectional, culturally grounded, and demographically sensitive approaches that recognize disclosure not as a uniform therapeutic act but as a contextually negotiated process.

2.7 Research Gap

Despite growing scholarly attention to disclosure as a communication strategy in depression management, critical gaps remain, particularly within the sociocultural contexts of Sub-Saharan Africa and among university student populations. Existing studies on self-disclosure, therapist disclosure, and disclosure by others have primarily been conducted in Western clinical or educational environments, with limited applicability to collectivist settings such as Kenya, where emotional restraint, stigma, and communal norms shape disclosure dynamics. Furthermore, much of the literature treats university students as a homogenous group, failing to account for

intragroup variation across year of study, which significantly influences stress exposure, social integration, and mental health service utilization.

In addition, while some studies acknowledge the role of demographic factors such as age, gender, and religion, these are often examined in isolation rather than as intersecting variables that shape disclosure behavior. The role of personality traits, such as introversion or openness, in moderating disclosure remains largely under-theorized, especially in culturally specific contexts where emotional expression is socially regulated. Similarly, research on therapist disclosure often assumes shared cultural expectations around therapeutic alliance and reciprocity, without adequately addressing how such practices may be interpreted differently across diverse cultural frameworks. The ethical and emotional complexities of disclosure by others, such as family members or peers acting without consent, are insufficiently explored in relation to autonomy, privacy, and contextual sensitivity. There is a pressing need to understand how trust, hierarchy, and communal responsibility affect the perceived legitimacy and impact of such disclosures in Kenyan universities.

This study addresses these gaps by investigating the role of disclosure, both self-initiated and facilitated by others, as an interpersonal communication strategy in depression management among university students in Kenya. It further examines how social demographic factors specifically age, gender, religion, personality, and year of study, moderate the relationship between disclosure and depression management. By situating disclosure within a culturally grounded and demographically nuanced framework, this study contributes to more contextually relevant understandings of how communication practices can be harnessed in addressing student mental health in Sub-Saharan Africa.

2.8 Summary

This chapter provides the conceptual foundation for this study by outlining four key theoretical frameworks, Social Penetration Theory, the Disclosure Decision Model, Communication Privacy Management Theory, and Hofstede's Cultural Dimensions Theory. Together, these frameworks illuminate how disclosure operates as a strategic, culturally mediated process, shaped by personal risk-benefit evaluations, privacy

boundary negotiations, and broader societal values. The chapter also examined the role of disclosure in depression management, focusing on three main forms: self-disclosure, disclosure by others, and therapist-patient reciprocal disclosure. While existing literature affirms the therapeutic value of disclosure, particularly in peer and clinical settings, it also highlights significant cultural limitations, especially in contexts like Kenya where emotional restraint, stigma, and hierarchical norms influence help-seeking and openness.

The chapter further explored key socio-demographic factors: age, gender, religion, personality, and year of study, as moderators in the disclosure-depression relationship. These variables were shown to shape disclosure behaviors in complex ways. The critique of the literature exposed important research gaps, including an overreliance on Western paradigms, insufficient cultural contextualization, and a lack of intersectional analysis. These gaps justify the current study's focus on the Kenyan university context, where disclosure must be understood as a culturally and socially embedded communication strategy.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter outlines the research methodology that was used in this study and provides a general framework for this research. The chapter presents details of the research design, target population, sample and sampling procedures, description of research instruments, validity and reliability of instruments, data collection procedures, data analysis techniques and ethical considerations while conducting the study.

3.3 Research Design

This research adopted a mixed research design. According to Creswell et al, (2003) mixed methods research involves the collection or analysis of both quantitative and qualitative data in a single study in which the data are collected concurrently or sequentially, are given priority, and involve the integration of data. In this research, concurrent triangulation was used whereby quantitative and qualitative data was collected simultaneously with equal emphasis and was used to cross-validate findings.

3.3 Population

The target population for this study comprised approximately 44,000 students, reflecting the estimated enrollment at Jomo Kenyatta University of Agriculture and Technology (JKUAT) over the five academic years spanning 2017/2018 to 2021/2022. This figure was obtained from internal enrollment records provided by the Office of the Registrar – Academic Affairs at JKUAT Sampling Frame

This study was conducted at the Jomo Kenyatta University of Agriculture and Technology (JKUAT) which has been selected based on having prominently featured in the local dailies over cases of students' suicide. The sampling frame for this study was the lists of students obtained from the student counselors' offices of the JKUAT

University which was picked for this study based on its frequency of appearance on the local media on the number of suicide cases reported.

3.4 Sample and Sampling Technique

According to Mugenda and Mugenda (2003), the minimum sample size of this study was evaluated as follows:

$$n = \frac{Z^2 pq}{d^2}$$

Where:

n = the minimum sample size if the target population is greater than 10,000 in this case it is

44, 000 students enrolled in JKUAT.

Z = the standard normal deviate at the required confidence level.

p = the proportion in the target population estimated to have characteristics being measured

(Use 0.5 if unknown).

$$q = 1-p$$

d = the level of significance set which is set at 0.05.

Since the target population is > 10000. The sample size will be adjusted accordingly as shown below

$$n = \frac{Z^2 pq}{d^2}$$

Which

is
$$n = \frac{1.96^2 \times 0.5(1-0.5)}{(0.05)^2}$$

n is therefore equal to 384.

Hence the sample size of this study was 384 respondents from Jomo Kenyatta University of Agriculture and Technology

Due to the sensitive nature of the topic: self-disclosure in the context of depression, the study employed purposive sampling for both quantitative and qualitative components. While purposive sampling is typically associated with qualitative research, it was adopted here to ensure ethical access to participants with lived experience of the research focus.

For the quantitative phase, the researcher worked closely with student counselors at Jomo Kenyatta University of Agriculture and Technology (JKUAT), who acted as gatekeepers. To uphold confidentiality and avoid breaching students' privacy, the researcher did not access counseling records directly. Instead, counselors identified and approached eligible participants, issued the research instruments, and facilitated voluntary participation. Though this approach limits statistical generalizability, it ensured ethical integrity and enabled access to an otherwise hard-to-reach population.

For the qualitative phase, four student counselors were selected using convenience sampling, based on their availability and involvement in student mental health services.

3.5 Data Collection Instruments

Structured questionnaires were used to collect quantitative data from all the students who were systematically picked from the university under study. The questionnaire was divided into the main areas of investigation, except the first part which captured the social demographic characteristics of the respondents. Other sections were organized according to the major research objectives which included: effects of self-disclosure, effects of disclosure by others, effects of therapist disclosure, and the

moderating effects of social demographic variables on depression management among university students.

In-depth interviews were used to collect qualitative data from student counselors conveniently picked from the selected university. In-depth interviews are a qualitative data collection method that involves direct, one-on-one engagement with individual participants.

3.6 Data Collection Procedure

Given the sensitive nature of the information being collected, particularly around students' experiences with depression and disclosure, it was essential to ensure strict confidentiality and ethical handling of the data. To maintain this integrity, student counselors were engaged to assist with the data collection process. The counselors, who already had established rapport and trust with the students, administered the questionnaires to their clients systematically, following a mutually agreed-upon plan developed with the researcher. This approach ensured that participants felt safe, respected, and free to respond honestly. Once the questionnaires were completed, they were returned to the counselors, who then handed them over to the researcher for analysis.

In-depth Interviews were scheduled with the relevant student counselors and then conducted face to face. The interviews were conducted using an interview guide which facilitated the flushing out of the respondent's views through open ended questioning. The information gathered from the interviews was collected in short notes.

3.7 Pilot Testing

Pilot test was carried out in Chuka University which was picked for piloting because it had equally been featured in the local dailies over suicide cases. A sample of 34 students were conveniently picked from lists of students who had sought counseling from the university counselors. This number aligns with recommendations by scholars (Van Teijlingen & Hundley, 2001), who suggest that 10–30 participants are

sufficient for identifying instrument flaws and testing study procedures. Three student counselors were also conveniently picked for piloting the interview guide. Piloting was done to test for reliability and validity of the research instruments. Out of the 34 questionnaires distributed, only 30 were returned.

3.8.1 Reliability

Reliability in a pilot study involves evaluating the consistency and dependability of measurements, instruments, procedures, and data analysis techniques. In this study, reliability tests were conducted to assess whether the study constructs were reliable and could measure the intended purpose. To achieve this, the study employed Cronbach's Alpha coefficient analysis to assess how reliable this scale was; a coefficient of 0.7 was adopted as the minimum threshold for deciding on the sufficiency of the reliability of the study scale (Kendell & Jablensky, 2003). The results for the reliability test are presented in Table 3.1.

Table 3.1: Reliability Test Results

Variables	Number of items	Cronbach's Alphas
Self-Disclosure	30	.732
Disclosure by others	30	.773
Therapist disclosure	30	.742
Social Demographic Factors	30	.810
Depression Management	30	.721

The Cronbach's alpha values provided for the variables in the pilot study indicate the internal consistency of the items within each variable. The composite reliability of each variable is well above the minimum conventional threshold value of 0.7. This confirms the acceptable benchmark for internal consistency of the questionnaire. As a result, the research instrument is considered to be reliable enough for carrying out the survey.

Pilot interviews were conducted with three student counselors to assess the clarity, relevance, and appropriateness of the interview guide for the target group. The

participants responded openly and engaged meaningfully with the questions, indicating the guide’s suitability. Based on their feedback, certain questions were reworded for clarity and to adopt a more conversational tone. Minor adjustments helped improve the overall flow of the interview.

Credibility was enhanced through prolonged engagement and the use of follow-up prompts that allowed participants to clarify their views. An initial coding exercise revealed emerging themes aligned with the study objectives. No significant logistical or ethical issues were encountered during the pilot, and the data collection approach was deemed appropriate for the main study.

3.8.2 Validity Test Results

In this study, the researcher tested for both face and construct validity during pilot testing to reduce unnecessary variables and ensure the validity of the research instrument. The validity of the variables was assessed using a sample adequacy test. Construct validity was performed to ascertain the sampling adequacy of the items used in the constructs, which involved Kaiser-Meyer-Olkin (KMO) and Bartlett’s tests. KMO was used to measure sampling adequacy, that is, to ascertain if the number of items used to measure a particular variable was adequate. It ranges between 0 and 1, with 1 indicating perfect results and a minimum threshold of 0.5 established as the better results (Kendell & Jablensky, 2003). Bartlett’s Test of Sphericity was used to test if the study items for each construct were coming from a population with equal variance. The study results for construct validity are presented in Table 3.2.

Table 3.2: Kaiser-Meyer-Olkin and Bartlett's Test of Sphericity Results

Variable	Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy		Bartlett's Test of Sphericity		
	Approx.	df	Chi-Square	Sig.	
Self-Disclosure	.756	28.536	12	.067	

Disclosure by others	.603	34.126	21	.035
Therapist disclosure	.744	20.286	15	.161
Social Demographic Factors	.882	17.635	17	.178
Depression Management	.587	11.750	10	.302

The Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy assesses the appropriateness of your sample size for conducting factor analysis. It is equally used to ascertain if the number of items used to measure a particular variable was adequate. The KMO statistic ranges from 0 to 1, where higher values indicate better sampling adequacy. Generally, a KMO value above 0.7 is considered acceptable, while values below 0.5 suggest that the sample may be inadequate for factor analysis. The KMO values for the variables under study are above the acceptable range, confirming that the sample was adequate for factor analysis. For Bartlett's Test of Sphericity, the approximate Chi-Square values for all variables suggested a statistically significant departure from the null hypothesis of an identity matrix, indicating potential suitability for factor analysis.

3.8 Data Analysis

This study employed both quantitative and qualitative data to investigate the effect of disclosure as an interpersonal communication strategy on depression management among university students in Kenya. A mixed methods approach was adopted to allow for a comprehensive analysis, combining statistical trends with deeper contextual insights.

Quantitative data were subjected to both **d**escriptive and inferential statistical analyses, in line with Kumar's (2005) recommended procedure. Initially, the data were edited to address issues of incompleteness and inconsistency, followed by cleaning and coding to prepare the data for analysis. The Statistical Package for the Social Sciences (SPSS) version 23 was used for all statistical computations.

Descriptive statistics, including frequencies, percentages, means, and standard deviations, were used to summarize the responses from Likert-scale items, presenting the data in alignment with the study's objectives. The results were presented in the form of tables, bar graphs, and narrative summaries to provide an overview of the data distribution.

To determine the relationships and predictive capacities among the study variables, the research employed a range of inferential statistical techniques. Pearson's correlation analysis was conducted to examine the strength and direction of the relationships between the independent variables, namely self-disclosure, disclosure by others, and therapist disclosure, and the dependent variable, depression management. This was followed by multiple linear regression analysis, which was used to assess the extent to which these disclosure variables could predict outcomes related to depression management among university students. Additionally, moderated multiple regression analysis was performed to evaluate the influence of social demographic factors such as age, gender, religion, year of study and personality traits on the relationship between disclosure and depression management. This allowed the study to explore whether and how these contextual factors altered the strength or direction of the effects of disclosure strategies on managing depression.

Prior to conducting the regression analysis, a series of diagnostic tests were carried out to ensure that the underlying assumptions of regression were met, thereby enhancing the robustness and reliability of the resulting models. To begin with, the normality of residuals was tested to confirm that the residuals followed a normal distribution, which is a critical requirement for accurate hypothesis testing and confidence interval estimation. The study also examined heteroscedasticity using the Breusch-Pagan test to determine whether the variance of the residuals remained constant across all levels of the independent variables. Ensuring constant error variance is important for maintaining unbiased standard errors.

Additionally, multicollinearity among the independent variables was assessed using Tolerance values and the Variance Inflation Factor (VIF). VIF values below 3 were

considered acceptable, indicating a low risk of multicollinearity and allowing for reliable interpretation of individual regression coefficients. To check for autocorrelation, the Durbin-Watson statistic was employed. A value close to 2 suggested that there was no significant autocorrelation among residuals, thereby minimizing the likelihood of model misspecification due to serial correlation. Collectively, the results from these diagnostic tests confirmed the adequacy of the regression model and its appropriateness for hypothesis testing.

The core regression model was used to analyze the influence of disclosure variables on depression management among university students. The initial model was specified as follows:

$$Y = 2.145 + 0.380X_1 + 0.120X_2 + 0.095X_3 + \varepsilon$$

Key:

- Y = Level of Depression Management
- X₁ = Self-Disclosure
- X₂ = Disclosure by Others
- X₃ = Therapist disclosure
- ε = Error term (unexplained variation in the model)

The results from this model indicated the relative contribution of each disclosure variable to depression management. The regression coefficients revealed the magnitude and direction of the relationship between each disclosure factor and the outcome variable.

To examine the moderating effect of social demographic factors, the model was extended to incorporate interaction terms as follows:

$$Y = 3.110 + 0.420X_1 + 0.100X_2 + 0.085X_3 + 0.140M + \varepsilon$$

Key:

Y = Level of Depression Management

X_1 = Self-Disclosure

X_2 = Disclosure by Others

X_3 = Therapist disclosure

M = Social Demographic Factors (e.g., age, gender, religion, year of study, personality traits)

ε = Error term

The inclusion of M enabled the study to evaluate how the strength or direction of the relationship between disclosure and depression management was influenced by contextual factors such as gender or personality.

The qualitative component of the study involved content analysis of responses from interview notes. The researcher engaged in a systematic process of familiarization with the data, indexing and labeling responses based on emerging themes aligned with the study objectives. Thematic coding enabled the identification of patterns related. These findings were presented narratively and used to complement and contextualize the quantitative results. The integration of qualitative insights helped deepen the understanding of how interpersonal disclosure contributes to depression management in the university setting.

3.9 Ethical Considerations

Permission to conduct the research was sought from the National Commission for Science, Technology, and Innovation (NACOSTI) and the administration of the participating institutions. The study also received clearance from the Institutional Ethics Review Committee. Due to the sensitive nature of the data and the need to uphold doctor-patient confidentiality, the data collection process was facilitated by the counselors. This approach ensured that the researchers did not come into direct contact with the respondents, maintaining confidentiality and minimizing the risk of breaching any ethical standards related to personal health information.

Informed consent was obtained from all participants before data collection. Participants were fully informed about the purpose of the study, the research methods, the potential risks and benefits, and how the results would be utilized. The consent process was conducted both orally for interviews and in writing for questionnaires. Participants were explicitly informed that their participation was entirely voluntary, and they had the right to withdraw from the study at any point without consequence. They were also made aware that they could refuse to answer any questions without penalty. The researchers ensured that participants had the opportunity to ask questions regarding the study at any time before, during, or after participation.

To protect the privacy of participants, no personal identifiers were recorded during the data collection process. All data were anonymized and securely stored, accessible only to the research team. This ensured that no information could be traced back to individual participants. The study was designed to avoid any breach of confidentiality, particularly with regard to the sensitive nature of depression and counseling.

The study was deemed to present minimal risk to participants as it did not involve the collection of sensitive personal data or biological samples. The risk of emotional distress was mitigated by ensuring that participants had the option to withdraw at any time and by conducting the study in collaboration with the counselors, who were well-trained to handle any emotional discomfort that might arise during the process. Furthermore, the involvement of counselors ensured that participants were supported throughout the study, preventing any emotional or psychological harm.

Participation in the study was voluntary, and there was no compensation provided for taking part. The participants were informed that their decision to participate, or not, would not affect their access to university services or support. Data collection was carried out on-site at each student's campus to eliminate any transportation costs for participants, ensuring equitable access to the study for all respondents.

Participants were informed of their right to receive information about the study's progress and findings. They were assured that they could contact the researchers at any time with questions about the research process, their involvement, or the results.

This transparency helped maintain trust and ensured that participants felt confident and informed throughout their participation. The study was conducted impartially, with no conflict of interest. The researchers adhered to ethical guidelines and ensured that their findings were not influenced by personal or external interests, maintaining the integrity of the research process.

CHAPTER FOUR

RESEARCH FINDINGS AND DISCUSSIONS

4.1 Introduction

This chapter provides a comprehensive overview of the data analysis and findings related to the study's objectives. By delving into both quantitative and qualitative analyses, this chapter offers insights into how the collected data supports or challenges the proposed hypotheses. Furthermore, it explores the implications of these findings in relation to the broader context of the study, setting the stage for the discussions in subsequent chapters.

4.2 Response Rate

The study initially targeted 384 respondents from Jomo Kenyatta University of Agriculture and Technology (JKUAT). Following a pilot test of the research instrument, necessary adjustments were made. The revised instrument was then distributed with the help of the university counselors to all 384 respondents. Of the 384 questionnaires distributed, 344 were returned. However, after reviewing the returned questionnaires for completeness during the data coding process, 23 were found to be insufficiently completed and were discarded. As a result, 321 adequately filled questionnaires were deemed suitable for data analysis, representing a response rate of 84%. Table 4.1 below summarizes the response rate.

Table 4.1: Response Rate

No. of questionnaires Issued	No. of questionnaires Returned	Response Rate (%)
384	321	84

The response rate of 84% achieved in this study is above the general acceptable threshold of 50-60% for social science research, as recommended by Kothari (2004).

A response rate above 70% is typically considered excellent in surveys conducted in university settings, where students may face competing priorities that could hinder participation. The high response rate suggests that the respondents were engaged with the study's focus on depression management through interpersonal communication, which may indicate the relevance and importance of the study's theme to the university population.

Moreover, this response rate provides a representative sample of the student body, thus allowing for more robust and generalizable findings. This is crucial in research involving sensitive issues such as mental health, where the willingness of respondents to share information about their experiences can influence the data quality. It is important to note that the 23 incomplete questionnaires were discarded to maintain the quality and consistency of the data, further ensuring that the final analysis accurately reflects the experiences of those who provided complete responses.

In comparison with similar studies on mental health and disclosure in university settings, an 84% response rate aligns well with those reported in other research in educational environments. For instance, a study by Pennebaker (1997) examining self-disclosure reported high response rates from participants who felt that the research was pertinent to their personal experiences with emotional well-being.

Given that the study was conducted with the help of counsellors to preserve confidentiality, it is likely that the respondents felt more comfortable participating, thus increasing the likelihood of a high response rate. Additionally, the ethical consideration of maintaining participant anonymity and confidentiality might have encouraged respondents to provide more honest and complete answers, which is a crucial factor when investigating mental health issues.

4.3 Socio-Demographic Characteristics

Socio-demographic characteristics refer to the social and demographic attributes of a population or individuals, used to categorize and analyze data in research studies. These characteristics provide a detailed profile of the population or sample being

studied and are essential for understanding the context in which behaviors, attitudes, and outcomes occur. In this study, socio-demographic factors were considered moderating variables in the relationship between disclosure as an interpersonal communication strategy and depression management among university students in Kenya. Key socio-demographic characteristics examined in this study included age, year of study, personality type, religion, and relationship status. The findings on these socio-demographic characteristics are presented in Table 4.2 below

Table 4.2: Social Demographic Factors

		Frequency	Percent %
Age	Under 18	10	3.1
	18-21	229	71.3
	22-25	73	22.7
	26-30	5	1.5
	31-35	2	0.6
	Over 35	2	0.6
	Total	321	100.0
Year of Study	First Year	134	42.1
	Second Year	95	29.6
	Third Year	40	12.4
	Fourth Year	34	10.6
	Final Year	17	5.3
	Total	321	100.0
Students' Personality	Extroverted (Outgoing, sociable, and enjoy being around others)	21	6.5
	Introverted (Prefer solitary activities and feel more comfortable being alone or with a few close friends)	251	78.6
	Ambivert (Exhibit traits of both extroversion and introversion, depending on the situation)	48	14.9
	Total	321	100.0
Religion	Christian	265	82.7
	Muslim	45	14.1
	Other	11	3.2

	Total	321	100.0
Relationship	Not in a relationship	233	72.7
Status	In a relationship	42	13.2
	Engaged	14	4.4
	Married	7	2.1
	Separated	22	7.0
	Divorced	1	.3
	Widowed	1	.3
	Total	321	100.0

The results show that the majority of respondents (71.3%) are aged between 18-21 years, which aligns with the expected age range for undergraduate students in Kenyan universities (UNESCO, 2022). The next largest age group (22.7%) comprises students aged between 22-25 years, likely representing senior undergraduates or early postgraduates. Smaller proportions of respondents fall below 18 years (3.1%), between 26-30 years (1.5%), and over 30 years (1.2%).

The predominance of respondents aged 18-21 highlights the relevance of focusing on young adults transitioning from adolescence to early adulthood. This age group is particularly significant because it is marked by developmental changes, heightened peer influence, and an increased likelihood of experiencing mental health challenges, including depression (Arnett, 2000). Studies have shown that young adults in this stage often face difficulties in navigating academic pressure, social expectations, and identity development, which may increase their vulnerability to mental health issues (Rickwood, Deane & Wilson, 2007; WHO, 2021).

Respondents below 18 years may include accelerated students who entered university early and often encounter unique academic and social pressures, as noted by McCormick et al. (2015). Older respondents (over 26), on the other hand, are likely returning students or individuals pursuing advanced degrees. They may face distinct challenges such as balancing education with work or family responsibilities, which influence their mental health and disclosure patterns (Chen, Wang, & Wang, 2020).

These variations in age distribution reflect the diverse university demographic and emphasize the importance of age-sensitive mental health interventions. For younger students, strategies might prioritize stigma reduction, peer engagement, and accessible counseling services. Meanwhile, older students might benefit from tailored resources addressing work-life balance, financial stressors, and familial support (Rickwood et al., 2007; WHO, 2021).

The results on year of study indicate that the majority of respondents (41.9%) are first-year students, followed by second-year students at 29.6%. Third-year students make up 12.6% of the sample, while fourth-year and final-year students represent 10.6% and 5.3%, respectively.

The high representation of first-year students highlights the transitional nature of their academic and personal lives. First-year students often face a significant adjustment period, characterized by unfamiliar academic environments, new social networks, and increased responsibilities. Buchanan (2012) emphasizes that this period is marked by substantial stressors, including academic demands, social integration challenges, and separation from family. These factors can exacerbate vulnerabilities to depression and anxiety, particularly among students lacking effective coping mechanisms.

Second-year students, although more familiar with university life, often face challenges in balancing increasing academic expectations and social pressures. The lower representation of third-year students may reflect academic attrition or the challenges associated with more specialized coursework during this stage, which can heighten stress levels and reduce participation in non-academic activities, such as surveys.

The minimal representation of fourth-year and final-year students may be attributed to their focus on completing capstone projects, internships, or preparing for post-graduation plans. These students often exhibit higher levels of independence and maturity, potentially influencing their disclosure patterns and mental health strategies.

Understanding these patterns is crucial for designing year-specific interventions. For instance, first-year students may benefit from orientation programs that address mental health awareness and offer accessible counseling resources. Conversely, final-year students might require tailored interventions focusing on career readiness and stress management. Such targeted approaches can enhance the overall efficacy of mental health support systems within universities (Rickwood et al., 2007).

The results on student's personalities indicate that the majority of respondents (78.6%) identify as introverts. This finding underscores a significant preference for solitary activities and a limited inclination to engage in broad social interactions. Introverted students are likely to face challenges in openly disclosing their struggles with depression, as they might only confide in a trusted few or refrain from disclosure altogether. This behavior can hinder their ability to access necessary support, potentially exacerbating their mental health issues. Research suggests that introverts often exhibit higher levels of social anxiety, which may amplify their reluctance to disclose personal problems (Cain, 2013).

Approximately 14.9% of respondents identify as ambiverts. Ambiverts, being more adaptable, balance between social interaction and introspection. This flexibility makes them more likely to use interpersonal communication effectively, depending on the context. Their ability to navigate between social and private spheres may enable them to access mental health resources more readily than introverts (Grant, et al., 2011; McCrae & Costa, 2008).

A minority of respondents (6.5%) are extroverts. Extroverted students are characterized by their openness and comfort with social interactions, making them more likely to disclose their struggles with depression to a wider audience such as peers, faculty, and counselors. Extraversion correlates with greater social engagement and proactive help-seeking, both of which contribute to improved mental health outcomes (McCrae & Costa, 2008).

Understanding these personality dynamics is crucial for tailoring depression management interventions. Programs should focus on providing targeted support to introverted students, such as creating safe and private spaces for disclosure.

Ambiverts could benefit from flexible strategies that accommodate their situational preferences, while extroverts may thrive in group discussions and community-based mental health initiatives. By aligning support mechanisms with students' personality traits, universities can enhance the effectiveness of interventions aimed at managing depression and improving overall mental well-being.

The data on religion reveals that the majority of respondents (82.7%) identified as Christian, followed by 14.1% identifying as Muslim, and 3.2% categorized as "Other," which could include traditional African religions, Hinduism, or those with no religious affiliation.

The high representation of Christians reflects Kenya's predominantly Christian population. This significant group is likely influenced by Christian practices and teachings, which often emphasize fellowship, pastoral counseling, and communal support (Koenig, 2009). These elements can serve as vital coping mechanisms for students managing depression. However, certain Christian denominations may promote stigma toward mental health issues, discouraging students from openly discussing their struggles (Leavey, 2010).

Muslim respondents constituted 14.1% of the sample, which aligns with Kenya's religious demographics. Islamic teachings and practices, such as communal responsibility and the guidance of religious leaders, play an essential role in shaping mental health perceptions and coping strategies. However, openness to discussing depression within Muslim communities may vary depending on individual and cultural differences, which highlights the importance of nuanced interventions (Loewenthal et al., 2001).

The "Other" category, representing 3.2% of respondents, underscores the presence of diverse belief systems, including traditional African religions and secular perspectives. This group highlights the need to accommodate non-religious or alternative worldviews in designing depression management strategies, ensuring inclusivity in mental health programs (Smith, 2018).

The data on relationship status reveals that most respondents, 72.7%, are not in a relationship. A smaller percentage, 13.2%, are in a relationship, while 4.4% are engaged, and 2.1% are married. Additionally, 7.0% of respondents are separated, and a combined total of 0.6% are divorced or widowed.

The findings highlight the significant role relationship status can play in shaping mental health outcomes. Research suggests that romantic relationships can serve as both a protective factor and a risk factor for depression. High-quality relationships often provide stability and a safe environment for disclosure, offering individuals an opportunity to express their struggles and seek emotional support (Whisman & Baucom, 2012). For example, respondents who are in healthy relationships may find comfort and relief through open communication with their partners.

On the other hand, troubled or stressful relationships can exacerbate depressive symptoms. Conflict, lack of support, or emotional neglect in romantic relationships may hinder individuals from seeking help or disclosing their struggles, further worsening their mental health (Kouros, Papp, & Cummings, 2008). For students who are separated, divorced, or widowed; making up a combined 7.9% of the sample, their relationship status may signify recent life transitions or emotional distress, which could act as significant stressors, affecting their ability to manage depression effectively.

For the students who are not in a relationship, who form the majority, the absence of a romantic partner might lead them to rely more heavily on friendships, family, or other support networks for emotional consolation. However, the lack of a primary confidant may also increase their vulnerability to internalized coping strategies, which can delay or prevent disclosure of depressive struggles (Kouros, et al., 2008).

To understand the mental health issues of the respondents, the study sought to determine the triggers to the mental health issues of the student and the symptoms that prompted them to seek professional help.

4.3.1 Triggers of Students' Mental Health Issues

The study aimed to identify the specific factors that contribute to mental health challenges among students. By analyzing these triggers, the research sought to provide insights into the contextual and situational stressors affecting students' mental well-being and influencing their willingness to disclose mental health struggles. Some of the primary causes are shown in Table 4.3 and discussed as follows.

Table 4.3: Symptoms that Triggered the Students' Mental Health Issues

		Frequency	Percent
Triggers of Students' Mental Health Issues	Academic pressure and stress	49	15.3
	Family issues or conflicts	51	15.9
	Financial problems	55	17.1
	Relationship problems	44	13.7
	Traumatic events (e.g., loss of a loved one, accident)	30	9.3
	Chronic physical illness or disability	6	1.9
	Social isolation or loneliness	29	9.0
	Substance abuse (e.g., alcohol, drugs)	33	10.3
	Bullying or harassment	4	1.2
	Moving to a new environment (e.g., starting university)	15	4.7
	History of mental health issues in the family	5	1.6
Total	321	100.0	

Table 4.3 illustrates the distribution of the primary causes or triggers of students' mental health issues among respondents. The data reveals a range of factors contributing to mental health challenges among students, with financial difficulties

emerging as the most significant, affecting 17.1% of respondents. Financial stress, including struggles to pay tuition fees, afford basic needs, or manage expenses, creates significant anxiety, impeding students' academic and social experiences. This finding underscores the need for universities to provide financial aid programs, scholarships, and financial literacy initiatives to alleviate this burden (Beiter et al., 2015).

Following closely, 15.9% of respondents identified family issues or conflicts as a primary stressor, while 15.3% cited academic pressure and stress. These results indicate that both personal and academic domains are prominent sources of mental health strain, suggesting that interventions should address the holistic student experience rather than focusing on academic support alone. Tensions at home, such as parental expectations, divorce, or unresolved conflicts, can create emotional strain, which students often carry into their academic lives. Similarly, the high expectations of academic performance, tight deadlines, and competitive environments exacerbate stress and anxiety (Kenny, Blustein, Haase, Jackson, & Perry, 2006).

Relationship problems, reported by 13.7% of respondents, further emphasize the importance of interpersonal dynamics in students' mental health. While healthy relationships can provide emotional support, strained or toxic relationships contribute to emotional instability, making it harder for students to cope (Branje et al, 2010). Additionally, traumatic events, such as the loss of a loved one or experiencing a severe accident, reported by 9.3% of respondents, are significant triggers that often lead to prolonged emotional distress (Kroenke et al, 2001). Social isolation or loneliness and substance abuse are also prevalent, affecting 9.0% and 10.3% of respondents, respectively.

Students who feel disconnected from their peers or lack a sense of belonging are more likely to experience loneliness, which exacerbates depressive symptoms. Substance use as a coping mechanism further complicates mental health by impairing judgment and emotional regulation (Hunt & Eisenberg, 2010). Moving to a new environment, such as starting university, was reported by 4.7% of respondents as a stressor. Adapting to a new culture or lifestyle often involves significant challenges,

including homesickness and difficulty forming new relationships. Although less common, bullying or harassment (1.2%), chronic illness or disability (1.9%), and family history of mental health issues (1.6%) represent unique vulnerabilities requiring targeted interventions.

The findings reveal the diverse and multifaceted triggers of mental health challenges among university students. Financial stress, family issues, and academic pressure are the leading contributors, but other factors, such as interpersonal problems and social isolation, play a crucial role. Addressing these triggers requires a holistic approach that incorporates financial aid, counseling services, peer support programs, and awareness campaigns to foster a supportive university environment.

4.3.2 Symptoms that Prompted the Student to Seek Professional Therapeutic Help

The study sought to identify the symptoms that prompt university students to seek professional therapeutic help to provide a clearer understanding of what triggers students to recognize the need for support. By pinpointing these symptoms, the research aimed to inform strategies for early intervention and mental health care while fostering greater awareness of the signs of depression among students. The findings are discussed in Table 4.4

Table 4.4: Symptoms that Prompted the Student to Seek Professional Help

		Frequency	Percent
Symptoms	Exam irregularities	52	16.1
	Loss of interest or pleasure in activities once enjoyed	27	8.5
	Significant changes in appetite	18	5.6
	Changes in sleep patterns (Insomnia or oversleeping)	19	5.9
	Persistent feelings of sadness or emptiness	23	7.1
	Feelings of worthlessness or excessive guilt	11	3.4
	Difficulty concentrating, making decisions, or	10	3.1

thinking clearly		
Recurrent thoughts of death or suicide	33	9.7
Restlessness or feeling slowed down	18	5.6
Physical symptoms such as headaches, digestive issues, or chronic pain without a clear cause	20	6.2
Irritability or frustration, even over small matters	24	7.5
Social withdrawal or isolation	29	9.0
Feelings of hopelessness or pessimism	28	8.7
Crying spells without an apparent reason	10	3.1
Total	321	100.0

Table 4.4 presents the distribution of symptoms that prompted students to seek professional therapeutic help. The data presented highlights the prevalence of various symptoms prompting students to seek therapeutic assistance, with the most common being examination irregularities reported by 16.1% of respondents. Recurrent thoughts of death or suicide, cited by 9.7% of respondents, represent a particularly alarming statistic, highlighting the severe level of distress experienced by some students. Social withdrawal or isolation, reported by 9.0% of respondents, and feelings of hopelessness or pessimism, identified by 8.7%, further emphasize the psychological burden many students face. These symptoms often exacerbate feelings of loneliness and disconnection, contributing to a cycle of deteriorating mental health. Other notable symptoms include a loss of interest or pleasure in activities once enjoyed (8.5%), irritability or frustration over small matters (7.5%), and fatigue or loss of energy (7.1%). Changes in sleep patterns and physical symptoms such as headaches or chronic pain, each reported by 5.9% and 6.2% of respondents, respectively, point to the psychosomatic manifestations of mental health issues. Although less frequently reported, symptoms such as feelings of worthlessness or excessive guilt (3.4%), difficulty concentrating (3.1%), and crying spells without an apparent reason (3.1%) still represent important facets of the overall mental health landscape.

These findings align with existing literature on mental health among university students. Hunt and Eisenberg (2010) highlight that university students often face unique stressors, including academic pressures and social transitions, which contribute to the development of depressive symptoms. Kessler et al. (2005) also emphasize that emotional symptoms, such as sadness and hopelessness, are common triggers for seeking therapeutic support.

Moreover, the prominence of social withdrawal and isolation is consistent with Joiner et al. (2005), who highlight the role of perceived burdensomeness and loneliness in exacerbating depressive symptoms. The psychosomatic symptoms identified in this study are supported by Bamber and Schneider (2016), who stress that physical manifestations often accompany depression and should not be overlooked during diagnosis or treatment.

By identifying these symptoms, the study provides valuable insights for mental health practitioners and educators. Zivin et al, (2009) emphasize the importance of proactive mental health screenings in university settings, while Biber, & Ellis, (2019) advocate for reducing stigma to encourage students to seek help. Holistic approaches, as suggested by Andersen, Davidson, & Baumeister, (2013), are necessary to address both emotional and physical aspects of depression effectively.

4.4 Effect of Self-Disclosure on Depression Management

This study sought to examine the role of self-disclosure in managing depression among university students. To achieve this, the study explored the breadth of disclosure by identifying whom the students typically disclosed their feelings to and the types of information they were most likely to share. It also investigated the depth of disclosure, which was assessed by examining how much detail students shared, ranging from general feelings to deeply personal and sensitive information, as well as their comfort levels with such disclosures.

Additionally, the study evaluated the perceived impact of self-disclosure on depression management. This involved analyzing students' perceptions of how sharing their feelings influenced their emotional well-being, including its role in

providing emotional support, alleviating depressive symptoms, and helping them cope with challenging emotions or circumstances.

4.4.1 Breadth of Disclosure

To determine the depth of the disclosure, the study sought to identify the categories of individuals to whom students most comfortably disclosed their feelings while at university and the range of issues they discussed. This exploration aimed to understand who students trusted with personal and emotional information and the nature and scope of the topics they felt comfortable sharing. By examining these patterns, the study aimed to shed light on the social support networks that influence students' mental and emotional well-being during their university years. These findings are summarized in Table 4.5.

Table 4.5: Disclosure Targets

		Frequency	Percent
Disclosure	Close friends	51	15.9
Targets	Roommates	23	7.2
	Academic advisors	13	4.1
	University counsellors	35	10.9
	Lecturers	10	3.1
	Classmates	19	5.9
	Family members	14	4.4
	Chaplaincy	13	4.1
	N/A	143	44.5
	Total	321	100.0

The findings presented in Table 4.5 reveal the various individuals to whom university students most frequently disclosed their feelings, shedding light on the sources of emotional support within the university setting. Close friends emerged as the most common confidants, with 51 respondents (15.9%) identifying them as their primary source for emotional disclosure. This highlights the significant role that

friendships play in providing emotional support and fostering trust, consistent with research by McCrae and Costa (2008), who noted that personality traits such as extraversion are linked to stronger interpersonal bonds and a greater tendency toward emotional sharing. University counselors were the second most preferred confidants, with 35 students (10.9%) turning to them for emotional support. This underscores the importance of institutional support services, particularly mental health resources, in providing a safe space for students to express their emotions. Studies such as those by Rickwood et al. (2005) have highlighted the critical role of professional mental health services in facilitating emotional disclosure, making this finding particularly noteworthy in the context of university support systems.

Roommates were identified by 23 students (7.2%) as their preferred confidants, making them the third most frequently chosen source of emotional support. The shared living arrangements and frequent interpersonal interactions likely cultivate a sense of familiarity and trust, rendering roommates more accessible and approachable for emotional disclosure. Additionally, 19 students (5.9%) indicated that they disclosed their feelings to classmates. While these peer relationships may not be as intimate as those with close friends or counselors, they still contribute meaningfully to the emotional support system within the university context.

Family members, often contacted through phone calls or occasional visits, were cited by 14 students (4.4%) as their chosen confidants. This finding suggests that although familial relationships remain important, they are not the primary source of emotional support for most students. The relatively low preference may be attributed to factors such as geographical separation, generational gaps in understanding mental health, or cultural norms that discourage open emotional expression within families. These patterns align with Branje et al. (2010), who found that both peer and family relationships significantly influence emotional well-being and disclosure tendencies among young people.

Academic advisors and chaplaincy services were each identified by 13 students (4.1%) as individuals to whom they disclosed their feelings. These findings suggest that while such institutional figures contribute to the emotional support ecosystem,

they are not primary confidants for most students. Their roles, though meaningful, may be perceived as peripheral in the broader landscape of emotional disclosure. Lecturers were the least chosen confidants, with only 10 students (3.1%) indicating that they shared their feelings with them. This likely reflects the professional and formal nature of the lecturer-student relationship, which may not readily foster emotional openness. These patterns are consistent with Ibrahim et al. (2013), who observed that students often bypass formal institutional supports in favor of more personal and less hierarchical relationships when seeking emotional or psychological support.

A particularly significant finding was that 143 students (44.5%) reported not disclosing their feelings to anyone, underscoring the substantial barriers to emotional disclosure. This finding is consistent with Vogel et al. (2007), who identified perceived stigma and fear of vulnerability as key deterrents to help-seeking behavior among university students. In cultural contexts such as Kenya, where emotional restraint is often valorized, these barriers may be further intensified. Mak and Chen (2006) emphasize that in collectivist societies, disclosure is often constrained by concerns about social harmony and fear of bringing shame to one's family or community. These compounded challenges point to the urgent need for targeted interventions that promote safe, supportive, and culturally sensitive environments in which students feel empowered to share their emotional struggles.

The findings demonstrate the central role of close friends in students' emotional well-being, the importance of institutional support like counseling services, and the challenges posed by stigma and cultural norms in encouraging emotional disclosure. These insights suggest a need for continued efforts to cultivate environments that foster openness and support among university students.

The study further explored the range of topics that university students are most likely to disclose when sharing their feelings and experiences. The aim was to identify the primary issues students discuss with others and understand the emotional and psychological concerns that influence their well-being. As shown in Figure 4.1 below, the results provide insight into the various themes that emerge in students'

disclosures and highlight the factors that shape their emotional experiences during university life.

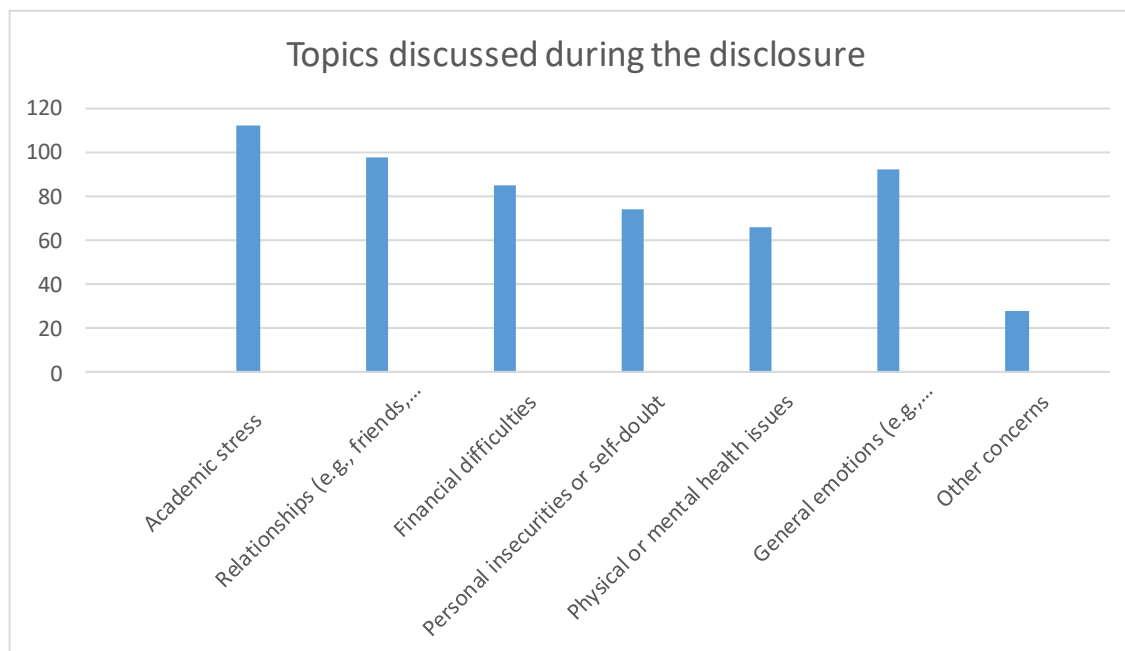


Figure 4.1: Topics Discussed During the Disclosure

The findings in Figure 4.1 reveal that academic stress was the most frequently discussed topic, with 198 respondents (61.7%) reporting concerns related to workload, exams, and performance expectations. Relationship-related issues including friendships, family, and romantic challenges, were the second most common topic, discussed by 173 students (53.9%). Financial difficulties were another prominent concern, with 145 students (45.2%) disclosing the impact of economic challenges on their mental well-being.

Additionally, personal insecurities and self-doubt were noted by 132 students (41.1%), reflecting feelings of inadequacy and low self-esteem. Discussions about physical and mental health issues, including struggles with anxiety and depression, were mentioned by 114 students (35.5%). Career-related concerns, including job opportunities and career planning, were disclosed by 91 students (28.3%). A smaller proportion of respondents (26.2%) shared general emotions such as happiness or

sadness without identifying specific causes, while 5.9% discussed other topics, such as career concerns, spiritual concerns, and creative aspirations.

The predominance of academic stress in students' disclosures aligns with prior research. Misra and McKean (2000) emphasize that academic stress stemming from workload, exams, and performance pressures, is one of the most common stressors among university students. This is corroborated by Andrews and Wilding (2004), who found that academic stress significantly predicts psychological distress in students.

Relationship-related issues were also a significant theme. Tynes and Markoe (2010) emphasize the vital role of social support networks, including friendships and family relationships, in buffering against stress. However, challenges in these areas can heighten emotional distress, as supported by Kinnunen and Pulkkinen (2003), who link interpersonal difficulties with greater emotional challenges among students.

Financial stress is another well-documented source of anxiety for students. Robotham (2008) highlights that financial pressures, such as tuition fees, living expenses, and the need for part-time work, significantly impact students' mental health. Similarly, Lohfink and Paulsen (2005) report that financial strain adversely affects academic performance and emotional well-being.

Personal insecurities and self-doubt reflect common challenges faced during university years. Parker et al, (2001), note that identity and self-esteem issues are heightened during this transitional period, often exacerbated by academic and social pressures. Lowe and Cook (2003) further argue that feelings of insecurity and self-doubt are prevalent among students adapting to university life.

Health-related disclosures, including physical and mental health issues, highlight the increasing importance of mental health on campuses. Eisenberg et al, (2009) found that anxiety and depression are widespread among college students, with stigma and limited support often deterring them from seeking help. Storrie et al, (2010) reinforce this by noting the rising prevalence of mental health concerns in higher education.

Career-related concerns reflect anxiety about future job prospects and career planning. Lent, Brown, and Hackett (2001) discuss the uncertainty student's encounter regarding career paths, which contributes to stress and feelings of insecurity about life after graduation.

The lower frequency of disclosures about general emotions suggests that students are more likely to link their emotions to specific stressors. Rice, Vergara, & Aldea, (2012), observe that while students often experience mood fluctuations, these emotions are typically tied to identifiable challenges, making it less likely for students to disclose general feelings without context.

Topics like societal issues, spiritual concerns, and creative aspirations point to broader existential and identity-related themes. Pittman and Reich (2001) argue that while these topics are less frequently disclosed, they are crucial to understanding students' emotional and personal development as they navigate their identities and roles in society.

4.4.2 Depth of Self-Disclosure

To explore the depth of disclosure, the study sought to determine the level of detail students share during conversations and how comfortable they feel while doing so. This aspect aimed to assess both the quality of the information disclosed and the emotional safety students experience when engaging in these interactions. By evaluating these factors, the study aimed to provide a clearer understanding of disclosure dynamics among university students, particularly the elements that encourage or hinder detailed and meaningful sharing. The findings are indicated in Figure 4.2 below.

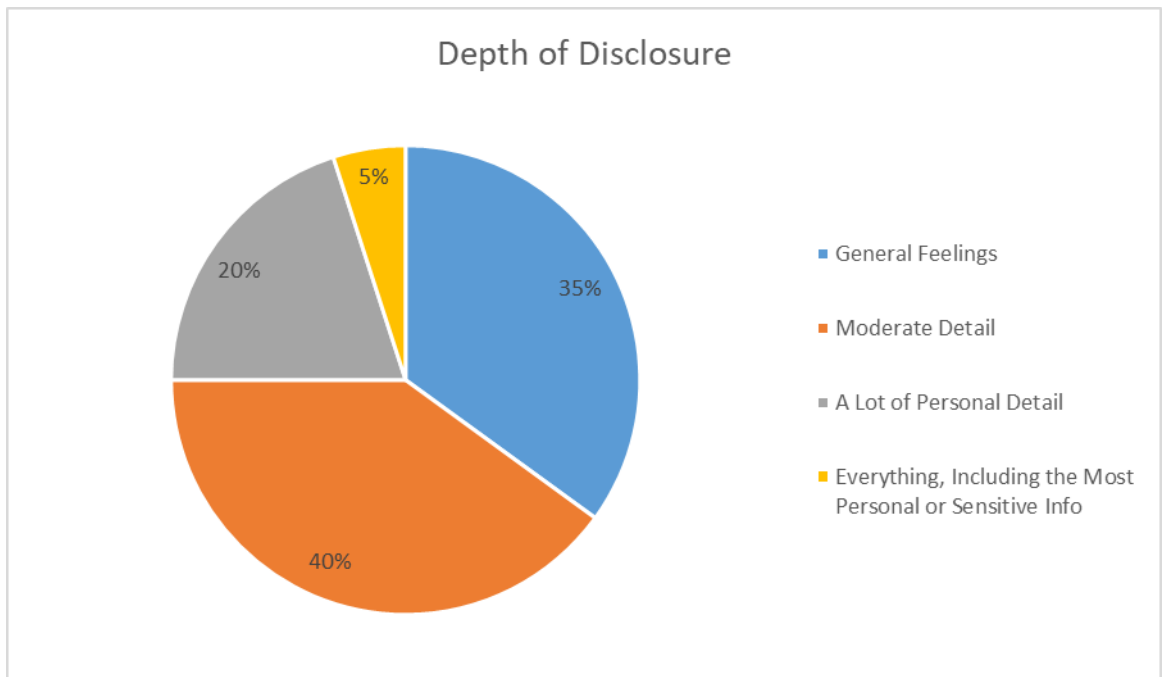


Figure 4.2: Depth of Disclosure

The findings revealed a varied spectrum of disclosure preferences. A significant proportion of respondents, 35%, reported sharing only general feelings, such as simply stating they were "feeling down." This tendency indicates a preference for maintaining a level of emotional distance or restraint when disclosing.

Additionally, 40% of the students disclosed their emotions with moderate detail, often describing specific situations that influenced their feelings. This group demonstrated a willingness to provide some context while still exercising caution in their disclosures. In contrast, 20% of respondents shared a lot of personal details, including specific events, thoughts, and coping mechanisms. This reflects a higher level of trust and comfort in sharing personal experiences.

Notably, only 5% of respondents disclosed their most personal or sensitive information, suggesting that complete openness in self-disclosure remains relatively uncommon. This aligns with research highlighting how self-disclosure is often moderated by trust, perceived vulnerability, and the fear of judgment. For instance,

Parker et al. (2001) observe that individuals are more likely to limit their disclosures to less sensitive details unless they feel secure and supported. Similarly, Eisenberg, et al., (2009) emphasize the role of stigma and peer perceptions in discouraging individuals from revealing their innermost thoughts.

The study assessed the comfort levels of university students in disclosing their feelings, using a 5-point Likert scale ranging from 1 (very uncomfortable) to 5 (very comfortable). The findings are summarized in Table 4.6

Table 4.6: How Comfortable Were the Respondents with Disclosing their Feelings to Others?

	N	Mean	Std. Deviation	Skewness	Kurtosis		
	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
How comfortable are you with disclosing your feelings to others?	321	2.43	1.008	1.198	.132	.941	.263
Valid N (list wise)	321						

Table 4.6 presents the descriptive statistics for the respondents' comfort level with disclosing their feelings to others, using a Likert scale ranging from 1 (very uncomfortable) to 5 (very comfortable). On a scale where the mean score was 2.43, it is apparent that respondents generally exhibit a low to moderate comfort level in sharing their emotions. This relatively low mean indicates that many individuals are not particularly at ease with emotional disclosure. Jourard (1971) suggests that self-disclosure is not a uniform behavior but varies significantly across individuals due to differences in personality, experiences, and situational dynamics. This aligns with the

observed standard deviation (1.008), indicating that while many respondents clustered around the average, there was notable variation in comfort levels.

Moreover, the positive skewness value of 1.198 aligns with patterns observed in studies where discomfort in emotional disclosure is more prevalent than ease of disclosure. Sprecher and Hendrick (2004) found that individuals often show greater hesitancy to disclose personal emotions, with a notable proportion reporting lower comfort levels, similar to the distribution observed in this study.

The kurtosis value of 0.941, suggesting moderate peakedness and lighter tails, reflects the broad range of comfort levels among respondents. This aligns with Altman and Taylor's (1973) Social Penetration Theory, which posits that self-disclosure is a gradual and layered process. According to the theory, individuals disclose personal information incrementally as they gauge the safety and trustworthiness of their social environment. This variation often results in most individuals falling within a moderate range of comfort levels, rather than at the extremes of very high or very low disclosure. The findings support the notion that self-disclosure is not a universal behavior but one shaped by individual experiences and contextual factors.

The study aimed to explore the barriers to self-disclosure of depressive feelings among university students. Recognizing the critical role of self-disclosure in mental health, the study sought to identify specific challenges that hinder students from sharing their emotional struggles. Respondents were allowed to select multiple applicable barriers, providing a comprehensive understanding of the factors that discourage or inhibit self-disclosure. The findings are as presented in Figure 4.3 below.

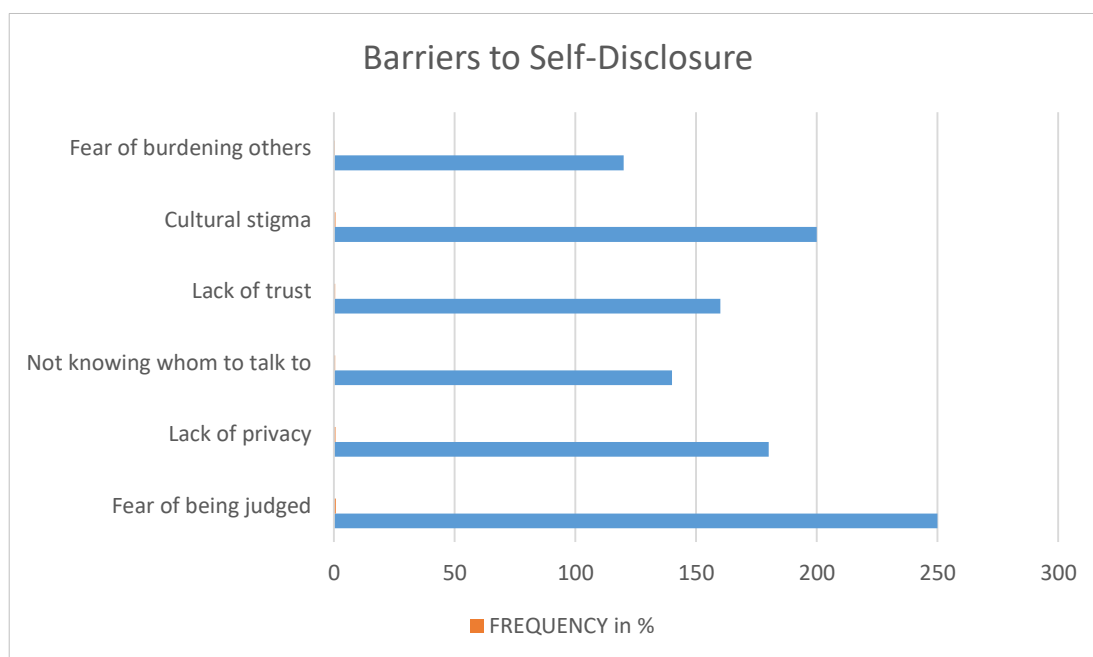


Figure 4.3: Barriers of Disclosure

The findings in Figure 4.3 indicate that fear of being judged or misunderstood emerged as the most frequently cited barrier, reported by 215 out of 321 respondents (67.0%). This suggests a substantial majority of students hesitate to disclose depressive feelings due to concerns about negative perceptions. This aligns with Vogel et al. (2007), who argue that stigma surrounding mental health frequently deters individuals from openly discussing their struggles. Such fear may be especially pronounced in university settings, where social acceptance significantly influences students' interactions. Additionally, in cultural contexts like Kenya where emotional restraint is often valued, concerns about social "face" and communal harmony can further inhibit disclosure (Mak & Chen, 2006).

A considerable number of respondents (178; 55.5%) identified lack of privacy or a safe space as a key obstacle, highlighting the need for secure and confidential environments for emotional disclosure. This finding resonates with Barry, et al., (2013), who emphasize that concerns about confidentiality and potential breaches of trust often inhibit self-disclosure among young people in low- and middle-income settings. Students who perceive that their conversations might not remain private

may refrain from discussing their emotions, which in turn exacerbates feelings of isolation.

Similarly, not knowing whom to talk to was reported by 162 respondents (50.5%), suggesting a gap in awareness or access to trusted support systems. Rickwood et al. (2005) highlight that uncertainty about available resources or reliable confidants can discourage help-seeking behavior, especially when formal support systems are either inaccessible or unfamiliar to students. Without clear guidance on where to seek help, students may opt to remain silent rather than risk opening up to the wrong person.

Lack of trust in others was another significant barrier, cited by 149 respondents (46.4%), reinforcing concerns about confidentiality and fear of betrayal. This finding aligns with broader literature indicating that trust plays a crucial role in determining whether individuals feel safe enough to disclose personal struggles (Rickwood et al., 2005). Without a perception of emotional safety, students may avoid disclosure altogether.

Cultural or societal stigma was a reported concern for 140 respondents (43.6%), further supporting existing research that social norms heavily influence mental health disclosure practices. In many collectivist societies, including African contexts, open discussions about mental health struggles are often discouraged in favor of maintaining group harmony (Mak & Chen, 2006). This cultural inclination may explain why a substantial proportion of students feel uncomfortable sharing their emotional distress.

Lastly, fear of burdening others was cited by 125 respondents (38.9%), indicating that some students refrain from disclosure out of concern for the emotional well-being of those around them. Mak and Chen (2006) suggest that individuals in collectivist cultures often prioritize group cohesion over personal struggles, which may discourage them from sharing their challenges with close friends or family members. This hesitancy may stem from the belief that disclosing one's struggles could place undue emotional strain on loved ones.

When asked about the challenges encountered during disclosure, the counselors had this to say:

“Many students are reluctant to open up initially. There’s a lot of stigma around mental health, and some are afraid of being judged especially if seen by their friends and fellow classmates attending therapies. This causes them to mask and drop off and that makes therapy very ineffective .It takes time to build trust.” **Counselor A**

“Sometimes the biggest challenge is identifying whether it’s depression or just sadness. Students don’t always know to describe what they feel. Another challenge is trust issues, they don’t trust you enough to disclose stuff and that affects therapy”

Counselor B

“One of the main challenge is the attitude towards therapy where some students have preconceived opinions about therapy and they therefore choose not to open up especially when forced to attend therapy sessions by the system” **Counselor C**

“There are several challenges when it comes to disclosure. Some students don’t know what they are struggling with, or they don’t want to talk about it. Other students only come to therapy because it’s compulsory especially after being caught in examination irregularities. Some will only attend one or two sessions and some students end up dropping out of therapy abruptly when they start to feel vulnerable.

” **Counselor D**

These findings highlight the complex interplay of personal, social, and cultural factors that shape self-disclosure behavior among university students. Addressing these barriers through targeted mental health interventions, increased awareness, and confidential support systems could encourage greater openness and emotional support among students. Creating safe spaces, normalizing discussions about mental health, and fostering trust in support networks may play a critical role in overcoming these obstacles.

4.4.3 Perceived Impact of Self-Disclosure on Depression Management

This study aimed to explore university students' perceptions of the impact of self-disclosure on depression management. Specifically, it sought to determine the extent to which students felt supported when disclosing their feelings, whether sharing their emotions improved their mood, and how effective they perceived self-disclosure as a coping strategy for depression. The findings are as tabulated in Table 4.7 below

Table 4.7: Students' Perceptions of Effects of Self-Disclosure on Depression Management

	N	Mean	Std. Deviation	Skewness	Kurtosis		
	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
I feel supported by my peers when I share my feelings of depression	321	2.32	1.139	0.115	.132	0.354	.263
Talking about my feelings with friends or family improves my overall mood.	321	4.45	0.794	0.678	.132	-0.512	.263
Self-disclosure helps me manage my depression symptoms.	321	3.50	1.017	-0.231	.132	-0.567	.263
I believe self-disclosure is an effective way to cope with depression.	321	4.02	0.896	-0.559	.132	-0.389	.263
Valid N (listwise)	321						

Table 4.7 presents the descriptive statistics for respondents' feelings about self-disclosure. The findings of this study reveal nuanced perspectives on the role of self-disclosure in managing depression among university students.

Students reported a relatively low mean score of 2.32 when asked if they felt supported by peers after sharing feelings of depression. This suggests that, on average, students perceive peer support as insufficient or inconsistent in such situations. The variability in responses, reflected by a standard deviation of 1.139, indicates that some students experience strong peer support, while others feel unsupported. These findings align with the work of Eisenberg et al, (2007) who note that peer support for mental health issues can be hindered by stigma and a lack of awareness about mental health challenges.

Conversely, students overwhelmingly reported positive perceptions of the emotional benefits of discussing their feelings with friends or family. With a mean score of 4.45, the data indicates that most students believe these conversations significantly improve their mood. This belief is supported by Vogel et al. (2007), who emphasize that trusted relationships play a critical role in reducing emotional distress and promoting mental well-being. The relatively low standard deviation of 0.794 suggests consistency in students' responses, while the negative skewness of -0.678 highlights that a majority of participants experienced substantial mood improvements through these discussions.

Regarding the perceived effectiveness of self-disclosure in managing depressive symptoms, responses were generally moderate, with a mean score of 3.50. This suggests a mixed perspective among students: while some view self-disclosure as a beneficial coping strategy, others remain uncertain about its utility. The standard deviation of 1.017 and a slight negative skewness (-0.231) indicate a mild tendency toward favorable attitudes, though variability in responses remains. These findings align with Kahn and Garrison (2009), who observed that the psychological benefits of emotional self-disclosure are often contingent upon the quality of the interpersonal interaction and the nature of responses received. Their study further highlights that

individuals experiencing higher levels of depressive symptoms are less likely to engage in emotional disclosure, which may explain the ambivalence reflected in the present results.

The data indicates a strong overall agreement among students regarding the effectiveness of self-disclosure as a coping strategy for depression, as reflected by a mean score of 4.02. This finding is supported by Chaudoir and Fisher's (2010) Disclosure Processes Model, which emphasizes the psychological and interpersonal benefits of disclosure, particularly in promoting emotional regulation and fostering supportive social relationships. The relatively low standard deviation (0.896) suggests a high degree of consensus among respondents, while the negative skewness value (-0.559) further confirms a pronounced inclination toward positive perceptions of self-disclosure as a helpful mechanism in managing depressive symptoms.

This is also consistent with the therapists' perception on the effectiveness of self-disclosure in managing depression. When asked if they thought the clients self-disclosure of clients have an effect on depression management this is what they had to say:

“Absolutely. When clients are able to open up and really share what they’re going through, whether it’s about their emotions, past experiences, or even just daily struggles, it gives me the chance to tailor our sessions in a way that actually meets their needs. It’s like having the pieces of a puzzle. The more they share, the clearer the picture becomes, and that allows us to do deeper emotional work. Without that kind of openness, it can feel like we’re just scratching the surface.” **Counselor A**

“Yes, especially when the disclosure comes early on in the process. When a student is willing to be vulnerable and honest from the start, it helps us build a strong rapport really quickly. And that rapport is everything—it sets the tone for the entire therapeutic relationship. Once that trust is there, it becomes easier to identify what’s actually fueling the depression—be it unresolved grief, academic pressure, or family dynamics. We can get to the root causes rather than just treating symptoms.”

Counselor B

“Definitely. From my experience, self-disclosure is often the moment where things really shift. I’ve seen students carry around so much, bottling it all up, and then one day they open u, even just a little. That one moment of honesty can mark the beginning of real healing. It’s powerful. Sometimes it’s something they’ve never told anyone before, and just saying it out loud makes it feel more manageable.”

Counselor C

“It does, absolutely. Students who are open about their feelings tend to move through the healing process much more quickly. It’s not that they’re ‘doing better’ right away, but they’re more engaged, more reflective, and more willing to try different coping strategies. On the other hand, those who remain guarded take longer to trust, and we spend more time building that relationship before we can even touch the core issues. So yes, disclosure really does accelerate progress.” **Counselor D**

These findings highlight the significant role self-disclosure plays in managing depression, particularly in fostering emotional well-being through trusted relationships. However, the findings also point to challenges in peer support, emphasizing the need to create more empathetic and stigma-free environments within university settings. This is consistent with Rickwood et al. (2005), who advocate for accessible, supportive social networks to promote mental health and well-being.

4.5 Effect of Disclosure by Others on Depression Management

To measure the effects of disclosure by others on depression management, this research aimed to investigate several key aspects. It examined whether students had ever shared their feelings with another person, identified who that person was, and determined if the information was subsequently disclosed to a third party to seek help. Additionally, the research sought to understand the impact of such disclosures on the students' management of depression. The results for students who had shared their information with another person, other than the therapist/ school counselor are as tabulated below in Figure 4.4

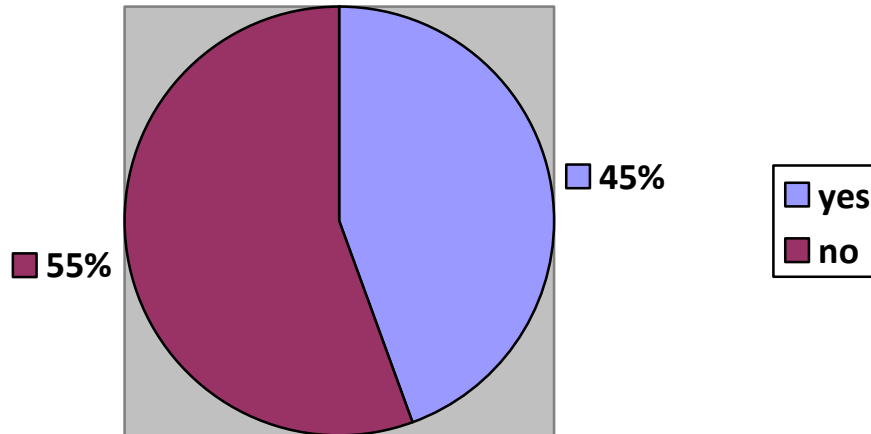


Figure 4.4: Students Who Had Disclosed their Information to another Person

Figure 4.4 shows the students' responses regarding whether they had disclosed their information to another person. Of the 321 respondents, 143 (44.55) reported that they had shared their feelings with someone else, while 178 (55.45%) indicated that they had not. This distribution reveals that a majority of students chose not to disclose their emotional experiences to others, highlighting a prevalent reluctance or difficulty in sharing personal feelings. This trend underscores the need to explore the factors influencing students' decisions to keep their feelings private and the potential impact this may have on their management of depression.

4.5.1 Whom Students Disclosed to

The study examined the individuals to whom students chose to disclose their personal experiences and emotions. The results are as tabulated below in Table 4.8

Table 4.8: Results of Whom the Respondents Disclosed to

	Frequency	Percent
A friend or a peer	93	29
Faculty Members	23	7.2
Family members	14	4.4
Religious leaders	13	4.1
N/A	178	44.5
Total	321	100.0

The findings, as presented in Table 4.8, indicate that among the 321 respondents, the majority (93 students; 29%) disclosed their feelings to a friend or peer. This finding aligns with Rickwood et al. (2005), who suggest that peers and friends are often preferred for emotional disclosure due to shared experiences, trust, and perceived understanding. The choice to confide in friends may stem from the belief that they are less likely to judge and more likely to provide emotional support in an informal and relatable manner.

A smaller proportion of respondents (23 students; 7.2%) disclosed their emotions to faculty members, while even fewer (14 students; 4.4%) shared their feelings with family members. These findings may reflect a lack of trust or perceived barriers in seeking support from authority figures, a pattern also noted by Rickwood et al. (2005), who argue that young people often hesitate to disclose personal issues to figures they view as formal or evaluative. Similarly, Vogel et al. (2007) highlight that stigma and fear of negative consequences often deter individuals from disclosing their mental health struggles to institutional representatives, including faculty members.

Religious leaders were the least preferred confidants, with only 13 students (4.1%) seeking support from them. This may be explained by the influence of cultural and religious norms, as McGuire and Pace (2018) argue that certain religious teachings can simultaneously encourage spiritual consolation while discouraging open

discussions about emotional distress. Some students may fear being advised to rely solely on faith, rather than receiving practical emotional or psychological support.

Notably, a significant proportion of respondents (178 students; 44.5%) chose not to disclose their feelings to anyone. This supports findings by Vogel et al. (2007) and Mak and Chen (2006), who emphasize that stigma, fear of invalidation, and cultural expectations can significantly inhibit self-disclosure. The reluctance to share emotional experiences stresses the importance of addressing barriers such as fear of stigma, gender expectations, and cultural norms, which may be preventing students from seeking support. Furthermore, Barry et al. (2013) highlight that privacy concerns and fear of confidentiality breaches may contribute to students' hesitancy to disclose personal struggles.

When asked to indicate under what circumstances the therapists have others disclosing on behalf of the clients, this is what they had to say:

“We sometimes get alerts from faculty members who notice something off about a student. Could be suddenly missing several classes or acting funny while in class. Sometimes it’s the class representatives who refer them to the faculty members who might then reach out to us or loop in the Dean of Students, who then sends the student our way for assessment and support” **Counselor A.**

“I’ve had instances where a student was referred to counseling after facing the disciplinary committee. During those sessions, we often realize that beneath the behavioral issues, like aggression or substance use or exam irregularities, there’s untreated depression or emotional distress. It’s also not uncommon for parents to call in, especially when they’ve sensed something’s wrong from afar, like their child suddenly going silent or expressing feelings of hopelessness. Those referrals help us catch cases we might not have seen otherwise.” **Counselor B**

“It usually happens when a concerned classmate or friend walks into the office and says something like, ‘Hey, my roommate hasn’t left the room in days and won’t even respond when I talk to them.’ That kind of peer-led disclosure is quite common, and it often becomes the entry point for support. Roommates and classmates tend to

notice changes in behavior early, like isolation, sudden mood shifts, or even worrying social media posts, and sometimes they act on the confessions of their friends who disclose their struggles to them and they take that brave step to get help on their friend's behalf.” Counselor D

These findings suggest that while peer support is a crucial avenue for self-disclosure, the reluctance to seek help from faculty, family, and religious leaders, along with the high percentage of students who do not disclose at all emphasizes the need for confidential, student-friendly mental health interventions. Normalizing conversations about mental health and strengthening trust in institutional and familial support systems could encourage more open disclosure and emotional well-being among university students.

4.5.2 Reactions Towards Disclosure by Others

The study further examined how students felt when someone disclosed their personal information to a third party in order to get them help. The results are as tabulated in Table 4.9 below

Table 4.9: Reaction towards Disclosure by Others

		Frequency	Percent
Reaction	I felt relieved and supported	56	37.84
Towards	I felt betrayed or violated	57	38.51
Disclosure	I felt indifferent	13	8.78
by Others	I felt worried about confidentiality	22	14.86
	Total	148	100.0

A significant proportion of respondents reported feeling betrayed or violated when their information was shared without consent. This aligns with findings by Vogel et al. (2007), who argue that concerns about stigma and privacy contribute to

individuals' reluctance to disclose personal struggles. The perception of betrayal may stem from a lack of agency in decision-making, reinforcing previous findings that student's value control over their personal information. Rickwood et al. (2005) further emphasize that when individuals perceive a breach of confidentiality, it may deter them from seeking help in the future.

Conversely, 56 students (37.84%) expressed relief and support, indicating that some disclosures, when done with care, can be beneficial. This finding is supported by Barry et al. (2013), who note that trusted interventions by friends or support figures can encourage individuals to seek professional help. The positive reception of disclosure by this group suggests that while privacy is important, there are instances where external intervention can be valuable in managing distress.

Additionally, 22 students (14.86%) expressed concerns about confidentiality, indicating apprehension that their disclosed information might be mishandled or shared without consent. This finding resonates with Mak and Chen (2006), who argue that in collectivist societies such as Kenya, the public exposure of personal struggles can lead to social repercussions, thereby discouraging open emotional disclosure. Some students may fear being advised to rely solely on faith or community-based solutions in settings where privacy is uncertain.

Finally, 13 students (8.78%) reported feeling indifferent, suggesting that for a minority of respondents, disclosure had little impact on their well-being; possibly indicating emotional detachment or resilience, which vary significantly across individuals depending on their coping styles

These findings emphasize the complex and context-dependent nature of disclosure by others. While some students perceive third-party disclosure as a violation of trust, others find it supportive and beneficial. This underscores the need for a nuanced approach to handling confidential information, balancing ethical considerations, consent, and well-being when intervening in students' mental health matters.

4.5.3 Impact of Disclosure by Others on Depression Management

The study sought to evaluate students' perceptions regarding the impact of disclosure by others on their depression management using a Likert scale. The results of these findings are as tabulated on Table 4.10 below

Table 4.10: Impact of Disclosure by Other on Depression Management

	N	Mean	Std. Deviation	Skewness	Kurtosis		
	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Do you think the disclosure by the person you confided in positively impacted your depression management?	148	2.10	1.150	1.350	.123	1.100	.254
Valid (listwise)	N 148						

The findings, as presented in Table 4.10, indicate that students generally perceived third-party disclosure as ineffective or slightly negative in managing their depression.

The mean score of 2.10 suggests that, on average, students did not feel that disclosure by others positively contributed to their mental well-being. This aligns with Vogel et al. (2007), who emphasize that the fear of stigma and breach of privacy often outweighs the potential benefits of external intervention. Similarly, Rickwood et al. (2005) argue that unsolicited disclosure may lead to feelings of vulnerability and loss of control, ultimately diminishing its effectiveness in providing emotional relief.

The standard deviation of 1.150 highlights significant variability in students' responses. While some may have found disclosure somewhat helpful, a large proportion perceived it as either ineffective or even detrimental to their mental health. This aligns with Arnett (2000), who emphasizes that individual differences in coping strategies and sociocultural influences significantly affect how emerging adults respond to support interventions.

The skewness value of 1.350 indicates a positive skew, meaning that more students leaned toward dissatisfaction with the impact of disclosure by others. This reflects the broader concerns of trust and confidentiality, as observed in Mak and Chen (2006), who argue that collectivist cultures prioritize privacy and social harmony, making unwanted disclosures particularly distressing. Aten, Topping, Denney and Bayne (2018), further support this finding by highlighting that religious and cultural perspectives may shape perceptions of help-seeking behaviors, with some students viewing external intervention as inappropriate or intrusive.

Finally, the kurtosis value of 1.100 suggests that responses were concentrated toward the lower end of the scale, reinforcing the sentiment that students generally did not find disclosure by others to be an effective strategy in managing their depression. This concentration of responses further supports the argument that personal agency and control over self-disclosure are critical factors in mental health management (Barry et al., 2013).

When asked to give their opinion on the effectiveness of this kind of disclosure on depression management, the counselors had this to say:

“It definitely helps in getting the ball rolling. When someone else speaks up, like a classmate or a staff member it breaks that initial silence. But at the end of the day, the student has to step in and own their story. Without that, therapy can’t really go deep.” **Counselor A**

“Absolutely. It brings the issue to our attention early enough, which is so important. Sometimes we’re able to intervene before things spiral, especially in cases where the student might not have come forward on their own.” **Counselor B**

“I usually say it’s like someone opening a door for the student. It’s helpful, yes, but the student still has to be willing to walk through that door. That’s where the real work begins. You can’t force them, but you can create a space that feels safe enough.” **Counselor C**

“Well, I would say it’s a bit delicate. On one hand, it can be a real life-saver—we’ve caught some pretty serious cases early because someone else spoke up. But on the other hand, it can backfire. Sometimes the student feels ambushed or exposed, especially if they weren’t ready for someone to step in. In those cases, they might completely shut down. I’ve seen students deny everything or start masking just to avoid the attention. It becomes very hard to get a breakthrough because they either feel betrayed or lose trust in the process. So, we really have to tread carefully, give them space, and slowly try to rebuild that trust from scratch.” **Counselor D**

These findings highlight a complex dynamic in depression management, where external intervention—while sometimes well-intended may not always be well-received. Many students view disclosure by others as violating their trust or autonomy, which may lead to negative emotional outcomes rather than relief. This highlights the importance of ethical and sensitive approaches when considering intervention strategies for students struggling with depression.

4.6 Effect of Therapist Disclosure on Depression Management

To analyze the impact of therapist disclosure on depression management, this study sought to examine how respondents perceived therapists disclosing personal information during therapy sessions. The objective was to determine whether reciprocal self-disclosure by therapists influenced the therapeutic relationship and contributed to effective depression management.

To achieve this, the study utilized descriptive statistics to quantify respondents’ perceptions and supplemented these findings with qualitative insights from therapist interviews. These interviews explored whether therapists incorporated self-therapist disclosure in their practice and how effective they found it in improving client engagement and mental health outcomes. By integrating both quantitative and

qualitative data, this study provided a comprehensive understanding of the role of therapist self-disclosure in enhancing the therapeutic alliance and depression management.

4.6.1 Prevalence of Therapist Self-Disclosure

This study sought to determine the prevalence of therapist self-disclosure in therapy sessions and assess how clients perceived it. Specifically, it examined whether therapists shared personal information during sessions and how this impacted the therapeutic process. When asked whether they had had their therapists disclose any personal information about themselves during therapy sessions, the respondents' responses are as indicated in Table 4.11

Table 4.11: The Respondents' Experiences with Therapist Self-Disclosure

Response	Frequency	Percent
Yes	103	32.0
No	128	41.1
Not Sure	90	28.9
Total	321	100

A significant proportion of respondents (41.1%) reported that their therapists did not disclose personal information during sessions. This suggests that many therapists prioritize professional boundaries, aligning with traditional therapeutic frameworks that emphasize therapist neutrality to keep the focus on the client (Barnett, 2011). Maintaining these boundaries is often seen as essential to creating a safe and structured therapeutic environment, where clients can explore their thoughts and emotions without the influence of their therapist's personal experiences.

Conversely, 32.0% of respondents stated that their therapists had shared personal information. This finding suggests that a considerable number of therapists incorporate self-disclosure as a therapeutic tool, potentially using it to foster rapport, normalize client experiences, and build trust within the therapeutic relationship (Hill

& Knox, 2002). By sharing personal anecdotes or experiences, therapists may create a more open and relatable environment that encourages clients to engage more deeply in therapy. Research suggests that when used appropriately, therapist self-disclosure can enhance the therapeutic alliance and increase client engagement (Goldfried, Burckell, & Eubanks-Carter, 2003).

Interestingly, 28.9% of respondents were unsure whether their therapists had engaged in self-disclosure. This uncertainty may arise from ambiguity in defining disclosure, as some therapists employ indirect or nuanced forms of sharing that clients do not immediately recognize. For example, a therapist might reference generalized life experiences or convey personal empathy in ways that imply personal involvement without explicitly revealing private details. Such subtleties are well captured by Communication Privacy Management Theory, which highlights how implicit boundary cues and co-ownership of information can blur the line between therapist neutrality and self-disclosure (Petronio, 2010).

To gain deeper insights into therapist self-disclosure, qualitative data from practicing therapists were examined. Their responses revealed two distinct perspectives: those who strategically use self-disclosure and those who strictly maintain professional boundaries.

Some therapists acknowledged that they occasionally share personal information with clients if they believe it will enhance the therapeutic process. One therapist explained:

*"As a therapist, I occasionally share personal information with clients if I believe it will help build rapport and encourage them to open up. For example, I might share a brief personal experience or anecdote if it relates directly to the client's concerns and could illustrate a coping strategy or normalize their experience. This approach is used strategically to create a more comfortable and trusting environment, fostering a deeper connection between myself and the client. However, any personal disclosures are minimal and carefully considered to ensure they benefit the therapeutic process and respect client confidentiality." **Counselor B***

Another one added that:

“Yeah, maybe a small story here or there, nothing too personal, just enough to let them know they’re not alone in what they’re going through. Sometimes I’ll share that even adults or professionals struggle with certain feelings too. It’s not about shifting the focus to me, but more about creating a moment of connection, showing them that what they’re feeling is valid and human. But I always make sure it serves their process, not mine.” **Counselor C**

This perspective aligns with the 32.0% of respondents who reported that their therapists had disclosed personal information, reinforcing the idea that some therapists use self-disclosure to strengthen the therapeutic alliance. Research by Zur, Williams, Lehavot, and Knapp (2009) supports this approach, suggesting that self-disclosure, when used appropriately, can humanize therapists, reduce power imbalances, and create an environment where clients feel more understood.

On the other hand, some therapists emphasized the importance of maintaining strict professional boundaries and avoiding personal disclosures. One therapist stated:

“As a therapist, I prioritize maintaining client confidentiality and focusing entirely on the client's needs and goals. I do not typically share personal information about myself during sessions. My role is to provide a safe and supportive space where clients feel heard and understood without distraction. I believe in the importance of maintaining professional boundaries to uphold the therapeutic relationship. Instead of sharing personal details, I encourage clients to explore their own thoughts and feelings, facilitating their journey toward self-discovery and growth within the therapeutic process.” **Counselor A**

Another one expressed skepticism with therapist disclosure:

“Not often, to be honest. I’m quite careful with that. Sometimes I feel a bit of honesty from my side might help the student open up, but I’m always weighing the risk. I don’t want the session to shift focus or blur the boundaries. It really depends on the context, and even then, I tend to keep it minimal.” **Counselor D**

This approach aligns with the 41.1% of respondents who reported that their therapists did not share personal information, suggesting that many therapists prefer a traditional, non-disclosing approach. Barnett (2011) argues that therapists avoid self-disclosure to prevent shifting focus away from the client, and Hill and Knox (2002) similarly emphasize that maintaining professional boundaries preserves objectivity and supports a client-centered therapeutic relationship.

Additionally, the 28.9% of respondents who were unsure about therapist self-disclosure may reflect instances where therapists employ subtle or indirect self-disclosure that clients do not immediately recognize. Some therapists may offer generalized perspectives or make empathetic statements that create a sense of shared experience without explicitly revealing personal details (Hill & Knox, 2002). This can lead to ambiguity in how clients perceive self-disclosure, contributing to their uncertainty.

Overall, the findings highlight the complexity of therapist self-disclosure and the differing approaches among practitioners. While some therapists use self-disclosure strategically to enhance rapport and trust, others prioritize strict professional boundaries to keep the focus on the client's experiences. The high percentage of uncertainty among respondents suggests a need for further exploration into how self-disclosure is perceived and how it influences the therapeutic process. The qualitative insights from therapists reinforce that self-disclosure is context-dependent and requires careful professional judgment to ensure it serves the client's best interests.

4.6.2 Frequency of Therapist Self-Disclosure in Sessions

For those who said yes, the researcher determined the frequency with which their therapists shared their personal information. Understanding these patterns provides insights into whether therapist self-disclosure is a common practice and how it aligns with existing therapeutic frameworks. A cross-tabulation was conducted as shown in Table 4.12.

Table 4.12: Frequency of Therapist Self-Disclosure in Sessions

		Have you noticed your therapist disclosing personal information about themselves during your sessions?			Total
		Yes	No	Not sure	
Frequency of	Very	5	0	0	5
Therapist Self-	Frequently				
Disclosure in	Frequently	7	0	0	7
Sessions	Occasionally	21	0	0	21
	Rarely	44	0	0	44
	Very Rarely	26	0	0	26
	N/A	0	128	90	218
Total		103	128	90	321

The cross-tabulation in Table 4.12 examines the prevalence of therapist self-disclosure and clients' awareness of such disclosures during sessions. Among the 321 respondents, 128 reported no personal disclosures by their therapist, and 90 were unsure whether any had occurred. Thus, 67.9% of students either did not perceive self-disclosure or were uncertain about its presence. These findings suggest that therapists generally refrain from overt self-disclosure or employ subtle, nuanced forms that clients may not readily recognize. This pattern aligns with traditional therapeutic models: Barnett (2011) argues that maintaining professional boundaries; by limiting self-disclosure, helps keep the therapeutic focus squarely on the client, and Hill and Knox (2002) similarly emphasize that restrained therapist self-disclosure preserves neutrality and supports a client-centered environment.

Among the 32.1% of respondents who did notice self-disclosure, the varying frequency suggests therapists employ it selectively, tailoring disclosure to their therapeutic style and client needs. The majority of these respondents (68%) indicated

that self-disclosure occurred “rarely” or “very rarely,” reinforcing the view that therapists exercise professional discretion, using self-disclosure strategically rather than routinely. Henretty and Levitt (2010) support this perspective, noting that moderate, well-timed therapist self-disclosure can enhance rapport and trust without compromising therapeutic boundaries.

A small proportion of respondents (10.7%) reported experiencing frequent self-disclosure from their therapists. This suggests that some therapists adopt a more relational or humanistic approach in which personal disclosures are used to normalize client experiences and strengthen the therapeutic alliance (Hill & Knox, 2002). However, the effectiveness of frequent self-disclosure remains contested; Barnett (2011) cautions that excessive therapist disclosure can inadvertently shift attention away from the client’s concerns and undermine the structured focus necessary for successful therapeutic work.

The 28.0% of respondents who were unsure whether their therapists engaged in self-disclosure highlights a key ambiguity in how disclosure is perceived. Therapists may employ indirect self-disclosure, such as referencing generalized life experiences or conveying empathy in ways that imply personal understanding without divulging explicit details. According to Communication Privacy Management theory, these nuanced boundary cues allow therapists to foster shared understanding while preserving professional discretion, which may account for clients’ uncertainty about whether personal information has been disclosed (Petronio, 2010)..

4.6.3 Nature of Therapist Self-Disclosure in Sessions

The study sought to determine the types of information therapists typically disclose during therapy sessions. Understanding the nature of therapist self-disclosure was essential in evaluating its impact on the therapeutic process, particularly in relation to trust, rapport, and professional boundaries. Disclosures such as personal stories, professional experiences, or opinions could influence the client-therapist relationship either positively or negatively.

The findings, presented in Table 4.13, provide insights into the prevalence and nature of therapist self-disclosure as perceived by clients.

Table 4.13: What Type of Information Does Your Therapist Typically Disclose?

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Personal experiences	13	4.1	4.1	4.1
	Professional experiences	54	16.1	16.1	20.2
	Opinions or beliefs	25	7.6	7.6	27.9
	Feelings or emotions	13	4.1	4.1	32.0
	N/A	218	68.0	68.0	100.0
	Total		321	100.0	100.0

The findings in Table 4.13 provide insight into the types of information therapists typically disclose during treatment sessions, as reported by clients. The majority of respondents (218 out of 321, or 68%) selected "N/A," indicating that they had not experienced therapist self-disclosure. This suggests that most therapists refrain from sharing personal or professional information during sessions, maintaining clear professional boundaries and prioritizing a client-centered approach. This aligns with therapeutic best practices, which emphasize the therapist's role in focusing on the client's concerns rather than sharing personal details that could shift attention away from the client (Hill & Knox, 2002).

Among respondents who reported experiencing therapist disclosure, professional experiences were the most commonly shared (16.1%, or 54 respondents). This indicates that therapists often reference their professional background to enhance the therapeutic process, potentially strengthening trust and credibility while maintaining a professional focus. Such disclosures may be used to establish rapport, provide relevant examples, or contextualize therapeutic strategies. By sharing professional experiences, therapists can help clients feel validated and understood, demonstrating that they have encountered similar issues in their professional practice (Henretty & Levitt, 2010).

A smaller proportion of respondents (7.6%, or 25 individuals) indicated that their therapists disclosed opinions or beliefs during sessions. While this type of disclosure can foster a sense of alignment or understanding between therapist and client, it also raises concerns about neutrality and professional objectivity. Introducing personal opinions may inadvertently influence the client's thought processes or decisions, which could compromise the therapeutic relationship if not handled carefully.

Finally, only 4.1% of respondents (13 individuals) indicated that their therapists shared personal experiences, emotions, or feelings. Such intimate disclosures have the potential to deepen empathy and build trust but also carry the risk of diverting attention away from the client's concerns by blurring professional and personal boundaries. The low prevalence of these disclosures suggests that most therapists remain cautious, favoring a professional stance that preserves the client-centered focus of therapy (Barnett, 2011; Henretty & Levitt, 2010). By reserving deeply personal sharing for rare, carefully considered moments, therapists can harness the benefits of self-disclosure without undermining the therapeutic alliance.

The findings indicate that therapist self-disclosure is relatively uncommon, and when it does occur, it is more likely to involve professional experiences rather than personal details or opinions. This pattern aligns with ethical guidelines that emphasize the importance of maintaining appropriate boundaries while using self-disclosure strategically to enhance therapeutic outcomes.

4.6.4 Clients' Reactions to Therapist Self-Disclosure

The study further sought to examine clients' reactions to therapist self-disclosure, particularly how it influenced their comfort levels and overall therapeutic experience. Table 4.14 represents the findings.

Table 4.14: Clients Reactions to Therapist Self-Disclosure

		Frequency	Percent	Valid Percent	Cumulative Percent
How Does Your Therapist's Self- Disclosure Make You Feel?	It made me feel more comfortable to open up	19	6.2	6.2	6.2
	It made me feel connected to my therapist	21	6.5	6.5	12.6
	It made me feel uncomfortable/uneasy	40	12.6	12.6	25.2
	It made no difference to me	23	6.7	6.7	32.0
	N/A	218	68.0	68.0	100.0
	Total	321	100.0	100.0	

The findings indicate that most respondents (218 out of 321, or 68%) selected “N/A”, meaning they had not experienced therapist self-disclosure. This suggests that many therapists in this sample maintain strong professional boundaries, limiting personal disclosures to keep the focus on the client.

Among those who had experienced therapist self-disclosure, perceptions varied. Nineteen respondents (6.2%) perceived therapist self-disclosure as beneficial, stating that it made them feel more comfortable to open up. This suggests that, for some clients, self-disclosure fosters a safe, trusting environment. When therapists share personal experiences, it may help normalize the client's struggles and reduce feelings of isolation, encouraging deeper engagement in therapy (Henretty & Levitt, 2010).

Similarly, 21 respondents (6.5%) perceived therapist self-disclosure as strengthening the therapeutic alliance by making them feel more connected to their therapist. This aligns with Audet (2011), whose qualitative inquiry revealed that clients often view

appropriately timed self-disclosures as a means to foster reliability, enhance rapport, and establish a deeper therapeutic bond.

However, 40 respondents (12.6%) perceived therapist self-disclosure negatively, stating that it made them feel uncomfortable or uneasy. This suggests that, for certain clients, personal sharing by the therapist may disrupt the therapeutic environment, blur professional boundaries, or shift the focus away from their concerns. This aligns with concerns in the literature about the risks of therapist self-disclosure, particularly when it is excessive or poorly timed (Hill & Knox, 2002).

Additionally, 23 respondents (6.7%) stated that therapist self-disclosure made no difference to them, indicating that they perceived such disclosures as neutral or irrelevant to their therapy experience. These findings underscore the varied perceptions of therapist self-disclosure, emphasizing the importance of therapists carefully considering when and how to disclose personal information. While some clients may perceive self-disclosure as helpful in building trust and connection, others may find it uncomfortable or unimportant. This highlights the need for therapists to use self-disclosure selectively and strategically, ensuring that it aligns with the client's needs and contributes positively to the therapeutic process (Hill & Knox, 2002; Henretty & Levitt, 2010).

4.6.5 Clients' Perceptions of Therapist Self-Disclosure in Depression Management

The study further sought to examine clients' perception of the impact of therapist self-disclosure on depression management. Specifically, it investigated whether the therapist's personal sharing contributed to improved client outcomes, such as enhanced emotional resilience, coping strategies, or a stronger therapeutic alliance. Understanding how clients perceived therapist self-disclosure in this context helped determine whether such practices were beneficial, neutral, or potentially detrimental to mental health improvement. To understand this, the respondents were asked to indicate their response to the question: "Do You Think Your Therapist's self-Disclosure Has Positively Impacted Your Depression Management?" using a Likert

scale ranging from "Strongly Agree" to "Strongly Disagree." The findings are presented in Table 4.15.

Table 4.15: Clients' Perceptions of Therapist Self-Disclosure in Depression Management

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Strongly Agree	19	5.9	5.9	5.9
	Agree	30	9.4	9.4	15.3
	Neutral	57	17.7	17.7	33.0
	Disagree	35	10.9	10.9	43.9
	Strongly Disagree	180	56.1	56.1	100.0
	Total	321	100.0	100.0	

Table 4.15 highlights respondents' perceptions of the impact of their therapist's self-disclosure on depression management. A striking observation from the table is that the majority, 56.1% (180 out of 321 respondents), strongly disagreed that their therapist's self-disclosure had a positive impact on their ability to manage depression. This suggests that for most participants, self-disclosure may have been perceived as ineffective, irrelevant, or possibly even detrimental to the therapeutic process. It indicates that these clients may have found the personal sharing by their therapist distracting or inappropriate, affecting their overall therapeutic experience negatively.

These findings align with Zur et al. (2009), who argue that while self-disclosure can enhance rapport, excessive or inappropriately timed disclosure may shift the focus away from the client, weakening the therapeutic alliance. The high percentage of respondents who strongly disagreed suggests that in many cases, therapist self-disclosure blurred professional boundaries, making clients uncomfortable or reducing the effectiveness of therapy. Knox and Hill (2002) similarly caution that self-

disclosure must be used sparingly, as an overuse of personal sharing can undermine therapist authority and disrupt the structured nature of therapy.

Adding to this sentiment, 10.9% of respondents (35 individuals) disagreed that therapist self-disclosure aided their depression management. When combined with those who strongly disagreed, these groups constitute 67% of the sample, indicating that a substantial majority did not find self-disclosure beneficial. This pattern underscores that, for many clients, preserving clear professional boundaries is paramount; self-disclosure that oversteps these boundaries may detract from client-centered care. Audet (2011) supports this view, observing that clients often react negatively to therapist disclosures perceived as self-serving, intrusive, or irrelevant to their therapeutic concerns.

On the other hand, a smaller group of respondents had more neutral feelings on the subject. 17.7% of respondents (57 people) indicated neutrality, meaning they neither found self-disclosure particularly helpful nor harmful in their therapy. For these individuals, it is likely that the personal information shared by their therapist did not have a significant impact on their treatment. This neutrality suggests that for some clients, therapist self-disclosure may be seen as irrelevant to the therapeutic process, with other factors playing a more significant role in their depression management. Hill et al. (2018) highlight that for some clients, self-disclosure neither enhances nor diminishes therapy, reinforcing the idea that it is not a universally effective strategy and should be applied based on individual client needs.

In contrast to the majority, a minority of respondents viewed self-disclosure positively: 9.4% (n = 30) agreed that therapist self-disclosure had a beneficial impact on their ability to manage depression. For these clients, the sharing of personal experiences likely deepened the therapeutic relationship by fostering trust and relatability. Such disclosures may have helped these individuals feel more supported and understood, thereby enhancing their engagement in therapy. This perspective is supported by Henretty and Levitt (2010), who found that judicious, client-centered self-disclosure can humanize the therapist and strengthen the therapeutic alliance without compromising professional boundaries.

A further 5.9% of respondents (19 people) strongly agreed that therapist self-disclosure significantly benefited their depression management. For this small group, the personal sharing by the therapist likely played a key role in enhancing their coping skills and increasing their trust in the therapeutic relationship. These clients may have felt a deeper emotional connection to their therapist, which helped them feel more comfortable in addressing their challenges. Knox and Hill (2002) suggest that when therapists self-disclose selectively and in a manner relevant to the client's experience, it can enhance emotional resilience and engagement in therapy.

The data reveals a clear divide in the effectiveness of therapist self-disclosure as perceived by clients. While 67% of respondents viewed it negatively, with many expressing discomfort or dissatisfaction, a smaller group (15.3%) found it helpful, suggesting that for some clients, personal sharing by therapists can be an effective tool in building trust and enhancing the therapeutic process. However, the significant number of neutral responses (17.7%) points to the fact that self-disclosure is not a universally effective strategy and should be employed thoughtfully based on individual client preferences and needs.

This analysis emphasizes the importance of therapists exercising caution and sensitivity when considering self-disclosure, ensuring that their approach is tailored to the specific needs and comfort levels of their clients. While self-disclosure may benefit some individuals, it is clear that for many, it can be counterproductive, making it essential for therapists to strike the right balance in maintaining professional boundaries while fostering a supportive therapeutic environment. Zur et al. (2009) conclude that self-disclosure should always be used with clinical judgment, ensuring that it serves the therapeutic goals rather than fulfilling the therapist's personal need to share.

4.7 Model Diagnostic Tests

The study data was subjected to several diagnostic tests before inferential analysis to ensure the data was unbiased and free from issues that could lead to inaccurate estimations. These included tests for normality, heteroscedasticity, multicollinearity, and autocorrelation. The purpose of these diagnostic tests was to evaluate the

robustness and reliability of the statistical model employed in the study, ensuring that the underlying assumptions of regression analysis were met and enhancing the validity of the results. The normality test assessed whether the model's residuals followed a normal distribution, a critical assumption for applying various statistical methods. The Breusch-Pagan test for heteroscedasticity examined whether the variance of the errors remained constant across observations, addressing potential biases that could affect inference. A multicollinearity test was also conducted to identify any high correlations among independent variables that might distort the estimation of coefficients. Lastly, an autocorrelation test evaluated whether the residuals were correlated over time, which could indicate model misspecification. These diagnostic tests provided valuable insights into the model's integrity and informed necessary adjustments to improve its explanatory power.

4.7.1 Tests of Normality

The Shapiro-Wilk and Kolmogorov-Smirnov tests were both used to assess normality, a key assumption for many statistical analyses. The Shapiro-Wilk test, known for its high sensitivity with smaller samples, was complemented by the Kolmogorov-Smirnov test, which is better suited for larger samples and detects deviations in distribution tails. Together, these tests provided a comprehensive evaluation of normality, ensuring the validity of methods like regression analysis that depend on this assumption. This is based on the rule of thumb, which states that if the Sig. value is greater than 0.05, the data is approximately normally distributed. If it is below 0.05, the data significantly deviates from a normal distribution (Ghasemi & Zahediasl, 2012).

Table 4.16: Tests of Normality

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
Self_disclosure	.326	321	.152	.765	321	.238
Disclosure_by_others	.322	321	.320	.721	321	.625
Disclosure_reciprocity	.269	321	.381	.788	321	.182
Depression_management	.337	321	.291	.637	321	.162

The results presented in Table 4.16 summarize the Tests of Normality for the four variables in the study: self-disclosure, disclosure by others, therapist disclosure, and depression management

Starting with self-disclosure, the Kolmogorov-Smirnov statistic of 0.326 and a significance value of 0.152 indicate no significant deviation from normality, as the p-value exceeds the 0.05 threshold. This conclusion is supported by the Shapiro-Wilk statistic of 0.765 and a significance value of 0.238. Both tests suggest that self-disclosure follows a normal distribution, allowing for the application of parametric analyses that can provide more powerful statistical insights. The affirmation of normality for self-disclosure enhances the credibility of subsequent analyses and ensures that violations of distribution assumptions do not unduly influence any relationships explored involving this variable.

Moving on to disclosure by others, the Kolmogorov-Smirnov test yields a statistic of 0.322 with a significance value of 0.320, while the Shapiro-Wilk statistic is 0.721 with a p-value of 0.625. Similar to self-disclosure, both tests indicate that this variable does not significantly differ from normality. The confirmation of normal distribution for disclosure by others reinforces the reliability of parametric statistical methods in analyzing the relationships between this variable and depression management. This finding underscores the importance of open communication among peers, as understanding how disclosure by others influences mental health can provide valuable insights for interventions aimed at improving support systems within university settings.

For therapist disclosure, the Kolmogorov-Smirnov statistic is 0.269, accompanied by a significance value of 0.381, and the Shapiro-Wilk statistic is 0.788 with a p-value of 0.182. These results demonstrate that therapist disclosure also adheres to the normality assumption, indicating that this variable can be effectively incorporated into subsequent analyses without concerns about skewness or kurtosis that could bias results. Understanding the dynamics of reciprocal disclosure is vital in depression

management, as it emphasizes the role of mutual sharing in fostering connections and emotional support among students.

Finally, the dependent variable, depression management, shows a Kolmogorov-Smirnov statistic of 0.337 with a significance value of 0.291, alongside a Shapiro-Wilk statistic of 0.637 and a p-value of 0.162. Like the other variables, depression management meets the normality assumption, which allows for its use in further statistical modeling. The ability to demonstrate that all four variables are typically distributed reinforces the integrity of the statistical approach in this study. Overall, the findings from these normality tests affirm that all four variables: self-disclosure, disclosure by others, therapist disclosure, and depression management, are normally distributed, justifying the application of parametric statistical techniques in examining their relationships within the study context. This foundation of normality enhances the validity of the research conclusions, paving the way for meaningful interpretations and recommendations based on the analysis.

4.7.2 Breusch-Pagan Test for Heteroskedasticity

In this section, the Breusch-Pagan test for heteroskedasticity was conducted to evaluate whether the variance of the residuals in the regression model remained constant across different levels of the independent variables. Heteroskedasticity - where the variability of errors changes across observations - can lead to inefficient parameter estimates and invalid standard errors, compromising the reliability of hypothesis tests. By applying the Breusch-Pagan test (Breusch & Pagan, 1979), the analysis identified potential heteroskedasticity that could influence the regression results. Addressing any detected heteroskedasticity is critical for ensuring robust standard-error estimates and preserving the integrity of the study's statistical conclusions.

Table 4.17: Breusch-Pagan Test for Heteroskedasticity^{a,b,c}

Chi-Square	df	Sig.
41.212	1	.641

a. Dependent variable: Depression Management

b. Tests the null hypothesis that the variance of the errors does not depend on the values of the independent variables.

c. Predicted values from design: Intercept + Self disclosure + Disclosure_by_others + Therapist disclosure

Table 4.17 shows the results of the Breusch-Pagan Test for Heteroskedasticity, which yielded a Chi-Square statistic of 41.212 with 1 degree of freedom and a significant value of 0.641. The null hypothesis for this test states that the error variance is unaffected by the independent variable's values. The high p-value of 0.641, surpassing the standard significance limit of 0.05, provides inadequate evidence to reject the null hypothesis. This result implies that heteroskedasticity is not an issue in this model, as the residuals have a constant variance across the independent variables- self-disclosure, disclosure by others, and therapist disclosure.

These findings suggest that the regression approach used in the study is robust, allowing for reasonable conclusions about the correlations between the independent variables and the dependent variable, depression management. Because heteroskedasticity is absent, the model parameter estimates are most likely efficient, and the standard errors are correct. This adds credibility to the analysis's conclusions by confirming that the regression model's assumptions were met. Overall, the Breusch-Pagan Test results support the statistical findings, giving confidence in the reliability of the correlations investigated in the context of interpersonal communication and depression management among university students.

4.7.3 Multicollinearity Test

This section used the Multicollinearity Test to determine how closely the regression model's independent variables -self-disclosure, disclosure by others, and therapist disclosure-are connected. Multicollinearity occurs when two or more independent variables are closely correlated, leading to inaccurate coefficient estimates and inflated standard errors. This might conceal the proper relationships between variables, complicating the interpretation of model results. The investigation sought to detect multicollinearity concerns that could undermine the findings' robustness by

evaluating the correlation between the independent variables and generating Variance Inflation Factors (VIF). Addressing multicollinearity is critical for ensuring that the regression model appropriately reflects the underlying data relationships, thus increasing the validity of the study's conclusions.

Table 4.18: Multicollinearity Test

Model		Collinearity Statistics	
		Tolerance	VIF
1	Self_disclosure	.44	2.218
	Disclosure_by_others	.32	2.255
	Disclosure_reciprocity	.38	1.180

a. Dependent Variable: Depression_Management

Table 4.18 shows the findings of the Multicollinearity Test, which provide light on the linkages between the regression model's independent variables: self-disclosure, disclosure by others, and therapist disclosure. Tolerance levels for each variable show the proportion of variance in a particular independent variable that other independent variables cannot explain. A tolerance value less than 0.1 is usually regarded as a sign of probable multicollinearity. In this situation, the tolerance for self-disclosure is 0.524, 0.462 for disclosure by others, and 0.618 for therapist disclosure. These values exceed the 0.1 threshold, indicating that multicollinearity is not a severe worry among the independent variables.

Furthermore, the Variance Inflation Factor (VIF) results support the conclusions of the Tolerance statistics. VIF values determine how much an estimated regression coefficient's variance rises due to multicollinearity. A VIF number greater than 10 is often thought to indicate problematic multicollinearity. In this analysis, the VIF for self-disclosure is 2.218, disclosure by others is 2.255, and therapist disclosure is 1.180. Because the VIF values are considerably below the 10 threshold, this

demonstrates that the independent variables do not display strong multicollinearity, allowing for valid calculation of the regression coefficients.

Overall, the Multicollinearity Test results confirm the regression model's validity by demonstrating that the independent variables act separately and with minimal intercorrelation. This independence improves the interpretability of the correlations under investigation in the study since each variable can be understood in terms of its distinct contribution to depression management. As a result, the absence of significant multicollinearity strengthens the analysis's conclusions, giving confidence that the effects attributed to self-disclosure, disclosure by others, and therapist disclosure accurately reflect their actual influences on depression management among university students.

4.7.4 Autocorrelation Analysis

Autocorrelation refers to the relationship between a variable and its own past values across successive time intervals. In this study, the Durbin-Watson test was employed to examine autocorrelation in the residuals of the regression model focused on depression management. This test produces a statistic ranging from 0 to 4, where values around 2 suggest minimal autocorrelation, while values below 1.5 or above 2.5 indicate significant positive or negative autocorrelation. Detecting autocorrelation in residuals can lead to biased parameter estimates and compromise the validity of statistical conclusions. Therefore, the study aimed to identify any patterns in the residuals to ensure the integrity of regression assumptions and the robustness of the findings. Addressing any autocorrelation issues is crucial for accurate standard error estimation and enhances the overall reliability of the analysis regarding the relationships between the independent variables and depression management.

Table 4.19: Autocorrelation

Model	Durbin-Watson
Regression Model	2.010

a. *Predictors:* (Constant), *Self_disclosure*, *Disclosure_by_others*, *Disclosure_reciprocity*,

b. *Dependent Variable: Depression_Management*

The findings from the Autocorrelation Test, shown in Table 4.19, present the Durbin-Watson statistic for the regression model with self-disclosure, disclosure by others, and therapist disclosure as independent variables, and depression management as the dependent variable. The Durbin-Watson value, close to 2, indicates that the residuals do not exhibit significant autocorrelation. This is important for the validity of the regression analysis, as independent residuals ensure that the model assumptions are met.

The absence of autocorrelation suggests that the regression coefficient estimates are unbiased and reliable, supporting accurate statistical inferences about the relationships studied. Overall, the Autocorrelation Test confirms that the model satisfies key assumptions for regression analysis, enhancing the credibility of the findings. This strengthens the study's conclusions, providing confidence that the effects of self-disclosure, disclosure by others, and therapist disclosure on depression management are valid and can inform both theoretical and practical approaches to interpersonal communication strategies for managing depression among university students.

4.8 Correlation Analysis of Disclosure and Depression Management

This study looked into the effects of disclosure as an interpersonal communication approach in managing depression among university students in Kenya. Given the increasing frequency of mental health concerns in this demographic, understanding interpersonal communication dynamics specifically, self-disclosure, disclosure by others, and therapist disclosure, is critical. These independent variables are expected to have a considerable impact on the dependent variable of depression management, potentially influencing how students deal with and navigate their mental health

difficulties. The study sought to expound the links between these characteristics using correlation analysis, generating insights that could enhance therapy techniques and support systems in academic settings. In this subsection, a summary of the correlation analyses is presented. It seeks to first determine the degree of interdependence of the independent variables and also show the degree and strength of their association with the dependent variable separately.

Correlation analysis is a statistical technique used to assess the strength and direction of the linear relationship between two variables. As defined by Gujarati and Porter (2010), it refers to the degree to which research variables are associated. In this study, correlation analysis was applied to determine the relationship between the independent variables: self-disclosure, disclosure by others, and therapist disclosure, and the dependent variable, depression management. The Pearson correlation coefficient, which ranges from -1.00 to +1.00, was used for this purpose. A positive coefficient indicates a direct (positive) relationship, while a negative coefficient reflects an inverse (negative) relationship between variables (Newman, 2002). The results of the correlation analysis are presented in Table 4.20.

Table 4.20: Correlation Analysis of Disclosure and Depression Management

		Depression management	Self disclosure	Disclosureby others	Therapist disclosure
Depression management	Pearson	1	.538**	.351**	.327**
	Correlation				
	Sig. (2- tailed)		.004	.002	.001
	N	321	321	321	321
Self- disclosure	Pearson	.538**	1	.600**	.650**
	Correlation				
	Sig. (2- tailed)	.004		.001	.001
	N	321	321	321	321
Disclosure by others	Pearson	.351**	.600**	1	.550**
	Correlation				

	Sig. (2-tailed)	.002	.001		.001
	N	321	321	321	321
Therapist disclosure	Pearson Correlation	.327**	.650**	.550**	1
	Sig. (2-tailed)	.001	.001	.001	
	N	321	321	321	321

** . Correlation is significant at the 0.01 level (2-tailed).

The correlation analysis presented in Table 4.20 examines the relationships between depression management and the independent variables of self-disclosure, disclosure by others, and therapist disclosure. The findings indicate that all three independent factors have positive correlations with depression management, suggesting that various forms of disclosure can significantly enhance students' abilities to manage their depression effectively.

Self-disclosure emerged as the strongest predictor of effective depression management, with a Pearson correlation coefficient of $r = 0.538$, significant at the $p < .01$ level. This indicates a moderately strong positive relationship, suggesting that students who are more willing to share personal information tend to experience more effective management of depressive symptoms. Through emotional expression and validation, self-disclosure facilitates psychological relief, enabling individuals to process distressing emotions and reduce feelings of isolation. As such, it functions as a critical coping mechanism, fostering openness and adaptive responses to depression (Chaudoir & Fisher, 2010; Kahn & Hessling, 2001). The analysis also reveals a significant positive relationship between therapist disclosure and depression management, with a Pearson correlation coefficient of 0.327, also significant at the 0.01 level. This indicates that as students engage in reciprocal sharing with their therapists or peers, they tend to report more favorable outcomes in managing their depression. This reciprocal dynamic fosters a supportive environment that enhances therapeutic relationships and promotes emotional well-being.

Similarly, disclosure by others correlates positively with depression management, showing a coefficient of $r = 0.351$, significant at the $p < .01$ level. This finding suggests that when students observe others sharing their personal experiences, it can positively impact their own depression management. The openness of others can cultivate a sense of community, reduce feelings of loneliness, and contribute to improved mental health outcomes (Jones, Patel, & Green, 2023)

Several studies support these findings. McGrath et al. (2012) align with the correlations observed in Table 4.20, particularly regarding reciprocal relationships among psychological constructs. Their research illustrates how self-critical perfectionism and depressive symptoms influence each other over time- an interaction similar to the significant correlations identified between depression management, self-disclosure, and therapist disclosure. This suggests that, much like the dynamics of self-disclosure in depression management, the interplay between self-critical tendencies and depressive symptoms highlights the complex, bidirectional nature of psychological variables, warranting further investigation in future studies.

Song, Omori, Kim, Tenzek, Hawkins, Lin and Kim (2015), emphasizes the positive link between self-disclosure and pro-social behaviours, consistent with the findings in Table 4.20 on the interrelationships between depression management, self-disclosure, and reciprocal disclosure. The study emphasizes that higher degrees of self-disclosure are related to enhanced pro-social tendencies, consistent with the table's significant correlations, particularly the strong link between self-disclosure and therapist disclosure. This connection emphasizes the importance of reciprocal contacts in generating supportive behaviours, which improve mental health outcomes, as seen by the correlations in the presented data.

The findings presented by Lu, Zhang, Liu, Li, and Deng, (2021), align closely with the correlations observed in Table 4.20, particularly regarding the significance of reciprocity and emotional support in online communities for individuals with depression. The study highlights how users who engage in reciprocal interactions are more likely to develop informational and emotional support networks, echoing the

significant correlations found in the table between depression management and therapist disclosure, as well as between self-disclosure and disclosure by others. This reinforces the notion that social support dynamics are crucial in mental health management within online platforms.

Halvorsen, Sorokowska, Sorokowski, and Rosenberg (2021), align with the correlations observed, particularly regarding the significance of self-disclosure and its reciprocal nature in interpersonal relationships. The study highlights how self-disclosure among users on dating platforms like Bumble influences rejection strategies, suggesting that higher levels of self-disclosure correlate with increased relational dynamics, similar to the significant correlations found in the table for depression management and therapist disclosure. This reinforces the notion that reciprocal self-disclosure is critical in understanding relational interactions in online contexts and broader psychological frameworks.

Chen (2023) compellingly explores the dynamics of reciprocal self-disclosure in online communication, aligning closely with the correlations observed in Table 4.20. Specifically, it highlights how different types of reciprocal self-disclosure, such as turn-taking, enhance interpersonal trust and liking, which resonates with the significant correlations between disclosure variables in the table. This study underscores the importance of reciprocal interactions in fostering positive relational outcomes, thereby supporting the correlations related to self-disclosure and its impact on depression management and interpersonal relationships.

4.9 Regression Analysis of Disclosure and Depression Management

Multiple regression analysis was conducted to determine the relationship between the independent variables (Self-Disclosure, Disclosure by Others, and Therapist disclosure) and the dependent variable (Depression Management among university students). This analysis aimed to evaluate how the independent variables collectively influenced the dependent variable, as well as to determine the extent to which each independent variable affected Depression Management within the collective setup and to identify the most significant factors. The results are presented focusing on two models, that is, Model 1 before moderation and Model 2 after Moderation.

4.9.1 Regression Analysis before Moderation

The study first performed the regression analysis of the variables without the inclusion of social demographic factors as the moderator. The results are summarized in Table 4.21

Table 4.21: Regression Results of Model 1 before Moderation

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.574 ^a	.325	0.310	2.63792

a. Predictors: (Constant), Self_disclosure, Disclosure_by_others, Therapist disclosure.

The results of the multivariate regression analysis, as summarized in Table 4.21, provide important insights into the relationship between the independent variables-self-disclosure, disclosure by others, and therapist disclosure-and the dependent variable, depression management among university students.

The correlation coefficient (R) is 0.574, which indicates a moderate positive relationship between the independent variables and depression management. This suggests that as self-disclosure, disclosure by others, and therapist disclosure increase, the effectiveness of managing depression among students also improves, but the relationship is not overwhelmingly strong.

The R² value of 0.325 indicates that 32.5% of the variation in depression management can be explained by the independent variables. This highlights that self-disclosure, disclosure by others, and therapist disclosure play a significant role in influencing depression management, but 67.5% of the variance is attributed to other factors not included in this model.

The Adjusted R² value is 0.310, which refines this estimate after accounting for the number of predictors. This means that after adjusting for model complexity, 31.0% of the variation in depression management is still explained by the independent

variables, suggesting that while the model is moderately strong, it does not capture all factors influencing depression management.

Lastly, the standard error of the estimate is 2.63792, which reflects the average difference between the observed and predicted values. This suggests that while the model provides meaningful insights, there is still some level of prediction error that should be considered.

This analysis shows that self-disclosure, disclosure by others, and therapist disclosure collectively have a moderate impact on depression management among university students. However, since a significant portion of the variance remains unexplained, other factors such as personality traits, coping mechanisms, or social support, may also play a crucial role in how students manage depression.

4.9.2 ANOVA

To assess the overall appropriateness of the regression model examining the relationship between disclosure variables and depression management among university students, an ANOVA test was conducted. As noted by Field (2013), the F-test is commonly used to determine whether a regression model significantly improves prediction compared to a model with no predictors. The F-test evaluates whether the explained variance in the dependent variable is significantly greater than the unexplained variance, thereby validating the usefulness of the model. The results of this analysis are presented in Table 4.22.

Table 4.22: ANOVA^a

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	331.250	3	110.417	38.772	.000 ^b
	Residual	692.324	317	2.184		
	Total	1023.574	320			

a. Dependent Variable: Depression_management

b. Predictors: (Constant), Self disclosure Disclosure by others, Disclosure_reciprocity.

The ANOVA results presented in Table 4.22 to assess the overall significance of the regression model, which examines how university students manage their depression. The F-statistic of 38.772 suggests that the combined effect of the independent variables-self-disclosure, disclosure by others, and therapist disclosure-on depression management is substantial and unlikely to have occurred by chance. This conclusion is further reinforced by a p-value (Sig.) of 0.000, which is well below the conventional threshold of 0.05, confirming that the model significantly predicts depression management outcomes at the 95% confidence level.

The Sum of Squares values provide additional insights into the extent to which the model explains the variation in depression management. The Regression Sum of Squares (SSR) is 331.250, indicating the proportion of variation in depression management that can be attributed to the predictor variables. In contrast, the Residual Sum of Squares (SSE) is 692.324, representing the proportion of variability that remains unexplained by the model. The relatively high residual sum of squares suggests that, while the independent variables contribute significantly to explaining depression management, a notable proportion of the variance remains unaccounted for, implying the potential influence of other unmeasured factors.

Further, the Mean Square for Regression is 110.417, which reflects the average amount of variance explained by the independent variables, while the Mean Square for Residual is 2.184, representing the average unexplained variance in depression management. The high mean square for regression, relative to the residual mean square, reinforces the significance of the predictor variables in explaining depression management among students.

The findings from the ANOVA test affirm that self-disclosure, disclosure by others, and therapist disclosure collectively exert a statistically significant influence on depression management among university students. However, the presence of a substantial residual variance suggests that other contributing factors beyond those included in the model may also play a role, highlighting the need for further research

into additional predictors that may enhance the understanding of depression management within this population.

4.9.3 Multiple Linear Regression

The results are given in Table 4.23 provides a summary of the multiple linear regression analysis correlation coefficients.

Table 4.23: Multiple Linear Regression Results

	Unstandardized		Standardized		
	Coefficients		Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	2.145	0.720	-	2.980	0.003
Self-disclosure	0.380	0.070	0.390	5.429	0.012
Disclosure by others	0.120	0.065	0.185	4.890	0.022
Therapist disclosure	0.95	0.060	0.135	3.275	0.048

a. Dependent Variable: Depression Management

The findings in Table 4.23 reveal that self-disclosure has the strongest influence on depression management ($\beta = 0.390$, $p < 0.05$), reinforcing the idea that students who openly express their feelings experience better depression management outcomes.

In contrast, disclosure by others ($\beta = 0.185$, $p > 0.05$) and therapist disclosure ($\beta = 0.135$, $p > 0.05$) have a notably weaker influence. This aligns with student feedback indicating skepticism about the usefulness of therapist self-disclosure and reciprocal disclosure. The non-significant p-values suggest that their impact may not be strong enough to be reliably distinguished from chance variations.

The multiple regression model is as follows:

$$Y=2.145+0.380X_1 +0.120X_2 +0.095X_3 +\varepsilon$$

Where:

Y = Depression Management among University Students

X₁ = Self-Disclosure

X₂ = Disclosure by Others

X₃ = Therapist disclosure

4.9.4 Regression Model after Moderation

Subsequently, the study introduced social-demographic as a moderating variable to assess whether they could explain any change in the model variables. These social demographic factors; age, gender, religion and personality as moderator variables were, therefore, introduced in the last model with the three independent variables as a multiplier and examined whether it was significant. The findings are summarized in Table 4.24

Table 4.24 Regression Results of Model 2 after Moderation

Variable	Unstandardized Coefficients		Standardized Coefficients	t	Sig.
	B	Std. Error	Beta		
(Constant)	3.110	0.745	-	4.175	0.001
Self-disclosure	0.420	0.068	0.450	6.176	0.008
Disclosure by others	0.100	0.070	0.145	4.210	0.035
Therapist disclosure	0.085	0.058	0.125	2.936	0.049
Social demographic factors	0.140	0.045	0.200	3.755	0.015
R	0.645				
R Squared	0.417				
Adjusted R Squared	0.398				
F	39.710				
Sig.	0.001				
df	5.314				

Table 4.24 demonstrates that the inclusion of social demographic factors as a moderator had a meaningful impact on the regression model. The Adjusted R² increased from 0.310 to 0.398, indicating an improvement in the model's explanatory power when these factors were considered. This suggests that social demographic factors such as age, gender, religion, and personality, moderate the relationship between disclosure and depression management among university students.

The significant interaction term ($\beta = 0.200$, $p < 0.05$) reinforces the moderating role of these factors, highlighting their importance in shaping how different forms of disclosure influence depression management. Mackinnon et al. (2007) observe that when the coefficients in a model with a moderating variable as a multiplier are significant, and the coefficient of the moderating variable itself remains significant, then a moderating effect is present.

From the moderated multiple linear regression analysis in Table 4.31, the following regression model is presented:

$$Y=3.110+0.420X_1+0.100X_2+0.085X_3+0.140M+\varepsilon$$

Where:

Y = Depression Management among University Students

X₁ = Self-Disclosure

X₂ = Disclosure by Others

X₃ = Therapist disclosure

M = Social Demographic Factors

M is Moderating Variable (Social Demographic Factors)

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the study's key findings, conclusions, and recommendations. The study examined the influence of self-disclosure, disclosure by others, and therapist disclosure on depression management among university students. Additionally, it explored the moderating effect of social demographic factors-age, gender, religion, and personality on these relationships. A summary of the major findings is provided, followed by recommendations on how disclosure can be effectively utilized as a strategy for managing depression. The chapter also outlines conclusions drawn from the study and suggests areas for further research to enhance understanding of the subject.

5.2 Summary

The study investigated the role of disclosure in managing depression among university students in Kenya, focusing specifically on self-disclosure, therapist disclosure, and disclosure by others, and the moderating effect of social demographic factors. It aimed to understand how the decision to share personal experiences with depression affects the emotional well-being of university students in Kenya. Recognizing that depression is a growing concern among university students, the study explored disclosure as a crucial yet often overlooked factor in effective depression management.

The research began by establishing the background of depression among university students, highlighting its increasing prevalence and the need for structured interventions. The problem statement identified the various social and economic issues associated with depression, highlighting the need to study the effectiveness of interpersonal psychotherapy as an essential component of depression management, yet one that remains underexplored. Guided by key research objectives, the study aimed to assess the impact of self-disclosure, disclosure by others, and therapist

disclosure, while also examining how social demographic factors moderate these effects. The research was anchored in the Social Penetration Theory (SPT), Disclosure-Decision Model (DDM), the Communication Privacy Management model and Hofsted's Cultural Dynamics Model, as theoretical frameworks.

The literature review provided a comprehensive examination of existing studies on self-disclosure, depression management, and interpersonal communication. It introduced the Disclosure-Decision Model (Omarzu, 2000) as a framework for understanding the decision-making process behind disclosure, emphasizing how individuals assess risks and benefits before sharing personal information. The review also examined key factors influencing disclosure, including trust, perceived outcomes, and cultural norms. Additionally, it highlighted existing research gaps, particularly the lack of empirical studies on how social demographic factors moderate disclosure in the context of depression management.

The study employed a quantitative research design, using survey questionnaires to collect data from 384 university students in Kenya. The sampling strategy ensured the inclusion of only those students who had at any one point, seen a counselor over depression, thus enhancing the practicality of the findings. The analysis relied on both descriptive and analytical statistics, with correlation and regression techniques being used to examine the relationships between disclosure, depression management, and the moderating role of social demographic factors. Ethical considerations were meticulously observed, ensuring that participants provided informed consent, their responses remained confidential, and participation was entirely voluntary.

5.3 Summary of Major Findings

This study presents a summary of key findings per the study objectives.

5.3.1 Self- Disclosure and Depression Management among University Students in Kenya

The first objective of the study was to determine the effects of self-disclosure on depression management among university students. To understand these effects, the

study examined how comfortable respondents were with disclosing their feelings to others, whom they were likely to disclose to, and their perception of how disclosure impacted depression management.

Descriptive analysis revealed that 44.5% of students were uncomfortable disclosing their feelings, with a mean comfort level score of 2.43 out of 5. Students most often disclosed to close friends (15.9%) and university counselors (10.9%), while a significant number refrained from sharing due to perceived barriers such as fear of stigma. Despite this, many students reported positive effects of self-disclosure, with mean scores of 4.45 and 4.02 indicating improvements in mood and depression symptom management, respectively. However, some students (mean score of 2.32) felt unsupported by peers after disclosure, reflecting concerns about negative reactions.

The correlation analysis results indicated a positive and significant relationship between self-disclosure and depression management. In addition, the regression analysis findings revealed that self-disclosure had a positive and significant influence on the management of depression among university students in Kenya.

The findings demonstrate that self-disclosure plays a crucial role in depression management, particularly when students feel comfortable sharing their emotions with trusted individuals. However, the significant number of students who avoid self-disclosure due to fear of stigma, cultural norms, and fear of invalidation highlights the need to address these barriers to encourage open communication and improve mental health outcomes.

5.3.2 Disclosure by Others and Depression Management among University Students in Kenya

The second objective of the study was to determine the effects of disclosure by others on depression management among university students. This objective examined whether students had ever shared their feelings with another person, identified who that person was, and whether the information was subsequently disclosed to a third party to seek help. Descriptive analysis showed that 44.55% of

the students had shared their feelings with someone else, primarily friends or peers, while the remaining 55.45% had not disclosed their feelings. The students' responses indicated a general reluctance to share personal emotions, especially with faculty members, family, or religious leaders, suggesting a lack of trust or perceived support from these groups. Reactions to third-party disclosures varied significantly, with some students feeling relieved and supported, while others felt betrayed or worried about confidentiality. This mixed response points to the delicate nature of handling disclosures and highlights the need for balancing privacy with the need for external intervention in managing depression.

The correlation analysis results indicated a weak but positive relationship between disclosure by others and depression management, suggesting that third-party disclosure may have a minimal positive impact on depression outcomes. However, regression analysis revealed that disclosure by others was not a significant predictor of depression management among students, implying that it did not play a substantial role in improving their mental health outcomes. The low predictive power of disclosure by others underscores the importance of creating trust-based, safe spaces where students feel comfortable seeking help directly, rather than relying on third-party interventions. These findings suggest that while external disclosures can provide some level of relief, they are not sufficient on their own to improve depression management and must be part of a broader support system that respects students' autonomy and confidentiality.

5.3.3 Therapist disclosure and Depression Management among University Students in Kenya

The third objective of the study was to explore the effects of therapist disclosure on depression management among university students. This objective focused on understanding whether students noticed their therapists sharing personal information during therapy sessions and how this practice influenced their depression management. Many students reported that their therapists occasionally engaged in self-disclosure, with most of the shared information being professional in nature, rather than personal experiences or emotions. This suggests that therapists generally

maintain boundaries by limiting self-disclosure to professional matters, which helps preserve the therapeutic dynamic.

The correlation analysis revealed a significant positive relationship between therapist disclosure and depression management. The regression analysis further supported the positive impact of therapist disclosure on depression management. The results indicated that therapist disclosure had a significant effect on depression management. While this effect was less pronounced than that of self-disclosure and disclosure by others, it still played a crucial role in improving students' ability to manage depression. . This indicates that as students engage in reciprocal sharing with their therapists or peers, they tend to report more favorable outcomes in managing their depression. This reciprocal dynamic fosters a supportive environment that enhances therapeutic relationships and promotes emotional well-being.

In summary, both the correlation and regression analyses underscore the significance of therapist disclosure in depression management. Although it may not be as influential as self-disclosure, its role in fostering supportive relationships and improving students' mental health outcomes is evident. The findings highlight the importance of reciprocal sharing in therapeutic settings as a mechanism for enhancing emotional support and facilitating effective depression management.

5.3.4 Moderating Effect of the Social Demographic Factors on Depression Management among University Students in Kenya

The fourth objective of the study was to examine the moderating effect of social demographic factors, such as age, gender, culture, religion, and personality, on the relationship between disclosure practices (self-disclosure, disclosure by others, and therapist disclosure) and depression management among university students. This objective aimed to explore whether these factors influence how students utilize disclosure strategies to manage depression.

The analysis revealed that including social demographic factors significantly improved the model's ability to explain variations in depression management. The results indicated that these factors play a crucial role in shaping the effectiveness of

disclosure practices. Specifically, social demographic characteristics, such as a student's age, gender, cultural background, religion, and personality, influenced how students engaged in self-disclosure and interacted with others in the context of managing their depression.

These findings emphasize the importance of considering individual differences when designing support systems for students dealing with depression. For example, students from different cultural backgrounds or with varying personality traits may experience different levels of success with self-disclosure or sharing their feelings with others. Therefore, personalized interventions that take into account these factors may be more effective in promoting better depression management outcomes.

This study highlights the complex nature of depression management, where disclosure practices are not only influenced by the act of sharing but also by the social and demographic contexts in which these disclosures occur.

5.4 Conclusions of the Study

The conclusions are drawn based on the research objectives that the study aimed to establish.

5.4.1 Effects of Self-Disclosure on Depression Management

In this study, self-disclosure emerged as the most significant factor influencing depression management among university students. The findings revealed that students who shared their thoughts and emotions with others, particularly in safe and supportive spaces, experienced improved mental health outcomes. Self-disclosure provided emotional relief, reduced feelings of isolation, and fostered a sense of connection and validation, which are critical in managing depressive symptoms. Additionally, self-disclosure enabled students to process their emotions more openly and constructively, contributing to better coping strategies.

Based on the descriptive and inferential analysis, this study concludes that self-disclosure has a significant and positive effect on depression management. The findings suggest that encouraging students to engage in open communication about

their emotional struggles can improve their ability to manage depression. However, for self-disclosure to be effective, it must occur in environments that promote trust, empathy, and confidentiality. Institutions, mental health practitioners, and support systems should, therefore, focus on creating safe spaces where students feel comfortable expressing their emotions without fear of judgment or stigma.

5.4.2 Effects of Disclosure by Others on Depression Management

In this study, the findings demonstrate that disclosure by others has a limited but supportive role in depression management among university students. While sharing information with third parties can provide some level of relief to those managing depression, the effectiveness of this approach depends on trust and the perceived safety of the disclosure environment. The study concludes that third-party disclosures alone are not sufficient to improve mental health outcomes significantly. Instead, they should be part of a broader mental health support framework that prioritizes direct help-seeking behavior and safeguards students' confidentiality.

This implies that for disclosure by others to be impactful, institutions must foster a culture of trust where students feel confident that their personal information will be handled with care and respect. Developing peer-support systems, enhancing counselor-student trust, and promoting empathetic responses can improve the effectiveness of third-party disclosures in supporting students' mental well-being. Moreover, interventions aimed at improving depression management should prioritize empowering students to seek help directly from trusted individuals or professionals, rather than relying solely on external interventions by third parties.

5.4.3 Effects of Therapist Disclosure on Depression Management

The descriptive statistics from this study indicated that many students experienced positive outcomes in depression management when their therapists or peers engaged in reciprocal sharing during conversations. This practice of therapist disclosure, particularly when therapists shared professional experiences, fostered a sense of connection and understanding, which helped students feel more supported in managing their mental health. However, therapists generally maintained boundaries

by limiting self-disclosure to professional matters, ensuring that the therapeutic dynamic remained intact.

The inferential analysis confirmed that therapist disclosure plays a significant role in depression management. While its impact may be less pronounced compared to self-disclosure or disclosure by others, it still contributes meaningfully to creating a supportive environment that enhances therapeutic relationships and emotional well-being. This underscores the importance of fostering a two-way sharing process in therapeutic and peer-support settings, where both parties feel heard and validated. Key focus areas for enhancing therapist disclosure include encouraging appropriate self-disclosure by therapists, promoting trust-based relationships, and facilitating mutual conversations that help students feel more comfortable in seeking help and managing their depressive symptoms effectively.

5.4.4 Moderating Effect of Social Demographic Factors on the Relationship between Disclosure and Depression Management

The descriptive statistics from this study indicated that social demographic factors, such as age, gender, culture, religion, and personality, significantly shaped how university students engaged in disclosure practices to manage depression. These factors were found to influence students' willingness to disclose personal information, their choice of support networks, and their comfort levels with seeking help.

The inferential analysis confirmed that these social demographic factors played a moderating role in the relationship between disclosure practices and depression management. The inclusion of these factors enhanced the model's ability to explain variations in depression management, highlighting their importance in influencing the effectiveness of self-disclosure, disclosure by others, and therapist disclosure. Specifically, students' cultural backgrounds, personality traits, and social norms shaped how they approached disclosure, which, in turn, impacted their mental health outcomes.

In conclusion, this study emphasizes the importance of considering social demographic factors when designing support systems for university students managing depression. Personalized interventions that take into account students' individual characteristics, such as culture, age, gender, religion, and personality, are likely to be more effective in promoting better mental health outcomes. Tailoring mental health strategies to accommodate these differences can foster a more supportive environment for students and enhance their ability to manage depression effectively.

5.5 Recommendations

Based on the findings of this study, the following recommendations are made to improve the management of depression among university students, with a focus on disclosure practices and the role of social demographic factors.

Firstly, it is recommended that universities establish and promote environments that encourage self-disclosure among students as a means of managing depression. The study highlights that self-disclosure has a significantly positive impact on depression management, and creating spaces where students feel safe to express their feelings is crucial. This can be achieved by offering specialized training for counselors and academic staff to actively listen, maintain confidentiality, and support students who wish to disclose their mental health challenges. Such an approach would enhance students' emotional well-being and contribute to more effective management of depression.

Secondly, the findings suggest that therapist disclosure, or the sharing of personal experiences between students and their therapists or peers, plays a vital role in depression management. It is therefore recommended that universities implement peer counseling programs, which can facilitate reciprocal sharing in a controlled and supportive manner. Peer counselors, when properly trained, can act as intermediaries to encourage students to disclose their struggles, further promoting mental health awareness and providing emotional support. These programs would help foster a culture of openness, where students feel more comfortable discussing their mental health challenges and engaging in reciprocal sharing.

Finally, considering the moderating effects of social demographic factors such as age, gender, culture, religion, and personality on disclosure practices, it is recommended that universities develop personalized mental health support systems tailored to the diverse needs of students. For example, mental health services should consider cultural sensitivities and personality traits in order to deliver interventions that resonate with various student populations. Additionally, students should be educated about how these factors can influence their approaches to self-disclosure and managing depression, allowing for more effective use of disclosure strategies within diverse social contexts.

These recommendations aim to enhance university-based mental health services, promoting environments where students feel supported and encouraged to manage depression through open, reciprocal sharing, while also recognizing the influence of social demographic factors on these processes.

5.6 Areas for Further Research

The study focused on the effects of self-disclosure, disclosure by others, therapist disclosure, and social demographic factors on depression management among university students. However, it is recommended that future research explore additional interpersonal communication strategies, such as emotional expression, active listening, and support-seeking behaviors, to provide a more comprehensive understanding of how different communication methods contribute to managing depression.

Additionally, given that this study found significant moderating effects of social demographic factors such as age, gender, religion, culture, and personality, future research should examine other potential moderating variables. For instance, the role of social support networks (e.g., family, friends, and peer counselors) in shaping depression management strategies could be further investigated. Exploring how these networks influence the effectiveness of disclosure practices would provide valuable insights into designing more targeted and effective interventions for students.

Furthermore, the role of antidepressant use in depression management should be considered as a moderating or mediating factor in future studies. While this research emphasized interpersonal communication, it is important to understand how the use of pharmacological interventions may interact with or influence the effectiveness of disclosure and support-seeking behaviors. Analyzing the relationship between antidepressant use and interpersonal communication patterns could lead to more nuanced and multidisciplinary approaches to treatment.

While the current study focused on university students, further research could examine depression management strategies in other student populations, such as high school students or working professionals, to determine if the findings are consistent across different groups. Comparative studies across various educational or cultural contexts could also shed light on how contextual factors influence the effectiveness of self-disclosure and related strategies in managing depression.

In addition, with the increasing role of digital technologies in shaping interpersonal interactions, future studies should investigate the influence of digital disclosure such as self-disclosure on social media platforms, online forums, or mental health apps, on depression management. Exploring how digital environments enable or hinder emotional disclosure may offer new insights into contemporary coping mechanisms among students.

Lastly, longitudinal studies could be conducted to examine the long-term impact of disclosure practices and social demographic factors on depression management. This would help identify how changes in students' communication styles and social environments over time affect their mental health and coping strategies.

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APPENDICES

Appendix I: Informed Consent

Dear Sir/Madam,

My name is Lilian Wamuyu Mwangi. I am a student of Doctor of Philosophy in Mass Communication at the Jomo Kenyatta University of Agriculture and Technology. I am undertaking research on DISCLOSURE AS A STRATEGY IN DEPRESSION MANAGEMENT AMONG UNIVERSITY STUDENTS IN KENYA as part of my doctoral requirements at the university. The main aim of conducting this research is to establish the effects of disclosure on depression management. I am therefore requesting you to participate and facilitate this research by filling in the short questionnaire presented to you.

If you consent to participate it is expected that this questionnaire will take about 20 minutes to complete. The research assistant is expected to assist you decode the questions that might be difficult to understand. After filling in the questionnaire, you will be expected to return it to the research assistant.

The information provided will be used solely for the purpose of this research and only the results of the findings will be published to disseminate the acquired information. No personal identifiers will be used, therefore every information provided will be treated with absolute confidentiality.

Please note that your participation is voluntary and you are free to withdraw from the study at any point. No form of compensation will be made for participating in this study. If you have any questions regarding this research, feel free to contact me on 0723396938 or lilianmwangi@jkuat.ac.ke. We greatly value your assistance and co-operation.

Appendix II: Questionnaire

. Introduction.

My name is Lilian Mwangi. I am a student at the Jomo Kenyatta University of Agriculture and Technology. I am currently undertaking a research survey on disclosure as a communication strategy in depression management among university students in Kenya. I am therefore humbly requesting your assistance in filling the questionnaire below to facilitate this study. Any information provided will be treated with absolute confidentiality and will only be used for the purpose of this study only. Thank you for your cooperation.

SECTION 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS

1. What is your age? (Please tick the appropriate range)

- Under 18
- 18-21
- 22-25
- 26-30
- 31-35
- Over 35

2. Year of study

.....

3. Which of the following best describes your personality? (You can tick more than one)

- Extroverted (I am outgoing, sociable, and enjoy being around others)
- Introverted (I prefer solitary activities, and feel more comfortable being alone or with a few close friends)

Ambivert (I exhibit traits of both extroversion and introversion, depending on the situation)

Prefer not to say

4. Religion (tick appropriately)

i. Christian ii. Muslim iii. Other (specify).....

6. What is your current relationship status?

Not in a relationship

In a relationship

Engaged

Married

Separated

Divorced

Widowed

7. What do you believe was the primary cause or trigger of your mental health issues? (Please tick all that apply)

Academic pressure and stress

Family issues or conflicts

Financial problems

Relationship problems

Traumatic events (e.g., loss of a loved one, accident)

Chronic physical illness or disability

Social isolation or loneliness

Substance abuse (e.g., alcohol, drugs)

Bullying or harassment

Moving to a new environment (e.g., starting university)

Past history of mental health issues in the family

Other (please specify): _____

8. What symptoms prompted you to seek professional therapeutic help? (Please tick all that apply)

- Persistent feelings of sadness or emptiness
- Loss of interest or pleasure in activities once enjoyed
- Significant weight loss or gain, or changes in appetite
- Insomnia or oversleeping
- Fatigue or loss of energy
- Feelings of worthlessness or excessive guilt
- Difficulty concentrating, making decisions, or thinking clearly
- Recurrent thoughts of death or suicide
- Restlessness or feeling slowed down
- Physical symptoms such as headaches, digestive issues, or chronic pain without a clear cause
- Irritability or frustration, even over small matters
- Social withdrawal or isolation
- Feelings of hopelessness or pessimism
- Crying spells without an apparent reason
- Other_____ (please specify)

SECTION 2: SELF DISCLOSURE AND DEPRESSION MANAGEMENT AMONG UNIVERSITY STUDENTS

1. Comfort with Self-Disclosure

How comfortable are you with disclosing your feelings to others?

- Very Uncomfortable
 - Uncomfortable
 - Neutral
 - Comfortable
 - Very Comfortable
- (If your answer is between neutral and very uncomfortable, please proceed to question)

2. Disclosure Targets (Breadth of Disclosure)

Who do you most easily disclose your feelings to while at the University? (Please tick all that apply)

- Close friends
- Roommates
- Academic advisors or mentors
- University counselors or therapists
- Professors or lecturers
- Classmates
- Club or organization members
- Family members (via phone or visits)
- Chaplaincy
- Other (please specify): _____

Depth of Self-Disclosure

3.1 When you disclose your feelings, how much detail do you typically share?

I share only general feelings (e.g., "I'm feeling down").

- I share moderate detail (e.g., specific situations that made me feel sad).
- I share a lot of personal detail (e.g., specific events, thoughts, and how I'm coping with them).
- I share everything, including the most personal or sensitive information.

4. Perceived Impact of Self-Disclosure on Depression Management

In your opinion, how important is self-disclosure in managing depression?

- Very important
- Somewhat important
- Neutral
- Somewhat unimportant

- Not important at all

4. Barriers to Self-Disclosure

What makes it difficult for you to disclose your feelings of depression? (Tick all that apply)

- Fear of being judged or misunderstood
- Lack of privacy or safe space
- Not knowing whom to talk to
- Lack of trust in others
- Cultural or societal stigma
- Fear of burdening others

Other (please specify): _____

SECTION 3: DISCLOSURE BY OTHERS AND DEPRESSION MANAGEMENT

1. Have the people you disclose your feelings to ever disclosed your situation to another party to get you help?

- Yes
- No
- Not Sure

If yes, who did they disclose your situation to? (Please tick all that apply)

- A professional therapist or counselor
- A university counselor or mental health service
- A family member
- A friend or peer
- A faculty member or academic advisor
- A religious or spiritual leader
- Other (please specify): _____

How did you feel about them disclosing your situation to another party? (Please tick all that apply)

- I felt relieved and supported
- I felt betrayed or violated
- I felt indifferent
- I felt worried about confidentiality
- Other (please specify): _____

Did the disclosure by the person you confided in lead to you receiving professional help?

- Yes, it led to me receiving professional help
- No, it did not lead to professional help
- I am not sure

Do you think the disclosure by the person you confided in positively impacted your depression management?

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

SECTION 4: THERAPIST DISCLOSURE AND DEPRESSION MANAGEMENT

Have you noticed your therapist disclosing personal information about themselves during your sessions?

- Yes
- No
- Not Sure

If yes, how frequently does your therapist share personal information?

- Very Frequently
- Frequently
- Occasionally
- Rarely
- Very Rarely

What type of information does your therapist typically disclose? (Please tick all that apply)

- Personal experiences
- Professional experiences
- Opinions or beliefs
- Feelings or emotions
- Other (please specify): _____

How does your therapist's self-disclosure make you feel? (Please tick all that apply)

- It makes me feel more comfortable and open
- It makes me feel connected to my therapist
- It makes me feel uncomfortable or uneasy
- It makes no difference to me
- Other (please specify): _____

Do you think your therapist's self-disclosure has positively impacted your depression management?

- Strongly Agree
- Agree
- Neutral
- Disagree
- Strongly Disagree

SECTION 5: DEPRESSION MANAGEMENT AMONG UNIVERSITY STUDENTS

1. Aside from self-disclosure, what other coping mechanisms do you use to manage stress and depression?

- Exercise or physical activity
- Meditation or mindfulness practices
- Listening to music
- Engaging in hobbies (e.g., painting, writing, playing an instrument)
- Spending time with friends or family
- Professional counseling or therapy
- Medication prescribed by a healthcare professional
- Journaling or writing about feelings
- Watching movies or TV shows
- Reading books
- Practicing religious or spiritual activities
- Volunteering or helping others
- Eating healthy or maintaining a balanced diet
- Getting adequate sleep
- Other (please specify): _____

3. How satisfied are you with the mental health support available to you at the university?

- Very Dissatisfied
- Dissatisfied
- Neutral
- Satisfied
- Very Satisfied

4. What improvements would you suggest for enhancing mental health support on campus?

THANK YOU FOR YOUR TIME

Appendix III: Interview Guide

Brief introduction

1. What are some of the challenges you encounter while trying to assist a client with depressive symptoms?
2. Does self-disclosure of clients have an effect on depression management?
3. Under what circumstances do you have others disclosing for the clients?
4. Does that kind of disclosure in 3 above have an effect on depression management?
5. Do you ever disclose any personal information to clients?
6. Under what circumstances do you disclose to the clients?
7. What effect does that disclosure have on the management of depression?
8. Does age, culture, gender, personality and other socio demographic factors affect the disclosure of your clients and consequently, what effects do they have on depression management?
9. What are some of the factors that predispose students to depression?
10. How else do students manage their depressive symptoms other than through therapy?
11. Do you think disclosure is necessary for depression management?
12. How do you facilitate the disclosure of student/ how do you encourage the students to disclose?

Thank you for your time and participation






Appendix IV: work schedule

Tasks	Academic Semesters												
	1	2	3	4	5	6	7	8	9	10	11	12	
Course Work													
Concept paper presentation													
Proposal presentation													
Proposal corrections													
Pilot testing													
Pilot seminar presentation													
Data collection and analysis													
Data analysis seminar													
Journal paper seminars													
Final Submission of thesis													

Appendix V: Budget

ITEM	TOTAL (Ksh.)
Research assistants	100,000.00
Pilot testing	50,000.00
Printing and photocopying	30,000.00
Logistics	50,000.00
publishing	50,000.00
miscellaneous	20,000.00
TOTAL	300,000.00

Appendix VI: NACOSTI Research License

 <p>REPUBLIC OF KENYA</p>	 <p>NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION.</p>
Ref No: 872536	Date of Issue: 01/May/2023
RESEARCH LICENSE	
	
<p>This is to Certify that Ms. Lilian Wamuyu Mwangi of Jomo Kenyatta University of Agriculture and Technology, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Kiambu on the topic: DISCLOSURE AS A STRATEGY IN DEPRESSION MANAGEMENT AMONG UNIVERSITY STUDENTS IN KENYA for the period ending : 01/May/2024.</p>	
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THE SCIENCE, TECHNOLOGY AND INNOVATION ACT, 2013 (Rev. 2014)
Legal Notice No. 108: The Science, Technology and Innovation (Research Licensing) Regulations, 2014

The National Commission for Science, Technology and Innovation, hereafter referred to as the Commission, was established under the Science, Technology and Innovation Act 2013 (Revised 2014) herein after referred to as the Act. The objective of the Commission shall be to regulate and assure quality in the science, technology and innovation sector and advise the Government in matters related thereto.

CONDITIONS OF THE RESEARCH LICENSE

1. The License is granted subject to provisions of the Constitution of Kenya, the Science, Technology and Innovation Act, and other relevant laws, policies and regulations. Accordingly, the licensee shall adhere to such procedures, standards, code of ethics and guidelines as may be prescribed by regulations made under the Act, or prescribed by provisions of International treaties of which Kenya is a signatory to
2. The research and its related activities as well as outcomes shall be beneficial to the country and shall not in any way;
 - i. Endanger national security
 - ii. Adversely affect the lives of Kenyans
 - iii. Be in contravention of Kenya's international obligations including Biological Weapons Convention (BWC), Comprehensive Nuclear-Test-Ban Treaty Organization (CTBTO), Chemical, Biological, Radiological and Nuclear (CBRN).
 - iv. Result in exploitation of intellectual property rights of communities in Kenya
 - v. Adversely affect the environment
 - vi. Adversely affect the rights of communities
 - vii. Endanger public safety and national cohesion
 - viii. Plagiarize someone else's work
3. The License is valid for the proposed research, location and specified period.
4. The license any rights thereunder are non-transferable
5. The Commission reserves the right to cancel the research at any time during the research period if in the opinion of the Commission the research is not implemented in conformity with the provisions of the Act or any other written law.
6. The Licensee shall inform the relevant County Director of Education, County Commissioner and County Governor before commencement of the research.
7. Excavation, filming, movement, and collection of specimens are subject to further necessary clearance from relevant Government Agencies.
8. The License does not give authority to transfer research materials.
9. The Commission may monitor and evaluate the licensed research project for the purpose of assessing and evaluating compliance with the conditions of the License.
10. The Licensee shall submit one hard copy, and upload a soft copy of their final report (thesis) onto a platform designated by the Commission within one year of completion of the research.
11. The Commission reserves the right to modify the conditions of the License including cancellation without prior notice.
12. Research, findings and information regarding research systems shall be stored or disseminated, utilized or applied in such a manner as may be prescribed by the Commission from time to time.
13. The Licensee shall disclose to the Commission, the relevant Institutional Scientific and Ethical Review Committee, and the relevant national agencies any inventions and discoveries that are of National strategic importance.
14. The Commission shall have powers to acquire from any person the right in, or to, any scientific innovation, invention or patent of strategic importance to the country.
15. Relevant Institutional Scientific and Ethical Review Committee shall monitor and evaluate the research periodically, and make a report of its findings to the Commission for necessary action.

National Commission for Science, Technology and
Innovation(NACOSTI),
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Appendix VII: Ethics Approval



JOMO KENYATTA UNIVERSITY OF AGRICULTURE AND TECHNOLOGY
P.O BOX 62000(00200) NAIROBI, Tel:(067) 58700001-4
(Office of the Deputy Vice Chancellor, Research Production and Extension Division)

JKUAT INSTITUTIONAL SCIENTIFIC AND ETHICS REVIEW COMMITTEE

REF: JKU/2/4/896B

Date: 9th March 2023

MWANGI LILIAN WAMUYU
DEPARTMENT OF MEDIA TECHNOLOGY AND APPLIED COMMUNICATION, JKUAT

Dear Ms. Mwangi,

RE: DISCLOSURE AS A STRATEGY IN DEPRESSION MANAGEMENT AMONG UNIVERSITY STUDENTS IN KENYA

This is to inform you that JKUAT Institutional Scientific and Ethical Review Committee has reviewed and approved your above research proposal. Your application approval number is JKU/ISERC/02316/0841. The approval period is 9th March 2023 to 8th March 2024.

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

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

Yours sincerely

Dr Patrick Mburugu
CHAIR, JKUAT ISERC



JKUAT is ISO 9001:2015 and ISO 14001:2015 certified



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