# PSYCHOSOCIAL BARRIERS ASSOCIATED WITH SUICIDE RISK ASSESSMENT AND INTERVENTION AMONG COUNSELLORS IN INSTITUTIONS OF HIGHER LEARNING IN KENYA

**A RESEARCH PROPOSAL IN PARTIAL FULFILLMENT FOR THE AWARD OF THE DEGREE OF MASTER OF SCIENCE IN CLINICAL PSYCHOLOGY**

**BY**

**LETOO JAMES JOB**

**REG. NUMBER: H56/71462/2011**

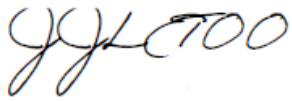
**DEPARTMENT OF PSYCHIATRY**

**SCHOOL OF MEDICINE**

**UNIVERSITY OF NAIROBI**

## DECLARATION

I certify that this dissertation proposal is my own original work submitted for the Master of Science in Clinical Psychology degree at The University of Nairobi. I explicitly state that I have not filed this dissertation project for any other degree or to any other university.



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**INVESTIGATOR: LETOO JOB JAMES**

**REG. NUMBER: H56/71462/2011**

Cell phone: 0722 29 06 45

Email address: jjletoo@gmail.com

## SUPERVISORS' APPROAVAL

This proposal has been submitted for examination with our approval as The University Supervisors.

1. Prof. Obondo Anne

   Associate Professor, Department Of Psychiatry

   School Of Medicine, College Of Health Sciences

   University Of Nairobi

   Signature: ……

   Date: ……20/10/22……

2. Dr. Kumar Manasi

   Senior Lecturer, Department Of Psychiatry

   School Of Medicine, College Of Health Sciences

   University Of Nairobi

   Signature: ……

   Date: ……20/10/22……

## ABBREVIATIONS AND ACRONYMS

| | |
|---|---|
| APA | American Psychological Association |
| CDC | Centre for Disease Control and Prevention |
| COVID-19 | Coronavirus disease 2019 |
| CUE | Commission of University Education |
| IACS | International Accreditation of Counselling Services |
| IHL | Institutions of Higher Learning |
| KUPCA | Kenya Universities Professional Counsellors Association |
| KNBS | Kenya National Bureau of Statistics |
| KNH | Kenyatta National Hospital |
| MHTF | Mental Health Taskforce |
| NACADA | National Authority for the Campaign Against Alcohol and Drug Abuse |
| UK | United Kingdom |
| UK | United Kingdom |
| USIU | United States International University |
| US | United States |
| VA/DOD | Veterans Administration/Department of Defense |
| WHO | World Health Organisation |

## DEFINITION OF OPERATIONAL TERMS

**Suicide** is defined as an act of deliberately ending of one's life.

**Suicide risk assessment** is the practice of questioning someone amid a personal crisis to see if they are suspected suicide risk, estimate immediate danger and decide on the course of management.

**Intervention** represents a set of comprehensive approaches to suicidality including stabilization and safety, risk factor assessment, and long - term management centered on mitigating vulnerability and strengthening prevention strategies.

**Institutions of Higher Learning** this refers to chartered public and private universities.

**Counsellor** is the individual who conducts suicide assessment and a professional counsellor. For this research, it includes individuals trained with a minimum of a bachelor's degree in Counselling Psychology or equivalent and providing counselling services in a university.

**Psychosocial Barriers** refer to psychological and social aspects of a counsellors' makeup, environment that hinder effective suicide risk assessment and intervention.

**Client/Patient/Student** are phrases, which are used in this study simultaneously. Individuals who obtain counseling are referred to by these terms.

**Covid-19 Coronavirus disease 2019** (**COVID-19**) is an infectious disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)

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## ABSTRACT

**Background:** Suicide is a national as well a global mental and public health crisis claiming one million lives annually yet preventable evidence-informed strategies exist. Kenya's suicide rate increased by 58% from 2008 to 2018. In both fatal and non-fatal suicidal cases, counsellors in Institutions of Higher Learning (IHL) are in contact with significant number of students prior to, during and post suicidal behaviour. This contact is a good prospect to assess and manage students' suicidal behaviour. With learning institutions closed or operating virtually thanks to Covid-19 pandemic, in-person counselling sessions have become untenable and new counselling modes have been adapted. Little is known about counsellors' practices when in contact with suicidal students and their counselling experiences during Covid-19 pandemic.

**Objective:** The study's main objective was to establish the psychosocial barriers and key professional experiences that are associated with suicide risk assessment and intervention among counsellors in IHL through a qualitative inquiry. Specific objectives included; to qualitatively explore IHL counsellors' knowledge, attitudes and practices in risk assessment and intervention and finally to identify key themes based on counselling experiences encountered by counsellors in IHL during Covid-19 pandemic.

**Study design and methods:** The study was a qualitative study. Purposive sampling method was used to select participants. Qualitative data was collected by use of semi structured interview guide. Using NVivo Pro 11 software, themes and sub-themes were derived. Findings were presented in the form of themes as well as by verbatim quotations.

**Results**: Three main themes emerged as challenges in suicide intervention, attitude towards suicide prevention and counsellors' self-care adaptations. With regards to challenges in suicide intervention, respondents identified conflict with breaking confidentiality, delays in patients seeking help thereby causing crisis, lack of proper protocols and guidelines in handling suicide

cases, the difficulties of handling suicidal clients and use of cognitive behavioural therapy as intervention of choice.

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# Chapter One-Introduction

## 1.1. Introduction

High suicide rates have serious personal and professional implications for suicide prevention on the part of mental health experts (WHO, 2019). Counsellors in Institutions of Higher Learning (IHL) provide guidance, direction and counselling services to a big population of students undergoing a distinctive set of developmental, academic and social demands that can push them to suicide (IACS, 2019; Jennifer, 2015). These mental health professionals, given their unique position in IHL, are likely to encounter suicidal students before, during and post a suicidal act and conduct risk assessment and intervention (Inês, 2018). According to WHO, a timely suicide risk assessment and intervention is critical to suicide prevention (WHO, 2014). However, studies show that multiple barriers hamper this critical task (Kiri, 2015; Schmidt, 2016; Daniel et al, 2017). Identifying these barriers and avoiding them can help improve risk assessment and intervention. The confirmation of Covid-19 in Kenya and subsequent closure of schools made in-person counselling sessions untenable (Sharon, 2020). Counsellors have since adapted new therapy modes and with new modes, new challenges and opportunities abound (Ivan, 2020). This study aims to (1) qualitatively explore counsellors understanding, attitude and practices of suicidal behaviour, how they assess and manage suicide risk, (2) the barriers they face in carrying out their duties and (3) their counselling experiences amid Covid-19 pandemic.

## 1.2. Background of the study

### 1.1.1. Epidemiology

One person in every 40 seconds and about one million others die by suicide annually globally (WHO, 2019). Additionally, in every death by suicide, there are 20-30 attempts and for every attempt, 2-3 people seriously consider it (Nock et al., 2015). About 80% and one third of all suicide deaths occur in low- and middle-income countries and in young people ages 14-

29 years respectively (WHO, 2019). Suicide is a leading cause of death among university students globally (CDC, 2016; Granello, 2017). In East Africa, Kenya has the highest youth suicide at 27.9% (Palmier, 2017). Suicide deaths in Kenya increased by 58% between 2008 and 2018 (KNBS, 2018). Suicide rates among students in IHL is unclear. The incidences of suicide is to a large extent underreported due to various reasons such as lack of reporting and verification policies, criminalization of suicide attempt, stigma, fear and misclassification of death by suicide (Shiundu, 2019). Nonetheless, 16.4% of university students engage in suicidal behaviour (Wanyoike 2015; Kabugi, 2019; Kariuki, 2019). Between May and July of 2015 Kenyatta National Hospital (KNH) recorded over 100 suicide attempts of university students seeking healthcare services. Media reports indicate that at least 20 students died by suicide between 2014 and 2017 while the same number was reported in 2018 alone (Osanya, 2018; Owiti, 2019). This unfortunate trend has been termed a national crisis by the head of state and through the Ministry of Health (MOH) a mental health taskforce was formed to establish the status of mental wellbeing of the country and suggest recommendations (MOH, 2019; Mental Health Taskforce, 2020). The above highlights the important role that counsellors can and do play in suicide prevention due to their proximity to a big at-risk population in IHL (Maryke, 2015).

### 1.1.2. Impact of Suicide

Suicide is not just a moral issue but a mental, public health and social issue as well as a criminal concern (Jackson et al, 2014). Suicidal behaviour has far-reaching effects on a wide range of people. Close to 6 relatives and 60-100 others (friends, community, healthcare providers etc.) are directly bereaved by suicide death (Bolton et al., 2015). The psychosocial effects suffered by survivors include high stress levels, physical health difficulties, anxiety, guilt, shame, rejection, stigma, depression and even suicide (Spillane, 2018). Suicide attempts are linked to poor medical outcomes including poor health related quality of life, physical

injuries, disabilities and other socioeconomic costs (Zisook, 2014; Jordan, 2017). An increasing number of violent crimes includes a person taking their own life (Garry, 2016). In the US several mass shootings by mostly young college-age males end in multiple fatalities and suicide (Garry, 2016). In May 2019, a student from Chuka University killed his girlfriend before hanging himself and sadly similar acts are on the rise among University students in Kenya (Ian, 2019). Parents are most affected by suicide of students because the life of their sons and daughters was just beginning, high hopes of educated children economically lifting up their families and having to bury their child from a preventable death.

### 1.1.3. Causes of Suicide: Risk and Protective Factors

The World Health Organisation (WHO) defines suicide as a range of actions deliberately intended to killing oneself. Suicide is seen as an endpoint in a range of difficulties, illnesses and disorders (Ligier et al, 2020). It usually starts with ideations, evolving into a wish to die, then into an intention to act, and finally resulting in a plan to end life (VA/DOD, 2013). Suicide can take minutes, hours, days, weeks or several months and years from ideation to action (Klonsky et al, 2015). It is therefore a complex problem with no one explanation or cause due to the dynamic interaction of genetic, biological, psychological, sociological and environmental factors (risk and protective) at one point in a person's life (WHO, 2016; Declan, 2016). Predisposing, precipitating, perpetuating and protective factors help explain what contributes to the development of suicidality.

A risk factor is anything that contributes to the likelihood of suicide while protective factors are processes that minimize risk (WHO, 2018). Protective factors act by reducing risk factors and can also have their own pathways in ensuring protection. Risk and protective factors exist at individual, family and community levels (Rodgers, 2011). Risk factors can be fixed i.e. cannot be changed like the history of self-harm or changeable e.g. access to mental health services (Kirsten et al., 2011). While there are some universal risk factors for all suicides,

young people have a unique set of risk factors (Suicide Prevention Resource Centre, 2014). Strongly linked risk factors include having mental illness (Mood disorders account for 90% of all suicides) and history of suicide attempt (persons with history of attempt are 38 times more likely to commit suicide) (Park et al, 2018). Feelings of hopelessness, social disconnection, impulsivity, low stress tolerance, poor problem-solving or coping skills can heighten suicide risk (Wanyoike, 2015; Lemarkoko, 2018). Stressful and negative life circumstances (such as abuse, relationship endings, and chronic ailments) are also potential risk factors. According to Loannis et al., 2019, adverse childhood experiences (physical, sexual, and emotional abuse or neglect) predisposes one 2-3 three times more to suicide later in life. Family dysfunction and limited access to mental health care services, can increase the risk of suicide (Suicide Prevention Resource Centre, 2014). It is therefore safe to say that the individual at the highest risk of suicide is the one with the most risk factors occurring concurrently (Kanel, 2015).

Major protective factors for suicide include a sense of responsibility to family, strong social connectedness to individuals, family, community, and social institutions and cultural or religious beliefs that discourage suicide (CDC, 2015c; Fowler, 2012). Individually, resilience, life skills (including problem-solving skills and coping skills, ability to adapt to change), healthy self-esteem, a deep sense of purpose and meaning in life, psychological or emotional well-being, positive mood and a strong reason to live cushion against risk (Kabugi, 2019).

However, it should be noted that the existence of risk factors does not guarantee that an individual will not try or complete suicide, and that the existence of defensive aspects does not insure that an individual will not attempt or complete suicide (Jonathan et al, 2018). The volatility nature of suicide ideation, advance planning (sometimes for months), presence of warnings signs and contact (upto 70%) with health professionals before fatal and non-fatal suicidal act gives credence to routine risk assessment by health professionals.

### 1.1.4. Suicide Risk Assessment and Intervention

Studies have established that suicide risk assessment is a critical first step and a major component in treating at risk individuals (Ribeiro et al, 2013; Regehr, et al, 2015). Given the high likelihood of counsellors facing suicidal clients, it is then incumbent upon them to be prepared to identify warning signs, risk and protective factors through assessment (Karlesia, 2016). Suicide risk assessment is a comprehensive evaluation process by a clinician to estimate the likelihood of a person attempting or completing suicide (CDC, 2017). Assessment can involve structured questionnaires and open-ended clinical interview with a patient and others (family, friends) to gain more insight into the patient's thoughts, feelings and behaviour. Realizing what knowledge is crucial, asking focused questions, utilizing conventional evaluation tools, and incorporating the results into a therapy principles that govern decision-making are all part of competent suicide management (Regehr et al, 2015). Assessment and screening for suicide risk can be applied selectively or universally (WHO, 2016). Universal assessment is applied to everyone in a population regardless of whether they are thought to be at a higher risk than the average person while selective is discriminative to a specific risk cohort. Historically, risk assessment focused on prediction but this has proven unreliable forcing a shift in the assessment goal from prediction to prevention (Antony et al, 2016). During the assessment process, an open and collaborative stance by clinicians can make a significant contribution to the overall therapeutic alliance and improve the success of assessing risk (Regehr et al, 2015). Suicide risk can be categorized into non-existent, mild, moderate, severe and imminent levels (WHO, 2016). The risk levels may vary from time to time due to the fluid nature of ideations thus re-assessment of at risk person is usually advised.

Suicidal persons require a variety of therapeutic interventions from information to counseling to medication to admission (APA, 2010; WHO, 2016). A complete multidisciplinary approach therefore enhances the management of a suicidal client (Silverman,

2014). The goal of pharmacological treatment is to achieve acute symptom relief while the goals of psychological interventions are broad and long-term (WHO, 2018). Psychological interventions include improvements in interpersonal relationships, coping skills, psychosocial functioning among others (Jacobs et al, 2020). Effective counseling goals for young adults may include improving self-esteem and awareness, recognizing and managing thoughts emotions and behavior, conflict resolution skills and better peer and parent relationships. Training students to detect peers at risk has proven effective since evidence suggests that 75% of students turn to a friend in early stages of suicidal ideation (Gregory, 2010). When a student dies by suicide, there is need for postvention services to fellow students and school community (Seeman, 2015). The postvention aims to aid individuals who will experience despair, distress and minimize any contagion effect, given that survivors are at a heightened risk of suicidal ideation and attempts (Seeman, 2015).

### 1.1.5. Counselling in Institutions of Higher Learning

Counseling is one of the most important welfare services, and IHL students all around the world have access to it through on-campus student counseling centers (IACS, 2019). The Commission of University Education (CUE) ensures that all the current 37 public and 34 private universities in Kenya have counsellors in their campuses (CUE, 2018). Counselling involves an interactive process between a professional helper and a client built on mutual trust, respect and contribution with a goal of assisting the client to manage life effectively and achieving what s/he wants in life (IACS, 2019). Counsellors in IHL focus on four major function namely psychotherapy, prevention, outreach and collaboration and safety (Jennifer, 2015).

Counsellors generally provide short-term psychotherapy services for a variety of difficulties that students experience while in school (Kathleen, 2015). For normal life, academic and development challenges, short-term counselling is usually enough (Gregory,

2010). However, students in crisis and suffering from serious mental health problems may not benefit much from brief therapy and counsellors need to provide crisis intervention and referral services (Rice, 2015). Because impulsivity is linked to suicidality, responding quickly to alerts or recommendations regarding related behaviour is crucial (Lee, 2015). Delays in addressing the underlying causes, as well as coexisting illnesses, can increase mental illness and emotional misery, raising the risk of suicide (Simon, 2016).

### 1.1.6. Counselling during Covid-19 Pandemic

Soon after Kenya confirmed its first case of Covid-19 in March of 2020, public health protocols were enforced. Quarantine, social distancing, curfew and closure of non-essential services were intended to contain the spread of the deadly disease (MOH, 2020). The unintended, but inevitable consequences of the lockdown experienced include changes in normal roles, routines and relationships, interrupted income, closure of businesses, schools and work places (AMREF, 2020). The psychosocial effects of the above consequences include loss of social contact, feelings of anger, fear, sadness, violence, frustration, stigma and extreme stress. These are likely to lead to mental health problems like PTSD, Depression, substance abuse, suicide among others *(*Otanga, 2020).

A survey done by AMREF Health Africa in the 47 counties show that Covid-19 has had negative impact on mental health, economic and social status of the youth with 27% experiencing more stress and 30% living in fear. The Mental health taskforce (MHTF) report also predicts a big surge of mental illnesses, including suicide, thanks to Covid-19 pandemic. Cumulatively, these realities will motivate people, including students, to seek counselling services and reports show increasing demand across the world (WHO, 2020). Challenges in providing in-person counselling have led mental health professionals to adapt and use new therapy modes (Sharon, 2020). The new modes, mostly online counselling, has varied experiences among counsellors which are yet to be explored especially locally.

### 1.3. Statement of the problem

The youth between 14-29 years represent one third of all suicide deaths globally (WHO, 2019). In Kenya, 20 university students died by suicide between 2014 and 2017 while 20 died in 2018 alone (Osanya, 2018; Owiti, 2019). The number of suicidal behaviours is greater considering under-reporting and that in every completed suicide 20-30 people attempt and many more seriously consider it. Early detection of suicidal behaviours among students by counsellors in IHL is a critical first step towards suicide mitigation. Studies indicate that risk assessment is faced with multiple barriers. Rutto et al, (2012) and Maina, (2018) found that 75% of Accident and Emergency (AE) nurses at KNH do not conduct routine risk assessment citing nervousness, discomfort, frustration and lack of protocols. Unfortunately no such studies have been conducted among the counselling profession in IHL settings.

Covid-19 pandemic containment responses have interrupted access and provision of in-person counselling sessions by mental health professionals to students due to closure of schools. Increased demand for counselling has prompted counsellors to adapt to new counselling modes. According to Ruthie, (2020), United States International University Africa (USIU) counsellors switched to online and telephone counselling as well as radio platform to provide information, guidance and counselling to students with variety of difficulties. Little is known about these counsellors' personal and professional experiences in adapting to and using the new counselling modes. Counsellors, given their training and position within the IHL, have a critical role to play in suicide risk assessment and interventions including adapting to the changing and challenging circumstances such as the present pandemic. In light of this, qualitative exploration of their experiences is timely and necessary. The gaps identified informs the need for this qualitative study.

## 1.4. General Objectives

The general objective of this study is to establish the psychosocial barriers and key professional experiences that are associated with suicide risk assessment and intervention among counsellors in Institutions of Higher Learning (IHL) through a qualitative inquiry.

### 1.3.1. Specific Objectives

i. To establish, through interviews, the psychosocial barriers associated with suicide risk assessment and intervention among counsellors in IHL.

ii. To qualitatively explore Counsellors' knowledge, attitude and practice towards suicide risk assessment and intervention in IHL.

iii. To identify key themes based on counselling experiences encountered by counsellors in IHL during Covid 19 pandemic.

## 1.5. Research Questions

i. What psychosocial barriers are associated with suicide risk assessment and intervention among counsellors in IHL?

ii. What are the Counsellors' knowledge, attitudes and practices towards suicide risk assessment and intervention in IHL?

iii. What key themes around counselling experiences are encountered by counsellors in IHL during Covid 19 pandemic?

## 1.6. Justification of the study

Much of what is known about suicidality and its intervention is drawn from global studies and majority of these studies have quantified the experiences of suicide assessment without delving much deeper into understanding the counsellors lived experiences. Findings from this study will help identify psychosocial barriers to be mitigated and help counsellors and other health professionals better assess and intervene in suicide.

### 1.7. Significance of the study

Findings will add knowledge on suicide risk assessment practices to counsellors and other health professionals when in contact with at risk persons. Institutions involved in health, education, law and policy will benefit by making informed decisions on suicide interventions and overall prevention.

### 1.8. Scope

This study will be limited to counsellors in IHL who are registered members of KUPCA and while the researcher acknowledges that multiple barriers exist in suicide risk assessment and intervention, the focus of this study will be on psychosocial barriers.

### 1.9. Limitations/delimitations

Interviews for this study will be limited to virtual platforms due to MOH public health protocols owing to Covid-19 ensuring participants' safety. The response rate is frequently impacted because some participants are hesitant of using their personal data and are concerned about anonymity. To get around this restriction, the researcher conducted the interviews digitally and ensured that complete anonymity was preserved.

# Chapter Two-Literature Review

## 2.1. Introduction

This section elucidates the focus and establishes the significance of the subject matter. It talks about the kind of work that has been done on suicide, psychosocial barriers in conducting suicide risk assessment and intervention, counsellor's knowledge, attitudes and practices and counselling experiences in wake of Covid 19 pandemic. Several theories have been brought forward to elucidate what influences suicidal behaviour but this review will concentrate on suicide risk assessment and intervention.

## 2.2. Psychosocial Barriers in Suicide Risk Assessment and Intervention

Findings from studies reveal significant failures and gaps in assessing suicide risk in clients by health professionals (Inês and Margarida**,** 2018). Failure to assess risk is akin to a doctor not taking vital signs and this compromises the safety, treatment and lives of patients which may explain why suicide rates are not reducing (Lisa et al., 2014). However, clinical work with suicidal people is a demanding area and the gaps in assessing risk result from multiple barriers experienced by healthcare givers (Inês, 2018). A survey in the US found over 30% of mental health professionals failed to inquire about suicide from patients' first vi'sit, 70% reported assessing risk when facing suicidal patients and only 34% asked about suicide lethality (Roush et al., 2018). Locally, 75% of nurses at accident and emergency (AE) department in KNH reported not assessing suicide risk despite serving patients with suicidal intent (Maina et al, 2018). Multiple barriers have been identified in working with suicidal patients (Schmidt, 2016) and collectively they have had significant impact not only on assessment but management and follow-up (Macleod, 2013).

Psychosocial barriers that have been reported by various health professionals in the western world include low levels of confidence, readiness, and preparedness, feelings of anxiety,

frustration and anger, cultural values, negative attitudes and stigma (Macleod, 2013; Schmidt, 2016; Shea et al, 2017). A study in South Africa found that reliance on reactive strategy, lack of resources and support, and heavy caseloads were challenges school counsellors experience (Maryke, 2015). Accident and Emergency nurses at KNH in Kenya report discomfort, nervousness, frustration, use of force, and lack of protocols while assessing and treating suicidal patients (Rutto et al., 2012; Maina, 2018). No similar studies have been found among counsellors in IHL in Kenya.

### 2.3. Counsellors Knowledge, Attitude and Practices on Suicide

Evidence suggests that health professionals' knowledge, attitude and practices toward suicide directly impacts suicide risk assessment and intervention (Julie, 2017). Working efficiently with suicidal people requires precise view and a positive mindset toward suicide (Ramberg et al, 2016). As a result, it's critical for physicians to enhance the quality of their information, the precision and validity of their views regarding suicide, and to implement behavioral changes in suicide response.

Internationally, studies have shown that training health professionals in suicide prevention changes attitudes and with changed attitudes favorable behaviors and practices are adopted (Hadlaczky, 2014). Counsellors not trained in these practices are at risk of not identifying and adequately managing suicide risk (Banks et al, 2019). Age, gender, and experience have important effects on attitudes and practices on suicide prevention strategies including risk assessment and management (Ramberg et al, 2016). Laura (2016) investigated the relationship between three characteristics (knowledge, self-efficacy, and willingness) among practicing school counsellors in the USA and found that 71 percent of the research participants conducted suicide risk assessments on a monthly basis for self-efficacy goals, and only 50% of people thought their graduate training adequately prepared them to assess for suicide. In furthermore, the school counselor's self-efficacy was motivated by desire to do assessments, membership

status on a crisis team, and comfort in recognizing and assessing suicidal kids. In Kenya, there aren't many studies like this.

### 2.4. Counselling experiences during Covid-19 pandemic

According to Amref Kenya, 27% of youth have experienced more stress and 30% others are living in fear due to Covid-19. These effects and other rapid psychosocial adjustments experienced individually and collectively can and have made more people to seek support, counselling and other mental health services (WHO, 2020). Collectively public health protocols have made in person counselling sessions untenable and the prospect of online therapy increased (Ivan, 2020). Counsellors have adapted traditional "warm" counselling practices to online counselling via "cold" screens (Nicholas, 2020). This new reality has received mixed reactions by both service providers and clients. There has been resistance and doubts as to whether online counselling can be as effective while on the other hand online therapy seems to have opened a new possibility for people (who previously wouldn't) to seek help due to stigma (Nicholas, 2020).

A survey conducted among students at the University of South Florida in the US shows that 85% of them agreed that their telehealth experience was comparable to an in-person visit. In Kenya, counsellors at the United States International University (USIU) switched to online and telephone as well as radio to meet their students varied psychosocial needs during Covid 19 lockdown (Sharon, 2020). It is not known what experiences both counsellors and students in IHL go through in using virtual counselling amid Covid 19 pandemic. This study will seek to find out counsellors personal and professional experiences during Covid 19 pandemic.

### 2.5. Theoretical Framework

The proposed study is guided by two models, Stress Diathesis Model and Integrative Regional Suicide Prevention Model.

### 2.5.1. Stress Diathesis Model of suicide

This theory helps in the understanding of the development of psychopathology including suicide. Diathesis means predisposition, vulnerability or sensibility. The theory suggests that individuals with a physiological predisposition (diathesis) interact with the environmental events (stressors) to trigger behaviours and psychological disorders such as suicide (Heeringen, 2012). To this end the model is used to help predict who is likely to develop a disorder and who may not and appropriate remedy designed. Diatheses are regarded as inborn and are typically understood to be relatively stable (but not unchangeable) across life (Belsky, 2009). They remain latent and hard to detect unless triggered by stimuli. A diathesis could be caused by genetic, psychological, biological, or environmental factors (Heeringen, 2012).

A life event or series of events that disrupts a person's psychological equilibrium or harmony and may precipitate the onset of a disorder is referred to as stress (Segal, 2019). A big life event, such as the loss of a father figure, or a chronic stressor, such as a terminal illness or a global pandemic, are all examples of stressors. Stress can also be linked to everyday activities like traffic jams, work stress, or bad behaviors. Understanding how psychopathology develops in individuals is complicated by stress (Saleh, 2017). However, if stress is applied, some people are more susceptible to developing a problem than others. This theory is helpful in this study since it explains the development of psychopathology and suicide in particular. It also helps clinicians to understand factors or possible contributors of suicidal behaviour and consequently pointing the importance of screening suicide risk.

### 2.5.2. Integrative Regional Suicide Prevention Model

Viktor Voros developed this suicide preventive model in 2010. The model consists of six key components:

1. Recognition of the warning signs;
2. Assessment and exploration of psychopathology and emotional crisis;
3. Assessment of the protective and risk factors;
4. Estimation of suicide risk;
5. Planning for intervention strategies;
6. Management of the suicidal patients through the different levels of interventions.

This study benefits from this model since evidence is clear that failure to routinely screen and assess suicidality, as an important first step, is detrimental to the management and safety of those at risk. The model asserts that only through assessment can mental health professionals (MHP) as gatekeepers, detect suicide early and provide appropriate intervention. Subsequent management through psychotherapeutic and pharmacological depending with accompanying illnesses and severity can save many lives from suicide death. This could help counsellors in assessing and managing patients with suicidal behaviour in every-day practice and therefore a significant method for the intervention and prevention of self-destructive behaviour among students in IHL.

# Chapter Three-Research Methodology

## 3.1 Introduction

This study seeks to understand the lived experiences of counsellors who are actively involved in the assessment and intervention of suicide risk. Most studies reviewed in literature have quantified the experiences of suicide assessment and have not delved much deeper into understanding the individual counsellors experience(s) or competency of the system or staff involved in providing assessment and intervention. The researcher will attempt to collect and comprehend the procedure for assessing suicide risk and intervention from counsellor's professional and personal perspective.

Qualitative research is guided by the assumption that people use what they see, hear, and feel to make sense of their life experiences and that they can narrate these experiences (Macleod, 2013). The main objective is to qualitatively explore the psychosocial barriers that are associated with suicide risk assessment and intervention among counsellors in IHL. Other objectives include exploring counsellor's knowledge, attitude and practice in suicide risk assessment and interventions and finally establishing counselling experiences encountered by counsellors in IHL during Covid 19 pandemic.

## 3.2 Research Design

A qualitative approach was employed in the study. Qualitative research is a process of systematic inquiry into the meanings, which people employ to make sense of their experience (Liamputtong, 2019). The investigator sought to comprehend and provide the description of suicide risk assessment and intervention from the personal and professional perspectives of counsellors (key informants). The statistics was based on the participants' own words in order to precisely depict their first-hand encounters. We see probing around suicide assessment, intervention and prevention to be a qualitatively driven approach because it provides a way of

describing the meaning of a particular lived (of distress and suicidal ideations and attempts) experience shared by these counsellors (Creswell, 2019). The broad study question for this study will be, “what are the Psychosocial Barriers you experience as you assess and intervene in suicide risk?”

### 3.3 Study Target Population

The target population for this study will be counsellors who provide counselling services to students in Universities in Kenya and are members of Kenya Universities Professional Counsellors Association (KUPCA). KUPCA has about 120 members spread across Kenya in both public and private universities.

### 3.4 Sample Size

The estimation of sample size involved interviews until data saturation point is reached. The point in data collection where incoming data produces minor or no new information (in this case themes) that address the study questions is known as data saturation (Olshansky, 2015). A qualitative technique is conducting in-depth interviews with a small number of subjects in order to uncover patterns and linkages of meaning. (Creswell, 2019). The researcher will target between 10 to 20 participants.

### 3.5 Study Site Description

Institutions of Higher Learning (IHL) in this study represents the fully fledged universities with charter. As at 2018, Kenya had a total of 37 public and 34 private universities (CUE, 2018). Many young adults, mostly between the ages of 18 and 30, are housed in campus institutions, where they encounter developmental, academic, and social pressures in a compact communal atmosphere. IHL hosts local and international students from all walks of life. Given the age bracket, students are vulnerable to multiple risk factors that may push them to suicidal behavior.

Counselling is one of the most important services in IHL and student counseling centers are housed in student affairs division under the leadership of dean of students. Counselling staff offer guidance, direction and short term counselling to normal life, developmental and academic challenges via individual, group, peer and family counselling sessions. Students presenting with suicidal symptoms receive immediate, extensive and collaborative therapy. At risk students generally tend to disclose suicidal ideations to peers rather than counsellors. Counsellors with knowledge of suicide, suicide risk assessment and interventions can effectively help students at risk.

### 3.6 Sampling Method

The researcher will employ purposive sampling in this study to find respondents characterized by the criteria set.

### 3.7 Inclusion and Exclusion criteria

Potential participants in this study will include;

1. Those who work for both public and private universities designated as student counsellors with a minimum of bachelor's degree in counselling psychology or equivalent and three years in that capacity. Counsellors with a minimum of bachelor's degree qualification are recognized by local professional associations as competent to conduct psychometric assessment including suicide risk assessment.

2. The participants should also be registered members of Kenya Universities Professional Counsellors Association (KUPCA). Being a member of a professional association ensures certain minimum expectations on the part of counsellors.

Exclusion criteria include;

1. Those with counselling qualification but assigned different roles other than counselling within the university.
2. Those with less than three years experience as student counsellors.

### 3.8 Participant Recruitment

The researcher obtained authorization from the Kenyatta National Hospital and the University of Nairobi Ethics and Research Committee (KNH/UONERC) before recruiting subjects and clearance from the National Commission for Science, Technology & Innovation (NACOSTI). Permission will also be requested from Kenya Universities Professional Counsellors Association (KUPCA) to conduct this study. Upon obtaining the approvals and participants' telephone and email contacts from KUPCA, the researcher will only recruit participants remotely. This is to ensure participants safety by avoiding face to face interviews owing to Covid 19.

A series of two interviews was used in the recruitment process. The first interview session sought consent (see Appendix II) from the participant by detailing the intended population, study aims, the study's rationale, the expected time commitment, benefits and utilization of information sought, as well as the researchers' contact information. The second session will focus on the main study interview. The approximate interview time will be between 45 to 60 minutes.

The study will involve asking socio-demographic details, psychosocial barriers inherent in risk assessment and intervention, Knowledge, Attitude and Practices on suicide risk assessment and intervention and counselling experiences amid Covid-19 pandemic.

### 3.9 Ethical Considerations

The investigations will uphold the ethical principles of voluntary participation, autonomy, justice, beneficence, nonmaleficence, and fidelity. Prior to data collection, the electronic informed consent was administered via email, which required the participants to fill in yes or no response. Other elements of the consent form included study's background, objectives, researcher contact information, and processes such as anonymity, time

commitment, data collection processes, risks and rewards, dates, and the study's cost-free and voluntary nature. In addition, the participants were assured confidential storage of data gathered.

### 3.10 Data Collection Process

Upon recruitment, interviews were conducted remotely owing to the challenges brought about by Covid 19 pandemic. During the initial interview, the investigator administered consent before embarking on the actual collection of relevant data. The researcher used the guided interview as the data collection method for the study.

### 3.11 Data Collection Instruments

Key demographic information was collected using a brief socio-demographic guide, which included the participant's age, gender, educational level, employment, and relevant experience. These metrics were acquired in order to combine the material from their interviews. Appendix III contains the interview guidance. The respondents were free to think about each of the questions and their experiences with suicide evaluation and intervention during the research procedure. All of the interviews were audio recorded by the researcher. Interviews done remotely, according to the researcher, can still explore the complete spectrum of emotions revealed by the subject. Because he/she can select a setting of his/her choice, interviews on this platform may boost the participants' comfort level during the interview while ensuring the highest level of anonymity.

### 3.12 Validity and reliability

In order to ensure reliability within qualitative research, the researcher will ensure that the interview questions have been understood well and experts will continuously review the tools. Additionally, a pilot study will be conducted as a pretest to examine any limitations to the tools

before carrying out actual data collection. The limitations will be reviewed and worked on. The pretest will involve individuals who are not within the sample frame.

### 3.13 Data Processing and Management

The researcher will undertake the following steps to clean and manage data collected;

1. Step 1 Ensuring each interview questions are adequately answered.
2. Step 2 Creating a system for labeling and storing audio interviews. This includes a unique name or case identifier for each interviewee.
3. Step 3 Providing for the safe storage of all materials collected, in this case password-protected in researchers laptop.
4. Step 4 Copies of important information will be backed up and backups updated as data preparation and analysis proceeds.
5. Step 5 Audio recorded material will be transcribed to a MS Word document.
6. Step 6 Reading and re-reading of the verbatim transcription of each interview based on audio recording, while searching for missing data, contradictions or inconsistencies.
7. Step 7 Identifying specific ways the participants spoke of an issue, describing what mattered to the participants, and the meaning of these things.
8. Step 8 Data analysis through identifying emergent themes and the connections/interrelations.

### 3.14 Data analysis and presentation

The researcher used themes in analysing the qualitative data. This will be most suitable since themes captures something important about the data in relation to the interview question and represents some level of patterned response or meaning with the data set" (Braun & Clark,

2006). After clarifying ways that participants speak of an issue, describing what matters to them and what they mean, emergent theme(s) and the connections or interrelations will be identified. Mapping of themes will then be conducted to connect and fit the themes in relation to the research questions. Every individual participant's core themes will then be tallied with other participants. Themes that will consistently occur throughout all the interviews will be chosen as representative of the key aspects of the counsellors lived experiences of suicide risk assessment and intervention of their clients. Findings will be presented in form of themes, which are illustrated through verbatim quotations.

# Chapter Four - Results

## 4.1 Introduction

This section begins with the discussion of respondents' background information. This includes details about demography, professional experience, place of work and academic qualifications. This is then followed by a description of the data analysis process within the context of interview questions. Data description is then preceded by a discussion of findings. The section concludes with a description of the findings and how they relate to the questions and purpose of the research.

## 4.2 Summary and Description of Respondents

The sample consisted of counsellors who were purposely selected because of their work in assessing and providing intervention to students presenting with suicide in Institutions of Higher Learning (IHL). Initially twenty-five respondents were invited to participate and out of them, 8 respondents were disqualified on account of not meeting the inclusion criteria. Three failed to respond even after repeated follow-up communication was done.

The researcher successfully interviewed twelve counsellors, of whom seven were women and five were men. Their ages ranged from twenty-five to fifty-five years old. Five and eight were from private and public universities respectively. Four had Undergraduate Degree, six had Master's Degree and two had PhD. The respondents' cumulative years of experience as counsellors ranged from six to fifteen years. Their experience in counselling while in IHL ranged between two to fifteen years. Table 4.1 below shows the summary of respondents' details.

Table 4.1: Demographics of each Respondent

| Demographic Details / Respondents | Gender | Age | University | Years in KUPCA | Years of practice | Years of practice in IHL | Academic levels |
|---|---|---|---|---|---|---|---|
| 1 | F | 25-35 | Public | 6-10 | 6-10 | 6-10 | Bachelor |
| 2 | F | 36-45 | Public | 6-10 | 11-15 | 6-10 | Masters |
| 3 | F | 25-35 | Public | 2-5 | 11-15 | 0-5 | Masters |
| 4 | F | 46-55 | Private | 2-5 | 11-15 | 0-5 | Masters |
| 5 | M | 36-45 | Private | 6-10 | 11-15 | 6-10 | PhD |
| 6 | F | 36-45 | Public | 6-10 | 6-10 | 0-5 | Bachelor |
| 7 | M | 45-55 | Private | 6-10 | 11-15 | 11-15 | Masters |
| 8 | M | 45-55 | Private | 6-10 | 11-15 | 11-15 | Masters |
| 9 | M | 25-35 | Public | 2-5 | 6-10 | 0-5 | Bachelor |
| 10 | M | 36-45 | Private | 2-5 | 6-10 | 6-10 | Masters |
| 11 | F | 36-45 | Public | 6-10 | 6-10 | 6-10 | PhD |
| 12 | F | 36-45 | Public | 6-10 | 11-15 | 6-10 | Bachelor |

Table 4.2: Age

| Age bracket (in years) | Mid point x | No. of counsellors Frequency (f) | xf |
|---|---|---|---|
| 26-35 | 30.5 | 3 | 91.5 |
| 36-45 | 40.5 | 6 | 243 |
| 46-55 | 50.5 | 3 | 151.5 |
| **Totals** | | **12** | **486** |

| |
|---|
| Mean age = xf/f<br>486/12= 40.5 years |

Table 4.3: Counselling experience in years

| **counselling experience in years** | **Mid-point X** | **No. of counsellors Frequency (F)** | **XF** |
|---|---|---|---|
| 1-5 | 3 | 0 | 0 |
| 6-10 | 8 | 5 | 40 |
| 11-15 | 13 | 7 | 91 |
| 16-20 | 18 | 0 | 0 |
| 21-25 | 23 | 0 | 0 |
| **Totals** | | **12** | **131** |
| Mean counselling experience = xf/f<br>131/12=10.9 years | | | |

Table 4.4: membership in KUPCA in years

| **Membership in KUPCA** | **Mid-point X** | **No. of counsellors** | **XF** |
|---|---|---|---|
| 1-5 | **3** | 4 | **12** |
| 6-10 | **8** | 8 | **64** |
| 11-15 | **13** | 0 | **0** |
| | | | |

| | | | |
|---|---|---|---|
| **Totals** | | | **76** |
| Mean KUPCA Membership = xf/f<br>76/12=6.3 years | | | |

Chart 4.1: Gender

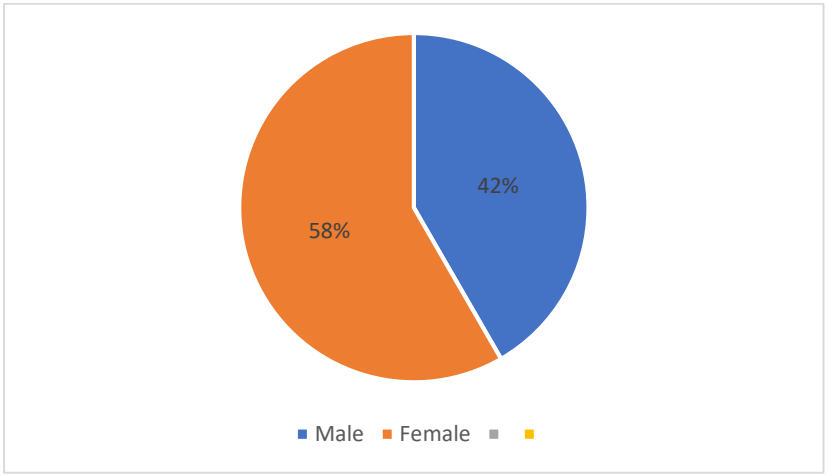



Chart 4.2: University

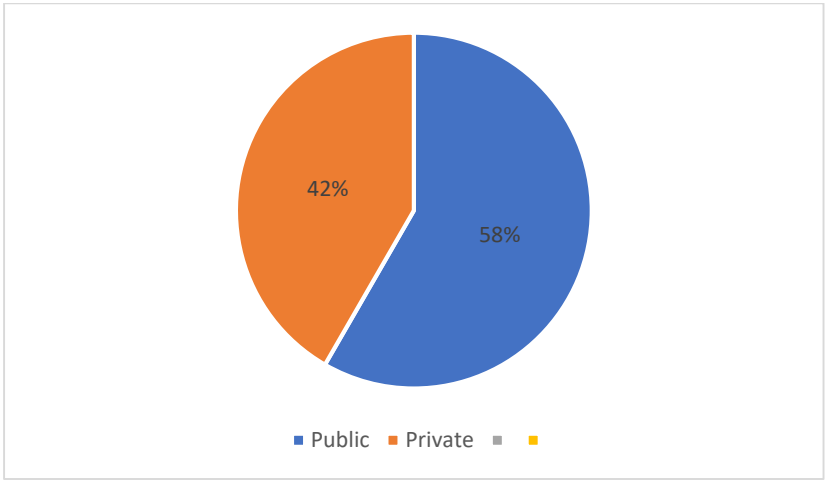
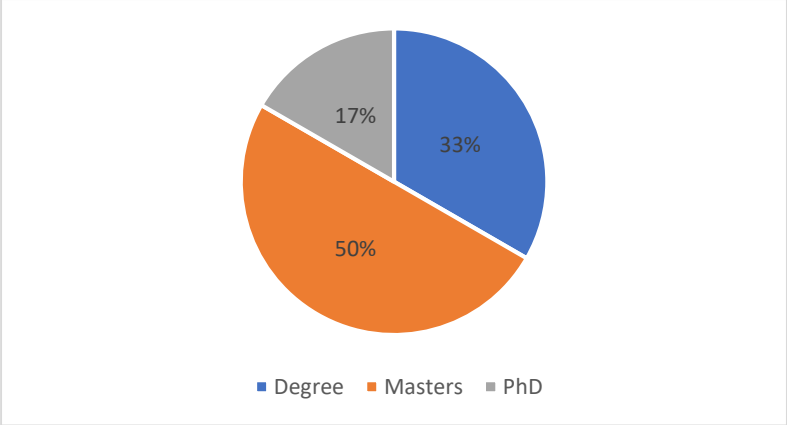



Chart 4.3: Academic qualification




### 4.3 Analysis of Data

The interview data was coded as one single data body and analyzed based on systematic coding using the NVivo Pro 11. The researcher carried out a simple thematic analysis keeping the core ideas around suicide triggers, intervention, barriers and covid 19 coping and adaptation of counsellors at IHL. The researcher conducted the interviews virtually.

Lengthy written transcription of data from interviews was conducted with the help of a transcriptionist to convert the digitally recorded interview data into Microsoft Word document. After qualitative analysis, three main themes were identified as indicated in table 4.5 below.

Table 4.2: Themes and Sub-themes

| Study Objective | Theme | Sub-theme | Findings |
|---|---|---|---|
| Psychosocial barriers associated with suicide risk assessment and intervention. | Barriers and challenges in suicide intervention | Conflict and ethical dilemma on disclosure | struggle on whether to break confidentiality of client by disclosing suicide to other parties to ensure safety. If not reported, a counsellor may be held responsible in case of death. |
| | | Delay in seeking for intervention | Cultural aspect especially men do not promptly access health intervention.<br>Referred by other students or peer counsellors |
| | | Lack of guidelines and protocols | There is lack of guidelines for managing suicide. The respondents just have "administrative reporting structure" and not adequate in management of suicide |

| | | | |
|---|---|---|---|
| | | Perceived difficulty to treat suicide | Respondents described treatment of suicide as very difficult, emotionally draining, stressful, sometimes counselor doubts if doing the right thing in management, avoidance of suicide clients |
| | | Management | Counselors use CBT, psychosocial support, call frequently, address stressors, consult with senior counselor, refer to psychiatrist if emotive, refer to chaplaincy, refer to medical department if attempted suicide was by drug over dose |
| knowledge, attitude and practice towards suicide risk assessment and intervention | Attitude towards suicide prevention | Suicide is preventable | participant's expression that "no one should die of suicide" is positive |
| | | Depression | Suicide was highly linked to depression |
| | | Risk factors for suicide | Male gender, low socio-economic status, poor background, family stress, conflicts, divorce, domestic violence, poor social skills, verbal hints, previous attempts, means to do it, plan and high depression level |
| | | Myths associated with suicide | Suicide is a curse which runs in a family, demon possession, attention seeking behavior, weak people commit suicide, if you talk about suicide you are giving the person ideas to do it. |
| Experiences encountered during Covid 19 pandemic | Counselors' self-care adaptations | Self-care in coping with covid 19 | Exercise, religious activities, music, trying new recipe, tele-counseling |
| | | Intervention adaptations | Virtual counseling, more community programs, working from home, learning how to use virtual communication platforms like zoom, |
| | | Inadequate support supervision | The employer has not facilitated for adequate support supervision |

**Challenges in suicide intervention**

**Conflicts and ethical dilemma in breaking confidentiality**

Participants reported that having to disclose students suicide risk to next of kin was a difficult task.

*"The trust a student has had on you to share but later telling them you have to break the confidence because of their safety. The trust you had earned is taken as betrayal"*

*Counsellor No. 5, 40 years old, holds a PhD,12 years counselling experience.*

Counsellors have a duty to warn and protect to avoid any liability but discussing this with clients is a difficult process because they always object.

*"A family sued a university for negligence after their daughter hanged herself and was found after a week. They claimed she had posted a suicide note on the university social media wall and it was ignored. Such cases bring a lot of fear on counsellors' part to be vigilant and makes you treat all cases as one size fits all. Also breaking news to parents that their son has attempted suicide is difficult. You may not know who is strong enough to receive the news. Because of emergency you find that you don't even prepare them well before you deliver the news" Counsellor No. 11, 42 years old, holds a PhD, 8 years counselling experience.*

This undertaking also hampers trust which is important for future therapy work since therapeutic alliance is weakened.

*"Controlling information of suicide attempt among students and social media is a challenge. Some students broadcast videos, photos of the student or their suicide notes. Re integrating this student back after treatment is a delicate balance. Breaking confidentiality to parents is a painful process for them. Sessions with parents when they come to collect their child is a difficult one. You try to tell the parents not to condemn or punish the student but to support them while they receive treatment but some don't get it."*

*Counsellor No. 12, 37 years old, holds a Bachelor's Degree, 12 years Counselling experience.*

**Delays in seeking help**

Counsellors expressed frustrations of having to deal with crisis because of delays in students seeking help early when issues are easy to manage. It was discovered that male students

struggle most with seeking help and only get identified after attempts or whenever they indicate distressing comments on social media.

*"Rarely do students having suicidal tendencies seek help. We mostly get when they have already attempted or referred by other students or peer counsellors."*
*Counsellor No. 6, 36 years old, holds a Bachelor's Degree, 7 years counselling experience.*

*"African culture doesn't encourage help seeking especially among men. ..... men don't cry, it's a sign of weakness. We need a safe way to engage men in therapy."*
*Counsellor No. 7, 45 years old, holds a Master's Degree, 15 years counselling experience.*

*"Those who seek it its easier to manage and those who don't its difficult its like you are intruding. I had a male student who attempted suicide and he kept telling me why we shouldn't allow him to just go and die after all it is my life"*
*Counsellor No. 11, 42 years old, holds a PhD, 8 years counselling experience.*

**Lack of guidelines and protocols**

Respondents expressed frustration in lack of clear institutional general or specific guidelines towards responding to suicide crisis. Many counsellors used the word "*lack of proper…?"* to describe the current situation in suicide practices in their institutions.

*"No…no protocols …no proper systems"*
*Counsellor No. 4, 46 years old, holds a Master's Degree, 11 years counselling experience.*

*"…We lack proper protocols. What is there is administrative reporting structures but nothing concrete for suicide management"*
*Counsellor No. 12, 37 years old, holds a Bachelors Degree, 12 years counselling experience.*

A clear institutional guideline and capacity building of counsellors would help in improving counsellors' confidence in handling suicide crisis in the future.

*"There is no prescribed guideline on managing suicide. We mostly pick out suicide when assessing depression"*

*Counsellor No. 8, 47 years old, holds a Masters Degree, 12 years counselling experience.*

**Perceived difficulty to treat suicide**

Participants were unanimous in admitting that suicide work is perhaps the most draining and difficult role for a counsellor. It has many dynamics and one experiences a mix of emotions which linger long after the client has left the session or referred for other support.

*"I must admit suicide is difficult for me"*

*Counsellor No. 3, 27 years old, holds a Master's Degree, 6 years counselling experience.*

Some described suicide work as the main source of burn out in their work with students. This makes constant debriefing and supervision extremely useful for counsellors and an understanding and supportive work environment.

*"I get burnt out and can't do any more client work that day. It is draining and it lingers on your mind for long. Even when parents collect their children you still worry if they commit suicide and it gets to the media and management gets on your case"*

*Counsellor No. 11, 42 years old, holds a PhD, 8 years counselling experience.*

Suicide is difficult that some respondents admitted to avoiding dealing with it altogether and prefer referral. This is also because the outcome is uncertain and one has minimal control.

*"I honestly avoid suicidal cases when I can. It is not an easy job and takes a toll on you especially when you lose a client."*

*Counsellor No. 6, 37 years old, holds a Bachelors degree, 7 years counselling experience.*

*"With suicide it is a 50-50 chance of anything happening. There is no certainty here because you are not in control. The emotions that you feel makes confidence elusive."*

*Counsellor No. 2, 36 years old, holds a Master's Degree, 12 years counselling experience.*

**Management**

Respondents said they use Cognitive behaviour Therapy (CBT) when managing suicidal clients in sessions. CBT challenges clients thought processes and helps broaden their overall view of their situation and avoid impulsive actions.

*"Mostly I use CBT because it challenges the clients thinking and help them think of alternatives."*

*Counsellor No. 1, 29 years old, holds a Bachelors Degree, 6 years counselling experience.*

It was also observed that suicide management requires inter and multidisciplinary approach and hence

"*...referral is made and then follow up after psychiatric intervention*."

*Counsellor No. 5, 40 years old, holds a PhD, 12 years counselling experience.*

The referral can be made to other practitioners

*"...if I notice the client is very emotive and out of control. I refer to a psychiatrist and antidepressants are given".*

*Counsellor No. 3, 27 years old, holds a Masters Degree, 6 years counselling experience*

However, some had concerns that forced referrals jeopardise management process

"*…Especially when the referral was forced, you are the one to follow up for appointment otherwise they don't come."*

*Counsellor No. 6, 37 years old, holds a Bachelors degree, 7 years counselling experience.*

**Attitude towards prevention**

**Suicide is preventable**

Counsellors believe that to a large extent suicide is preventable and can be avoided.

*"...I know majority of suicide cases can be stopped. We have saved many students here in campus. I may not quantify but a big majority."*

*Counsellor No. 2, 36 years old, holds a Masters Degree, 12 years counselling experience.*

*"...No one deserves to die from suicide. We can do more to prevent many deaths".*

*Counsellor No. 6, 36 year olds, holds a Bachelors Degree, 7 years counselling experience.*

*"This prevention was pegged to detection and intervention efforts …80% if detection or assessment is done early many victims could be rescued"*

*Counsellor No. 12, 37 years old, holds a Bachelor's Degree, 12 years counselling experience.*

**Depression**

Respondents reported that mood disorders are mainly responsible triggers for suicidal behaviour

"*…Taking one's life. It is mostly depression to blame."*

*Counsellor No. 6, 36 years old, holds a Bachelors Degree, 7 years counselling experience.*

According to counsellors' students who present with suicide are mostly experiencing a state of hopelessness in their situation and believe that their problems can only be dealt with by harming themselves.

*"it is a process of hopelessness…. Interview with"*

*Counsellor no. 3, 27 years old, holds a Master's Degree, 6 years counselling experience.*

**Risk factors for suicide**

Participants identified a number of factors as risk factors playing a role in suicidal behaviour. Some of the things they mentioned include being male and family issues.

*"…gender determines a lot because men clients are more likely to commit suicide"*

*Counsellor No. 4, 46 years old, holds a Masters Degree, 11 years counselling experience.*

*"…Family background is a key factor. Family stress, conflicts, divorces, domestic violence at home affects students".*

*Counsellor No. 9, 32 years old, holds a Bachelor's Degree, 6 years counselling experience.*

Counsellors also talked about the impact of social connection

"*Social connection, poor social connection makes one at risk. Students who have poor skills in relating to others find themselves lonely and when in problems they can be suicidal. The diagnosis of depression is significant contributor"*

*Counsellor No. 6, 36 years old, holds a Bachelors Degree, 7 years counselling experience.*

**Myths associated with suicide.**

Suicide management and prevention efforts is influenced by certain beliefs that counsellors considered myths. Some of the myths counsellors have regarding discussing suicide with a client

*"That if you talk to someone about suicide you give them the ideas to actually do it ."*

Socially people believe that "…*someone is bewitched…The other one is that suicide is a curse running in that family".*

*Counsellor No. 2, 36 years old, holds a Masters Degree, 12 years counselling experience.*

*Others still believe that suicide " is Attention seeking behaviour… It is a form of demonic possession"*

*Counsellor No. 7, 45 years old, holds a Masters Degree, 15 years counselling experience.*

*"some rituals performed to those who die reveal their beliefs about suicide for instance. In our custom when someone hangs himself a tree must be cut to appease the gods because it is a bad omen…. The dead must also be buried at night so as to chase bad spirits…. suicide is a satanic act"*

*Counsellor No. 4, 46 years old, holds a Masters Degree, 11 years counselling experience.*

**Counsellors' adaptation**

**Self-care in coping with covid 19**

All participants expressed experiencing negative impact of the pandemic including negative emotions

"*Easily irritable, too sensitive and anxious…. constant stress and high pressure, anxiety, frustration and burnout."*

*Counsellor No. 3, 27 years old, holds a Masters Degree, 6 years counselling experience.*

Some expressed socioeconomic challenges

"*I had to face pay cut for three months. Many of my plans changed and postponed other opportunities. Emotional support by colleagues was cut off, and a lot of boredom."*

*Counsellor No. 11, 42 years old, holds a PhD, 8 years counselling experience.*

There was grief resulting to loss of family members

"' *I suffered loss of two family members. My Uncle and brother died from Covid. The stress of quick burial and stigma that came with it was just terrible".*

*Counsellor No. 5, 40 years old, holds a PhD, 12 years counselling experience.*

Participants reported to have used a variety of coping mechanism during the pandemic period. The choices of coping styles were influenced by demographical factors. For instance, counsellors who are married and have families

"*Improvised activities… Exercises, running in the evenings, Karura forest was my new routine, dancing with the kids to let off steam".*

*Counsellor No. 1, 29 years old, holds a Bachelors Degree, 6 years counselling experience.*

*These activities were both indoor and outdoor including "dancing to good music, embraced cooking and tried new recipes with my daughter. Played indoor games".*

*Counsellor No. 11, 42 years old, holds a PhD, 8 years counselling experience.*

*Counsellors faith also played a significant role in coping because "Spirituality and constant prayer were my way of coping with the stresses and bad days. We have a prayer group in our church where we had virtual fellowship and support each other."*

*Counsellor No. 6, 36 years old, holds a Bachelors Degree, 7 years counselling experience.*

Counsellors based in the rural parts of the country expressed easier coping given that they had no lockdowns that severely limited movement or restrictions

"*…the free time helped a lot. I made good use of the last year. I was busy on my farm and had no time to think about covid only when watching news. The blessing of upcountry was that it was safer and less fearful"*

*Counsellor No. 9, 32 years old, holds a Bachelor's Degree, 6 years counselling experience.*

another said

*"For us in upcountry farming really helped. It was not very tough since bills were minimal and had more time in my farm. Actually I have done a lot of projects I could never have done. I am expecting more yield and production from my harvest."*

*Counsellor No. 4, 46 years, holds a Master's Degree, 11 years counselling experience*

Some said they got structured and professional support that aided positive coping

"*Employer organized and planned for virtual tele counselling and support for all staff. Luckily for us in the village there was no lockdown so sometimes I just had long drives alone and music to distract*"

*Counsellor No. 10, 38 years old, holds a Master's Degree, 8 years counselling experience.*

and supervision

"*Constant supervision that we have with my colleagues helps decompress the stresses so that you don't take your issues to clients. Though not easy because we are all in difficult times. Clients deserve better*"

*Counsellor No. 1, 29 years old, holds a Bachelor's Degree, 6 years counselling experience.*

Counsellors also expressed being overwhelmed and that coping was sometimes negative and unhealthy

"*… My drinking became frequent and family complained... I also slept a lot."*

*Counsellor No. 8, 47 years old, holds a Master's Degree, 12 years counselling experience.*

**Adjustments and Intervention**

Respondents reported that their caseloads increased due to increased prevalence of mental illnesses during the pandemic.

"*Mental illnesses has definitely gone up. I have referred many cases of severe depression, suicide and trauma. When we opened school we also realized the number of expectant students had gone up"*

*Counsellor No. 3, 27 years old, holds a Master's Degree, 6 years counselling experience.*

During the pandemic counsellors said they had to evolve their care to their students and adapt through technology.

*"Technology has really facilitated access to care. Counselling is now easily accessible, safer and with anonymity one can seek services without stigma"*

*Counsellor No. 2, 36 years old, holds a Master's Degree, 12 years counselling experience.*

they also indicated that

*"Many new adjustments had to be made. The university expanded our roles to also serve staff who were distressed, cases went up dramatically as the pandemic progressed. There is a day I had about 50 calls. Sessions was limited to brief support"*

*Counsellor No. 10, 38 years old, holds a Master's Degree, 8 years counselling experience.*

### 4.3 Summary of Findings

The main objective of this study was to explore the psychosocial barriers associated with suicide risk assessment among counsellors in IHL. Gaps in counsellors' practices when in contact with suicidal clients dominated the participant's responses. The participant's major barrier in their suicide work had to do with breaking confidentiality as a protective measure to their clients. Many reported to be conflicted in performing this safeguarding duty as to their clients this was betrayed trust and that those who this information is given to, some parents and school administration, mishandle it. Other important barriers highlighted by the respondents was the stress of handling suicide crisis of delayed help seeking. The cases of attempted suicide is already a crisis point according to the counsellors and an anxiety-ridden undertaking they would wish to avoid. They also perceived suicide work with clients as a generally difficult, draining and potentially traumatizing. Lack of support by clear protocol, tools and competency based training to manage suicide was also another concern identified. Finally, the management of choice for counsellors when in contact with suicide clients was cognitive behavioural therapy because it helps challenge suicidal thinking which is biased at the time of ideation.

Ironically the respondents reported that suicide death is to a large extent avoidable and that no one deserves to die by suicide. This is a positive attitude towards the effort of reducing stigma around suicide and mental health in general. Respondents were able to point our key myths that are held by victims as well as society regarding suicide. They also acknowledged their institutional systems weaknesses hampering proactive responses. This is despite the risk and warning factors being well understood and possibly modifiable. Depression, being male and a sense of disconnection socially are profound suicide risk factors.

In regards to the Covid 19 pandemic counsellor's adaptation and self-care was the major theme. Respondents report experiencing increased caseloads. Counsellors adapted their practice to their own homes and by utilizing virtual or online platforms to remain accessible by

their students. The challenges with this migration was the transitional and adjustment stressors. Connectivity, cost, disruption, lack of case note taking and filing, and restricted emotional expression by clients were mentioned as encountered barriers. The impact of the pandemic was equally felt by the respondents. From loses of loved ones to lose of incomes, opportunities and support systems. Initial stages of the pandemic received a chaotic coping mechanism at individual level with loneliness, oversleeping, poor routine and substance. Healthy and more productive coping styles mentioned included spirituality, prayers, family support, family activities, support of colleagues and peers. Those in rural areas had less stress since curfews and lockdowns did not affect them as the cities. Finally employers eventually facilitated some to find support in a structured format.

# Chapter Five-Discussion and Recommendation

## 5.1 Introduction

Counsellors in IHL come into contact with students presenting with suicidal behaviours. Their presence and ability to respond by way of assessing risk and provide timely intervention can save many lives and offer relief to many distressed students. However, these Counsellors experience barriers that stand in the way of them effectively perform their duties. This study's objective was limited to exploring the psychosocial barriers counsellors in IHL face while assessing suicide risk among students.

According to the report by the Mental Health Taskforce (2020), one of the challenges Kenya faces in providing quality mental health care is the acute shortage of professionals to match the high demand. However, the situation is different and better for the population of students in IHL. They are served by counsellors and allied professionals in their institutions who provide guidance and counselling to them when in need. The Commission of University Education ensures that all IHL have fully functioning student welfare services particularly counselling and medical. This service is a protective factor to many vulnerable students who experience suicide risk.

Having staff and counselling services is an important first step but it is only part of the job. The quality of the services provided is equally important. When the quality of services provided is poor the goal of securing students mental health will not be achieved as desired. Quality is especially important when it is expected that counsellors provide crisis intervention to suicidal students. Their competence in assessing and managing suicide risk is critical to overall suicide prevention in IHL. This study tried to qualitatively explore counsellors experiences in dealing with suicide cases and the barriers they face.

### 5.2 Discussion

This study found that counsellors in IHL in Kenyan public and private universities face numerous psychosocial barriers that is associated with suicide risk assessment and interventions. Participants expressed overall perceived difficulty in suicide work. Working with suicidal clients is mentally and emotionally draining, potentially traumatic, career and job threatening. Robert Schmidt, 2016 exploratory descriptive survey design to determine practitioner (professional counsellors, school counsellors, social workers, school psychologists and psychologists) levels of preparedness, levels of confidence and methods used to assess suicide risk in youth found insufficient and inconsistent levels of preparedness and confidence, with respondents predominantly using an informal, non-structured interview method to obtain suicide risk level. At KNH, Accident and Emergency (AE) nurses reported discomfort, nervousness, frustration and lack of assessment and management protocols (Rutto et al., 2012; Maina, 2018). School counsellors in South Africa reported heavy caseloads, lacking resources and support as main barriers (Maryke, 2015).

Ethical questions and dilemmas was noted as a significant barrier. It was noted that counsellors find themselves in limbo as to when, how and with who to break confidentiality as an ethical requirement. Negotiating this questions comes with realities that students may face disciplinary process owing to suicide attempts being offensive to code of conduct and deciding which next of kin clients find proximal to consent informing. Montreuil et al (2021), in their study on everyday ethics of suicide care by mental health providers found numerous issues including issues related to maintaining privacy, confidentiality, freedom and the therapeutic relationship.

Finally, it was discovered that clients delayed help seeking behaviour was identified as another major barrier. This delay means that participants end up dealing with crisis after attempts. Managing crisis is a stressor that they would wish to avoid. Sophia Lustig et al, (2021)

in their study on adolescents with self-harm thoughts and behaviours found a substantial delay in receiving appropriate intervention.

Regarding knowledge, attitude and practices on suicide risk and intervention, it was found out that participants are aware of risk and warning signs in suicide. They demonstrated good understanding of management practices and myths. They recognized that high percentage of suicide is preventable with prompt help and proximity to and access to support and care. However, they expressed gaps in practice. Many reported inadequate skills to intervene. They blamed lack of school preparation and insufficient on the job training supported by employers as well as professional body. This was confirmed by Goldstone and Bantjes, (2017) in South Africa where mental health practitioners managing suicidal patients with SUD expressed little to no training in college and on the job training. Most respondents reported that the training or education they have received does not allow them to address everyday ethical issues related to suicide care (Montreuil et al, 2021). These insufficiencies in training were identified as major gaps in preventing suicide effectively. Montague Karlesia et al, (2016) however opines that obtaining a degree or higher level of training in college is only a good starting point for counsellor-in-training, professional counsellors must undertake continuous education, advanced training through their associations to build and maintain their expertise.

It was found that counselling evolved over time to online platform as face to face counselling proved untenable. This was also confirmed by Lerardi et al (2022) that CO VID-19 pandemic has increased online counselling interventions, including those aimed at university students. Counsellors were impacted negatively by Covid 19 pandemic. They experienced loss, grief, host of negative emotions and adjustment difficulties. The study also found out that participants had variety of coping styles in wake of Covid 19 pandemic. Coping styles were largely determined by family or marital status and location. Those with families had support while single participants expressed loneliness and difficulties coping at the initial

stages. Those in cities especially Nairobi and Mombasa where lockdown was enforced with limited movement also struggled as opposed to those in rural areas with less stringent enforcement and wide support base. Participants were able to adjust their practice with virtual platform with time. Most utilized online counselling when in personal proved risky or unavailable.

### 5.3 Recommendations

This scope of this study had limitations and to mitigate the limitations more studies should be replicated to all mental health professionals serving different populations in different settings. A diverse mix of respondents would provide a rich material that would be enlightening. Diverse experiences in dealing with suicide cases would help the quality of practice and improve the care that many people depend on. This study has revealed that IHL counselling centres lack protocol to handle suicide and without standard tools to assess suicide risk. Further research should be focused on exploring protocols that exist in different contexts where mental health services are offered.

Another aspect of study that future studies should focus on is the personal and professional impact that crisis intervention counsellors experience. Suicide is part of crisis intervention and literature suggests a myriad of negative impact on part of counsellors. This studies should also elucidate the support systems and coping that counsellors require as they participate in suicide assessment and management.

Further research should also focus on suicide training for counselling students in the various institutions that prepare counselling professionals. This would reveal if there are gaps that needs to be filled by improving quality of preparation. Respondents in this study reported lack

of preparation to handle suicide cases. This was reported by respondents with all levels of qualification.

The researcher recommends suicide risk assessment and management continuous training for the counsellors to boost their confidence in their practice. This will also ensure they are effective in their work and prevent more suicide deaths of students.

University institutions need to be supported to review and update evidence based suicide prevention strategies. A clear guideline to counsellors on how to go about handling suicidal cases and management including referrals will go a long way to improve institutional support to counselling staff.

Counsellors need to have regular supervision and support whenever they handle suicidal cases. Many expressed burn out and wish to avoid suicidal cases since they lack adequate and relevant support after handling suicidal cases.

Mentorship programs for young counselling professionals beginning their careers should be provided to ensure they are not overwhelmed by the specific roles of handling suicide cases. Senior and more experienced student counsellors can offer mentorship within the institution while the association can provide platform for continuous training and supervision support.

Institutions of Higher Learning should consider including social workers in university counselling or wellness centres. Social workers are able to reach out to students in crisis wherever they are and support the counselling work. Social workers will therefore bridge a gap that is felt as delayed help seeking.

Covid 19 pandemic is the first of its kind to have a global impact at the scale witnessed. Every aspect of life as was known has been impacted. More studies needs to be done on the impact it has on counselling practice given the nature of the pandemic. Equally studies on effectiveness of online counselling compared to traditional in person approach.

### 5.4 Summary and conclusion

Assessing and providing intervention in suicide risk is an important undertaking by counsellors. Early assessment of risk is key towards preventing suicidal behaviours and even death. Although counsellors in IHL possess the knowledge and right attitude towards suicide, they experience difficulties of lack of training in assessment and management. This deficit well explains their practice difficulties when faced with suicidal students. The identified psychosocial barriers could be reduced or managed when counsellors have confidence in their abilities and work in environments that are sufficiently equipped with assessment tools.

Counsellors play a critical role in IHL by serving a high risk populous group. Studies that focus on counsellors practice are scarce and it is hoped that the findings of this study will help in providing insider's view. It is also hoped that the study will raise more interest for further research and improve practice on suicide management.

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# APPENDICES

## APPENDIX I

### Letter of Introduction

James Job Letoo
P.O. Box 75099-00200
NAIROBI
Kenya.
Email: jjletoo@gmail.com

Date: _____

The Chairperson,
Kenya Universities Professional Counsellors Association (KUPCA)
PO BOX 30197 – 00100
Nairobi
Tel: (020) 313104
Email: universitiescounselors@yahoo.com

Dear Sir/Madam,

**RE: LETTER OF INTRODUCTION AND INTERVIEW GUIDE**

I am a student at The University of Nairobi pursuing a Master of Science Degree in Clinical Psychology. I am carrying out a study on '**Psychosocial Barriers Associated with Suicide Risk Assessment and Intervention among Counsellors in Institutions of Higher Learning (IHL) in Kenya'**.

I'm currently gathering data for this study. You have been recognized as being among the study's participants, and I politely need your cooperation in making this study a success. As a result, I respectfully urge that you take the time to reply to the enclosed interview guide. I want to assure you that your responses will be kept completely private and used just for the purposes of this study.

I appreciate your time and responses very much. I'd love it if you could finish the interview guide within the next week so that I may move on to the next stage of the research. Your support will be much appreciated.

Yours sincerely,

**James .J. Letoo**

**STUDENT REG. NO. H56/71462/2011**

# APPENDIX II

## CONSENT FORM

### PSYCHOSOCIAL BARRIERS ASSOCIATED WITH SUICIDE RISK ASSESSMENT AND INTERVENTION AMONG COUNSELLORS IN INSTITUTIONS OF HIGHER LEARNING (IHL) IN KENYA

| | | |
|---|---|---|
| **Investigator**:<br>James .J. Letoo | **Institution**:<br>Department of Psychiatry, University of Nairobi | **Contact:**<br>Cell: 0722 290 645<br>Email: jjletoo@gmail.com |
| **Supervisors**:<br>Prof Obondo Anne &<br>Dr. Manasi Kumar | **Institution**:<br>Department of Psychiatry, University of Nairobi | P.O. Box 19676<br>Kenyatta National Hospital,<br>Email: dpt-psychiatry@uonbi.ac.ke<br>Tel: 2723719/3, 2726300 Ext. 43562 |
| **Ethics Committe** | **Institution**:<br>KNH/UoN-ERC | P.O. Box 20723 – 00202 Nairobi,<br>Tel: 726300-9, Fax: 725272,<br>Email: uonknherc@uonbi.ac.ke |

**Investigator's Statement**

I, James Letoo, a clinical psychology student at The University of Nairobi, Department of Psychiatry wish to do a study entitled **Psychosocial Barriers Associated with Suicide Risk Assessment and Intervention among Counsellors in Institutions of Higher Learning.** This research study is part of the requirement for completion of my postgraduate degree course under the supervision of Prof. Obondo and Dr. Kumar Manasi who are my lecturers at the Department of Psychiatry, University of Nairobi.

**Background Information**

Suicidal behaviours are prevalent in Kenya and the impact is wide-ranging yet preventable. Suicidal behaviours has risen in our universities and this study seeks to establish counsellors' practices when in contact with suicidal clients. With Covid 19 pandemic and resulting impact on mental health, your online counselling experiences is key. The information obtained will help universities, mental health practitioners and relevant health agencies in suicide prevention.

**Study Participants**

The investigator will recruit 20 Counsellors working in Universities (both public and private) who are registered members of Kenya Universities Professional Counsellors Association (KUPCA).

**Procedures of the study**

Consent form will be presented to you and you will need to sign it showing that you have agreed to take part in the study. The study will involve asking you demographic details, Knowledge, Attitude and Practices on suicide and psychosocial barriers inherent in suicide risk assessment. These questions will be in form of interview guide. The researcher will be available

to answer any questions during and after the interview. Participation in the survey may take 30 to 45 minutes to complete.

**Follow up**

Follow up will be done after the research is completed and presented to the Department of Psychiatry for approval. All the participants who will take part in the study will be contacted via phone calls or online and given appropriate feedback on what the study results produce in relation to their experiences.

**Study Length**

This study will take a total of three weeks to carry out.

**Risk, Stress or Discomfort and Benefits**

The researcher anticipate some anxiety and discomfort arising from invasive and sensitive questions about suicide. During the process of the study let the researcher be aware and appropriate help will be provided. The researcher is a trained counsellor and will provide psychological support and/or link you to other help at no cost. The researcher hopes that the study will be of benefit in suicide assessment, management and overall prevention.

**Voluntarism**

Participation in this study is **voluntary**, and there, is no right or wrong answer. If we should come to any question you do not want to answer, just go on to the next question; or you can stop the interview at any time. However, I hope that you will participate in this study since your views are important.

**Confidentiality**

All information given here is **private and confidential** and will not be shared with your University or other people except the supervisors who are part of the research team.

## INVESTIGATOR'S SIGNATURE

_____ Date: _____

## PARTICIPANT'S STATEMENT AND SIGNATURE

The study described above has been explained to me. I consent to take part in this activity. I have had the chance to ask questions. If I have questions in the future about the research, I know I can consult the researcher and or the supervisors listed.

**Participant's Name:_____**

**Signature: _____ Date:_____**

# APPENDIX III

## PART 1: BIOGRAPHICAL DATA

**1.** Gender: Male [ ] Female [ ]

**2.** Indicate your age in years by ticking appropriately:

A. 25 – 35 [ ]
B. 36 – 45 [ ]
C. 46 – 55 [ ]

**3.** Indicate your marital status

A. Single

B. Married

C. Other (please indicate) _____

**4.** Indicate the university you work for by ticking appropriately:

A. Private university [ ]
B. Public university [ ]

**5.** Indicate the number of years you have been a KUPCA member by ticking appropriately:

A. 2 – 5 [ ]
B. 6 – 10 [ ]
C. Above 10 [ ]

**6.** Indicate your counseling experience in years of continuous practice by ticking appropriately:

A. 5 and below [ ]
B. 6 – 10 [ ]
C. 11 – 15 [ ]
D. 16 – 20 [ ]
E. Above 20 [ ]

**7.** Of the above in (5) how many in IHL setting?

A. 5 and below [ ]
B. 6 – 10 [ ]
C. 11 – 15 [ ]
D. 16 – 20 [ ]
E. Above 20 [ ]

**8.** What is your highest counseling academic / professional qualification?

A. PhD [ ]
B. Masters [ ]
C. 1st Degree [ ]

# INTERVIEW GUIDE

## PART 2: KNOWLEDGE, ATTITUDE AND PRACTICE ON SUICIDE RISK AND INTERVENTION

1. What is your understanding of suicide?
2. Do you think suicide is a mental illness?
3. What do you understand by suicide risk assessment?
4. How do you determine the seriousness of a client's risk potential?
5. What suicide myths do you encounter?
6. What are your views on the terms (completed suicide, successful suicide and commit suicide)?
7. What proportion of suicide do you consider preventable?
8. What do you feel about your role in suicide risk assessment and intervention?
9. Do you feel confident to managing suicidal behavior?
10. Do you feel adequately equipped to assess and manage with suicide cases?
11. Do you use any suicide assessment protocols or standardized tools and what are they?
12. What management approaches do you use to manage suicide?
13. What ethical dilemmas do you face in suicide assessment and intervention practice?
14. Do you consult with other professions?
15. Do you make referrals for suicide cases?

## PART 3: PSYCHOSOCIAL BARRIERS ASSOCIATED WITH SUICIDE RISK ASSESSMENT AND INTERVENTION

1. What Patient-Specific Barriers do you experience in assessing and intervening in suicide?
   A. Does the gender of the student influence risk assessment and intervention?
   B. Does student help-seeking behaviour a factor in risk assessment and intervention?
   C. Does student treatment compliance affect risk assessment and intervention?
   D. Does the student's year of study affect assessment and intervention outcome?
   E. What other psychosocial factors put barriers to assessment and intervention of risk?
2. What Counsellor-Specific Barriers do you experience in assessing and intervening in suicide?
   A. What personal disposition hinders suicide risk assessment and intervention?
   B. Does the Experience and training influence risk assessment and intervention?
   C. Does the counsellors Confidence play a role in risk assessment and intervention?
   D. What role does emotion play during suicide assessment and intervention?
   E. Does counsellors Lived suicide experience play a role in assessment and intervention?

## PART 4: IMPACT OF COVID 19 PANDEMIC ON COUNSELLORS PERSONAL AND PROFESSIONAL LIFE

1. How has your professional practice changed as a result of the Covid-19 pandemic?
   A. What changes in counselling practice have you noticed in the wake of Covid-19 pandemic?
   B. Have you made any changes in your own practice because the Covid-19 pandemic?
   C. What things facilitate or hinder your ability to adequately practice during the Covid-19 pandemic?
   D. Describe changes you have experienced with patients that you attribute to Covid-19 pandemic?"

2. How are you personally impacted by the Covid-19 pandemic?

    A. What has happened to you psychologically during the Covid-19 pandemic?
    B. Have you experienced any change in mood during the Covid-19 pandemic?
    C. If your mood changed because of Covid-19 pandemic, what if anything do you do with those feelings?
    D. Does anything ‘spill over’ into interactions with your clients?”

# APPENDIX IV

## RESEARCH PROPOSED BUDGET

| S/NO. | Item Description | Amount |
|---|---|---|
| 1. | Charges for the KNH/UoN-ERC Proposal Review | 2,000 |
| 2. | Charges for the NACOSTI permit | 2,000 |
| 3. | Printing and photocopying | 10,000 |
| 4. | Stationery | 10,000 |
| 5. | Airtime and Data | 10,000 |
| 6. | Travelling | 50,000 |
| 7. | Meals and Accommodation | 35,000 |
| 8. | Publication Cost | 100,000 |
| | Sub-Total | 220,000 |
| 9. | Contingency (10% of subtotal) | 22,000 |
| | **Total** | **250,000** |
| | **Sources of Funds** | **Amount** |
| | Self | 250,000 |
| | **Total** | **242,000** |

# APPENDIX V

# PROPOSED WORK PLAN

| ACTIVITIES | 2019/2020 | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | OCT | NOV | DEC | JAN | FEB | MAR | JUN | JULY | AUG |
| Choosing the Dissertation topic | | | | | | | | | |
| Reviewing Literature | | | | | | | | | |
| Writing the Dissertation proposal | | | | | | | | | |
| Submition to Ethics committee | | | | | | | | | |
| Correction and resubmition | | | | | | | | | |
| Seek authority to collect Data | | | | | | | | | |
| Data Collection | | | | | | | | | |
| Data Analysis & Report writing | | | | | | | | | |
| Defense at department | | | | | | | | | |
| Correction and Submission | | | | | | | | | |

REPUBLIC OF KENYA

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Date of Issue: 19/January/2021

# RESEARCH LICENSE

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This is to Certify that Mr.. JAMES JOB LETOO of University of Nairobi, has been licensed to conduct research in Bungoma, Embu, Kakamega, Kericho, Kiambu, Kisumu, Laikipia, Machakos, Mombasa, Muranga, Nairobi, Nakuru, Nyeri on the topic: PSYCHOSOCIAL BARRIERS ASSOCIATED WITH SUICIDE RISK ASSESSMENT AND INTERVENTION AMONG COUNSELLORS IN INSTITUTIONS OF HIGHER LEARNING IN KENYA for the period ending : 19/January/2022.

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P. O. BOX 30197 -00100, **NAIROBI**
TEL: (020) 313104
E-mail: universitiescounselors@yahoo.com

**REF: KUPCA/PN/08/20**

27th July, 2020.

TO WHOM IT MAY CONCERN

**RE: LETTER OF COLLABORATION**

Kenya Universities Professional Counsellors' Association (KUPCA) has received a request from James Job Letoo, dated 25th July 2020 to conduct his Master's Degree Research with our members. A copy of the proposed research forwarded to us is titled "*PSYCHOSOCIAL BARRIERS ASSOCIATED WITH SUICIDE RISK ASSESSMENT AND INTERVENTION AMONG COUNSELLORS IN INSTITUTIONS OF HIGHER LEARNING IN KENYA*". We will collaborate with him in his research process. Any further assistance given to him will be highly appreciated. For further information, you can contact me through 0721225646 or pngugi@karu.ac.ke.

Yours Faithfully,

Peter Ngugi.

**KUPCA – Secretary**

# PSYCHOSOCIAL BARRIERS ASSOCIATED WITH SUICIDE RISK ASSESSMENT AND INTERVENTION AMONG COUNSELLORS IN INSTITUTIONS OF HIGHER LEARNING IN KENYA

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