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

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

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DECLARATION

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

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DEDICATION

This thesis is dedicated to my father, Richard, in recognition of the vision he carried of seeing his children attain the highest levels of education.

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ABBREVIATIONS AND ACRONYMS

ACHA	American College Health Association
APA	American Psychological Association
CPM	Communication privacy management theory
DDM	Disclosure-Decision Model
DSM-5-TR	The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision
HHS	Health and Human Services
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

Depression Depression is a mood disorder characterized by persistent sadness, loss of interest or pleasure, and emotional, cognitive, and physical symptoms that significantly impair an individual's functioning (WHO, 2017). In this study, depression referred to the mental health condition experienced by university students, with emphasis placed on its management rather than diagnosis or severity.

Depression Management Depression management refers to the strategies and interventions used to reduce depressive symptoms, improve emotional well-being, and enhance coping (Cuijpers et al., 2014; WHO, 2023). In this study, it was operationalized as students' perceived ability to cope with depression and improve their emotional well-being through disclosure practices, and was measured using Likert-scale items assessing the perceived effectiveness of disclosure in managing depression.

Interpersonal Communication Interpersonal communication is the exchange of information, ideas, and emotions between two or more individuals through verbal and non-verbal communication (Hartley, 2002). In this study, interpersonal communication was operationalized through disclosure practices, namely self-disclosure, disclosure by significant others, therapist self-disclosure, as mechanisms influencing depression management.

Interpersonal Psychotherapy (IPT) Interpersonal psychotherapy is a structured, evidence-based therapeutic approach that seeks to

improve interpersonal relationships and social functioning to reduce symptoms of depression (Bleiberg & Markowitz, 2019). In this study, IPT provided the therapeutic context for understanding counsellor-client interactions but was not directly measured.

Self-Disclosure Self-disclosure is the intentional sharing of personal thoughts, emotions, feelings, or experiences with another person that would otherwise remain unknown (Robinson, 2017). In this study, self-disclosure was operationalized by the breadth of disclosure (to whom students disclosed), the depth of disclosure (the amount of personal information shared), comfort with disclosure, and students' perceptions of its contribution to depression management, measured using Likert-scale questionnaire items.

Disclosure by significant others Disclosure by significant others refers to the sharing of an individual's private or sensitive information by another person, either with or without the individual's consent (Petronio, 2013). In this study, it was operationalized by determining whether another person disclosed the student's mental health information to a third party, identifying who made the disclosure, the reasons for disclosure, and students' perceptions of its influence on depression management.

Therapist Self-Disclosure Therapist self-disclosure is the intentional sharing of a therapist's personal experiences, feelings, or opinions with a client when it is considered

beneficial to the therapeutic process (Hill & Knox, 2002; Johnsen *& Ding, 2021). In this study, it was operationalized* by assessing whether therapists disclosed personal information during counselling sessions and examining students' perceptions of how such disclosure influenced trust, rapport, and depression management.

Individual characteristics

Individual characteristics are personal characteristics such as age, religion, culture, personality, and educational level that influence communication behaviour and mental health outcomes (Hofstede, 1980). In this study, these factors were operationalized as moderating variables measured through respondents' self-reported demographic characteristics and analyzed to determine their moderating effect on the relationship between disclosure practices and depression management.

ABSTRACT

Depression remains one of the leading mental health challenges affecting university students worldwide, with increasing prevalence among young adults due to academic pressures, social transitions, financial constraints, and interpersonal difficulties. In Kenya, university students continue to experience high levels of depressive symptoms despite the availability of counselling services. Although interpersonal communication is central to counselling interventions, limited empirical evidence exists on the role of disclosure practices in depression management within Kenyan universities. This study therefore examined disclosure as an interpersonal communication strategy in depression management among university students at Jomo Kenyatta University of Agriculture and Technology (JKUAT), Kenya. Specifically, the study investigated the influence of self-disclosure, disclosure by significant others, and therapist self-disclosure on depression management, and examined the moderating effect of individual characteristics on these relationships. The study was anchored on the Social Penetration Theory, the Disclosure Decision Model, the Communication Privacy Management Theory, and the Interpersonal Theory of Depression. A concurrent triangulation mixed-methods research design guided the study within the pragmatist research philosophy. The target population comprised approximately 44,000 undergraduate students enrolled at JKUAT, while the accessible population consisted of 1,634 undergraduate students who had attended counselling services at the University Counselling Centre within the twelve months preceding data collection. A quantitative sample of 384 students was determined using Cochran's formula, while four university counsellors participated in the qualitative strand. Consecutive purposive sampling was employed to recruit eligible student participants, while purposive sampling was used to select the counsellors based on their professional experience. Quantitative data were collected using structured questionnaires, whereas qualitative data were obtained through key informant interviews. Quantitative data were analysed using descriptive statistics, Pearson correlation, multiple regression, moderation analysis, and other appropriate inferential statistics, while qualitative data were analysed thematically. The findings from both strands were integrated during interpretation to provide a comprehensive understanding of the phenomenon. The findings established that self-disclosure was the strongest predictor of depression management among university students. Disclosure by significant others also demonstrated a positive and statistically significant influence on depression management, while therapist self-disclosure exhibited a positive but comparatively weaker effect. The study further established that the composite construct of individual characteristics significantly moderated the relationship between disclosure practices and depression management, indicating that the effectiveness of disclosure strategies varied across different individual characteristics. Qualitative findings corroborated the quantitative results by demonstrating that disclosure, when applied appropriately and within supportive therapeutic relationships, enhanced trust, emotional expression, and engagement in counselling, thereby strengthening depression management. The study concludes that disclosure constitutes an important interpersonal communication strategy in the management of depression among university students, although its effectiveness depends on the nature of disclosure and individual client characteristics. The study recommends that universities strengthen counselling programmes by promoting

appropriate self-disclosure practices, enhancing supportive communication environments, and designing counselling interventions that are responsive to students' individual characteristics. The findings contribute to interpersonal communication scholarship by extending understanding of disclosure processes within mental health contexts and provide empirical evidence to inform university counselling practice, institutional mental health policy, and future research on communication-based interventions for depression management among university students.

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

Mental health has become an increasingly important public health concern, not only because of the growing burden of mental illness but also because of the complex factors that influence how individuals recognize psychological distress, seek help, and engage with available support systems. While advances in psychiatry and psychology have contributed significantly to the diagnosis and treatment of mental disorders, there is growing recognition that successful mental health management extends beyond clinical interventions. Increasingly, attention has shifted towards the interpersonal processes that influence whether individuals access support, adhere to treatment, and develop effective coping mechanisms (Patel et al., 2018; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Within this broader discourse, communication has emerged as an important component of mental health management because it shapes how individuals express emotional distress, mobilize social support, and engage with professional services.

Among the various mental health conditions affecting young adults, depression remains one of the most significant. According to the World Health Organization (WHO, 2021), approximately 280 million people worldwide live with depression, making it one of the leading causes of disability globally. University students are particularly vulnerable because they experience multiple transitions simultaneously, including increased academic demands, financial pressures, changing social relationships, and uncertainty about future careers (Dyrbye, Thomas, & Shanafelt,

2006; Ibrahim, Kelly, Adams, & Glazebrook, 2013). These experiences place students at greater risk of psychological distress and highlight the need for interventions that extend beyond treatment to include strategies that encourage timely help-seeking and sustained engagement with mental health services.

Although counselling services and psychological interventions have become more accessible within many institutions of higher learning, their effectiveness depends largely on whether students are willing to communicate their emotional experiences and seek support. Research has consistently shown that many students experiencing depressive symptoms delay or avoid seeking help despite recognizing the need for assistance (Eisenberg, Hunt, & Speer, 2012; Gulliver, Griffiths, & Christensen, 2010). Fear of stigma, concerns about confidentiality, negative attitudes towards counselling, and uncertainty about how others will respond often discourage students from discussing their mental health challenges. Consequently, many continue to struggle in silence, limiting opportunities for early intervention and increasing the likelihood of poor mental health outcomes.

Communication therefore becomes central to understanding how students respond to depression. Through interpersonal communication, individuals share emotions, seek reassurance, negotiate social support, and develop relationships that facilitate coping and recovery. One of the most important communication processes within this context is disclosure. Disclosure provides individuals with an opportunity to communicate experiences that would otherwise remain private, enabling them to receive emotional support, practical assistance, and professional intervention. However, disclosure is rarely a straightforward process. Decisions about whether to disclose, whom to disclose to, and how much information to reveal are influenced by perceived risks, anticipated reactions, trust, and the nature of interpersonal relationships (Greene, Derlega, Mathews, 2006; Vogel, Wester, & Larson, 2007). These considerations suggest that disclosure is not simply an individual behaviour but an interpersonal communication process that may influence how effectively depression is managed.

Existing scholarship has largely examined disclosure from the perspective of self-disclosure, emphasizing the role of individuals communicating their own experiences to trusted others. While this remains important, disclosure within mental health contexts extends beyond self-disclosure alone. Friends, family members, lecturers, and other significant individuals may disclose concerns on behalf of someone experiencing depression in an effort to facilitate access to professional support. Similarly, counsellors may engage in carefully considered therapist self-disclosure to strengthen therapeutic relationships, normalize clients' experiences, and encourage openness during counselling sessions (Hill & Knox, 2002; Zur, Williams, Lehavot, & Knapp, 2009). These different forms of disclosure represent distinct interpersonal communication processes that may influence depression management in different ways. Examining them collectively provides a more comprehensive understanding of disclosure than focusing exclusively on one form of communication.

Despite the growing body of research on depression among university students, much of the existing literature has concentrated on estimating prevalence, identifying associated risk factors, and examining psychological or behavioural outcomes (Auerbach et al., 2016; Ibrahim et al., 2013). These studies have made important contributions to understanding depression as a public health concern. However, comparatively less attention has been given to disclosure as an interpersonal communication strategy that influences how students access support, engage with counselling, and manage depressive symptoms. Where disclosure has been examined, studies have often focused on isolated aspects of the disclosure process, with limited consideration of the complementary roles of disclosure by significant others, therapist self-disclosure, and reciprocal disclosure. This has left important gaps in understanding how different disclosure practices contribute to depression management.

In Kenya, concern over the mental health of university students has continued to grow following increasing reports of psychological distress, suicide, and other mental health challenges within institutions of higher learning. Although local studies have documented the prevalence of depression and examined factors associated with poor mental health among university students (Ndetei et al., 2011;

Othieno, Okoth, Peltzer, Pengpid, & Malla, 2014), relatively little attention has been given to the communication processes that influence how students manage depression. Consequently, there remains limited empirical evidence on how different forms of disclosure facilitate help-seeking, strengthen therapeutic engagement, and promote recovery within university settings. Furthermore, little is known about whether factors such as age, culture, religion, personality, and socio-economic background influence the relationship between disclosure and depression management among university students in Kenya.

Against this background, this study examined disclosure as an interpersonal communication strategy for managing depression among university students in Kenya. Specifically, the study investigated the effects of self-disclosure, disclosure by significant others, therapist self-disclosure, and therapists self-disclosure on depression management, while examining the moderating influence of selected individual characteristics. By shifting the focus from depression as a psychological condition to disclosure as an interpersonal communication process, the study contributes to communication scholarship while generating evidence that may inform university mental health interventions and support services.

1.1.1 Interpersonal Communication and Mental Health Management: A Global Perspective

The management of depression has increasingly been recognized as extending beyond clinical treatment to include interpersonal communication processes that influence how individuals express psychological distress, access support, and engage with recovery. While pharmacological and psychological therapies remain central to treatment, scholars have argued that communication plays a critical role in facilitating help-seeking, strengthening therapeutic relationships, and promoting emotional well-being (Goldsmith, 2004; Greene, 2009). This broader understanding reflects a shift from viewing depression solely as a clinical condition to recognizing the social interactions through which individuals seek and receive support.

Within higher education, depression continues to present a significant challenge to student well-being and academic success. Global evidence indicates that university

students experience higher levels of psychological distress than the general population due to academic demands, financial pressures, social adjustment, and developmental transitions associated with emerging adulthood (Auerbach et al., 2018; Bruffaerts et al., 2018). These pressures have contributed to increased utilization of university counselling services and growing concern over students' mental health across institutions worldwide.

Communication has emerged as a central element in addressing these challenges because students frequently rely on interpersonal relationships before seeking professional assistance. Research demonstrates that conversations with friends, family members, mentors, and mental health professionals often constitute the first point of contact in the help-seeking process (Derlega, Winstead, Greene, Serovich, & Elwood, 2004). Through these interactions, individuals obtain emotional reassurance, practical guidance, and referrals to appropriate mental health services. Consequently, the effectiveness of mental health interventions depends not only on the availability of counselling services but also on students' willingness to communicate their experiences and the responsiveness of those around them.

Despite these benefits, communication about depression remains constrained by stigma, fear of discrimination, concerns about confidentiality, and uncertainty about how others may react. Such concerns often discourage students from revealing psychological distress even when support services are readily available (Corrigan, 2004; Clement et al., 2015). As a result, many students delay seeking assistance until symptoms become more severe, limiting opportunities for early intervention and recovery.

Increasingly, scholars have argued that disclosure should not be viewed as a single communication event but as a dynamic interpersonal process influenced by relationships, context, and expectations of support. This perspective has expanded research beyond individual self-disclosure to consider the roles of trusted others, counsellors, and reciprocal communication in facilitating mental health management (Petronio, 2013; Greene, 2009). Although these developments have advanced understanding of communication in mental health care, relatively little research has

examined how these different forms of disclosure collectively influence depression management among university students, particularly in developing country contexts.

1.1.2 Regional Perspective: Disclosure and Mental Health Management in the African Context

The role of interpersonal communication in mental health management has increasingly attracted attention across African countries, particularly as governments and institutions seek to address the growing burden of depression among young people. However, decisions about whether to disclose psychological distress are shaped by diverse cultural, religious, and social contexts that vary considerably across the continent. Rather than reflecting a single African perspective, disclosure practices are influenced by local beliefs about mental illness, family relationships, community expectations, and the availability of formal mental health services (Patel, 2007; Sorsdahl, Stein, & Lund, 2012).

In several African countries, cultural interpretations of mental illness continue to influence disclosure practices and help-seeking behaviour. For example, studies conducted in Nigeria have shown that depression and other mental health conditions are, in some communities, attributed to spiritual causes, witchcraft, or moral transgression, making individuals reluctant to discuss their experiences openly or seek professional care (Gureje et al., 2005). Similar observations have been reported in parts of Ghana, where fear of social judgement and concerns about bringing shame to one's family discourage disclosure of emotional difficulties (Osafo, Knizek, Akotia, & Hjelmeland, 2011). These findings illustrate how cultural beliefs shape communication about mental health differently across contexts rather than representing a uniform African experience.

Mental health stigma remains another important factor influencing disclosure. Although the nature and intensity of stigma vary across countries, studies consistently show that negative societal attitudes discourage young people from discussing psychological distress or accessing counselling services. In Ethiopia, for instance, university students have been found to conceal symptoms of depression because of fears of discrimination and social exclusion (Abera, Robbins, & Tesfaye,

2015). In South Africa, students similarly report concerns that disclosure may result in labelling or negative perceptions by peers and academic staff, leading many to delay seeking professional support (Bantjes et al., 2016). These findings suggest that stigma operates not only at the individual level but also within institutional and social environments where students negotiate decisions about disclosure.

Help-seeking behaviours among university students also differ across African settings but frequently reflect a preference for informal support networks before engaging formal mental health services. Research from Ghana and Uganda indicates that students are more likely to discuss emotional difficulties with family members, close friends, or religious leaders than with professional counsellors, particularly where counselling services are limited or where trust in formal mental health systems is low (Kaggwa et al., 2022; Quarshie, Osafo, Akotia, Peprah, & Andoh-Arthur, 2020). These interpersonal relationships often serve as the first point of emotional support and may influence whether students eventually access professional care.

Family members, peers, and wider community networks therefore occupy an important position within mental health communication across many African societies. In contexts where collective social relationships are highly valued, decisions about disclosure are rarely made in isolation but are influenced by expectations of family involvement, peer acceptance, and community norms. While these relationships can provide emotional support and encourage help-seeking, they may also discourage disclosure where mental illness is viewed negatively or associated with social stigma (Campbell-Hall et al., 2010). Consequently, the effectiveness of disclosure as a strategy for managing depression depends not only on an individual's willingness to communicate but also on how significant others respond to that disclosure.

Although studies across Africa have generated valuable insights into stigma, help-seeking, and social support, relatively few have examined disclosure itself as an interpersonal communication process. Much of the existing research has focused on the prevalence of depression, barriers to accessing mental health services, or attitudes towards mental illness, with limited attention given to how different forms of

disclosure- including self-disclosure, disclosure by significant others, and Therapist's self-disclosure-shape depression management among university students. This gap provides an important basis for examining disclosure as an interpersonal communication strategy within the Kenyan university context.

1.1.3 Local Perspective: Disclosure and Depression Management among University Students in Kenya

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 counselling (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 counselling 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 counselling 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 counselling services within universities (Munyua, 2018). While recent efforts have introduced mental health awareness campaigns and limited counselling 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 management extends beyond clinical diagnosis and treatment to include the interpersonal processes through which individuals communicate psychological distress, seek support, and engage with available interventions. Contemporary mental health approaches increasingly recognize that recovery is influenced not only by clinical care but also by the quality of social interactions and communication surrounding the individual (Street, Makoul, Arora, & Epstein, 2009; Goldsmith, 2004). Consequently, interpersonal communication has become an important component of mental health management because it facilitates emotional expression, support seeking, and access to professional care.

Disclosure is one of the primary interpersonal communication strategies through which individuals experiencing depression communicate their emotional experiences and mobilize support from others. According to Chaudoir and Fisher's (2010) Disclosure Processes Model, disclosure creates opportunities for social support, reduced psychological burden, and improved psychological adjustment when individuals receive supportive responses. Similarly, Communication Privacy Management Theory (Petronio, 2002) explains that disclosure is influenced by individuals' decisions about privacy ownership, trust, and the anticipated consequences of sharing personal information. These perspectives suggest that disclosure is neither automatic nor incidental but a deliberate communication process that can influence mental health outcomes.

Within university settings, interpersonal communication assumes particular importance because students rely on multiple social networks, including peers, family members, lecturers, and counsellors, when coping with psychological distress. Research has shown that supportive interpersonal relationships encourage help-seeking, strengthen resilience, and improve psychological well-being, whereas poor communication, fear of stigma, and lack of supportive responses discourage disclosure and delay access to appropriate care (Rickwood, Deane, Wilson, & Ciarrochi, 2005; Clement et al., 2015). The effectiveness of university counselling services therefore depends not only on their availability but also on students' willingness to communicate their experiences and engage with available support systems.

From a communication perspective, depression management is therefore understood as both a psychological and interpersonal process. Communication determines how distress is expressed, how support is mobilized, and how therapeutic relationships are developed. Understanding disclosure within these interpersonal interactions provides an important basis for strengthening communication-based interventions that complement existing counselling and mental health services in universities.

1.3 Statement of the Problem

Depression remains one of the most significant mental health challenges affecting university students, with implications for academic performance, interpersonal relationships, psychological well-being, and overall quality of life. In response, universities have increasingly established counselling centres, peer support programmes, mental health awareness initiatives, and referral systems to promote early identification and management of depression. These interventions are intended to encourage help-seeking and improve students' access to psychological support. However, despite these efforts, many students continue to experience psychological distress without fully utilizing the available mental health services, raising concerns about the effectiveness of existing depression management approaches (Republic of Kenya, 2020).

Evidence from Kenyan universities indicates that depression remains prevalent despite the availability of counselling services. Othieno et al. (2014) reported that 35.7% of students at the University of Nairobi experienced moderate depressive symptoms, while 5.6% experienced severe depression. More recently, Otieno et al. (2024) found that 57.7% of students at the Technical University of Mombasa exhibited depressive symptoms. Depression among university students has further been associated with poor academic performance, impaired social functioning, substance use, and suicidal behaviour, with a national survey reporting that 60.9% of undergraduate students had experienced suicidal behaviours, including suicidal ideation, planning, or attempts (Ambayo, Karume, & Kihara, 2021). These findings suggest that current approaches to depression management may not be adequately addressing students' mental health needs.

Effective depression management depends not only on the availability of counselling services but also on students' willingness to communicate their psychological distress and engage with available support systems. Disclosure is a critical interpersonal communication process through which individuals seek emotional support, access professional care, and develop coping strategies. However, disclosure is influenced by factors such as trust, perceived confidentiality, reciprocal communication,

therapist-client interactions, and individual characteristics. When these communication processes are constrained, students may delay help-seeking, remain socially isolated, or fail to benefit fully from existing mental health interventions.

Although previous studies in Kenya have largely examined the prevalence, determinants, and consequences of depression among university students, limited attention has been given to disclosure as an interpersonal communication strategy for depression management. In particular, there is insufficient empirical evidence on how self-disclosure, disclosure by significant others, Therapist's self-disclosure, and individual characteristics factors influence depression management among university students in Kenya. This study therefore sought to examine the effect of disclosure as an interpersonal communication strategy in the management of depression among university students in Kenya, with a view to informing counselling practice, university mental health programmes, and communication-based interventions.

1.4 Objectives

1.3.1 General Objective

To determine the effect of disclosure as an interpersonal communication strategy in depression management among 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 significant others on depression management in university students in Kenya.
3. To examine the effect of Therapist's self-disclosure on depression management in university students in Kenya.
4. To analyze the moderating effect of individual characteristics 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 significant others on depression management in university students in Kenya?
3 What is the effect of Therapist's self-disclosure on depression management in university students in Kenya?
4 What is the moderating effect of individual characteristics factors on the relationship between disclosure and depression management in university students in Kenya?

1.6 Significance of the study

Academic Significance

This study contributes to the growing body of knowledge on interpersonal communication and mental health by providing empirical evidence on the role of disclosure as an interpersonal communication strategy in the management of depression among university students in Kenya. While existing studies have largely focused on the prevalence, determinants, and psychological outcomes of depression, this study extends the discourse by examining how communication processes, specifically self-disclosure, disclosure by significant others, Therapist's self-disclosure, and the moderating influence of individual characteristics factors, contribute to depression management. In doing so, the study broadens scholarly understanding of the communicative dimensions of mental health management within the context of higher education.

The study also makes a theoretical contribution by examining the applicability of the Disclosure Decision Model and Communication Privacy Management Theory in explaining disclosure behaviour within the context of depression management among university students. By testing these theories in a Kenyan university setting, the study provides context-specific evidence on their relevance in understanding how individuals make disclosure decisions, negotiate privacy boundaries, and utilize

interpersonal communication in managing psychological distress. The findings may therefore contribute to the refinement and contextual application of these theoretical perspectives in communication and mental health research.

Methodologically, the study demonstrates the value of integrating quantitative and qualitative approaches in examining complex interpersonal communication processes. By combining students' experiences with the perspectives of university counsellors, the study provides a more comprehensive understanding of disclosure practices in depression management than would have been achieved through a single-method approach. This methodological approach may inform future communication and mental health research that seeks to investigate similar phenomena within higher education and comparable social contexts.

Practical Significance

The findings of this study may provide evidence to support universities in strengthening student mental health programmes by highlighting the role of interpersonal communication in depression management. Specifically, the findings may inform the development or refinement of counselling services, peer support initiatives, and communication strategies that encourage appropriate disclosure and facilitate timely access to mental health support among students.

For mental health practitioners, particularly university counsellors, the study provides insights into how different forms of disclosure influence students' engagement with counselling and depression management. These insights may be useful in informing counselling practices that promote trust, appropriate Therapist’s self-disclosure, and supportive communication within therapeutic relationships.

The study may also inform policymakers and institutions responsible for student welfare and mental health by providing context-specific evidence on communication factors that influence depression management among university students. Such evidence may contribute to the development and implementation of policies and programmes aimed at strengthening mental health support within institutions of higher learning and enhancing students' access to appropriate psychosocial services.

Finally, the study provides a foundation for future research by identifying communication-related dimensions of depression management that warrant further investigation. Future researchers may build on these findings by examining disclosure practices in other educational settings, cultural contexts, or mental health conditions, thereby contributing to the continued advancement of scholarship in interpersonal communication and mental health.

1.7 Scope of the Study

This study was geographically confined to Jomo Kenyatta University of Agriculture and Technology (JKUAT) in Kiambu County, Kenya. The university was purposively selected because it is one of Kenya's largest public universities, with a diverse student population drawn from different socio-economic, cultural, and geographical backgrounds, making it an appropriate setting for examining interpersonal communication and depression management among university students.

The study specifically focused on undergraduate students who had attended at least one counselling session at the University's Counselling Centre between January 2022 and December 2022. Restricting participation to this period ensured that respondents had relatively recent counselling experiences, thereby minimizing recall bias while allowing them sufficient exposure to reflect on disclosure practices and their role in depression management.

The presence of an established counselling service provided access to participants with lived experiences relevant to the study objectives, particularly those relating to disclosure and depression management. In addition, JKUAT has experienced mental health challenges similar to those reported in other public universities in Kenya, including depression, psychological distress, and student suicides, highlighting the relevance of the institution as a setting for this study (Othieno et al., 2014; Mutwiri et al., 2023; Otieno et al., 2024).

Conceptually, the study was limited to examining disclosure as an interpersonal communication strategy for depression management. Specifically, it investigated the

effects of self-disclosure, disclosure by significant others, and Therapist's self-disclosure on depression management, while examining the moderating influence of individual characteristics, namely age, culture, religion, and personality. The study did not examine other interpersonal communication strategies, psychological interventions, psychiatric treatment approaches, or broader determinants of depression beyond the variables specified in the conceptual framework.

The theoretical scope of the study was grounded in four complementary frameworks that informed the conceptualization and interpretation of the findings. Social Penetration Theory was used to explain the development of interpersonal relationships through self-disclosure, while the Disclosure Decision-Making Model examined the factors that influence individuals' decisions to disclose personal information. Communication Privacy Management (CPM) Theory provided a framework for understanding how individuals regulate private information and negotiate disclosure boundaries within therapeutic and social contexts. Finally, the Interpersonal Theory of Depression anchored the dependent variable by explaining how interpersonal communication, social support, and relationship quality influence the management of depression.

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 complexity 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 methodological limitations that may have influenced the recruitment process and the interpretation of the findings. The primary limitation

related to participant recruitment. Since the study targeted undergraduate students who had previously attended counselling sessions, the researcher could not directly identify or contact eligible participants because counselling records are protected by ethical principles of confidentiality and privacy. Consequently, access to participants was facilitated through university counsellors, who acted as gatekeepers and identified students who met the inclusion criteria.

Although this approach ensured compliance with ethical requirements and protected participants' confidentiality, it also introduced the possibility of selection bias because the researcher had no direct control over participant identification or recruitment. The study therefore relied on the professional judgment of the counsellors to apply the inclusion and exclusion criteria consistently. This limitation was mitigated by providing counsellors with clear recruitment guidelines based on predefined eligibility criteria, thereby promoting consistency in participant selection.

A further methodological concern was the potential for perceived coercion and social desirability bias arising from the involvement of counsellors in the recruitment process. Because participants were approached by individuals who provided them with counselling services, some students may have felt obliged to participate or may have believed that declining participation could affect their relationship with the counsellor. Similarly, participants may have provided responses they perceived to be socially acceptable or desirable rather than fully reflecting their experiences. To minimize this risk, counsellors informed prospective participants that participation was entirely voluntary, that declining participation would not affect the counselling services they received, and that they were free to withdraw from the study at any stage without any consequences. In addition, questionnaires were completed anonymously, and no identifying information was collected, thereby reducing the likelihood that participants would feel compelled to provide responses that reflected favourably on themselves or their counsellors (Polit & Beck, 2021; Creswell & Creswell, 2018).

The gatekeeper recruitment procedure also affected the pace of data collection. Since recruitment depended on eligible students presenting for follow-up counselling

appointments during the study period, it took approximately eight months to obtain the required sample size. Although this extended the data collection period, it ensured that recruitment occurred within routine counselling practice while respecting participants' privacy and autonomy.

Finally, the study was unable to conduct in-depth interviews with student participants because of the sensitive nature of depression and the ethical obligation to protect participants' emotional well-being and confidentiality. Consequently, qualitative data were obtained only from university counsellors, while students contributed quantitative data through self-administered questionnaires. Although this limited the depth of participants' personal narratives, the mixed-methods design and triangulation of quantitative findings with counsellors' perspectives provided complementary insights into disclosure practices 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 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 Interpersonal Theory of Depression.

2.2.1 Social Penetration Theory

Social Penetration Theory (SPT), developed by Altman and Taylor (1973), emerged from attempts to explain how interpersonal relationships evolve through communication. Drawing from social psychology, the theory conceptualizes relationship development as a gradual process in which individuals move from superficial exchanges to increasingly intimate levels of communication through self-disclosure. The central proposition is that interpersonal closeness is neither accidental nor instantaneous but develops progressively as individuals negotiate the risks and benefits associated with revealing personal information.

The theory rests on the assumption that individuals are rational decision-makers who evaluate the potential rewards and costs of disclosure before revealing personal information (Altman & Taylor, 1973). As trust develops, disclosure becomes broader, encompassing a wider range of topics, and deeper, involving increasingly private thoughts, emotions, and experiences. This progression is expected to strengthen interpersonal relationships by fostering trust, mutual understanding, and emotional intimacy. Within the context of depression management, these assumptions suggest that disclosure is not merely an act of sharing information but a

communicative process through which supportive relationships are established and maintained.

One of the principal strengths of Social Penetration Theory is its systematic explanation of how interpersonal relationships develop through communication. Unlike theories that focus primarily on message exchange, SPT emphasizes disclosure as the mechanism through which relational intimacy is constructed. This perspective has made the theory influential in counselling, psychotherapy, health communication, and interpersonal communication research, where the quality of communication is often associated with emotional support, trust, and psychological well-being (Greene, Derlega, & Mathews, 2006). The theory is particularly useful in explaining why supportive disclosure within therapeutic relationships and peer interactions may contribute positively to depression management.

Despite its influence, Social Penetration Theory has attracted substantial criticism. One of the most persistent critiques concerns its assumption that relationship development follows a predictable, linear progression. Subsequent research has demonstrated that disclosure patterns are often dynamic, recursive, and influenced by situational, cultural, and relational factors rather than unfolding in a uniform sequence (Petronio, 2002). Individuals may disclose highly personal information early in a relationship under particular circumstances, while in other situations they may deliberately withhold information despite long-standing relationships. This suggests that disclosure decisions cannot always be explained solely through the gradual progression proposed by SPT.

The theory has also been criticized for placing considerable emphasis on self-disclosure while giving comparatively less attention to contextual influences such as culture, power relations, social norms, and privacy concerns. In collectivist societies, for example, disclosure decisions are often shaped by family expectations, cultural values, and fear of stigma rather than individual assessments of relational intimacy (Gudykunst & Ting-Toomey, 1988). These considerations are particularly relevant in mental health communication, where concerns about social judgement may

discourage individuals from openly discussing experiences of depression regardless of the quality of interpersonal relationships.

These limitations notwithstanding, Social Penetration Theory remains relevant to the present study because it provides a useful explanation of how disclosure contributes to the development of supportive interpersonal relationships that facilitate depression management. The theory helps explain why students who progressively disclose their emotional experiences may receive greater social support, while reciprocal disclosure from peers or counsellors may strengthen trust and encourage continued communication. However, because SPT provides limited explanation of how individuals negotiate privacy boundaries and make disclosure decisions in contexts characterized by stigma and sensitivity, it does not fully account for the complexities surrounding mental health disclosure.

Consequently, while Social Penetration Theory provides an important foundation for understanding the relational dynamics of self-disclosure, it is complemented in this study by Communication Privacy Management Theory and the Disclosure Decision Model, both of which extend the analysis by explaining how individuals regulate private information and evaluate the risks and benefits associated with disclosing experiences of depression.

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, counselling, 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 explains why some university students chose to disclose their experiences of depression while others remained silent. Before disclosing, students weighed the potential benefits, such as receiving support, against perceived risks, including stigma, judgment, and breaches of confidentiality. The model therefore provides a useful framework for understanding students' disclosure decisions in the management of depression. 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 Provides a framework for understanding students' disclosure behaviour. 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 (Petronio & 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 Interpersonal Theory of Depression

The Interpersonal Theory of Depression was first advanced by James C. Coyne (1976) to explain the role of interpersonal relationships in the development, maintenance, and recovery from depression. Unlike cognitive theories that primarily attribute depression to dysfunctional thinking patterns, Coyne argued that depression is fundamentally embedded within social interactions and communication processes. The theory emerged from observations that individuals experiencing depression often seek reassurance and emotional support from others, but that repeated reassurance-seeking and negative communication patterns may gradually strain interpersonal relationships, reduce social support, and inadvertently maintain depressive symptoms. Consequently, the theory shifted attention from intrapersonal explanations of depression to the quality of interpersonal relationships and communication as central determinants of psychological well-being.

The theory proposes that depression and interpersonal communication exist in a reciprocal relationship. Depressive symptoms influence how individuals communicate with others, while the quality of interpersonal interactions influences the progression or management of depression. Individuals experiencing depression frequently withdraw from social relationships, communicate less openly, or experience difficulties expressing their emotional needs. These communication patterns often reduce opportunities for emotional support and reinforce feelings of loneliness, rejection, and hopelessness. Conversely, supportive interpersonal relationships characterized by empathy, trust, and effective communication facilitate emotional expression, strengthen social support, and contribute positively to depression management (Coyne, 1976).

One of the major strengths of the Interpersonal Theory of Depression is its recognition that depression cannot be understood solely as an individual psychological condition but should also be examined within its interpersonal context. The theory has significantly influenced mental health practice, particularly the development of Interpersonal Psychotherapy (IPT), an evidence-based intervention that focuses on improving interpersonal relationships and communication to alleviate depressive symptoms (Klerman, Weissman, Rounsaville, & Chevron, 1984). Numerous studies have demonstrated that strengthening interpersonal communication, improving social support, and enhancing relationship quality contribute to improved depression outcomes across diverse populations (Cuijpers, Donker, Weissman, Ravitz, & Cristea, 2016).

Despite its contribution, the theory has received several criticisms. First, it places considerable emphasis on interpersonal relationships while giving comparatively less attention to biological, genetic, and cognitive factors known to influence depression. Critics argue that depression is a multifaceted condition whose development and management cannot be fully explained through interpersonal processes alone (Beck, 1976). Second, the theory assumes that interpersonal difficulties are central to most depressive experiences, yet the relative importance of interpersonal relationships may differ across individuals and cultural contexts. Consequently, the theory provides only a partial explanation of depression and is best considered alongside

complementary perspectives that account for disclosure decision-making and privacy regulation.

Nevertheless, the Interpersonal Theory of Depression provides an appropriate framework for the present study because it positions interpersonal communication as an important mechanism through which depression is managed. The theory helps explain why students who disclose their emotional experiences, receive supportive responses from peers or counsellors, and engage in trusting interpersonal relationships may experience improved psychological well-being. It further provides a theoretical basis for understanding how disclosure facilitates access to emotional support, strengthens therapeutic relationships, and enhances coping with depression. Within the context of this study, the theory therefore anchors the dependent variable-depression management-by explaining the communication processes through which disclosure contributes to improved mental health outcomes among university students.

Yes. In most theses, this section should be concise. It is only meant to demonstrate that the theories complement one another and collectively support the study, not to repeat the theoretical discussions.

2.2.5 Relationship Among the Theories

The four theories adopted in this study are complementary and collectively explain the relationship between disclosure and depression management among university students. Social Penetration Theory explains how gradual self-disclosure facilitates the development of trust and supportive interpersonal relationships. Communication Privacy Management Theory extends this perspective by explaining how individuals regulate private information and determine when, how, and to whom personal experiences are disclosed. Together, these theories explain the communication processes underlying students' disclosure decisions.

The Disclosure Decision-Making Model complements these perspectives by explaining the cognitive evaluation that precedes disclosure, whereby individuals weigh the perceived risks and benefits before deciding whether to reveal personal

information. Finally**,** Interpersonal Psychotherapy (IPT) provides the therapeutic perspective by explaining how improved interpersonal communication and supportive relationships contribute to the management of depression. Collectively, the four theories provide a comprehensive framework for understanding disclosure as both a communication process and a therapeutic mechanism through which depression management among university students can be enhanced.

2.3 Conceptual Framework

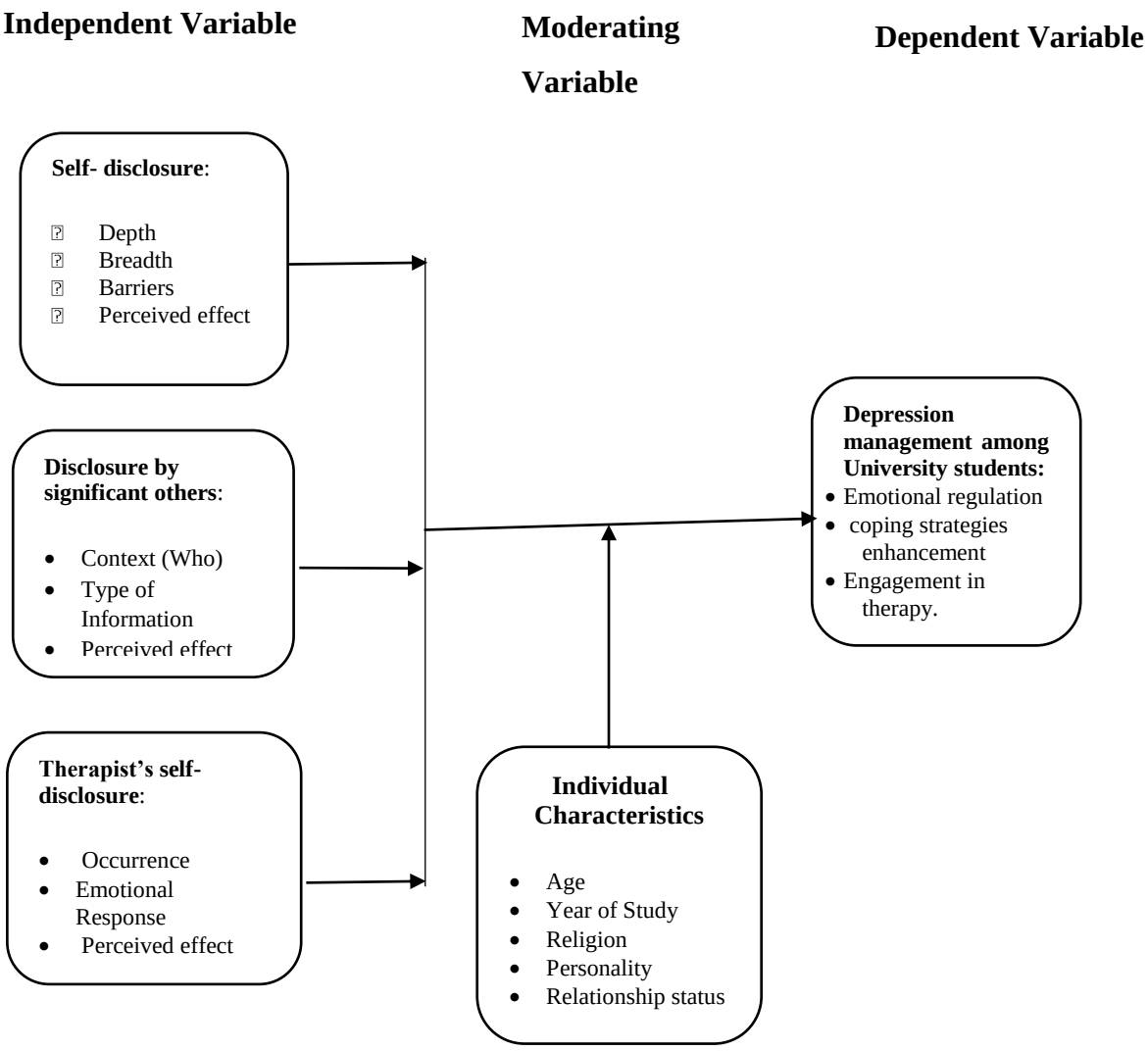

Figure 2.1: Conceptual Framework

In this conceptual framework, self-disclosure, disclosure by significant others, and Therapist's self-disclosure were identified as the independent variables, while depression management was the dependent variable. Individual characteristics, including age, year of study, 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 significant 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's self-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 individual characteristics considered as moderators between disclosure and depression management, in this study includes, age, 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. Personality traits was measured using a questionnaire where participant indicated their personality category among introverts, extroverts and ambivets.

Religion was assessed on the basis of self-reporting by the participants and so was the year of study.

2.4 Review of Variables

The purpose of this section is to examine the major concepts underpinning the study and to situate them within existing scholarly discourse. The review explores the conceptual literature on self-disclosure, disclosure by significant others, Therapist's self-disclosure, and depression management, highlighting how these variables have been defined, interpreted, and linked within interpersonal communication and mental health research. It also considers the influence of selected individual characteristics on disclosure behaviour and depression management. The section establishes the foundation for the empirical review and provides the basis for understanding the relationships examined in the study.

2.4.1 Self-disclosure and Depression Management

Self-disclosure is widely regarded as one of the most fundamental processes through which interpersonal relationships are initiated, developed, and sustained. It refers to the deliberate communication of personal thoughts, feelings, experiences, and concerns to another person, with the expectation that such communication will facilitate understanding, trust, and emotional support (Jourard, 1971; Greene, Derlega, & Mathews, 2006). Within interpersonal communication, self-disclosure extends beyond the mere sharing of private information; it is a relational process through which individuals negotiate intimacy, establish mutual understanding, and create opportunities for social and psychological support. The extent to which individuals choose to disclose, however, is influenced by perceptions of trust, anticipated responses from the recipient, and the social context within which communication occurs (Petronio, 2002).

The relationship between self-disclosure and psychological well-being has received considerable scholarly attention. Early conceptualizations viewed disclosure as an important mechanism for promoting emotional adjustment by allowing individuals to externalize distressing experiences rather than suppress them (Jourard, 1971).

Contemporary literature similarly recognizes disclosure as an important component of psychological coping because verbalizing emotional experiences facilitates emotional regulation, reduces psychological burden, and enables individuals to access social and professional support systems (Greene et al., 2006). Within mental health contexts, disclosure is therefore regarded as an important step in the management of depression because it allows individuals to communicate emotional distress, receive validation, and engage with appropriate support networks before symptoms become more severe.

The effectiveness of self-disclosure, however, depends largely on the quality of interpersonal relationships within which disclosure occurs. Relationship scholars argue that disclosure is not an isolated communicative act but a reciprocal process that develops as interpersonal trust increases. As relationships mature, individuals become more willing to reveal increasingly personal information, thereby strengthening relational intimacy and emotional connectedness (Altman & Taylor, 1973; Derlega, Winstead, Mathews, & Braitman, 2001). Ongoing disclosure also contributes to relationship maintenance by fostering openness, mutual understanding, and emotional support, all of which are particularly important when individuals are coping with psychological distress (Stafford & Canary, 2021). In the context of depression management, these relational qualities create supportive environments in which individuals feel psychologically safe to communicate emotional struggles and seek assistance.

Although self-disclosure is generally associated with positive psychological outcomes, scholars acknowledge that disclosure is rarely a straightforward decision. Individuals continuously weigh the anticipated benefits of disclosure against potential risks such as rejection, discrimination, embarrassment, or loss of privacy (Petronio, 2002). The perceived competence, trustworthiness, and responsiveness of the disclosure recipient further influence whether individuals feel comfortable sharing sensitive information (Chaudoir & Fisher, 2010). Consequently, disclosure may either facilitate psychological recovery or expose individuals to additional emotional distress depending on how recipients respond. Effective disclosure

therefore requires supportive interpersonal environments characterized by empathy, confidentiality, and acceptance.

The manner in which self-disclosure is understood and practiced is also shaped by cultural norms and social expectations. In many Western societies, disclosure is commonly viewed as an indicator of openness, authenticity, and healthy interpersonal functioning. In contrast, communication within many African societies is influenced by communal values that place considerable emphasis on family reputation, collective identity, and social harmony. Under such circumstances, openly discussing personal or psychological difficulties may be perceived as exposing family vulnerabilities or disrupting social cohesion (Atilola, 2015; Gureje, Lasebikan, Ephraim-Oluwanuga, Olley, & Kola, 2005). Consequently, individuals experiencing depression may choose to conceal emotional struggles or restrict disclosure to a limited circle of trusted family members, religious leaders, or close friends. These cultural expectations illustrate that disclosure behaviour is socially constructed and cannot be understood independently of the cultural environment within which communication occurs.

Within university settings, self-disclosure assumes particular significance because emerging adulthood is characterized by identity development, increased independence, and changing interpersonal relationships (Arnett, 2000). During this transition, students frequently encounter academic, social, and emotional challenges that increase their need for supportive communication. However, concerns about stigma, confidentiality, and negative social evaluation may discourage students from discussing their psychological experiences openly, even when institutional counselling services are available (Rickwood, Deane, Wilson, & Ciarrochi, 2005). In Kenya, similar concerns have been reported, where fear of being labelled, misconceptions surrounding mental illness, and limited confidence in counselling services continue to influence students' willingness to disclose emotional difficulties (Othieno, Okoth, Peltzer, Pengpid, & Malla, 2014; Republic of Kenya, 2020). These realities suggest that the effectiveness of self-disclosure as a communication strategy depends not only on individual willingness but also on the interpersonal and institutional environments within which disclosure takes place.

Existing literature portrays self-disclosure as an important interpersonal communication process that facilitates emotional expression, strengthens supportive relationships, and promotes access to psychological support. At the same time, its effectiveness is influenced by relational trust, perceived confidentiality, cultural expectations, and the anticipated responses of disclosure recipients. Understanding these communication dynamics is therefore essential in examining how self-disclosure contributes to depression management among university students, particularly within the Kenyan university context where interpersonal, cultural, and institutional factors collectively shape disclosure behaviour.

2.4.2 Effect of Disclosure by Significant Others on Depression Management

Depression is often accompanied by symptoms such as hopelessness, withdrawal, impaired concentration, and reduced motivation, all of which can diminish an individual's willingness or ability to seek professional help independently (American Psychiatric Association, 2022). In many instances, the first step toward treatment is therefore initiated not by the individual experiencing depression but by people within their immediate social environment who recognize behavioural or emotional changes and communicate these concerns to appropriate support systems. This process, referred to in this study as disclosure by significant others, encompasses situations in which family members, friends, peers, lecturers, counsellors, or other trusted individuals disclose concerns about a person's mental health to healthcare providers, university authorities, or other support networks with the intention of facilitating timely intervention. Unlike self-disclosure, where individuals voluntarily reveal their own experiences, disclosure by significant others occurs when another person assumes the responsibility of communicating concerns about an individual's psychological well-being.

The importance of significant others in depression management is well established within collaborative and family-centred models of mental healthcare. Family members and close social networks are often the first to recognize changes in behaviour, emotional functioning, or social withdrawal that may indicate the onset or worsening of depression. Their observations frequently influence whether

professional help is sought, particularly where the individual lacks insight into their condition or is reluctant to seek assistance because of stigma or fear of discrimination (Dixon et al., 2000). Family psychoeducation models similarly emphasize that involving significant others in the treatment process improves continuity of care, strengthens adherence to treatment, and creates supportive environments that enhance recovery outcomes (Lucksted, McFarlane, Downing, & Dixon, 2012). Rather than replacing the individual's autonomy, disclosure by significant others is viewed as a supportive mechanism that facilitates earlier recognition of mental health needs while promoting collaborative care.

Within university settings, peers, lecturers, and student leaders frequently assume comparable gatekeeping roles. Students experiencing depression often exhibit declining academic performance, prolonged absenteeism, social isolation, emotional distress, or behavioural changes that are first noticed by those around them rather than by mental health professionals. Gatekeeper intervention models propose that equipping members of the university community to recognize these warning signs and appropriately communicate concerns substantially increases the likelihood of early identification and referral to counselling services (Cross, Matthieu, Lezine, & Knox, 2010; Isaac et al., 2009). Rather than constituting an invasion of privacy, responsible disclosure by significant others functions as an important pathway through which students who might otherwise remain unidentified gain access to appropriate mental health support.

Nevertheless, disclosure by significant others presents important ethical and communication dilemmas. While timely disclosure may facilitate access to treatment and reduce the risk of deterioration or self-harm, inappropriate disclosure may undermine trust, violate confidentiality, and discourage future help-seeking. Communication Privacy Management Theory (Petronio, 2002) provides a useful framework for understanding these tensions by proposing that private information is jointly managed once it is shared with another person. According to the theory, significant others become co-owners of private information and must negotiate privacy boundaries by deciding whether disclosure serves the individual's best interests while respecting expectations of confidentiality. Boundary turbulence may

occur when private information is disclosed without the individual's consent or contrary to established privacy expectations, potentially damaging interpersonal trust and future communication.

These communication principles are reflected in professional confidentiality standards governing healthcare practice. For example, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 permits healthcare providers to disclose confidential patient information without consent only under specific circumstances, such as when disclosure is necessary to prevent serious harm to the patient or others or where disclosure is required by law. Although HIPAA is a United States statute, it illustrates internationally recognized principles that balance individual privacy with the ethical duty to protect life and facilitate appropriate care. Within university counselling settings, these principles underscore that disclosure by significant others should be guided by necessity, proportionality, and respect for the individual's autonomy, ensuring that communication supports rather than compromises therapeutic relationships.

These perspectives demonstrate that disclosure by significant others constitutes an important interpersonal process through which individuals experiencing depression are identified, supported, and linked to appropriate care. The literature further suggests that the effectiveness of such disclosure depends on the nature of interpersonal relationships, the social context in which disclosure occurs, and the availability of responsive support systems. These observations provide a useful foundation for examining the empirical evidence on how disclosure by significant others has influenced depression management across different settings.

2.4.3 Effect of Therapist's Self-Disclosure on Depression Management

Therapist's self-disclosure refers to the intentional sharing of personal information, experiences, feelings, or reactions by a therapist with a client for a therapeutic purpose. Unlike client self-disclosure, which forms the basis of counselling, Therapist's self-disclosure is used selectively to facilitate the therapeutic process, strengthen the therapeutic alliance, normalize clients' experiences, and encourage further disclosure where appropriate (Zur, 2007). Although Therapist's self-

disclosure remains one of the more debated counselling interventions, empirical evidence increasingly suggests that when used judiciously, it can positively influence therapeutic outcomes.

Empirical studies consistently demonstrate that Therapist's self-disclosure can strengthen the therapeutic relationship by increasing clients' perceptions of therapist warmth, genuineness, and trustworthiness. In an experimental study, Barrett and Berman (2001) found that clients whose therapists appropriately disclosed relevant personal experiences reported stronger therapeutic alliances and greater improvements during therapy compared to those whose therapists maintained strict neutrality. The findings suggest that carefully considered Therapist's self-disclosure may reduce interpersonal distance and foster an atmosphere in which clients feel understood and accepted.

Similarly, Knox, Hess, Petersen and Hill (1997) reported that clients generally perceived Therapist's self-disclosure positively when it was directly relevant to their concerns and clearly intended to benefit the therapeutic process. Appropriate Therapist's self-disclosure enhanced rapport, encouraged clients to discuss sensitive issues more openly, and contributed to greater emotional engagement during counselling. However, disclosures that appeared excessive or unrelated to the client's concerns were perceived negatively and were considered potentially disruptive to therapy.

A comprehensive review by Henretty and Levitt (2010) further concluded that Therapist's self-disclosure is most effective when it is brief, purposeful, and responsive to the client's immediate therapeutic needs. Across the studies reviewed, Therapist's self-disclosure was associated with stronger therapeutic alliances, increased client openness, and improved perceptions of counselling effectiveness. However, the authors emphasized that the benefits of Therapist's self-disclosure depend on its timing, relevance, and appropriateness rather than on the mere act of disclosure itself.

More recent evidence continues to support these findings. Audet (2011), in a qualitative examination of Therapist's self-disclosure, found that clients frequently

interpreted appropriate Therapist's self-disclosure as an indication of authenticity and empathy, which enhanced trust and facilitated deeper emotional exploration. The study also noted that Therapist's self-disclosure reduced perceived power differentials between therapist and client, creating a more collaborative therapeutic relationship. Nevertheless, the study cautioned that disclosures motivated by the therapist's personal needs rather than the client's welfare could undermine professional boundaries and weaken the therapeutic alliance.

A qualitative meta-synthesis conducted by Alfi-Yogev, Kivity, Hasson-Ohayon and Ziv-Beiman (2018) similarly found that therapist self-disclosure consistently promoted stronger therapeutic relationships, increased client insight, and enhanced perceptions of therapist credibility across diverse counselling settings. Clients described Therapist's self-disclosure as helpful when it normalized their experiences, conveyed empathy, and demonstrated genuine understanding of their emotional struggles. Conversely, disclosures perceived as excessive or poorly timed diverted attention from the client's concerns and reduced the effectiveness of therapy.

Further evidence by Alfi-Yogev, Hasson-Ohayon, Lazarus, Ziv-Beiman and Slonim (2020) reinforces the view that Therapist's self-disclosure should be individualized to the client's needs. Their findings indicate that the effectiveness of Therapist's self-disclosure is influenced by factors such as the client's characteristics, the stage of therapy, and the relevance of the disclosure to the issues under discussion. Appropriate disclosure was associated with improved therapeutic engagement and greater client participation, whereas poorly matched disclosures risked creating confusion, dependency, or discomfort.

The empirical literature suggests that Therapist's self-disclosure can contribute positively to depression management by strengthening the therapeutic alliance, promoting trust, encouraging client self-disclosure, and enhancing emotional engagement during counselling. However, these benefits are contingent upon the therapist's ability to exercise sound professional judgment regarding the timing, relevance, and purpose of disclosure. While substantial evidence supports the role of Therapist's self-disclosure in improving therapeutic processes, limited empirical

attention has been given to its influence on depression management among university students in Kenya. This study sought to address this gap by examining the effect of Therapist's self-disclosure on depression management within the context of university counselling services.

2.4.4 Moderating Effect of Individual Characteristics on the Relationship between Disclosure and Depression Management

The relationship between disclosure and depression management does not occur uniformly across all individuals. Rather, the extent to which disclosure contributes to improved psychological outcomes may depend on certain individual characteristics. In behavioural and social science research, a moderating variable influences the strength or direction of the relationship between an independent and a dependent variable rather than exerting a direct effect on the outcome itself (Baron & Kenny, 1986). In the present study, age, year of study, relationship status, religion, and personality were conceptualized as moderators because they may influence the extent to which disclosure contributes to effective depression management among university students.

Age is one of the individual characteristics that may shape the effectiveness of disclosure in managing depression. Younger university students often experience challenges associated with identity development, emotional regulation, and adjustment to university life, factors that may make them less willing to communicate psychological distress openly. Consequently, although disclosure may facilitate access to emotional support, younger students may derive comparatively fewer benefits if they remain reluctant to disclose their experiences. Older students, having accumulated greater life experience and emotional maturity, may be better able to engage in meaningful disclosure and utilise available support systems, thereby strengthening the positive effect of disclosure on depression management (Arnett, 2000; Tamres, Janicki, & Helgeson, 2002).

Similarly, the year of study may influence how disclosure translates into improved mental health outcomes. Students in their first year often face transitional challenges, including adapting to a new academic environment, developing social networks, and

coping with increased independence. These challenges may heighten emotional distress while simultaneously discouraging disclosure due to uncertainty or fear of stigma. As students progress through university, they are more likely to establish supportive peer relationships and become familiar with institutional counselling services, increasing the likelihood that disclosure will result in meaningful psychological support and improved depression management (Barry, Clarke, Jenkins, & Patel, 2013; Ibrahim, Kelly, Adams, & Glazebrook, 2013).

Religious beliefs may also moderate the relationship between disclosure and depression management. Religion can provide emotional support, hope, and a sense of belonging, all of which may encourage individuals to disclose emotional difficulties within trusted communities. However, the influence of religion varies across contexts. In some settings, mental illness is interpreted through spiritual or moral lenses, discouraging open discussion of psychological distress and limiting professional help-seeking. Under such circumstances, disclosure may be less likely to translate into effective depression management because individuals may fear negative judgement or prefer spiritual interventions over formal counselling. Conversely, religious environments that promote compassion and encourage professional mental health support may strengthen the positive effects of disclosure on psychological well-being (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001; Pargament et al., 1998).

Personality is another characteristic that may influence the effectiveness of disclosure in managing depression. Individuals with extraverted personalities generally exhibit greater comfort with interpersonal interaction and emotional expression, making them more likely to disclose personal difficulties and benefit from supportive responses. In contrast, introverted individuals often prefer privacy and may disclose emotional concerns less readily, potentially limiting opportunities to receive social and professional support. Consequently, while disclosure may contribute to depression management for both personality types, its positive effect may be stronger among individuals who are naturally inclined toward interpersonal communication (McCrae & Costa, 2008; Ren, Zhang, & Li, 2024). However, personality should not be viewed as determining whether disclosure occurs, but

rather as influencing the extent to which individuals engage in disclosure and benefit from the support that follows.

Relationship status may similarly alter the relationship between disclosure and depression management. Students in supportive romantic relationships may have greater opportunities to discuss emotional concerns and receive reassurance, thereby reinforcing the therapeutic benefits of disclosure. Conversely, students who are single or experiencing relationship conflict may have fewer opportunities for emotional expression or may perceive lower levels of available support. Under such circumstances, disclosure may produce weaker improvements in depression management because the supportive interpersonal environment necessary for effective coping is less readily available (Derlega et al., 2001; Tamres et al., 2002).

Collectively, the literature suggests that the effectiveness of disclosure in managing depression is contingent upon individual characteristics rather than disclosure alone. Age, year of study, religion, relationship status, and personality may strengthen or weaken the relationship between disclosure and depression management by shaping individuals' willingness to communicate psychological distress, the support they receive following disclosure, and their engagement with counselling services. Examining these moderating effects therefore provides a more detailed understanding of why disclosure may contribute more strongly to depression management for some university students than for others.

2.4.5 Depression Management among University Students

Management of depression among university students requires interventions that address both the psychological symptoms of the disorder and the social contexts in which they occur. Current clinical guidelines recommend several evidence-based approaches, with the choice of treatment depending on the severity of symptoms, the individual's circumstances, and available resources. The most widely supported interventions include pharmacotherapy, Cognitive Behavioural Therapy (CBT), and Interpersonal Psychotherapy (IPT), either as standalone treatments or in combination (National Institute for Health and Care Excellence [NICE], 2022; American Psychological Association, 2019).

Cognitive Behavioural Therapy (CBT) is one of the most extensively researched psychological interventions for depression. Developed by Aaron Beck, CBT is based on the premise that depression is maintained by maladaptive patterns of thinking that influence emotions and behaviour. Treatment therefore focuses on helping individuals identify, challenge, and modify negative automatic thoughts and dysfunctional beliefs while encouraging behavioural activation and problem-solving skills (Beck, 1979). Numerous systematic reviews have demonstrated that CBT produces significant reductions in depressive symptoms among adolescents and young adults, making it one of the first-line psychological treatments for depression (Cuijpers et al., 2023).

Interpersonal Psychotherapy (IPT), in contrast, conceptualizes depression within the context of interpersonal relationships rather than maladaptive cognitions. Developed by Klerman, Weissman, Rounsaville, and Chevron (1984), IPT assumes that depressive symptoms are closely linked to difficulties in interpersonal functioning, including unresolved grief, interpersonal disputes, role transitions, and social isolation. Treatment therefore seeks to improve communication patterns, strengthen interpersonal relationships, and enhance social support. Unlike CBT, which primarily focuses on changing thought processes, IPT emphasizes improving interpersonal interactions as a pathway to reducing depressive symptoms (Weissman, Markowitz, & Klerman, 2018).

Evidence comparing these interventions suggests that both CBT and IPT are effective in treating depression, although they operate through different therapeutic mechanisms. Meta-analyses indicate that both approaches achieve comparable reductions in depressive symptoms, with CBT demonstrating greater emphasis on cognitive restructuring, while IPT is particularly effective where interpersonal conflict, relationship difficulties, or deficits in social support contribute to depression (Cuijpers et al., 2016; Cuijpers et al., 2023). Because university students frequently experience challenges related to peer relationships, family separation, identity development, and social adjustment, interpersonal factors often become central to both the development and management of depression.

For this reason, the present study is anchored primarily on the interpersonal perspective to depression management. Rather than examining psychotherapy as a clinical intervention, the study focuses specifically on disclosure as an interpersonal communication strategy through which students access emotional support, strengthen therapeutic relationships, and facilitate recovery from depression. Within this context, disclosure is viewed as an important communication process that complements existing therapeutic approaches, particularly Interpersonal Psychotherapy, by facilitating emotional expression, trust, and supportive interpersonal relationships.

2.5 Empirical Review of Relevant Studies

The preceding sections reviewed the conceptual and theoretical literature relating to the study variables. However, understanding the relationships among these variables requires examination of empirical evidence generated from previous studies. Accordingly, the following sections review empirical studies that have examined the influence of self-disclosure, disclosure by significant others, Therapist's self-disclosure, and individual characteristics on depression management among university students. The review critically evaluates the methodologies, findings, and limitations of previous studies in order to identify the knowledge gaps that justify the present study.

2.5.1 Self-Disclosure and Depression Management

Empirical evidence consistently demonstrates that self-disclosure contributes positively to depression management by facilitating emotional expression, strengthening social support, and encouraging engagement with mental health services. A systematic review by Gonsalves, Nair, Roy, Pal and Michelson (2023), examining disclosure-based interventions among adolescents and young adults, found that structured opportunities for individuals to openly discuss their emotional experiences were associated with significant reductions in depressive symptoms. The review further established that the benefits of disclosure extended beyond emotional relief to include improved interpersonal connectedness and greater willingness to seek professional support. These findings suggest that self-disclosure functions not

merely as a communicative act but as an important therapeutic mechanism through which individuals begin the process of psychological recovery.

Similar findings have been reported in clinical settings. Keller, Valdez, Schwei and Jacobs (2016), in a qualitative study conducted among women receiving primary healthcare services in the United States, found that participants experienced greater emotional relief when healthcare providers created safe and empathetic environments that encouraged open discussion of depressive symptoms. The study demonstrated that disclosure was more likely to occur when providers actively initiated conversations about emotional well-being, listened without judgement, and established trusting relationships with patients. Likewise, Al-Krenawi and Graham (2011), examining mental health care within Middle Eastern communities, observed that although cultural expectations often discouraged open discussion of emotional distress, individuals who disclosed their experiences within supportive therapeutic environments reported improved emotional well-being and greater engagement with treatment. Collectively, these studies demonstrate that the effectiveness of self-disclosure depends not only on an individual's willingness to communicate distress but also on the responsiveness of the recipient and the environment within which disclosure occurs.

Evidence from peer-support interventions similarly highlights the importance of disclosure in managing depression. Naslund, Aschbrenner, Marsch and Bartels (2016) found that sharing lived experiences within peer support groups strengthened participants' sense of belonging, reduced feelings of isolation, and improved self-esteem, all of which contributed to better management of depressive symptoms. However, the study also noted that individuals with lower emotional expressiveness, including those experiencing social anxiety or introverted personality traits, participated less actively in disclosure processes and consequently derived fewer benefits from peer support. These findings suggest that although disclosure-based interventions are generally beneficial, individual characteristics may influence both the willingness to disclose and the extent to which disclosure contributes to depression management.

Evidence from Kenya, though relatively limited, points in a similar direction. Shah, Laving, Okech-Helu and Kumar (2021), in their study among medical students in Nairobi, reported that students who openly discussed emotional difficulties with trusted friends, family members or counsellors demonstrated better psychological well-being than those who managed their struggles in isolation. The study highlighted the protective role of supportive interpersonal relationships in promoting help-seeking and reducing depressive symptoms. However, the investigation focused primarily on the availability of social support and did not examine disclosure itself as an interpersonal communication process or explore the factors that influence students' decisions to disclose emotional difficulties.

Although the reviewed studies consistently demonstrate the therapeutic value of self-disclosure, several limitations remain evident. Most of the existing evidence has been generated within Western clinical and university settings, raising questions regarding its applicability in cultural contexts where disclosure of psychological distress may be shaped by different social norms and expectations. Furthermore, many studies conceptualize disclosure as one component of broader psychological or counselling interventions rather than examining it as an independent interpersonal communication strategy. Existing Kenyan research similarly concentrates on social support, help-seeking behaviour, or the prevalence of depression, with limited attention given to how self-disclosure influences depression management or the interpersonal communication processes through which disclosure facilitates recovery. These limitations provide the basis for examining self-disclosure as an interpersonal communication strategy for depression management among university students in Kenya.

2.5.2 Disclosure by Significant Others and Depression Management

Empirical evidence suggests that significant others—including family members, peers, lecturers, counsellors, and other trusted individuals—play an important role in facilitating depression management by recognizing symptoms of psychological distress and encouraging access to professional support. Although this role has largely been examined within the broader concepts of social support, gatekeeping,

and help-seeking, the communication process through which significant others disclose concerns about another person's mental health has received comparatively less empirical attention.

Isaac et al. (2009) conducted a systematic review of eleven empirical studies to evaluate the effectiveness of gatekeeper training programmes in suicide prevention and early mental health intervention. The review found that individuals who regularly interacted with vulnerable populations, including teachers, peers, family members, and community leaders, became significantly more capable of identifying symptoms of emotional distress, initiating supportive conversations, and referring affected individuals to appropriate mental health services following training. The findings demonstrated that disclosure initiated by significant others can facilitate early intervention and improve access to professional care before psychological distress progresses to more severe outcomes. However, the review focused primarily on suicide prevention programmes and did not specifically examine depression management among university students or conceptualize disclosure by significant others as an interpersonal communication process.

Similarly, Cross, Matthieu, Lezine, and Knox (2010) evaluated the effectiveness of a gatekeeper training programme among school personnel in the United States using a quasi-experimental design. The study reported significant improvements in participants' ability to recognize emotional distress, engage at-risk individuals in supportive conversations, and facilitate referrals to mental health professionals. These findings reinforce the importance of significant others in promoting early access to mental health services. Nevertheless, the study was conducted within secondary school settings and examined institutional gatekeepers rather than naturally occurring disclosure within family, peer, or university environments. Furthermore, depression management was not considered as the primary outcome, limiting understanding of how disclosure by significant others contributes to long-term psychological recovery.

Family involvement has also received considerable empirical attention as a mechanism for supporting individuals experiencing mental illness. Lucksted,

McFarlane, Downing, and Dixon (2012), in their review of family psychoeducation interventions, found that family members frequently contributed to improved treatment adherence, reduced relapse, and enhanced psychosocial functioning by recognizing changes in behaviour, communicating concerns to healthcare providers, and supporting treatment decisions. The study demonstrated that significant others often facilitate access to care by acting as intermediaries between individuals experiencing mental illness and mental health professionals. However, the review primarily focused on severe mental illnesses such as schizophrenia and bipolar disorder rather than depression among university students. Moreover, family involvement was examined mainly after diagnosis, providing limited understanding of disclosure by significant others as an early communication strategy for depression management.

Within the African context, Kaggwa et al. (2022) conducted a multicentre cross-sectional study among university students in Uganda to examine mental health challenges and patterns of help-seeking following the COVID-19 pandemic. The study established that although many students experienced symptoms of depression and psychological distress, professional help-seeking frequently occurred only after encouragement from peers, family members, or trusted university staff. Students who received such encouragement were significantly more likely to utilize counselling and psychological services than those who relied solely on personal coping strategies. These findings highlight the important role played by significant others in recognizing emotional distress and facilitating access to mental health care within university settings. However, the study conceptualized these interactions within the broader framework of social support and help-seeking rather than examining disclosure by significant others as a distinct interpersonal communication behaviour. In addition, it did not investigate how demographic or cultural factors influence the effectiveness of such disclosures.

Evidence from Kenya presents a similar pattern. Shah, Laving, Okech-Helu, and Kumar (2021) investigated depression and help-seeking behaviour among medical students in Nairobi and found that students who received encouragement from trusted individuals, including friends, family members, and university counsellors,

were more likely to seek professional mental health support than those who attempted to manage their psychological distress independently. The study demonstrated that significant others often influence recognition of depressive symptoms and facilitate access to counselling services. However, the study approached these interactions from a help-seeking perspective and did not explicitly examine disclosure by significant others as an interpersonal communication process. Furthermore, its focus on medical students from a single institution limits the applicability of the findings to the wider university student population in Kenya.

These empirical studies demonstrate that significant others frequently facilitate depression management by recognizing psychological distress, initiating supportive conversations, and encouraging professional help-seeking. Nevertheless, existing evidence has largely conceptualized these interactions within the broader constructs of gatekeeping, family involvement, and social support, with limited empirical attention given to disclosure by significant others as a communication strategy in its own right. Additionally, empirical evidence from African universities remains limited, while studies conducted in Kenya have focused predominantly on help-seeking behaviour rather than examining how disclosure by significant others influences depression management. Consequently, there remains limited empirical understanding of the role of disclosure by significant others in the management of depression among university students in Kenya, a gap that the present study seeks to address.

2.5.3 Therapist's Self-Disclosure and Depression Management

Therapist's self-disclosure has increasingly attracted empirical attention as an interpersonal communication strategy capable of strengthening the therapeutic alliance and improving mental health outcomes. Unlike client self-disclosure, Therapist's self-disclosure involves the intentional revelation of relevant personal experiences, emotions, or reactions by the therapist for the benefit of the client. Although its use remains debated within psychotherapy, empirical evidence generally suggests that carefully managed Therapist's self-disclosure can enhance trust, normalize clients' experiences, reduce feelings of isolation, and encourage

greater engagement in treatment. However, the effectiveness of Therapist's self-disclosure appears to depend largely on its timing, relevance, and appropriateness within the therapeutic relationship.

Barrett and Berman (2001) conducted one of the earliest experimental studies examining the effects of therapist self-disclosure on psychotherapy outcomes. Clients were randomly assigned to therapists who either engaged in appropriate personal disclosure or maintained a neutral therapeutic stance. The findings indicated that clients who experienced appropriate Therapist's self-disclosure reported significantly stronger therapeutic alliances, greater perceptions of therapist warmth and empathy, and improved psychological outcomes. The authors argued that Therapist's self-disclosure reduces interpersonal distance, making therapists appear more authentic and approachable, thereby encouraging clients to discuss emotionally difficult experiences more openly. Despite these positive findings, the study was conducted within a controlled clinical setting in the United States and did not specifically examine depression management among university students. Furthermore, the influence of individual client characteristics on responses to Therapist's self-disclosure was not explored.

Building on this evidence, Henretty and Levitt (2010) conducted a comprehensive qualitative review of twenty-one empirical studies investigating therapist self-disclosure in psychotherapy. Their review found that Therapist's self-disclosure was generally associated with stronger therapeutic relationships, increased client satisfaction, and enhanced perceptions of therapist genuineness when disclosures were brief, intentional, and directly related to the client's presenting concerns. Conversely, disclosures that were excessive, poorly timed, or irrelevant frequently disrupted therapy by shifting attention away from the client and creating role ambiguity. The review therefore concluded that the effectiveness of Therapist's self-disclosure depends less on whether disclosure occurs than on how it is implemented within the therapeutic process. However, the studies included in the review were conducted almost exclusively in North America and Europe, limiting the applicability of these findings to culturally diverse contexts where norms governing interpersonal communication and emotional expression differ substantially.

More recent evidence by Alfi-Yogev, Kivity, Hasson-Ohayon, and Ziv-Beiman (2018) further reinforces the therapeutic value of appropriate Therapist's self-disclosure. Through a qualitative meta-analysis of psychotherapy studies, the authors found that Therapist's self-disclosure and therapeutic immediacy consistently enhanced clients' perceptions of authenticity, trustworthiness, and emotional safety. Clients frequently reported feeling less isolated and more willing to discuss painful experiences when therapists appropriately shared relevant personal information. At the same time, the review emphasized that Therapist's self-disclosure should always remain client-centred, with its effectiveness being contingent upon therapeutic context, client readiness, and professional judgement. While the review provides robust evidence supporting Therapist's self-disclosure, the studies synthesized originated almost entirely from Western clinical settings, leaving uncertainty regarding how such communication strategies function in African mental health contexts.

Within Kenya, empirical evidence on Therapist's self-disclosure remains limited. Agutu, Aloka, and Kevogo (2021) investigated the relationship between counsellor deliberate self-disclosure and therapy-seeking behaviour among undergraduate students in Kenyan universities using a convergent mixed-methods design involving 352 students. The study established a positive and statistically significant relationship between counsellor self-disclosure and students' willingness to seek therapy, suggesting that appropriate disclosure by counsellors reduces psychological distance, strengthens trust, and encourages students to engage with counselling services. The authors concluded that deliberate Therapist's self-disclosure can contribute to stronger therapeutic relationships when used professionally and purposefully. Nevertheless, the study focused primarily on therapy-seeking behaviour rather than depression management and did not examine whether Therapist's self-disclosure contributes to improved psychological outcomes among students already experiencing depression. In addition, the study did not investigate the moderating influence of demographic characteristics such as age, gender, or personality on the effectiveness of Therapist's self-disclosure.

The empirical evidence presented, consistently demonstrates that Therapist's self-disclosure can strengthen therapeutic relationships by enhancing trust, reducing emotional distance, and encouraging greater client engagement. However, existing studies have predominantly examined Therapist's self-disclosure within Western clinical environments, with limited evidence emerging from African settings. In Kenya, available research has largely focused on counsellor disclosure as a predictor of therapy-seeking behaviour rather than its influence on depression management outcomes. Consequently, there remains limited empirical understanding of how Therapist's self-disclosure contributes to depression management among university students and whether its effectiveness varies across different demographic groups. Addressing these gaps is essential for developing culturally appropriate communication strategies that enhance counselling effectiveness within Kenyan universities.

2.5.4 Depression Management among University Students

Empirical research on depression management among university students has largely focused on evaluating the effectiveness of institutional mental health interventions, treatment outcomes, and students' engagement with available psychological services. Although universities have increasingly established counselling centres and mental health programmes, evidence suggests that effective management of depression remains a significant challenge across higher education institutions.

Auerbach et al. (2018) conducted the World Health Organization World Mental Health International College Student Initiative involving first-year students from universities across eight countries. The study established that depression was among the most prevalent mental disorders affecting university students, yet only a small proportion of affected students accessed available treatment services. Despite the presence of institutional mental health programmes, many students continued to experience persistent depressive symptoms due to delayed treatment, limited service utilization, and inadequate early identification. The study concluded that universities should strengthen comprehensive depression management systems capable of identifying and supporting students before symptoms become severe. However, the

research focused primarily on treatment utilization and institutional capacity without examining the interpersonal factors that may influence successful depression management.

Hunt and Eisenberg (2010) reviewed empirical studies on mental health among university students and found that although counselling services had expanded considerably within higher education institutions, treatment coverage remained substantially lower than the estimated burden of depression. The review further demonstrated that depression management was constrained by institutional challenges, including insufficient counselling personnel, increasing student demand, and low utilization of available services. While the review provides important evidence regarding systemic challenges affecting depression management, it synthesizes findings largely from North American universities, limiting the applicability of its conclusions to developing countries where mental health systems operate under different structural and cultural conditions.

Within the African context, Oppong Asante and Andoh-Arthur (2015) investigated the prevalence and management of depression among university students in Ghana. The study found that although students recognized depression as a serious health concern, formal mental health service utilization remained low, with many students relying on informal coping mechanisms despite experiencing significant psychological distress. The authors concluded that universities needed integrated mental health programmes that combined prevention, early identification, and accessible treatment services. Nevertheless, the study concentrated primarily on prevalence and coping strategies and did not examine the interpersonal communication processes that may facilitate effective depression management.

Similarly, Othieno et al. (2014) examined depression among students at the University of Nairobi and reported that a substantial proportion of students exhibited moderate to severe depressive symptoms despite the availability of university counselling services. The study identified economic hardship, academic pressures, and social challenges as important contributors to students' mental health difficulties and recommended strengthening institutional mental health programmes through

early detection and targeted interventions. However, the study did not evaluate the effectiveness of existing depression management approaches nor investigate the interpersonal mechanisms through which students engage with available support systems.

This empirical evidence demonstrates that depression continues to pose a significant challenge within universities despite increasing institutional investment in mental health services. Existing studies have largely concentrated on prevalence, treatment utilization, and institutional responses, with comparatively limited attention devoted to understanding the interpersonal processes that may enhance the effectiveness of depression management. In particular, there remains limited empirical evidence on how disclosure practices contribute to successful depression management among university students in Kenya. Addressing this gap provides the basis for the present study.

2.5.5 Individual Characteristics Moderation on the Relationship between Disclosure and Depression Management

Individual characteristics have increasingly been recognized as important contextual factors that influence the effectiveness of interpersonal communication strategies in mental health interventions. Rather than exerting direct effects alone, variables such as age, personality, religion, and year of study may alter the extent to which disclosure contributes to improved depression management. Consequently, recent empirical studies have increasingly examined these characteristics as moderating influences within disclosure and help-seeking processes.

Eisenberg, Hunt, and Speer (2012) investigated mental health help-seeking among university students across several American universities using a cross-sectional survey design. The study found that students who received encouragement from peers, family members, and university staff were significantly more likely to seek professional counselling than those who did not receive such encouragement. However, the relationship varied across demographic groups. Female students and older students demonstrated greater willingness to respond positively to supportive interpersonal communication than younger and male students, suggesting that age

and gender moderated the effectiveness of interpersonal disclosure in promoting access to mental health services. Despite these findings, the study focused on help-seeking behaviour rather than depression management and was conducted within a Western university context, limiting the transferability of the findings to Kenyan universities.

Swickert, Rosentreter, Hittner, and Mushrush (2010) examined the relationship between personality traits, self-disclosure, and perceived social support among university students. Using survey data collected from undergraduate students, the researchers established that extraversion strengthened the positive relationship between emotional disclosure and perceived social support, while introverted individuals benefited less from similar disclosure experiences. The findings suggest that personality influences the effectiveness of disclosure by shaping individuals' willingness to communicate emotional distress and utilize available support networks. However, the study measured perceived social support rather than depression management outcomes and did not examine therapist or significant-other disclosure as forms of interpersonal communication.

Beiter et al. (2015) investigated stress, depression, and help-seeking behaviour among university students in the United States. The study reported that first-year students experienced significantly higher levels of psychological distress but were less likely to access counselling services or disclose emotional difficulties than students in advanced years of study. As students progressed through university, familiarity with institutional support systems and increased social integration enhanced both disclosure and utilization of mental health services. These findings suggest that year of study may influence the effectiveness of disclosure-based interventions. Nevertheless, the study examined disclosure primarily as part of help-seeking behaviour and did not evaluate whether year of study moderates the relationship between disclosure and depression management.

Within the African context, Shah, Laving, Othieno, and Kumar (2021) examined depression among medical students in Nairobi using a cross-sectional survey design. The study found that students who reported stronger social support and greater

willingness to discuss emotional challenges with trusted individuals experienced lower levels of depressive symptoms. The relationship, however, varied across demographic groups, with differences observed according to age, gender, and religious affiliation. The authors concluded that individual characteristics shape both help-seeking behaviour and responsiveness to available support systems. Despite these important findings, the study did not explicitly examine disclosure as an interpersonal communication strategy nor test the moderating role of demographic variables statistically. In addition, the study was limited to medical students, whose experiences may differ from those of the broader university population.

Collectively, existing empirical evidence suggests that individual characteristics influence how students engage in disclosure and utilize mental health support. However, previous studies have largely examined these variables as independent predictors of help-seeking or depression rather than as moderators of the relationship between disclosure and depression management. Furthermore, most empirical evidence originates from Western contexts, with relatively few studies examining these interactions within Kenyan universities. Consequently, there remains limited empirical evidence on whether characteristics such as age, religion, year of study, and personality strengthen or weaken the relationship between disclosure and depression management among university students in Kenya. Addressing this gap forms an important contribution of the present study.

2.6 Critique of Existing Literature

The reviewed literature demonstrates that disclosure is increasingly recognized as an important interpersonal communication process in the management of depression. Nevertheless, several conceptual, methodological, and contextual limitations emerge across the existing body of knowledge. Although scholars generally acknowledge the value of disclosure in promoting emotional support, strengthening therapeutic relationships, and facilitating access to mental health services, the literature remains fragmented, with most studies examining individual forms of disclosure in isolation rather than as complementary communication processes.

With respect to self-disclosure, existing studies consistently report positive psychological outcomes, including reduced depressive symptoms, improved emotional regulation, and stronger social support networks. However, much of this evidence is derived from Western populations where openness about personal experiences is generally encouraged. Consequently, the literature tends to assume that self-disclosure is universally beneficial, paying limited attention to the cultural and social contexts within which disclosure occurs. In societies where mental illness is highly stigmatized and emotional restraint is socially valued, disclosure may expose individuals to discrimination, social exclusion, or negative labelling. Furthermore, many studies emphasize the outcomes of self-disclosure without sufficiently examining the interpersonal conditions—such as trust, perceived safety, reciprocity, and relationship quality—that determine whether disclosure ultimately contributes to effective depression management.

Similarly, studies examining disclosure by significant others have largely focused on its contribution to early identification of mental health problems, referral, and access to treatment. While this literature demonstrates that family members, peers, lecturers, and other trusted individuals often play an important role in connecting students to mental health services, relatively little attention has been given to the communication dynamics surrounding third-party disclosure. Existing studies seldom examine how individuals perceive having their mental health condition disclosed by others, particularly where disclosure occurs without prior consultation or consent. Consequently, important issues relating to autonomy, privacy, confidentiality, and interpersonal trust remain insufficiently explored. Moreover, most empirical evidence originates from healthcare or community settings outside Africa, limiting understanding of how disclosure by significant others operates within Kenyan universities where communal relationships, family obligations, and mental health stigma may shape disclosure decisions differently.

The literature on Therapist's self-disclosure similarly presents mixed findings. Although appropriate Therapist's self-disclosure has been associated with stronger therapeutic alliances, increased client trust, and improved engagement during counselling, existing studies largely evaluate Therapist's self-disclosure within

formal psychotherapy settings. Comparatively little attention has been paid to the conditions under which Therapist's self-disclosure becomes beneficial or counterproductive, particularly within culturally diverse environments. The literature also pays limited attention to how students interpret Therapist's self-disclosure within university counselling settings, where expectations regarding professional boundaries, authority, and confidentiality may differ considerably from those observed in Western clinical practice. Consequently, evidence remains insufficient regarding the contribution of Therapist's self-disclosure to depression management among university students in non-Western contexts.

The review further indicates that individual characteristics have frequently been treated as background variables rather than as factors that may fundamentally shape disclosure processes. Although studies acknowledge that characteristics such as age, year of study, religion, and personality influence emotional expression and help-seeking behaviour, these variables are rarely examined as moderators of the relationship between disclosure and depression management. Existing research therefore provides limited understanding of how disclosure may produce different outcomes across diverse student populations. In particular, relatively little evidence exists on how these individual characteristics interact with cultural expectations, stigma, and interpersonal relationships to influence disclosure behaviours within African university settings.

Methodologically, the reviewed studies are dominated by cross-sectional survey designs conducted in Europe and North America, limiting both causal inference and contextual transferability. Many studies also examine disclosure within clinical populations or community mental health settings rather than among university students, whose experiences are shaped by unique academic, developmental, and social pressures. Furthermore, relatively few studies integrate multiple forms of disclosure within a single analytical framework, resulting in a fragmented understanding of how self-disclosure, disclosure by significant others, and Therapist's self-disclosure collectively contribute to depression management.

The reviewed literature provides substantial evidence that disclosure is an important component of depression management. However, it also reveals important conceptual, contextual, and methodological gaps that warrant further investigation. In particular, limited attention has been given to examining disclosure as a multidimensional interpersonal communication process within Kenyan universities, where cultural norms, stigma, and individual characteristics may significantly shape disclosure behaviours and their influence on depression management. The present study addresses these limitations by examining the effects of self-disclosure, disclosure by significant others, and Therapist's self-disclosure on depression management while accounting for the moderating influence of selected individual characteristics among university students in Kenya.

2.7 Research Gap

Although existing literature has established that disclosure can play an important role in supporting individuals experiencing depression, empirical evidence remains fragmented in several respects. Most studies have examined self-disclosure, disclosure by significant others, and Therapist's self-disclosure independently, with limited attention to how these communication processes collectively influence depression management. Furthermore, the available evidence is largely derived from Western clinical and educational settings, making its applicability to Kenyan universities, where cultural norms, stigma, interpersonal relationships, and institutional realities shape disclosure practices differently, uncertain. Existing studies have also given limited attention to the moderating influence of individual characteristics such as age, religion, personality, and year of study on the relationship between disclosure and depression management. Consequently, there is insufficient empirical evidence on how disclosure, viewed as a multidimensional interpersonal communication strategy, contributes to depression management among university students in Kenya. This study addresses this gap by examining the effects of self-disclosure, disclosure by significant others, and Therapist's self-disclosure on depression management while assessing the moderating influence of selected individual characteristics within the Kenyan university context.

2.8 Summary

This chapter reviewed the theoretical, conceptual, and empirical literature underpinning the study. It examined four theoretical frameworks—Social Penetration Theory, the Disclosure Decision-Making Model, Communication Privacy Management Theory, and the Interpersonal Theory of Depression—which collectively explain how disclosure influences interpersonal relationships, therapeutic interactions, and depression management. The chapter further reviewed literature on the study variables, namely self-disclosure, disclosure by significant others, Therapist's self-disclosure, depression management among university students, and the moderating role of selected individual characteristics. Empirical evidence from global, regional, and local studies was synthesized to establish the current state of knowledge, identify areas of convergence and divergence, and highlight existing conceptual, contextual, and methodological gaps. The chapter concludes that, despite growing recognition of disclosure as an important communication process in mental health management, limited empirical evidence exists on how different forms of disclosure collectively influence depression management among university students within the Kenyan context, particularly when individual characteristics are considered. These identified gaps provide the justification for the present study. The next chapter presents the research methodology adopted to address the study objectives and answer the research questions.

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.

3.2 Research Philosophy

This study was guided by the pragmatist research philosophy, which advocates the use of research methods that are most appropriate for addressing the research problem rather than adhering exclusively to a single philosophical tradition. Pragmatism recognizes that complex social phenomena often require multiple forms of inquiry and therefore supports the integration of quantitative and qualitative approaches to generate a more comprehensive understanding of the phenomenon under investigation (Saunders, Lewis, & Thornhill, 2019).

The choice of pragmatism was informed by the nature of this study, which sought both to examine the statistical relationships between disclosure practices and depression management among university students and to explore the experiences and professional perspectives of university counsellors regarding disclosure within therapeutic settings. While the quantitative component measured the effects of self-disclosure, disclosure by significant others, therapist self-disclosure, and individual characteristics on depression management, the qualitative component provided contextual explanations that enriched the interpretation of the quantitative findings. Pragmatism therefore provided an appropriate philosophical foundation for integrating these complementary forms of evidence.

Ontologically, the study adopted the pragmatist assumption that reality is both objective and socially constructed. The study acknowledged that depression management and disclosure practices exist as observable phenomena that can be measured empirically, while recognizing that students and counsellors may interpret and experience these phenomena differently depending on their individual circumstances and social contexts (Morgan, 2014). Consequently, the study accepted the existence of multiple realities while also recognizing the value of objective measurement.

Epistemologically, the study assumed that knowledge is generated through both empirical observation and participants' lived experiences. Quantitative data obtained through structured questionnaires provided objective evidence of the relationships among the study variables, whereas qualitative interviews with university counsellors generated contextual knowledge regarding disclosure practices and therapeutic processes. The integration of these two forms of evidence enabled a more comprehensive understanding of the role of disclosure in managing depression among university students than would have been achieved through a single methodological approach.

Accordingly, the pragmatist philosophy provided the methodological flexibility necessary to employ a mixed-methods approach, allowing the researcher to combine statistical analysis with qualitative inquiry to address the study objectives comprehensively.

3.3 Research Design

This study adopted a mixed-methods research design. According to Kumar (2019), mixed-methods research combines quantitative and qualitative approaches within a single study to capitalize on the strengths of both methods and provide a more comprehensive understanding of the research problem. The design was considered appropriate because the study sought not only to examine the statistical relationships between disclosure practices and depression management among university students but also to explore counsellors' experiences and perspectives regarding disclosure during the therapeutic process.

The study specifically employed a concurrent triangulation design, in which quantitative and qualitative data were collected during the same phase of the research process, analyzed independently, and integrated during interpretation (Creswell & Creswell, 2018). Equal priority was accorded to both strands of data, with the quantitative component providing measurable evidence of the relationships among the study variables and the qualitative component offering contextual explanations that enriched the interpretation of the quantitative findings.

Triangulation occurred in three ways. First, method triangulation was achieved through the use of structured questionnaires administered to undergraduate students alongside semi-structured interviews conducted with university counsellors. Second, data source triangulation was achieved by collecting information from two different participant groups: students who had experienced counselling services and professional counsellors who routinely provided mental health support to students. Third, findings triangulation was undertaken during data interpretation by comparing, corroborating, and integrating the quantitative results with the qualitative themes. For example, quantitative findings demonstrating the positive relationship between self-disclosure and depression management were compared with counsellors' accounts describing how students who openly disclosed their experiences developed stronger therapeutic relationships and demonstrated better engagement in counselling. Similarly, quantitative findings on the limited effectiveness of disclosure by significant others were interpreted alongside counsellors' observations that third-party disclosure could facilitate early intervention but occasionally generated resistance among students who felt their privacy had been compromised. The convergence of evidence from both data strands enhanced the credibility, validity, and completeness of the study findings by providing complementary perspectives on the role of disclosure in managing depression among university students.

3.3 Target 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. This population was considered appropriate because university students constitute one of the groups most vulnerable to depression due to academic demands, financial challenges, interpersonal relationships, and the transition to independent living. The study therefore focused on undergraduate students as they represented the broader population to which the findings were intended to generalize.

3.3.1 Accessible Population

Although the target population consisted of all undergraduate students, the accessible population was limited to undergraduate students who had attended counselling services at the JKUAT University Counselling Centre within the twelve months preceding data collection period which was done during the 2022/2023 academic year. Based on records obtained from the University Counselling Centre, it was estimated that approximately 1,634 students had accessed counselling services during this period. The restricting of the accessible population to students who had utilized counselling services ensured that participants had firsthand experience with counselling and disclosure processes relevant to the objectives of the study. The limiting participation to students who had attended counselling within the previous twelve months helped minimize recall bias by improving the accuracy of participants' recollection of their disclosure experiences and the perceived influence of those experiences on depression management.

3.3.2 Inclusion Criteria

Participants were considered eligible for inclusion in the study if they were registered undergraduate students at Jomo Kenyatta University of Agriculture and Technology during the study period and had attended at least one counselling session at the University Counselling Centre within the twelve months preceding data collection. The study included only students aged eighteen years and above who voluntarily agreed to participate after providing informed consent. These criteria ensured that respondents possessed recent and relevant counselling experiences, enabling them to

provide reliable information regarding self-disclosure, disclosure by significant others, therapist self-disclosure, therapist self-disclosure and depression management.

3.3.3 Exclusion Criteria

The study excluded postgraduate students because the research specifically targeted undergraduate students whose academic and psychosocial experiences differ from those of postgraduate learners. Undergraduate students who had never attended counselling services at the University Counselling Centre were also excluded because they lacked the experiences necessary to evaluate disclosure practices within a counselling context. Similarly, students attending their first counselling session at the time of recruitment were excluded, as they had not yet developed sufficient counselling experiences to meaningfully assess the role of disclosure in managing depression. University staff, external counselling clients, and individuals who declined to provide informed consent were also excluded from participation.

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

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

Substitution:

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

$$n = \frac{3.8416 \times 0.25}{0.0025}$$

$$n = \frac{0.9604}{0.0025}$$

n =384.16

n is therefore equal to 384.

The quantitative sample size of 384 respondents was determined using Cochran's (1977) formula for estimating sample sizes for large populations. Cochran's formula was adopted because it provides an adequate sample size for quantitative studies where the population is large and the population proportion is unknown. The calculated sample size was considered sufficient to provide adequate statistical precision and statistical power for descriptive, correlational, regression, and moderation analyses.

Following the determination of the sample size, participant recruitment employed consecutive purposive sampling. While Cochran's formula established the number of respondents required for the quantitative component of the study, consecutive purposive sampling was used to identify participants who possessed the specific characteristics necessary to address the research objectives. As observed by Saunders, Lewis, and Thornhill (2019), determining an appropriate sample size and selecting a sampling technique are distinct methodological decisions that serve different purposes within the research process. Similarly, Etikan, Musa, and Alkassim (2016) argue that purposive sampling is appropriate where participants possess specific knowledge or experiences relevant to the phenomenon under investigation. Consequently, Cochran's formula informed the required sample size, while consecutive purposive sampling determined participant eligibility.

Recruitment was conducted at the Jomo Kenyatta University of Agriculture and Technology (JKUAT) University Counselling Centre during the data collection period. To safeguard participants' privacy and maintain confidentiality, the researcher did not have direct access to counselling records or client identities. Instead, the university student counsellors acted as gatekeepers, identifying students who met the predetermined inclusion and exclusion criteria and inviting them to participate in the study. Every eligible undergraduate student who presented for a scheduled counselling appointment during the data collection period was informed about the study and invited to participate voluntarily until the desired sample size was attained. Students attending their first counselling session were not approached because they had not yet acquired sufficient counselling experience to meaningfully evaluate disclosure practices and their influence on depression management.

The use of consecutive purposive sampling ensured that every accessible participant who satisfied the eligibility criteria and presented during the study period had an opportunity to participate in the study. Unlike convenience sampling, which relies solely on participant availability, consecutive sampling systematically recruits all eligible participants encountered over a specified period, thereby minimizing arbitrary participant selection and enhancing the representativeness of the accessible population (Polit & Beck, 2021). This approach was particularly appropriate because

only students with prior counselling experience could provide meaningful information regarding disclosure practices and depression management.

For the qualitative component, the four student counsellors attached to the JKUAT University Counselling Centre were recruited using purposive sampling. Their selection was based on their direct professional involvement in providing counselling services to students experiencing depression and their extensive knowledge of disclosure practices within the university counselling setting. Their professional experience enabled them to provide rich, context-specific insights that complemented and triangulated the quantitative findings.

3.5 Data Collection Instruments

Structured questionnaires were used to collect quantitative data from all the students who were purposively 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 significant others, effects of Therapist's self-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 counsellors 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 counsellors were engaged to assist with the data collection process. The counsellors, 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 counsellors, who then handed them over to the researcher for analysis.

In-depth Interviews were scheduled with the relevant student counsellors 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 counselling from the university counsellors. 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 counsellors 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 significant others	30	.773
Therapist's self-disclosure	30	.742
Individual characteristics	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 counsellors 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 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. Chi-Square	**df**	**Sig.**
Self-Disclosure	.756	28.536	12	.067
Disclosure by significant others	.603	34.126	21	.035
Therapist's self-disclosure	.744	20.286	15	.161
Individual characteristics	.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 descriptive and inferential statistical analyses**,** in line with Kumar's (2019) 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 significant others, and Therapist's self-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 individual characteristics such as age, 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:

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

Key:

- Y = Level of Depression Management

- X_1 = Self-Disclosure
- X_2 = Disclosure by significant others
- X_3 = Therapist's self-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 individual characteristics, the model was extended to incorporate interaction terms as follows:

$$Y=3.110+0.420_{X1}+0.100_{X2}+0.085_{X3}+0.140_{M}+\varepsilon$$

Key:

Y = Level of Depression Management

X_1 = Self-Disclosure

X_2 = Disclosure by significant others

X_3 = Therapist's self-disclosure

M = Individual characteristics (e.g., age, 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 personality.

Qualitative data collected in this study were analysed using thematic analysis with the aid of NVivo software. Thematic analysis was considered appropriate because it provides a systematic and flexible approach for identifying, organizing, and interpreting patterns within qualitative data (Braun & Clarke, 2006). The approach enabled the study to explore counsellors' perspectives on the role of disclosure as an interpersonal communication strategy in depression management among university students.

The analysis commenced with data familiarization, whereby all interview recordings were transcribed verbatim and read repeatedly to gain a comprehensive understanding of the data. During this stage, preliminary ideas, recurring issues, and notable patterns relating to self-disclosure, disclosure by significant others, therapist self-disclosure, depression management, and the influence of individual characteristics were identified and documented.

The second stage involved coding the data. A hybrid coding approach, incorporating both deductive and inductive coding, was employed. Deductive codes were developed from the study objectives, research questions, and conceptual framework, focusing on key concepts such as self-disclosure, disclosure by significant others, therapist self-disclosure, depression management, and individual characteristics. Inductive coding complemented this process by allowing new themes and insights to emerge directly from the counsellors' narratives, ensuring that issues not anticipated during the design of the study were captured.

To ensure consistency and maintain participant confidentiality, each counselor was assigned a unique identification code prior to analysis. The four counsellors were coded as CNS-A, CNS-B, CNS-C, and CNS-D**.** These identifiers were used throughout the coding, analysis, and presentation of the findings in place of participants' names, thereby preserving anonymity while maintaining data traceability.

Following the coding process, related codes were grouped into broader categories within NVivo, facilitating the development of themes and sub-themes aligned with the study objectives. NVivo enhanced the organization, retrieval, comparison, and

management of coded data, enabling systematic examination of similarities and differences across participants' perspectives.

The identified themes were subsequently reviewed, refined, and clearly defined to ensure coherence, internal consistency, and alignment with the research objectives. The final themes formed the basis for the presentation and interpretation of qualitative findings in Chapter Four and were supported by verbatim quotations from the counsellors to enhance the credibility and authenticity of the findings.

Finally, the qualitative findings were integrated with the quantitative results during interpretation to provide a comprehensive understanding of the role of disclosure as an interpersonal communication strategy in depression management among university students. This integration facilitated triangulation of evidence, strengthened the credibility of the findings, and enabled a richer interpretation of the study results.

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 counsellors. 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 counselling.

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 counsellors, who were well-trained to handle any emotional discomfort that might arise during the process. Furthermore, the involvement of counsellors 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 counsellors 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. 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.

Given that the study was conducted with the assistance of university counsellors to preserve confidentiality, participants may have perceived an implicit obligation to participate or to provide responses that they believed were expected by the counsellors. This introduces the possibility of social desirability bias, whereby respondents provide socially acceptable rather than entirely truthful responses. To mitigate this potential bias, the counsellors' role was strictly limited to identifying eligible participants and distributing the questionnaires. They neither witnessed the completion of the questionnaires nor had access to the participants' responses. Prior to participation, respondents were informed that their involvement was entirely voluntary, that declining to participate would not affect their relationship with the counsellors or access to counselling services, and that they were free to withdraw from the study at any stage without any consequences. In addition, the questionnaires were completed anonymously and contained no personal identifiers, ensuring that neither the researcher nor the counsellors could link responses to individual participants. These measures were intended to minimize perceived coercion, reduce social desirability bias, and encourage honest and independent responses.

4.3 Individual Characteristics

Individual 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, individual characteristics factors were considered moderating variables in the relationship between disclosure as an interpersonal communication strategy and depression management among university students in Kenya. Key individual characteristics examined in this study included age, year of study, personality type, religion, and relationship status. The findings on these individual characteristics are presented in Table 4.2 below

Table 4.2: Individual Characteristics

		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 Status	Not in a relationship	233	72.7
	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 demographic characteristics of the respondents were examined to determine whether the study sample adequately reflected the target population and to provide a basis for assessing the representativeness and generalizability of the study findings. The findings indicate that the majority of respondents were aged between 18 and 21 years (71.3%), were first-year students (41.9%), identified as introverts (78.6%), were Christians (82.7%), and were not in a romantic relationship (72.7%). These characteristics suggest that the study largely captured the profile of a typical undergraduate student population in a Kenyan public university.

The age distribution closely reflects the general age profile of undergraduate students in Kenya, where the majority of learners enrol in university immediately after completing secondary education. Similarly, the predominance of Christian respondents is consistent with Kenya's national religious composition, in which Christianity constitutes the largest religious affiliation according to the 2019 Kenya Population and Housing Census. These similarities suggest that, with respect to age and religion, the study sample is reasonably representative of the broader undergraduate student population. In addition, respondents were drawn from all years of study, thereby ensuring that perspectives were obtained from students at different stages of their academic programmes, although students in the lower years of study were more highly represented. This pattern is not uncommon in public universities where lower academic levels typically have larger student enrolments than senior classes.

Unlike age and religion, however, there are no established national statistics describing the personality profiles or relationship status of university students in

Kenya. Consequently, it is not possible to determine whether the predominance of respondents identifying as introverts or those who were not in romantic relationships accurately reflects the wider university population. Nevertheless, the inclusion of respondents with different personality orientations and relationship statuses provided sufficient variation for examining these variables within the study, particularly because personality was investigated as a moderating variable in the relationship between disclosure and depression management

the demographic profile demonstrates that the study successfully captured the characteristics of the target population, providing an appropriate basis for examining the relationship between disclosure practices and depression management among undergraduate students. The close alignment of key characteristics, particularly age and religious affiliation, with those reported for the broader Kenyan university population supports the representativeness of the sample. While the study was undertaken within a single public university using purposive sampling, the diversity of respondents across age groups, years of study, personality orientations, religious affiliations, and relationship statuses strengthens the credibility of the findings within the study context. Accordingly, the findings provide meaningful insights into disclosure and depression management among undergraduate students in comparable university settings, while recognizing that broader national generalizations should be made within the methodological scope of the study.

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 emphasizes 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, counselling 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 thinking clearly	10	3.1
	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. Although exam irregularity is not a symptom or trigger to mental health, the university policy requires that students caught with examination irregularities to see the students' counsellors before being readmitted back to the uni8versity. This could possibly explain these high numbers 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 worsen 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 persistent sadness (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 Targets	Close friends	51	15.9
	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 indicate that university students differed considerably in the individuals to whom they disclosed their emotional struggles, suggesting that disclosure decisions were largely influenced by the level of trust and emotional closeness within interpersonal relationships. Close friends emerged as the most preferred confidants, with 51 respondents (15.9%) indicating that they primarily disclosed their feelings to them. University counsellors were the second most preferred source of support, cited by 35 respondents (10.9%), followed by roommates (23 respondents, 7.2%) and classmates (19 respondents, 5.9%). In contrast, relatively few students disclosed their feelings to family members (14 respondents, 4.4%), academic advisors (13 respondents, 4.1%), chaplaincy services (13 respondents, 4.1%), or lecturers (10 respondents, 3.1%). Most notably, 143 respondents (44.5%) indicated that they did not disclose their emotional struggles to anyone.

The predominance of close friends as the preferred recipients of emotional disclosure suggests that students are more likely to confide in individuals with whom they share strong interpersonal relationships than in formal institutional support systems. Although university counselling services were the second most preferred source of support, the considerably lower proportion of students who disclosed to counsellors compared with close friends indicates that professional services may not represent

the first point of contact for many students experiencing emotional distress. This pattern supports Rickwood et al. (2005), who observed that young people typically adopt a staged help-seeking process in which informal sources of support are consulted before professional services. However, the findings also suggest that within the Kenyan university context, peer relationships remain substantially more influential than institutional support structures in facilitating emotional disclosure.

The relatively low proportions of students who disclosed to family members (4.4%), lecturers (3.1%), academic advisors (4.1%), and chaplaincy services (4.1%) are equally noteworthy. These findings imply that while these individuals occupy positions that could potentially provide emotional or professional support, they are not widely perceived as appropriate recipients of sensitive personal information. This may reflect concerns regarding confidentiality, fear of judgment, or uncertainty about the type of support likely to be received. Similar observations have been reported by Ibrahim et al. (2013), who found that university students frequently prefer informal support networks over institutional actors when experiencing psychological distress. Unlike many Western universities, where faculty members increasingly serve as mental health gatekeepers, the present findings suggest that their role in facilitating emotional disclosure remains limited within the study context.

A particularly important finding is that 143 respondents (44.5%) reported that they had not disclosed their feelings to anyone. This proportion represents nearly half of the study population and suggests that a substantial number of students may be attempting to manage emotional distress in isolation. Rather than simply indicating unwillingness to seek help, this finding raises concerns regarding the existence of barriers that discourage disclosure. Vogel et al. (2007) attribute such reluctance primarily to anticipated stigma associated with mental health problems. However, the present findings suggest that stigma alone may not fully explain students' behaviour. The coexistence of a strong preference for close friends alongside a high proportion of non-disclosure indicates that students appear to make careful decisions regarding when, how, and to whom they disclose personal information. This observation aligns with Communication Privacy Management Theory (Petronio, 2002), which proposes

that individuals disclose private information only after weighing the potential benefits against the perceived risks of disclosure.

These findings demonstrate that emotional disclosure among university students is fundamentally relationship-centred. Students appear to prioritise trust, familiarity, and perceived psychological safety over formal authority when deciding whether to disclose emotional difficulties. The findings therefore suggest that strengthening depression management within universities requires interventions that extend beyond expanding counselling services to include strengthening peer support networks, improving students' confidence in institutional support systems, and creating environments in which emotional disclosure is perceived as both safe and beneficial.

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 presented in Figure 4.1 indicate that students predominantly disclosed concerns relating to immediate academic and psychosocial challenges rather than broader life issues. Academic stress emerged as the most frequently discussed concern, reported by 198 respondents (61.7%), followed by relationship-related challenges involving family, friends, and romantic relationships (173 respondents, 53.9%). Financial difficulties were also commonly disclosed, with 145 respondents (45.2%) identifying economic pressures as a source of emotional distress. Other frequently discussed concerns included personal insecurities and self-doubt (132 respondents, 41.1%), physical and mental health challenges (114 respondents, 35.5%), and career-related anxieties (91 respondents, 28.3%). Comparatively fewer respondents disclosed general emotions without identifying a specific cause (84 respondents, 26.2%), while only 19 respondents (5.9%) discussed other concerns such as spirituality, societal issues, or creative aspirations.

The predominance of academic stress suggests that students' emotional well-being is closely intertwined with their academic experiences. Rather than existing as an isolated educational challenge, academic demands appear to constitute a central source of psychological distress that prompts students to seek emotional support. This finding is consistent with Misra and McKean (2000), who identified academic workload and examination pressures as primary stressors among university students. Similarly, Andrews and Wilding (2004) demonstrated that academic pressures are significant predictors of psychological distress. However, the present findings extend this understanding by showing that academic challenges are not merely experienced individually but also represent the issues students are most willing to communicate when they choose to disclose emotional difficulties.

The prominence of relationship-related concerns and financial difficulties further illustrates that students' disclosures extend beyond academic life to encompass broader social and economic realities. The high proportion of respondents discussing relationship challenges (53.9%) suggests that interpersonal relationships remain an important context within which emotional well-being is negotiated during university

life. Likewise, the substantial proportion reporting financial concerns (45.2%) reflects the growing influence of economic pressures on students' psychological well-being. These findings are consistent with studies by Robotham (2008) and Lohfink and Paulsen (2005), which demonstrate that financial strain contributes significantly to stress among university students. Nevertheless, the present study indicates that students do not experience these stressors in isolation; rather, academic, relational, and financial pressures appear to coexist, creating multiple and interconnected sources of emotional distress that shape disclosure behaviour.

The findings also reveal that a considerable proportion of students disclosed personal insecurities, self-doubt, and mental health concerns. Although fewer respondents explicitly discussed anxiety or depression (35.5%) than academic or relationship problems, this does not necessarily imply that mental health challenges are less prevalent. Instead, it may suggest that students are more comfortable discussing the circumstances contributing to emotional distress than explicitly identifying or labeling their psychological condition. This interpretation resonates with previous research by Eisenberg et al. (2009), which found that concerns about stigma frequently discourage students from openly discussing mental health problems even when they readily discuss the underlying stressors.

An equally important observation is that only 26.2% of respondents disclosed general emotions without linking them to a specific issue, while very few (5.9%) discussed broader concerns such as spirituality or creative aspirations. This pattern suggests that students tend to frame emotional disclosure around concrete, identifiable experiences rather than abstract emotional states. In other words, disclosure appears to be problem-oriented rather than emotion-oriented, with students communicating the situations that generate distress rather than the emotions themselves. This finding provides further insight into how university students conceptualize and communicate emotional difficulties, reinforcing the view that disclosure functions as a means of seeking understanding and support for specific life challenges rather than simply expressing feelings.

According to these findings, students' disclosure practices are shaped by the issues that most directly affect their daily lives. Academic demands, interpersonal relationships, and financial pressures dominated students' disclosures, highlighting the interconnected nature of these challenges in influencing emotional well-being. The findings further suggest that students are more inclined to communicate the sources of their distress than to explicitly discuss depression itself, underscoring the importance of understanding disclosure as a contextual communication process through which underlying emotional difficulties are expressed.

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.

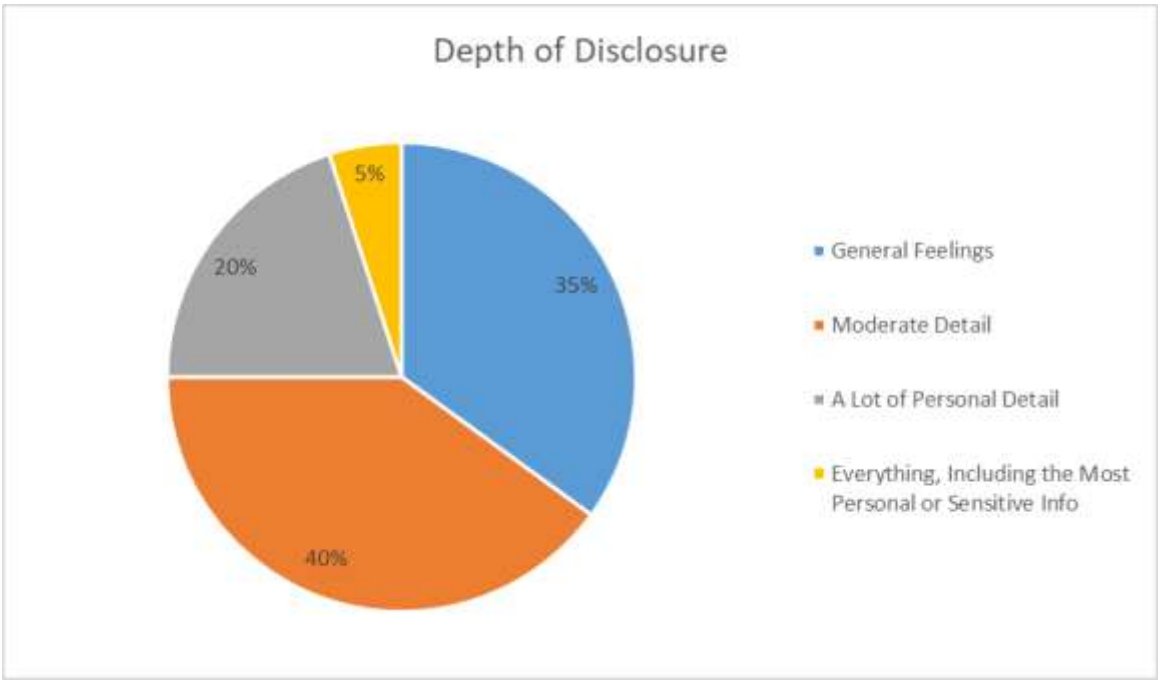

Figure 4.2: Depth of Disclosure

Figure 4.2 illustrates that students differed considerably in the depth of information they were willing to disclose. The largest proportion of respondents (40%) reported disclosing their emotions with moderate detail by describing situations that influenced their feelings without revealing highly personal information. A further 35% limited their disclosure to general expressions of emotion, such as indicating that they were "feeling down," while 20% shared extensive personal information, including the circumstances surrounding their emotional experiences and the coping strategies they employed. Only 5% indicated that they disclosed their deepest or most sensitive thoughts and experiences.

The predominance of moderate disclosure suggests that students are generally willing to communicate emotional distress but remain selective about the extent of information they reveal. Rather than withholding information completely, many appear to negotiate a balance between seeking support and protecting their privacy. This finding supports the proposition of Communication Privacy Management Theory (Petronio, 2002), which argues that individuals manage private information by carefully regulating what they reveal and what they choose to conceal. The findings therefore suggest that disclosure among university students is not an all-or-nothing process but one that involves continuous negotiation of personal boundaries.

The relatively high proportion of respondents who disclosed only general feelings **(35%)** further indicates that emotional expression does not necessarily translate into full disclosure of personal experiences. Students may acknowledge emotional distress while deliberately withholding details they perceive as highly personal or potentially stigmatizing. This pattern is broadly consistent with Eisenberg et al. (2009), who found that concerns about stigma and negative evaluation often discourage university students from fully disclosing mental health challenges. However, the present findings also suggest that students are not simply avoiding disclosure; instead, they appear to adopt varying levels of openness depending on what they consider safe to communicate. This extends previous findings by

demonstrating that disclosure exists along a continuum rather than as a binary decision to disclose or remain silent.

The finding that only 5% of respondents disclosed their most personal experiences is particularly noteworthy. While previous studies, such as Parker et al. (2001), attribute limited disclosure to fear of judgment and perceived vulnerability, the present study indicates that complete openness is uncommon even among students who choose to disclose. This suggests that trust alone may not fully explain disclosure depth. Instead, students appear to retain control over highly sensitive information even within supportive relationships, reinforcing the view that disclosure involves ongoing evaluation of potential benefits and risks. Within the Kenyan university context, where concerns about confidentiality and mental health stigma remain prevalent, such cautious disclosure may represent a protective communication strategy rather than simply reluctance to seek support.

Overall, the findings demonstrate that university students are more inclined to engage in selective disclosure than complete openness. The tendency to disclose emotions while limiting the depth of personal information suggests that effective depression management depends not only on whether students disclose but also on the extent to which they feel psychologically safe to communicate sensitive experiences. Consequently, understanding the depth of disclosure provides important insight into how students negotiate vulnerability while seeking support for depression.

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 respondents' level of comfort in disclosing their feelings to others on a five-point Likert scale, where 1 represented "Very Uncomfortable" and 5 represented "Very Comfortable." The findings yielded a mean score of 2.43, indicating that, on average, respondents were generally uncomfortable with disclosing their emotions to others. This suggests that emotional disclosure is not a behaviour that students engage in easily, despite the potential role of disclosure in facilitating depression management.

The standard deviation of 1.008 indicates moderate variability in respondents' comfort levels, suggesting that while discomfort with disclosure was common, students differed in the extent to which they felt comfortable sharing their emotions. This variation implies that emotional disclosure is not experienced uniformly across the student population but is likely influenced by individual and contextual factors.

The positive skewness value of 1.198 indicates that the distribution was skewed toward the lower end of the scale, confirming that a larger proportion of respondents reported lower levels of comfort with emotional disclosure than higher levels. This finding suggests that reluctance to disclose emotional difficulties is more

characteristic of the study population than openness. The kurtosis value of 0.941 further indicates that responses were moderately concentrated around the centre of the distribution, with relatively few respondents reporting either extreme discomfort or extreme comfort.

The overall pattern observed in these findings is consistent with previous empirical studies showing that university students often experience difficulties discussing emotional problems despite recognising the importance of seeking support. For example, Vogel et al. (2007) found that concerns about stigma and negative evaluation frequently discourage students from openly discussing psychological distress. Similarly, Eisenberg et al. (2009) reported that although many students experience mental health challenges, relatively few feel sufficiently comfortable to disclose these concerns or seek professional support. The present findings therefore reinforce existing evidence that emotional discomfort remains an important barrier to disclosure among university students. At the same time, the variation in comfort levels observed in this study suggests that disclosure should not be viewed as a uniform behaviour but rather as a process influenced by individual experiences and perceptions of psychological safety, consistent with the propositions of Social Penetration Theory (Altman & Taylor, 1973).

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.

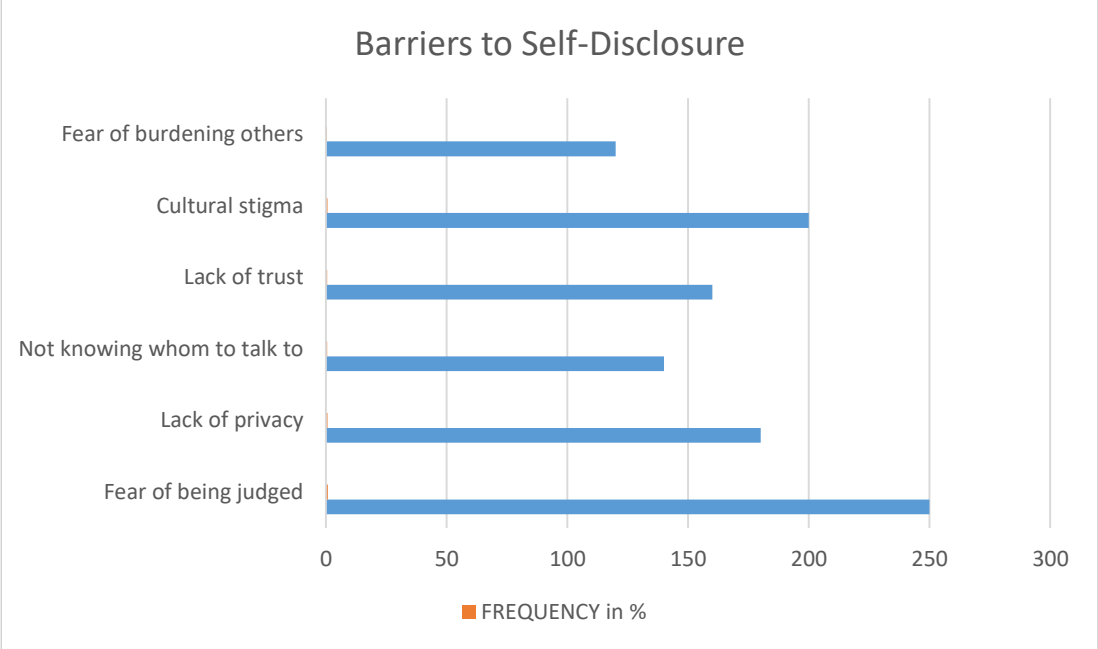

Figure 4.3: Barriers of Disclosure

The findings presented in Figure 4.3 indicate that fear of being judged or misunderstood was the most frequently reported barrier to self-disclosure, cited by 215 respondents (67.0%). This finding suggests that students perceive emotional disclosure as carrying considerable social risk, making them reluctant to communicate their emotional struggles even when support may be available. The qualitative findings reinforce this interpretation. One counsellor observed:

"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 therapy. This causes them to mask and drop off and that makes therapy very ineffective. It takes time to build trust." (CNS1, JKUAT, 15 March 2022).

The counsellor's experience demonstrates that fear of judgement extends beyond anticipated stigma to influence actual help-seeking behaviour, including reluctance to begin counselling and discontinuation of therapy. The convergence of the quantitative and qualitative findings suggests that stigma remains a significant

impediment to effective depression management. These findings are consistent with Vogel et al. (2007), who identified fear of negative evaluation as one of the strongest barriers to self-disclosure and professional help-seeking among university students.

A further 178 respondents (55.5%) identified lack of privacy or a safe space as a major obstacle to disclosure. This finding indicates that students' willingness to disclose depends not only on their personal readiness but also on their confidence that sensitive information will remain confidential. The interviews with counsellors provide additional insight into this concern. As one counsellor explained:

"Sometimes the biggest challenge is identifying whether it's depression or just sadness. Students don't always know how to describe what they feel. Another challenge is trust issues; they don't trust you enough to disclose stuff and that affects therapy." (CNS2, JKUAT, 15 March 2022).

This finding suggests that concerns about confidentiality and trust may undermine the therapeutic relationship before meaningful disclosure can occur. Barry et al. (2013) similarly observed that young people are less likely to disclose psychological distress when they are uncertain about the privacy of the counselling environment or fear that personal information may not remain confidential.

The findings further show that 162 respondents (50.5%) reported not knowing whom to talk to when experiencing emotional distress. While this may appear to reflect limited awareness of available support services, the qualitative findings indicate that the challenge extends beyond simple knowledge deficits. Counsellor D noted:

"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." (CNS4, JKUAT, 20 March 2022).

These observations suggest that uncertainty about where to seek help is closely linked to limited recognition of emotional distress and reluctance to engage with counselling services. This finding extends the work of Rickwood et al. (2005), who associated delayed help-seeking with uncertainty about available support, by demonstrating that students may also struggle to recognise when professional intervention is needed.

Similarly, 149 respondents (46.4%) identified lack of trust in others as a barrier to disclosure, while 140 respondents (43.6%) cited cultural or societal stigma. Rather than representing independent barriers, the qualitative evidence suggests that these challenges are closely interconnected. Counsellor C explained:

"One of the main challenges 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." (CNS3, JKUAT, 15 March 2022).

This finding indicates that students' reluctance to disclose is influenced not only by interpersonal trust but also by broader perceptions of counselling and mental health. Students who enter counselling with negative expectations may be less willing to establish the trust necessary for meaningful disclosure. These findings are consistent with Mak and Chen (2006), who argue that societal attitudes and cultural norms surrounding mental illness shape individuals' willingness to disclose emotional difficulties.

Finally, 125 respondents (38.9%) reported that they avoided disclosure because they feared burdening others with their problems. Although this was the least frequently reported barrier, it highlights an important aspect of students' decision-making. Rather than viewing disclosure solely as a means of obtaining support, some students appeared equally concerned about the potential emotional consequences their disclosure might have on family members, friends, or peers. This finding suggests that disclosure is not only a personal decision but also a relational one, in which students weigh their own emotional needs against perceived responsibilities towards others.

The integration of the quantitative and qualitative findings demonstrates that barriers to self-disclosure are interconnected rather than isolated. Fear of judgement, concerns about confidentiality, uncertainty regarding mental health, distrust, and negative perceptions of counselling collectively influence students' willingness to communicate emotional distress. While the survey findings establish the prevalence of these barriers, the counsellors' experiences explain how they manifest in practice through delayed help-seeking, reluctance to engage in therapy, and premature withdrawal from counselling. Taken together, the findings illustrate that self-disclosure is shaped by both individual perceptions and the broader social environment, reinforcing the view that successful depression management depends not only on the availability of counselling services but also on students' confidence that disclosure will occur within relationships characterised by trust, confidentiality, and psychological safety.

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	321	4.45	0.794	0.678	.132	-0.512	.263

feelings with friends or family improves my mood.							
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 respondents' perceptions of the contribution of self-disclosure to depression management. Overall, the findings indicate that while students generally viewed self-disclosure as an effective strategy for managing depression, they expressed reservations about the extent to which they received meaningful support from their peers after disclosing.

The statement *"I feel supported by my peers when I share my feelings of depression"* recorded the lowest mean score (M = 2.32, SD = 1.139), indicating that many students did not perceive their peers as a reliable source of emotional support following disclosure. Although some respondents reported positive experiences, the relatively high standard deviation suggests considerable variation in students' experiences. This finding implies that disclosure alone does not necessarily guarantee supportive responses. Instead, the effectiveness of self-disclosure appears to depend on the quality of the interpersonal environment in which disclosure occurs. This finding is consistent with Eisenberg et al. (2007), who observed that university students frequently encounter stigma, misunderstanding, or inadequate responses from peers despite being willing to discuss mental health concerns.

The qualitative findings provide further insight into this pattern. One counsellor explained:

"Sometimes the biggest challenge is identifying whether it's depression or just sadness. Students don't always know how to describe what they feel. Another challenge is trust issues; they don't trust you enough to disclose stuff and that affects therapy." (CNS2, JKUAT, 15 March 2022).

Similarly, another counsellor observed:

"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 therapy. This causes them to mask and drop off and that makes therapy very ineffective. It takes time to build trust." (CNS1, JKUAT, 15 March 2022).

These accounts suggest that students' perceptions of limited peer support are closely linked to concerns about stigma, trust, and fear of negative judgement. Together, the quantitative and qualitative findings indicate that the benefits of self-disclosure may be constrained where supportive interpersonal relationships are lacking.

In contrast, respondents expressed strong agreement that talking about their feelings with friends or family improved their mood (M = 4.45, SD = 0.794). The high mean and relatively low variability demonstrate a strong consensus that discussing emotional experiences provides immediate emotional relief. This finding suggests that although students may question the support they receive from peers generally, they nevertheless perceive conversations within trusted relationships as emotionally beneficial. This distinction highlights the importance of relationship quality rather than disclosure itself. These findings support those of Vogel et al. (2007), who reported that supportive interpersonal relationships enhance emotional well-being by reducing feelings of isolation and psychological distress.

The qualitative findings reinforce this observation. As one counsellor explained:

"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 up, even just a little. That one moment of honesty can mark the beginning of real healing. Sometimes it's something they've never told anyone before, and just saying it out loud makes it feel more manageable." (CNS3, JKUAT, 15 March 2022).

The counsellor's experience suggests that the therapeutic value of disclosure extends beyond receiving advice or solutions. Rather, the act of verbalising emotional experiences may itself contribute to emotional relief and represent an important first step in the recovery process.

Respondents also expressed generally positive perceptions regarding the statement that self-disclosure helps manage depression symptoms (M = 3.50, SD = 1.017). Although the mean indicates overall agreement, it was notably lower than the rating for mood improvement, suggesting that students differentiate between immediate emotional relief and longer-term management of depression. While disclosure appears to alleviate emotional distress, students may not perceive it as sufficient, on its own, to address the broader psychological and behavioural dimensions of depression. This finding is comparable to that of Kahn and Garrison (2009), who argued that the effectiveness of emotional disclosure depends largely on the quality of interpersonal responses and the support available following disclosure.

The interviews with counsellors offer further explanation for this finding. According to one participant:

"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. Those who remain guarded take longer to trust, and we spend more time building that relationship before we can even touch the core issues." (CNS4, JKUAT, 20 March 2022).

This observation suggests that self-disclosure should be viewed as an enabling process rather than a treatment in itself. By fostering trust and therapeutic engagement, disclosure creates conditions that allow other therapeutic interventions to become more effective.

Finally, respondents expressed strong agreement that self-disclosure is an effective way of coping with depression (M = 4.02, SD = 0.896), indicating broad confidence in disclosure as a coping strategy. The qualitative findings strongly support this perception. As one counsellor explained:

> *"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 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."* (CNS1, JKUAT, 15 March 2022).

Similarly, another counsellor noted:

> *"When a student is willing to be vulnerable and honest from the start, it helps us build a strong rapport very quickly. Once that trust is there, it becomes easier to identify what's actually fuelling the depression, whether it's unresolved grief, academic pressure, or family dynamics."* (CNS2, JKUAT, 15 March 2022).

The convergence between the survey findings and the counsellors' experiences demonstrates that self-disclosure contributes to depression management by facilitating emotional expression, strengthening therapeutic relationships, and enabling more individualized psychological support. Rather than functioning merely as an act of communication, self-disclosure emerges as a mechanism through which students access emotional validation, establish trust, and engage more meaningfully in the therapeutic process.

The integrated findings demonstrate that students generally perceive self-disclosure as beneficial for depression management, particularly in improving emotional well-

being and facilitating engagement with support systems. However, the findings also reveal that the effectiveness of disclosure depends less on the act of disclosure itself than on the quality of the response it receives. Where disclosure is met with trust, empathy, and confidentiality, it promotes emotional relief and therapeutic progress. Conversely, where students anticipate stigma, judgement, or inadequate support, the potential benefits of disclosure are diminished. The convergence of the quantitative and qualitative evidence therefore underscores that self-disclosure is a relational process whose effectiveness is shaped by the social and therapeutic environments within which it occurs.

4.5 Effect of Disclosure by Significant Others on Depression Management

To measure the effects of disclosure by significant 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

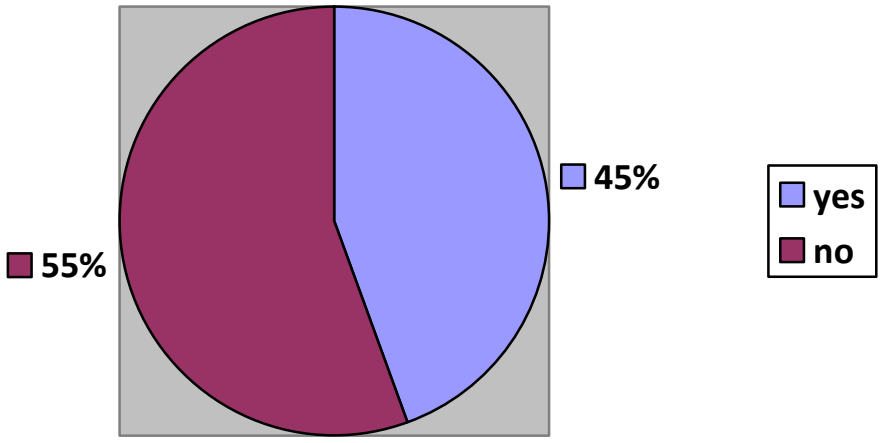

Figure 4.4: Students Who Had Disclosed their Information to Another Person

Figure 4.4 presents respondents' experiences regarding whether they had disclosed their emotional struggles to another person. The findings indicate that 143 respondents (44.55%) had shared their feelings with someone else, while 178 respondents (55.45%) reported that they had not. The predominance of non-disclosure suggests that, for many students, emotional difficulties remain private rather than being communicated to others. This finding is important because disclosure is often regarded as the first step towards accessing emotional and professional support. Where disclosure does not occur, opportunities for timely intervention may be limited.

The finding also suggests that disclosure among university students is selective rather than universal. Although a substantial proportion of respondents were willing to share their feelings, the fact that the majority chose not to disclose indicates that emotional support may not be routinely sought even when students experience psychological distress. Rather than reflecting an absence of need, the finding demonstrates that disclosure is a deliberate interpersonal decision that students do not make automatically.

These findings are consistent with those of Eisenberg et al. (2009), who found that a considerable proportion of university students experiencing mental health challenges did not seek help despite recognising psychological distress. Similarly, Gulliver et al. (2010) reported that many young adults experiencing mental health difficulties avoid disclosing their problems, thereby delaying access to appropriate support and intervention. The present findings reinforce this evidence by demonstrating that non-disclosure remains common among university students, even within an environment where counselling services are available.

These findings demonstrate that disclosure of emotional difficulties is not a common practice among the majority of students. This suggests that depression management may be constrained not only by the availability of support services but also by students' willingness to communicate their emotional experiences to others. Consequently, understanding the circumstances under which students choose to disclose, and the outcomes of such disclosure, becomes essential in explaining the contribution of disclosure to depression management.

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 presented in Table 4.8 show clear differences in the individuals to whom students chose to disclose their emotional struggles. Among the 321 respondents, 93 students (29%) reported disclosing their feelings to a friend or peer, making peers the most common source of emotional support. In contrast, substantially fewer students disclosed to faculty members (23; 7.2%), family members (14; 4.4%), or religious leaders (13; 4.1%). Most notably, 178 respondents (55.4%) indicated that they had not disclosed their feelings to anyone, suggesting that non-disclosure remains the dominant response among students experiencing emotional distress.

The predominance of peer disclosure suggests that students are more likely to seek support from individuals with whom they share similar experiences and social environments than from formal authority figures. However, the finding that more than half of the respondents did not disclose their feelings at all indicates that even peer relationships do not necessarily translate into emotional disclosure. This implies that the decision to disclose is influenced not only by the availability of support but also by students' willingness to entrust others with sensitive personal information.

The qualitative findings provide important insight into this pattern. Counsellors consistently reported that students rarely present themselves for counselling voluntarily and that, in many instances, access to mental health support begins through the intervention of peers or university personnel rather than through self-referral. One counsellor observed:

"It usually happens when a concerned classmate or friend walks into the office and says, 'My roommate hasn't left the room in days.' Roommates and classmates tend to notice changes in behaviour early, and sometimes they take the brave step to seek help on behalf of their friend." (CNS-D, JKUAT, 20 March 2022).

Similarly, another counsellor explained:

"We sometimes get alerts from faculty members who notice something off about a student. Sometimes class representatives raise concerns which are then communicated to the Dean of Students before the student is referred for counselling." (CNS-A, JKUAT, 15 March 2022).

These narratives demonstrate that although students may hesitate to disclose their struggles directly to professionals, peers often act as the first point of recognition and facilitate access to mental health services. They also help explain why peer relationships emerged as the primary avenue of disclosure in the quantitative findings.

The relatively low proportions of students disclosing to faculty members, family members and religious leaders suggest that these groups are less frequently perceived as sources of emotional support for depression-related concerns. Rather than indicating that these actors are unimportant, the findings imply that students may differentiate between individuals they trust for emotional conversations and those they perceive as occupying evaluative, disciplinary or advisory roles. This interpretation is consistent with Rickwood et al. (2005), who found that young people generally prefer informal support networks before approaching formal sources of help. Similarly, Vogel et al. (2007) observed that anticipated stigma and concerns about negative evaluation frequently discourage disclosure to authority figures.

A significant number of 178 students (55.4%) reported not disclosing their emotional difficulties to anyone. This suggests that silence remains a common response to psychological distress among university students. While disclosure is widely recognised as an important pathway to emotional support, the findings indicate that a

substantial proportion of students continue to manage their distress privately, potentially delaying access to appropriate intervention. Similar patterns have been reported by Gulliver et al. (2010), who found that many university students experiencing mental health difficulties choose not to seek help despite recognising their emotional challenges.

Both the quantitative and qualitative findings demonstrate that disclosure among university students occurs primarily through trusted peer relationships, while formal support networks play a comparatively limited role in initiating conversations about emotional distress. At the same time, the high proportion of students who do not disclose at all underscores that enhancing depression management requires not only strengthening counselling services but also creating conditions that increase students' confidence to communicate their psychological struggles before they reach crisis levels.

4.5.2 Reactions Towards Disclosure by Significant Others

The study further examined respondents' reactions when an individual to whom they had disclosed their emotional difficulties subsequently shared that information with a third party in an effort to obtain help. This analysis was based only on the 143 respondents whose personal information had been disclosed by another person in an effort to seek help. Respondents whose information had not been disclosed to a third party (n = 178) were not required to respond to this question because the item was not applicable to their experiences.

Table 4.9: Reaction towards Disclosure by significant others

		Frequency	Percent
Reaction Towards Disclosure by significant others	I felt relieved and supported	56	37.84
	I felt betrayed or violated	57	38.51
	I felt indifferent	13	8.78
	I felt worried about confidentiality	22	14.86
	Total	143	100.0

The findings presented in Table 4.9 reveal that respondents held markedly different views regarding disclosure by significant others. Of the 143 respondents whose information had been disclosed to a third party, 57 (38.51%) reported feeling betrayed or violated, while a nearly equal proportion, 56 (37.84%), indicated that they felt relieved and supported. The almost identical proportions suggest that disclosure by significant others is not uniformly perceived as either positive or negative. Rather, its impact appears to depend on how the disclosure occurs and how it is interpreted by the individual concerned.

The finding that slightly more respondents felt betrayed than supported indicates that issues of privacy and personal autonomy remain central to students' perceptions of third-party disclosure. For many respondents, the disclosure of personal information without their direct involvement appears to have been interpreted as a breach of trust rather than an act of support. This finding is consistent with Vogel et al. (2007), who argue that perceived threats to privacy discourage openness about mental health concerns, and with Rickwood et al. (2005), who contend that breaches of confidentiality may undermine future willingness to seek psychological support.

Conversely, the almost equal proportion of respondents who reported feeling relieved and supported demonstrates that third-party disclosure may also function as an important pathway to accessing assistance. These findings suggest that where individuals are unable or unwilling to seek help themselves, intervention by trusted others may facilitate access to appropriate support. This interpretation supports Barry et al.'s (2013) observation that trusted peers and significant others can play an important role in initiating help-seeking among young people experiencing psychological distress.

A further 22 respondents (14.86%) reported feeling worried about confidentiality after their information had been disclosed. Although this proportion was considerably lower than those expressing either relief or betrayal, it reinforces the importance students attach to maintaining control over personal information. Concerns about confidentiality suggest that even when disclosure is intended to provide support, uncertainty regarding who will have access to personal information

may discourage future disclosure. Similar concerns have been reported by Mak and Chen (2006), who observed that fear of social consequences often shapes attitudes towards mental health disclosure within collectivist societies.

Only 13 respondents (8.78%) indicated that they felt indifferent to the disclosure. The relatively small proportion suggests that disclosure by significant others is rarely perceived as inconsequential. Instead, the findings demonstrate that such disclosure tends to evoke clear emotional responses, whether positive or negative, reflecting the personal and sensitive nature of communicating mental health concerns.

These findings demonstrate that disclosure by significant others represents a complex interpersonal process rather than a universally beneficial intervention. The near balance between respondents who perceived disclosure as supportive and those who experienced it as a violation of trust suggests that the effectiveness of third-party disclosure depends not merely on the act of disclosure itself, but on the extent to which it preserves trust, respects individual autonomy, and is perceived as being undertaken in the person's best interests. This finding helps explain why, despite its potential to facilitate access to care, disclosure by significant others was not found to be a significant predictor of depression management in the subsequent regression analysis.

4.5.3 Impact of Disclosure by Significant 0thers on Depression Management

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

The findings presented in Table 4.10 indicate that respondents generally did not perceive disclosure by significant others as having a positive influence on the management of their depression. The mean score of 2.10 suggests that, overall, students were more likely to view third-party disclosure as ineffective than beneficial. The positive skewness (1.350) and relatively concentrated distribution of responses (kurtosis = 1.100) further indicate that this perception was shared by a substantial proportion of respondents rather than being driven by a few isolated views. Although the standard deviation (1.150) reflects some variation in opinion, the overall pattern suggests that students placed considerable value on maintaining control over when, how, and to whom their personal experiences were disclosed.

These findings differ from studies that portray disclosure by significant others as an inherently beneficial pathway to mental health support. For example, Barry et al. (2013) argues that intervention by trusted peers or significant others may facilitate early help-seeking among young people experiencing psychological distress. While this may be true, the present findings suggest that the perceived effectiveness of such disclosure depends less on the intervention itself and more on how it is experienced by the individual. Where students perceive third-party disclosure as compromising their privacy or autonomy, its therapeutic value appears to diminish. This interpretation is consistent with Vogel et al. (2007), who contend that concerns about confidentiality and stigma often shape individuals' willingness to engage with mental health support services, and with Rickwood et al. (2005), who emphasize that preserving trust and personal agency is central to effective help-seeking.

The qualitative findings provide important insight into this apparent contradiction. Although students generally viewed third-party disclosure less favourably, the counsellors consistently acknowledged its value as an entry point into mental health care, particularly for students who might never seek assistance voluntarily. As one counsellor observed:

"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." (Counsellor A, JKUAT, 15 March 2022).

Similarly, another counsellor explained:

"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." (Counsellor C, JKUAT, 15 March 2022).

These perspectives suggest that disclosure by significant others functions primarily as a catalyst for accessing professional support rather than as a therapeutic intervention in itself. Its effectiveness therefore depends on whether the student subsequently accepts and actively participates in the support process.

At the same time, the qualitative evidence also explains why many students rated third-party disclosure negatively. Counsellor D acknowledged that although such disclosure can prevent crises by enabling early intervention, it may also generate feelings of exposure and distrust when undertaken without the student's readiness or consent:

"Sometimes the student feels ambushed or exposed... 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." (Counsellor D, JKUAT, 20 March 2022).

This observation complements the quantitative findings by demonstrating that the effectiveness of disclosure by significant others is not determined solely by the act of disclosure but by the student's perception of the process. Where disclosure is experienced as supportive and respectful, it may facilitate timely intervention; however, where it is perceived as a violation of trust, it may undermine therapeutic engagement and reduce its contribution to depression management.

The integration of the quantitative and qualitative findings demonstrates that disclosure by significant others is a context-dependent intervention rather than an inherently beneficial strategy for depression management.While it may provide an

important pathway to professional intervention, its contribution to depression management depends on preserving trust, respecting students' autonomy, and fostering their willingness to participate in the therapeutic process. This finding also provides a plausible explanation for the weak influence of disclosure by significant others observed in the subsequent inferential analysis.

4.6 Effect of Therapist's Self- Disclosure on Depression Management

To analyze the impact of Therapist's self-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-disclosure in their practice and how effective they found it in improving client engagement and mental health outcomes. The study integrated quantitative and qualitative findings to provide a comprehensive understanding of how therapist self-disclosure influences the therapeutic alliance and contributes to 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

The findings presented in Table 4.11 indicate that therapist self-disclosure was not a universal practice among counsellors. Of the 321 respondents, 128 (41.1%) reported that their therapists did not disclose personal information, 103 (32.0%) indicated that therapists did engage in self-disclosure, while 90 respondents (28.9%) were unsure whether any therapist self-disclosure had occurred.

The largest proportion of respondents reporting that therapists did not disclose personal information suggests that professional boundary maintenance remains the dominant counselling approach within the university setting. This finding indicates that many therapists deliberately maintain a client-centred therapeutic relationship in which the emphasis remains on the student's experiences rather than the therapist's personal life. However, the finding that nearly one-third of respondents experienced some form of therapist self-disclosure demonstrates that this practice is also relatively common and appears to be used selectively rather than routinely. Rather than representing opposing therapeutic philosophies, the findings suggest that therapist self-disclosure is applied as a clinical judgement dependent on the needs of individual clients and the therapeutic context.

The relatively large proportion of respondents who were uncertain whether therapist self-disclosure had occurred is equally noteworthy. Unlike explicit disclosures, therapist self-disclosure may occur subtly through brief personal examples, expressions of shared experiences, or empathetic statements that clients may not consciously interpret as personal disclosure. Consequently, therapist self-disclosure appears to exist along a continuum ranging from clearly identifiable personal revelations to more implicit forms of communication, making its occurrence less obvious to some clients.

The qualitative findings provide important insight into this pattern by demonstrating that therapists themselves adopt different approaches to self-disclosure. Two

counsellors described self-disclosure as a deliberate therapeutic strategy used sparingly to strengthen rapport and encourage clients to open up.

"As a therapist, I occasionally share personal information with clients if I believe it will help build rapport and encourage them to open up... any personal disclosures are minimal and carefully considered to ensure they benefit the therapeutic process." (Counsellor B, JKUAT, 15 March 2022)

Similarly, another counsellor explained:

"Yeah, maybe a small story here or there, nothing too personal... It's not about shifting the focus to me, but creating a moment of connection... I always make sure it serves their process, not mine." (Counsellor C, JKUAT, 15 March 2022)

These narratives explain why almost one-third of respondents reported experiencing therapist self-disclosure. Rather than disclosing personal information indiscriminately, the counsellors described using carefully selected disclosures to normalize students' experiences, strengthen therapeutic rapport and facilitate emotional openness. The qualitative evidence therefore suggests that therapist self-disclosure is employed as an intentional therapeutic technique rather than a routine conversational practice.

Conversely, the interviews also explain why the largest proportion of respondents reported that therapists did not disclose personal information. Two counsellors emphasized that maintaining professional boundaries was central to effective therapy.

"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 without distraction... maintaining professional boundaries is essential." (Counsellor A, JKUAT, 15 March 2022)

Likewise, another counsellor noted:

"Not often, to be honest. I'm always weighing the risk. I don't want the session to shift focus or blur the boundaries... even then, I keep it minimal." (Counsellor D, JKUAT, 20 March 2022)

These accounts complement the quantitative findings by demonstrating that therapists consciously balance the potential benefits of self-disclosure against the need to preserve professional boundaries. The variation observed among respondents therefore appears to reflect differences in therapeutic style rather than inconsistency in professional practice.

The findings are consistent with Hill and Knox (2002), who argue that therapist self-disclosure is most effective when used selectively and purposefully rather than routinely. They also support Barnett (2011), who emphasizes that maintaining professional boundaries remains fundamental to ethical therapeutic practice. Viewed together, the quantitative and qualitative evidence suggests that therapist self-disclosure within the university counselling context is neither universally adopted nor universally avoided. Instead, it functions as a context-dependent therapeutic intervention, applied according to professional judgement and the specific needs of individual clients.

4.6.2 Frequency of Therapist Self-Disclosure in Sessions

To better understand the nature of therapist self-disclosure, respondents who indicated that their therapists disclosed personal information were further asked to indicate how frequently such disclosures occurred during therapy sessions. Only the 103 respondents who answered "Yes" to the preceding question were required to respond to this item, while respondents who indicated "No" or "Not sure" were not applicable to this analysis, as reflected by the 218 responses recorded as *N/A* 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 Therapist Self-Disclosure in Sessions	Very Frequently	5	0	0	5
	Frequently	7	0	0	7
	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

Among the respondents who had experienced therapist self-disclosure, the findings indicate that the practice occurred infrequently. The largest proportion (44 respondents; 42.7%) reported that therapist self-disclosure occurred rarely, while 26 respondents (25.2%) indicated that it occurred very rarely. Together, these findings show that approximately two-thirds (67.9%) of respondents who had experienced therapist self-disclosure perceived it as an occasional rather than routine feature of therapy. By contrast, 21 respondents (20.4%) reported that therapists disclosed personal information occasionally, whereas only 12 respondents (11.7%) indicated that such disclosures occurred frequently or very frequently.

These findings suggest that therapist self-disclosure is generally applied with considerable professional restraint rather than as a regular therapeutic practice. The predominance of "rarely" and "very rarely" indicates that therapists appear to reserve personal disclosures for situations in which they are likely to serve a specific therapeutic purpose instead of becoming part of routine interaction. This pattern suggests that therapist self-disclosure is viewed as a clinical intervention whose value

depends on timing, relevance, and the client's needs rather than the quantity of information shared.

The qualitative findings reinforce this interpretation. Counsellors consistently described therapist self-disclosure as a deliberate and carefully controlled intervention rather than a routine aspect of therapy. As one counsellor 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... any personal disclosures are minimal and carefully considered to ensure they benefit the therapeutic process." (Counsellor B, JKUAT, 15 March 2022)

Similarly, another counsellor stated:

"Yeah, maybe a small story here or there, nothing too personal... I always make sure it serves their process, not mine." (Counsellor C, JKUAT, 15 March 2022)

Conversely, therapists who rarely engaged in self-disclosure attributed this to the need to maintain professional boundaries and preserve the therapeutic focus on the client.

"I do not typically share personal information about myself during sessions... maintaining professional boundaries is essential." (Counsellor A, JKUAT, 15 March 2022)

Likewise:

"Not often, to be honest... I don't want the session to shift focus or blur the boundaries, so I keep it minimal." (Counsellor D, JKUAT, 20 March 2022)

The convergence between the quantitative and qualitative findings demonstrates that therapist self-disclosure is not characterized by how often it occurs, but by how intentionally it is used. The interviews explain why most respondents experienced therapist self-disclosure only rarely: therapists consciously weigh its potential

therapeutic benefits against the need to maintain professional boundaries and client-centred practice.

These findings suggest that therapist self-disclosure was used as a deliberate therapeutic technique rather than as a routine feature of counselling. This interpretation is consistent with Hill and Knox (2002), who argue that the effectiveness of therapist self-disclosure depends on its relevance to the client's needs and its appropriate use within the therapeutic relationship. Similarly, Henretty and Levitt (2010) contend that the benefits of therapist self-disclosure are determined less by its frequency than by its timing, purpose, and therapeutic appropriateness.

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	

Table 4.13 presents the types of information therapists disclosed during counselling sessions as perceived by the respondents. The findings show that 218 respondents (68.0%) selected *Not Applicable*, indicating that they had not experienced any form of therapist self-disclosure. This pattern reinforces the findings presented in the preceding sections, which showed that therapist self-disclosure was not a routine feature of counselling sessions. This observation is consistent with Hill and Knox (2002), who argue that therapist self-disclosure should be guided by its therapeutic relevance rather than becoming a routine component of counselling.

Among respondents who reported experiencing therapist self-disclosure, professional experiences were the most frequently disclosed, accounting for 54 respondents (16.1%). In contrast, disclosure of opinions or beliefs was reported by 25 respondents (7.6%), while personal experiences and feelings or emotions were each reported by only 13 respondents (4.1%). The distribution suggests that when therapists choose to disclose, they are considerably more likely to draw on their professional experiences than reveal personal aspects of their lives. This indicates that Therapist's self-disclosure is primarily used to facilitate the counselling process through professional expertise rather than personal self-revelation. Henretty and Levitt (2010) similarly observe that Therapist's self-disclosures are generally most effective when they remain professionally relevant and directly contribute to the client's therapeutic goals.

The qualitative findings provide further insight into this pattern. Therapists consistently described self-disclosure as a carefully considered therapeutic intervention rather than an automatic response during counselling sessions. One counsellor 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... any personal disclosures are minimal and carefully considered to ensure they benefit the therapeutic process." (Counsellor B, JKUAT, 15 March 2022)

Similarly, another counsellor noted:

"Yeah, maybe a small story here or there, nothing too personal... I always make sure it serves their process, not mine." (Counsellor C, JKUAT, 15 March 2022)

These accounts corroborate the quantitative findings that disclosures were predominantly professional rather than personal. They suggest that therapists consciously regulate the depth and content of their disclosures to maintain the therapeutic focus on the client while using limited disclosure to foster rapport and normalize clients' experiences. This reflects what Henretty and Levitt (2010) describe as purposeful therapist self-disclosure, where the therapeutic value lies not in the amount of information shared but in its relevance to the client's needs.

The relatively low proportions reporting disclosure of therapists' personal experiences (4.1%) and feelings or emotions (4.1%) further suggest that therapists deliberately avoid forms of disclosure that may blur professional boundaries. This interpretation is reinforced by the perspectives of counsellors who preferred maintaining clear therapeutic boundaries. As one counsellor stated:

"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." (Counsellor A, JKUAT, 15 March 2022)

Another counsellor similarly observed:

"I'm quite careful with that... I don't want the session to shift focus or blur the boundaries." (Counsellor D, JKUAT, 20 March 2022)

These qualitative findings help explain why personal forms of Therapist's self-disclosure were reported by very few respondents. Rather than reflecting an absence of rapport, the limited disclosure appears to represent a deliberate ethical practice aimed at preserving professional boundaries while ensuring that any disclosure remains therapeutically beneficial. Barnett (2011) argues that therapist self-disclosure should always be evaluated according to whether it advances the client's therapeutic interests rather than satisfying the therapist's personal needs.

The quantitative and qualitative findings indicate that therapist self-disclosure within the study context is selective, professionally oriented, and therapeutically purposeful. Instead of relying on personal narratives, therapists predominantly draw upon professional experiences to strengthen the therapeutic relationship while maintaining appropriate professional boundaries. This pattern demonstrates that effective therapist self-disclosure is defined less by the amount of information shared than by its clinical relevance, timing, and contribution to the client's therapeutic progress (Hill & Knox, 2002; Henretty & Levitt, 2010).

4.6.4 Clients' Reactions to Therapist Self-Disclosure

Beyond establishing whether therapist self-disclosure occurred, the study examined how respondents interpreted and responded to such disclosures. Specifically, it sought to determine whether therapist self-disclosure enhanced clients' comfort, strengthened the therapeutic relationship, created discomfort, or had no discernible influence on the therapeutic experience. The findings are presented in Table 4.14.

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 presented in Table 4.14 show that the majority of respondents (218; 68.0%) indicated that their therapists had not engaged in self-disclosure. This finding is consistent with the earlier results on the prevalence of therapist self-disclosure and reinforces the observation that most therapists maintain professional boundaries by limiting personal disclosures during therapy sessions. The remaining responses demonstrate that, among students who experienced therapist self-disclosure, reactions were varied, suggesting that its effectiveness depends not merely on whether disclosure occurs, but on how it is perceived by the client.

Only 19 respondents (6.2%) reported that therapist self-disclosure made them feel more comfortable to open up. Although this represents a relatively small proportion of the overall sample, it demonstrates that appropriately used self-disclosure can facilitate emotional openness for some clients. Rather than suggesting that therapist self-disclosure is universally beneficial, these findings indicate that its value lies in its ability to reduce interpersonal distance for certain clients. This interpretation is consistent with Henretty and Levitt (2010), who argue that therapist self-disclosure is most effective when it is intentional, relevant to the client's concerns, and used to advance therapeutic goals rather than satisfy the therapist's personal needs.

Similarly, 21 respondents (6.5%) indicated that therapist self-disclosure made them feel more connected to their therapist. This finding suggests that self-disclosure may strengthen the therapeutic alliance by increasing perceptions of therapist authenticity and relatability. Rather than merely creating familiarity, carefully managed disclosure appears to foster trust, an essential element in effective psychotherapy. This finding supports Audet (2011), who found that clients often perceive appropriate therapist self-disclosure as enhancing rapport and strengthening the therapeutic relationship.

In contrast, the largest substantive response category comprised the 40 respondents (12.6%) who reported that therapist self-disclosure made them feel uncomfortable or uneasy. This finding indicates that therapist self-disclosure is not inherently beneficial and may undermine the therapeutic relationship when clients perceive it as inappropriate or distracting. The findings therefore suggest that the effectiveness of therapist self-disclosure depends less on the act of disclosure itself than on its timing, relevance, and appropriateness within the therapeutic context. This observation is consistent with Hill and Knox (2002), who caution that therapist self-disclosure may weaken therapeutic boundaries if it shifts attention from the client's experiences to those of the therapist.

A further 23 respondents (6.7%) indicated that therapist self-disclosure made no difference to their therapy experience. This finding suggests that for some clients, therapeutic outcomes are influenced more by the overall quality of the therapeutic relationship than by the therapist's willingness to share personal experiences. In such cases, therapist self-disclosure appears neither to strengthen nor weaken engagement, indicating that it is one of several factors that contribute to effective therapy rather than a prerequisite for successful counselling.

The findings demonstrate that therapist self-disclosure does not produce a uniform response among university students. While some clients perceive it as facilitating openness and strengthening the therapeutic alliance, others experience discomfort or regard it as inconsequential. This suggests that therapist self-disclosure should not be viewed as a standard counselling technique but as a context-dependent intervention

whose effectiveness depends on client characteristics, therapeutic timing, and professional judgement. The results therefore support contemporary counselling literature, which recommends that therapist self-disclosure be employed selectively and only where it is likely to advance the client's therapeutic goals rather than the therapist's personal expression.

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 presents respondents' perceptions of the contribution of therapist self-disclosure to depression management. The findings indicate that perceptions were predominantly unfavourable. More than half of the respondents (180; 56.1%) strongly disagreed that therapist self-disclosure had positively influenced their depression management, while a further 35 respondents (10.9%) disagreed. Collectively, these responses account for 67.0% of the study population, suggesting that therapist self-disclosure was generally not perceived as an important contributor to depression management among the students.

However, this finding should not be interpreted as evidence that therapist self-disclosure is inherently ineffective. Rather, when considered alongside the findings presented earlier in the study, it reflects the limited exposure respondents had to therapist self-disclosure. As shown in Table 4.11, only 103 respondents (32.0%) reported that their therapists had disclosed personal information during therapy sessions, while the majority either indicated that no self-disclosure had occurred or were unsure whether it had occurred. It is therefore unsurprising that many respondents did not perceive therapist self-disclosure as having influenced their recovery, since they had little or no opportunity to experience the intervention. The predominance of negative responses may therefore reflect the absence of therapist self-disclosure in many therapeutic encounters rather than dissatisfaction with the practice itself.

The sizeable proportion of respondents who disagreed that therapist self-disclosure contributed to depression management nevertheless suggests that the mere act of Therapist’s self-disclosure does not automatically translate into positive therapeutic outcomes. Instead, clients appear to evaluate therapist self-disclosure according to its relevance and usefulness within therapy. This interpretation supports Zur et al. (2009), who argue that therapist self-disclosure is beneficial only when it is purposeful, clinically appropriate, and clearly directed toward advancing the client's therapeutic goals. Similarly, Hill and Knox (2002) contend that therapist self-disclosure is a therapeutic technique rather than an intervention whose effectiveness depends on how, when, and why it is employed. Consequently, disclosures perceived

as unnecessary or unrelated to the client's concerns may contribute little to the therapeutic process.

A further 57 respondents (17.7%) adopted a neutral position, indicating that therapist self-disclosure neither enhanced nor hindered their depression management. Rather than reflecting uncertainty, this neutrality may suggest that therapist self-disclosure was not sufficiently salient within the therapeutic encounter to influence clients' perceptions of recovery. This finding reinforces the argument that the therapeutic value of self-disclosure is context dependent and that other aspects of the therapeutic relationship, such as empathy, active listening, professional competence, and trust, may be perceived as more influential in facilitating psychological improvement (Hill et al., 2018).

Conversely, a minority of respondents viewed therapist self-disclosure positively. Thirty respondents (9.4%) agreed, while 19 respondents (5.9%) strongly agreed that therapist self-disclosure had positively influenced their depression management, representing 15.3% of the sample. Although comparatively small, this group demonstrates that therapist self-disclosure can contribute meaningfully to therapy when clients perceive it as authentic, relevant, and supportive. Rather than valuing disclosure for its own sake, these respondents appear to have interpreted carefully selected personal sharing as evidence of therapist genuineness, empathy, and understanding. This observation is consistent with Henretty and Levitt (2010), who argue that judicious therapist self-disclosure can strengthen the therapeutic alliance by increasing clients' sense of connection and trust without compromising professional boundaries.

The findings therefore suggest that clients' perceptions of therapist self-disclosure are shaped less by whether disclosure occurs than by how it is experienced within the therapeutic relationship. For the majority of respondents, therapist self-disclosure either did not occur or was not perceived as contributing to depression management, whereas a smaller proportion experienced it as beneficial when it enhanced connection, trust, and therapeutic engagement. These findings support the view that therapist self-disclosure should not be regarded as a routine therapeutic practice but

as a clinical intervention whose effectiveness depends on timing, relevance, and responsiveness to individual client needs (Hill & Knox, 2002; Zur et al., 2009).

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 significant _others	.322	321	.320	.721	321	.625
Therapist's Disclosure	.269	321	.381	.788	321	.182
Depression_management	.337	321	.291	.637	321	.162
a. Lilliefors Significance Correction						

The Shapiro-Wilk and Kolmogorov-Smirnov tests were used to assess whether the study variables were normally distributed, an important assumption for parametric statistical analyses. According to Ghasemi and Zahediasl (2012), a significance value ($p > .05$) indicates that the data do not significantly deviate from a normal distribution.

The results presented in Table 4.16 indicate that all four study variables satisfied the normality assumption. For self-disclosure, the Kolmogorov-Smirnov test yielded a statistic of 0.326 ($p = .152$), while the Shapiro-Wilk test produced a statistic of 0.765 ($p = .238$). Since both significance values exceed the recommended threshold of .05, the null hypothesis of normality was not rejected, indicating that the distribution of self-disclosure scores did not significantly depart from normality.

Similarly, disclosure by significant others met the assumption of normality. The Kolmogorov-Smirnov statistic was 0.322 ($p = .320$), while the Shapiro-Wilk statistic was 0.721 ($p = .625$). Both tests produced non-significant results, suggesting that the observed distribution was approximately normal.

The results further indicate that therapist self-disclosure was normally distributed. The Kolmogorov-Smirnov test produced a statistic of 0.269 ($p = .381$), whereas the Shapiro-Wilk test yielded a statistic of 0.788 ($p = .182$). Since the significance values for both tests exceeded .05, the assumption of normality was satisfied for this variable.

Finally, the dependent variable, depression management, also met the normality assumption. The Kolmogorov-Smirnov statistic was 0.337 (p = .291) and the Shapiro-Wilk statistic was 0.637 (p = .162). Both tests were non-significant, indicating that the distribution of depression management scores did not significantly differ from a normal distribution.

Overall, the Kolmogorov-Smirnov and Shapiro-Wilk tests consistently produced significance values greater than .05 for all four variables. These findings indicate that the assumption of normality was satisfied, justifying the use of parametric statistical techniques in the subsequent inferential analyses.

4.7.2 Breusch-Pagan Test for Heteroskedasticity

The Breusch–Pagan test was conducted to determine whether the variance of the residuals remained constant across different levels of the independent variables. Homoscedasticity is a key assumption of linear regression because it ensures that the estimated coefficients are efficient and that the associated standard errors, confidence intervals, and significance tests are reliable. Conversely, heteroskedasticity may produce biased standard errors, leading to misleading statistical inferences (Breusch & Pagan, 1979).

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_ significant others + Therapist's self-disclosure

The results presented in Table 4.17 indicate a Chi-square statistic of 41.212 with 1 degree of freedom and a p-value of 0.641. Since the significance value exceeds the conventional threshold of 0.05, the null hypothesis of homoscedasticity is not

rejected. This indicates that the variance of the residuals does not vary systematically across the levels of the independent variables, suggesting that the assumption of constant error variance was satisfied.

The absence of heteroskedasticity implies that the estimated regression coefficients are efficient and that the corresponding standard errors are unlikely to be distorted by unequal error variances. Consequently, the hypothesis tests, confidence intervals, and significance levels generated by the regression model can be interpreted with confidence. These findings demonstrate that the relationships between self-disclosure, disclosure by significant others, therapist self-disclosure, and depression management are unlikely to be affected by heteroskedasticity-related estimation bias.

The results of the Breusch–Pagan test confirmed that the regression model satisfied the homoscedasticity assumption, supporting the validity and reliability of the subsequent inferential analysis. Consequently, the observed relationships can be interpreted without concern that unequal residual variances biased the parameter estimates or statistical inferences.

4.7.3 Multicollinearity Test

The multicollinearity test was conducted to determine whether the independent variables included in the regression model were highly correlated with one another. High multicollinearity inflates the standard errors of the estimated coefficients, making it difficult to determine the unique contribution of each predictor to the dependent variable. To assess multicollinearity, Tolerance and Variance Inflation Factor (VIF) statistics were computed. According to Hair et al. (2019), tolerance values below 0.10 or VIF values exceeding 10 indicate problematic multicollinearity.

Table 4.18: Multicollinearity Test

Model		Collinearity Statistics	
		Tolerance	VIF
1	Self_Disclosure	.44	2.218
	Disclosure_by_Significant_Others	.32	2.255

	Therapist's Self-Disclosure	.38	1.180

a. Dependent Variable: Depression_Management

The results presented in Table 4.18 indicate that all the independent variables satisfied the assumptions relating to multicollinearity. The tolerance values ranged from 0.32 to 0.44, all of which exceeded the recommended minimum threshold of 0.10. These findings indicate that none of the independent variables shared sufficient variance with the others to raise concerns about multicollinearity.

The Variance Inflation Factor (VIF) values further support this conclusion. Self-disclosure recorded a VIF of 2.218, disclosure by significant others 2.255, and therapist self-disclosure 1.180. All three values are substantially below the recommended cut-off value of 10, indicating that multicollinearity was not present in the regression model.

The absence of multicollinearity demonstrates that each independent variable contributed distinct information to the model. Consequently, the estimated regression coefficients can be interpreted as representing the unique contribution of self-disclosure, disclosure by significant others, and therapist self-disclosure to depression management, without substantial distortion arising from intercorrelations among the predictors. This supports the stability of the regression estimates and enhances confidence in the subsequent inferential analysis.

4.7.4 Autocorrelation Analysis

The Durbin-Watson statistic was used to assess whether the residuals from the regression model were independent of one another. Although autocorrelation is more commonly associated with time-series data, examining the independence of residuals provides an additional diagnostic check of the regression model. A Durbin-Watson statistic close to 2.0 indicates that the residuals are independent, whereas values substantially below 2.0 suggest positive autocorrelation and values substantially above 2.0 indicate negative autocorrelation (Field, 2018).

Table 4.19: Autocorrelation Analysis

Model	Durbin-Watson
Regression Model	2.010

a. Predictors: (Constant), Self_disclosure, Disclosure_by_Significant_Others, Therapist's Self-Disclosure,

b. Dependent Variable: Depression_Management

The results presented in Table 4.19 indicate a Durbin-Watson statistic of 2.010. Since this value is very close to the recommended value of 2.0, the residuals can be considered independent, indicating that the regression model did not exhibit significant autocorrelation.

The absence of autocorrelation demonstrates that the residuals were randomly distributed and that the observations were independent. Consequently, the estimated regression coefficients and their associated standard errors are unlikely to be distorted by correlated residuals, thereby supporting the validity of the statistical inferences drawn from the regression model.

The findings therefore indicate that the regression model satisfied the assumption of independent errors. This provides additional evidence that the relationships between self-disclosure, disclosure by significant others, therapist self-disclosure, and depression management were estimated without bias arising from autocorrelated residuals, thereby strengthening the reliability of the subsequent regression analysis.

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 significant others, and Therapist's self-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 significant others, and Therapist's self-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	Disclosure by Significant others	Therapist's Self-disclosure
Depression Management	Pearson Correlation	1	.538**	.351**	.327**
	Sig. (2-tailed)		.004	.002	.001
	N	321	321	321	321
Self-Disclosure	Pearson Correlation	.538**	1	.600**	.650**
	Sig. (2-tailed)	.004		.001	.001
	N	321	321	321	321
Disclosure by Significant Others	Pearson Correlation	.351**	.600**	1	.550**
	Sig. (2-tailed)	.002	.001		.001
	N	321	321	321	321
Therapist's Self-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).

Table 4.20 presents the Pearson correlation coefficients between the independent variables (self-disclosure, disclosure by significant others, and therapist self-disclosure) and the dependent variable (depression management), as well as the interrelationships among the independent variables. All the observed correlations were positive and statistically significant at the 0.01 level ($p < .01$), indicating that higher levels of disclosure were associated with better depression management among university students.

Among the three independent variables, self-disclosure exhibited the strongest positive association with depression management ($r = .538$, $p = .004$). This represents a moderate positive relationship, suggesting that students who are more willing to disclose their thoughts, emotions, and personal experiences are more likely to report better management of depressive symptoms. Although the relationship is statistically significant, the correlation coefficient also indicates that self-disclosure alone does not explain depression management, implying that other psychological, social, and environmental factors also contribute to students' mental health outcomes. This finding supports the proposition that self-disclosure facilitates emotional processing, reduces psychological burden, and promotes access to social support, all of which contribute to improved psychological well-being (Chaudoir & Fisher, 2010; Kahn & Hessling, 2001).

Disclosure by significant others also demonstrated a positive and statistically significant relationship with depression management ($r = .351$, $p = .002$). Although weaker than self-disclosure, this moderate association suggests that support initiated through trusted friends, family members, or other significant individuals contributes positively to students' management of depression. The comparatively lower correlation may indicate that while external support is valuable, its effectiveness depends on factors such as the quality of relationships, perceived trust, and the student's willingness to accept help. This finding is consistent with Rickwood et al. (2005), who argue that supportive interpersonal relationships encourage help-seeking and facilitate positive mental health outcomes.

Similarly, therapist self-disclosure was positively associated with depression management ($r = .327$, $p = .001$), representing the weakest, though still statistically significant, relationship among the three disclosure variables. The relatively smaller coefficient suggests that therapist self-disclosure may contribute to depression management by strengthening rapport and trust within the therapeutic relationship, but its influence appears to be more modest than that of clients' own self-disclosure. This finding reinforces the view that therapist self-disclosure is most effective when used selectively and purposefully to support the therapeutic process rather than as an intervention in itself (Henretty & Levitt, 2010; Hill & Knox, 2002).

The correlation matrix further reveals significant positive associations among the independent variables. Self-disclosure was strongly associated with therapist self-disclosure ($r = .650$, $p = .001$) and moderately associated with disclosure by significant others ($r = .600$, $p = .001$). In addition, disclosure by significant others and therapist self-disclosure were positively correlated ($r = .550$, $p = .001$). These findings suggest that the different forms of disclosure tend to coexist rather than operate independently. Students who are willing to disclose personal experiences may also be more receptive to therapeutic interactions and more likely to receive support from significant others. At the same time, the correlation coefficients remain well below levels that would indicate problematic multicollinearity, confirming that each disclosure variable captures a distinct aspect of interpersonal communication.

The observed relationships support interpersonal communication theories that conceptualize disclosure as a reciprocal process through which trust, emotional support, and psychological adjustment are developed. Chaudoir and Fisher's (2010) Disclosure Processes Model proposes that disclosure promotes psychological well-being by facilitating emotional expression and access to supportive relationships, while Social Penetration Theory (Altman & Taylor, 1973) explains how progressive disclosure strengthens interpersonal bonds. The positive correlations observed in this study are therefore consistent with theoretical expectations that greater openness in interpersonal communication is associated with improved depression management among university students.

The correlation analysis demonstrates that self-disclosure, disclosure by significant others, and therapist self-disclosure are all significantly associated with depression management, with self-disclosure exhibiting the strongest relationship. However, correlation does not establish causation; therefore, these findings indicate statistical associations rather than causal effects. The extent to which each disclosure variable independently influences depression management is examined in the subsequent regression analysis.

4.9 Regression Analysis of Disclosure and Depression Management

Multiple regression analysis was conducted to examine the relationship between the independent variables (self-disclosure, disclosure by significant others, and therapist self-disclosure) and the dependent variable (depression management among university students). The analysis sought to determine the extent to which the independent variables collectively explained variation in depression management, while also assessing the individual contribution of each predictor. The findings are presented in two models: Model 1 (before moderation) and Model 2 (after moderation).

4.9.1 Regression Analysis before Moderation

The first regression model was estimated without incorporating individual characteristics as a moderating variable. The results are presented 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]	.329	0.310	2.63792

a. Predictors: (Constant), Self_disclosure, Disclosure_by _Significant_others, Therapist's self-disclosure.

The results presented in Table 4.21 describe the extent to which self-disclosure, disclosure by significant others, and therapist self-disclosure collectively explain variations in depression management among university students.

The multiple correlation coefficient (R = 0.574) indicates a moderate positive relationship between the observed depression management scores and the values predicted by the regression model. This suggests that the model demonstrates a reasonable ability to predict depression management from the three disclosure variables.

The coefficient of determination ($R^2 = 0.329$) shows that the independent variables jointly explain 32.9% of the variation in depression management. This implies that differences in self-disclosure, disclosure by significant others, and therapist self-disclosure account for approximately one-third of the observed variation in depression management among the respondents. The remaining 67.1% of the variation is attributable to other factors not included in the model, such as individual psychological characteristics, coping strategies, social support systems, or other contextual influences.

The adjusted coefficient of determination (Adjusted $R^2 = 0.310$) indicates that, after adjusting for the number of predictors included in the model, approximately 31.0% of the variation in depression management remains explained. The relatively small difference between the R^2 and Adjusted R^2 values (0.329 and 0.310, respectively) suggests that the model is reasonably stable and that the explanatory power is not substantially inflated by the inclusion of multiple predictors.

The standard error of the estimate (2.63792) represents the average deviation between the observed depression management scores and those predicted by the regression model. A smaller standard error generally indicates greater predictive accuracy; thus, the value obtained suggests that the model provides a reasonably accurate estimate of depression management, although some unexplained prediction error remains.

The model demonstrates moderate explanatory power, indicating that the three disclosure variables collectively contribute meaningfully to explaining variations in depression management among university students. However, a substantial proportion of the variation remains unexplained, suggesting that depression management is influenced by additional factors beyond the disclosure variables examined in this study.

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	336.760	3	112.253	51.810	.000[b]
	Residual	686.814	317	2.167		
	Total	1023.574	320			

a. Dependent Variable: Depression_ management

b. Predictors: (Constant), Self- disclosure Disclosure by significant others, Disclosure_ reciprocity.

The ANOVA results presented in Table 4.22 indicate that the regression model is statistically significant in explaining depression management among university students. The model yielded an F-statistic of 51.810 with a significance level of $p < .001$, indicating that the set of predictor variables-self-disclosure, disclosure by significant others, and therapist self-disclosure-collectively explain a significant proportion of the variation in depression management. The probability of obtaining this result by chance is extremely low, demonstrating that the regression model provides a significantly better fit than a model without the predictor variables.

The Regression Sum of Squares (SSR) of 336.760 indicates the amount of variation in depression management explained by the three disclosure variables, while the Residual Sum of Squares (SSE) of 686.814 represents the variation that remains unexplained by the model. Although the predictors account for a statistically significant proportion of the variance, the larger residual sum of squares suggests that

depression management is also influenced by other factors that were not included in the present model.

The Mean Square for Regression (112.253) is substantially higher than the Mean Square for Residual (2.167), resulting in the statistically significant F-statistic. This indicates that the variation explained by the regression model is considerably greater than the unexplained variation, confirming the predictive value of the disclosure variables.

The ANOVA results therefore demonstrate that self-disclosure, disclosure by significant others, and therapist self-disclosure jointly constitute a statistically significant model for predicting depression management among university students. These findings justify proceeding to the examination of the individual regression coefficients to determine the unique contribution of each predictor to depression management.

4.9.3 Multiple Linear Regression

Table 4.23 presents the results of the multiple linear regression analysis examining the influence of self-disclosure, disclosure by significant others, and therapist self-disclosure on depression management among university students..

Table 4.23: Multiple Linear Regression Results

	Unstandardized Coefficients		Standardized 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 significant others	0.120	0.065	0.185	4.890	0.022
Therapist's self-disclosure	0.095	0.060	0.135	3.275	0.048

a. Dependent Variable: Depression Management

Table 4.23 presents the results of the multiple linear regression analysis examining the influence of self-disclosure, disclosure by significant others, and therapist self-disclosure on depression management among university students.

The regression coefficients indicate that all three disclosure variables positively predicted depression management. Self-disclosure emerged as the strongest predictor ($\beta = 0.390$, $B = 0.380$), suggesting that an increase in self-disclosure was associated with the greatest improvement in depression management after controlling for the other predictors in the model. This finding indicates that students who were more willing to disclose their thoughts and emotions were more likely to report better depression management outcomes.

Disclosure by significant others also made a positive contribution to depression management ($\beta = 0.185$, $B = 0.120$), although its influence was considerably smaller than that of self-disclosure. Similarly, therapist self-disclosure had the weakest positive contribution to the model ($\beta = 0.135$, $B = 0.095$), indicating that while therapist self-disclosure was associated with improved depression management, its unique contribution was comparatively modest.

The regression equation for Model 1 is therefore expressed as:

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

Where:

Y = Depression Management among University Students

X_1 = Self-Disclosure

X_2 = Disclosure by significant others

X_3 = Therapist's self-disclosure

4.9.4 Regression Model after Moderation

The study subsequently introduced individual characteristics as the moderating variable to determine whether they altered the relationship between the disclosure variables and depression management. Specifically, age, religion, and personality were incorporated into the regression model as the moderating construct to examine whether they enhanced the explanatory power of the model and significantly influenced the relationship between the independent variables and depression management. The results are presented in Table 4.2

Table 4.24 Regression Results of Model 2 after Moderation

	Unstandardized Coefficients		**Standardized Coefficients**	**t**	**Sig.**
Variable	**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 Significant Others	0.100	0.070	0.145	4.210	0.035
Therapist's Self-Disclosure	0.085	0.058	0.125	2.936	0.049

Individual Characteristics	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, 315				

The results presented in Table 4.24 indicate that introducing the composite construct of individual characteristics into the regression model improved its explanatory power. The coefficient of determination (R^2) increased from 0.329 in Model 1 to 0.417 in the moderated model, while the Adjusted R^2 increased from 0.310 to 0.398. This improvement indicates that incorporating the composite construct of individual characteristics enhanced the model's ability to explain variation in depression management among university students. Specifically, the moderated model explained 41.7% of the variation in depression management compared to 32.9% explained by the model without the moderator, suggesting that individual characteristics strengthened the predictive capacity of the regression model.

Further, the regression coefficient for the composite construct of individual characteristics was positive and statistically significant ($\beta = 0.200$, $p = 0.015$). This finding indicates that the composite construct of individual characteristics made a significant contribution to the prediction of depression management beyond the effects of self-disclosure, disclosure by significant others, and therapist self-disclosure. The improvement in the model following the inclusion of the moderator suggests that the combined influence of individual characteristics shapes the relationship between disclosure and depression management among university students. This finding is consistent with MacKinnon et al. (2007), who note that moderation is demonstrated when the inclusion of a moderating variable significantly improves the explanatory power of a regression model and influences the relationship between the predictor variables and the outcome variable.

The moderated multiple regression model is therefore expressed as:

$Y=3.110+0.420_{X1}+0.100_{X2}+0.085_{X3}+0.140_{M}+\varepsilon$

Where:

Y = Depression Management among University Students

X_1 = Self-Disclosure

X_2 = Disclosure by significant others

X_3 = Therapist's self-disclosure

M = Individual characteristics

M is Moderating Variable (Individual characteristics)

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 significant others, and Therapist's self-disclosure on depression management among university students. Additionally, it explored the moderating effect of individual characteristics-age, 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's self-disclosure, and disclosure by significant others, and the moderating effect of individual characteristics. 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 significant others, and

Therapist's self-disclosure, while also examining how individual characteristics moderate these effects. The research was anchored in the Social Penetration Theory (SPT), Disclosure-Decision Model (DDM), the Communication Privacy Management model and Interpersonal Theory of Depression, 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 individual characteristics 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 individual characteristics. 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 sought to determine the effect of self-disclosure on depression management among university students in Kenya. The findings demonstrate that self-disclosure is an important interpersonal communication process that supports effective depression management. Students who openly shared their emotional experiences with trusted individuals were more likely to report improved emotional well-being, suggesting that disclosure facilitates emotional relief, strengthens social support, and promotes engagement with appropriate mental health interventions. However, the findings also indicate that self-disclosure is constrained by fear of stigma, negative social judgement, and concerns about confidentiality, causing many students to withhold their emotional struggles despite the potential benefits of disclosure. Consequently, the study concludes that while self-disclosure is a valuable strategy for depression management, its effectiveness depends largely on the presence of supportive relationships and environments that encourage openness, trust, and psychological safety.

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

The second objective of the study sought to determine the effect of disclosure by significant others on depression management among university students in Kenya. The findings indicate that disclosure by significant others plays a limited role in the management of depression compared to self-disclosure. Although trusted individuals such as friends, family members, or peers may facilitate access to emotional support and professional assistance by recognizing distress and encouraging help-seeking, the effectiveness of such disclosure is highly dependent on the circumstances under which it occurs. The findings suggest that students value autonomy and confidentiality in matters relating to their mental health, and disclosures made without their knowledge or consent may generate feelings of discomfort, mistrust, or loss of control rather than emotional relief.

The study further establishes that disclosure by significant others is not, in itself, sufficient to improve depression management. Rather, its value lies in complementing other support mechanisms by facilitating timely intervention where students may be unwilling or unable to seek help independently. Consequently, the findings accentuate the importance of balancing the need for supportive intervention with respect for students' privacy, autonomy, and informed participation in decisions concerning their mental health. The study therefore concludes that disclosure by significant others is most effective when it occurs within relationships characterized by trust, sensitivity, and a genuine concern for the well-being of the student.

5.3.3 Therapist's Self-Disclosure and Depression Management among University Students in Kenya

The third objective of the study sought to determine the effect of Therapist's self-disclosure on depression management among university students in Kenya. The findings demonstrate that appropriate Therapist's self-disclosure contributes positively to depression management by strengthening the therapeutic relationship and fostering an environment characterized by trust, empathy, and emotional safety. Students perceived carefully managed Therapist's self-disclosure as an indication of genuineness and understanding, which encouraged greater openness during counselling sessions and enhanced their willingness to engage in the therapeutic process.

The findings further suggest that the effectiveness of Therapist's self-disclosure depends not on the quantity of personal information shared by the therapist but on the relevance, appropriateness, and professional judgment exercised in its use. Therapist's self-disclosure appears to be most beneficial when it serves the client's therapeutic needs by normalizing emotional experiences, reinforcing hope, and facilitating meaningful dialogue without shifting the focus away from the client. Conversely, maintaining appropriate professional boundaries remains essential in preserving the integrity of the counselling relationship and ensuring that disclosure continues to support, rather than detract from, therapeutic outcomes.

The study concludes that Therapist's self-disclosure is an important therapeutic communication strategy that can enhance depression management when applied ethically, purposefully, and within the boundaries of professional counselling practice. The findings emphasize the importance of equipping university counsellors with the communication competencies necessary to use Therapist's self-disclosure effectively as part of student mental health interventions.

5.3.4 Moderating Effect of the Individual Characteristics on Depression Management among University Students in Kenya

The fourth objective of the study was to examine the moderating effect of individual characteristics, such as age, culture, religion, and personality, on the relationship between disclosure practices (self-disclosure, disclosure by significant others, and Therapist's self-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 individual characteristics 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, 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 Significant Others on Depression Management

In this study, the findings demonstrate that disclosure by significant 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 significant 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's Self-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's self-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's self-disclosure plays a significant role in depression management. While its impact may be less pronounced compared to self-disclosure or disclosure by significant others, it still contributes meaningfully to creating a supportive environment that enhances therapeutic relationships and emotional well-being. This emphasizes 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's self-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 Individual Characteristics on the Relationship between Disclosure and Depression Management

The descriptive statistics from this study indicated that individual characteristics, such as age, 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 individual characteristics 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 significant others, and Therapist's self-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 individual characteristics when designing support systems for university students managing depression. Personalized interventions that take into account students' individual characteristics, such as culture, age, 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 individual characteristics.

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 counsellors 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’s self-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 counselling programs, which can facilitate reciprocal sharing in a controlled and supportive manner. Peer counsellors, 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 individual characteristics such as age, 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 individual characteristics on these processes.

5.6 Areas for Further Research

The study focused on the effects of self-disclosure, disclosure by significant others, Therapist's self-disclosure, and individual characteristics 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 individual characteristics such as age, 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 counsellors) 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 personalized 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 individual characteristics 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: INDIVIDUAL 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 counsellors 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 SIGNIFICANT 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'S SELF-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 counselling 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: NACOSTI Research License

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **872536**

Date of Issue: **01/May/2023**

RESEARCH LICENSE

This is to Certify that Ms.. Lilian Wumuyu 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.

License No: **NACOSTI/P/23/25593**

872536

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

See overleaf for conditions

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 the 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),
Off Waiyaki Way, Upper Kabete,
P. O. Box 30623 - 00100 Nairobi, KENYA
Telephone: 020 4007000, 0713788787, 0735404245
E-mail: dg@nacosti.go.ke
Website: www.nacosti.go.ke

Appendix VI: 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

INSTITUTIONAL ETHICS REVIEW COMMITTEE
- 9 MAR 2023
APPROVED
P.O. Box 62000-00200 NAIROBI
www.jkuat.ac.ke
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