AN EVALUATION OF COUNSELLING THERAPY MANAGEMENT FOR ENHANCING MENTAL HEALTH AMONG UNDERGRADUATE STUDENTS WITH PERSONALITY DISORDERS IN SELECTED KENYAN UNIVERSITIES

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A Thesis Submitted in Partial Fulfillment of the Requirements for the Award of the Degree of Doctor of Philosophy in Disaster Management and Humanitarian Assistance of Masinde Muliro University of Science and Technology

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DECLARATION AND CERTIFICATION

This thesis is my original work prepared with no other than the indicated sources, support and has not been presented elsewhere for a degree or any other award.

Signature: …….. Date: ……

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CERTIFICATION BY THE SUPERVISORS

The undersigned certify that they have read and hereby recommend for acceptance of Masinde Muliro University of Science and Technology a thesis entitled "**An Evaluation of Counselling Therapy Management for Enhancing Mental Health among Undergraduate Students with Personality Disorders in Selected Kenyan Universities"**

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DEDICATION

This work is dedicated to all the students in universities that may be struggling with personality disorders.

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Abstract

With the ever increasing number of disasters, personality disorders are inevitable. Personality disorders manifest in at least ten different ways, and can usually be diagnosed and managed through psychotherapeutic interventions. The prevalence of these disorders among undergraduate students and the degree to which counselling therapies offered in universities are able to address them is an information gap this study set out to fill. The main objective of the study was therefore to evaluate the effectiveness of the counselling therapy management of personality disorders among undergraduate students with personality disorders in Kenyan universities. Specific objectives were to examine the nature and extent of the personality disorders, examine management of counselling therapies and facilities available, and evaluate effectiveness of counseling services in addressing the personality disorders. Three theories that guided the study were Albert Bandura's Theory of Social Learning, Ian Pavlov's Theory of Classical Conditioning and Carl Rogers' Person-Centred Therapy that were used to construct a conceptual framework depicting the likely relationship between the independent and dependent variables. The study adopted an ex post facto and cross sectional survey research designs in which descriptive and evaluative elements also featured. The target population comprised all students, Deans of Students, Medical Officers and Counsellors in all universities in Kenya. Using the lottery method, 4 universities were randomly selected, from which a study sample size of 404 respondents comprises 384 students, 4 Deans of Students, 12 Student Counsellors and 4 Medical Officers were drawn. The cluster, random and purposive sampling techniques were used. A pilot study was conducted to ensure the validity and reliability of the research tools through pretesting/piloting. For validity, content validity was determined in advance through discussions and consultations with university supervisors and expert judgment of experienced practitioners in the field of counselling therapy. To ensure reliability of the tools, testing was done using Cronbach Alpha's split-half method. Reliability was calculated from the pilot sample using SPSS and yielded a co-efficient of 0.72, which was deemed reliable as it had met the internal consistency. Data was collected from both primary and secondary sources (questionnaire, interview schedule, observation schedule and literature from relevant offices). Quantitative data collected was analyzed using an online site and the Statistical Package for Social Sciences (SPSS), then Microsoft Excel and presented in graphs, pie charts, tables, percentages and digital photographs. Qualitative data from key informants was received in verbatim, transcribed and recorded in themes. Data from observation checklist was presented in a table and in plates. Findings revealed that there was a high prevalence of personality disorders (94.8%) among undergraduate students, yet majority (83.6%) had never attended counselling, but all those who had (16.4%), reported positively on the impact of counselling. This implies that counseling was effective in helping them to address their interpersonal and emotional problems. The study also found that 75% of the universities were understaffed with regard to the counsellors, and that counselling rooms were poorly furnished. The study recommends that undergraduate students are screened for personality disorders upon entry into university to detect presence of personality disorders and on exit, determine the effect of therapies offered during the course of their studies. It also recommends that staffing be enhanced in all Counselling Departments; better furniture be availed for counselling. It is also recommended that further research be carried out to establish why few undergraduates do not use counseling services.

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ABBREVIATIONS AND ACRONYMS

The abbreviations and acronyms used in this study are as follows:

APA	American Psychiatric Association
APA	American Psychological Association
ASPD	Anti Social Personality Disorder
APD	Avoidant Personality Disorder
BPD	Borderline Personality Disorder
BT	Behaviour Therapy
CBT	Cognitive Behaviour Therapy
CT	Cognitive Therapy
CUE	Commission for University Education
DBT	Dialectical Behaviour Therapy
DPD	Dependent Personality Disorder
DSM-IV	Diagnostic and Statistical Manual of Mental disorders. 4th, Edition,
EQ	Emotional Quotient/Intelligence
FT	Family Therapy
FGD	Focus Group Discussion
GLUK	Great Lakes University of Kisumu
HPD	Histrionic Personality Disorder
IPT	Interpersonal Therapy
KDF	Kenya Defense Force
KNCHR	Kenya National Commission for Human Rights
MDGs	Millennium Development Goals
MMUST	Masinde Muliro University of Science and Technology

NACOSTI	National Council of Science, Technology and Innovation
NHS	National Health Service
NPD	Narcissistic Personality Disorder
OCPD	Obsessive-Compulsive Personality Disorder
PAR	Pressure and Release Model
PD	Personality Disorder
PPD	Paranoid Personality Disorder
PTSD	Post Traumatic Stress Disorder
SDGs	Sustainable Development Goals
SPD	Schizoid Personality Disorder
STPD	Schizotypal Personality Disorder
UNHCR	United Nations High Commissioner for Refugees
UNESCO	United Nations Educational and Scientific Organzation
UNISDR	United Nations International Stratey for Disaster Reductiion
UPR	Unconditional Positive Regard
USAID	United States Agency International Development
USIU-A	United States International University-Africa
WHO	World Health Organization
WTC	World Trade Centre

DEFINITION OF OPERATIONAL TERMS

The following terms have been defined in the context of this study as follows:

Adaptability refers to a continuous or infinite dimension, related to the capacity of a family to function competently in effecting change and tolerating differentiation of members

Anti-Social Personality Disorder (ASPD) refers to a type of chronic mental condition in which a person's ways of thinking, perceiving situations and relating to others are dysfunctional and destructive. People with antisocial personality disorder typically have no regard for right and wrong and often disregard the rights, wishes and feelings of others.

Conflict refers to competitive or opposing action of incompatibles: antagonistic state or action (as of divergent ideas, interests, or persons). It also refers to a mental struggle resulting from incompatible or opposing needs, drives, wishes, or external or internal demands.

Counselling Therapy refers to the non-prophylactic intervention for mental conditions associated with personality disorders. Specifically, it refers to the counseling strategies in place to assist undergraduate students within the public university system

Effectiveness refers to the degree to which counselling services are successful in helping students to manage their personality disorders

Emotional Intelligence refers to the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and action.

Incidence of a Personality Disorder refers to the annual diagnosis rate, or the number of new cases of the Personality Disorder diagnosed each year. Hence, these two statistical types can differ: a short time disease like flu can have high annual incidence but low prevalence, but a life-long disease like diabetes has a low annual incidence but high prevalence.

Mental Disorder refers to a wide range of mental conditions or disorders that affect one's mood, thinking and behavior. It includes depression, anxiety, schizophrenia etc. The term is interchangeably used with personality disorders.

Personality refers to the set of enduring behavioral and mental traits that distinguish human beings. Hence, personality disorders are defined by experiences and behaviors that differ from societal norms and expectations.

Personality disorder refers to an enduring pattern of inner experience and behavior that deviates from the norm of the individual's culture. The pattern is seen in two or more of the following areas: cognition; affectivity; interpersonal functioning; or impulse control.

Sociopath refers to an antisocial person who is callous, irresponsible, egocentric, and impulsive, fails to learn from experience or punishment, and is without remorse or shame.

Prevalence of Borderline Personality Disorder refers to the estimated population of people who are managing Borderline Personality Disorder at any given time (that is, people with Borderline Personality Disorder).

CHAPTER ONE

INTRODUCTION

1.0 Background to the Study

Personality disorders can be enhanced especially during disasters (Solomon & Green, 1992) as well as conflicts which are inevitable aspects of human life. Often, the social disruption comes from people afflicted with personality disorders that go undiagnosed and therefore untreated. Personality disorders are associated with high levels of dysfunction (Nakao, Gunderman, Philips *et al.*, 1992).

The American Psychiatric Association (APA, 2000) defines personality disorder as an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture. This pattern is manifested in the areas of cognition that is, ways of perceiving and interpreting self, other people and events; affectivity that is, the range, intensity, ability, and appropriateness of emotional response; interpersonal functioning; and impulse control. The enduring pattern of inner experience and behavior, that is, the symptoms usually lead to significant distress or impairment in social, occupational or other important areas of functioning.

The psychosocial functioning of people with personality disorders can vary widely. Their history of interpersonal relationships, educational and work history, psychiatric and substance abuse history indicate marked impairments; significant areas of the patient's life, such as intimate relationships or occupational functioning are adversely affected (Ward, 2004). People with antisocial personality disorder, for instance, are

vulnerable to mood problems such as major depression and anxiety, self-mutilation and other forms of self-harm, as well as dying from homicide, suicide, or accident.

According to the Diagnostic and Statistical Manual of Mental Disorders, 4th ed. (DSM-IV, 2000), personality disorders are psychiatric disorders characterized by chronic patterns of inner experience and behaviour that are inflexible and present across, a broad range of situations. They have a marked impact on patients' interpersonal relationships, and social and occupational functioning, and can even lead to problematic interactions in the medical setting. Social function is affected by many other aspects of mental functioning apart from that of personality. However, whenever there is persistently impaired social functioning in conditions in which it would normally not be expected, the evidence suggests that this is more likely to be created by personality abnormality than by other clinical variables (WHO, 1992; Nur, *et al*., 2004).

The primary goal of universities is to prepare students for successful careers in the outside world (Boulton and Lucas, 2008). Universities are expected to take care of the students' various types of problems, be they physical, emotional, social or family (Luderman et al., 2000). If students develop emotional problems, they should be attended to immediately. When for instance, they experience a disaster like the Al-Shabaab attack on Garissa University that happened in 2015, it is likely that many will be left emotionally devastated. When Garissa University was attacked, students were in shock. There was merciless shooting and killing of about 148 people and dozens injured (Momanyi, 2015; Onyango *et al*., 2015). Survivors had to run for their life, hide or were hurt in the process. Some walked through the blood of those who had been killed. Such

scenes are not easily forgotten and can linger in one's mind for a long time.(Solomon and Green, 1992). During such a time after a disaster, individuals are mourning, but as Math *et al*, (2015) observe, if grieving goes on for too long, survivors may require trauma/grief-focused interventions. If the students develop personality disorders, no matter how severe they are, psychotherapy especially cognitive behavior therapy or psychodynamic counselling can be used (Gabbard, 2000).

At the end of their studies, the students are expected to emerge equipped both physically and mentally to play their role of contributing to national development. While universities expend vast resources to ensure the intellectual aspects of the students are catered for, their mental and emotional health does not receive as much attention. The emotional health is impaired by the personality disorders. Yet it is now emerging that emotional intelligence is just as important as a person's intelligence quotient. According to Schutz and Nizieski (2012), emotional intelligence includes the ability to (i) percecive emotions, (ii) use emotions to facilitate thoughts, (iii) understand emotional information and (iv) regulate emotions. The authors further assert that patients with mental disorders have lower overall emotional intelligence and that patients with depression have problems experiencing positive feelings and pleasure. Hence they have low emotional scores. Studies also show that depressed patients tend to be less skilled and attend more to negative emotions (Schutz and Nizieski, 1997).

The prevalence of personality disorders worldwide is generally below 20% of the population, and less than 5% for specific disorders. According to Davison (2002), the management of individuals with personality disorder is one of the most challenging

areas of psychiatry, and that patients with personality disorders have multiple and diverse needs. In Africa, where resources are scarce, medical aid is minimal and poverty abounds, management of persons with personality disorders during disasters may be more challenging. Humanitarian assistance, though provided, is usually limited due to lack of preparedness and awareness.

One reason that personality disorders may not be diagnosed is the misconception that they are not mental disorders. The World Health Organization defines a mental disorder as the existence of a recognizable set of symptoms and behaviours, in most cases associated with distress and interference with social function" (WHO, 1992). Fortunately, although there are a number of difficulties in managing patients with personality disorder, their problems are easier to tackle if the patients are properly assessed, their individual needs identified and an appropriate plan formulated (Davison, 2002).

Ager and Loughry (2004) noted that civil conflict, natural disasters, pandemic disease and famine continue to place the work of humanitarian assistance high in public consciousness. Humanitarian agencies have contributed from many disciplines such as agriculture, engineering, social anthropology and medicine. Unfortunately, there has been little contribution from psychology. However, Ager and Loughry recommended cognitive behavior therapy for PTSD, complicated grief for adults and trauma and depression for youth.

For people affected by poverty or disaster, health is essential to a better future. With good health, they can attend school, be productive at work, care for their families and contribute to strong communities. Health is, therefore, fundamental to all aspects of development. Hence the formulation of the Sustainable Development Goals (SDGs) to improve the lives of the people of the UN member states was timely (Derek *et al*., 2015). The SDGs are a new set of universal goals and expand on the millennium development goals (MDGs), which expired in 2015. The SDGs are a new agenda for sustainable development adopted by world leaders from 193 countries. The new agenda outlines 17 Sustainable Development Goals (SDGs) to end poverty, promote well-being and protect the planet. More importantly, SDG 3 focuses on health: "Ensure healthy lives and promote well-being for all at all ages." SDG 3 calls for dramatic and inspiring achievements, including ending the epidemics of AIDS, tuberculosis, and malaria and achieving universal health coverage. The SDGs will eventually be part of the global Health 2035 vision. More relevant to this study are targets 3.4 and 3.5. Target 3.4: By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being. Target 3.5: Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. These two health targets for SDG 3 are linked to mental health of undergraduate students that this study is concerned with.

In Kenya, the health sector forms a key component of the social pillar of Vision 2030, the other pillars being: Economic, Political and Foundations pillar. The goal of the social pillar is to develop a population that is healthy and productive and able to fully participate in and contribute to other sectors of the economy. The World Health

Organization (WHO) constitution defines health by emphasizing the mental, social and spiritual dimensions of health. The World Health Organization observes that a healthy individual is a man who is well-balanced bodily and mentally, and well adjusted to his physical and social environment (Yach, 1998). The WHO constitution states: "Health is a state of complete, physical, mental and social well-being and not merely the absence of disease or infirmity."

Houston and First (2017) observed that immediately after a natural disaster, it is normal for people to experience fear, anxiety, sadness or shock. However, if these symptoms continue for weeks or months after the event, they may result into psychological problems. The disaster mental health problem studied most by psychologists and psychiatrists is post-traumatic stress disorder. This can occur after frightening events that threaten one's own life and the lives for family and friends. Following a disaster, people might lose jobs or be displaced from their home. This can lead to depression. Substance abuse can increase following disasters (Houston & First, 2017). In a study of Hurricane Katrina, survivors who had been displaced to Houston, Texas, approximately one third reported increasing tobacco, alcohol and marijuana use after the storm.

In addition, domestic violence increases after disasters. For instance a study indicates that after Hurricane Katrina among women in Mississippi who were displaced from their homes, domestic violence rates increased dramatically (Houston & First, 2017). Houston and First assert that perpetrators may feel a loss of control following the disaster and turn to abusive behavior to try to gain that control back in their personal relationships.

The September 11th, 2001 attack on America by al-Qaida terrorist network had the most extensive impact not only on physical facilities, but more on human beings. Two American Airlines Boeing 767 crashed into the New York City World Trade Centre causing a devastating inferno which resulted in the collapse of the structure and killing close to 3000 people. The emotional effects caused by the September 11 attack were tremendous. They included: 1,300 orphans created; 20% of people living within one mile radius from the twin Towers suffering from Post-Traumatic Stress Disorder; 200% increase in PTSD among Manhattanites post 9/11; about 10,000 of the city's public school students suffering from PTSD as a result of 9/11 (Melnik *et al,* 2002).

Although many disaster survivors show resilience, studies have shown mental and behavioural health issues cropping up weeks, months and even years after a disaster. Rebuilding can be a long process. In the case of the 9/11 attack, the nation felt vulnerable immediately after the attack. However, as time went on, the people developed resilience. Nevertheless psychological effects still hang on especially for residents in the immediate environment ((Melnik *et al*., 2002).

Disaster survivors can be helped after disasters by connecting them to their friends and by use of mental health interventions such as psychological first aid through community systems (Houston & First, 2017).

During disasters counseling is provided to victims and survivors in the emergency and during recovery and rehabilitation. Counselling is a critical therapeutic intervention in the management of personality disorders which develop. Knowledge of the core

characteristics of these disorders allows physicians to recognize, diagnose, and treat affected patients (Ward, 2004). It is a common misconception to think that only seriously ill or "crazy" people need counseling help. Studies show that over eighty percent of people can benefit from counseling at some time in their lives. So, it is normal to need counseling when special concerns or difficult feelings arise. Most people have a problem with anxiety, depression, stress, relationships, *et cetera* at some point in their life. Counseling provides a special setting in which individuals learn about themselves, thereby enabling them to be more effective in their relationships with others and with themselves. There are different types of therapies available to address the disorders, based on the preference of the counsellor and the situation. These are Behavior therapy, Cognitive therapy, Dialectical behavior therapy (DBT), Interpersonal therapy, Psychodynamic therapy, and Family therapy.

Short-term or brief approaches emphasize a narrow focus on a specific problem or issue. Treatment is limited from ten sessions to six months. Behavior therapy focuses more on specific behaviors (than underlying causes) and emphasizes concrete techniques to change those behaviors. Cognitive therapy uses techniques designed to alter the way a person thinks about themselves and their situation in order to make their thinking more adaptive. Psychoanalytic/Psychodynamic therapy uses the ('transference') relationship between the therapist and client as the focus of treatment (Margolies, 2013).

Underlying emotional issues which are left over from childhood relationships with parents are reworked in the relationship with the therapist. More than one meeting per

week is often needed. Gestalt therapy focuses on the client's 'here and now' experience (rather than on the past) and uses a variety of techniques to promote awareness of and contact with aspects of experience and of the self which have been suppressed. Humanistic approaches emphasize the real relationship between the therapist and client, while couples/marital therapy focuses on problems in a marriage or other love relationship by improving partners' understanding of each other's needs, facilitating communication and exploring unstated assumptions about the relationship (Brown, Comtois & Linehan, 2002).

Owing to its impact on personality disorders, Cognitive Therapy has been used a lot in counselling. Freeman (1983) defines it as a relatively short-term form of psychotherapy which is active, directive, and in which the therapist and patient work collaboratively. Freeman argues that the goal of therapy is to help patients uncover their irrational and dysfunctional thinking, reality-test their thinking and behavior, and build more adaptive and functional techniques for responding both inter and intra personally. According to Freeman (1983), the goal of cognitive therapy is not to 'cure', but rather to help the patient develop better coping strategies to deal with his or her life and work. By helping the patient uncover his or her irrational or dysfunctional belief systems, the cognitive therapist sets the model for patients to continue this process on their own. Mental health services all have considerable experience of dealing with patients with personality disorders. Many patients receiving psychiatric services suffer from a personality disorder, although relatively few are explicitly being treated for it (Davison, 2002). Having a personality disorder during adolescence doubles the risk of having anxiety,

mood disorders, self-harming behaviour and substance use disorders during early adulthood (Johnson *et al.,* 1999).

Therapy management for personality disorders in the developed world is far more advanced than in the developing world. Looking at the status of the Kenya mental health sector, a recent report by KNCHR (2011) reveals that in Kenya in general, the mental health infrastructure is not as developed as it should be. The report highlights among other things, that there is entrenched stigma and discrimination against persons with mental disorders and low level of awareness on mental health. It also points out that the mental health sector has been severely neglected. For instance, persons with mental disorders have been neglected and abandoned in facilities. Worse still, mental health facilities, services and goods are unavailable or inaccessible to majority of the Kenyan population. This implies that even within Kenyan universities, there are no facilities for persons with mental disorders.

In universities, mental health problems and even strikes are not only felt, but also spill out in form of riots, demos by students who may have personality disorders. This information contributes to the current study by pointing out the weakness in the referral and supportive administrative structures that are supposed to undergird the provision of counselling therapy and mental health services in Kenyan universities. It also gives an indication that students affected by mental disorders such as personality disorders will likely shy away from seeking out the services due to the prevailing stigma associated with mental ill health in Kenya. This in itself arises from the above-mentioned ignorance in the community.

1.2 Statement of the Problem

Undergraduate students in Kenyan universities by and large struggle with conflict. This conflict can be intrapersonal or interpersonal and comes from personality disorders. Personality disorders result in disrupted lives and relationships (Schacter *et al*, 2010). Studies about university students worldwide indicate that many students suffer from depression, anxiety and many other emotional problems. According to Lezenweger *et al.* (2007), all personality disorders are associated with anxiety, mood, and impulse control and substance disorders.

People with Avoidant Personality Disorder (AvPD) for instance, tend to be hypersensitive to social rejection or criticism. They also subject themselves to self-imposed social isolation, and have problems in occupational functioning (Millon & Davis, 1996). Those with Paranoid Personality Disorder (PPD) are burdened with an irrational suspicion and mistrust of others, interpreting motivations as malevolent (Waldinger, 1997), while the ones with Anti-Social Personality Disorder (ASPD) harbour a pervasive pattern of disregard for and violation of the rights of others, lack of empathy, bloated self-image, manipulative and impulsive behavior (Kreisman & Strauss, 2004). A Borderline Personality Disorder (BPD) leads to suicide, a phenomenon frequently witnessed among undergraduate students in Kenyan public universities. Studies show that the lifetime risk of suicide among people with BPD is between 3% and 10% (Gunderson & Links, 2008). A Histrionic Personality Disorder, in which the person is plagued with a pattern of attention-seeking behavior and excessive emotions, can also seriously hamper the undergraduate's interpersonal relationships, especially with lecturers and the academic fraternity. The same applies to persons with

Narcissistic Personality Disorder whose craving for grandiosity and admiration, combined with a lack of empathy can result in harm to others through their insensitivity (Ronningstam, 2011).

The final outcome of most personality disorders is a high vulnerability to suicide and impulsivity (Brady *et al.,* 2010). This necessitates the provision of quality and appropriate counselling and other mental health services by the department of students' welfare managed by the Dean of Students. University counsellors find the presenting problems in undergraduate students normally include difficulty in decision making, broken relationships, family problems, financial challenges and academic problems. Nyaga et al. (2014) assert that although counseling services are usually provided in various Kenyan universities, there still seems to be noticeable students' antisocial behaviour in public universities, This implies that the services may not be correctly addressing the students' mental health issues.

The magnitude of the problem of personality disorders among university students in Kenyan universities has not been researched on so far. It was, therefore, not known how personality disorders could negatively impact one's life, and yet personality disorders can result in disrupted lives and relationships of students. No literature was found on the prevalence and influence of PDs in Kenyan universities, Society does acknowledge that some students display weird or abnormal behavior, but it was only suspected that the rampant conflict caused by undergraduate students on campus could be behind personality disorders.

A variety of therapy options and their associated techniques are necessary to adequately address the personality disorders, but the universities and counsellors may not have adequately skilled staff and facilities to help the students. Experts recommend that the counsellor to counsellee ratio in institutions like universities be not more than 1 to 1500. In most cases, however, one counsellor serves a student population of over 10,000 and is, therefore, over worked. As a result, the impact of their services is not felt. In fact, despite the presence of counsellors in Kenya's universities, alcoholism, violence and other crimes still happen, one of the major reasons being that counselling services have not been fully appreciated and used in Kenya (Nyaga, 2014).

Sometimes the problem is one of lack of awareness of the availability of counselling services on the part of students, or the misconception that counselling is only for those with severe emotional and mental problems. Many have come from the secondary schools where guidance and counselling were more of a disciplinary measure rather than a positive, mental health option one could seek out. The experiences of high school 'counselling' creates a negative bias in the mind of the undergraduate, thereby acting as a barrier for the university counsellor (Nyaga, 2014).

Above all, the degree to which the university counselling services were able to address these problems of the students was not evident in literature. The problem is that although counselling as a means of psychological and mental therapy is used in all universities in Kenya, problems still exist. Suicide attempts, rape and violence are on the increase. It is usually assumed that when university students are aggrieved, they can seek redress in an amicable way. Nevertheless they use force and aggression which

usually ends in them being tear-gassed by police in retaliation. Examples of violence can be recalled when students go on rampage when their colleague is hurt or killed erroneously. The study, therefore, set out to evaluate the effectiveness of counselling therapy management of personality disorders among undergraduate students in Kenyan universities.

1.3 Research Objectives

The general objective of the study was to evaluate the effectiveness counselling therapy management of personality disorders among undergraduate students in Kenyan universities.

The specific objectives of the study were to:

i. Examine the nature and extent of personality disorders among undergraduate students in Kenyan universities

ii. Examine management of counselling therapies and facilities available to undergraduate students in the Kenyan universities

iii. Evaluate effectiveness of the counselling services provided in addressing Personality Disorders among the undergraduate students

1.4 Research Questions

The research seeks to answer the following questions:

i. What is the nature and extent of personality disorders among undergraduate students in Kenyan universities?

ii. How are counselling therapies and facilities are available to undergraduate students in the universities managed?

iii. How effective are the counselling services in addressing Personality Disorders among the undergraduate students?

1.5 Justification of the Study

There is need to study more about personality disorders and their impact on the development of personality of individuals, particularly undergraduate students. These are future leaders.

Without such a study, therefore, senseless suicides, depression and poor interpersonal relationships may persist among the undergraduate students struggling with personality disorders that are unaddressed by the system. The study should make a significant contribution in providing information to counsellors in the university setting on ways to improve their services. It will provide the Commission for University Education (CUE), another platform on which to monitor the quality of counselling services being offered in Kenyan universities. It is useful for the university administrators to assess their own contribution to the counselling programme, and its influence on the behavior of the students. It was important to identify the gaps existing in making the counseling and therapy services effective. By providing information on how the mental health services in the university can be enhanced, the study may contribute to much-needed policy reforms in the mental health sector of Kenya (NCHCR, 2011). NCHCR recognizes that mental ill health impedes the achievement of other health and development outcomes and exacerbates poverty, thereby impeding the achievement of Vision 2030, Kenya's

development blueprint. Information on disasters and personality disorders should help counsellors provide adequate counseling to students during disasters. Equipped with the same information, students should also know how to seek help in case of a disaster like the one that happened in Garissa University.

The study also sought to serve academic purposes, to identify gaps in information and literature for future studies. In addition, the process of research may help to raise student awareness on the issues surrounding personality disorders and the interventions available for them from university counsellors.

1.6 Scope of the Study

The study was carried out in Kenyan universities. Four universities were randomly picked for the study. These are situated in Western region (Masinde Muliro University of Science and Technology), the Nyanza region (Maseno University and the Great Lakes University of Kisumu), and in the Capital City in Nairobi (United States International University-Africa).

The focus was on undergraduate students from first through fourth academic year of study. The study included Deans of Students, Medical Officers and Counsellors who served as key informants. The key informants provided in-depth information on students regarding personality disorders and counselling services available. The study also limited itself to the evaluation of the counselling therapy services offered to the undergraduate students which was assessed against the variables intended for the study, one of them being the expressed satisfaction of the students in the study.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter presents the literature that informed the study. The literature provides a better understanding of the underlying theoretical principles that guided the disciplined enquiry into relationships existing among the identified variables of interest to this study.

The literature is reviewed around the objectives of the study with the following themes: Psychodynamic theories of personality development, humanistic theories of personality development, trait theories of personality development, social cognitive theories of personality development, the concept of Emotional Intelligence, the nature of personality disorders, therapy management options and their effects on personality disorders, mental health and disasters and methodological approaches that informed the study. At the end of the chapter, a conceptual model is constructed, illustrating the relationship between the variables. The chapter summary is given. Sources of literature included journals, theses, books and the internet.

2.2 Theories of Personality Development

Personality refers to the relatively enduring characteristics that differentiate one person from another and that lead people to act in a consistent and predictable manner, both in different situations and over extended periods of time (Boeree, 2006). There are several theories of personality which can be grouped according to four broad orientations.

These are Psychodynamic (Psychoanalytical) approaches; Humanistic approaches; Trait approaches; and Social Cognitive approaches to personality.

2.2.1 Psychodynamic (Psychoanalytical) Theories of Personality Development

In the Psychodynamic (psychoanalytical) Theories of Personality development, the source of information about the personality is obtained from expert analysis of people in therapy. The cause of behavior is the thoughts, and feelings; the unconscious internal conflict associated with childhood experiences. It is also believed that the unconscious conflicts between pleasure-seeking impulses and social restraints. The Psychoanalytical theorists (Sigmund and Anna Freud, Erik Erikson and Carl Jung tend to believe that the answers to the important questions lie somewhere behind the surface, hidden, in the unconscious. Other psychoanalytic theorists like Alfred Adler, Karen Horney and Erich Fromm, however, later differed with Freud. Karen Horney and Erich Fromm agreed that social and cultural factors were of great significance in shaping personality. Alfred Adler on the other hand, believed in the unity of personality, that people were complete beings with a purposeful nature of behaviour. He also believed that people are actors and creators of their lives and not merely being shaped by childhood experiences. Anna Freud (1895-1982) was faithful to Freud and became his symbolic successor (Boeree, 1998). Unlike her father, she was interested in the dynamics of the psyche rather than the structure (Boeree, 1988) and later developed what is now known as the ego psychology in which the ego is considered to be the 'seat' of behavior.

Freud's theory (1856-1939) suggests that personality is composed of the id, the ego, and the superego (McLeod, 2007). The id is the unorganized, inborn part of personality

whose purpose is to immediately reduce tensions relating to hunger, sex, aggression, and other primitive impulses. The Id is constantly striving to satisfy basic drives (Pleasure Principle). The ego, on the other hand, restrains instinctual energy in order to maintain the safety of the individual and to help the person to be a member of society; seeks to gratify the Id in realistic ways (Reality Principle). The superego is the rights and wrongs of society and consists of the conscience and the ego-ideal. It is the voice of conscience that focuses on how we ought to behave.

According to Freud (1856-1939), an individual's feelings, thoughts, and behaviors are the result of the interaction of the id, the superego, and the ego. The id, the ego, and the superego are continually in conflict with one another. This conflict generates anxiety. According to Freud, if the ego did not effectively handle the resulting anxiety, people would be so overwhelmed with anxiety that they would not be able to carry on with the tasks of everyday living. The ego tries to control anxiety that is, to reduce anxiety through the use of ego defense mechanisms. However, these defense mechanisms reduce or redirect the anxiety by distorting reality. A defense mechanism is a psychological tendency that the ego uses to help prevent people from becoming overwhelmed by any conflict (and resulting anxiety) among the id, the ego, and the superego. Defense mechanisms operate at an unconscious level; a person is not aware of them during the time that they are actually using them. The defense mechanisms include: repression, regression, reaction formation, rationalization, denial, displacement, projection and sublimation.

Difference in opinion between Freud and his followers somehow weakens his theory. Although there has been proof that individuals are affected by negative childhood experiences, it is not right for people to live in negativity always. Hence Maslow (1987) advocated for enjoyment of life through fulfillment of basic and higher needs. Alfred Adler and Carl Jung believed in human beings being goal oriented and with purposeful behavior. Carl Jung believed in there being a conflict between the personal and collective unconscious, as well as an ongoing balance between introversion and extroversion. Adler (1870-1937), on his part, theorized about a person's constant striving for superiority, driven by a motivation to master their environment. Adler advanced the notion of an inferiority complex. Karen Horney theorized that personality is cultural rather than biological.

In the view of this study, a personality disorder could manifest in a person who likely developed a defense mechanism at some stage in their life in order to counter the anxiety arising from a conflict between the id, ego and super ego. It would also likely explain how counselling therapy can remedy this situation by helping the person develop a healthy self-concept that is anxiety-free. Hence this literature contributes to the study by enriching the discussion on personality disorders. Freud's psychoanalytic theory of personality suggests that personality develops through a series of stages, each of which is associated with a major biological function. At each level, there is a conflict between pleasure and reality. The resolution of this conflict determines personality. At any stage, "a fixation" can occur: If needs are either under-gratified or over-gratified, we become fixated at a particular stage.

The psychoanalytic theory, though it shows one has conflicts within, it does not consider interpersonal conflicts, nor does it say how the conflicts can be resolved. This study, therefore, brings to light how intrapersonal conflicts can turn into interpersonal conflicts and how they can be resolved through the counselling therapy. This theory has contributed significantly to the knowledge on personality development through contributions from the various psychoanalysts at different points in history.

2.2.2 Humanistic Theories of Personality Development

In Humanistic Personality Theories, the source of information about personality is obtained from self-reports from the general population and people in therapy. In this approach, the cause of behavior, thoughts, and feelings are rooted in self-concepts, and self-actualizing tendencies. The main advocates of this approach are Abraham Maslow, Carl Rogers, George Kelly, Ludwig Binswanger and Viktor Frankl. In the opinion of this study, if the cause of behavior in the students is rooted in the self-concept, then counselling therapy that works to develop a healthy self-concept goes a long way in addressing personality disorders.

Maslow (1968, 1970) developed the hierarchy of human needs where he theorized that people in life are motivated to work towards meeting their needs, and that one must satisfy lower needs before one satisfies higher needs. Maslow describes the characteristics of the self-actualized person as being creative and open to new experiences; committed to a cause or a higher goal; trusting and caring for others, yet not dependent; and having the courage to act on their convictions. This would imply that people exhibiting such characteristics may be those with well-formed personalities

and therefore free from a personality disorder. However, it is not possible that one is completely free from personality disorders.

Rogers (1986) theorized about the self-concept which is the way a person views themselves. He stated that each person has a Real Self that may be at odds with the Ideal Self; people have a need for positive regard or approval from others. Usually there are conditions under which other people will approve of a person, and consequently the individual will try and change their behavior to obtain approval. The person's need for Unconditional positive regard sometimes generates conflict and anxiety within the individual because they are not being true to their ideal self. Carl Rogers theorized that well-adjusted persons have congruence between self-concept and their experience, whereas poorly adjusted persons suffer a variance between the two.

In their proposals, Freud laid emphasis on biological factors as responsible for personality development while Carl Jung, Alfred Adler, K. Horney and E. Fromm were of the idea of different environmental aspects to be responsible for personality development. The Nature-Nurture controversy states that for a personality to develop, nature works closely with environment. The place in which one is brought up, the people around that person, his/her inborn traits as well as characteristics inherited from their ancestors all contribute.

2.2.3 Trait Theories of Personality Development

Trait approaches have tried to identify the most basic and relatively enduring dimensions along which people differ from one another--dimensions known as traits. In

the Trait Personality theories the source of information about personality is obtained from observation of behavior and questionnaire responses from the general population as well as from people in therapy. In this approach, the cause of behavior, thoughts, and feelings is attributed to stable internal characteristics. Some of the theorists emphasize a genetic basis. Major contributors to these theories include Eysenck (1916-1997).

Eysenck & Eysenck (1985) came up with the two major trait dimensions of introversion versus extroversion (quiet versus sociable), and Neuroticism versus emotional stability (moody versus calm). Under the unstable categorization, he described the person as exhibiting traits of being moody, sober, anxious, rigid, pessimistic, reserved, unsociable and quiet (melancholic). Also under the category of unstable are the traits of one being touchy, restless, aggressive, excitable, changeable, impulsive, optimistic and active (choleric).

Similarly, Cattell's Trait Theory distinguished 3 types of traits: Dynamic, Ability, and Temperament. The latest development in these theories is the 5 factor theory. Here, personality theorists have converged on the view that there are 5 basic personality dimensions. The first is emotional stability versus neuroticism, where stability is marked by a calm, secure, self-satisfied disposition, while neuroticism is demonstrated by more anxious, insecure and self-pitying behavior on the part of the individual. The second factor is extraversion (sociable, fun-loving, affectionate) versus introversion (retiring, sober, reserved); the third is openness (imaginative, independent) versus close-mindedness (practical, conforming); while the fourth factor is agreeableness (kind, trusting, helpful) versus disagreeableness (ruthless, suspicious, uncooperative). The fifth

factor is conscientiousness (organized, careful, and disciplined) versus undependable (disorganized, careless, impulsive).

While it is true that people differ from one to another in definite ways, it is also true that that people cannot strictly fit into categories mentioned by Eysenck and Cattell. For instance someone may be of emotional stability (Cattell's Trait Theory), but he/she may sometimes be not so calm or self satisfied owing to prevailing circumstances.

2.2.4 Social Cognitive Theories of Personality Development

In this approach, the source of information about personality is obtained from experiments, observations of behavior, and questionnaire responses from the general population. These theories attribute the causes of behavior, thoughts, and feelings to reciprocal influence between people (cognitions and behavior) and their environmental situations, colored by their perceptions of control. In this approach, it is believed that behavior is learned through conditioning and observation, and that what people think about their situation ultimately affects their behavior.

Bandura advanced the Theory of Social learning whose origins are in behaviorism. This theory emphasizes the role of learning in personality. (Classical Conditioning, Operant Conditioning. Modeling). Bandura asserted that instead of studying what's going on inside the person (traits), it was important to study what is going on outside the person (environment). In other words, to assess how the environment shapes personality. Bandura also emphasized the importance of cognition in personality development. He believed that people develop a sense of self-efficacy, which are their beliefs about their

ability to achieve goals. Individuals with higher self-efficacy accept greater challenges and try harder to meet challenges. Bandura also discussed the notion of Reciprocal Determinism which is how the individual and the environment continually influence one another. Bandura emphasized the environment and cognition in the development of personality. As mentioned earlier, both the environment and nature, including that cognition, contribute towards the formation of personality.

Despite the shortcomings, Bandura's (1986) Theory is a major contributor to the current study. If behavior can be influenced by perception and attitude, then counselling therapy, which helps the person rectify distorted views of life situations can lead to an alteration of the behavior that comes from personality disorders. In the university setting, with continued exposure to therapy in a relatively controlled environment, the student with a personality disorder could actually end up being cured of the same by the time they finish their course. At the very least, it would mean that relationships and career are not sabotaged by dysfunctional behaviour arising from the personality disorder.

2.2.5 The Concept of Emotional Intelligence (EQ)

Although strictly not a theory explaining how personality develops, it is worthwhile discussing an upcoming phenomenon that suggests that despite personality flaws one may possess, there is a way of working around them to prevent them sabotaging one's life and relationships. The psychologists Salovey and Mayer first used the term emotional intelligence in 1990. They defined it as 'a form of social intelligence that involves the ability to monitor one's own and others' feelings and emotions, to

discriminate among them, and to use this information to guide one's thinking and action. Salovey and Mayer went on to develop more research in an effort to measure emotional intelligence and its significance.

The scholars believed that there are a small number of specific skills all of which have to do either with accuracy or effectiveness. They summarized this as accuracy at perceiving and understanding emotional state in the self and in others, and the effectiveness of regulating, controlling and using these emotions in order to achieve one's goals. Hence they proposed that the four fundamental aspects of emotional intelligence are first recognizing emotions, understanding them which are then followed by regulating and using them. Though a new concept, EQ is an important element in regulating, controlling and using emotions, particularly in personality development.

2.3 The Nature and Prevalence of Personality Disorders

Numerous large-scale surveys of the of mental disorders in adults in the general population have been carried out since the 1980s based on self-reported symptoms assessed by standardized structured interviews, usually carried out over the phone. Mental disorders have been found to be common, with over a third of people in most countries reporting sufficient criteria to be diagnosed at some point in their life (WHO, 2000). They reported in 2001 that about 450 million people worldwide suffer from some form of mental disorder or brain condition, and that one in four people meet criteria at some point in their life (Sherer, 2002).

The disorders are classified into three categories; Coid, *et al*., (2006) provide details of characteristics of people with personality disorders based on diagnosis groupings for the Diagnostic and Statistical Manual of Mental Disorders (DSMD, IV) Clusters A, B and C. Cluster A consists of paranoid, schizoid and schizotypal personality disorders; Cluster B is made up of borderline, narcissistic, histrionic and antisocial; and Cluster C consists of avoidant, dependant and obsessive-compulsive personality disorders. It also appears that some disorders typically afflict one gender more than the other. Research shows that men are more susceptible to obsessive-compulsive, narcissistic and Schizotypal personality disorders. Females, on the other hand are more susceptible to borderline personality disorder.

According to Ward (2004), personality disorders are heterogeneous in their clinical features and etiology. Their symptom complexes are caused by combinations of hereditary temperamental traits, and environmental and developmental events. From the Diagnostic and Statistical Manual of Mental Disorders, 4th ed., Ward (2004) derived and summarized these disorders in Table 2.1.

Table 2.1 Summary Descriptions of Personality Disorders

Cluster A—Odd or eccentric	Cluster B—dramatic, emotional, or erratic	Cluster C—anxious or fearful
Paranoid	Antisocial	Avoidant
Pervasive pattern of mistrust and suspiciousness Begins in early adulthood	Disregard for rights of others Violation of rights of others Lack of remorse for wrongdoing	Social inhibition Feelings of inadequacy Hypersensitivity to criticism
Presents in a variety of contexts	Lack of empathy	
Schizoid	Borderline	Dependent
Detachment from social relationships Restricted range of emotional expressions	Instability of interpersonal relationships, self-image, and affects Marked impulsivity	Excessive need to be taken care of Submissive behavior Fear of separation
Schizotypal	Histrionic	
Social and interpersonal deficits	Excessive emotionality Attention-seeking behavior	Obsessive-compulsive
Cognitive or perceptual distortions and eccentricities	Narcissistic	Preoccupation with orderliness and perfectionism
	Grandiosity Need for admiration	Mental and interpersonal control

Source: American Psychiatric Association. Dysfunctional personality traits. In: Diagnostic and statistical manual of mental disorders, 4th ed., primary care version. Washington, D.C.: American Psychiatric Association, 1995:169–74.

Lenzenweger et *al.* (2007) indicate that all three personality disorder clusters are associated with anxiety, mood, impulse control and substance disorders, with highest odds ratios found with Cluster B personality disorders. Within this cluster of disorders, the young, unemployed and poorly educated provide highest rates of diagnoses. This literature is significant as it highlights a demographic set in which the undergraduate

students mostly belong to. Consequently, it is within this group that the disorders will most likely be found.

2.3.1 Paranoid Personality Disorder

Paranoid personality disorder (PPD) is a mental disorder characterized by paranoia and a pervasive, long-standing suspiciousness and generalized mistrust of others. The irrational suspicion and mistrust of others causes them to misinterpret their motivations as malevolent. Individuals with this personality disorder may be hypersensitive, easily feel slighted, and habitually relate to the world by vigilant scanning of the environment for clues or suggestions that may validate their fears or biases. Paranoid individuals are eager observers. They think they are in danger and look for signs and threats of that danger, potentially not appreciating other evidence (Waldinger, 1997).

An undergraduate student with this condition can find it hard to adjust to campus life, especially in the initial stages. This may translate to strained relations and poor academic performance. People with this particular disorder may have a tenacious sense of personal right (MacManus, 2008). The current study explored the extent to which this applies to undergraduate students in Kenyan universities. According to McManus and Fay (2008), individuals suffering from Paranoid Personality Disorder may be at greater than average risk of experiencing major depressive disorder, agro-phobia, obsessive compulsive disorder, or alcohol and substance-related disorders. The scholars contend that PPD occurs in about 0.5%–2.5% of the general population and occurs more commonly in males. The percentage occurrence of this disorder among Kenyan undergraduates was an information gap the current study sought to fill.

2.3.2 Schizoid Personality Disorder (SPD)

Schizoid personality disorder (SPD) is a personality disorder characterized by a lack of interest in social relationships, a tendency towards a solitary lifestyle, secretiveness, emotional coldness, and apathy. Affected individuals may simultaneously demonstrate a rich, elaborate and exclusively internal fantasy psychology, (Laing, 2004). Most individuals diagnosed with SPD have trouble establishing personal relationships or expressing their feelings in a meaningful way. They may remain passive in the face of unfavorable situations. Their communication with other people may be indifferent and concise at times. Because of their lack of meaningful communication with other people, those who are diagnosed with SPD are not able to develop accurate images of how well they get along with others. Such images are believed to be important for a person's self-awareness and ability to assess the impact of their own actions in social situations.

Laing (2004) suggests that when one is not enriched by injections of interpersonal reality, the self-image becomes increasingly empty and volatilize, which leads the individual to feel unreal (Laing, 2004). When the individual's personal space is violated, they feel suffocated and feel the need to free themselves and be independent. People who have SPD tend to be happiest when they are in a relationship in which the partner places few emotional or intimate relationship demands on them. It is not people as such that they want to avoid, but emotions both negative and positive (Laing, 2004). This means that it is possible for schizoid individuals to form relationships with others based on intellectual, physical, familial, occupational, or recreational activities as long as these modes of relating do not require or force the need for emotional intimacy, which the affected individual will reject. Withdrawal or detachment from the outer world is a

characteristic feature of schizoid pathology (Masterson & Klein, 1995). It is possible that undergraduate students suffering from this condition would not be able to engage at an intimate level, which could then impact negatively on their social relationships. This needs to be known and addressed before the student can leave the university to be productive in the outside world. It can be seen that all people are social beings including people with schizoid disorders. Hence they can be in a relationship but would not wish intimate involvements. This requires genuine understanding of the needs of such people.

2.3.3 Schizotypal Personality Disorder (STPD)

This is a personality disorder is characterized by a need for social isolation, anxiety in social situations, odd behavior and thinking, and often unconventional beliefs. People with this disorder feel extreme discomfort with maintaining close relationships with others, so they avoid forming them. Peculiar speech mannerisms and odd modes of dress are also diagnostic signs of this disorder. In some cases, people with STPD may react oddly in conversations, not respond, or talk to themselves (Matsui, *et al*., 2004). People suffering from STPD frequently misinterpret situations as being strange or having unusual meaning for them; paranormal and superstitious beliefs are not uncommon. Such people frequently seek medical attention for anxiety or depression instead of their personality disorder. According to Adams & Sukter (2001), Schizotypal personality disorder occurs in 3% of the general population and is slightly more common in males.

Schizotypal personality disorder usually co-occurs with major depressive disorder, and generalized social phobia. Furthermore, sometimes schizotypal personality disorder can co-occur with obsessive compulsive disorder (Walker *et al.*, 2004; Kastler & Bollini, 2004). According to these scholars, some persons with schizotypal personality disorders go on to develop schizophrenia.

2.3.4 Antisocial Personality Disorder

Antisocial personality disorder is characterized by a pervasive pattern of disregard for, or violation of, the rights of others. There may be an impoverished moral sense or conscience and a history of crime, legal problems, and impulsive and aggressive behaviour (APA, 2000a). ASPD falls under the dramatic/erratic cluster of personality disorders (Schacter *et al.*, 2010).

The scholars maintain that people with this disorder display a pervasive pattern of disregard for and violation of the rights of others, as indicated by three or more of the following: a failure to conform to social norms, with respect to lawful behaviors as indicated by repeatedly performing acts that are grounds for arrest; deception, as indicated by repeatedly lying, use of aliases, or tricking others for personal profit or pleasure; impulsivity, or failure to plan ahead; irritability and aggression, as indicated by repeated physical fights or assaults; reckless disregard for safety of self or others; consistent irresponsibility, as indicated by repeated failure to sustain consistent work behavior or honor financial obligations ;and lack of remorse, as indicated by being indifferent to or rationalizing having hurt, mistreated, or stolen from another (Schacter

et al., 2010.). Such behaviour occurs in universities where students have ASPD from time to time.

Students with this kind of condition even plan and execute strikes; they assault others, damage university property and loot business people's premises without the slightest feeling of guilt. Universities, instead of finding out root causes of such behviour, merely punish the culprits or expel them. Backgrounds of such students should be established long in advance so that the institution can be assisted in totality.

2.3.5 Borderline Personality Disorder

Borderline personality disorder (BPD), also called emotionally unstable personality disorder, is a condition, the essential feature of which is a pattern of marked impulsivity and instability of affect, interpersonal relationships, and self-image. It is a pervasive pattern of instability in relationships, self-image, identity, behavior and affect, often leading to self-harm and impulsivity. People with BPD are especially sensitive to feelings of rejection, isolation and perceived failure (Stiglmayr *et al.*, 2005). The pattern is present by early adulthood and occurs across a variety of situations and contexts. There is evidence that men diagnosed with BPD are approximately twice as likely to commit suicide as women diagnosed with BPD (Kreisman & Strauss, 2004). There is also evidence that a considerable percentage of men who commit suicide may have undiagnosed BPD (Paris, 2008).

Other symptoms usually include intense anger and irritability. People with BPD often engage in idealization and devaluation of others, alternating between high positive

regard and great disappointment. Self- harm is common. The most distinguishing symptoms of BPD are marked sensitivity to social rejection, and thoughts and fears of possible abandonment (Gunderson, 2011). Before learning other coping mechanisms, their efforts to manage or escape from their intense negative emotions may lead to self harm and suicidal behavior (Brown *et al*., 2002). They are often aware of the intensity of their negative emotional reactions and, since they cannot regulate them, they shut them down entirely. This can be harmful to people with BPD, since negative emotions alert people to the presence of a problematic situation and move them to address it (Zanarini *et al*., 1998). Although the term suggests rapid changes between depression and elation, the mood swings in people with BPD actually occur more frequently between anger and anxiety and between depression and anxiety (Koenigsberg *et al*., 2002).

People with BPD act impulsively because it gives them immediate relief from their emotional pain. However in the long term people with BPD suffer increased pain from the shame and guilt that follow such actions (Hawton *et al.*, 2000). BPD causes considerable disruption in interpersonal relationships. People with BPD can be very sensitive to the way others treat them, feeling intense joy and gratitude at perceived expressions of kindness, and intense sadness or anger at perceived criticism or hurtfulness (Amtz, 2005). This literature highlighting the social problems brought on by BPD provides valuable discussion material for the current study. However, it does not give any indication of the prevalence of this condition among university students, a gap the current study fills.

2.3.6 Histrionic Personality Disorder

Histrionic personality disorder (HPD) is defined by the American Psychiatric Association as a personality disorder characterized by a pattern of excessive attention-seeking emotions, usually beginning in early adulthood, including inappropriately seductive behavior and an excessive need for approval. Histrionic people are lively, dramatic, vivacious, enthusiastic, and flirtatious. HPD affects four times as many women as men (Seligman, 1984). It has a prevalence of 2–3% in the general population and 10–15% in inpatient and outpatient mental health institutions (DSM-IV,2000). HPD lies in the dramatic cluster of personality disorders . People with HPD have a high need for attention, make loud and inappropriate appearances, exaggerate their behaviors and emotions, and crave stimulation. Associated features include egocentrism, self-indulgence, continuous longing for appreciation, and persistent manipulative behavior to achieve their own needs (Bienenfeld, 2006).

People with HPD are usually high-functioning, both socially and professionally. They usually have good social skills, despite tending to use them to manipulate others into making them the center of attention (Arthur, 2006). HPD may also affect a person's social and romantic relationships, as well as their ability to cope with losses or failures. Individuals with HPD often fail to see their own personal situation realistically, instead dramatizing and exaggerating their difficulties. They may go through frequent job changes, as they become easily bored and may prefer withdrawing from frustration. Because they tend to crave novelty and excitement, they may place themselves in risky situations. All of these factors may lead to greater risk of developing clinical depression (Fancher & Rutherford, 2012).

2.3.7 Narcissistic Personality Disorder

Narcissistic Personality Disorder (NPD) is a personality disorder in which a person is excessively preoccupied with personal adequacy, power, prestige and vanity, mentally unable to see the destructive damage they are causing to themselves and to others in the process. It is estimated that this condition affects one percent of the population (Groopman & Cooper, 2006). According to Freeman *et al* (2000), people who are diagnosed with a narcissistic personality disorder are characterized by exaggerated feelings of self-importance. They have a sense of entitlement and demonstrate grandiosity in their beliefs and behavior. They have a strong need for admiration, but lack feelings of empathy.

Symptoms of this disorder include; the person expects to be recognized as superior and special, without superior accomplishments; expects constant attention, admiration and positive reinforcement from others; envies others and believes others envy him/her; is preoccupied with thoughts and fantasies of great success, enormous attractiveness, power, intelligence; lacks the ability to empathize with the feelings or desires of others; and is arrogant in attitudes and behavior. Other symptoms include an inability to keep healthy relationships with others, being easily hurt or rejected, appearing unemotional, and exaggerating special achievements and talents (Freeman *et al*, 2000). The degree to which these traits manifest in undergraduate students of Kenyan universities is not revealed in literature. A gap that was of necessity was filled by the current study in order to facilitate planning for appropriate corrective actions.

2.3.8 Avoidant Personality Disorder

Avoidant personality disorder (AvPD), also known as anxious personality disorder, is a condition recognized as afflicting persons when they display a pervasive pattern of social inhibition, feelings of inadequacy, fear, and avoidance of interpersonal relationships (APA, 2000b). Individuals afflicted with the disorder tend to describe themselves as ill at ease, anxious, lonely, and generally feel unwanted and isolated from others (Millon and Roger, 1996). They avoid social interaction for fear of being ridiculed, humiliated, or disliked. Avoidant personality disorder is usually first noticed in early adulthood. Child neglect and social rejection are both associated with an increased risk for the development of Avoidant Personality Disorder (James, 2009).

People with avoidant personality disorder are preoccupied with their own shortcomings and form relationships with others only if they believe they will not be rejected. Loss and rejection are so painful that these individuals will choose to be alone rather than risk trying to connect with others. This disorder poses a career challenge to an undergraduate that is required to cultivate teambuilding and positive social interaction skills in preparation for the working world (Reichborn-Kjennerud *et al,* 2007). It can particularly derail the person seeking employment after studies, because they may become unduly demoralized after the first few rejections from prospective employers. Hence it is important that the condition be addressed while the youth is still undergoing formative training at the university level.

2.3.9 Dependent Personality Disorder

Dependent personality disorder (DPD), formerly known as asthenic personality disorder is a condition that is characterized by a pervasive psychological dependence on other people. This personality disorder is a long-term condition in which people depend on others to meet their emotional and physical needs, with only a minority achieving normal levels of independence. Individuals with DPD see other people as much more capable to shoulder life's responsibilities, to navigate a complex world, and to deal with the competitions of life (Millon *et al*., 2004). Other people appear powerful, competent, and capable of providing a sense of security and support to individuals with DPD. Dependent individuals avoid situations that require them to accept responsibility for themselves; they look to others to take the lead and provide continuous support (Faith, 2009).

DPD judgment of others is distorted by their inclination to see others as they wish they were, rather than as they are. These individuals are fixated in the past. They maintain youthful impressions; they retain unsophisticated ideas and childlike views of the people toward whom they remain totally submissive. Individuals with DPD view strong caretakers, in particular, in an idealized manner; they believe they will be all right as long as the strong figure upon whom they depend is accessible (Bernstein, 2010).

These individuals will decline to be ambitious and believe that they lack abilities, virtues and attractiveness. The solution to being helpless in a frightening world is to find capable people who will be nurturing and supportive toward those with DPD. Within protective relationships, individuals with DPD will be self-effacing, obsequious,

agreeable, docile, and ingratiating. They will deny their individuality and subordinate their desires to significant others. They internalize the beliefs and values of significant others. They imagine themselves to be one with or a part of something more powerful and they imagine themselves to be supporting others. By seeing themselves as protected by the power of others, they do not have to feel the anxiety attached to their own helplessness and impotence (Millon *et al*., 2004).

The affected person will be more than meek and docile; admiring, loving, and willing to give their all. The person will be loyal, unquestioning, and affectionate toward those upon whom they depend. Dependent individuals play the inferior role to the superior other very well; they communicate to the dominant people in their lives that those people are useful, sympathetic, strong, and competent. With these methods, individuals with DPD are often able to get along with unpredictable or isolated people (Bernstein, 2010).

Individuals with DPD, in spite of the intensity of their need for others, do not necessarily attach strongly to specific individuals. The person will become quickly and indiscriminately attached to others when they have lost a significant relationship (Millon *et al.*, 2004). It is the strength of the dependency needs that is being addressed; attachment figures are basically interchangeable. This personality disorder can work both for and against the undergraduate student. On the one hand, it can help the person cooperate with people in the university fraternity that others would deem impossible to get along with. But on the other hand, the disorder can prevent the student from developing the necessary life skills that includes ability to live and work independently,

confident in one's own abilities. While on campus it can disable a student by making them over rely on colleagues for sustenance, and even academic success. The literature is silent on the prevalence of this condition in undergraduate students in Kenyan public universities. This is a gap the current study sought to fill.

2.3.10 Obsessive-Compulsive Personality Disorder

Obsessive–compulsive personality disorder (OCPD), also called anankastic personality disorder, is a condition characterized by a pervasive pattern of preoccupation with orderliness, perfectionism, mental and interpersonal control and a need for power over one's environment, at the expense of flexibility, openness, and efficiency. It causes major suffering and stress, especially in areas of personal relationships. Persons affected with this disorder may find it hard to relax, always feeling that time is running out for their activities and that more effort is needed to achieve their goals. They may plan their activities down to the minute—a manifestation of the compulsive tendency to keep control over their environment and to dislike unpredictable things as things they can't control (Pinto *et al.*, 2008). This control extends to control over food, leading to eating disorders. Those with eating disorders also show perfectionistic striving in other domains of life than dieting and weight control. Overachievement at school, for example, has been observed among anorexics, largely as a result of their perfectionistic striving and over-industrious behavior (Viallettes, 2001). This condition occurs in about 1% of the general population. It is seen in 3–10% of psychiatric outpatients. The disorder most often occurs in men.

Perception of own and others' actions and beliefs tend to be polarized, that is, "right" or "wrong", with little or no margin between the two) for people with this disorder. As might be expected, such rigidity places strain on interpersonal relationships, with frustration sometimes turning into anger and even violence. This is known as disinhibition (Villemarette-Pittman *et al.,* 2004). People with OCPD often tend to general pessimism and/or underlying form(s) of clinical depression (Pilkonis & Frank, 1998). This can at times become so serious that suicide is a risk (Raja & Azzoni, 2007).

This literature is useful in that the current study endeavors to discuss the implications of students having OCPD, based on the revealed trends. The phenomenon discussed of eating disorders may be especially relevant as female undergraduates are typically young women susceptible to peer pressure to maintain a certain physical image. All the foregoing literature on personality disorders contributes to the current study by providing variables with which to measure and discuss the likely presence of these conditions in the undergraduate students. It also points to an awning information gap that the study fulfills in establishing the extent to which PDs are in the undergraduates in Kenyan universities, and the degree to which the institutions are able to address the associated issues.

In the opinion of the researcher, when Deans of Student and counsellors are equipped with this kind of information, it is easy to identify students with problems and see how they can help them accordingly. If however, staff in Student Affairs department sees students presenting with strange behavior and nothing is done, they will have failed to recognize the mental problems being experienced by students. Hence information on

personality disorders has up to now not been considered as a major concern, yet intrapersonal and interpersonal conflict results from many of these mental disorders as has been indicated.

2.3.11 Prevalence and Social Burden of Personality Disorders

Trull *et al.,* (2010) found alcohol dependence is very strongly related to any personality disorder diagnosis in their study, with approximately half of those with antisocial, histrionic and borderline personality disorders also reporting lifetime alcohol dependence. All the personality disorders were found to be associated with high levels of perceived stress, less social support, suicide attempts, interpersonal difficulties and problems with legal authorities (Trull *et al.*, 2010). Given that undergraduates are given to alcohol abuse, this literature is informative in providing indicators that could likely point to personality disorders; namely chemical dependence. The literature does not, however, provide information on the extent to which this phenomenon is true for undergraduate students in Kenyan universities. The current study sought to fill the gap.

The World Health Organization is currently undertaking a global survey of 26 countries in all regions of the world (Alonso *et al.,* 2013). The first published figures on the 14 country surveys completed to date, indicate that, of those disorders assessed, anxiety disorders are the most common in all but one country (prevalence of about 18.2%) and mood disorders next most common in all but two countries (prevalence about 9.6%), while substance disorders (at 6.4%) and impulse-control disorders (at 6.8%) were consistently less prevalent. The data being disseminated is on worldwide incidence and prevalence estimates of individual disorders, not collectively as the current study aims

to do. Obsessive-compulsive disorder is two to three times as common in Latin America, Africa, and Europe as in Asia and Oceania. Schizophrenia appears to be most common in Japan, Oceania, and Southeastern Europe and least common in Africa. Bipolar disorder and panic disorder have very similar rates around the world (Mateos and Luis, 2013a).

Studies of the prevalence of personality disorders have been few and small-scale, but a broader Norwegian survey found a similar overall prevalence of almost 13.4%, based on meeting personality criteria over a prior five-year period. Rates for specific disorders ranged from 0.8% to 2.8%, with rates differing across countries, and by gender, educational level and other factors (Torgersen *et a*l., 2001). A US survey that incidentally screened for personality disorder found an overall rate of 14.79% (Grant *et a*l., 2004). However, these statistics are widely believed to be underestimated, due to poor diagnosis (especially in countries without affordable access to mental health services) and low reporting rates, in part because of the predominant use of self-report data, rather than semi-structured instruments (Mateos and Luis, 2013b).

These studies on prevalence of PDs have been few and small. Mental health is an important feature of any population. It is, therefore, apparent in the opinion of the researcher, that many governments have not seriously considered to undertake establishing of the realistic prevalence of PDs.

2.3.12 The Social Burden of Personality Disorders

Personality disorders have a significant impact on mental health services and patient management, even when they are not the primary focus of treatment. Patients with comorbid personality disorders have more severe Axis I symptomatology (Casey and Tyrer, 1990). Patients with major depression, panic disorder and obsessive–compulsive disorder who have a comorbid personality disorder show a poorer response to a range of treatments (Reich & Green, 1991). Patients with comorbid psychotic disorders and personality disorders are among the heaviest users of psychiatric services (Kent *et al*, 1995). A community survey found that individuals in the community with evidence of personality disorder make more out-patient mental health visits and have more hospital admissions than those without personality disorder. The more severe the personality disorder pathology the greater the utilization of mental health services (Reich *et al*, 1989). Similarly, Menzies *et al* (1993) found that individuals with personality disorders were frequent users of mental health and criminal justice services in the year prior to treatment in a therapeutic community. It is apparent that personality disorders need more attention as a national health issue in Kenya.

Studies using research diagnostic instruments have found that 20–40% of psychiatric out-patients and about 50% of psychiatric in-patients fulfill criteria for a personality disorder (Reich and Green, 1991; Dowson & Grounds, 1995). However, this is rarely the primary focus of treatment. National Health Service (NHS) hospital in-patient data showed that the primary diagnosis was personality disorder in only 9954 (4%) of 243 039 completed in-patient admissions for treatment of mental disorders (Department of Health, 2000a). Individuals with personality disorders, particularly of the antisocial,

paranoid and borderline types, frequently present within a criminal justice context. They account for a large proportion of assessments of patients detained by police under Section 136 of the Mental Health Act 1983 in inner-city areas (Spence & McPhillips, 1995). A survey of psychiatric morbidity in prisons in England and Wales estimated that 78% of male remand prisoners, 64% of male sentenced prisoners and 50% of female prisoners had a personality disorder (Singleton *et al*, 1998). Within high secure forensic psychiatric services there is much overlap in the clinical needs of those with a primary diagnosis of personality disorder and those admitted for treatment of a mental illness such as schizophrenia (Maden *et al*., 1995). All have similar needs for social skills training, anger management and drug and alcohol treatment. Although there is an overlap in the needs of people with PDs and those with mental illnesses, there is need for proactive action to prevent the former from being treated as psychiatric cases before they reach that state.

2.4 Therapy Management Options and their Effects on Personality Disorders

Kyalo & Chumba (2011) in their study on the Role of Counselling Services and Students' Social and Academic Adjustment in Egerton University in Kenya, maintain that guidance is a process that consists of a group of services offered to individuals to assist them in securing the knowledge and skills needed in making adequate choices, plans and interpretation essential to satisfactory adjustment in diverse areas. The services are therefore designed to result in efficiency which requires the individual to make adjustments in order to be an effective member of the society. Counselling is a process that helps an individual analyze him/herself by relating his capabilities, achievements, interests and mode of adjustment to new decisions made. The scholars

argue that guidance and counselling programmes in higher institutions of learning address the needs of the students so as to enhance their adjustment to the immediate environmental challenges that affect their social growth and academic performance. Kyalo and Chumba (2011) maintain that the fundamental goals in counselling services are essential in increasing the students' feeling of personal adjustment and effective interaction in their immediate environment. They go on to assert that the counselling services offered to the students in counselling centre in the university enable the students develop a positive attitude towards social and academic aspects in their new environment. Unfortunately the cited study fails to provide alternative therapy management options especially such as mental health for the all round development of an individual..

Margolies (2013) states that there are many different approaches to psychotherapy, and that the use of one method or another depends on the psychologist's or therapist's training, style and personality. The scholar goes on to add that some psychologists use one approach with all patients; others are eclectic, and some tailor their approach based on particular patients' needs, symptoms and personality. Although the approaches are often seen as distinct, in the implementation and even theoretically there is often overlap. Rigidly adhering to one way of thinking or therapy approach often limits results and misses the whole picture, and may result in an approach that feels foreign or false to the patient.

2.4.1 Behavior Therapy (BT)

Behavior Therapy (BT) is focused on helping an individual understand how changing their behavior can lead to changes in how they are feeling. The theory posits that human beings are not merely passive but self-reactors with a capacity to direct and regulate themselves and act as principal agents of desired change in behaviour (Bandura, 1969). The goal of behavior therapy is usually focused on increasing the person's engagement in positive or socially reinforcing activities. Behavior therapy is a structured approach that carefully measures what the person is doing and then seeks to increase chances for positive experience. It includes techniques of Self-Monitoring, Schedule of Weekly Activities, Role Playing and Behavior Modification.

2.4.2 Cognitive Therapy (CT)

This therapy is based on the theory that much of how we feel is determined by what we think. Disorders, such as depression, are believed to be the result of faulty thoughts and beliefs. By correcting these inaccurate beliefs, the person's perception of events and emotional state improve. Research on depression has shown that people with depression often have inaccurate beliefs about themselves, their situation and the world. Common cognitive errors and real life examples include Personalization(relating negative events to oneself when there is no basis), Dichotomous Thinking(seeing things as black and white, all or none), Selective Abstraction (focusing only on certain aspects of a situation, usually the most negative, and Magnification-Minimization (distorting the importance of particular events). Cognitive therapists work with the person to challenge thinking errors like those mentioned above. By pointing out alternative ways of viewing a situation, the person's view of life, and ultimately their mood will improve. Research

has shown that cognitive therapy can be as effective as medication in the long-term treatment of depression.

2.4.3 Dialectical Behavior Therapy (DBT)

DBT treatment is a cognitive-behavioral approach that emphasizes the psychosocial aspects of treatment. The theory behind the approach is that some people are prone to react in a more intense and out-of-the-ordinary manner toward certain emotional situations, primarily those found in romantic, family and friend relationships. DBT theory suggests that some people's arousal levels in such situations can increase far more quickly than the average person's, attain a higher level of emotional stimulation, and take a significant amount of time to return to baseline arousal levels.Generally, dialectical behaviour therapy (DBT) may be seen as having two main components, namely individual sessions and group sessions.

The first component is individual weekly psychotherapy sessions that emphasize problem-solving behaviour for the past week's issues and troubles that arose in the person's life. Self-injurious and suicidal behaviours take first priority, followed by behaviours that may interfere with the therapy process. Quality of life issues and working toward improving life in general may also be discussed. Individual sessions in DBT also focus on decreasing and dealing with post-traumatic stress responses (from previous trauma in the person's life) and helping enhance their own self-respect and self-image. Both between and during sessions, the therapist actively teaches and reinforces adaptive behaviours, especially as they occur within the therapeutic relationship. The emphasis is on teaching patients how to manage emotional trauma

rather than reducing or taking them out of crises. Telephone contact with the individual therapist between sessions is part of DBT procedures (Brown, Comtois & Linehan, 1993).

During individual therapy sessions, the therapist and client work toward learning and improving many basic social skills.Interpersonal therapy, part of individual therapy, focuses on the interpersonal relationships of the depressed person. The idea of interpersonal therapy is that depression can be treated by improving the communication patterns and how people relate to others. Techniques of interpersonal therapy include; Identification of Emotion which involves helping the person identify what their emotion is and where it is coming from; Expression of Emotion , which involves helping the person express their emotions in a healthy way; Dealing With Emotional Baggage, involving helping people bring unresolved issues from past relationships to their present relationships.

In the second component, weekly group therapy sessions generally last for two and a half hours, are led by a trained DBT therapist. The group participants learn skills from one of four different modules, namely interpersonal effectiveness, distress tolerance/reality acceptance skills, emotion regulation, and mindfulness skills.

2.4.4 Psychodynamic Therapy (PT)

This is also known as insight-oriented therapy, focuses on unconscious processes as they are manifested in a person's present behaviour. The goals of psychodynamic therapy are a client's self-awareness and understanding of the influence of the past on

present behaviour. In its brief form, a psychodynamic approach enables the client to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and desire to abuse substances. Several different approaches have evolved from the psychoanalytic theory and have been clinically applied to a wide range of psychological disorders.

Family therapy, a variation of psychodynamic therapy, views a person's symptoms as taking place in the larger context of the family. Just as a particular department in a business organization may suffer because of the problems in another department, a person with depression may be responding to larger family issues. For example, a depressed adolescent's symptoms may be related to her parents' marital problems. Family Therapy (FT) is a style where cognitive; behavior or interpersonal therapy may be employed. However, it is most often used with interpersonal therapy. Some special techniques of family therapy include a genogram, which is a family tree constructed by the therapist. It looks at past relationships and events and what impact these have on the person's current emotional technique. FT also employs a technique called Systemic Interpretation, which views depression as a symptom of a problem in the larger family. Under the Communication Training technique, dysfunctional communication patterns within the family are identified and corrected. People are taught how to listen, ask questions and respond non-defensively.

Free association is a technique used in psychoanalysis (and also in psychodynamic theory) which was originally devised by Sigmund Freud out of the hypnotic method of his mentor and coworker, Josef Breuer. Berne (1976) observed that free association was

important because the patients spoke for themselves rather than repeating the ideas of the analyst; they worked through their own material rather than parroting another's suggestions (Berne, 1976). Freud called free association the fundamental technical rule of analysis. He boasted that through free association, therapists instructed the patients to put themmselves into a state of quiet, unreflecting self-observation, and to report to them whatever internal observations they were able to make, taking care not to exclude any of them, whether on the ground that it is too *disagreeable* or too *indiscreet* to say, or that it was too *unimportant* or *irrelevant*, or that it was *nonsensical* and needed not be said.

In free association, psychoanalytic patients are invited to relate whatever comes into their minds during the analytic session, and not to censor their thoughts. This technique is intended to help the patient learn more about what he or she thinks and feels, in an atmosphere of non-judgmental curiosity and acceptance. Psychoanalysis assumes that people are often conflicted between their need to learn about themselves, and their (conscious or unconscious) fears of and defenses against change and self-exposure. The method of free association has no linear or preplanned agenda, but works by intuitive leaps and linkages which may lead to new personal insights and meanings: 'the logic of association is a form of unconscious thinking' (Bollas, 2008).

When used in this spirit, free association is a technique in which neither therapist nor patient knows in advance exactly where the conversation will lead, but it tends to lead to material that matters very much to the patient. 'In spite of the seeming confusion and lack of connection...meanings and connections begin to appear out of the disordered

skein of thoughts...some central themes' (Berne, 1976). The goal of free association is not to unearth specific answers or memories, but to instigate a journey of co-discovery which can enhance the patient's integration of thought, feeling, agency, and selfhood.

Interpersonal Psychotherapy (IPT) is a time-limited treatment that encourages the patient to regain control of mood and functioning typically lasting 12–16 weeks (Frank,1971) IPT is based on the principle that there is a relationship between the way people communicate and interact with others and their mental health Interpersonal Psychotherapy of Depression was developed in the New Haven-Boston Collaborative Depression Research Project by Gerald Klerman, MD, Myrna Weissman, PhD, and their colleagues for the treatment of ambulatory depressed, nonpsychotic, nonbipolar patients. Interpersonal psychotherapy has been proven as an effective treatment for Bulimia nervosa, family therapy (Weissman, 1998) and Major depressive disorder (Joiner and Kistner, 2006), and Various other disorders. Although originally developed as an individual therapy for adults, IPT has been modified for use with adolescents and older adults (Weissman & Markowitz, 1998).

IPT has its strengths and limitations. It is particularly accessible to patients who find dynamic approaches mystifying or the ‘homework’ demands of Cognitive Behavioural Therapy (CBT) daunting. IPT has been specially modified for adolescents (Mufson *et al.,* 1993) who may find CBT too much like school work, whereas IPT addresses relationships which is a primary concern. IPT is abstemious in its use of technical jargon, a bonus for those who distrust ‘ psychobabble’. Fairburn, in a 1997 study, reported that both patients and therapists in his bulimia studies expressed a preference

for IPT over CBT (Fairburn, 1997). For general psychiatrists, a perceived limitation of IPT is it has not yet been modified for the management of psychoses (although this limitation is true of much prominent psychotherapy). The CBT model requires such expertise for its use with this population that it would be considered risky for a trainee to attempt its use without expert training and support (Morris, 2002). As with any face-to-face therapy, it is demanding of the individual in that effort must be made to attend pre-arranged dates for the therapy sessions. Whereas substantive effort may not be needed for 'homework' tasks, the therapy involves the re-enactment of past negative feelings which, as well as creating a danger of emotional harm, often requires more effort than that required in CBT sessions. Another 1996 study concluded after his experiment that both IPT and CBT showed a tendency for symptoms to recur, thus limiting the long term-effectiveness of these psychological therapies (Barkham *et a*l. 1996). Any study showing the success of such therapies often fail to take into account poor attrition rates, which are very common among psychological therapies, as many patients drop out because they feel the therapy isn't working (Vanda, 2015).

2.4.5 Importance of Counsellor Characteristics in Counselling Therapy

Literature outlines the characteristics of a good counsellor as being one who is patient, a good listener, compassionate, nonjudgmental, research-oriented, empathetic, discrete, encouraging, self-aware and authentic (McLeod, 2015). Patience is required as the client processes the discussion; it sometimes takes time for the client to accept certain things and to move towards positive changes. Some people need to discuss something many times before they are prepared to make a move in any particular direction. Good listening skills are vital because counselors spend a significant amount of time listening

to their clients, and must be content to give the client time to express their story and their feelings. The characteristic of compassion is very important as it makes clients feel the counsellor cares about them, and this genuine concern yields positive results (Shallcross, 2012).

The counsellor will need to stay current on the research in order to help clients. The characteristic of empathy is particularly relevant for a counsellor. It is the ability to understand and share the feelings of others, even if one doesn't agree with their perspective. Empathy enables the counsellor to understand how the clients feel, in order to address their issue effectively. Being discrete is about confidentiality which is of utmost importance so the client can trust the counsellor with their most intimate concerns. The ability to encourage is important for a counselor (McLeod, 2008).

Literature states that many clients are struggling to find hope in their situation, and therefore one of the primary jobs of a counsellor often involves instilling hope in a hopeless individual (McLeod, 2015). Self awareness is about the counsellor being aware of their own fears, insecurities, and weaknesses in order to be effective in the therapeutic relationship. Finally, authenticity is vital when working with clients because they will know if a counsellor is not showing genuine concern, because they will not open up or trust the advice they are given.

Rogers (1986), in his theory of client centered therapy, elaborates on the factors that make for a successful therapy outcome. These are almost identical to what has been

discussed above. According to Carl Rogers' Client – centered Therapy (McLeod, 2008), success can be predicted by two variables. The first is the client's, student's or patient's own motivation to employ their inner resources for change. The second has to do with the quality and characteristics of the helping relationship. It is believed that, within each human being, there is the potential and tendency to develop in a positive manner. Rogers described three characteristics that in his research he found to be present in relationships where individuals had actually become more fully functioning. He came to believe that those three qualities or characteristics were actually "necessary" to effectively facilitate change. He also concluded that they were "sufficient" and enough. The three core conditions as articulated by Rogers are: Empathic understanding - To sense the other's private world as if it were your own, without ever losing the 'as if' quality. Rogers thought it was essential for the person to feel deeply understood. To do that meant going 'inside' the other person's frame of reference to get a real sense of what the person's experiences felt like. Thereafter to be able to communicate that knowing and understanding back to the other person deeply and accurately (McLeod, 2008).

Congruency is defined as being freely and deeply yourself within the relationship, your actual experience accurately represented by your own self-awareness and what you actually are in this moment of time. Rogers believed that being authentic - not playing a role or being phony - was an essential part of the equation. He thought that the therapist needed a very high degree of self-knowledge in order to maintain a consistent degree of personal transparency. Rogers also spoke of Unconditional positive regard (UPR); the finding of oneself experiencing a warm acceptance of each aspect of the other person's experience as a real part of that person. Rogers was describing an unconditional

warmth, a momentary setting aside of judgment to promote an atmosphere of trust and openness (McLeod, 2008).

Literature is silent on the actual therapies and techniques being practiced in the universities of Kenya, as well as the qualities of the therapists; a gap that the current study sought to fill. The foregoing literature contributes significantly to the current study by providing variables against which to assess the counsellor characteristics in the universities.

2.4.6. Importance of Counseling Environment in Counseling Therapy

Pearson & Wilson (2012) carried out a qualitative study which explored the difference a counselling room can make to the work between counselor and client. The scholars found a range of ideal attributes was indicated, including preferences for larger workspaces, natural light, use of aesthetically pleasing decor, and provision for clients to have choice in seating. Earlier scholars had also established similar observations. The effect a healthcare environment can exert on mood and behavior was established by Dijkstra, Pieterse, & Pruyn (2008). Other scholars backed up this finding, going ahead to assert that "A poorly designed counselling area may reduce the quality of the interaction between client and counselor; making efforts to provide a less clinical environment may have benefits for all" (Phelps *et al.*, 2008, p. 404). The therapeutic setting has also been shown to have an influence on the emotional states of patients (Sklar, 1988). Creating counselling spaces that are user friendly and emotionally safe may mean more productive outcomes.

Chaikin, Derlega, and Miller (1976) recommended therapists consider the physical environment of their consulting room. Elements important in a counselling environment include comfortable seating, carpet, subdued co-ordinate colors, natural lighting, artworks, plants, large windows and views of nature (Phelps *et al.,* 2008). Self-disclosure was found to be more forthcoming and extensive in "a warm, intimate room (pictures on the wall, soft cushioned furniture, rug, soft lighting) than in a cold, non-intimate room (bare cement, block walls, overhead fluorescent lighting)" (Chaikin et al., 1976, p. 479).

Research in environmental psychology has provided support for the idea that settings can influence "sociability, interpersonal attraction, and prosocial behavior" (Amato & McInnes, 1983, p. 121). An early study by Mintz (1956) found that participants in an "ugly room" were more likely to complain of monotony, fatigue, and headache, an'a to be diagnosed at some point in their life. They reported in 2001 that about 450 million worldwide suffer from some form of mental disorder or brain condition The goal of counselling is to learn about one's habits and patterns of feeling and behavior and how they cause the person problems.

Thereafter the counsellee can then learn new habits and patterns which will be more successful for them. It is widely believed, and experience has shown that many of the problem-causing habits and patterns are things people have done all their lives and are so automatic that they don't even think about them as learned or optional behavior. Ward (2004) maintains that, within psychological settings, overall well-being and reduction in distress or provision of coping skills through psychological therapy is

effective. The scholar argues that there is strong evidence showing that psychotherapies are effective for treating personality disorders as well as improving occupational and social functioning in individuals with such diagnoses. In a systematic review of psychotherapy for personality disorders, Verheul & Herbrink (2007) found evidence that cognitive behavior, psychodynamic therapy, long-term outpatient and short-term day hospital group and individual therapies are all effective.

In addition to counselling therapy, in severe cases, pharmacological interventions can be used to manage symptoms of personality disorders (Lara and Akiskall, 2006). Antidepressants can sometimes be used in personality disorder for symptoms such as mood and emotional difficulties (Paris, 2011). A 9-year longitudinal study done by Hawkins *et al* (2005) to examine the long-term effects of promoting positive adult functioning (including through counselling) and preventing mental health problems, crime, and substance use, found that, at 21 years of age, full-intervention participants reported significantly better regulation of emotions, compared with controls, as well as significantly fewer symptoms of social phobia and fewer thoughts about suicide.

Another study indicating the efficacy of counselling in managing the emotional problems of young people was carried out in Scotland (Bondi *et al*., 2006). It sought to evaluate how successful a Youth Counselling Services initiative had been in providing confidential counselling services for young people in school and in the community, and in supporting young people experiencing behavioral, social and emotional problems in their personal development and in fulfilling their potential. Among the study objectives was one to measure therapeutic change and effectiveness, and another to assess

satisfaction with the counselling service among young people who had used it. The results of the evaluative study showed that, of those who attended at least two sessions, the great majority reported improvements in self-rated well-being, and none reported any deterioration. Service-users who participated in in-depth interviews reported high levels of distress immediately prior to seeing the counselor and described not knowing who to turn to for support initially. All derived substantial benefit from counselling and expressed very high levels of satisfaction. They described improvements in relationships with others and in their capacity to regulate their emotions.

A number of factors have been identified as being critical to the success of counselling young people. In their study, Bondi *et al* (2006) identified these to include a variety of exercises, activities and use of creative media; the advice, strategies, options and techniques offered by the counselor; the counselor's flexibility, availability and responsiveness between the counselling sessions; and the counselling room. Exercises and activities include, for instance, drawing family trees and pictures, listing personal qualities and making self-portraits and masks. An important strategy is the ability of the counsellor to help the counselee think through their situation and identify options or strategies for achieving their goals. As young people are prone to losing control or self-harming, the subjects in the study reported the benefits of being taught techniques for managing their feelings and impulses, interrupting negative thinking patterns, and for identifying alternative courses of action (Bondi *et al*). The counsellor's availability between sessions, either on the 'phone or in person, was highly regarded by service-users, and contributed to them feeling well supported and cared for.

The foregoing literature provides critical indicator variables for measuring the service provider factors that, as has been established, contribute to the effectiveness and quality of the counselling offered. Hence, it facilitates the assessment of the types of service provider factors that may have gone into influencing the effectiveness of the therapy offered to undergraduate students by the Kenyan university. It also demonstrates the validity of self-reported improvement in mental and emotional state, and expression of satisfaction with the services as a measure of the effectiveness of counselling therapy. This literature provides the current study with variables to measure improved status in the personality disorder; namely, less emotional distress, increased capacity to regulate emotions, improved interpersonal relationships as attitudinal outcomes of effective counselling services.

The literature contributes to the current study by illustrating that a relationship exists between therapy intervention and the mental state of the psychologically disturbed. These are key variables for the study, and the literature helped in the formulation of a conceptual framework that depicts the relationship between the dependent and independent variables It also points to an information gap on the same, as such an assessment in university counselling services in Kenya needs to be done. The literature also contributes to the study by providing a measure by which the university counselling services can be evaluated, namely, satisfaction level of the counselees, and reported improvements in relationships with others and emotional self-regulation. This helps in determining the effectiveness of counselling services, thus it is addressing objective number three.

2.4.7 Effect of Enhancing Emotional Intelligence through Counselling

University students are primarily in the institutions of higher learning to be equipped with skills that can launch them into successful careers. Yet these careers can be sabotaged where an individual lacks social intelligence. Possession of a personality disorder, as seen earlier, invariably leads to a disruption in social relationships. Fortunately, a number of studies have proven that emotional intelligence can indeed be enhanced, and that it can lead directly to improved performance in the workplace. Salovey and Mayer (1990) maintained that success depends on one's ability to persist in difficult situations, and to get along with colleagues and subordinates. This is difficult to do when one suffers from certain types of personality disorders, but fortunately, it is a skill that can be learned.

After a series of research works, Daniel Goleman broke down the four domains of emotional intelligence into 16 competencies that can readily be taught in a counselling setting. Within the first domain of self-awareness, Goleman (1995) proposed the reading of one's own emotions and recognizing their impact. This is followed by an accurate self-assessment of knowing one's own strengths and limits. Finally is the self-confidence where a person develops a sound sense of one's self worth and capabilities.

In the second domain of self-management, Goleman (1990) proposes emotional self-control which entails keeping disruptive emotions and impulses under control. Self-management also involves transparency (displaying honesty and integrity); adaptability (flexibility in adapting to changing situations or overcoming obstacles); achievement

(the drive to improve performance to meet inner standards of excellence); initiative (readiness to act and seize opportunities); and optimism (seeing the upside in events)

The third domain is social awareness. Here the person is required to exhibit empathy (sensing others' emotions, understanding their perspective, and taking active interest in their concerns). The domain also entails demonstrating organizational awareness (reading decisions and the current networks and political power play in the work setting). Service is also required, which is the recognizing and meeting of (clients') needs. In the fourth domain of relationship management, the person is expected to demonstrate inspirational leadership, influence, the ability to develop others (bolstering others' ability through feedback and guidance), act as a change catalyst, manage conflict, build bonds and exhibit teamwork (co operation) (Goleman,1990).2.5

2.5 Effectiveness of Counselling Therapy

Available literature on evaluation of counselling is limited. The effectiveness of counselling has been a neglected area (Janice & Mellor-Clark, 2003) and although demands of academic life are increasingly stressful for students in Higher Education, there is limited research about the extent of those attending student counselling (MacKenzie & Murray, 2015). In their study (Janice & Mellor-Clark, 2003; they examined data from 7 UK student counseling services in evaluation of the services. Results indicated that counseling was efficient with 70% of clients showing improvement from pre- to post-therapy. However, they found that students who completed the counseling course showed significantly greater improvement than those

who dropped out. This is significant because it shows that effectiveness is determined by sustained participation as well as consistency.

MacKenzie and Murray (2015) carried out a study to evaluate reliable and clinically significant change for students with self-reported academic success. In total, 129 students attended counseling. Findings were that 117 (92%) students reported experiencing academic success. Counselling resulted in reliable change for 67%.

Research on effectiveness in developing countries is even more limited than in developed countries. However, Kamunyu (2016) argues that although transition to university life can be stressful for all students, counselling and other types of intervention can be used to mitigate this problem. The author is rightly concerned that only a minority of university students who experience psychological distress seek professional counselling. In a quest to establish the prevalence of counseling services among university students in Kenya, the author carried out a study. Findings of the study revealed that university students were faced with various life challenges such as academic, psychological, social, personal, economic, health, physical, vocational and spiritual. However, only 35% of students with issues in both public and private universities sought counseling. Although this study was concerned about the use of counselling services by university students, it did not consider the quality/effectiveness of the services. Hence her recommendation was that counsellors launch a vigorous campaign to attract students to the services.

2.6 Mental Health and Disasters

Disasters are events that challenge the individual's and community's ability to adapt, which carries the risk of adverse mental health outcomes including posttraumatic psychopathologies ((Davidson *et al*., 2006). Mental health is an integral and essential component of health. Mental health and well-being are fundamental to our collective and individual ability as humans to think, emote, interact with each other, earn a living and enjoy life. It should, therefore, be a vital concern of individuals, communities and societies to promote, protect and restore mental health. Yach (1998) notes that from time immemorial, it has been recognized that there is a close interaction between a healthy mind and a healthy body and that health was valued highly and had to be preserved at any cost. Hence mental health is more than just the absence of mental disorders or disabilities. The UN and WHO stress the total well-being of human beings (Yach, 1998);

Human beings may struggle to be free from ill health, but may not be free from the effects of disasters. Math *et al.* (2015) affirm that disasters can be classified as natural and man-made ones. While natural disasters are milder in terms of evoking mental health morbidity, willful acts such as terrorism are most severe (Math *et al.*, 2015). Disaster mental health services are based on the principles of preventive medicine which has moved from relief-centred post-disaster management to a multi-dimensional integrated community approach. The approach is based on six 'Rs' and these are: Readiness (Preparedness), Response (Immediate Action), Relief (Sustained rescue work), Rehabilitation (Long-term remedial measures using community resources), Recovery (Returning to normalcy) and Resilience (Fostering).

The authors continue to observe that a disaster mental health of reactions of a community and individuals has a specific sequence of phases. These are: the heroic, honeymoon, disillusionment and restoration phases. In the heroic phase, immediately after the disaster, survivors rescue fellow human beings, feed them and shelter them. This phase lasts from a day to weeks. The second phase is the honey-moon phase where support from relief agencies, administration in terms of free food, medical aid. This phase lasts from 2-4 weeks and notably, relief and resources start weaning. The disillusionment phase sets in and discrimination, injustice and corruption feature. Consequently, this kind of ground breeds mental morbidity and lasts about 36 months. When this happens, the normal human reaction is grief to loss of whatever kind, be it home, lives or property. Abnormal reactions include abnormal grief (delayed, oscillating and exploding). Common mental disorders that can be seen in a disaster affected population are: adjustment disorders, depression, posttraumatic stress disorder, anxiety disorders and substance abuse. Math *et a*l (2015) report a prevalence of PTSD at 4-60%.

Researchers have assigned that the PTSD is the signature diagnosis among post disaster mental morbidity (Galea, Nandi & Vlahov, 2005; Math *et al.*, 2015; Houston & First, 2017). A review of studies conducted between 1980 and 2003 on PTSD especially on human-made/technological disasters found that there was substantial burden of PTSD among persons who experience a disaster.

Immediately after a natural disaster, it is normal, therefore, for people to experience fear, anxiety, sadness or shock (Sederer, 2014; Houston & First, 2017). However, if these symptoms continue for weeks or months after the event, they may result into psychological problems. When Hurricane Sandy struck the northeastern coast of the United States, it caused devastation resulting in mental health problems (Sederer, 2014). Mental health services were provided to disaster survivors in the impacted individuals and communities. A report by Melnik *et al* (2002 on USA September 2001 attack, summarized various psychological and emotional effects of the people. They cited among others, anger, fear, increase in alcohol consumption and cigarette smoking, sleep problems, nervousness, hopelessness, and worry. The attack caused vulnerability to individuals and the whole of the US. The US had always the confidence of combating any disaster no matter how severe, but because disasters are unpredictable, the damages of the WTC and loss of lives brought a lot of helplessness to the people of America (Melnik *et al*, 2002).

Disasters continue to impact on people in different countries from year to year. For some, it is the cyclones or tsunamis. For others it is floods or landslides. Yet for others it is earthquakes or volcano eruptions. Man in his innovative ways, always tries to find ways to curb the effects of disasters (USAID, 2002) or by getting rid of them altogether. The International Strategy for Disaster Reduction (ISDR) is a global framework of the UN for action to enable societies to become resilient to the effects of natural hazards. This helps reduce human, economic and social losses. It involves a conceptual shift from an emphasis on disaster response to the management of risk through the integration of disaster reduction into sustainable development.

The four goals of the Strategy are: to increase public awareness about disaster reduction, to obtain commitment from public authorities, to stimulate inter-disciplinary and inter-sectoral partnerships, and to improve the scientific knowledge of the causes of natural disasters and the consequences of the impact of natural hazards (UN, 2002).

The ISDR attempts to clarify some key concepts in relation to Disaster Risk Reduction. For instance, while there is no natural disaster, there is a natural hazard and a disaster is the result of a hazard's impact on society. The effects of a disaster, therefore, are determined by the extent of a community's vulnerability to the hazard. Disaster reduction is the systematic development and application of policies, strategies and practices to minimize vulnerabilities and disaster risk in society. A natural hazard is a natural process occurring in the biosphere that is damaging in effect e.g. earthquakes, tsunamis, volcanic activity, landslides, floods, tropical cyclones, drought, sand or dust storms. Sustainable development is development which meets needs of the present without compromising the ability of future generations to meet their own needs.

Sangay *et al. (*2010) point out that experience from disasters indicates that there is need for preparedness at the individual and at community levels in order to withstand a disaster and its consequences. The authors looked at several Pressure and Release Models (Wisner et al, 2004; Carreno *et al.*, 2007, Billing and Madengr, 2006, Cutter *et al*, 2008 and UNISDR) and concluded that to withstand a disaster and its consequences

depends on risk mitigation activities and preparedness together with individuals and institutional capacities.

The survey on the USA 9/11 attacks recorded widespread psychological and emotional effects in all segments of the three states' populations following the World Trade Centre (WTC) attacks (Melnik *et al,* 2015). However, the survey did not reach all people who might have been impacted by the attacks. These were persons without a telephone i.e. persons of low socio-economic status; persons who were not in a position to discuss their emotional and psychological problems at the time and lastly, persons who might have moved from the area after the attacks (Melnik *et al.,* 2015).

In a UNISDR's Global Assessment report, there are two essential elements in the formulation of a risk cited. These are a potential event (hazard) and the degree of susceptibility of elements exposed to that source or vulnerability (Ciurean *et al.*, 2013).

RISK = HAZARD X VULNERABILITY

UNISDR defines risk as the combination of the probability of an event and its negative consequences. A hazard is a dangerous phenomenon: a substance, human activity or condition that may cause loss of life, injury or other health impacts, loss of livelihoods and services, social and economic disruption or environmental damage.

Ciurean *et al.* (2013) continue to point out that vulnerability depends on multiple aspects arising from physical, social and environmental factors, which interact in space and time e.g. poor design and construction of buildings, lack of awareness, limited recognition of risks and preparedness. Vulnerability therefore, depicts: amount of damage caused to a system by a particular hazard and the state that exists within a

system before it encounters a hazard. Vulnerability is the degree of loss to a given element at risk resulting from occurrence of a natural phenomenon of a given magnitude.

Various models have been used to explain vulnerability. The Pressure and Release Model (PAR) indicates a system's vulnerability to hazards consists of i) linkages to the broader human and environmental conditions and processes; ii) perturbations and stressors/stresses; iii) the human-environment system of concern (including exposure and responses. The Pressure and Release Model operates at different spatial (place, region, world), functional and temporal scales and takes into account interaction of the multiple perturbations and stressors/stresses. Hazards are regarded as being influenced from inside and outside of the analyzed system. The Pressure and release model according to the authors is based on the commonly used equation which defines risk as a function of the hazard and vulnerability. It emphasizes the underlying driving forces of vulnerability and the conditions therein that contribute to disaster situations when a hazard occurs.

Vulnerability is associated with these conditions at three progressive levels namely: Root causes like limited access to power; dynamic pressure for example rapid population increase and unsafe conditions in the environment such as dangerous slopes. This conceptual framework helps identify vulnerability towards addressing its root causes and driving forces in the human-environment system (Ciurean *et al.*, 2013). The Enhanced Pressure-Release (Disaster Crucnch} Model is displayed in Figure 2.1.

The Pressure and Release Model (PAR

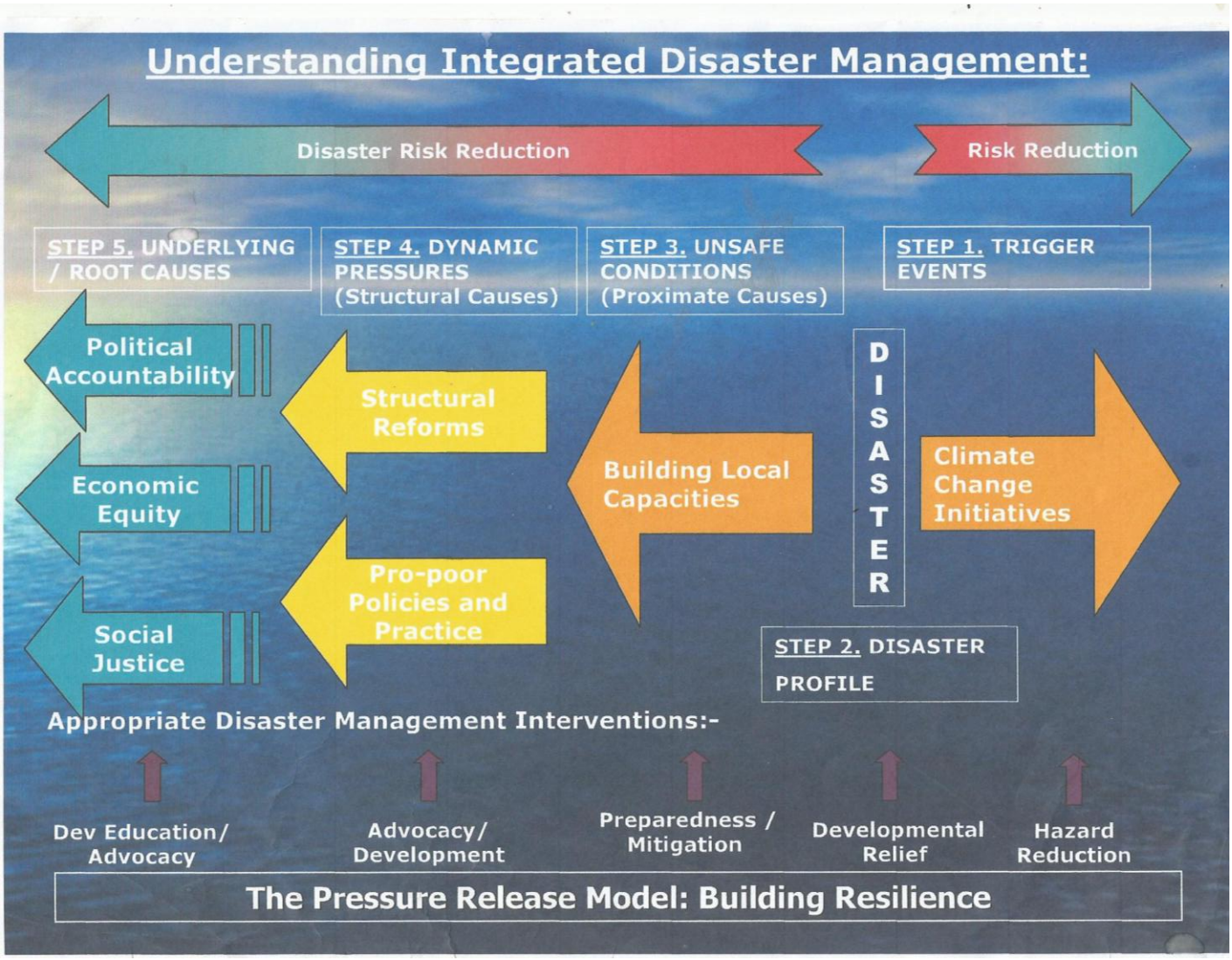

Figure 2.1: The Pressure and Release Model (PAR)

In this model in Step 1, trigger events are identified e.g. floods from heavy rains (natural hazard). Assessment can be done to identify the past, present and likely hazards as well as unmet needs (Step2). The nature and behavior of the hazard (floods) are also examined. In Step 2, impact assessment of the disaster (floods) is done by looking at the elements at risk e.g. the human, social, natural resources e.g. trees, physical infrastructure such as buildings, economic or livelihood e.g. and business premises/assets. Priority unmet needs such as healthcare, water, sanitation etc are also assessed. In step 3, vulnerability is assessed in identifying factors that create unsafe

conditions. Capacities are also assessed. These will include the people's strengths (assets e.g. boats which can row them away to a safe place in case of extreme flooding, belongings and resources. In doing all this, the community impacted must be given a chance to participate. The actors, (state and civil society) must involve other structures such as community/members, from local level upwards as well as policies and practices(Step 4). In step 5, the underlying causes of the disaster must analyzed. These are social e.g. beliefs, culture etc, political, economic and natural. With everyone participating adequately, it is likely that the situation will have been reversed. In other words, the disaster risk will be reduced and the situation restored to its earlier position, thus creating resilience among the people.

UNISDR defines resilience as "the ability of a system, community or society exposed to hazards to resist, absorb, accommodate to and recover from the effects of a hazard in a timely and efficient manner, including through the preservation and restoration of its essential basic structures and functions" (UNISDR, 2009 in USAID,2011).

The Press and Release Model as discussed can explain the pressure caused when certain phenomena interact. It can also show when the position has been reversed. When counseling services are provided and adequately so, the likelihood is that there will be pressure/burden lifted off the shoulders of the person being counselled. However if the counseling is not adequately done, then the pressure of the problems will still push the person down until there is a crush or crunch (when at the lowest level after a disaster). Hence clients/counselee have to be helped to bounce back to their normal life after

being impacted by a problem such as development of overwhelming emotions, a personality disorder, a loss through death accident and the like.

2.7.2 Disaster Risk Reduction in Kenya

Kenya has experienced many disasters, man-made, natural or technology based in the last decade. These included Al-Shabaab attacks, road motor accidents and collapsing buildings, among others. Disaster risk reduction or simply disaster reduction is the concept and practice of reducing disaster risks through systematic efforts to analyze and manage the causal factors of disasters, including reduced exposure to hazards, lessened vulnerability of people and property, wise management of land and environment and improved preparedness for adverse effects.

A number of studies have been carried out to assess effects of such disasters and how they were managed. Maitai (2013) in a study on challenges associated with terrorist risk reduction strategies in Kenya concentrated on the Nairobi Central Business District. Her findings included a weak disaster risk reduction management where communities were not sensitized and there was no coordination between relevant agencies that would have participated in the endeavor. Psychological effects resulted from death of workers and family members; loss of security, recovery of survivors from the impacted communities was painful while other survivors sustained poor mental health with post-traumatic stress disorder (PTSD).

Another study by Momanyi analyzed the impact of Al-Shabaab terrorist attacks in Kenya. Momanyi's (2015) findings revealed psychological, economic and political

impact on the people. Psychological impacts included fear and paranoia, trauma, hatred and Islamophobia. Those who experienced trauma did not want to have anything that reminded them of the disaster. For instance some women who had been at Westgate shopping Mall did not want to ever visit Westgate in case the Al-Shabaab attack occurred again..This implies that psychological effects of post-disaster period hang on for a long time. It also means that a lot of people in the affected community can easily end up with post-traumatic disorder because of the frightening experience that they suddenly undergo.

The economic impact meant business was poor. There were alo fewr tourists visiting. Politically, the government was to blame for Al-Shabaab attacks because of the presence of the Kenya Defense Forces (KDF) in Somalia. However, one good thing is that the Government enacted the Ant-terrorism law in 2014.(Momanyi, 2015).

Arising from the two studies, in the opinion of the researcher, Kenya as a nation has not reached that level of preparedness to combat disasters. There is need to do more in the way of legislation concerning disaster management. Todate the National Disaster Polcy is still in draft form since 1998. There is need to set up county bodies that are going to be active and fully functional and who can execute appropriate and fast responses whenever disasters strike. As at now there is quite limited literature both on international and national disasters.

2.7 Methodological Approaches that have Informed the Study

A number of studies have been carried out in Kenya that have informed the methodological approach of the current study. The first is the study by Kyalo & Chumba (2011), which informed two of the theories adopted to guide the study. In their study that looked at the factors influencing the social and academic adjustment of undergraduate students of Egerton University, Kyalo & Chumba (2011) relied on theories of social learning to guide their work. The scholars relied on the classical conditioning as advocated by Pavlov, and B.F Skinner's Operant theory of learning, and Bandura's Theory of Social Learning. The theories describe and explain the student's adjustment and the interactions with the selected factors at the University environment. The theories are found in the general domain of the behavioristic approach to behavior modification which holds that, adjustment as a process involves the variation of an individual's behavior for more harmonious functioning in a changed circumstance. In this approach, behavior is learned through interaction with others in an environment. The interaction between the person and the environment involves human beliefs and cognitive competencies that are developed and modified by social influences and structures within the environment. (Such structures include counselling therapies, as in the current study).

Kyalo and Chumba (2011) also informed the current study's decision of using a questionnaire as a primary data collection tool. The two scholars state that, according to Kathuri and Pals (1993), most techniques for measuring social and psychology environment rely on verbal material in the form of questionnaires and interviews. To examine their research objectives, hypotheses and related literature, the researchers

developed two data collection instruments, which comprised a questionnaire (both closed and open ended questions.), and an interview schedule for the Dean of students, student counsellors and the students' peer counsellors. The use of interview schedule supplements the questionnaire for qualitative data as it provides for probing.

Kyalo and Chumba (2011) assert that they opted for the questionnaire because it is time saving and allowed collection of data from a larger sample of individuals. Each instrument targeted specific information from the respondents. The students' questionnaires sought to obtain information on the influence of social economic factors, interpersonal relationship skills, academic discipline, students' attitudes towards the university environment, gender, year of study and role of guidance and counselling on students' social and academic adjustment at the university. The student peer counselors', university student counselors' and the Dean of students' affairs' Interview schedule sought the information on the role of guidance and counselling and the overall social and academic adjustment of students at the university. The approach of using primary data collection tools (questionnaires and interview schedules) by Kyalo & Chumba (2011) was found relevant for the current study because of the similarities of the two in targeting undergraduate students and Deans of Students in soliciting information regarding the influence of counselling on student behaviour.

Kyalo and Chumba (2011) also adopted an ex post facto Causal- comparative research design. This research design is a systematic empirical inquiry in which a researcher has no ability to control the independent variables because their manifestations have already occurred and therefore cannot be manipulated by the researcher. The design was found appropriate because it allowed the researchers to investigate the possibility of causal

relationship between variables which in this study constituted the selected factors as the independent variables and the students' social and academic adjustment as the dependent variables the scholars argue that this design is particularly suitable in social, educational and psychological contexts where independent variables lie outside the researchers' control.

A similar reasoning was applied to the current study which sought to examine the causal relationship between therapy management and prevalence of personality disorders in the students, as the independent and dependent variables respectively. Like the scholars' work, the study is an inquiry in a psychological context where the variables lie outside the researcher's control. The current study was however, not comparative in nature.

The methodological approach of a study done by Nyaga, *et al* (2014) on the 'Effectiveness of Guidance and Counselling Services on University Students' Development of Academic, Social and Personal Competencies' also informed the current study insofar as selection criteria for the study subjects and sampling strategy were concerned. Quantitative data was collected by use of a questionnaire that was administered to 369 third and fourth year full-time undergraduate students enrolled in public and private universities in Kenya. In addition, qualitative data was collected through an interview conducted among ten (10) student counsellors. Purposive and stratified random sampling techniques were used to select the respondents, a technique the current study borrowed from.

The current study adapted a sampling methodology mix, using purposive and non-proportional quota sampling to select the study subjects. The choice of students included was informed by the study of Bondi *et al.,* (2006);the researchers included young people who had used the service, in order to get data for the most immediate measure of how successful the counselling provided had been. However, they also included young people who had not used the service, as they deemed this essential to gather the views of potential users of the service, particularly to capture the reasons why they might be disinclined to seek counselling, and what could be done to make the services more accessible and appealing to them. Therefore the current study similarly included students who had used the therapy services, as well as those who had not.

2.8 Conceptual Framework

This study was informed by the behavioural theories. In combination, they facilitated the development of conceptual framework for the study.

2.8.1 Bandura's Theory of Social Learning

The current study was first informed by the Social Learning Theory which argues that the behaviour of an individual or a group acts as a stimulus for similar thoughts, attitude and behaviour on the parts of the observers. Bandura (1986) asserts that people learn by observing the behavior of others and that some serve as models that are capable of eliciting behaviour change in certain individuals. The theory was useful in that it addresses the key issues of behaviour acquisition and mode of adjustment relevant for students during their stay at the University. Thus, behavior is not solely by inner drives

or environments, but as a result of an interactive association between inner process and environmental variables.

In the current study, the notion of behaviour learned by observing is applicable for undergraduate students who observe others and (in a desire to fit in), emulate or aspire after behaviour perceived as acceptable or desirable. Hence, a student with a personality disorder may become aware of his/her social behavioral shortcomings by observing the behaviors of their emotionally stable peers. Conversely, a popular student with a personality disorder may have their behavior emulated by others, to the detriment of the latter's' social development. The change in attitudes through observation may directly cause psychological, social and academic adjustment among the students at University. Hence what is emulated can be either positive or negative. Bandura believed that, the vast majority of the habits acquired in lifetime are learnt by observing and imitating other people. However, Bandura's Theory does not accommodate the notion of reinforcement and adjusting behavior based on verbal information given or controlled stimuli to elicit certain behaviour. These are products of therapy, and for that, the study had to draw upon an additional theory.

2.8.2 Pavlov's Theory of Classical Conditioning

To accommodate the shortcoming in Banduras theory, the study drew upon Ivan Pavlov's Classical Conditioning Theory (1849-1936), which, according to Kyalo & Chumba (2011), provides a fluid approach to the description of repeated and systematic association between the students' adjustment (conditioned stimuli) and the selected factors (unconditioned stimulus). The association is, therefore, assumed to produce a

response (adjustment) towards the university environment. According to the above researchers, this implies that, the students encounter social and academic challenges that require the development of life skills in order to overcome and cope with the challenges. Therefore, students' adjustment is a continuous process that leads to a change in behaviour which becomes conditioned when reinforced. Hence, students learn and develop new and desirable behaviour through conditioning process especially through counselling in the university environment.

In the case of the current study, this theory is applicable with regard to behaviour change reinforced through counselling therapies. For instance, a student with avoidant personality disorder is counselled and starts to exhibit signs of self-confidence, courage and interacts with others freely, he or she is likely to enhance that behaviour after receiving praise for improvement. Also if student with obsessive-compulsive disorder displays to the counsellor during the counselling process that he or she has reduced the number of times they are preoccupied with orderliness, perfectionism and a need for power over others and they are complimented, they are likely to continue controlling those vices.

The change in the personality disorder behaviour is the conditioned stimulus, and the counselling interventions of the university are the unconditioned stimulus to which the students are expected to respond. In Kyalo's & Chumba's (2011) study, the interaction of the variables was linear and causative. However, both theories do not capture the role of the requisite conditions for effective therapy to take place. Hence a third theory was adapted.

2.8.3 Carl Rogers' Client-Centered Therapy

The theory that guides both the second and the third objectives of the study is Carl Rogers' (McLeod, 2008) 'client- centered therapy' which describes the requisite conditions for effective counselling therapy. Rogers (1902-1987), a renowned and pioneering American psychologist, published the groundbreaking book 'Counselling and Psychotherapy' that described what he termed "client-centered therapy". In it he offered the insight that a relationship between client (patient) and therapist characterized by what he called the "core conditions" was the essence of the healing or growth experience.

He demonstrated through enormous amounts of research that therapy works when clients are free to determine their own agenda for their life and therapy and to describe their own subjective experience in their own way. Secondly, when they are in a relationship with someone who has faith in them, listens empathetically and accurately for the deeper meanings of what they are communicating, and who deals with them honestly without roles or manipulation; and thirdly when the relationship is as egalitarian as possible without a "power-over" authoritarian posture. Rogers strongly asserted the importance of the therapist exercising empathy, congruence and unconditional positive regard toward the client. Roger's theory, therefore, contributes to the current study by bringing out those aspects of counselling which depict effectiveness in therapy.

The three theories were used to construct a conceptual model to guide the study. In the current study, the independent variable is the counselling therapy management, which

takes the form of different approaches offered from a specific service provider setting (the room, equipment, skills and attitudes of the counsellor, and so on). The dependent variable that is influenced by the therapies is the undergraduate's personality disorder. The intervening variables are: age, level of study, gender, attitude towards counselling, peer pressure, home background and the university policies/programmes. The behavioural and attitudinal modification outcomes are knowledge of the availability of the services, the degree of perceived manifestation of the personality disorder in the student, willingness to participate in counselling therapy process, expressed satisfaction with counseling services, less emotional distress, increased capacity to regulate emotions and improved interpersonal relationships. The conceptual model developed for the current study is illustrated in Figure 2.2.

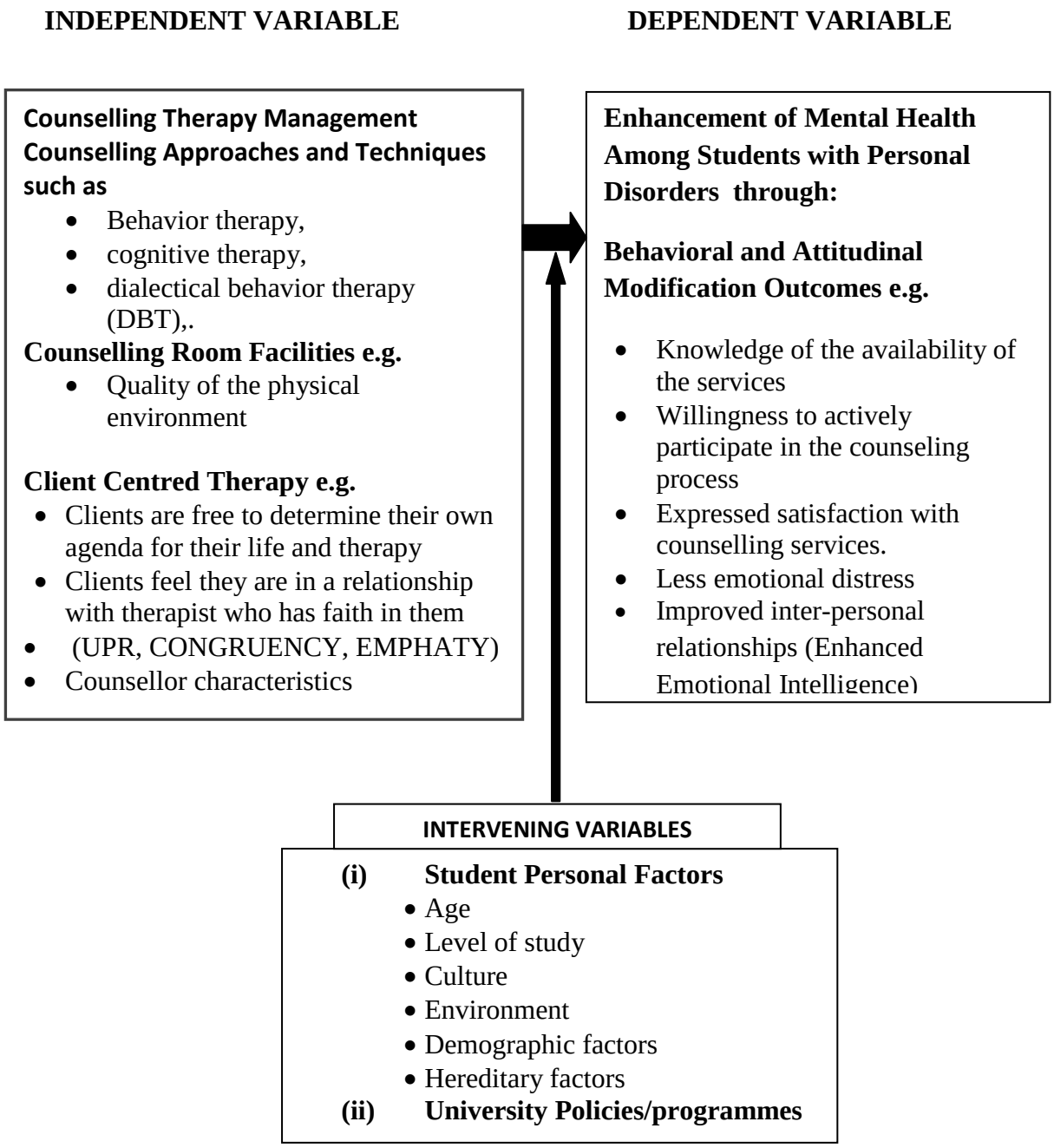

Figure 2.2: Conceptual Model of Relationship between Counselling Therapy Management (Independent Variable), Personality Disorders among the Students (Dependent Variable), (Intervening Variables)
Source: Researcher (2015)

The broad conceptual statement guiding this study is that there is likely a relationship that exists between counselling therapy and the manifestation of personality disorders

among university students. The direct relationship is also moderated by the personal characteristics of the students and intervening factors. The specific conceptual statements for this study indicate that the variables portrayed in the conceptual model relate to each other in the ways described as follows:

Undergraduate students who possess a personality disorder are likely to undergo positive attitude and behavior modification when exposed to counselling therapy. This is expressed as satisfaction with counselling services, less emotional distress, increased capacity to regulate emotions, and improved interpersonal relationships. For instance, a student who manifests a personality disorder such as PPD and is exposed to counselling therapy by a counsellor with a positive attitude and who uses the Person-centred theory is likely to experience change emotionally. This will be expressed in form of improved interpersonal relationships since the client feels he or she is in a relationship with the therapist who has faith in him or her. Also a student with a personality disorder, being influenced by peer pressure but who is exposed to counselling in a conducive counselling environment is likely to express satisfaction with the counselling services.

A relationship can be created between the independent and dependent variables as well as intervening and students' personal factors in the same way and, lead to positive outcomes. For example if cognitive therapy is considered as an independent variable, it gives the counsellor opportunity to explore how clients' thoughts or thinking patterns can influence mental condition. Acute anxiety or stress can lead to personality disorders such as paranoia, obsessive-compulsive neurosis. Therefore, behavior modification which is the dependent variable in this study occurs as a positive outcome when clients

who happen to be undergraduate university students get knowledge of counselling therapies that enable them to change their thinking orientations that lead to desirable behavioural changes or modification, which in turn leads to less emotional stress and ability to regulate their emotions. This may reduce the rate of personality disorders among university students, subsequently they may not be paranoid, schizoid, avoidant, obsessive compulsive among others. At times intervening variables such as age, or level of study of students may affect the operations o independent variable. For instance the older students who are in third or fourth years of their study may be experienced and have more knowledge of counselling therapies as compared to their first year counterparts. This makes the former students to be more adjusted to conditions that may be responsible for causing personality disorders compared to the latter group of students (first years) who may be hesitant to go for psychological therapy as intervention measures for their personality disorders.

The counselling therapy itself as given in Figure 2.2 comprises different techniques and approaches such as behavior therapy; cognitive therapy; dialectical behavior therapy (DBT); interpersonal therapy; psychodynamic therapy and family therapy, environments and is administered by counsellors. The counsellors' characteristics (counsellor as a person and the quality of relationship offered, counsellor's flexibility, availability and responsiveness between the counselling sessions), interacting with a specific environment (counselling room and facilities) have implications on the degree to which the different approaches they employ will be effective in influencing undergraduate students with personality disorders. The severity of the personality disorder condition will likely affect the degree to which the counselling therapy will

lead to behavior modification in the undergraduate student. The effectiveness of the counselling therapy is also contingent upon the knowledge of the availability of the services by the student, and their willingness to patronize the same.

The intervening factors (age, level of study, gender, attitude towards counselling, peer pressure and counsellor's attitude) together with the students' personal factors (awareness of counselling services, possession of PDs, and willingness to use counselling services) work together with the Independent variable (counselling approaches and techniques as well as the counselling Room facilities and the Client-centred Therapy) under the guidance of the counsellor to produce the desired behaviour modification in students affected by personality disorders which are dependent variables.

2.10 Chapter Summary

This chapter reviewed the literature that was used to develop the study. It began by looking at the classical theories of personality development, namely the Psychodynamic (Psychoanalytical) approaches; Humanistic approaches; Trait approaches; and Social Cognitive approaches to personality. It was seen that the Psychoanalytical theorists (Sigmund and Anna Freud, Erikson, Jung, Adler, Horney, and Fromm) tend to believe that the answers to the important questions lie somewhere behind the surface, hidden, in the unconscious. According to Freud, if the ego did not effectively handle the resulting anxiety, people would be so overwhelmed with anxiety that they would not be able to carry on with the tasks of everyday living. It therefore tries to control anxiety through

the use of ego defense mechanisms which, however, distort reality, thereby predisposing the person to develop a personality disorder.

It was seen that, in Humanistic Personality Theories, the source of information about personality is obtained from self-reports from the general population and people in therapy, the main advocates of this approach being Maslow, Rogers, Kelly, Binswanger and Frankl. In this approach, if the cause of behavior in the students is rooted in the self-concept, then counselling therapy that works to develop a healthy self-concept goes a long way in addressing personality disorders (Sparknotes, 2016). Humanistic theories focus on the ability of human beings to think consciously and rationally, to control their biological urges and to achieve their full potential. In Rogers's view, the self concept is the most important feature of personality and includes thoughts, feelings and beliefs. Abraham Maslow on the other hand thought people with good mental health had characteristics like awareness and acceptance of self, openness and spontaneity, ability to enjoy work and other positive values (Heffner, 2014).

The Trait approaches, it was seen, try to identify the most basic and relatively enduring dimensions along which people differ from one another--dimensions known as traits, while in the Social Cognitive Theories of Personality Development, it is believed that behavior is learned through conditioning and observation, and that what people think about their situation ultimately affects their behavior (McLeod, 2016; McLeod, 2013). Bandura asserted that instead of studying what's going on inside the person (traits), it was important to study what is going on outside the person (environment). In other words, it was important to assess how the environment shapes personality. The concept

of emotional intelligence by Salovey and Mayer was seen to be a modern idea that is defined as the ability to monitor one's own and others' feelings and emotions, to discriminate among them, and to use this information to guide one's thinking and action. The chapter then went on to look at the nature of personality disorders, of which 10 were identified and described (Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, and Obsessive-compulsive). From there, the prevalence and social burden of personality disorders was reviewed, followed by a look into the different therapy management options (Behavior therapy, cognitive therapy, dialectical behavior therapy, psychodynamic therapy), and their effects on Personality Disorders. The chapter then reviewed the importance of counsellor characteristics in counselling therapy, and the role played by the counselling environment, and the proven effectiveness of Counselling Therapy. The chapter ends with a presentation of the methodological approaches and three main theories that informed the study (Bandura's, Pavlov's and Rogers'); followed by a diagrammatic depiction of the conceptual framework with an explanation of how the independent variable, the dependent variable and the intervening variables interact.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter presents: study sites, study population, research design, sampling strategy and analysis of the data collected.

3.2 Research Design

The study adopted an ex post facto and cross sectional survey research design. This research design is a systematic empirical inquiry in which a researcher has no ability to control the independent variables because their manifestations have already occurred and therefore cannot be manipulated. In the current study, the counselling therapies are already in place, as were the manifestation of personality disorders among the undergraduate students. Cross sectional research design helps in measuring the status quo at a given point in time, as opposed to following a cohort of study respondents over an extended period of time. It helps in studying students' attitudes about counselling therapies used in universities in Kenya. The researcher gave respondents questionnaires to indicate their attitudes and beliefs about counselling therapies. Students at different levels were used to collect information which was analyzed. There were also descriptions of the counselling services provided, and evaluative aspects to measure the effectiveness of the counselling therapies among undergraduate students that had personality disorders. A summary of the research designs is displayed in Table 3.1.

Table 3.1 Research Designs

Specific Objective	Variables	Research Design
Examine the nature and extent of personality disorders among undergraduate students in Kenyan universities	Typical characteristics of Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, Obsessive-compulsive. Personal factors such as age, year of study, programme (course),gender, ethnic background, marital status etc.	Ex-post facto Cross sectional survey
Examine the management of counselling therapies and facilities availed to undergraduate in the Kenyan universities	**Counselling approaches and counsellor characteristics** • Behavior therapy • Cognitive therapy • Dialectical behavior therapy (DBT) • Interpersonal therapy • Psychodynamic therapy • Counsellor characteristics **Behavioural and attitudinal modification outcomes** • Awareness of availability of counselling services • Willingness to participate in counselling	Ex-post facto Cross sectional Descriptive
Evaluate effectiveness of the counselling services in addressing Personality Disorders among the undergraduate students	• Satisfaction level of Student Counsellees • Less emotional distress in counsellees • Increased capacity of counsellees to regulate emotions • Improved interpersonal relationships of counsellee	Ex-post facto Cross sectional

Source: Researcher (2015)

3.3 Study Sites

The study was carried out in four randomly selected universities out of the total thirty-nine (22 public and 17 private) universities in Kenya. The total number of fully fledged public and chartered private universities is 39 (Advance-Africa.com

3.3.1Map of the Study Area

The map of study sites is shown in Figure 3.1

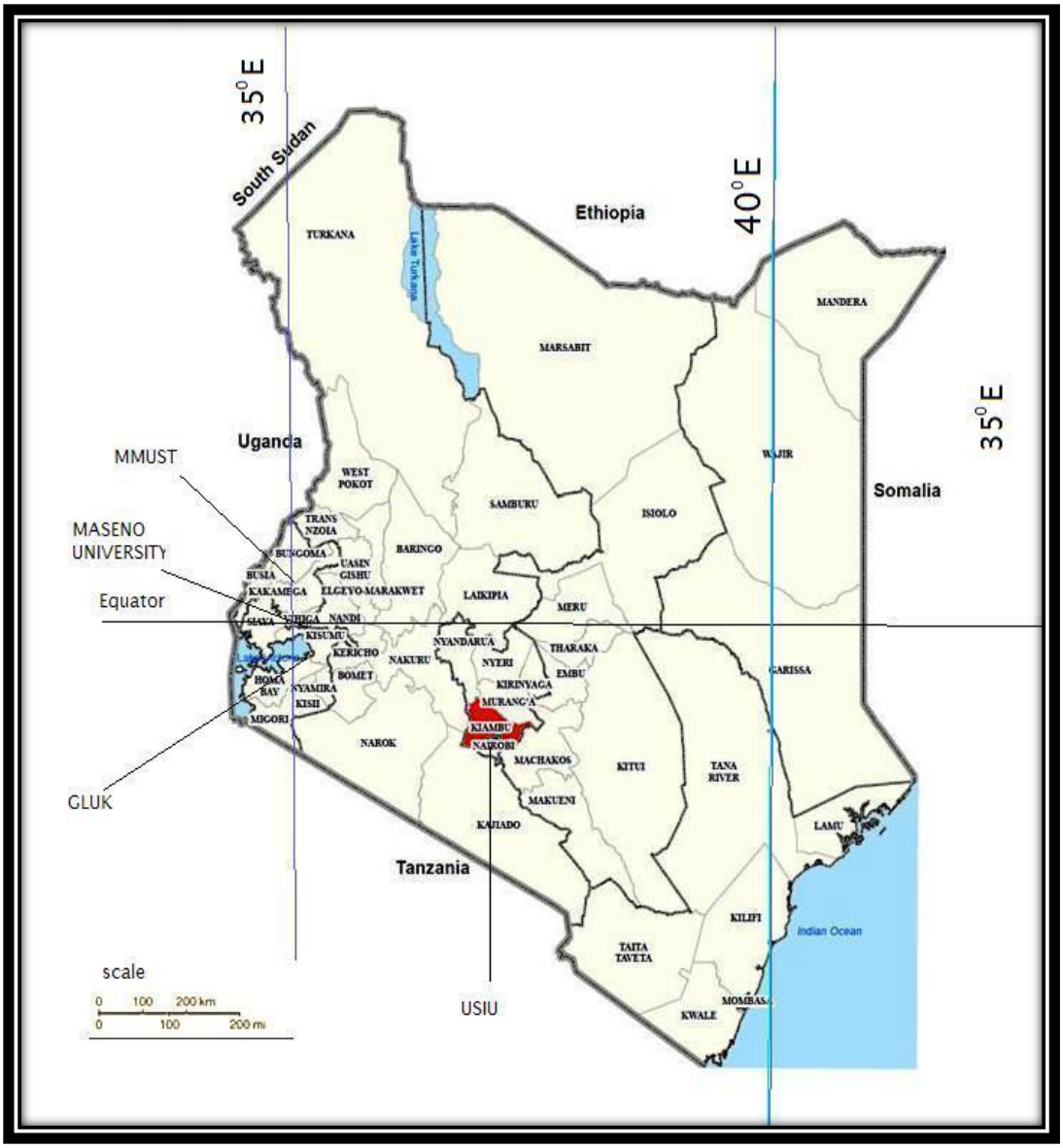

Figure 3.1 Map of Kenya Showing Location of Kenyan Universities Sampled for the Study

Source: www. google.com

These were Maseno University, Masinde Muliro University of Science and Technology (MMUST), the Great Lakes University of Kisumu (GLUK) and United States International University-Africa(USIU-A). Maseno University is a university based in

Maseno, near Kisumu, in Kenya and was founded in 1991. It has over ten thousand students pursuing various programs offered in the University's campuses. The university is in Maseno Township along Kisumu-Busia road, some 25 km from Kisumu City and 400 km North-West of Nairobi. It has two campuses: the Kisumu one and the main campus. The main campus is along Kisumu-Busia road, while the Kisumu campus is located in Kisumu City. The name "Maseno" was coined out of the name of a tree known in Luo and Luhya dialects as "Oseno" or "Oluseno" respectively. The tree stood next to the spot where the first missionaries in the region erected their base.

Masinde Muliro University of Science and Technology, formerly Western University College of Science and Technology, is a public university in Kenya. MMUST became a fully accredited public university in 2007. Before being elevated to full university status, it was a constituent college of Moi University (Eldoret). The college was established in January 1972, known as Western College or WECO, a college of Arts and Applied Sciences, awarding certificates and diplomas in technical courses. Currently, the student enrollment at MMUST is well over 5000.

Great Lakes University of Kisumu is a fully chartered university with its main campus located beyond Mamboleo on the Kisumu-Miwani Road. GLUK has campuses and teaching sites namely: Milimani centre, Nairobi, Kokise, Kisii, Mbita, Mfangano, Mumias, Oyugis, Siaya, Kapsabet and Garissa. The institution, which begun as a community-based organization training healthcare workers in 1979, has grown to reach a student population of 1,200 spread across three campuses. GLUK became the third university in Western Kenya after Maseno University and MMUST. The demand for

university education in the region has been increasing with several public and private universities setting up campuses and constituent colleges in urban centres of Kisumu, Kakamega and Kisii. However, lack of adequate finances has hampered the growth of universities like GLUK, making expansion slow and forcing students from the region to relocate in search of institutions of higher learning. The main aim of GLUK is to develop effective managers of development initiatives in the Great Lakes Region of Africa. GLUK also equips its students with additional skills aligned and designed for Kenya's vision 2030. The University serves Kenyan and International students. The academic experience at GLUK is enriched by the latest in teaching techniques, mentorship and collaborative programmes with various Universities.

United States International University Africa (USIU-Africa) is located in Kasarani area, off Nairobi-Thika Road in the suburb of Kenya's capital city of Nairobi. The university is an independent, not-for-profit institution serving 6,032 students representing 70 nationalities; 85% of who are domestic and 15% international.

Owing to the importance of counselling in learning institutions, it is assumed that most Kenyan universities have counselling services under the department of Student Affairs, whose primary mandate is to assist students in the development of skills for establishing and maintaining effective satisfying personal and social relationships. The staff in counselling centres assists students to cope with crises and to learn how to resolve challenges. They also guide students in decision making, clarify alternatives for students and nurture students' growth (Kyalo & Chumba, 2011). The Kenya National Commission on Human Rights (KNCHR) carried out an audit on the mental health

system in Kenya. It was found that, as a result of stigma and discrimination against mental illness and persons with mental disorders, the policies and practices of the government of Kenya have been inadequate and resulted in a mental health system that is under resourced and unable to offer quality inpatient and outpatient care to the majority of Kenyans who need it (KNCHR, 2011). This includes young people joining the university who may therefore have undiagnosed personality disorders.

3.4 Study Population

The unit of observation was the university, while the units of analysis were the undergraduate students and the counselling services at each study site. The target population (more than 10,000) included all students, Deans of Students, Medical Officers and Counsellors from all universities in Kenya. The Study population is in Table 3.2.

Table 3.2: Study Population

Study Population Unit	Study Population
Undergraduate University Students in Kenya	More than 10,000
Closest friends of the selected students	More than 10,000
Key Informants	
• Deans of Students in all universities	All
• University Medical Officers in all universities	All
• Student counselors in all universities	All

Source: Field Data (2015)

3.5 Sample Size Determination and Sampling Procedure

The following procedure was used to identify the number of subjects for the study, and the selection of those that actually participated.

3.5.1 Sample Size

The estimated population (N) of the undergraduate students in the universities in the study is known to be more than 10,000. The Fisher *et al*. (1991) formula for sample size determination where the population (N) is known to be greater than 10,000 is therefore applicable and is used to calculate and arrive at the sample size of 384 students. The formula is:

$n = \frac{z^2pq}{d^2}$ **Equation 3.1:** Fisher *et al*., (1991) for Sample Size Determination

Where;

n= the desired sample size by probabilistic sampling when the population is more than 10,000

z= the standard normal deviate at the required confidence level that is 1.96

p=the proportion in the target population estimated to have the characteristic being measured that is 0.5 (which is 50%)

q=1-p that is. 0.5

d=the level of statistical significance set

As there is no estimate available of the proportion in the target population assumed to have the characteristics of interest, 50% is used as recommended by Fisher *et al.* (1991) which when substituted, $n = \frac{1.96 \times 0.5 \times (1 - 0.5)}{0.05}$

$= 384$

The key informants, namely 4 Deans of Students, 12 counsellors and 4 University Medical Officers were purposively selected from each university for their in depth knowledge on the variables. Each was picked from the selected university.

3.5.2 Sampling Procedure

The study employed multi-stage, random mixed methods sampling techniques, in which different methods are used at different phases of selection. Selection was done from the 39 chartered universities (22 public and 17 private) in Kenya (CUE.org.ke, 2014; AAA, 2000). All the Kenyan universities were divided according to phases and later divided into clusters. The first phase was randomly selecting 4 universities to represent the 29 Kenyan-based universities. The random method used was lottery, where all the names of the public universities and all the names of the private universities were written on small pieces of paper which were placed in two separate hats. The hats were shaken and then one piece of paper picked from each. The hats were shaken again and a second paper picked to the two universities for the study. The figure of 4 is roughly 10% of the total number of both public and private universities (39) chartered by the time of the study. This is consistent with Kothari's (2002) view. According to Kothari (2002), this percentage is adequate representation in a qualitative study such as the current one which aims to evaluate the proficiency of the counselling services in addressing personality disorders. Hence 10% of the 39 universities (approximately 4) were selected.

The next stage was cluster sampling where the selected universities were assigned codes as study clusters. This was followed by non-proportionate quota sampling where the total number of respondents was divided equally among the four clusters, meaning 96 students was sampled from each university. To identify the actual respondents for interview, stratified random sampling was used among the students found available at the time of the study. Table 3.3 shows the study population summary for the study.

As for Deans of Students and University Medical Officers to be included in the study, they were purposively selected from the selected universities since in universities; there is usually just one of each of these categories of staff. Hence one of each was picked from each of the four universities except counsellors who are usually more than one in a university. Hence one dean of students, one medical officer and three counsellors were selected from each of the four selected universities, making a total of twenty officers. If the number of counsellors were three, they were all picked in order to get a variety of experiences and pinions from them. If there were more than three counsellors in one university, then they were asked to pick piece of paper marked either "Yes" or" No". In doing this, they were allowed to make a choice. Those who picked "Yes" were the ones who were included in the study. This data is displayed in Table 3.3.

Table 3.3 Sample Population Unit, Study Population Sampling Method and Size

Study Population Unit	Study Pop Size (N=39) – [universities]	Sampling Method 10%	Sample Size 4
Undergraduate Students	>10,000	Non proportionate quota sampling	384
Closest peer of student	>10,000	Purposive	384
Deans of Students	All	Saturated	4
Counsellors	All	50% of available counsellors	12
University Medical Officers	All	Saturated	4

Source: Researcher (2015)

3.6 Data Collection Instruments

Data was collected from both primary and secondary sources as follows:

(i) Primary Data

Primary data is first hand information that is acquired through various instruments of data collection. The data for this study was collected using tested tools. These were: a questionnaire, interview schedules, observation checklist, counselling evaluation form, focus group discussion and review of relevant literature. The observation checklist on the counselling environment was supplemented with answers from the students, the counsellors, Deans of Students and Medical officers.

3.6.1 Questionnaire for Student Respondents

Prior to distributing the questionnaire, the principal researcher had to get the respondents' consent to participate in the study after selecting them. Luckily for the four universities where data was collected, cooperation from respondents was high. The principal researcher and a trained research assistant distributed the questionnaires to student respondents and gave clear instructions on how to fill in the document. The part of the questionnaire to assess the existence of a personality disorder is derived from an on-line diagnostic site that was used in identifying the personality disorders in the students (4degeez.com - Appendix 1A and 1B).The questionnaire was used for pre-testing in one of the universities that was not in the sample population. Before administering it to the sample population, necessary corrections were made to ensure all items were clear. At least 96 questionnaires were administered to students in each of the four universities selected for the study.

Questionnaires are a suitable tool for collecting a large amount of information at a go so they save time. Using the questionnaire, the researcher was able to collect information

from almost 400 students within about four weeks, yet if they were all to be interviewed, it would have taken months. Because each respondent fills out their own questionnaire, a certain amount of confidentiality is kept. During data collection, the researcher noted that some students did not want to be known to have a personality disorder. Hence individual questionnaires meant no one had direct access to the other's information. However, questionnaires are disadvantageous in that response rates can be quite low. Furthermore there is no direct response so the researcher cannot ask for further information. Above they are quite expensive. Fortunately in this study the researcher did not suffer a significant low rate of response because officers (deans of students and student counsellors) commanded respect of their students. The response was 100% from all respondents (Appendix 2).

3.6.2 Interview Schedules

Interview schedules are oral questionnaires where respondents don't have to write but simply answer questions face to face (Mutai, 2000). Although they may be expensive, interviews are advantageous of completeness and accuracy (Francis,..). For maximum benefit, interviewers have to be trained. In this study, interviews were administered by the principal researcher and research assistant who had been trained to key informants who comprised deans of students, student counsellors and university medical officers in each of the four selected universities for the study. Respondents were contacted by phone in advance after the official request and arrangements were made as to when interviews were to take place. At each station (university) the researcher ensured that respondents were comfortable in order to give sensitive information especially about students. It was also ensured that the information which was sometimes confidential

was being given to the right people. For the sake of flexibility, interviews consisted of both closed and open-ended questions (Appendices 2A, 2B and 2C).

3.6.1.3 Observation Checklists

The observation schedule assists the researcher as is observed by Mutai (2000), to go beyond the outward appearances and probe the perceptions, motives, beliefs, values and attitudes of the people involved. An observation checklist was used in the current study to assess the counselling room and environment in its contribution to effective counselling therapy. The checklist was compiled from variables identified in the literature reviewed, such as physical location, relative comfort, and freedom from external disturbances, serenity and any other factors that would make the counselling environment conducive. This was then used to evaluate the effectiveness of the counselling environment. Items on the checklist included location, ventilation, lighting, furniture and overall condition of the atmosphere (Appendix 2D).

Observation of the counselling room and environment was done after the students had filled in their questionnaire and key informants had been interviewed. Observation therefore, supplemented the information given by the respondents on the condition and suitability of the counselling facilities. This was done at each of the 4 universities included in the study.

The evaluation form was used to measure the satisfaction level of the students with the counselling services. The form was adopted from the one used in Bristol university (Section II of Appendix 1A).

3.6.4 Focus Group Discussions

Kombo (2006) suggests that a focus group is a special type of group in terms of purpose, size, composition and procedures. It comprises 8-12 individuals who share certain characteristics relevant to the study. The discussion is intended to obtain information from participants' beliefs and perceptions on a defined area of interest. With regard to this study, focus group discussions would have been held with significant individuals in each of the four universities used in the study. These were mainly peer counsellors, as they were better placed to give their opinion. However, since the close friends/peers of the respondents had filled in a confidential form, that was considered sufficient information. Hence there was no need for FGDs for this study.

(ii) Secondary Data

Secondary data is data neither collected directly by the researcher nor specifically for the user (Kombo, 2006). It ca be data from publications such as government documents. In the case of the current study, the secondary data was mainly the documents for records in the offices of the Student Affairs departments pertaining to the counselling contract and evaluation forms. These were collected after the principal researcher and research assistant had requested for them from the Deans and Counsellors.

Table 3.4 Summary of Data Collection Instruments

Study Population Unit	Sampling Method	Sample Size	Data Collection Tool	Appendix Number
Undergraduate Students	Non proportional quota sampling	384	Individual Questionnaire	1A
Closest peer of respondent	Purposive	384	Questionnaire	1B
Deans of Students	Saturated	4	Key Informant Interview Guide	2A
Counsellors	Purposive, 50%	12	Key Informant Interview Guide Observation Checklist	2B 2C
University Medical Officers	Saturated	4	Key Informant Interview Guide	2D

Source: Researcher 2015

3.7 Pilot Study

A pilot study is a small 'pre-survey' of a major one carried out in order to check the method of data collection and ensure that questions to be asked are of the right kind (Public Social Update, 2001). Pilot studies are usually carried out using a different sample altogether from the one sampled for the stud Public Social Update, 2001). In this particular study, pre-testing was done at Maasai Mara University. The pilot study was carried out to ascertain the items in the questionnaire were the right ones, that they were easily understood and that they were measuring what they were expected to do. In other words, the pilot study partly ascertains that there is validity in the research instruments to be used in the study.

3.7.1 Validity of the Research Instruments

(i) Validity

In order to ensure that the data collected using the questionnaires adequately represents the domains of the variables that are to be measured; the researcher determined in advance their content validity. This was done through discussions and consultations with university supervisors, and expert judgment of experienced practitioners in the field of counseling therapy.

Expert judgment was used to ensure that the data collected using the questionnaires adequately represented the domains of the variables that were measured. Expert judgment as a method of determining validity was informed by the observation of Kothari (2002) who stated that the determination of content validity is largely subjective and intuitive, and can therefore be determined using expert judgment of how well the instrument meets standards. Through this process, it was made clear whether the instruments designed for the study actually measured what was intended. Research assistants were trained in order to assist in collecting data in each university. They were for instance taught how to ask questions during interviews, noting down important points; how to put probing questions without scaring respondents; keeping time with appointments and keeping ethics while dealing with human beings.

(ii) Reliability of the Research Instruments

The tools were piloted in order to guarantee their reliability. A pilot study was carried out to ensure the reliability of the data collection instruments. The piloting of the research instruments was done at Maasai Mara University which was identified through convenience sampling. The test sample was 10% of the study sample size (Mugenda, 2008). Hence, 40 students and their close peers, making a total of 80, were included in the pilot study. Owing to cost involved, one trained research assistant helped with the data collection.

Reliability testing was done using Cronbach Alpha's split-half method. Reliability is the degree to which an instrument when tested it consistently measures whatever it is targeted to measure. The more reliable the test is, the more confidence we can have that the scores obtained from the administration of the test are the same if the test were to be re-administered. According to Mugenda & Mugenda (1999), reliability in research is influenced by random error in the data, which is the deviation from the true measurement due to factors such as over estimation, underestimation, inaccurate coding, and interview bias. It can be overcome by trying to minimize this random error in order to increase the reliability of the data collected by computing a reliability co efficient that indicates how reliable the data for each variable are. This co efficient was calculated from the pilot data and found to be 0.72.

Reliability is defined as the consistency of results from a test. Theoretically, each test contains some error – the portion of the score on the test that is not relevant to the construct that you hope to measure. One of the ways to measure reliability or internal

consistency, which the current study adapted, is the 'split-half' method. Split-Half Reliability determines how much error in a test score is due to poor test construction. To calculate reliability, the researcher administers one test once and then calculates the reliability index by coefficient alpha (Cronbach's Alpha), Kuder-Richardson formula 20 (KR-20) or the Spearman-Brown formula. The current study used the Cronbach's alpha formula since it can be readily more accurately calculated using the SPSS computer programme that will be availed for data analysis. Cronbach's alpha is also the recommended preferable statistic to calculate the split-half reliability where a study administers a Likert Scale that does not have just one correct answer. The current study has a number of Likert scales to measure a number of constructs. The cut-off points for internal consistency using this statistic are as described below (Cronbach & Shavelson, 2004).

Cronbach's alpha	Internal consistency
$\alpha \geq 0.9$	Excellent
$0.7 \leq \alpha < 0.9$	Good
$0.6 \leq \alpha < 0.7$	Acceptable
$0.5 \leq \alpha < 0.6$	Poor
$\alpha < 0.5$	Unacceptable

The split-half reliability method indicates how consistently the measure assesses the construct of interest. The reliability was calculated from the pilot sample, using SPSS and was found to be 0.72. As this met the internal consistency threshold, the tool was deemed reliable for application in the main study.

3.8 Data Analysis and Presentation

The data were first cleaned through editing and ensuring there were responses to every question. All the returned questionnaires and written answers to interviews were edited

for accuracy, completeness and serialization in order to allow the researcher identify responses that may have had errors, and then organized the collected data in a systematic manner. Secondly, the structured student questionnaire (quantitative data) was post-coded where it was found necessary, to facilitate analysis using the Statistical Package for Social Sciences (SPSS). Thirdly, the data were presented in graphs, pie charts, tables and digital photographs. Qualitative data from interviews were received in verbatim, transcribed and recorded in themes and sub themes. Data gathered through the observation checklist was also presented in a table as well as plates focusing on the variables mentioned earlier, location and availability of suitable furniture, among others. Summary of the data analysis is displayed in Table 3.5.

Table 3.5 Summary of Data Analysis

Specific Objective	Measurable Variable	Method of Analysis
(i) Examine the nature and extent of personality disorders among undergraduate students in Kenyan universities	Typical characteristics of Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, Obsessive-compulsive. demographic characteristics of students	• Descriptive Statistics: Frequencies and percentages • Qualitative
(ii) Find out types of counseling therapies, availed in the Kenyan universities	**Counselling approaches** • Behavior therapy • Cognitive therapy • Dialectical behavior therapy (DBT) • Interpersonal therapy • Psychodynamic therapy and • Family therapy **Service provider factors** • Counsellor Characteristics • Counselling Room Environment	• Qualitative • Descriptive Statistics (frequencies and percentages)
(iii)Evaluate effectiveness of the counseling services in addressing Personality Disorders among the undergraduate students	• Recommended management of personality disorders • Satisfaction level of Student Counsellees • less emotional distress in counsellees • increased capacity of counsellees to regulate emotions • improved interpersonal relationships of counsellees	• Qualitative • Descriptive Statistics (frequencies & percentages)

Source: Researcher (2015)

3.9 Assumptions of the Study

The study made the following assumptions:

i. The respondents participated in the study and provided truthful responses.

ii. That none of the respondents included in the study was biased in his/her opinion in providing information in line with the study objectives.

iii. That it was possible to measure the satisfaction level of students regarding the counseling services offered at their universities.

iv. University counselors offer diverse types of counseling therapies to students.

v. The effectiveness of the counseling services has an effect on the Personality Disorders manifested by undergraduate students.

3.10 Limitations

The limitations to the study and the ways they were overcome are as listed below:

i. Some students were reluctant to participate because of feeling stigmatized about the possibility of harbouring a personality disorder being reluctant to participate. This was overcome by reassuring them of anonymity

ii. Some students' friends who were required to provide supplementary information felt shy to disclose the true condition of their friend out of a sense of loyalty. This limitation was overcome by once again reassuring the respondent's friend about the confidential nature of the study, and that identities would remain protected as questionnaires only had code numbers instead of names.

iii. Owing to confidentiality, inability to access certain secondary data such as personal files of students likely to have personality disorders. Here information from deans of students was invaluable.

3.11 Ethical Considerations

When dealing with people and animals, researchers must consider ethical issues (Kombo, 2006). For instance researchers must respect subjects. Hence they must obtain informed consent from them before including them in their studies. In the current study, the participants were treated with due respect. Participation of students in the research was on a voluntary basis and there was no coercion to anyone whatsoever. The research assistant clearly explained the purpose of the study and obtained informed consent of the respondents prior to giving out the questionnaires for self-administration. There was full revelation as to the purpose for collecting the information. The data collected from the study was made available to the stakeholders because of their role in providing quality counselling services for undergraduate students. However, where necessary, confidentiality was maintained.

Prior to data collection, all respondents were appropriately contacted and their consent to participate in the study sought. University authorization was sought through the School of Graduate Studies to conduct the study, and a research permit obtained from the National Council of Science, Technology and Innovation.

It was of paramount importance that certain information was not divulged during data collection and that respondents were also protected. This expectation was adhered to by the researcher who ascertained that no personal information of any participant was divulged and that no respondent felt threatened either physically or at any one time. Confidentiality was, therefore, observed where it was necessary. In order to accord

respondents due respect, data interpretation was appropriately done with no exaggerations.

3.12 Chapter Summary

This chapter presented study sites and discussed the study population, research design, sampling strategy and analysis of the data collected. It started by giving an overview of the four selected universities included in the study namely: Maseno, Masinde Muliro, the GLUK and USIU-Africa. The chapter described the study population which included 384 randomly selected students, 4 deans of students, 4 medical officers and 12 student counsellors purposively selected from the four universities. The four universities were selected through lottery method. The study research design adopted - the ex-post facto design was also discussed. The sampling strategy used was the random-mixed methods sampling techniques. The four universities representing 10% of all Kenyan universities were sampled through lottery random method. Non-proportionate quota sampling was used to divide equally the 384 student respondents between the four universities to give 96 students to be sampled from each university. Actual student respondents from each university were selected using random sampling among available students. Deans of students, medical officers and student counsellors were purposively selected from each university. The next chapter presents discussions and findings to fill gaps identified through literature review.

CHAPTER FOUR

THE NATURE AND EXTENT OF PERSONALITY DISORDERS AMONG UNDERGRADUATE STUDENTS IN KENYAN UNIVERSITIES

4.1 Introduction

This chapter presents and discusses the findings from objective one which was to 'examine the nature and extent of personality disorders among undergraduate students in Kenya'. After the introduction, it starts with presentation of respondents' background information in section 4.2 such as: distribution of students across the clusters, their age distribution, academic year of study, gender distribution and prevalence of personality disorders among them. In section 4.3, it presents and discusses the nature and extent of personality disorders among university students and ends with the chapter summary in section 4.4.

4.2 Students' Background Information

The study gathered some background information on the students that agreed to participate in the study.

4.2.1 Distribution of Student Respondents across the Clusters

Table 4.1.Distribution of student respondents from the clusters (n=384)

Cluster (Institutions)	f	(%)
GLUK	96	(25)
Maseno	96	(25)
MMUST	96	(25)
USIU	96	(25)
TOTAL	**384**	**(100)**

Source: Field Data, 2015

An equal number of students were drawn from each cluster. The distribution is displayed in Table 4.1.

Table 4.1 shows equal distribution of 96 (25%) student representations across the clusters (universities) namely: GLUK, Maseno, MMUST and USIU-Africa. The process assisted in reducing bias and inequality in the number of respondents, despite the clusters' various capacities.

4.2.2 Age Distribution of the Students

Majority of the students, 311 (81%) in the study was found to be aged between 20-25 years, while (11%) were aged above 25years. A significant proportion, 30(8%) were younger than 20 years. The data is represented in Figure 4.2.

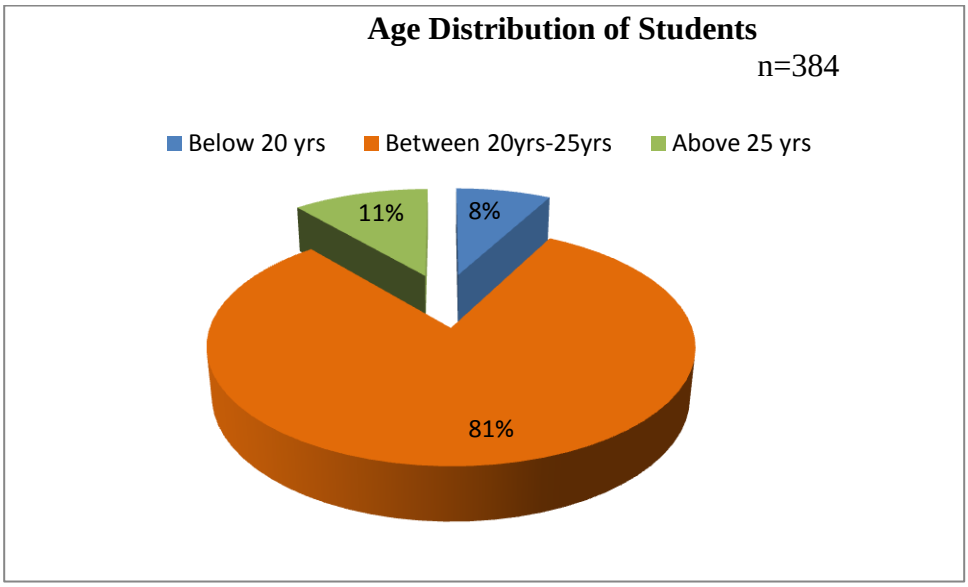

Figure 4.2: Age Distribution of Students
Source: Field Data, 2015

Having a group aged below 20 years carries implications on emotional development and social adjustment. Age is therefore an important factor in explaining increase in students with mental health problems worldwide (Macaskill, 2012). Many of these

students may be living away from home for the first time, exposed to unprecedented freedom. According to Dale (2010), age 19-24 years for college and university students was typical in Canada. In 1992, 57% of university students were 17-24 years. However, by 2007, 17-24 accounted for 65% of university students.

As MacKean (2011) points out, 15- 25 is a natural age of the onset of mental disorders, an age when many young people are attending university. A new set of social skills is required in the new setting. For those with personality disorders, this is the age and environment where they are most likely to clearly manifest. The youthful age of respondents also points to a period in life where many want to experiment and discover themselves (MacKean, 2011). Hence there is a growing awareness that mental health is a key requirement of university life and affects learning and academic success (Mackean, 2011; Macaskill, 2012). One of the medical officers corroborated with Mackean and Macaskill when interviewed. He informed the study that there is a lot of sexual experimentation because most of the students are at the adolescent age when hormones are extremely active and the campus environment provides too much freedom; so if it is not well managed, results in a lot of problems.

4.2.3 Academic Year of the Students

In the study, though the students were randomly selected, almost half the sample population, 170(44.3%) as shown in Figure 4.3 were found to be in their second year of study, followed by 100 (26%) in their first year of study. Those in the third and fourth years and above constituted 65 (16.9%) and 49 (12.8%) of study subjects, respectively. The data is displayed in Figure 4.3.

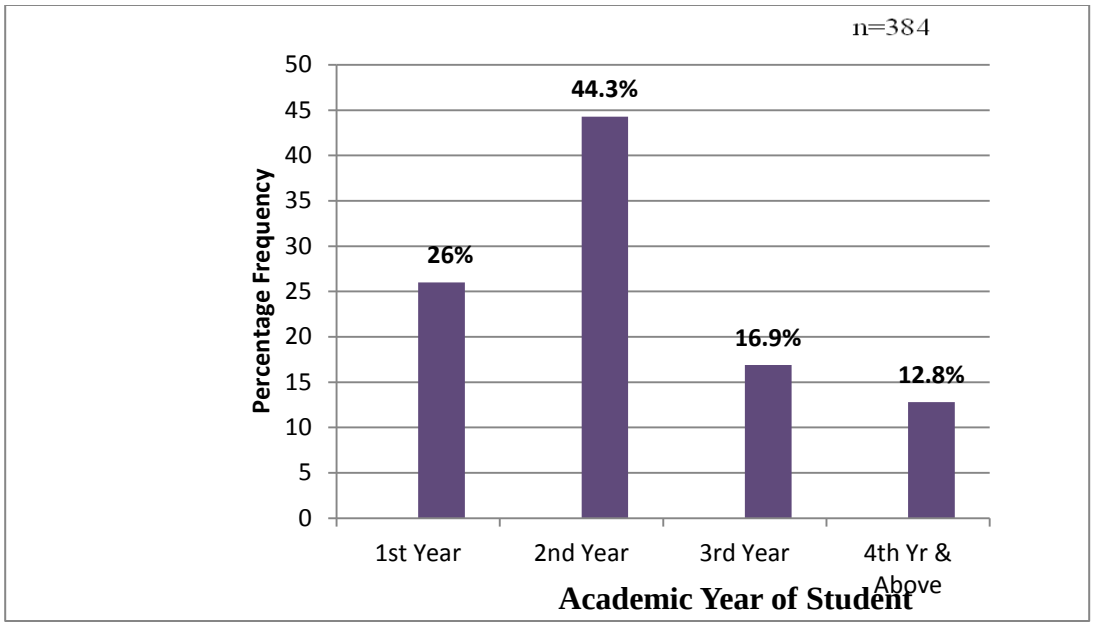

Figure 4.3: Distribution of Students' Academic Year
Source: Field Data, 2015

The implications for the study are that all year groups should have experienced some form of counselling. The information drawn particularly from the first and fourth years that have attended counselling potentially provides some measure of the input from counselling, based on the assumption that the fourth years have had more exposure and therefore benefitted more from the counselling interventions.

4.2.4 Gender Distribution of the Students

The data displayed in Figure 4.4 indicates that 206 (53.6%) of students were male, and 178 (46.4%) were female, which was a fairly balanced distribution despite the randomization technique applied in selection. This finding is consistent with the enrollment ratio typically to be found in most universities, especially Kenya where there are more male students than female ones. Hence, the study sample represents the proportions currently existing in most universities. However, as Ratcliffe (2013) has

observed, in the United Kingdom, male undergraduate students were outnumbered by their female counterparts in most universities, especially those that are art and design oriented. Ratcliffe (2013) suggests three reasons for this scenario: cultural reasons, girls outperform boys, and it also depends on the schools where those students go. In Kenyan universities, the main reasons for more males than female students are due traditionally to poorer performance by females as well as cultural reasons in this patriarchal society. Women are also outnumbered by men in universities because of their gender roles As Njeru (2003) observes, there is a near-gender parity enrollment, retention, completion and progression rates for both boys and girls in primary and secondary education in Kenya. In public university education, however, there is still a big gap unlike in private universities where enrollment. Gender disparities are seen in enrollment rates, dropout rates and survival rates where women are disadvantaged at earlier levels especially when girls get pregnant in primary or secondary schools and drop out of school or are married off forcefully by their parents. Wainaina (2011) argues that women fail to enroll in higher education because of the rigidity of traditional higher education programmes which leave no room for them to combine their multiple gender roles with studies. Maina (2009) supports this by stating that at university level, women form 40% of the total students.

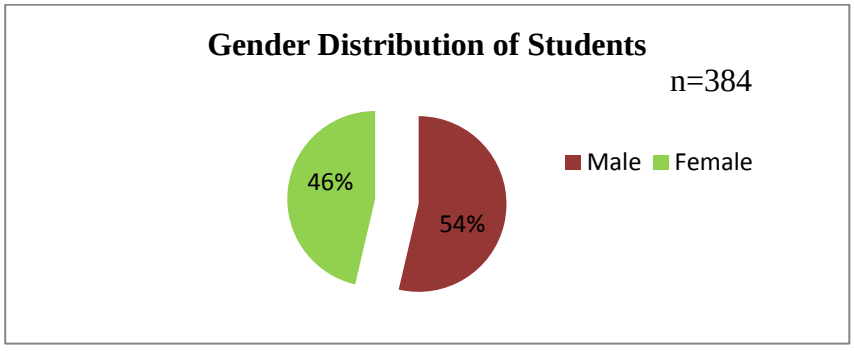

Figure 4.4: Gender Distribution of Students
Source: Field Data, 2015

4.3 Prevalence and Nature of Personality Disorders

This section addresses PDs under the subsections: prevalence and their nature.

4.3.1 Prevalence of Personality Disorders

The distribution of responses regarding whether or not the student has a personality disorder, based on self-assessment online tests revealed that 364 (94.8%) do indeed possess a personality disorder, while only 20 (5.2%) tested negative to the condition. The results are displayed in Figure 4.5.

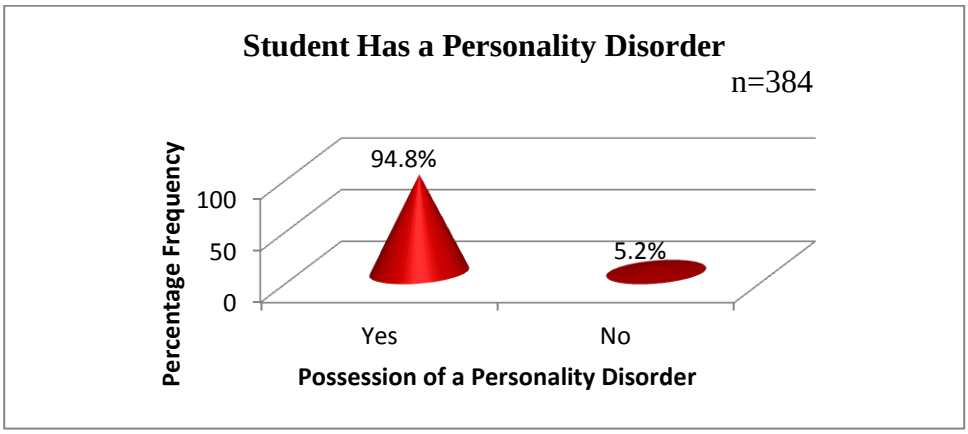

Figure 4.5: Distribution of Students with a Personality Disorder
Source: Field Data, 2015

This finding is supported by medical officers' opinions during interviews on the prevalence of personality disorders in the university which averaged at 1(20%). This figure is close to the one cited in literature, where studies using research diagnostic instruments have found that 20–40% of psychiatric out-patients fulfill criteria for a personality disorder (Reich & Green, 1991; Dowson & Grounds, 1995; Moran, 1999). Australian based studies were carried out by the Ausralian Medical students Association (AMSA) which concluded that psychiatric issues amongst youths, particularly

university students are worldwide (Wahid, 2013). According to the report, at least 83% Australian university students were a high risk population who suffered anxiety disorders such as mood and conduct disorders of depression, anxiety and suicidal behavior. Similarly, WHO (2000) maintains that mental disorders have been found to be common, with over a third of people in most countries reporting sufficient criteria to be diagnosed at some point in their life.

Deans of Students, when asked to report from their records, the proportion of students likely to have personality disorders, 3(75%) gave a figure ranging from 2-3(2-3%). At the same time they reported that the proportion of those attending the counselling services who are diagnosed with personality disorders were just under 8(2%). The Deans hastened to clarify that the 8(2%) is only of students that show up for counselling. Nevertheless, this implies almost all the counselling cases that present themselves invariably possess a personality disorder.

According to literature, studies of the prevalence of personality disorders have been few and small-scale. However, a broader Norwegian survey found an overall prevalence of almost 13.4%, with rates for specific disorders ranging from 0.8% to 2.8%, with rates differing across countries (Torgersen *et al*, 2001). A US survey found an overall rate of 14.79% (Grant *et al,* 2004). Nevertheless, these statistics are widely believed to be underestimated, due to poor diagnosis and low reporting rates in part because of the predominant use of self-report data, rather than semi-structured instruments (Mateos & Luis, 2013b).

Given the disruptive nature of personality disorders on peoples' relationships (be they working, platonic or intimate ones), this high statistic has implications for the general level of peace and the potential for conflict on a mass level arising from tensions built up at interpersonal levels. Among the student body, it is therefore possible that, based on the findings of Spence & McPhillips (1995), the instigators of destructive behaviour on campus riots may be students with personality disorders, particularly of the antisocial, paranoid and borderline types, because the scholars assert that such individuals frequently present within a criminal justice context and account for a large proportion of assessments of patients detained by police.

When close friends of the students were asked to fill out a separate questionnaire that assesses whether or not the subject exhibits symptoms of any personality disorder, the results indicate that 378 (98.0 %) do exhibit these symptoms. The fact that the friend also indicates that the student has a personality disorder serves to confirm the results of the online test, especially since about three quarters identify the exact same condition as is given by the online test

The results from the friend's assessment are displayed in Figure 4.6.

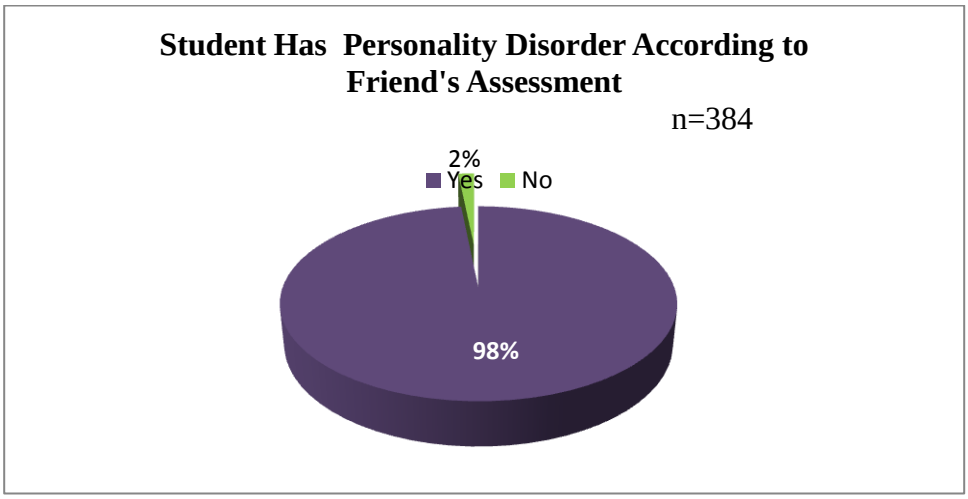

Figure 4.6: Presence of Personality Disorder According to Friend's Assessment\Source: **Field Data, 2015**

Furthermore, the friend's assessment result matched the respondent's online result in 258 (67.4%) of the cases as shown in Figure 4.7.

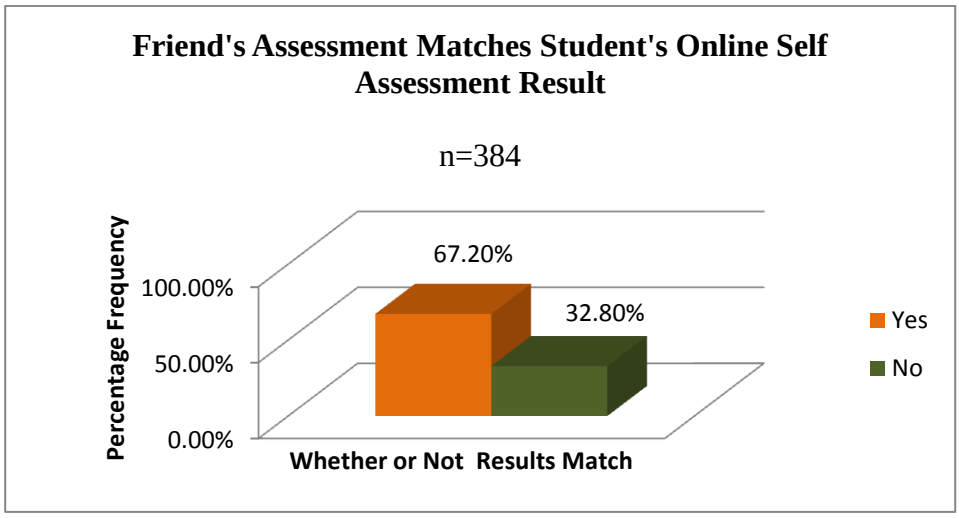

Figure 4.7: Responses on a Match between Own assessment and Friend's Assessment
Source: Field data, 2015

The two assessment results did not match in only 26(32.8%) cases. Friends/peers of the respondents are assumed to know their friends well. So if they adhered to the researcher's instruction on giving information as honestly as possible, the results from their responses would highly tally with those of the online test. The data confirms real existence of a problem that needs to be addressed. It implies that the assessment by the friends was very reliable, as the data closely aligned itself with that garnered from an objective online test. It also implies that the study subjects were quite honest in their responses; enough to ensure the data is not distorted, but a clear reflection of the truth. Above all it implies that university students suffer from personality disorders as confirmed by Deans of Students and corroborated by Saleem *et al* (2011); El-Hosseiny *et al* (2004) and Redhwan & Dhekra (2012). Various factors contribute to the increase

in emotional problems of youth on campus. Students at university are at a transitional stage to adulthood and they experience stresses caused by social-economic and psychological factors. Macaskill (2012) asserts that when the students live away from home for the first time, to make new friends and handle finances, this contributes to their risk factors, thus making them vulnerable to mental health problems. Students know one another well and as peers, they can tell if one is going through certain experiences. They are therefore in a position to give an honest opinion about their friends. However, what is not certain is if they are in a position to assist one get out of that problem, be it personal, social or family. If so many students have PDs and are aware, it is of great importance that university authorities move with speed to make sure that the necessary interventions are strengthened to assist students function at their best.

Three (75%) out of the four (100%) Medical Officers who participated in the study reported the manifestations of personality disorders most common at the universities as being psychiatric cases. The symptoms they witness are typically violence, confusion, depression and persistent headaches all of which are not linked to any pathology. Some reportedly also present with insomnia. One medical officer from one of the universities that participated in the study stated:

> We have had cases of mania where the student is violent, beating up the others, but this has mostly been related to alcohol intake. Hard drugs and drinks tend to bring on psychosis in those who are prone. As often as they get alcohol-related problems is as often as we treat them for alcohol poisoning (Key Informant, 2015).

The use of alcohol and drugs by persons suffering from personality disorders is not an unusual phenomenon. Lenzenweger *et al.* (2007) indicates that all personality disorders are associated with anxiety, mood, and impulse control and substance disorders. Therefore, the medical officer who claims that the student's violence and misbehavior is

precipitated by alcohol and drugs may be unaware that it is actually the inner disturbance of the personality disorders pushing the students to alcohol and drug use, perhaps as a coping mechanism (Mellos *et al.*, 2010)

4.3.2 Nature of the Personality Disorders

Table 4.1 is a summary of findings on the type of personality disorders found in the study sample of undergraduate students from the four universities namely: GLUK, Maseno, MMUST and USIU-Africa.

Table 4.1 Frequency Distribution of Nature of the PDs among Undergraduate Students

Paranoid	129	33.6%
Schizoid	52	13.5%
Schizotypal	19	4.9%
Avoidant	9	2.3%
Dependent	12	3.1%
Narcissistic	20	5.2%
Obsessive Compulsive	63	16.4%
Histrionic	15	3.9%
Antisocial	25	6.5%
Borderline	19	4.9%
None	21	5.5%
Total	384	100%

Source: Field Data, 2015

From the data, the most common manifestations were found to be paranoid 129 (33.6%), and obsessive compulsive 64 (16.4%). The prevalence of this condition is much higher than the one described in literature; the scholars McManus and Fay (2008) contend that PPD occurs in about 0.5%–2.5% of the general population The condition of Paranoid is one where the person is afflicted with a pervasive pattern of mistrust and suspiciousness, which begins in early adulthood and presents in a variety of contexts. The implication is that a large proportion of the undergraduate student body interacts in an atmosphere of mistrust. This hurts social relationships, and this way of relating is bound to spill over into the rest of society when the undergraduates eventually join the workforce, unless it is addressed beforehand.

According to Waldinger (1997), Paranoid individuals are eager observers; they think they are in danger and look for signs and threats of that danger, potentially not appreciating other evidence. The fact that it begins in early adulthood means the university setting is the best place and time to address it before it causes its victims more harm. The incidence of schizotypal was reported to be 19 (4.9%), avoidant was 9 (2.3%); dependent was 12 (3.1%); narcissistic was 20 (5.2%); schizoid was 52 (13.5%); histrionic 15 (3.9%); antisocial was 25 (6.5%); and borderline was 19 (4.9%).

From personal observation of the researcher during data collection, Deans of Students deal with all the welfare matters concerning students on a daily basis. They solve many students' problems whether the problems are social, personal, academic or psychological. The students' behaviour will usually indicate that something is wrong so they take appropriate action in assisting the student concerned solve his/her problem.

Table 4.1 gives the summary of the results of personality disorders among undergraduate s who participated in the study sample.

From Table 4.1, the paranoid PD is most frequent 129 (33%) among undergraduate students followed by obsessive –compulsive 63(16.4%, Schizoid 52(13.5%), anti-social PDs 25(6.5%), narcissistic 20(5.2%), borderline PD 19(4.9%), Histrionic 15(3.9%), Dependent 12(3.1%) with list common PD as avoidant 9(2.3%). Those who did not think there were PDs among undergraduate students were 21(5.5%). This category of respondents either did not know what PDs are or did not know how to interpret behaviour of people with emotional problems. These personality disorders especially the first four with highest frequencies (paranoid, obsessive-compulsive, schizoid and anti-social) have serious implications owing to their nature and potential harm. While all of them may lead to antisocial behaviour and damage interpersonal relationships, they also will impact negatively on academic performance.

The study sought to establish roughly what proportion of the student population has been diagnosed as having personality disorders over the last one year. During interviews, counsellors were asked to give their opinion. They were also asked which the most common types of manifestations were. Findings from the counsellors showed that at least half of them (50%) were not clear on how to classify the disorders, except to describe the presenting symptoms. In MMUST, for example, one of the counsellors reported that the most common phenomenon is depressed male students due to broken relationships with a girlfriend on campus. The counsellor claimed that it is mainly boys who have problems when after a number of years of supporting a girlfriend (such as

paying her fees), she breaks off ties with him claiming that he is a drunkard, or has other problems she cannot deal with. The boys then need to go through counselling in order to overcome the trauma of the broken relationship. In GLUK the counsellor reported he had not diagnosed any personality disorder. Yet another counsellor in the study claimed that once in a while a student will come in suffering from hallucinations, but that it is usually linked to drug abuse.

From the finding on interviews with counsellors, it can be deduced that some staff in Student Affairs Departments have not been trained to identify students with various personality disorders. It is also clear that many mental disorders of undergraduate students result from consumption of alcohol and use and abuse of drugs.

Novotney (2014) concurs that many college and university students are under pressure with mental health issues and the need for counselling services is increasing all the time. In a 2013 US National College Health Assessment, about one-third of US College students had suffered from depression in the last 12 months. In addition, more than 30 per cent of students who had sought services for mental health issues had seriously considered attempting suicide at some point in their lives (Novotney, 2014)..

The findings by the close friends of the students regarding the most common manifestation as being paranoid in 124 (32.2%), is almost exactly the same as the on line tests 129 (33.6%) and the remarks of the 4 (100%) Deans of Students. Results are displayed in Figure 4.8.

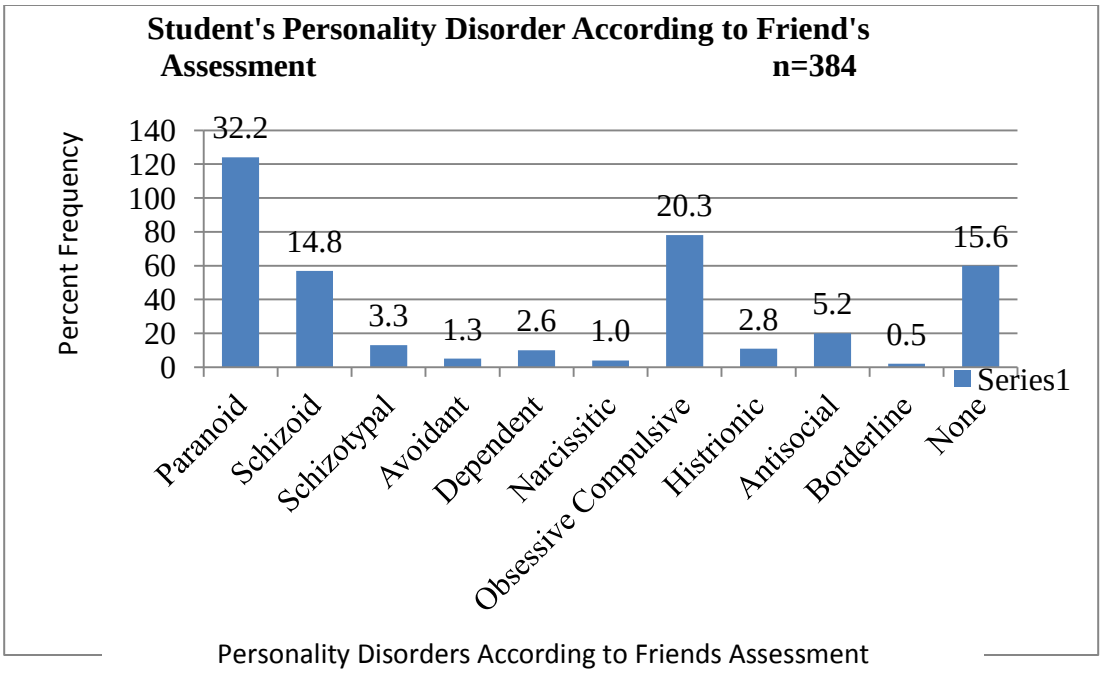

Figure 4.8: Nature of Personality Disorder According to Friend's Assessment
Source: Field Data, 2015

The 124 (32%) students suffering from paranoia are generating an atmosphere of mistrust and suspicion on campus; the 78 (20%) obsessive compulsive are preoccupied with orderliness and perfectionism, and practice mental and interpersonal control; the 57 (15%). Schizoids are detached from social relationships (Masterson & Klein, 1995), exhibiting a restricted range of emotional expressions; the 10 (2.6%). Dependents have an excessive need to be taken care of (Millon *et al*, 2004), exhibit submissive behavior and fear of separation; the 20 (5%) with antisocial PD interact with a disregard for the rights of others, lacking remorse for wrongdoing and empathy toward fellow students (Schacter *et al*, 2010); the 13 (3%) schizotypal cases go around with social and interpersonal deficits, compounded by perceptual distortions and eccentricities (Matsui *et al*, 2004); another 11 (3%) histrionics are excessively emotional and exhibit attention-seeking behavior (Bienenfield, 2006); the 4 (1%) narcissistic students harbor

grandiosity and a need for admiration (Freeman *et al*, 2000); while another 5 (1%) avoidant are plagued with social inhibitions, crippled by feelings of inadequacy, and hypersensitive to criticism (Millon & Roger, 1996); and another 2 (0.5%) are borderlines struggling with instability of interpersonal relationships, self-image, and marked impulsivity (Stiglmyr *et al*, 2005).

In the view of the researcher, the perceived level of existence of personality disorders generates a volatile dynamic that can readily erupt into conflict on campus at different levels and intensities. Based on the data from their peers, the undergraduate students are trying to live and study harmoniously while struggling with personality disorders. Deans of students confirmed this when they informed the study about how the personality disorders disrupt the students' lives by causing them to be absent from class. They find it hard to socialize freely with the other students. One of the deans reported:

Nature of Personality Disorder

> The condition disrupts them a lot. It is enough to keep one out of school for a while. There is one in particular who could not cope. He fought a lot and was very combative. He even threatened to knife someone. He terrorized the other students especially at night. With the female students it is usually threatening other colleagues over relationships. These usually turn out to be case of paranoia (Key Informant, 2015).

Generally when students are under the influence of drugs such as bhang, they are hostile and behave wild and confused. Some may even develop psychological problems like depression which may interfere with their academic performance. During the interview, the dean who gave the above statement also revealed that one of their male students had schizophrenia which turned out to be hereditary. He apparently suffered from paranoia and frequent mood swings that made him difficult to get along with. That is why it is

important that this kind of information appears in the personal details form of every student to aid in identifying and dealing with students' new or recurring mental problems of students. Regular use of alcohol and other drugs cause negative effects to users such as depression, psychosis and severe anxiety and impaired judgment (Washington and Lee University (2012). When interviewed in the current study, one Medical Officer asserted that the students get into activities that put them at risk of paranoia, because of stress, peer pressure, and alcoholism. The negative effects of the drug and alcohol abuse in the student body include rape of female students, and falling into pre-coma states from acute alcoholic intoxication. The medical officer went on to inform the study,

> Last week a girl was found around the local market area and was brought in comatose. We resuscitated her. Fortunately she recovered well. Usually a coma precedes death (Key Informant, 2015).

First time alcohol consumers normally suffer drastic effects like passing out after which the victim does not eknow what happened to them. It is not surprising to find relatively new female students because of the naivety, overdrinking and due to lack of experience; they get extremely affected health wise. Some have found themselves in strange environments after such incidents, not knowing how they got there. This concurs with the finding through the Medical Officers who highlighted the rampant drug abuse among students, which have been known to be linked to emotional disorders (Lenzenweger *et al.,* 2007). One confessed that,

> There is a certain drug going round among female students which is designed to induce abortion. They take the drug, and when they start bleeding they are brought here. We usually refer them to the public hospital (Key Informant, 2015).

It was also asserted by a key medical officer that,

> Some of the students are mentally disturbed. Only last week a student came after delivering a baby from an unplanned pregnancy. Her friend had also delivered but had died in the process. This caused her friend to fall into a deep depression. She is currently being counseled and on psychiatric treatment (Key Informant, 2015).

During FGD, Medical Officers informed the study that, as a result of their condition, the students' studies suffer. Some of them then engage in irresponsible sex to ease stress, which instead results in unplanned pregnancies, resulting in even more stress. Usually the students' parents are not aware of what is going on. The medical officer from GLUK informed the study that they had dealt with two cases of hysteria in the 6 months prior to the study. Counsellors, on their part, reported they were not sure about the links between substance abuse and personality disorders, but they did confess that drug and alcohol abuse are a problem among the students. It was even asserted that some students begin drinking in the morning. Many studies agree that apart from development of depression, this kind of scenario leads to students' poor academic performance (Redhwan *et el*, 2012; Saleem *et al* and Walker, 2005).

Based on the findings and discussion in regard to the first objective which was to 'examine the nature and extent of personality disorders among the undergraduate students in Kenyan universities' it was established that there is prevalence of personality disorders among the undergraduate students in Kenyan universities. These include: Paranoid, Schizoid, Schizotypal, Avoidant, Dependent, Narcissistic, obsessive-compulsive, histrionic and anti-social personality disorders. However, the most prevalent personality disorders were found to be paranoid and obsessive compulsive.

Studies indicate that psychiatric issues especially among university students are worldwide and that college and university years present an age of the onset of psychological conditions of depression, anxiety and obsessive-compulsive disorder (Wahid, 2013; Brown University, 2016; Wangari *et al*., 2012).

4.4 Chapter Summary

This chapter presented and discussed the findings of the study regarding its first objective. It began with a brief description of some demographic features of the students. It was seen that a majority of 81% students were aged between 20-25 years, while 10% were younger than 20 years. There was a comment made on the implications of this. The total sample that constituted 44.3% were found to be in their second year of study, followed by 26% in their first year of study (Figure 4.3). Those in the third and fourth years and above constituted 16.9% and 12.8% of study subjects, respectively, see Figure 4.3. It was seen that 53.6% of respondents were male, while 46.4% were female, see Figure 4.4. Based on self-assessment online tests, it was revealed that 94.8% do indeed possess a personality disorder, while only 5.2% tested negative to the condition, see Table 4.1.

When close friends of the student were asked to fill out a separate questionnaire that assesses whether or not the subjects exhibit symptoms of any personality disorder, the results indicated that 98 % did, indeed exhibit the symptoms, and about three quarters identified the exact same condition as was indicated by the online test. The friend's assessment result matched the respondent’s online result in 67.4% of the cases (Fig. 4.7). With regard to the nature of the disorders, it was seen that the most common

manifestations were paranoid (32%), and obsessive compulsive at about 20.3%. The other manifestations were Schizoid (15%); Dependent (16%); Antisocial (5%); Schizotypal cases (3%), Histrionics (3%), Narcissistic (1%), Avoidant (1%) and Borderline (1%). This was seen displayed in Figure 4.8. The next chapter presents and discusses the findings of the second objective which was to examine the management of counselling therapies and facilities availed to students.

CHAPTER FIVE

MANAGEMENT OF COUNSELLING THERAPIES AVAILED TO UNDERGRADUATE STUDENTS IN KENYAN UNIVERSITIES

5.1 Introduction

This chapter discussed the findings of the second objective which was 'to examine the management of counselling therapies and facilities availed in the universities.' This includes the counselling approaches and their associated techniques, the characteristics of the counsellors the students are exposed to, and the counselling room environment that serves as a platform for the therapy intervention offered. The chapter ends with a summary. In this chapter, f stands for frequencies, % for percent and n for the target sample.

5.2 Counselling Approaches and Techniques Employed

The study sought to establish the counselling approaches and techniques that students had been exposed to during counselling. They were, therefore asked whether they were engaged in a variety of activities during sessions. Twenty six (6.8%) respondents out of 384 (100%) said yes, 29(7.6%) said No, 8(2.1%) were somehow sure while majority 321(83.6%) said the question was not applicable. The study found that only 63(16%) students who attended counselling were exposed to a range of counselling activities which form part of the techniques under the various therapy approaches. The 26 (6.80%) who attended counselling attested to this. This data is displayed in Figure 5.1.

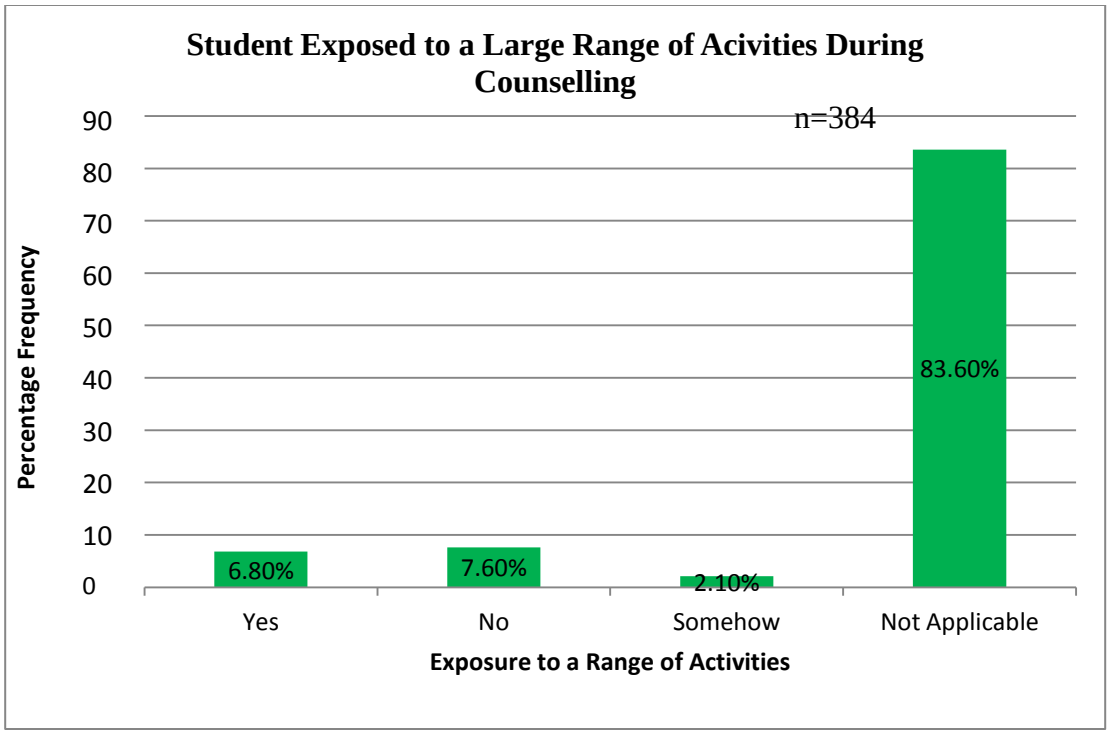

Figure 5.1: Availability of a Range of Activities during Counselling for students in Kenyan universities
Source: Field Data, 2015

Activities that were availed for the students during counselling sessions included drawing family trees and pictures; listing respondents' personal qualities; making self-portraits and masks; thinking through options; taught techniques to manage impulses and feelings and identifying alternative courses of action. Majority 321(83.6%) of students had apparently not attended counselling, so they were not exposed to the various activities. Those who had attended and who affirmed having been exposed to the counselling activities 26(6.80%) were about proportional to those who attended counselling but were in the negative 29(7.60). This implies that possibly the counsellors who saw the respondents in question through counselling did not actually expose them to those activities.

Activities that clients are involved in are supposed to assist them therapeutically. As Malchiodi (2003) points out, art therapy for instance, is based on the idea that the creative process or art making is healing and a form of non-verbal communication of thoughts and feelings. Malchiodi (2003) further states that art therapy is used for personal growth, for increasing self understanding and assists in emotional reparation. Counselling activities related to art help individuals find meaning in life and achieve insight (Malchiodi, 2003). Hence university students who have attended counselling will, therefore, be different as they have achieved these and other skills of self-management. If majority of students have not attended counselling according to the current study, then it will take a long time for a change to be noticed especially in behaviour. Moreover, it means if individuals with PDs are not seeking counselling, there is no way they are being assisted to get out of the problem. What authorities need to do is to find ways of availing counselling to as many students as possible. In that way, even those with PDs, can easily be identified and assisted accordingly.

5.2.1 Most Frequently Used Approaches and Techniques

This section presents results and discusses the most frequently used approaches and techniques in counselling. From the findings those students that attended counselling, 26 (6.8%) reported that they were definitely exposed to a large range of activities during counselling, 8 (2.1%) claimed that they were somehow exposed to various activities, while 29 (7.6%) claimed that they had not. When asked about the kind of exercises and activities the counsellees are given to do , and the coping skills with which they are equipped, counsellors asserted that it was mainly talking one on one, and some group therapy sessions. At MMUST for instance, the counsellor mentioned having a weekly

'coffee hour'. Activities include brainstorming sessions over identified issues. There are also times when networking is done with the students' parents in order to get a fuller picture of the issues at hand. Counsellors described different approaches and techniques which fall under the broad categories outlined in literature. The coffee-hour brainstorming weekly sessions are good but it was apparent that it was not an approach that could help students to be exposed to how and which could help them sort their problems out even when not with the counsellor. The most frequently used counselling approaches tools are presented in Table 5.1.

Table 5.1 Most Frequently Used Counselling Therapy Approaches and Techniques by Counsellors

n-384

Type of counseling approach	f	%
Behaviour Therapy (BT)	12	100
Role Playing	9	75
Free Association Technique	12	100
Cognitive Therapy (CT)	12	100
Dialectical Behavior Therapy (DBT)	12	100%
Interpersonal Therapy Techniques	9	75%

Source: Field Data, 2015

One of the most common approaches in use was found to be Behavior Therapy (BT), with all the 12 (100%) counsellors reporting that they used it. As discussed in literature

review, BT focuses on helping an individual understand how changing their behavior can lead to changes in how they are feeling (Bandura,1969). BT was used to help the students change their conduct, especially with regard to excessive alcohol intake and violence. Since BT includes techniques of Self-Monitoring, Schedule of Weekly Activities, Role Playing and Behavior Modification, the counsellors said they encouraged the students to participate more in daily and weekly sports and other recreational activities that do not involve substance abuse. It was also reported that the techniques of role playing were used by 9(75%) of the counsellors to help the student get in touch with their own emotions and find ways of responding better to adverse situations, such as when a girlfriend or boyfriend left them which, unfortunately, was reported to be a common occurrence among undergraduates. The change response counsellors aim for through this technique is to effect behavior modification.

Another common approach in use was Cognitive therapy, with 100% of the counsellors reporting that they used it often. As literature elaborates, CT is based on the theory that much of how people feel is determined by what they think. Disorders, such as depression, are believed to be the result of faulty thoughts and beliefs (Margolies, 2013). All the Counsellors in the universities which participated in this study were found to commonly face depressed students, and therefore reported to rely on this approach to help them correct the inaccurate beliefs, and perception of events in the affected students, in a bid to alter their emotional state. The study found that the Counsellors and Deans function as cognitive therapists, working with the student to challenge irrational thinking. Just as in the literature on the subject, the counsellors

reported that they indeed point out to the affected students' alternative ways of viewing their situation, and in that way the student's mood improved.

Undergraduate university students who were young adults emerging from the adolescent age category, invariably got caught up in romantic relationships. Often times, however, counsellors revealed that these are short-lived, leaving the participants emotionally shattered, particularly the jilted ones. Yet the parties to the broken relationship were forced to co –exist on campus since they need to continue attending classes. This is the case even if one or the other becomes suicidal.

A counsellor in one of the universities narrated an example where, following one such traumatic break up, the two undergraduate students were completely unable to bear the sight of each other on campus, leading the office to request one of them to defer their studies, in order to allow the other a chance to finish and vacate campus with minimal disruption. However, this is not always possible or feasible; the Deans and Counsellors must then teach the students how to manage the emotional trauma rather than physically taking them out of their crises. This approach is essentially the Dialectical Behavior Therapy (DBT) treatment, which is a cognitive-behavioral approach, emphasizing the psychosocial aspects of treatment. It was in use by all 12 (100%) of the counsellors interviewed.

Just as the literature explains, the theory behind the approach is that some people are prone to react in a more intense and out-of-the-ordinary manner toward certain emotional situations, primarily those found in romantic, family and friend relationships.

DBT theory suggests that some people's arousal levels in such situations can increase far more quickly than the average person's, attain a higher level of emotional stimulation, and take a significant amount of time to return to baseline arousal levels. In the example of the split couple as given by the key informant, it took a semester for the emotional stimulation in the traumatized couple to return to baseline. Counsellors revealed that through DBT, their aim was to help the student restore their self-respect and self-image. Both between and during sessions, the therapist actively teaches and reinforces adaptive behaviours, especially as they occur within the therapeutic relationship. This is in line with what Kyalo & Chumba (2011) found; the scholars maintain that the fundamental goals in counselling services are essential in increasing the students' feeling of personal adjustment and effective interaction in their immediate environment.

All the 12 (100%) Counsellors also said they often use the 'Free Association' technique developed by Sigmund Freud, one of the founding fathers in the field of psychology. In free association, psychoanalytic patients are invited to relate whatever comes into their minds during the analytic session, and not to censor their thoughts. This technique is intended to help the patient learn more about what he or she thinks and feels, in an atmosphere of non-judgmental curiosity and acceptance. This is possible because, as seen earlier in the literature reviewed, psychoanalysis assumes that people are often conflicted between their need to learn about themselves, and their (conscious or unconscious) fears of and defenses against change and self-exposure (Bollas, 2008).

When used in this spirit, free association is a technique in which neither therapist nor patient knows in advance exactly where the conversation will lead, but it tends to lead to material that matters very much to the patient, because, as Berne (1976) says that even when there is confusion, one can begin to make sense of disordered thoughts. The university counsellors' goal in using free association was to instigate a journey of co-discovery which can enhance the patient's integration of thought, feeling, agency, and selfhood.

From the responses of Key Informants, the study found that the Interpersonal therapy techniques are commonly used by 9(75%) of the 12(100%) counsellors. During such times they have individual therapy sessions, where the client works toward learning and improving many basic social skills. The Interpersonal psychotherapy (IPT) is particularly appropriate in the university setting, as it is a time-limited treatment that encourages the patient to regain control of mood and functioning typically lasting 12–16 weeks (Frank,1971) . Based on the principle that there is a relationship between the way people communicate and interact with others and their mental health, Interpersonal Psychotherapy of Depression is well adapted for the treatment of ambulatory depressed, non-psychotic, non-bipolar patients. Further, IPT is appropriate for effective treatment for Bulimia nervosa, (Weissman, 1998) and Major depressive disorder (Joiner & Kistner, 2006), both of which manifest in personality disorders.

University counsellors' choice of this therapy is also commendable because, according to Weissman & Markowitz (1998), although originally developed as an individual therapy for adults, IPT has been modified for use with adolescents and older adults, the age bracket in

which most undergraduates fall. Moreover, the study finds this method appropriate because researchers (Mufson et *al*., 1993) report that it is particularly accessible to patients who find dynamic approaches mystifying, or the 'homework' demands of Cognitive Behavioural Therapy (CBT) daunting. The scholars assert that IPT has been specially modified for adolescents (Mufson *et al.*, 1993) as it addresses relationships as a primary concern. However, the study conducted by Barkham *et a*l., (1996) showed a tendency for symptoms to recur, thus limiting the long term-effectiveness of this psychological therapy. This implies the students given this therapy would still require close follow up after graduating from university. Figure 5.2 shows the results.

5.2.2 Regularity/Frequency of Therapy Sessions

The study sought to establish the regularity of the counselling sessions from respondents, recognising this as being important, based on the literature reviewed (Linehan, 1993). The results are shown in Figure 5.2.

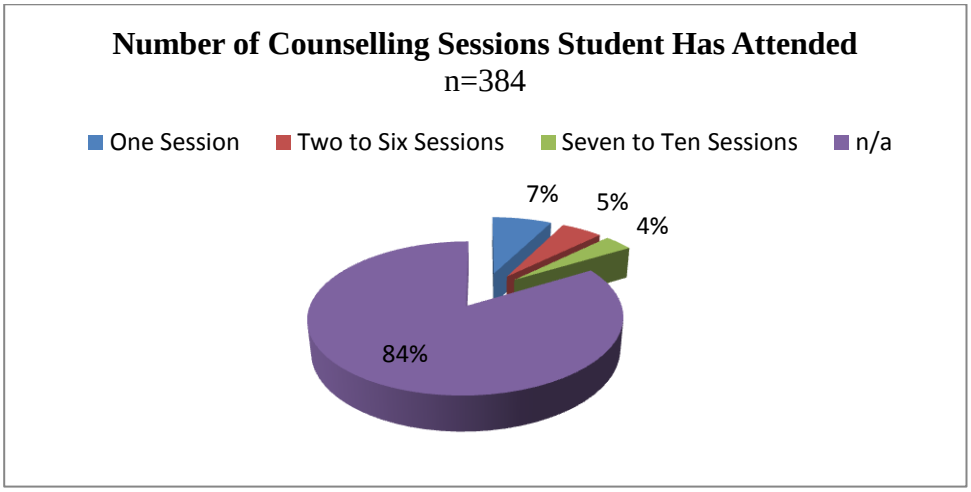

Figure 5.2: Frequency of Use of the Counselling Service
Source: Field Data, 2015

The results indicate that 19(5%) had attended two to six sessions, and 15 (4%) had attended seven to ten sessions, making a total of 35 (9%) of counsellees attending more than one session with their counsellors. Twenty-seven (7%) counsellees had attended one session. Yet majority of 322(84%) respondents had not attended counselling. It is possible that some of these were still undergoing the process of counselling. Frequency of sessions have implications on the quality of relationship forged with the therapist; Littauer *et al* (2005) assert that a good connection between therapist and client can happen quite quickly, even within the first 10 minutes, but on average it takes 2-3 sessions for a relationship to be formed. Deans of Students as noted earlier, expressed disappointment that only about 2(2%) of students attend counselling which is in agreement with the findings of the student respondents 63(16%).

Students who had attended counselling only a few times may be those whose problems ended or they were now in a position to solve their issues on their own outside therapy (Peters & Miller, 2004). . On the other hand, those attending a few counselling sessions may have given up and were discouraged. It is important that counsellors do a follow-up to know reasons why counsellees only attend a few sessions of counselling. The counselling relationship between counsellor and counsellee contributes greatly to how successful therapy will be. Counselling is about building rapport and trust with the counsellor so that a client feels comfortable to open up and voice their worries (Martin, 2016). The relationship is built on trust and confidentiality and can make all the difference between a positive and a negative counselling experience.

The frequency of sessions is a mark of DBT, which the 12 (100%) of counsellors reported

they employed. It included teaching students skills in interpersonal effectiveness, distress tolerance/reality acceptance skills, emotion regulation, and mindfulness skills were taught (Borchard, 2011). These serve to counter the effects of personality disorders. For example, students with antisocial PD which causes a lack of empathy, the affected person is taught to be mindful, those with the mood swings of Borderline PD learn how to regulate their emotions, and those afflicted with the chronic anxieties of Avoidant PD learn distress tolerance.

5.2.3 Interpersonal Therapy Techniques Employed

Table 5.2 shows results of some of the counselling activities the students were exposed to, which lean heavily toward Interpersonal therapy.

Table 5.2 Counselling Activities under the Interpersonal Therapy Approach (n=63)

	=63		n=384			
Counseling Activities	f	%	f	%	f	%
Student was taught techniques for Managing impulses and feelings and	41	10.7	22	(5.7)	321	(83.6)
Identifying alternative courses of action	48	12.5	15	(3.9)	321	(83.6)
Student was taught tow to interrupt Negative thinking patterns	16	(4.2)	47	(12.2)	321	(83.6)
Counselling activity involved listing Student's personal qualities	40	(10.4)	23	(6.0)	321	(83.6)

Source: Field data, 2015

Table 5.2 shows that majority 41 (10.7%) of those attending counseling 63 (100%) answered in the affirmative that counselling activities involved making self-portraits and masks while 22 (5.7% answered negatively. Results also show that 38 (9.9%) of those were helped to think through options for achieving counselling goals. The thinking process involved identifying the emotions that various courses of action elicit. A large proportion of counselees 48(12.5%), reported that they had been taught techniques for managing impulses and feelings and identifying alternative courses of action. This skill is important for managing a range of personality disorders, particularly Avoidant PD where the person is hypersensitive to criticism, Anti-Social Personality

Disorder (where there is lack of empathy and violation of the rights of others), and obsessive compulsive disorder where the victim is pre-occupied with orderliness and perfectionism. This can be disruptive in situations where students have to share rooms, and more so in the interpersonal relationships of the victim who feels compelled to control others.

In this study, 16 (4.2%) of students attending therapy reported that they were taught how to interrupt negative thinking patterns, while the remaining 47(12.2%) counsellees said they had not. This skill is particularly important for students suffering from Borderline PD which is associated with feeling betrayed and out of control. These negative feelings arise from negative thought patterns, all resulting in a disruption of relationships (Hawton *et al.,* 2000). This skill is in fact important for students in addressing any negative thought processes that come from other personality disorders such as Paranoid PD, Schizoid, Schizotypal, Avoidant, and Dependent. The technique of listing students' personal qualities was employed on 40(10.4%) of the students that attended counselling. This skill is important to help the student realize positive aspects about the self, which will help build confidence in the face of crippling insecurities brought on by a personality disorder.

It may be that the 23(6%) that were not exposed to this technique may not have needed it as part of their therapy. Cases such as those with Antisocial PD already have an inflated view of their own worth to the detriment of their relationships. Literature does, also point out that listing personal qualities is a technique used to provide high-quality care where providers understand and respect their clients' needs, attitudes, and concerns,

and that these client perceptions are in turn affected by personal, social, and cultural factors. Research highlights the benefits of addressing client perspectives on quality of care, since it leads to improved client satisfaction, continued and sustained use of services, and improved health outcomes (Bertrand *et al.*, 1995; Kols and Sherman, 1998; Vera, 1993).

Generally all respondents who said 'No' to all the counselling activities either did not need to learn the techniques or the techniques were simply not employed by the counsellor. Yet it can be seen how useful the techniques all are. They all point at mature ways of solving problems. A very significant finding is that in all cases, majority of respondents 321 (83.6%) of the total sample population 384 (100) did not attend counselling. This is serious considering the fact that counselling is necessary for sorting out individuals' emotional problems. Studies identify barriers to help-seeking behaviour in student populations such as lack of time, privacy concern, and lack of emotional openness and financial constraints. Barriers such as a lack of perceived need for help, lack of awareness of existence of the services and scepticism about treatment effectiveness. Jarski (2015) has cited 17 excuses that people give to avoid going to therapy. Among the most important reasons are: i) I don't want anyone to know that I go to therapy; ii) I want to be sure it works or iii) I don't need counselling. This is consistent with some of the reasons respondents gave for not attending counselling in the current study namely that they did not need counselling.

5.2.4 Use of Art Therapy Technique

Among the techniques used in counselling was the construction of family trees or genograms (Galvin, 2010), self portraits and other pictures (Malchiodi, 2003). As discussed earlier in section 5.2, a genogram is a family tree/diagram constructed by the therapist. It looks at past relationships and events and what impact these have on the person's current emotional technique, while the self-portrait is a simple art therapy idea that can reveal a lot about a person. The basic idea with this type of art therapy is that the person communicates, through art, how he or she sees him/herself. When students were asked about this, 35(9%) reported that these techniques had been fully employed, while 8(2%) indicated that they were partially used. From all those that attended counselling, 19(5%) said the technique had not been used**.** This data is displayed in Figure 5.3.

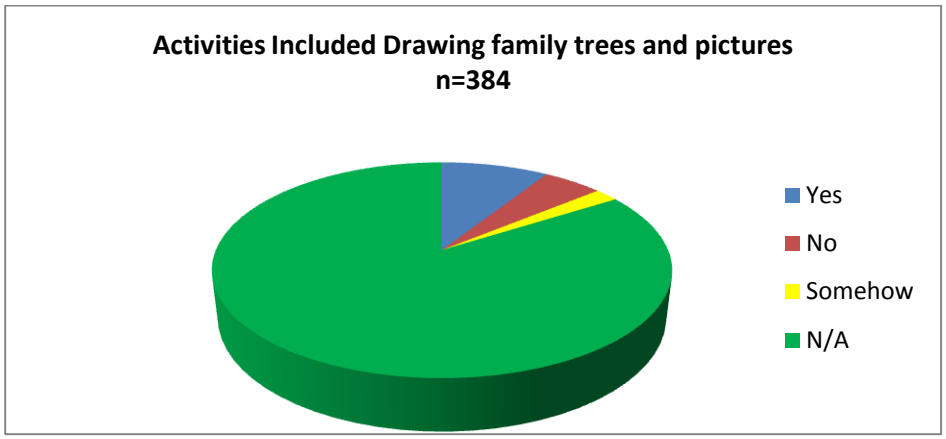

Figure 5.3: Drawing Techniques Were Part of Counselling Activity
Source: Field Data, 2015

The results imply that respondents who said the art therapy had not been used or had been partially used may not have actually been exposed to it. It is also possible they were not keen to realize the importance of such therapy. It was commendable for the counsellors to include the art therapy activity as it gives a lot of insight and information about the client

and their family situation (Galvin,2010), thereby enabling them to get to the root causes of their personality disorder. In practice, some therapists usually wait until at least the third art therapy session with the client to do this activity. This is where frequency of counselling sessions attended becomes important.

This creative counselling approach is also effective because, as is seen in literature, it allows for a stronger therapist/client relationship to develop; the client's creative strengths are identified; it removes many mental blocks the client has; the client becomes more self-aware and learns new creative ways towards a healthier life; it promotes a deeper healing and growth in therapy (Malchiodi, 2003); the unconscious mind becomes more conscious to the client; and people of all ages, cultures, and religions can benefit from using creativity in therapy, indeed within the Kenyan university setting, especially at USIU, there is a wide variety of cultures and religions that must be taken into consideration by the therapist. (Stangline, 2015).

5.2.5 Use of Prophylactic Supplementary Interventions

Medical officers mentioned the prophylactic (medical) methodologies they use on affected students. One type of treatment is prescribing sleeping tablets for a short time, for those with chronic insomnia, and then they are referred to the general hospital (for public universities) in extreme cases. The university clinician continues to monitor them even after referral. One of them said that:

> In the last one year we have had two cases. One of them came with the condition from home. There are often cases of hypoglycemia (low blood sugar) from alcohol intake in the public universities. They are treated with dextrose then counselled on the dangers of excessive alcohol use,

> and how it should be consumed, because, one clinician confessed that it is hard to tell them to stop (Field data, 2015)

To assist students go through their university education successfully, they are provided with all the support, be it in mental health, physical health or academics (Ndikaru, 2012). Although Deans of Students do not deal directly with student health matters, they liaise with medical staff to ensure that their needs are taken care of. In this particular case, both emergency treatment and counselling are administered before the student is referred to a general hospital. Literature by Mayo Foundation for Research shows that personality disorders need long-term treatment (Edwards *et al*, 1998). A patient afflicted by personality disorders may, therefore, need a team which may include: a primary doctor, a psychiatrist, a psychotherapist, a pharmacist, family members and social workers.

The researchers further assert that although there is no specific medication for personality disorders, some types of psychiatric medications may help with various PD symptoms (Edwards *et al*, 1998). Antidepressants are used when an individual has depressed mood, anger, impulsivity or irritability. Mood stabilizers are used to even out mood swings and reduce irritability, impulsivity and aggression. Antipsychotic medications (or neuroleptics) are used when one loses touch with reality (psychosis) or when one has anxiety or anger problems on the other hand there is no specific medication (Edwards *et al*, 1998). However, as discussed earlier, the mental health infrastructure is not as developed as expected. Hence the services remain minimal (KNCHR, 2011).

Nevertheless alcohol consumption and use of drugs is a big challenge on university campuses. With a lot of freedom on campus for students who consider themselves adults but who are not in control, many succumb to the practice and end up victims of abuse and poor mental health (Alonso & Adolfo, 2014). As observed earlier, the presence of PDs in an individual may enhance one's level of alcoholism (Lezenweger, 2007).

5.3 Counsellor Characteristics

The characteristics of the counsellor, an independent variable in the study, is an important contributing factor to the success of counseling therapy, since it determines the type of relationship that will be fostered with the student client. As one way of gauging this relationship, the study asked students whether or not they would recommend their counsellor to a friend. Of the 61(16%) that had used the university counselling services, 31(8%) strongly agree and 23(6%) agree. Only 8(2%) were not sure whether or not they would make one such recommendation. The data is in Figure 5.4.

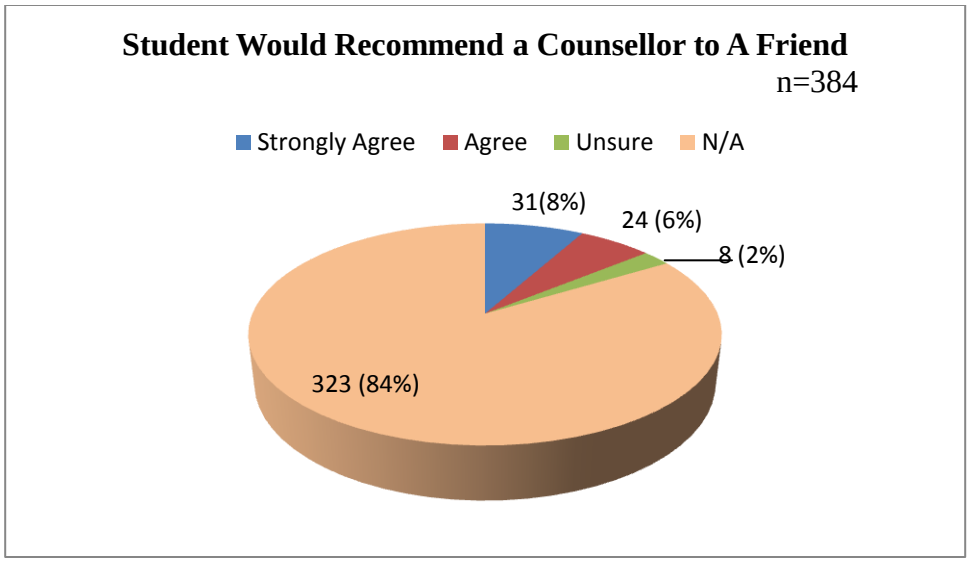

Figure 5.4: Distribution of Responses Regarding Student Recommending the Counsellor to a Friend
Source: Field Data, 2015

This finding implies that 55(87%) of those who actually attended counselling 63(100%) were confident in their counsellor's competence and willingness to help them, enough to recommend him or her to a friend.

All deans (100%) in the study stated that all their counsellors have received sufficient training and experience to work with the students. The counsellors are accountable to the university for the quality and appropriateness of the work they offer. Students have a choice of changing counsellors. The Dean at a private university said:

> There are times a student may feel I am overly authoritative as a Dean of students, and they are therefore unable to be counseled by me. So I refer them to my colleague. I find out they need to switch when they don't want to come back again or are not open. There is a staff shortage; most of the universities only had 3 counsellors (Key Informant, 2015).

Deans of Students, due to the nature of their work that they do, are sometimes considered to be disciplinarians. There may be need, therefore, to refer a student in need of counselling to another counsellor or another officer with whom the student may feel free to discuss his/her issues. If a counsellor feels unable to work with a client or the client is reluctant to work with counsellor, one should refer the client (McMahon's, 2014; Davies, 2014). When students were asked about the characteristics of the people that had counselled them, they gave responses summarized in Table 5.3.

n=384

Characteristic	f	%	f	%	f	%	f	%	f	%
Student Feels the University Counsellor is Warm and Approachable *(empathetic)*	13	3.40	28	7.30	14	3.60	8	2.10	321	83.60
Student feels the University Counsellor Acts natural (*Congruency)*	24	6.30	17	4.40	0	0.00	22	5.70	321	83.60
The University Counsellor is Committed to treating Student as Equals (*Unconditional Positive Regard*)	19	4.90	17	4.40	15	3.90	12	3.10	321	83.60
Counsellor was Available to the student Between Sessions, Either on Phone or In Person *(Empathetic)*	31	8.10	27	7	2	0.50	3	0.80	321	83.60
Counsellor's Availability Contributed to a Feeling of being well Supported and cared For in the student *(Empathetic)*	20	5.20	27	7	13	3.40	3	0.80	321	83.60
Counsellor Provided Support Before Student Faced Challenging Events *(Empathetic)*	29	7.60	22	5.70	5	1.30	7	1.80	321	83.60
Counsellor Treated Student With Respect *(UPR)*	21	5.50	30	7.80	9	2.30	3	0.80	321	83.60
Counsellor Was on Time for Appointments *(Congruency, UPR)*	26	6.80	19	4.90	12	3.10	6	1.60	321	83.60
Counsellor Worked With the student to Set Goals For Counselling *(UPR)*	24	6.30	37	9.60	2	0.50	0	0	321	83.60
Counsellor Was Genuinely Interested in Helping the student *(Empathetic)*	31	8.10	19	4.90	10	2.60	3	0.80	321	83.60
Total Average	**24**	**6.3**	**23**	**6.1**	**8**	**2.2**	**7**	**1.8**	**321**	**83.6**

Source: Field Data, 2015

From the results in Table 5.3, 48(12%) out of the total 63(16%) that actually underwent therapy felt that the counsellor exhibits the key characteristics of a good therapist as outlined by Carl Rogers, who describes what he called the "core conditions" constituting the essence of the healing or growth experience, namely empathy, congruence and unconditional positive regard. As displayed in Table 5.3, the core characteristic of empathy was reportedly present in the counsellors; 41(11%) out of a possible 63(16%), felt the university counsellor was warm and approachable; 58(15%) indicated that the counsellor was available to them between sessions, either on phone or in person; 47(12%) claimed the counsellor's availability contributed to a feeling of being well supported and cared for; 51(13%) reported that the counsellor provided support before the student faced challenging events; and 50(13%) indicated that they felt the counsellor was genuinely interested in helping the student.

These findings are positive with regards to objective two of the study, to establish if the therapies offered to students are effective in addressing personality disorders. From the report, those attended valued counselling positively, which implies that they learnt positive things about the services. because, as Rogers (1986) theorized, therapy works when the client is in a relationship with someone who has faith in them, listens empathetically and accurately for the deeper meanings of what they are communicating, and who deals with them honestly without roles or manipulation.

Rogers (1986) thought it was essential for the person to feel deeply understood, and doing that meant going 'inside' the other person's frame of reference to get a real sense of what the person's experiences felt like, and then to be able to communicate that

knowing and understanding back to the other person deeply and accurately. The findings also imply that the counsellors must have also subscribed to what Moore (2006) suggests as empathy being also communicated in non- verbal communication such as an increase in eye contact, body posture, tone of voice and listening skills. The study also revealed that 15.9%, almost all of those who attended counselling (16%), confirmed that the counsellor worked with them to set goals for counselling.

This is in line with what Rogers' extensive research work contributes to successful therapy; it fulfills the condition where the clients are free to determine their own agenda for their life and therapy and to describe their own subjective experience in their own way. This fulfills the principle of unconditional positive regard on the part of the counsellor, which was also displayed in what students reported about the counsellor treating them with respect 51(13.3%); and being on time for appointments 45(11.7%). Rogers described unconditional positive regard (UPR) as an acceptance of each aspect of the other person's experience as a real part of that person; an unconditional warmth, and momentary setting aside of judgment to promote an atmosphere of trust and openness. The findings that 36(9.3 %) of the students felt the counsellor treated them with respect (and as equals) is in line with the core condition described by Rogers of there being a need for the relationship to be as egalitarian as possible without a "power-over" authoritarian posture. The counsellors being reported by 45(11.7%) of students as generally being on time for appointments, demonstrates the respect existing in the client-counsellor relationship, a critical ingredient in successful therapy.

Thirdly, the study established that counsellors possessed the third characteristic critical to successful therapy which is congruency. He defined it as being authentic, as opposed to being phony. The findings of the study show that 41(10.7%) out of the 63(16%) students felt that their University Counsellor acts natural, fulfills the condition of congruency, and subscribes to what Rogers prescribed as being an essential part of the equation, since the therapist needs a very high degree of self-knowledge in order to maintain a consistent degree of personal transparency. Counsellor characteristics contribute greatly to the efficiency of therapy. Although results show that counsellors are congruent, the study has found that they are too few to effectively manage counselling According to the International Association of Counselling Services standards set for counselling, a working counsellor to client ratio should be at least 1:1500 or 1:1600. Anything higher than that will mean students are not being served well or that their academic work is being compromised as they have to wait in long queues (Gallagher, 2014); Andreula (2013) argues that mental health professionals can themselves become prone to health issues if they overdo. Since they meet clients with problems in difficult situations hoping for either relief or change, they have to look after their health which can otherwise deteriorate to burnout, heart problems or exhaustion (Andreula, 2013). If this happens, counselling services will be ineffective.

5.4 Counselling Room Environment

Data on the counselling environment was collected by asking the students to give their opinions, as well as through direct observation.

5.4.1 Student Opinion on Counselling Room

The opinions of the students how they rated the counselling room are summarized in Table 5.4.

Table 5.4: Students' Assessment of their Counselling Room
n=384

Physical Location of the Counselling Room is Good	26	6.8	36	9.5	2	0.5	321	83.6
Counselling Room is Comfortably Furnished	29	7.6	23	6.0	26	6.9	321	83.6
Counselling room is Free from External Disturbances	35	9.1	28	7.3	-	-	321	83.6
Counselling Room is a Quiet, Peaceful and Reflective Place	30	7.8	27	7.0	6	1.6	321	83.6
One Can Experience Freedom and Calm in the Counselling Room	41	10.7	16	4.2	6	1.6	321	83.6
Overall Counselling Room is Conducive	39	10.2	12	5.5	3	0.8	321	83.6

Source: Field Data, 2015

Overall, most of those that attended counselling 39(10.2%), generally felt the counselling room they used was conducive. This may well be a question of perception, since, compared to the recommendations spelt out in the literature reviewed, and the direct observations of the data collectors, 3(75%) out of the 4(100%) clusters fell short. Nevertheless, the aspects the students were most dissatisfied with regarding their counselling environment were the location of the counselling room 36(9.5%), external disturbances 28(7.3%), and the lack of peace and quiet to make it a reflective place 27(7%). The implications of their dissatisfaction with the environment are a reduced

impact in therapy outcomes.

In most Kenyan universities, student counselling services are either adjacent to or within the Dean of Students' office. That office being one of the most visited by students and outsiders in any university, is the least suitable an environment for counselling. It is usually busy and without that serenity, quiet and peaceful atmosphere. The Dean of Students is also a very busy person so he/she may not have the time to do individual or group counselling. Being in such an environment brings stigma to those seeking counselling services.

A positive counselling environment is one that is capable of stimulating the client (Ebenuwa-Okoh, 2011). In his study, Ebenuwa-Okoh (2011) established a correlation between a stimulating environment and mental development where the physical (tables and chairs), social (music, videos) and emotional (the counsellor's disposition e.g. genuineness) components work together to bring about effective counselling.

Information on the counselling environment was gathered through direct observation. Results from the observation checklists reflected data that is similar to that voiced by the students. From direct observation and key informant interviews, the counselling environment does not always have the necessary pre requisites to aid a successful counselling session. In all the universities visited,, however, the rooms were well-ventilated and well lit. Table 5.5 summarizes the data from the observation checklists compiled at each university

Table 5.5: Observed Condition of Counselling Environment

OBSERVED CONDITION	CLUSTER ONE	CLUSTER TWO	CLUSTER THREE	CLUSTER FOUR
Room is well-ventilated	Yes	Yes	Yes	Yes
Room is well-lit and bright	Yes	Yes	Yes	Yes
Furniture for counselee comfortable/ Recliners	No	No	No	Yes
Drinking water/refreshment available	Yes	No	No	Yes
Level of Privacy Acceptable	No	Yes	No	Yes
Overall atmosphere is quiet, peaceful, comfortable and reflective	No	Yes	No	Yes

Source: Field Data, 2015

In 3(75%) of the cases, the furniture was not very appropriate for counselling, even though 29(7.6%) of the students themselves had said they were comfortable enough. In 2(50%) of the universities visited, it was observed that water and refreshments were available for the students, the level of privacy was acceptable and overall ambiance deemed peaceful and reflective. These findings are significant in light of what other scholars have found with regard to the importance of the counselling environment to the success of the counselling effort. The qualitative study by Pearson & Wilson (2012), establishing the preference for larger work spaces, natural light, use of aesthetically pleasing decor, and provision for clients to have choice in seating, indicates that the universities had done well in this regard, and had made good efforts towards ensuring the success of the therapy sessions. Earlier scholars had also established similar observations; the effect a healthcare environment can exert on mood and behaviour was

established by Dijkstra *et al,* (2008). Other scholars like Phelps *et al,* (2008) were in agreement with this finding.

Similarly, if self-disclosure is more forthcoming and extensive in a warm, intimate room (Chaikin *et al,* 1976), then the bare cement floors and overhead fluorescent lighting observed in 2(50%) of the universities works against their therapy goals for their student clients. All in all, because the counselee is the end beneficiary of the counselling process, and because most 39(10.2%) of those who attended therapy found the environment to their satisfaction, it can be concluded that they were able to attain the benefits of the therapy, and the environment was not a hindrance despite its shortcomings.

Apart from Maseno University and the United States International University-Africa, the other two universities in the study offer their counselling services either in the Dean of Students' office or within the Student Affairs Department where there is not much privacy or in a counselling office but which does not have those desired qualities of a conducive counselling environment (Ebenuwa-Okoh, 2011). On the other hand, the counselling room and surroundings at Maseno University, clearly depict the kind of serenity and peace advocated for in Bondi *et al* (2006), where it was found that the quality of the physical environment in which counselling is offered, including its location helped service-users.

Arising from the findings and discussion in relation to the second objective which was to 'establish the counselling therapies and facilities availed to undergraduate students in

Kenyan universities', it was found that the selected techniques are indeed appropriately designed to address the different manifestations of personality disorders among the students in Kenyan universities. The counselling therapies and techniques included here are: behaviour therapy, role play, free association technique, cognitive therapy, dialectical behaviour therapy and interpersonal therapy techniques.

5.6 Chapter Summary

In this chapter, the different therapies employed by counsellors across all the universities in the study were discussed. The chapter discussed how the most frequently used approaches and techniques included Role playing, Free Association, Cognitive Therapy, Dialectical Behavior Therapy and Interpersonal Therapy Techniques. It was seen how the latter (IPT) is particularly appropriate in the university setting, as it is a time-limited treatment that encourages the patient to regain control of mood and functioning typically lasting 12–16 weeks. Each of the counselling therapies in use was discussed in light of its relevance in addressing the spectrum of personality disorders afflicting the undergraduate students.

The chapter then went on to look at the characteristics of the counsellor, as it is an important contributing factor to the success of counselling therapy, since it determines the type of relationship that will be fostered with the student client. Based on the characteristics and relationship developed with their individual university counsellors, 14% out of a possible 16% reported that they would indeed recommend the counsellor to a friend (Figure 5.4). When assessed against Rogers' ideal list of desired characteristics for optimal therapy output, the study learned from 12% of the 16% counselees, that indeed university counsellors demonstrate empathy, congruence and

unconditional positive regard toward their clients (Table 5.3). The Counselling Room Environment was discussed as it plays an important role in the success of counselling therapy. Both the findings from direct observation and reports from the counselees were compared with what literature recommends as the ideal setting for counselling. Most of those that attended counselling (10.2%), generally felt the counselling room they used was conducive. The aspects the students were most dissatisfied with regarding their counselling environment were the location of the counselling room (9.5%), external disturbances (7.3%), and the lack of peace and quiet to make it a reflective place (7%). Results from the observation checklists reflected data that is similar to that voiced by the students. The next chapter discusses findings pertaining to the third objective of the study which was to evaluate the effectiveness of the counseling services in addressing personality disorders among undergraduate students in Kenyan universities.

CHAPTER SIX

EFFECTIVENESS OF COUNSELLING SERVICES IN ADDRESSING PERSONALITY DISORDERS AMONG UNDERGRADUATE STUDENTS IN KENYAN UNIVERSITIES

6.1 Introduction

This chapter presents and discusses the study findings pertaining to the third objective which was to: 'evaluate the effectiveness of the counseling services in addressing personality disorders among undergraduate students in Kenyan universities'. The chapter starts by exploring respondents: reasons for uptake of the universities' counselling services before looking at the effectiveness of university counselling services. It then looks at the actual uptake of the services by students. Reported shortcomings and recommended areas of improvement are discussed next and finally the chapter summarizes the findings.

6.2 Students' Reasons for Uptake of University Counselling Services

In addressing this objective, the study began by establishing the main factors prompting university students to seek out counselling therapy. The findings are displayed in Figure 6.1.

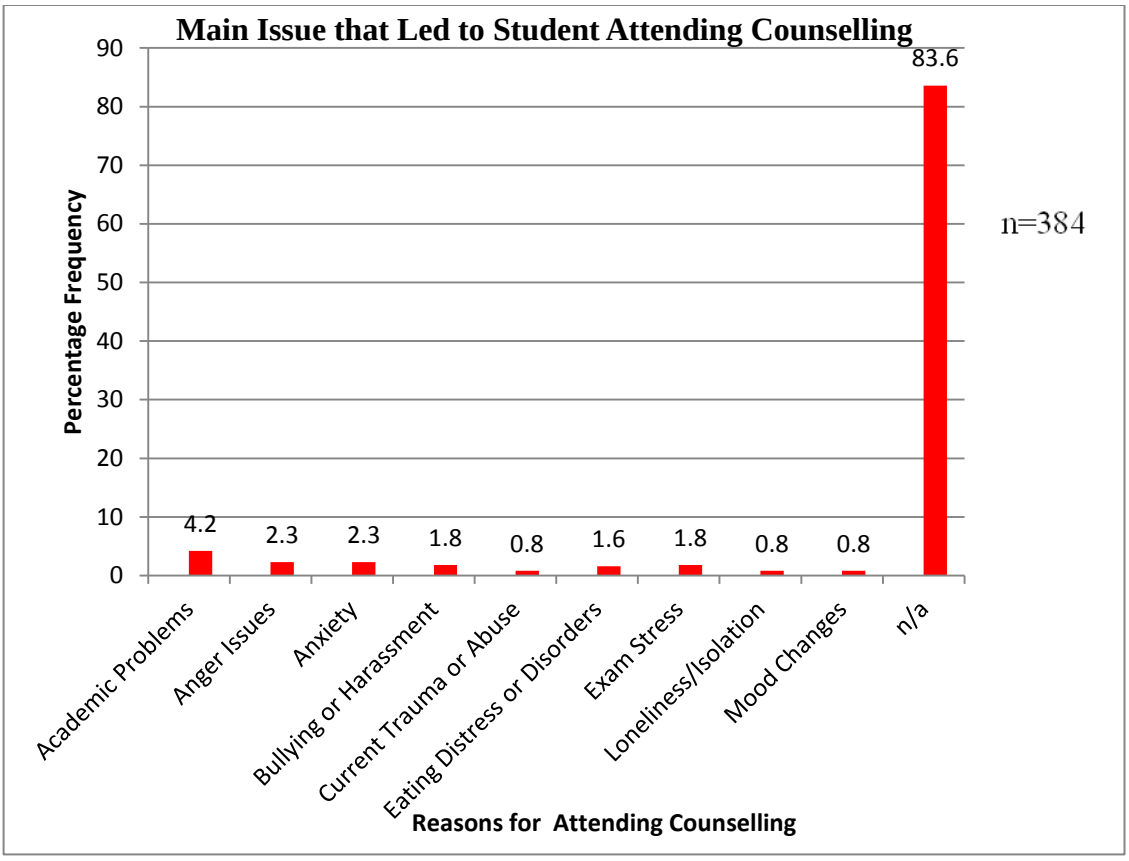

Figure 6.1: Distribution of Reasons for using University's Counselling ServicesSource: Field Data, 2015

While 3(0.8%) of the students indicated they seek counselling services because of mood changes, loneliness, or trauma abuse respectively, majority 16(4.2%) sought out counselling because of academic problems. On one hand it could be said that these academic problems may well be symptomatic of other deeper hidden issues which are brought to the fore during counselling. The study also revealed that anger 9(2.3%), anxiety 9(2.3%), eating disorders 6(1.6%), exam stress 10(1.8%), and bullying or harassment 10(1.8%) drove students to the therapy offered by their respective universities.

This study observes that the emotions and behavioral tendencies presenting as mood changes, isolation, eating disorders, bullying, anxiety and anger, are in themselves symptoms in a number of personality disorders; for example, detachment from social relationships features in Schizoid PD, eating disorders manifest in Obsessive Compulsive PD, anxiety in Dependent PD, and mood swings are found in Histrionic PD (APA, 1995). Similarly, the findings are in line with the assertions of Lenzenweger *et al* (2007) who indicate that all three personality disorder clusters are associated with anxiety, mood, impulse control and substance abuse disorders.

The study also found that, of the 384 students sampled, only 63 (16.4%) actually used the counselling services, which is a very small proportion, prompting the question as to why more have not gone for therapy, given the high prevalence of manifest personality disorders among the students. In view of the fact that, as seen in earlier chapters, key informants confess to there being a problem of excessive alcohol use and broken relationships among the student body, it would have been expected that more would seek out the counselling services. It may be that many are not aware that the services exist and are readily available for them. It could also be that the students assess themselves as not being in need of therapy, or simply that they are not confident in the services offered, or there are not enough counsellors to go around. As discussed earlier, there could be other reasons why majority of students do not attend counselling namely that they don't want to be known to be seeking therapy; that they want to be sure the therapy works or lack of the perceived need for help (Jerski, 2015;

It was obvious that not many students were attending counselling despite the fact that many students were portrayed to have PDs. Subsequently all the Deans of Students 4(100%) admitted that there was need for improvement concerning the running of programmes such as counselling. One in particular mentioned that they wanted to carry out research to find out the area requiring more input. She pointed out that, through the intake form, they were able to summarize the cases they had over the semester and the areas that require improvement and support. However, scarce resources were also noted as a limiting factor. One Dean in a public university claimed;

> We used to have many counsellors but now there are just 3. Quite a number have left for other organizations (Field data, 2015).

Seventy-five percent (3) of the deans stated that it was indeed time for a review of their services; there is need to find out from the students themselves the degree to which they are helping them progress, and to recommend ways in which the approach may need to be changed and the strategies required to address the situation on the ground.

Universities in Kenya benchmark with each other on academic, welfare and administrative issues. For instance in terms of provision of counselling services, young universities learn from the older ones on how to improve the services. Some studies have found that counselling services are increasingly required especially with rising numbers of students seeking counselling (Couglan, 2015), and in particular, emotional support. Nevertheless, belonging to a large community like the International Association of Student Affairs and Services (IASAS) would assist universities in Kenya to streamline and overhaul the services in Student Affairs departments. IASAS is an informal confederation of Higher Education services professionals from around the

world. Unfortunately although Kenya belongs to Africa which is one of the member regions of IASAS, little has happened since 1998 when the World symposium was organized by UNESCO (Luderman *et al.*, 2012). IASAS members are expected to be actively engaged in defining the need for and organization of student affairs and services professionals and programmes.

The challenge of resources in Student Welfare Services seems to be worldwide as indicated in the study by Alani *et al.* (2010) who support the findings of the current study. Their study examined the situation of welfare services in several universities in South-Western Nigeria. Results showed that the provision of welfare services in all universities was inadequate and in turn led to poor learning in students. The study also established that there were few (insufficient) staff not only in university medical centres, but even in counselling centres. Above all there was lack of trained and qualified staff in counselling centres. Unfortunately this scenario is common in developing countries where counselling is still new and not fully appreciated (Nyaga, 2014). Studies indicate that counselling is developing slowly in Third World Countries (Soliman, 1991). Soliman argues that if counselling is to be instrumental in the development of developing countries, it needs to be accurately interpreted, difficulties need to be identified and remedies need to be found.

6.3 Effectiveness of University Counselling Services

Students were asked to give their opinion on how satisfied they were with the counselling services. Majority 323(84%) of the students did not have an opinion because they had not attended the counselling services. However, of the 63(16%) that

did attend counselling, 53(14%) said the services were satisfactory. Only 7(2%) said they had not found the services satisfactory. Their responses are displayed in Figure 6.2.

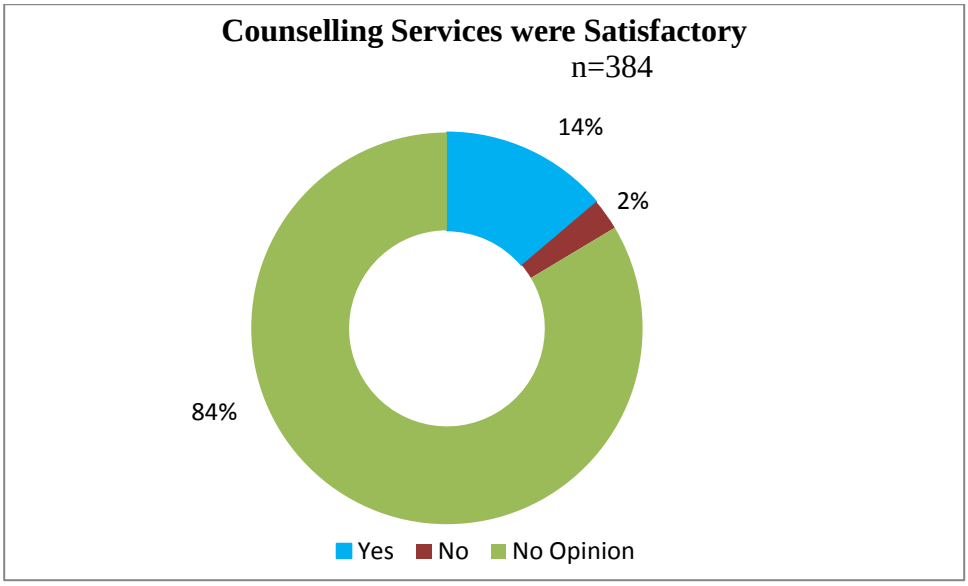

Figure 6.2: Student Responses on Satisfaction with University Counselling Services
Source: Field data, 2015

If the English adage, 'the test of the pudding is in the tasting' is anything to go by, then it can be said that the services are by and large satisfactory. The 54(14%) students out of the total 384(100%) who attended counselling agreed that the services were effective. This finding agrees with that of McCarthy *et al* (1998) in whose study, three-quarters of the clients reported that they were glad they had gone for counselling, while only 12(3 %) regretted having gone. Just like in this study, McCarthy indicated that 75% of respondents found the services helpful as they had either improved or recovered. Those who had not gone in both cases had no opinion to give owing to the lack of experience. Although the number of those who benefitted by the services was small, the fact that nearly all who attended counseling rated the services highly, it shows the services were

satisfactory. In the current study, the deans and counsellors were in agreement with this in support of the evident effectiveness of the counselling therapy.

Nyingi (2014) argues that although students agree on the importance of Guidance and Counselling in schools, the services are not given due attention. In addition, students claim that counselling is carried out in unsuitable venues such as dining halls, open grounds, principals' offices, deputy principals' offices and classrooms. This is in agreement with results from respondents in the current study who asserted that students were likely to be stigmatized. Generally, a counselling environment should be one where the client feels free, safe and comfortable to share confidential information. It should be a place free of interruptions. McLeod (2008) asserts that the Rogerian Therapy implies that the counsellor should be genuine, warm and understanding. It does not only involve physical aspects, but also the counsellor, the relationship between the counsellor and counsellee and core conditions for counselling.

Medical Officers, as key informants, were asked to assess the counselling therapies availed to students with personality disorders in the universities. When asked to give their opinion on the counselling therapies availed to students with Personality Disorders, medical officers reported that:

> The students tell us themselves. We have no way of assessing how the counsellors are doing their work". Yet another confessed, "We are still very deficient. Staffing is not adequate and the students have a lot of problems. We need more counsellors and the skills of the current ones need enhancing. We have had cases occasionally in the ward when we call upon the counsellors to provide their services but we don't really see their effectiveness, and fall back on our nurses to continue counselling the ailing students (Field data, 2015).

On their part, Deans of Students from the universities surveyed said the counselling interventions have been successful to some extent in helping undergraduates with personality disorders. They said the effectiveness is measured by the students' ability to be more assertive (where they were previously avoidant), and others are better able to organize themselves. Mostly, they are able to communicate. At MMUST, students sign a contract form for those who want to engage in long term counselling. At GLUK, the Dean of Students asserted that the intervention of community support has been effective with positive results of reformed behavior on the part of the students. The measure used to evaluate the effectiveness at the universities is through interviewing other students and heads of departments on the behavior of the affected individuals.

The counsellors, another category of key informants for the study, reported that they are able to assess their effectiveness through the gratitude of the students who return to report that their lives and relationships are improved. Counsellors asserted that some of the students' parents also call back to express appreciation, citing positive changes in their children. On other occasions, it is the students' lecturers that provide feedback to the counsellors on how the student behaviour has stabilized. Many studies show that significant change occurs when students experience counselling (Gatua, 2014; McKenzie *et al*, 2015, Murray *et al*, 2015 and Olabisi,2000). Gatua asserts that Guidance and Counselling enhances positive, social and emotional adjustment. In order to determine levels of reliable change and clinically significant change based on self-report of impact of counselling on academic issues, McKenzie analyzed existing data from 129 university students. Results showed that 92% (117) students reported experiencing academic change. The study by Murray *et al* (2015) on evidence of

effectiveness of university student counselling found there was significant improvement by 63%.

One counsellor in the current study asserted that,

> The students, as a result of the counselling therapy, claim their love affairs no longer end in bitterness. They are able to part as friends, whereas before, the boys used to be suicidal (Key Informant, 2015).

Learning to end any relationship amicably is a mature way of behaviour. The alternative is usually unreasoning behaviour which can end up in abrupt decisions such as suicide. Most attempted suicide cases are based on feelings of loneliness, worthlessness due to illness or loss. Since suicide attempts can be made actual, they should be dealt with urgently to prevent them happening or refer for prophylactic action. In their study, Hawton *et al.* (2002) found that depressed people are the most likely to commit suicide. Phelps *et al.* (2013) contend that in order to prevent suicide, there should be collaboration among staff by first identifying students in distress, referring them if necessary and counselling them. Dealing with distress in students should therefore, always be proactive to avoid later regrets.

6.3.1 Counselling Effectiveness Outcome of Improved Interpersonal Relationships

One of the variables identified to measure effectiveness of counselling is the reported improvement in interpersonal relationships. The data is displayed in Figure 6.3.

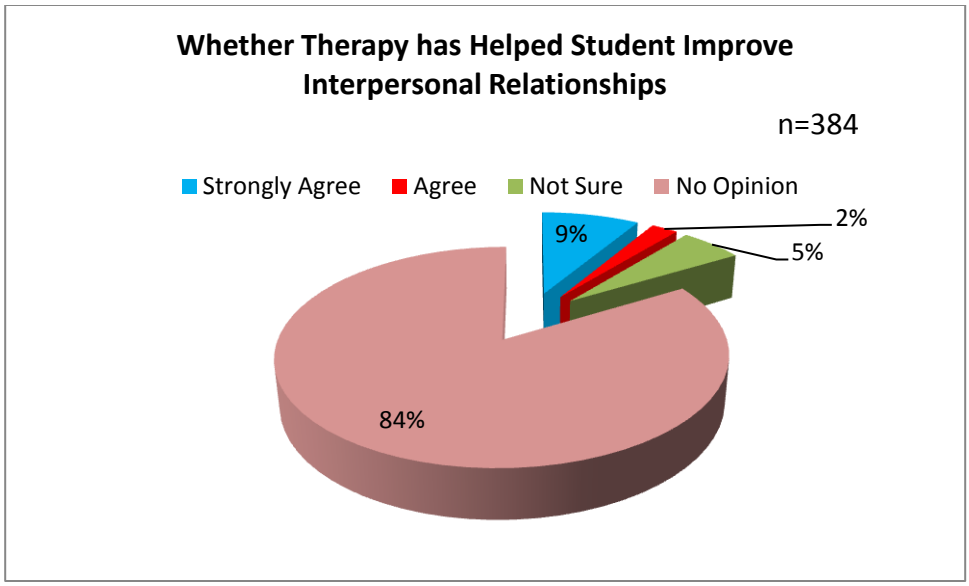

Figure 6.3: Whether Therapy has Helped Students Improve Interpersonal Relationships
Source: Field Data, 2015

When asked whether therapy had helped in improving interpersonal relationships, majority 321(84%) had no opinion since they had not attended counselling. Of those that attended counselling, 35(9%) strongly agreed, while 8(2%) agreed that their interpersonal relationships had indeed improved. In total, 43(11%) respondents benefitted from counselling since they talked positively about the services. 19(5%) were not sure whether or not their interpersonal relationships had improved. Perhaps this was because they had not taken stock of how the relations had changed, or they could not attribute the change to the counselling. The study by ACCORD had similar results, where six out of ten (60%) of the clients who had attended counselling reported that it was beneficial to their relationship (McKeon *et al* (2002).

6.3.2 Counselling Effectiveness Outcome of Less Emotional Stress

The study sought to evaluate the effectiveness of counselling through reported reduction in emotional stress by the respondents. Of all the students in the study, 43(11%) confirmed that counselling had helped them experience less emotional stress, while 19(5%) said it had not. The ones reporting in the affirmative were 43(11%) of the total number 384 (100%) that were questioned about the university counselling therapy services. The information is presented in Figure 6.4.

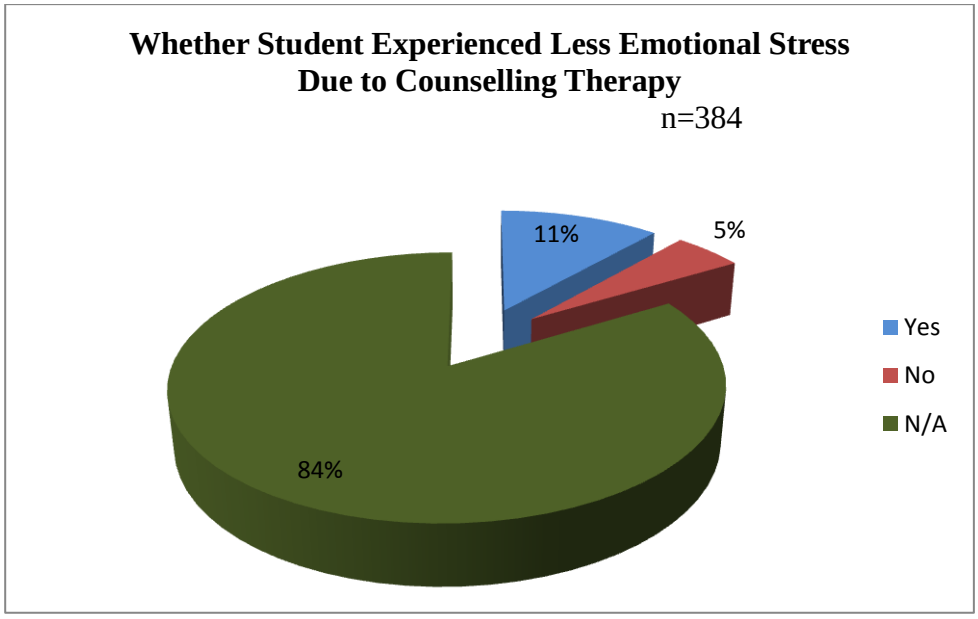

Figure 6.4: Whether Therapy Outcome is Less Emotional Stress
Source: Field data, 2015

The findings demonstrate that counselling had helped the students that underwent it. These agree with the ACCORD study by McKeon *et al.* (2002) where dramatic reductions in stress levels at the end of counselling were reported. The need for and impact of counselling has also been reported by many other sources. For instance, research carried out by Wallace (2012) on the impact of counselling on academic outcomes had two key findings namely: (i) Seventy-five percent of clients either

'improved' or 'recovered'; (ii) Seventy-five percent of students who completed counselling were helped to stay at university, to improve their academic achievement' to improve their overall experience of being student and to develop employability skills. Wallace, (2012) concludes that the main impact of counselling is that through counselling, students develop increased understanding and increased ability to cope with problems and to become more optimistic and more hopeful.

6.3.3 Effectiveness Outcome of Improved Capacity to Regulate Emotions

The study sought to find out whether or not counselling therapy had increased the capacity of respondents to regulate their emotions. This was one of the measures of the intervention's effectiveness. The Yes and No responses from students are presented in Figure 6.5.

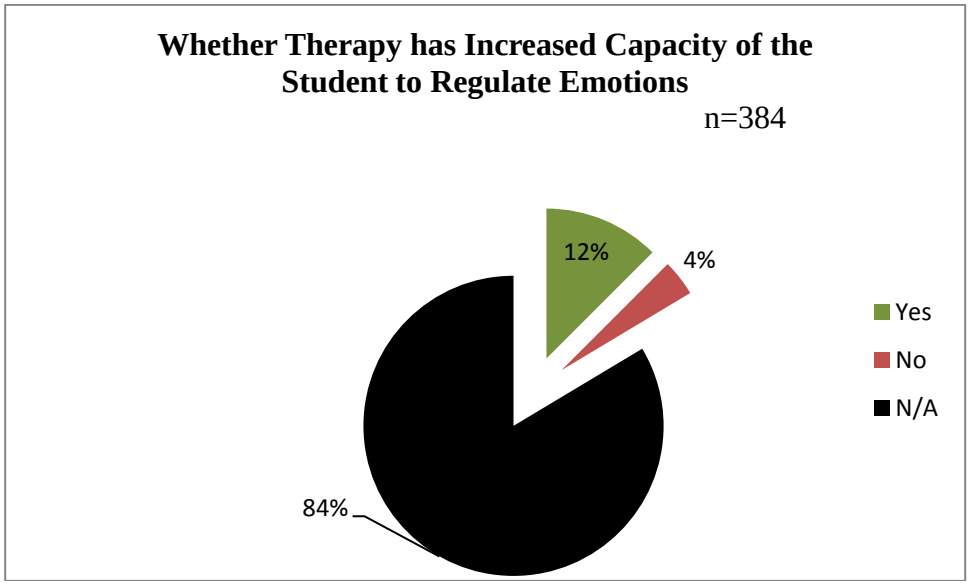

Figure 6.5: Whether Therapy Outcome is Increased Ability to Regulate Emotions Among students
Source: Field data, 2015

While majority 321(84%) had no answer, 46(12%) answered in the affirmative and 15 (4%) answered in the negative. Majority 321(84%) who had no answer obviously had not attended counselling. The 46(12%) reported that the therapy had increased their capacity to regulate their emotions. The other 15(4%) said the therapy had not helped them to do so. The findings are in line with those of Bondi *et al* (2006) among students in Scotland; where the results of the evaluative study showed that, of those who attended at least two sessions of counselling, the great majority reported improvements in self-rated well-being, in interpersonal relationships and in their capacity to regulate their emotions.

6.3.5 Overall Effectiveness of Therapy as Assessed by Students

The study sought to establish the overall effectiveness of the university counselling services. Students were asked their general opinion on this. The results are displayed in Figure 6.6.

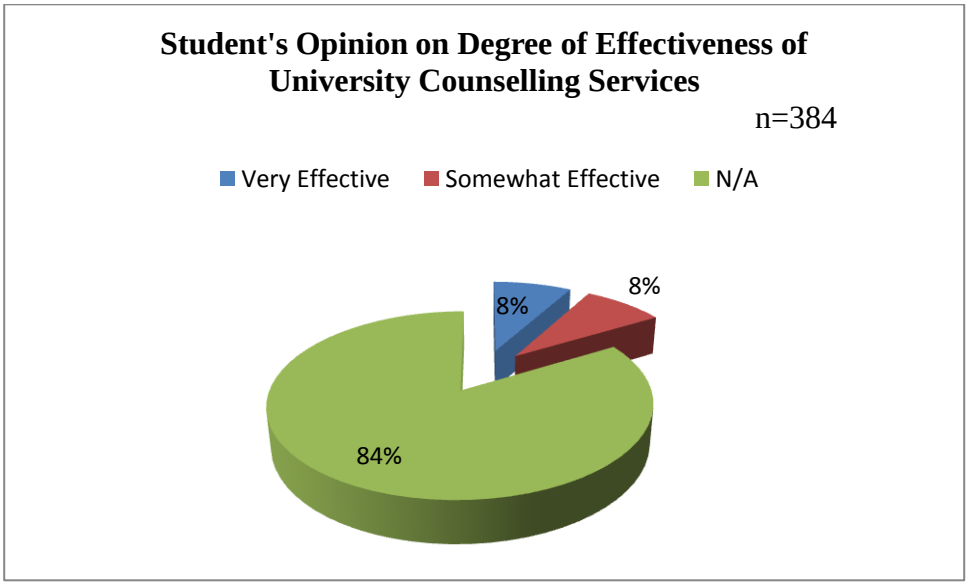

Figure 6.6: Student's Opinion on Effectiveness of University Counselling Services

Source: Field Data, 2015

Majority of respondents 321(84%) did not have an answer (N/A). Thirty (8%) and 30(8%) rated the services as "Very effective" and "Effective" respectively. The latter two groups had attended counselling while majority 321(84%) had not. Being the end users and beneficiaries of the counselling services, the students were the ones best placed to give an overall opinion on the degree to which the therapy had been effective in addressing personality disorders. All those that attended the services across all the universities surveyed reported that the services had indeed been effective. These findings imply that irrespective of the approaches and techniques employed by the various counsellors across the universities, the results were positive. Literature indicates this to be true; as was seen earlier (Bondi *et al*, 2006), some studies point to modest variations in the effectiveness of different approaches for different conditions, the overwhelming message from the studies being that orientation is not a significant factor in relation to effectiveness (Roth & Fonagay, 1996).

The similar effects achieved by different counselling orientations is entirely consistent with the argument that it is the quality of the therapeutic relationships counsellors are able to offer to clients that is the crucial factor in determining the effectiveness of counselling (Roth and Parry 1997). Consequently specific techniques matter only in the context of the quality of the therapeutic relationship available. Hence it may be inferred that the university students who were not very satisfied with the results of their counselling experiences may have suffered a poor therapeutic relationship with their respective counsellors. Some quantitative evidence is available about the mental health status of clients when they first present for counselling to university and college counselling services. Statistics compiled by the British Association for Counselling and

Psychotherapy indicate very high rates of mental distress among students in general. Yet, as Morrison *et al* (2013) found, therapy has a positive effect on the severity of personality disorders (Morrison *et al*, 2013).

6.4 Patronage of the University Counselling Therapy

In the view of the researcher, uptake of a service can be an indicator of how effective it is in addressing the problems it is designed to resolve. The study looked at some of the characteristics of the university services uptake.

6.4.1 Main Person Referring Students for Counselling

The study found that most of the time amongst the students that attended counselling, 23(6%) students took themselves to the counsellor, indicating a reasonable level of willingness and awareness of the services. This shows that the individuals concerned realized the importance of the services. It seems that they realized the importance of their education and were reaching out to any option that could help them overcome their academic challenges.

It is significant that the next (to self) most frequent source of referral to counselling was the wardens in the halls of residence (5%). This means this cadre of staff is vigilant on student matters and should probably be included in training and awareness on PDs as well as the means of counselling students. One Warden confessed that during weekends they bear the burden of trying to resolve the relationship and other issues of the students, and are even required to provide counselling when they are ill-equipped to do

so. Indeed wardens are an important support team in university accommodation who are responsible for residents' welfare.

The chaplaincy 3(10%), university lecturer 1(0.5 %,) friend or acquaintance 2(1%), and other student service were the other sources of referral used by students. Majority 321(84%) of respondents have been consistent in this study, did not attend counselling. Hence their answer was Not Applicable." The data is displayed in Figure 6.7.

n=384

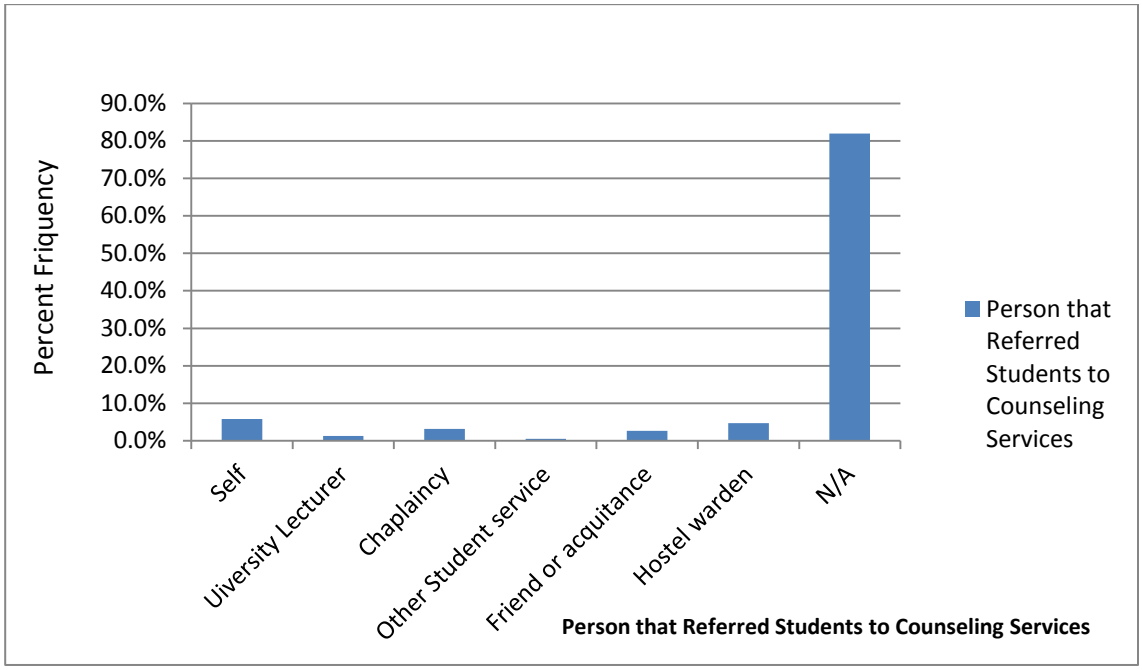

Figure 6.7: Distribution of Responses Regarding Person that Referred Student to Counselling Services
Source: Field Data, 2015

6.4.2 Proportion of the Student Body Patronizing the Counselling Services

Out of the total sample population 384 (100%), only 63(16.4%) students reported having attended the university counselling services. Compared with the percentage that were found to exhibit personality disorder traits (well over 80%), this figure is very low. This shows that counselling services are not being used fully. It implies that the

awareness of the users is rather low and there is need for universities to find out why the services are going to waste. A few facts here show contradiction. While counsellors have been employed and there a high prevalence of PDs, students were not going for counselling. This shows resources were being wasted since not many students made use of counseling to eradicate their emotional problems. Yet it has been proved that couselling services are a necessary intervention strategy.

The study sought to establish whether students use university counselling services or not. The data is displayed in Figure 6.8.

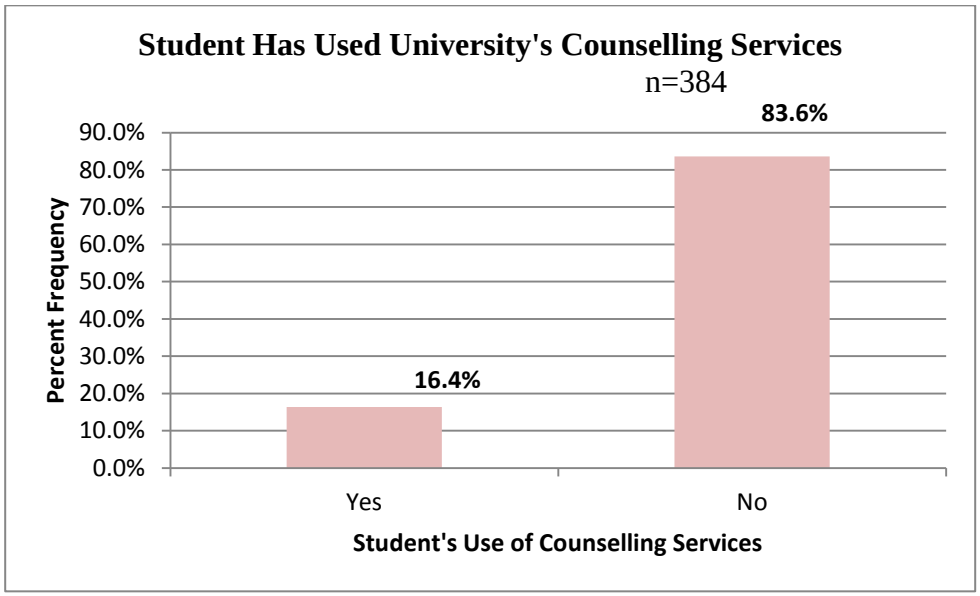

Figure 6.8: Distribution of Students That Have Used University's Counselling Services
Source: Field Data, 2015

Asked whether they use university counselling services, only 63(16%) of students answered in the affirmative while 321(84%) said "No." As discussed earlier, the percentage of those who had attended counselling is too low compared to those having personality disorders and who, therefore, need counselling. As hinted before in

discussion, the only reasons that can make students not go for counselling are that there is lack of sufficient publicity and awareness among students about counselling services. It is also possible that students have had a negative experience earlier especially in High School and have developed a negative attitude towards it. Nevertheless generally the issues of counselling carry stigma of one being unable to deal with their issues on their own. Misconceptions still exist. This is also linked to general availability of counselling therapy services. Most of the students were reported to bring themselves to the counselling centre. Others were referred by peer counsellors and lecturers. One counsellor when interviewed, also claimed that they spot counsellees out as they move around among the student body. At MMUST, the counselling service is advertised through weekly informal student gatherings dubbed 'coffee hour'. Yet another counsellor at a private university said that most of the students with problems were identified through classroom teaching especially when lecturers taught about the theories of counselling, and then later students would bring themselves for counselling. Deans of Students reported earlier in the study of having noted the low use of counselling services by the students and have indicated that there was need to do something about the noted shortcomings in their departments.

Generally one of the reasons why individuals don't go to counselling is stigma. Individuals can be stigmatized for seeking counselling (Prior, 2011). Worse still, mental illness stigma can be really damaging. The British Journal of Counselling proposes two approaches to deal with stigma of mental health where people with mental illness are framed 'just like everyone else' and solidarity where the public agrees to stand by those with mental illness regardless of their symptoms (Corrigan, 2016). It is important for all

staff to work together to assist those who are afflicted with PDs. Once identified in whatever way, they should be treated with respect and referred for therapy accordingly.

6.4.3 Reasons Some Students Do Not Use University Counselling Services

Non patronage of a service can sometimes be an indicator of its effectiveness that is, assuming the prospective clients are aware of its existence. However, when asked about why they did not attend counselling services, 173(45%) of the proportion indicated that they did not feel the need to do so. This is very important information given that many of them were found to be with a personality disorders. It implies a low awareness level on the PDs and how they manifest. More importantly it indicates that the students may not be aware that help is available and hence low confidence in the services offered. However, another significant proportion 92(24%) confessed that they were not even aware that the counselling services were available on campus for them.

The study sought to establish reasons why students had not used university counselling services. The study found that the most common reason given by students for not using the university counselling services was that172(45%) never felt the need to), followed by those that did not even know that the services exist 92.1(24%). While 58(15%) gave other reasons, not of significance, 61(16%) said the services were non-applicable (N/A) for them. The data is illustrated in Figure 6.9.

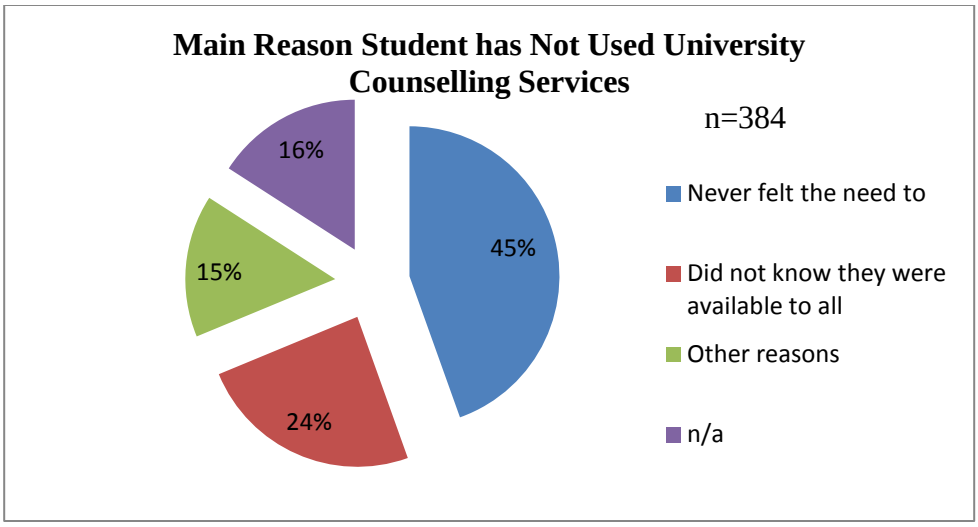

Figure 6.9: Distribution of Responses as to why Students did Not Use University Counselling Services
Source: Field Data, 2015

This finding illustrates the common misconception of the role of counselling in people's lives (Jarski, 2013) and that counselling is for 'other people'. Many feel it is for extreme psychiatric cases or for delinquents (in high school). The finding also shows that there is general ignorance about the existence of the personality disorders and their manifestations and effects in one's life. Page (2014) was overwhelmed when she asked university students to share about their mental health experiences. Many were afraid to share because of the stigma associated with mental illness. However, many disclosed how lonely they felt and how they thought no one cared about them (Page, 2014). This applies to many university students who are not aware not only about their own mental health status or even how to identify symptoms in a colleague who has a problem. Universities should make it a policy to screen students upon enrollment and create more awareness. This way the university would have more information on cases of personality disorders and therefore design appropriate interventions to comprehensively address the issue.

6.5 Reported Shortcomings and Recommended Areas of Improvement

In order to properly evaluate the counselling services, the study sought to know from the Key Informants particularly medical officers, ways in which the services could be improved. In this way, they were actually revealing the weakness in their systems, as well as suggesting measures to strengthen the counselling services in order to reach more students.

When asked about ways in which the therapy services to students with PDs could be improved, some of the medical officers from the public universities confessed that,

> The services need to be improved by us. We need more clinicians to assist. We are overwhelmed with work so we do not spend too much time with a patient. We tend to hurry up the session because there is often a long line of students waiting to be attended to. Hence we need more time (Key Informants)

They also mentioned the need for more rooms to enhance privacy. In MMUST, for instance, the consultation room doubles up as the counselling room and is too close to other rooms;

One clinician admitted that the system of diagnosing can indeed be improved;

> We need to find a way to diagnose properly. We might be missing some. Maybe the percentage of students with personality disorders is higher than I think, but we are not reaching them. We should be keener especially when students keep coming back with the same ailment that may well be psychosomatic (Medical Key Informant 2015).

Shortage of clinicians means long queues of students who must be at lectures at any one time. Some may even give up and leave. Studies show that no proper diagnosis can be done in a hurry. If one has to get to the root causes of PDs for example, they may need

more time. Rabin (2014) states that shorter visits by patients may enable patients to have prescriptions. However, they certainly will not benefit from the process of behaviour modification. Hence physicians and other medical staff need to consider the overall hospital picture as well as the life and health of individual patients. There is always demand on time for hospital staff, but they must be mindful of the patients (Dugdale *et al*, 1999). In the same way, confidentiality is extremely essential. Clients must be able to know that the information they give to the clinician will not 'leak' to anyone else. Rooms should also be available as well as the required equipment as expressed by the medical officers during interviews.

Medical officers also reiterated the need for better infrastructure in terms of furniture and staffing. According to them, one or two counsellors are not enough. The medical office at GLUK pointed out that strengthening of the HIV testing and management infrastructure is necessary because majority of students that test positive invariably sink into depression, especially when subjected to stigma. He also recommended that there be public health campaigns carried out to raise awareness on the existence and nature of personality disorders, and that help is available at the university level for dealing with the same.

The sentiments of medical officers were supported by the Deans of Students who admitted that more staff were needed on the ground, as well as upgraded counselling facilities that are soundproofed and properly furnished including a counselling couch. They went on to suggest that adequate finances to maintain contact with people like parents and the referral system be availed by the university administration. One of the

Deans in a private university pointed out the importance of networking with other agencies that provide complementary services, such as alcoholics anonymous. He remarked that:

> We as a university need to be able to help fund because it is very expensive to put an individual through alcohol rehabilitation (Key Informant 2015)

Normally when one goes for rehabilitation, they are taken through the process for three months and the treatment is very expensive. Universities through their Alcohol and Drug Abuse (ADA) Committees should assist the individuals (both staff and students) affected.

Yet another Dean confessed that,

> We are general practitioners. We need more specialized training to address the issue of personality disorders among students (Key Informant 2015).

This statement is very relevant and timely. Medical officers and other medical staff should be more equipped with knowledge and skills on PDs if the war against PDs is to be won.

The Dean at one of the private universities confessed that they do not have much documentation and forms in the counselling process, but that they would improve as the student population grows, as it will mean more of them will be residential. At the time of the study there were only 80 residential students. He said that although they do not have any guidelines or the Ethical Framework for Good Practice in Counselling and Psychotherapy as produced by the Ministry of Health of the Government of Kenya, they follow their own code of conduct as practitioners, and that nevertheless it was high time

they came up with their own guidelines. Counsellors recommended that there is a need to sensitize people on the importance of counselling being not just for desperate, extreme cases. They asserted that many people have challenges, but they are not aware that help is available. The counsellors also recommended that the facilities be improved e.g. more office space and counselling rooms, as well as recruiting more counsellors. One counsellor at a private university commented that,

> Counselling is done in any room randomly. No specific room has been set aside for it. Most institutions do not value counselling much because not enough resources and facilities are availed. Even at the medical hospital, there is hardly any room set aside for counselling (Key Field data, 2015).

The foregoing statement is a loud cry of counselling staff for action on students' mental health. This key informant went on to recommend that there be established rooms in the university set aside only for counselling. He also recommended specialized training for the counsellors to be able to detect and handle Personality Disorders among the student body. He said sometimes students ask for prayer, and counsellors fail to recognize that the student actually needs counselling.

In some cases, medical prophylactic interventions are required but the counsellor is not able to quickly detect this. It may be commendable to begin therapy at high school, as part of the pre university preparation, and to continue it during the duration of the students stay, so that at the end of a number of years, the incidence of PDs will be significantly reduced, if the study by Hawkins *et al.* (2005) is anything to go by. The scholars' 9-year longitudinal study to examine the long-term effects of promoting positive adult functioning (including through counseling) and preventing mental health

problems, crime, and substance use, found that, at 21 years of age, full-intervention participants reported significantly better regulation of emotions, compared with controls, as well as significantly fewer symptoms of social phobia and fewer thoughts about suicide.

From the point of view of the researcher, it seems and in agreement with many concerned observers (Nyg *et a*l, 2014) that counselling as a service has never been given the seriousness it deserves. What university authorities ought to do is to innovate and revisit the establishment of the counseling services.

Based on the findings and discussion in regard to the third objective which was to 'evaluate effectiveness of the counselling services in addressing personality disorders among undergraduate students in Kenyan universities,' it was established that the counselling services were effective in addressing personality disorders among undergraduate students in Kenyan universities who used them. The effectiveness was measured by positive outcomes in behavioural and attitudinal modification demonstrated through expressed satisfaction with counselling services; confessed reduction in emotional distress and an increased capacity to regulate emotions; and an expressed improvement in interpersonal relationships. In section 6.2, medical officers report that they learn about effectiveness of counselling services through students in spite of the shortage of counsellors. Deans of Students interpreted counsellors' effectiveness through positive changes they saw in students. These changes included: assertiveness for students who previously were avoidant; ability to be organized for students who were disorganized before and ability to communicate for those who had a

problem earlier. Deans of Students and medical officers also were in agreement that although counselling helps students resolve their problems, there was a lot more to done.

Through the observation schedule, effectiveness of the facilities was rated according to the items on the checklist for the four universities in the study. Most facilities were raed effective in the circumstances according to availability in each case, but it was hoped that improvements would be made.

6.6 Chapter Summary

The foregoing chapter discussed the findings pertaining to the third objective of the study, on evaluating the counseling services availed to university students. It began by examining the main reasons students go for counseling, and found that the majority of 4.2% seeking therapy did so because of academic problems. The satisfaction level of the students was seen to stand at 14%out of the 16% that actually went for counseling. The services were deemed effective as far as aiding students improve their interpersonal relationships because of all those that attended counseling, 11% reported in the affirmative while 5% were not sure. Effectiveness was also seen through 69% of those counseled admitting they have less emotional stress, and 12% of the 16% that patronized the service claiming to have an enhanced capacity to regulate their emotions. Regarding the overall effectiveness of therapy as assessed by students, all those that attended the services across all the universities surveyed reported that the services had indeed been effective, irrespective of the technique or approach employed. Patronage issues were also discussed. Finally, Key Informants pointed out the areas requiring improvement as being mainly staff numbers and training, counseling rooms and

appropriate furniture. The next chapter presents the summary, conclusions and recommendations.

CHAPTER SEVEN

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

7.0 Introduction

The general objective of the study was to evaluate the effectiveness of the counseling Services in addressing personality disorders among undergraduate students in Kenyan Universities. In order to achieve this broad objective, quantitative as well as qualitative research approaches. Ex-post facto cross-sectional research design was adopted for the study. The study used descriptive statistics in analyzing data. The findings of the study were discussed in chapters four; five and six in relation to the specific objectives. This chapter presents the summary of the study, as drawn from the discussions of its findings. The chapter goes on to present the conclusions drawn by the study, based on the objectives. At the end of the chapter, recommendations are made for further research and for policy action.

7.1 Summary of Study Findings

Undergraduate students world-wide experience emotional problems which interfere with their studies. These problems arise from personality disorders which may lead to vulnerability to conflict in form of suicide and impulsivity (Brady *et al*, 2010). Personality disorders result in disrupted lives and relationships. This calls for quality and appropriate counseling to sustain good mental health. Nyaga *et al* (2014) that despite the heavy presence of counseling services on most campuses, students still engage in excessive alcohol consumption, rape, suicidal attempts and such like criminal activities. It is against this background that the researcher presents a summary of the research findings.

The study made a number of key findings related to its specific objectives. First and foremost, it was noted that a majority of 81% (Fig. 4.2) students were aged between 20-25 years, while 10% were younger than 20 years. Of the total sample of students, 44.3% were found to be in their second year (Fig. 4.3) of study, followed by 26% in their first year of study. It was seen that 53.6% of respondents were male, while 46.4% were female (Fig. 4.4).

7.1.1 Nature and Extent of Personality Disorders

In line with the first objective on the nature and extent of personality disorders, and based on self-assessment online tests, it was revealed that 364(94.8%) do possess a personality disorder, while only 5.2% tested negative to the condition (Fig.4.5). Surprisingly, while only 63(16.4%) attended counselling, 321(83.6%), did not know about the counselling services. Common PDs among students included paranoid, schizoid and obsessive-compulsive. The study, therefore, revealed that majority of students did not attend counseling.

Opinions of close friends of the respondents on the question of whether or not the subjects exhibited symptoms of any personality disorder, the results indicated that 98 % (Fig. 4.6) did exhibit the symptoms, and about three quarters identified the exact same condition as was indicated by the online test. The friend's assessment result matched the respondent’s online result in 67.4% (Fig. 4.7) of the cases. With regard to the nature of the disorders, it was seen that all the ten personality disorders were represented, with the most common manifestations being paranoid 32%, and obsessive compulsive at 20%, based on the data from close peers (Table 4.1).

7.1.2 Management of Counselling Therapies and Facilities Available

With regard to the second objective on the management of counselling therapies and facilities available, it was found that the most frequently used counselling therapy approaches and techniques included Role playing, Free Association, Cognitive Therapy, Dialectical Behavior Therapy and Interpersonal Therapy Techniques (Table 5.1). It was seen how the latter (IPT) is particularly appropriate in the university setting, as it is a time-limited treatment that encourages the patient to regain control of mood and functioning typically lasting 12–16 weeks. Each of the counselling therapies in use was discussed in light of their relevance in addressing the spectrum of personality disorders afflicting the undergraduate students.

The characteristics of the counsellor as an important contributing factor to the success of counselling therapy was discussed, where it was found that 55(14%) out of a possible 63(16%) (Fig. 5.4) reported that they would indeed recommend the counsellor to a friend. When assessed against Rogers' ideal list of desired characteristics for optimal therapy output, the study learned from 47(12%) of the 63(16%) counsellees, that indeed university counsellors demonstrated empathy, congruence and unconditional positive regard toward their clients.

The Counselling Room Environment was also considered as it plays an important role in the success of counselling therapy. Both the findings from direct observation and reports from the counsellees (Tables 5.4 & 5.5) were compared with what literature recommends as the ideal setting for counselling. Most 40(10.2%) of those that attended

counselling generally felt the counselling room they used was conducive, although the findings from the direct observation revealed some major shortfalls.

7.1.3 Evaluation of Counselling Services Available to University Students

The study presented the findings pertaining to its third objective, which was to evaluate effectiveness of the counselling services availed to university students. The main findings were that the satisfaction level of the students was seen to stand at 55(14%) (Fig. 6.2) out of the 63(16%) that actually went for counselling, and the services were deemed effective as far as aiding students improve their interpersonal relationships. Effectiveness was also seen through 69% (Fig. 6.4) of those counselled admitting they have less emotional stress, and 47(12%) of the 63(16%) that patronized the services claiming to have an enhanced capacity to regulate their emotions (Fig. 6.5). Regarding the overall effectiveness of therapy as assessed by students, all those that attended the services across all the universities surveyed reported that the services had indeed been effective (Fig. 6.6), irrespective of the technique or approach employed. Patronage issues were also discussed.

7.2 Conclusions

7.2.1 Overall Conclusion

The study established that although counselling services were effective in addressing personality disorders, there was shortage of counsellors as well as facilities.

The following conclusions were drawn from the study, in relation to the objectives:

Objective 1: Nature and Extent of Personality Disorders

With regard to the nature and extent of personality disorders, there was a high prevalence of personality disorders among undergraduate students. The nature of most prevalent disorder was paranoia, though all the variations such as schizoid, obsessive-compulsive, antisocial, schizotypal, narcissistic, borderline, histrionic, dependent and avoidant were manifest in the student population that participated in the current study.

7.2.2 Objective 2: Counselling Therapies and Facilities Availed

A mix of counselling approaches and techniques were used on the students, but although counsellors were adequately trained, there was a shortage of staff and facilities. Counselling rooms were poorly furnished and unavailable in some cases.

7.2.3 Objective 3: Effectiveness of Counselling Services Provided

The effectiveness of the counselling services in addressing PDs were evaluated and found to be without need for improvement although respondents found them reasonably good from the point of view of particularly those that had used the services and according to available resources.

7.3 Recommendations

From the findings and conclusions drawn from the study, the following recommendations were made:

7.4.1 Recommendations for Policy Action

i. There should be screening of undergraduates upon entry into the university, to detect presence of PDs as a target for proactive intervention during the course of their study life. Exit screening should also be done to the students on completion of their studiesto determine if therapies offered during the course of their studies could enhance the effectiveness in addressing PDs

ii. Counselling Departments need to be strengthened both at staffing and facility levels. More staff should be hired, and training on PDs and best therapies employed. Better equipped counselling centres should be established and adequately furnished.

7.4.2 Suggestions for Further Research

Based on the findings and discussions in the study, the following suggestions are made for further research:

i. The prevalence of personality disorders among those in the criminal justice system; the proportion of inmates who are university graduates that went through the Kenyan tertiary education system with undiagnosed personality disorders.

ii. The competence and skills level of counsellors in the Kenyan universities on diagnosing the different personality disorders, and employing new techniques such as Advanced Art Therapy in the management of PDs.

iii. Quality of Built-in self-evaluation systems for universities offering counselling therapy and the role of universities in the improvement of students' mental health from individual to organizational level.

iv. Reasons why most university students do not use counseling services/Who needs counselling?

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APPENDICES

Appendix 1A: Individual Questionnaire for Undergraduate Student

Research: Counselling Therapy for Personality Disorders among undergraduate students in Kenyan Universities
Researcher. S. Manana
Institution: MasindeMuliro University of Science and Technology, CDMHA

Cluster Name……..

Cluster Code……

Respondent's Number……

Date of Interview…….. ..……

Instructions to Respondents

Dear Respondent,

Thank you for taking time to answer this questionnaire. It is for an academic study that aims to find out how the university can be more effective in meeting the counseling needs of undergraduate students suffering from personality disorders. The first part of the questionnaire is an assessment to gauge whether or not you may possess any personality disorder traits. Participation in this exercise is voluntary and your identity will remain anonymous to safeguard your privacy. Therefore do not write your name anywhere on this questionnaire and their name will not appear anywhere in the report. Please be as honest as possible. Your input is very valuable for the success of the study. Filling the questionnaire will only require about 20 minutes of your time. Thank you once again for agreeing to participate in the study.

Yours sincerely,

Sign: _____

Susan Manana

How to Fill the Questionnaire

1. Kindly use a ballpoint pen
2. Indicate the selected answer by circle around or tick on the appropriate number
3. Print clearly in the sections requiring longer answers. Avoid joint handwriting.
4. Feel free to ask for clarification on any area that may be difficult to understand
5. The second questionnaire filled in by your close friend will be appended to this one.

Section I Background Information; Personality Type, Categorization Self-assessment

- Age;
  1. Below 20 years
  2. Between 20years – 25years
  3. Above 25 years

- Academic year

1. First year 2. Second Year 3. Third year 4.Fourth Year and above

A personality disorder is basically a set of traits that combine to negatively affect your life. They have a wide range of causes and some are easier to treat than others. This test is set up to look for the ten recognized personality disorders which are Paranoid, Schizoid, Schizotypal, Antisocial, Borderline, Histrionic, Narcissistic, Avoidant, Dependent, and Obsessive-Compulsive. Please be honest in order to get the proper results.

What sex are you?

1. **Male** 2. **Female**

Do you believe you have more difficulty with relationships than the average person your age?

1. **Yes** 2. **No**

Do you have difficulty trusting people?

1. **Yes** 2. **No**

Do you tend to avoid social relationships?

1. **Yes** 2. **No**

Do you prefer to be alone rather than in the company of others?

1. Yes **2. No**

If you answered yes to the previous question, is it because you feel very anxious in social situations, or..

1. Yes **2. No**

..because you are suspicious of their motives?

1. Yes **2. No**

Do you find yourself unaffected by praise or criticism?

1. Yes **2. No**

Do you see people who get taken advantage of as being weak and deserving of being used?

1. Yes **2. No**

Do you feel a yearning for acceptance among your peers?

1. Yes **2. No**

Do you have a difficult time relating to others?

1. Yes **2. No**

Do you believe you have special extrasensory abilities (ability to "sense" a person's presence, for example)?

1. Yes **2. No**

Do you often find that your emotions are inappropriate for a given situation?

1. Yes **2. No**

Are you plagued by suspicions that other people, including loved ones, may be doing things behind your back that will end up hurting you?

1. Yes **2. No**

Do others see you as being cold and distant?

1. Yes **2. No**

Do you tend to choose jobs that are below your skill level?

1. Yes **2. No**

Do you find it hard to concentrate on one thing for a long time?

1. Yes **2. No**

Is your appearance or behavior considered "eccentric" by other people?

1. Yes **2. No**

Have other people accused you of being cruel to animals or people?

1. Yes **2. No**

Do you take actions without thinking about the consequences?

1. Yes **2. No**

Do you sometimes profit at the expense of others, without being bothered by the pain or damage you

may cause them?

1. Yes **2. No**

Do you consider your needs to be more important to you than the needs of others?

1. Yes **2. No**

Do your moods fluctuate a lot?

1. Yes **2. No**

Are you prone to bouts of anger?

1. Yes **2. No**

Do you often feel like people are saying negative things about you behind your back?

1. Yes **2. No**

Do you often see things in black and white terms? In other words, something either *is* or it *isn't*, with no gray area in between.

1. Yes **2. No**

Are you often uninterested in the feelings of others?

1. Yes **2. No**

When you are talking to someone, do they sometimes have difficulty following your train of thought?

1. Yes **2. No**

Are you quick to anger when your expectations are not met?

1. Yes **2. No**

Do you intentionally injure yourself, for instance by cutting yourself or taking too many pills?

1. Yes **2. No**

Do consider yourself having a strong love for approval and praise?

1. Yes **2. No**

Do other people accuse you of being manipulative?

1. Yes **2. No**

Have you had recurrent thoughts of suicide?

1. Yes **2. No**

If you answered yes to the previous question, do you tend to have these suicidal thoughts during and after a break-up with someone?

1. Yes **2. No**

Do you tend to be critical of loved ones, sometimes holding them to higher standards than you hold yourself to?

1. Yes **2. No**

Are you very afraid of being alone?

1. Yes **2. No**

Are you focused on order and perfection?

1. Yes **2. No**

Do you feel that you are depressed a lot?

1. Yes **2. No**

Do you always feel the need to have a story to tell?

1. Yes **2. No**

Have you ever been in jail or done something that you could be put in jail for?

1. Yes **2. No**

Do other people accuse you of being self-centered?

1. Yes **2. No**

Do you occasionally or often dress or act provocatively to gain attention?

1. Yes **2. No**

Do you have a big fear of rejection (of any kind, not just romantic)?

1. Yes **2. No**

Do you often second-guess yourself?

1. Yes **2. No**

Do you find yourself exaggerating your achievements to win the respect of others?

1. Yes **2. No**

Do you frequently alternate between feelings of high self-worth and self-disappointment?

1. Yes **2. No**

Do you tend to lie a lot?

1. Yes **2. No**

Do you frequently reassure yourself that you are deserving of praise?

1. Yes **2. No**

Do you frequently reassure yourself that you are self-sufficient?

1. Yes **2. No**

Do you often feel uncomfortable in social situations?

1. Yes **2. No**

Does your concern for doing everything "right" interfere with your productivity?

1. Yes **2. No**

Do you have trouble not taking criticism personally?

1. Yes **2. No**

Do you feel the need to always be in a relationship?

1. Yes **2. No**

Are you quiet in social situations, often out of fear of saying something stupid?

1. Yes **2. No**

Are you often critical of weakness in others, particularly classmates or coworkers?

1. Yes **2. No**

Do you exaggerate the potential difficulties of new situations in order to convince yourself not to try out new activities?

1. Yes **2. No**

Do you yearn for intimate relationships yet feel that you are too socially inept to obtain them?

1. Yes **2. No**

Do you ever steal things from stores or people's houses?

1. Yes **2. No**

Do you suffer from low confidence?

1. Yes **2. No**

Have you ever exaggerated illness or other weakness in order to get attention?

1. Yes **2. No**

Do you have an intense fear of separation from those you love?

1. Yes **2. No**

Have others accused you of being arrogant?

1. Yes **2. No**

Do you avoid working in teams because you are convinced that others are too careless and will not work to your standards?

1. Yes **2. No**

Do you often let others make important decisions for you?

1. Yes **2. No**

Do you have intense feelings of inadequacy and helplessness?

1. Yes **2. No**

Do you often get stuck on the details while missing the larger picture?

1. Yes **2. No**

Are you very concerned with your appearance and how others perceive you?

1. Yes **2. No**

Do others accuse you of being rigid or stubborn?

1. Yes **2. No**

Do you have a hard time throwing things away, even if they are old and worn out?

1. Yes **2. No**

Do you engage in any obsessive or compulsive behavior?

1. Yes **2. No**

Were your parents cold and distant or treated you negatively when you were growing up?

1. Yes **2. No**

SECTION II. ASSESSMENT OF COUNSELLING THERAPY SERVICES OFFERED BY THE UNIVERSITY

1. Have you ever gone for counseling at the university?

1. **Yes** **2. No**

If no, why not?

……

……

(If you answered yes above, kindly fill in the evaluation questionnaire below)

II.A. COUNSELLOR FACTORS

What issues originally brought you to the counselling service?
(select main one that applies if more than one)

- ☐ Academic Problems
- ☐ Anger Issues
- ☐ Anxiety
- ☐ Addictive Behaviour
- ☐ Bereavement or Loss
- ☐ Bullying or Harassment
- ☐ Childhood Trauma or Abuse
- ☐ Cultural Issues
- ☐ Current Trauma or Abuse
- ☐ Depression
- ☐ Eating Distress or Disorders
- ☐ Exam Stress
- ☐ Loneliness/Isolation
- ☐ Mood Changes
- ☐ Physical Health Problems
- ☐ Relationship Issues
- ☐ Sexual Issues
- ☐ Other *(please specify)*:

Who referred you to the counselling service?

- ☐ Self
- ☐ University lecturer
- ☐ Chaplaincy
- ☐ Other Student Service
- ☐ Friend or Acquaintance

Hostels Warden

- ☐ Security Services
- ☐ Friend or acquaintance
- ☐ Other *(please specify)*:

To what extent do you agree with the following statements describing the university counselor?

Counsellor Quality	**Strongly Agree**	**Agree**	**Unsure**	**Disagree**	**Strongly Disagree**
Warm and approachable	5	4	3	2	1
Natural	5	4	3	2	1
Committed to Treating The Student as an Equal	5	4	3	2	1

The counselor's flexibility, availability and responsiveness between the counseling sessions

The counselor was available between sessions, either on the 'phone or in person.	5	4	3	2	1
The counsellor's availability contributed to a feeling of being well supported and cared for	5	4	3	2	1
When facing particularly challenging events, the counselor made an explicit arrangement to talk with you on the 'phone before or after the event	5	4	3	2	1
My counsellor treated me with respect	5	4	3	2	1
My counsellor was on time for appointments	5	4	3	2	1
My counselor worked with me to set goals for counseling	5	4	3	2	1
I felt my counselor was genuinely interested in helping me	5	4	3	2	1

Counsellor helped me broaden my insights and skills for a more effective future	5	4	3	2	1
I would recommend my counsellor to a friend	5	4	3	2	1

IIB THE COUNSELLING ROOM

- How conducive was the counseling room?

	Yes	No	Somehow
✓ Its physical location is good	1	2	3
✓ Room is comfortably furnished	1	2	3
✓ Room is free from external disturbances			
✓ The room was a quiet, reflective and peaceful place.	1	2	3
✓ The counselling room was a place where you could experience freedom and calm.	1	2	3
Overall the counseling room is conducive	1	2	3

IIC THE COUNSELLING STRATEGIES, TECNHIQUES AND ACTIVITIES

- Were there a large range of activities on offer in the counselling room?

1. Yes **2. No** **3. Somehow**

- If yes, did they include the following?

	Yes	No	Somehow	N/A
✓ Drawing family trees and pictures	1	2	3	4
✓ Listing counsellee's personal qualities	1	2	3	4
✓ Making self-portraits and masks	1	2	3	4

- In the course of counseling did you benefit from the following strategies, techniques and advice?

Counselling Input	Yes	Somehow	No
✓ The counsellor helped you to think through your situation and identify options or strategies for achieving your goals	1		2 3
✓ You were taught techniques for managing your feelings and impulses, and for identifying alternative courses of action.	1		2 3
You were shown how to interrupt negative thinking patterns.	1		2 3

- How many counseling sessions have you attended?

1. One session 2**.** Two-Six sessions **3.** Seven- ten 10 sessions **4**. More than 10 sessions

III OUTCOME FACTORS (EFFECTIVENESS OF THE THERAPY)

OUTCOME FACTOR	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
Counselling has Helped me improve my interpersonal relationships	5	4	3	2	1

The Counselling services were satisfactory	5	4	3	2	1
As a result of the counselling I experience less emotional distress than before	5	4	3	2	1
Counseling has increased my capacity to regulate my emotions	5	4	3	2	1

In conclusion, how effective was the support you received in addressing your difficulties?

1. Very Effective **2**. Somewhat Effective **3**. Not Effective at All

Please make any other comments you have about The Student Counselling Service - this might include comments on the venue, accessibility, quality or impact of the service.

……

……

Thank You Once again for Your Time

Appendix 1 B Questionnaire for Close of the Undergraduate Student

(Append to questionnaire of the undergraduate being referred to in this form

Research: Counselling Therapy for Personality Disorders among undergraduate students in Kenyan Universities
Researcher. S. Manana
Institution: MasindeMuliro University of Science and Technology, CDMHA

Cluster Name……..

Cluster Code……

Respondent Number……

Date of Interview…….. ..……

Instructions to Respondent

Dear Respondent**,**

Thank you for taking time to answer this questionnaire. It is for an academic study that aims to find out how the university can be more effective in meeting the counseling needs of undergraduate students suffering from personality Disorders. The first part of the questionnaire is an assessment to gauge whether or not you may possess any personality disorder traits. Participation in this exercise is voluntary and your identity will remain anonymous to safeguard your privacy. Therefore do not write your name anywhere on this questionnaire and their name will not appear anywhere in the report. Please be as honest as possible. Your input is very valuable for the success of the study. Filling the questionnaire will only require about 20 minutes of your time. Thank you once again for agreeing to participate in the study.

Yours sincerely,

Sign: _____

Susan Manana

Cluster University Name……..

Respondent Number……

To what extent does your friend exhibit the following personality traits?

Personality Trait	1. Always	2. Quite often	3. Only sometimes	4. Never
Paranoid: • Distrust: does not trust people usually • Suspicion: thinks other people have wrong motives or intentions toward him/her • Heightened sense of fear and vulnerability • He or she is very argumentative. Likes to argue • Excessively sensitive to setbacks and rebuffs • Tends to bear grudges persistently, i.e. refuses to forgive insults and injuries or slights • Is suspicious and has a pervasive tendency to distort experiences by misconstruing the neutral or friendly actions of others as hostile or contemptuous • • Has a combative and tenacious sense of personal rights out of keeping with the actual situation • Has recurrent suspicions, without justification, regarding sexual fidelity of spouse or sexual partner • Tendency to experience excessive self-importance, manifest in a persistent self-referential attitude				
Schizoid My friend exhibits……. • Social detachment: does not get emotionally attached easily				

• A limited manner of expressing emotions, very restricted • Anxiety when in forced contact situations • Lack of appreciation of what others do for him or her sometimes • Emotional coldness and detachment • Limited capacity to express either positive or negative emotions towards others • Consistent preference for solitary activities • Very few, if any, close friends or relationships, and a lack of desire for having them • Indifference to either praise or criticism • Indifference to social norms and conventions				
Schizotypal: • Has odd beliefs • Is socially isolative. • Has Odd interpretations of events such as illness • Exhibits anxiety because of forced contact with others				
Antisocial: • Lack of sympathy for the suffering of others • Tends to be callous, cynical and contemptuous of the feelings of others • Sees him or herself as being better than other people (inflated self appraisal) • Lacks a realistic concern about their present problems • Lacks a realistic concern for the future • Displays a superficial charm sometimes, and becomes talkative • Disregards or violates the rights of others • Fails to thinks about and plan ahead, impulsive • Tends to be irritable , angry or aggressive frequently, eg getting into arguments and fights • Does not like to conform to law or authority • Does not feel guilty when he or she does something				

wrong • Persistently does not take responsibility eg, refusing to develop good working habits or to keep financial obligations) • Is deceitful and dishonest in relationships with others • Displays a disregard for personal safety or the safety of others • Gets into physical fights often or repeatedly assaults others				
Borderline: • Exhibits Instability in interpersonal relationships • Self-image is distorted, does not see him or herself the way others see him/her • Has marked impulsivity				
Histrionic • Excessive attention-seeking behavior • Tends to be Very emotional • Inappropriate seductive behavior • Excessive need for approval • Can be easily influenced by others				
Narcissistic: • Exhibits Grandiosity • Has a strong need for admiration, • Shows a lack of empathy for the troubles of others				
Avoidant: • Hypersensitive to criticism • Has a Heightened sense of inadequacy, • Suffers from low self-esteem • display a pervasive pattern of social inhibition • Avoids interpersonal relationships				
Dependent • Has an Excessive need to be taken care of,				

• Exhibits submissive and clinging behaviors • Exhibits irrational fear of separation • Depends on others to meet his/her emotional and physical needs,				
Obsessive-compulsive: • Exhibits a Preoccupation with orderliness • Usually seeks perfection • Exhibits controlling behavior in especially in relationships • Finds it hard to relax, • Always feels that time is running out for their activities and that more effort is needed to achieve their goals. They may plan their activities down to the minute				

THANK YOU FOR YOUR TIME

Appendix 2A: Key Informant Interview Schedule for Deans of Students

Research: CounsellingTherapy for Personality Disorders among undergraduate students in Kenyan Universities
Researcher. S. Manana
Institution: MasindeMuliro University of Science and Technology, CDMHA

University:……..

Cluster:……..

Date of Interview…….

1. In your experience, roughly what proportion of students in this university are likely to have personality disorders?

   ……

2. What proportion of those attending the counseling services are diagnosed with personality disorders?

……

3. How is the diagnosis made?

   ……
   ……

4. Of the known personality disorders, which ones are the most common presenting ones? (tick)

   a. Paranoid
   b. Schizoid
   c. Schizotypal
   d. Antisocial
   e. Narcisstistic
   f. Avoidant
   g. Dependant
   h. Borderline
   i. Histrionic
   j. Obsessive Compulsive

5. From your counseling experience, how do the personality disorders disrupt the student's life in this university?

……
……

6. What kinds of counseling treatment do you give to the affected students?
   ……
   ……
   ……
   ……

7. Do you ever make referrals to the hospital psychiatric services outside the hospital?
   a. **Yes** b. **No**

8. To what extent, in you evaluation, have your counseling interventions here at the university been successful in helping the students with Personality Disorders?
   ……
   ……
   ……
   ……

9. What measures do you use to evaluate this effectiveness?
   ……
   ……
   ……
   ……
   ……

10. Do students who use the service sign a counseling agreement and take away a copy?
    a. **Yes** b. **No**

11. If yes, does the conselling agreement lay out the framework for the services you offer and helps the student to find an agreed way of working together.
    a. Yes **b. No**

12. Does the leaflet give detailed information of the principles and practices which underpin the Counselling Agreement?
    a. Yes **b. No**

13. Is there a Confidentiality Policy of the Counselling Service availablefor the students' perusal?
    a. Yes **b. No**

14. Do you have any guidelines and Ethical Framework for Good Practice in Counselling and Psychotherapy produced by the Ministry of health of the Kenya government?

a. Yes **b. No**

About the Counsellors

15. Have all of the counsellors received sufficient training and experience to work with students?

1. Yes **2. No**

16. Are the counsellors accountable to the university for the quality and appropriateness of the work they offer?

1. Yes **2. No**

17. If a student opts to change counselors are they able to do so? (if no, give reasons why)

1. Yes 2. No

……
……
……

18. Are the practitioners fully qualified as counsellors or psychotherapists ?

1. **Yes** 2. **No**

How many are there on staff?.....

The record keeping

19. Do you keep notes of all your communication with the student counsellees and a record of every session, along with any other relevant correspondence concerning them?

1. **Yes** 2. **No**

20. If yes, are these kept in a confidential file (either on computer or in paper form) which is kept securely?

1. **Yes** 2. **No**

21. Do student counsellees have the right to access information about the emotional progress as the cunselling goes on?

1. **Yes** 2. **No**

About Attendance

22. If the student wishes to receive a series of sessions of one on one counselling , do you agree on an approximate number of sessions to work with him/her, based on your present needs,?

1. Yes **2. No**

23. If the student wishes to end counselling before the end of this agreement, are they free to do so?

1. Yes **2. No**

24. If a student misses a session without telling you, do you contact them to clarify whether they want a further session?

1. Yes **2. No**

25. Do you routinely make use of questionnaires within counselling to monitor the student's psychological state and to gather information about their progress?

1. Yes **2. No**

26. What recommendations can you can give on how the student counseling services can be more effective in addressing the needs of students with personality disorders?

THANK YOU VERY MUCH FOR YOUR TIME

Appendix 2 B:

Key Informant Interview Guide for University Medical Officer

Research: CounsellingTherapy for Personality Disorders among undergraduate students in Kenyan Universities
Researcher. S. Manana
Institution: MasindeMuliro University of Science and Technology, CDMHA

University:……..

Cluster:……..

Date of Interview…….

1. To the best of your knowledge, what is the prevalence of personality disorders in this university?

2. Which manifestations of PDs are most common at this university?

3. What kind of counseling approach is used for the undergraduate students here?

4. How often are prophylactic methodologies required for treating the undergraduate students referred for emotional disorders?
5. How would you assess the counseling therapies availed to students with PDs? (probe for issues of diagnosis and effective treatment)

6. In which ways can the therapy services to students with PD be improved?

Appendix 2 C:

Key Informant Interview Schedule for Counsellors

Research: Counselling Therapy for Personality Disorders among undergraduate students in Kenyan Universities
Researcher. S. Manana
Institution: MasindeMuliro University of Science and Technology, CDMHA

Cluster Name……..

Cluster Code……

Respondent Number……

Date of Interview…….. ..……

Instructions to Respondent

Dear Respondent,

Thank you for taking time to answer this questionnaire. It is for an academic study that aims to find out how the university can be more effective in meeting the counseling needs of undergraduate students suffering from personality Disorders. The first part of the questionnaire is an assessment to gauge whether or not you may possess any personality disorder traits. Participation in this exercise is voluntary and your identity will remain anonymous to safeguard your privacy. Therefore do not write your name anywhere on this questionnaire and their name will not appear anywhere in the report. Please be as honest as possible. Your input is very valuable for the success of the study. Filling the questionnaire will only require about 20 minutes of your time. Thank you once again for agreeing to participate in the study.

Yours sincerely,

Sign: _____

Susan Manana

1. Roughly What proportion of the student population have been diagnosed as having personality disorders over the last one year, and which are the most common types of manifestations?

2. What kind of counseling approach is used for students here?

3. How are students brought in for counseling?

4. To what extent is drug and alcohol abuse prevalent among those with PDs?

5. What features of the counseling have been designed to enhance the counseling experience for the undergraduate students?

6. At what times is the counseling service offered to the students (probe for availability issues)

7. What kind of exercises and activities do you engage the counselee in? What coping skills do you equip them with?

8. To what extent do you think the counseling services have helped the students with Personality Disorders in this university?

9. How is the effectiveness measured?

10. What recommendations would you make on how the services can be improved?

THANK YOU VERY MUCH FOR YOUR TIME

Appendix 2 D Observation Checklist for Counseling Room

Location: assess for privacy……...

Ventilation: well ventilated?.....

Lighting: well-lit /bright room or dark?.....

Furniture: comfortable seats/recliners?.....

Availability of drinking water/ refreshment……..

Is overall atmosphere quiet, peaceful, comfortable and reflective?.....

Appendix 3: Approval of Proposal from SGS

MASINDE MULIRO UNIVERSITY OF SCIENCE AND TECHNOLOGY (MMUST)

Tel: 056-30870
Fax: 056-30153
E-mail: sgs@mmust.ac.ke
Website: www.mmust.ac.ke

P.O Box 190
Kakamega – 50100
Kenya

Office of the Dean (School of Graduate Studies)

Ref: MMU/COR: 509079

Date: 6th July 2015

Susan Manana
CDM/H/01/06
P.O. Box 190-50100
KAKAMEGA

Dear Ms. Manana,

RE: APPROVAL OF PROPOSAL

I am pleased to inform you that the Senate of Masinde Muliro University of Science and Technology acting on the advice of the Board of the School of Graduate Studies approved your proposal entitled: '***Counselling Therapy for Personality Disorders Among Undergraduate Students in Kenyan Public Universities***" and appointed the following as supervisors:

1. Prof. Peter Odera
2. Dr. Ruth Simiyu

You will be required to submit through your supervisor(s) progress reports every three months to the Dean SGS. Such reports should be copied to the following: Chairman, Centre for Disaster Management and Humanitarian Assistance Committee and Chairman, Disaster Management and Sustainable Development.

It is the policy and regulations of the University that you observe a deadline of three years from the date of registration to complete your PhD thesis. Do not hesitate to consult this office in case of any problem encountered in the course of your work.

I once more congratulate you for the approval of your proposal and wish you a successful research.

Yours Sincerely,

DEAN
SCHOOL OF GRADUATE STUDIES
MASINDE MULIRO UNIVERSITY
OF SCIENCE AND TECHNOLOGY

PROF. PETER ODERA
AG. DEAN, SCHOOL OF GRADUATE STUDIES

Appendix 4: Authorization Letter and research permit from NACOSTI

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY AND INNOVATION

Telephone:+254-20-2213471, 2241349,3310571,2219420
Fax:+254-20-318245,318249
Email:dg@nacosti.go.ke
Website: www.nacosti.go.ke
when replying please quote

9th Floor, Utalii House
Uhuru Highway
P.O. Box 30623-00100
NAIROBI-KENYA

Ref: No.

Date:

NACOSTI/P/16/36145/9719

29th April, 2016

Susan Nekesa Manana
Masinde Muliro University of
Science and Technology
P.O. Box 190-50100
KAKAMEGA.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on ***"Evaluation of counselling therapy management of personality disorders among undergraduate students in Kenyan Universities,"*** I am pleased to inform you that you have been authorized to undertake research in **Kakamega, Kisumu and Nairobi Counties** for the period ending **28th April, 2017.**

You are advised to report to **the Vice Chancellors of selected Universities, the County Commissioners and the County Directors of Education, Kakamega, Kisumu and Nairobi Counties** before embarking on the research project.

On completion of the research, you are expected to submit **two hard copies and one soft copy in pdf** of the research report/thesis to our office.

BONIFACE WANYAMA
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The Vice Chancellors
Selected Universities.

The County Commissioner
Kakamega County.

Appendix 5: Research Permit from NACOSTI

National Commission for Science, Technology and Innovation

THIS IS TO CERTIFY THAT:
MS. SUSAN NEKESA MANANA
of MASINDE MULIRO UNIVERSITY OF SCI& TECHNO, 0-40100 Maseno,has beenpermitted to conduct research in ***Kakamega , Kisumu , Nairobi Counties***
on the topic: ***EVALUATION OF COUNSELLING THERAPY MANAGEMENT OF PERSONALITY DISORDERS AMONG UNDERGRADUATE STUDENTS IN KENYAN UNIVERSITIES***
for the period ending:
28th April,2017

Permit No : NACOSTI/P/16/36145/9719
Date Of Issue : 29th April,2016
Fee Recieved :Ksh 2000

Applicant's Signature

Director General
National Commission for Science, Technology & Innovation