SELECTED EXTRINSIC MOTIVATION FACTORS AS DETERMINANTS OF ENGAGEMENT IN PSYCHOTHERAPY AMONG CLIENTS: A CASE OF MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL, NAIROBI, KENYA

MEEK MUTHEU LIO

A Thesis Submitted to the Graduate School in Partial Fulfillment of the Requirements for the Award of the Degree of Masters in Counseling Psychology of Chuka University

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DECLARATION AND RECOMMENDATION

Declaration

This thesis is my original work and has not been presented for an award of diploma or conferment of a degree in this or any other university

Signature .....Date.....9/10/2024.....
Meek Mutheu Lio
AM23/40019/19

Recommendation

This thesis has been examined, passed and submitted with our approval as University supervisors.

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DEDICATION

I dedicate this to my family and my supervisors who tirelessly helped me as I endeavored to complete this thesis.

ACKNOWLEDGEMENT

I wish to extend my gratitude to my supervisors; whose tireless dedication and wisdom were crucial in arming me with the empirical tools for undertaking this study. I also owe gratitude to the faculty members who were instrumental in sharing much needed knowledge which helped broaden my perspective on how to handle research, data collection and thesis writing. I am also entirely indebted to my family who were an enormous pillar of strength, their constant encouragement helped me remain steadfast and dedicated to reaching my goal of completing this study ethically and thoroughly. I also extend appreciation to my friends who motivated me when I was particularly fatigued by the entire process, their encouragement was vital in my mental and emotional nourishment. Finally, I wish to extend thanks to the participants of this study, who voluntarily took their time to answer the questions provided in the questionnaire. Without their participation, this thesis would not be complete.

ABSTRACT

Psychotherapy relies on verbal communication between mental health providers and clients to achieve set goals, with client engagement being essential for successful therapeutic outcomes. In Nairobi's mental health facilities, non-engaged clients often abscond, fail to comply with therapeutic instructions, and miss sessions, indicating that extrinsic motivation may be necessary to encourage their participation. Therefore, this study examined selected extrinsic motivation factors as determinants of engagement in psychotherapy among clients. The objectives of this study were to examine how coercion, social stigma and psycho-education determine engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital, Nairobi, Kenya. This study utilized a descriptive survey study research design as this design allowed for evaluating the study variables without any manipulation. The total population for this study were 200 respondents in Mathari National Teaching and Referral Hospital and a sample size of 132 respondents was an adequate representation of the population. Proportionate sampling was used to determine the number of clients and psychologists, which provided a sample size constituting of 119 clients and 13 psychologists. An exclusion criterion was utilized to determine the appropriate clients for participation in the study and all clients with extreme emotional and cognitive deregulation were excluded from this study. Data was collected by use of a questionnaire utilizing a Likert scale, and from an interview guide to enable triangulation. To test the reliability, Cronbach's Alpha Coefficient was used and the reliability coefficient threshold of 0.86 was considered as appropriate for the instrument. The research instruments were validated through a pilot study and expert feedback from supervisors in Chuka University. Data were analyzed using descriptive statistics through the Statistical Package for the Social Sciences (SPSS) version 27 and through a thematic analysis. The results concluded that coercion and social stigma were negative determinants of engagement among clients, while psycho-education was a positive determinant of engagement among clients in Mathari National Teaching and Referral Hospital. Therefore coercion and social stigma were overall a detriment to client engagement while psycho-education bolstered engagement among clients. The recommendations of the study were to develop individualized therapy plans that consider each client's unique needs, to minimize coercion and social stigma in relation to psychotherapy, to focus on promoting client autonomy, to adapt interactive psycho-education practices which promote participation in psychotherapy, and to empower clients to advocate for their specific psychotherapeutic needs.

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LIST OF ACRONYMS AND ABBREVIATIONS

ABC	:	Activating Event, Belief and Consequence
NACOSTI	:	National Commission for Science, Technology and Innovation
REBT	:	Rational Emotive Behavior Theory
SUD	:	Substance Use Disorder
SDT	:	Self Determination Theory

CHAPTER ONE
INTRODUCTION

1.1.Background of the Study

Psychotherapy is an important part of global development as it promotes mental health and wellbeing. According to World Health Organisation (2023), mental illnesses are ranked as major contributors to disability and globally, there is a large proportion of individuals in need of mental care. Despite the data, there is a discrepancy between the people in need of mental health treatment and those who receive psychotherapeutic interventions and this is linked to a lack of engagement in therapy among clients. A lack of engagement in therapy can precipitate a relapse of mental health symptoms, failure to manage exiting symptoms, and an overarching belief in therapy as being ineffective. Resistance is viewed as an inevitable part of psychotherapy, particularly in its formative stages, a factor which indicates client's hesitance about therapeutic interventions (Beutler, Harwood, Michelson, Song, & Holman, 2011). Lambert (2015) states that a majority of clients who go through psychotherapy experience positive change. Furthermore, psychotherapy often produces positive outcomes, whereby clients are able to learn coping skills for managing symptoms (Miller, Hubble, Duncan & Wampold, 2010). However, in order to successfully navigate psychotherapy, it is important for clients to be engaged in it.

Globally, there are evident instances of client non-engagement in psychotherapy; an issue which is associated with unsuccessful therapeutic outcomes. According to Cenci (2017), only 20% of clients receive treatment for their mental health conditions and from that demographic, 40-60 % drop out prior to achieving treatment goals. This illustrates a great proportion of clients who do not achieve remission due to dropping out; a form of non-engagement in therapy. Hassan, Ragheb, Malick, Abdullah, Ahmad, Sunderji and Islam (2021) conciliated that under-utilizing mental health facilities can worsen symptoms, leading to isolation from the community and exacerbated depressive symptoms. Therefore, clients who do not engage in psychotherapy, are significantly less likely to gain the quality of care necessary to achieve therapeutic goals (Lefforge, Donohue & Strada, 2007).

Due to the issue of client non-engagement, mental health practitioners have taken steps to foster engagement among clients. Instead of viewing it as an unfixable obstacle, therapists recognize non-engagement as a common feature of the therapeutic process. In Europe, psychologists work to promote client engagement through efforts such as building a working alliance in sessions. In a study conducted in England, it was evidenced that a therapeutic alliance was linked to positive client engagement and that therapist characteristics can play a major role in positively impacting client engagement (Daniels, Holdsworth, & Tramontano, 2017). Similarly, in a study in Spain, utilizing positive verbal reinforcement was identified as a strategy to enhance client engagement and by working collaboratively within the sessions, clients were able to adhere readily to psychotherapy instructions. In Australia, attempts to boost client engagement in psychotherapy have gone further with client centered approaches being identified as an instrumental means of enhancing client retention (Gainsbury, 2017). In America, Mlotek (2013) reported that among traumatized participants, using emotion focused psychotherapy helped promote client engagement. Findings in this context noted that the use of empathy was a foreground for engagement and overall client participation with therapeutic materials.

Although there is an evident comprehension on the importance of client engagement, there is still an issue of engagement in psychotherapy in Africa. A major barrier to accessing mental health care is client resistance to Western psychotherapy with Africans stating a preference for traditional healing methods. As presented by Baloyi and Ramose (2016), Africans require more psychological practices tailored to fit their cultural frameworks. The current psychological climate is largely Western dominated, with foreign theories shaping a majority of the practice. The preference for traditional healing methods is rooted with the African need for practices more aligned with the culture (Mwiti, 2024). Africans still contextualize their psychological illnesses in relation to traditional beliefs (Mhm, 2011), illustrating the value of a more integrated psychotherapeutic approach.

Instead of engaging, there is an under-utility of psychotherapy in Africa which is associated with a lack of perceived need for psychotherapy. For instance, Dzokoto, Anum, Affram, Agbavitoh, Dadzie, Mintah, Norman, Owusu-Prempeh, Tawam, Turkson, and Osei-Tutu (2021) elucidated that Ghanaian participants would fail to attend therapy because of a lack of understanding of the purpose of psychotherapy. This can be linked to a limited comprehension of mental illness and prognosis. These results aligned with Okafor, Oyewale, Ohazurike, and Ogunyemi (2022) who noted in their study that a lack of mental health literacy in Nigeria was linked to resistance to psychotherapy. These findings suggest that there is still work to be done on promoting client engagement in psychotherapy in African nations. With non-engagement being an issue in the African context, psychological ailments are likely going untreated, further diminishing individuals' quality of life.

According to Masambia (2014) Kenyan communities have been slow to adopt psychotherapy as a cure to psychological distress. Instead, the preferred option when dealing with mental illness among the Kenyan community has largely be to consult an elder or spiritual leader. There is an estimated 25-40% of inpatients and outpatients in Kenya having a mental health disorder with anxiety, depression and substance abuse making up the majority of diagnosed conditions in general hospitals (Memiah *et al.*, 2022). Statistically, Kenya is classified as the 5th African country with high rates of depression. One in every four Kenyan will present with a mental illness during their lifetime and the youth are increasingly being affected by personality disorders, anxiety and attention deficit disorders. The ratio of medical practitioner to population in Kenya is 13 trained personnel for every 10,000 Kenyans, a value lower than the minimum standard of 41 for every 10,000 (Marangu *et al.*, 2021). With a mere 116 psychiatrists, nationwide, mental health care in Kenya receives little priority.

A lack of engagement in therapy presents as an issue in Kenya, as psychotherapy is yet to be fully accepted and well comprehended locally (Masambia, 2014). Musyimi, Mutiso, Ndetei, Unanue, Desai, Patel, Musau, Henderson, Nandoya, and Bunders (2017) observed in their study that instead of engagement, Kenyan clients created obstacles in treatment by denying diagnoses, missing appointments and avoiding talk therapy altogether. These acts are to the detriment of the client, often leading to

unsuccessful treatment outcomes**.** Among these treatment outcomes, patient relapse is high in Kenya with many clients relapsing in symptoms due to a lack of follow-up and non-adherence to treatment plans (Gathaiya, 2011). Findings from rehabilitation centers in Kenya denote that the rate of relapse is 60-80% and that these trends hold true throughout counties with addiction and mental health issues (Kuria, 2013).

Among the counties in Kenya, Nairobi confers as having among the highest rates of relapse and mental health facilities in Nairobi portray numerous instances of non-engagement in therapy. For instance, Gathaiya, (2011) provide that schizophrenia relapse is at a rate of approximately 58-97% with these statistics being linked to client non-compliance. Falkenström, Gee, Kuria, Othieno and Kumar (2017) provide further that clients in mental health facilities in Nairobi showed significantly low attendance rates due to attrition, confirming a problem with non-engagement in therapy. Research further elucidated that within psychiatric institutions in Nairobi the rates of verbal, physical aggression and absconding therapy were high, corresponding with the notion that patients in Nairobi vie towards resistant tendencies in therapy (Kwobah, Kiptoo, Jaguga, Wangechi, Chelagat, Ogaro, & Aruasa, 2023).

Extrinsic motivation could prove vital in determining engagement in psychotherapy among clients if comprehensively utilized. Among the forms of extrinsic motivation, coercion, social stigma and psycho-education can all present as external stimuli or incentives which can drive clients to engage in therapy. These can be identified as extrinsic motivators for psychotherapy as they drive individuals to act in relation to therapy. In that frame, these extrinsic motivators may have positive or negative effects on client engagement, as the effects of extrinsic motivation are highly nuanced (Turner, 2017). Literature is limited in that there is no consensus on the efficacy of extrinsic motivation on engagement among clients, meaning the extrinsic motivators in this study could be negative or positive determinants of engagement. (Wolfe, Kay-Lambkin, Bowman, & Childs, 2013). Therefore, answering the question of whether coercion, social stigma and psycho-education are determinants of engagement could be instrumental in improving retention, adherence and remission among clients. Addressing this gap in research forms the basis of this study.

1.2.Statement of the Problem

A client who engages in psychotherapy is open minded, attends therapeutic sessions, collaborates with mental health professionals and adheres to therapeutic interventions. Such clients are more likely to experience positive therapeutic outcomes and symptom recovery. However, clients in referral mental health facilities in Nairobi County risk increased rates of symptom relapse, and dismal quality of life owing to lack of engagement in psychotherapy. There is need to assist clients towards taking an active role in seeking psychotherapy and participating in the treatment plans and this can be achieved through the utilization of extrinsic motivation. Therefore, this study intended to examine how selected extrinsic motivation factors determined engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital, the only government referral mental hospital in Nairobi, Kenya.

1.3. Purpose of the Study

The purpose of the study was to examine selected extrinsic motivation factors as determinants of client engagement in psychotherapy in order to promote evidence-based interventions to enhance engagement among clients. Insights on these extrinsic motivation as determinants of engagement in psychotherapy can enable policymakers to implement evidence-based approaches that help to encourage engagement in psychotherapy.

1.4. Research Objectives

The study objectives included:

i. Examining how coercion determines engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital, Nairobi, Kenya
ii. Assessing how social stigma determines engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital, Nairobi, Kenya
iii. Investigating how psycho-education determines engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital, Nairobi, Kenya

1.5. Research Questions

The research questions included:

i. How does coercion determine engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital, Nairobi, Kenya?

ii. How does social stigma determine engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital, Nairobi, Kenya?

iii. How does psycho-education determine engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital Nairobi, Kenya?

1.6. Significance of the Study

This study assists policymakers in the Kenya Board of Mental Health, by providing insights that will enable the formulation of relevant policies to promote engagement in psychotherapy among clients. Relevant government ministries can be able to utilize this research to develop systems to safeguard the wellbeing of clients while enhancing client engagement. The study holds significance for parents and guardians of clients in psychotherapy who can stand to benefit by identifying and fostering any behavior which aids engagement among clients. Furthermore, psychotherapists can derive evidence-based interventions from the study premise to address client engagement. The results in turn shall enable clients to navigate psychotherapy more effectively, thereby benefitting from therapy. Researchers can also be able to undertake similar or broader studies based on the premise of the study to investigate how specific extrinsic motivators determine client engagement. Finally, the findings of this study contribute to the body of knowledge in counseling psychology by providing literature on selected extrinsic motivation factors as determinants of engagement in psychotherapy among clients in the Kenyan context.

1.7. Scope of the Study

The study was conducted in Mathari National Teaching and Referral Hospital, a public mental health facility which offers both substance use and mental disorder treatment in Nairobi, Kenya. As a referral mental hospital, Mathari National Teaching and Referral Hospital is a facility where clients are often referred after non-engagement with psychotherapeutic interventions. Furthermore, coercion, social

stigma and psycho-education are often present in mental hospitals in Nairobi and can act as external incentives in relation to engagement in psychotherapy among clients. The study engaged clients undergoing psychotherapy and their therapists as this demographic provided relevant context for the study premise. The study focused on clients who were cognitively and emotionally capable of participation. The focus of this study was solely to examine coercion, social stigma and psycho-education as determinants of engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital.

1.8. Limitations of the Study

Due to the sensitive nature of the study, it was determined that the participants would not wish to give honest responses to the research instruments. To overcome this, the study purpose was comprehensively explained and all participants were assured of confidentiality. The respondents were informed that coding would be used instead of their names and were given the chance to withdraw from the study at any point.

1.9. Assumptions of the Study

The study assumed that all participants would be able to interact with the instruments and would provide the required feedback. The study assumed that the clients were aware of various domains in regards to coercion, social stigma and psycho-education. Furthermore, the study assumed that the specific extrinsic motivators utilized were most relevant for the Kenyan context as they are common in local mental health facilities.

1.10. Operational Definition of Terms

The following are the definitions of terms which are operationalized to fit the context of the study.

Coercion : Coercion involves interventions or actions that are involuntary or lacking a person's consent. In the context of this study, coercion refers to being forced or pressured into and within psychotherapy. Coercion in this study includes restraint, involuntary institutionalization, familial or societal pressure to attend psychotherapy and attempts to manipulate client decisions in regards to psychotherapy.

Client : A client is an individual who is utilizing the services of a given organization or professional. This study operationally defines a client as an individual who is utilizing psychotherapy under a mental health professional.

Engagement in psychotherapy : Engagement in psychotherapy refers to a client's active participation in therapy. Within the context of this study, engagement in psychotherapy encapsulates client attendance, client participation, homework compliance and a positive perspective of therapy and a strong client-therapist relationship.

Extrinsic motivation : Extrinsic motivation is the act of being motivated to do something in order to achieve a desired outcome or consequence. This study operationally defines extrinsic motivation as motivation by which an individual performs an activity due to the presence of an external incentive or for the purpose of acquiring an outcome separate from the activity itself.

Non-engagement in psychotherapy : In this study, non-engagement in psychotherapy is a lack of client engagement in that it involves absconding, client non-attendance, non-compliance, no therapeutic alliance and a lack of participation in psychotherapy.

Psycho-education : Psycho-education refers to educating a population about mental illness, prognosis and treatment. This study defines psycho-education as the dissemination of knowledge about mental illness to clients. Psycho-education in this study involves providing verbal and written information on client diagnosis in psychotherapy, as well as homework given to clients to gain information about mental health conditions.

Resistance in psychotherapy : In this study, resistance in psychotherapy is the overall opposition a client has towards the therapeutic process.

Social Stigma : Social stigma is conventionally defined as discrimination against a person due to characteristics that differ with the majority population. This study defines social stigma as negative attitudes against clients suffering from mental illness. The forms of social stigma identified in this study include familial, societal and institutional stigma. This stigma can present in the form of negative beliefs and remarks about mental illness, using shame as an incentive to seek treatment, social rejection due to a mental condition, and discrimination due to one's mental diagnosis.

Therapist : The conventional definition of a therapist is an individual who is trained to professionally treat illnesses. In this study a therapist refers to a professional who utilizes comprehensive training in the treatment of mental disorders by use of verbal communication.

Psychotherapy : Psychotherapy refers to treatment conducted with the aim of treating a mental illness. In the context of this study, psychotherapy is defined as the treatment of mental illnesses through the use of verbal interactions with a mental health professional. In this study, psychotherapy and therapy will be used interchangeably.

Unengaged clients : In this study unengaged clients refer to clients who do not actively engage or participate in the psychotherapeutic process.

CHAPTER TWO

LITERATURE REVIEW

2.1. Overview of Extrinsic Motivation, Engagement and Non-Engagement in Psychotherapy

2.1.1 Extrinsic Motivation

Extrinsic motivation encompasses a variety of means to end relationships such as eating to have a functional body, learning in order to gain knowledge and exercising in order to improve health. Simply, extrinsic involves external incentives or stimuli, whereas motivation involves desires or fears which direct actions towards a desired outcome (Locke & Schattke, 2019). Extrinsic motivation has the ability to generate interest in a task that previously was not of interest. For unpleasant and unappealing activities, utilizing extrinsic motivation is strategic in inducing action (Lemos & Veríssimob, 2013). Moreover, external incentives can act as profitable consequences which can foster determination and persistence. Finally, extrinsic motivators have the capacity to alleviate the stress over a task by diverting one's focus to the incentive, external stimuli or reward.

The four forms of extrinsic motivation are external regulation, introjected regulation, identified regulation, and integrated regulation (Legault, 2020) and each type presents with unique facets said to promote or reduce the drive to act. External regulation is the most basic form of extrinsic motivation, where an individual provides an external reward or consequence as an incentive to act (Ryan & Deci, 2022). Experts denote that external regulation does not nurture autonomy with debate existing on its efficacious nature (Sandoval-Norton, Shkedy, & Shkedy, 2019). Introjected regulation, is typified by the internalization of an external condition to act, such as an individual acting because of a social pressure to do so. These two forms of extrinsic motivation do not nurture autonomy, and are often classified as negative motivation structures.

A more autonomously focused form of extrinsic motivation is identified regulation. Identified regulation is a type of extrinsic motivator where an individual perceives an extrinsic motivator as something of value (Bell, 2010). This could imply seeing the value of an external incentive and being able to engage in an activity because of this

understanding. The last form of extrinsic motivation, integrated regulation is the form of extrinsic motivation with the highest level of autonomy whereby an individual fully internalizes the value of an extrinsic motivator and views themselves as the sort of person who would engage in the incentivized act. Ryan and Deci (2022) suggest that the more the autonomy in terms of motivation, the more positive the outcomes.

Ryan and Deci (2022) identified the significance of internalizing the different types of extrinsic motivation as a means of ensuring lasting behavioral change. In fact, it is postulated that extrinsic motivation acts in a continuum, where a client moves from being controlled to being more autonomously driven by extrinsic incentives. Being autonomously motivated here, relies on internalizing extrinsic motivators. Bell (2010) concurred that when an individual internalizes extrinsic motivation, they are motivated to perform tasks from the basis of their own internal values. In this sense, an individual move from being forced to act, to being someone who performs an act because it aligns with their identity. Internalizing an extrinsic motivator is itself highly subjective, making the efficacy of extrinsic motivation nuanced and complex.

It is difficult to state what type of extrinsic motivation will be most effective for a particular individual. As affirmed by Ng and Ng, (2015) every learner has the capacity to be motivated in a different way. For instance, although monetary incentives are commonly perceived as ineffective motivators, Turner (2017) provided literature which concluded that monetary incentives can be effective extrinsic motivators. In this study money was an effective incentive for lower level employees who gravitated towards companies which provided monetary rewards. Simply, lower level employees depended upon monetary rewards more than higher level ones, and therefore placed higher value on this incentive. It is clear that values are too subjective to be boxed in and generalized to the entire population and the authors recommended further research on the differences in how people prioritize extrinsic motivation in their lives.

Recognizing differences in the efficacy of extrinsic motivation highlights the need for diverse perspectives when designing methods of encouraging engagement. Studies on extrinsic motivation in relation to psychotherapy have noted that contextual views and values form the basis for the efficacy of extrinsic motivation. For instance, Hachtel, Vogel and Huber (2019) provide that certain extrinsic motivators which are deemed detrimental in psychotherapy can be beneficial in promoting adherence, thereby giving clients back their quality of life. Evidence sustains that the same extrinsic motivator can have diverging influences on clients based on their individual needs and perspectives (Bozdağ & Çuhadar, 2022). Furthermore, viewing an extrinsic motivator as something of value can bolster client retention in psychotherapy by enhancing help seeking behavior (Srivastava & Panday, 2016). Researchers like Eisenberger argue that extrinsic motivators are in fact advantageous and powerful motivators (Shenaq, 2021), therefore these motivators have the ability to encourage and increase one's interest in psychotherapy. In essence, extrinsic motivators may need highly contextual and individualized perspectives in order to be effective elicitors of engagement.

2.1.2 Engagement in Psychotherapy

Engagement in psychotherapy has been conceptualized in diverse ways, with many attempts to unanimously identify it paradigms. Authors sought to empirically identify what client engagement involves by extensively reviewing literature in order to arrive at an evidence-based consensus (Bright, Kayes, Worrall & McPherson, 2015). Client engagement was conceptualized as a positive client to therapist relationship and a client's expression of engagement through measurable behaviors. Holdsworth, Bowen, Brown, and Howat (2014) agreed that engagement can be segmented into observable client behavior such as client attendance, client participation in psychotherapy, compliance with therapeutic homework or assignments, and establishing a positive therapeutic relationship. In this study engagement in psychotherapy among clients encompasses attendance, active participation, a strong working alliance, homework compliance, openness, and a positive view of psychotherapy.

Mental health professionals have long identified the need to elicit engagement from clients in order to promote positive behavioral change. Mahrer, Murphy, Gagnon and Gingras (1994) suggest that a clinician look at themselves as the primary promoter of client engagement, taking an active approach to enhancing participation in the therapeutic process. Mitchell (2009) suggested certain techniques for effectively evoking engagement in clients such as being curious, creative, respectful and open-minded. It is evident that at the forefront of psychotherapy is often the therapeutic relationship and Block and Greeno (2011) noted that clinicians are more likely to achieve success in psychotherapy if they establish a trusting environment. Therapists should ideally exhibit qualities that are beneficial when establishing a strong therapeutic alliance; characteristics such as authenticity, empathy, neutrality and respect.

Client engagement positively impacts treatment outcomes, enhancing the potential for therapeutic success. Engaging in psychotherapy aids in the implementation of therapeutic insights and in this way a client is able to utilize skills learned in session and transition those skills into real world settings. To confirm this, Hlavaty, Brown, and Jason, (2011) evidenced in their study that engaging through compliance led to positive treatment outcomes for clients. From the eighty two participants in this study, it was found that the participants who complied with therapeutic tasks gained improved mental and social functioning. Kazantzis, Whittington, Zelencich, Kyrios, Norton, and Hofmann (2016) concurred that client engagement leads to effective outcomes that persist beyond the term of psychotherapy. In other words, even after session completion, clients who actively participate in psychotherapy have lasting positive behavior change.

Client engagement plays a crucial role in determining the success of therapeutic interventions. By actively participating in psychotherapy, clients can achieve positive outcomes and maintain progress beyond the duration of treatment (Kazantzis *et al.*, 2016). Addressing barriers to engagement is essential in maximizing the effectiveness of mental health interventions. Schauman, Aschan, Arias,Beards, and Clement (2013) recommend that facilitating engagement requires attending to clients based on their personal preferences and values. Therefore, providers must adopt a holistic approach

that considers the needs and motivations of clients in order to promote meaningful engagement and facilitate lasting recovery.

Within this study, coercion, social stigma, and psycho-education in the context of client engagement do not function in isolation. These extrinsic motivators coexist in the psychotherapeutic context, feeding off each other to create compelling interactions in relation to engagement. For instance, certain psycho-education initiatives may prove ineffective where social stigma surrounding mental health prevails (Wasil *et al.*, 2021). Furthermore, coercion, may be more effective in settings where psycho-education has prepared clients to recognize the value of psychotherapeutic methods for alleviating symptoms (Rosen, Hiller, Webster, Staton, & Leukefeld, 2004). In the instance where coercion negatively impacts social relationships, social stigma may illicit engagement whereby clients engage in therapy in attempts to improve social connection (Owen *et al.*, 2013).

The gap in literature thus far is that findings do not support each other, with study results showing opposing views on the efficacy of these selected extrinsic motivation factors on determining engagement in psychotherapy. Wolfe *et al.*, (2013) sustain that it is important not to generalize on the efficacy of certain extrinsic motivators, affirming that extrinsic motivators can provide both positive and negative outcomes. The interactions between coercion, social stigma and psycho-education create complex dynamics in environments where these variables are all present (de Menil, Knapp, McDaid, & Njenga, 2014; Kamunyu, Ndungo, & Wango, 2010; Ongeri, 2021); and the comprehension of these interactions may prove imperative in determining client engagement.

2.1.3 Non-engagement in Psychotherapy

A lack of engagement in psychotherapy is depicted as a client's unwillingness or opposition to starting, attending or cooperating in therapy. It is when a client rejects the input made by a psychotherapist. This is a common barrier to psychotherapy globally as it disrupts the therapeutic process. Psychoanalysts view non-engagement as both an enduring and impermanent state. Freud defined a lack of engagement as characteristics which interfere with a positive reaction to psychotherapy (Howes, Thase, & Pilinger, 2022). Non-engagement in psychotherapy here supposedly acts as

a reflection of a patient's unconscious struggle and the mitigation of said resistance involves bringing to awareness the client's repressed emotions (Beutler, Moleiro, & Talebi, 2002).

Cognitive behaviorists differ from the psychoanalytic view in that they deem non-engagement in psychotherapy to be opposition caused by irrational or distorted thoughts (Yaman, 2021). Newman (2002) voiced that the cognitive perspective involves acquiring an empathetic comprehension as to the cause of non-engagement in psychotherapy and actively educating the client on their resistance and capability for adaptability. Rogers (2007) in accordance with the client centered approach, viewed non-engagement in psychotherapy as a client's natural defense mechanisms when feeling threatened by the therapeutic attitudes and environment. In the context of psychotherapy, it is a common part of the therapeutic process and mental health practitioners should take care to develop effective tools in mitigating non-engagement in psychotherapy.

Non-engagement in psychotherapy can take the form of interrupting or cutting off the therapist, unwillingness to acknowledge the problems, deflecting responsibility and making excuses for one's maladaptive behavior. Premature dropouts, missing appointments and not doing assignments are also common forms of resistance. As noted by King (1997), a client may be resistant to psychotherapy because of internalized shame, societal misconceptions about the therapeutic process, underestimating their diagnosis and their goals not being adequately aligned. Ryan, Lynch, Vansteenkiste and Deci (2011) posit that clients can show non-engagement in psychotherapy by appearing superficially motivated while fending off any suggestions to change. In essence non-engagement in psychotherapy is a client's conscious or unconscious attempt to sabotage the therapeutic process.

Mahalik (1994) provided five scales of identifying a lack of engagement in a client including opposition to change, opposition of the therapist, opposition of insight, opposition of material and opposing the expression of distress. A lack of engagement is often perceived as a client's refusal to cooperate with a clinician when met with difficult emotions. Watson (2002) affirms that clients are likely to show resistance when they have feelings of shame and insecurity. Mahalik (1994) acceded that clients

often show a lack of engagement when hoping to escape a painful emotion and that resistance in therapy can look like taking on a flat affect, or rejecting any chances to be open and vulnerable in session. The therapist is left at an impasse as the client is unwilling to engage fully. The success of therapy is dependent on the client's participation, making non-engagement in psychotherapy a significant impediment to the process.

Those afflicted with mental health conditions are often hesitant to receive necessary care as a result of stigmatizing attitudes towards their diagnosis. Their debilitating symptoms often cause the mentally ill to feel shame, inadequacy, and a general mistrust that their conditions cannot be resolved. According to the Substance Abuse and Mental Health Services Administration, in 2014, less than half of the 43 million adults with mental illness in the United States received necessary mental health services. Despite their diagnosis, many adults do not receive treatment even when available interventions are present (Chekroud *et al.*, 2018). This could be as a result of an overarching belief in the inefficacy of psychotherapy or in the enduring state of mental disorders.

Data is evident throughout literature which sustains that many do not adhere to and complete their therapeutic stay. According to Greenberg (2012) one in every five clients prematurely dropout from therapy. Werbart and Wang (2012) state that the dropout rate for clients is 30-50% with patients with comorbid symptoms being less likely to commence therapy in Sweden. Younger and female patients are more commonly inclined to dropout though the data is still inconclusive. Dropping out at a high rate is especially concerning as research states that eleven to thirteen sessions are necessary for most clients to recover. (Hansen, Lambert, & Forman, 2002; Lambert, 2007). This illustrates the great proportion of clients who do not achieve remission due to non-engagement in psychotherapy to therapy.

The practical obstacles to treatment for individuals with mental illness are financial, transportation and uncertainty about appropriate treatment locations. The psychological barriers to treatment are often stigma -either social or internalized- doubts about efficacy and a fear of losing autonomy (Chekroud *et al.*, 2018). Andrade, Alonso, Mneimneh, Wells, Al-Hamzawi, Borges, and Kessler (2014) noted

that resistance in therapy is prevalent largely due to low-perceived need for therapy with 63.8% of clients preferring to handle their symptoms independently. It was noted that a major barrier to treatment was the client's attitude. This was depicted by a perception of treatment as being ineffective. It was the most common reason for treatment dropout, accounting for 39.8% of the cases, whereas 26.9% of the participants reported negative experiences with their treatment providers as the reason for drop out. It could be implied that there is a lack of faith in the efficacy of psychotherapy. This lack of faith commonly leads to missed appointments and this presents practitioners with the issue of wasted resources.

Due to its pervasive nature, researchers have sought to provide a link between non-engagement and motivation, hoping to identify factors exacerbating and mitigating client resistance. These studies unearthed multiple forms of motivation, noting that extrinsic motivation is a paramount motivator involving the provision of external consequences or the presence of an external stimuli as instigators to act (Bell, 2010). Not all activities promote an internal drive for participation, and as a lack of engagement implies a lack of an internal drive to adhere to therapy, extrinsic motivation plays a critical role in its context. Optimizing methods of promoting client engagement therefore becomes imperative, if clients are to obtain the benefits of mental health interventions (Gibbons *et al.*, 2019). Therefore, extrinsic motivators could be significant assets in bolstering engagement among clients who undertake psychological interventions.

2.2. Coercion as a Determinant of Engagement in psychotherapy

Coercion can be identified as external regulation and identified regulation, the forms of extrinsic motivator by which an individual acts due to an external consequence or pressure, making it the least autonomous form. It is whereby a client feels compelled to participate in psychotherapy or in particular therapeutic interventions. Wolfe *et al.*, (2013) identified that not all clients who are coerced into treatment feel like they lack autonomy, and tend to do so if they experience perceived coercion. It is the perception that one is being coerced into treatment that commonly is associated with negative attitudes. Bukhari, AlKetbi, Rashid, Ahmed and Shakir (2021) denoted that coercion can leave a client feeling resentful of the intrusion forced therapy poses on their lives. If a client's maladaptive behavior has defined them or is part of their culture then

therapy can act as a threat to this current way of life. However, it is important to note that individuals who utilize coercion in therapy, often do so with the intention to foster engagement (White & Miller, 2007) and the efficacy of this approach is highly determinant on the context.

Coercion is a tool often used to initiate clients into psychotherapy in an effort to induce and sustain retention. To achieve this, coercion can involve placing pressure on a client by showcasing the negative consequences of not receiving mental health intervention such as social and legal repercussions. This has been found to be advantageous in promoting engagement as it outlines to clients the negative outcomes associated with not making any behavioral changes (Wolfe *et al.*, 2013). Conversely, White and Miller, (2007) found in their study that coercing American participants worked initially in maintaining client adherence but overtime, the evident use of force, did little to boost client motivation for therapy. Instead mandated therapy bolstered high rates of reactivity in psychotherapy and later relapse. This evidence affirms that coercion may not be a beneficial extrinsic motivator in the long-term and that without added incentive, coercion can result in controlled behavior change that will diminish once the effects of control wear off (Hachtel *et al.*, 2019).

Research sustains that it is important for a client to develop a sense of control even in an overtly coercive environment in order to establish engagement. In a study conducted by Jacobsen (2013), social workers helping involuntary clients in America sought to find methods of fostering engagement and the findings emphasized the necessity to provide clients with choices in order to mitigate resistant behavior. This concurred with Fifer *et al.*, (2021) who surmised that Australian clients from their study would often resist forced therapeutic interventions, but chose to actively engage in therapy when provided with control in sessions. In this study, eradicating coercion by encouraging control even in psychotherapy that began through coercion, aided in overcoming resistance. These findings sustain that when autonomy is established in the therapeutic environment, clients are more likely to engage.

The process of using coercion is nuanced and complex, with clients having the capacity to perceive control in therapy as beneficial. White and Miller, (2007) found that before viewing coercion negatively, clients in their study readily accepted coercion as a necessary part of their treatment. The acceptance of coercion was linked to the clients' perception of addiction as negative and the belief that coercion was necessary in order to achieve sobriety. These findings preclude that the negative perception of addiction could lead clients to accept coercion as a necessity if sobriety is viewed at a high regard. Rosen, Hiller, Webster, Staton, and Leukefeld, (2004) confirmed this view in a study conducted to examine the relationship between client engagement in a coercive therapeutic environment. From the sample of two hundred and twenty incarcerated males, it was found that the clients were able to engage in psychotherapy regardless of coercion; and this was contingent upon clients recognizing the problematic nature of their addiction.

Coercion does not always lead to negative outcomes and mandated therapy can be beneficial, making this a complex external stimulus. In a study on Kenyan University students undertaking Counseling on a Post-Doctoral Level, mandatory psychotherapy was viewed as a largely positive part of the learning experience. Approximately seventy one percent of the participants saw mandated therapy as a helpful part of the Counseling curriculum with few believing that therapy needed to be voluntary (Egunjobi, Asatsa, & Adhiambo, 2021). In this case, participants were able to compliantly undertake forced psychotherapy, as there was an underlying sense of value in coercion within therapy. Simply, the clients understood that making therapy mandatory was necessary to ensure participation. Therefore, clients can still view psychotherapy as positive when coerced, if there is a perceived sense of value in mandatory therapy (Egunjobi *et al.*, 2021).

While coercion may initially prompt individuals to seek therapy or adhere to treatment, its sustained presence risks undermining the authenticity and efficacy of therapeutic outcomes (White & Miller, 2007). However, the outcome of coercion as an extrinsic motivator is not inherently detrimental (Hachtel *et al.*, 2019). Coercion in psychotherapy becomes a nuanced form of motivation which can be utilized to foster positive therapeutic outcomes. Wolfe *et al.*, (2013) argued that it is important not to generalize on the outcome of mandated therapy as it has been found to be both

advantageous and disadvantageous. Particularly in the Kenyan context, mandatory therapy is commonly utilized and coercion is often used under the notion that it can evoke engagement. The gap in literature comes from the presupposition that coercion will have negative effects on client's perceptions and involvement in therapy, with this not being a universal truth. In the realm of psychotherapy, coercion stands as a complex force, capable of both facilitating and impeding engagement in therapeutic processes.

2.3. Social Stigma as a Determinant of Engagement in psychotherapy

Social stigma can be identified as introjected regulation, the form of extrinsic motivator whereby individuals act in order to alleviate some form of social pressure. Social stigma is prevalent in the context of mental health, as mental illness is not generally viewed favorably. Subu, Wati, Netrida, Priscilla, Dias, Abraham, and Al-Yateem, (2021) suggested that social stigma is often a result of faulty perceptions indicative of feelings of shame and devaluation. Furthermore, Chekroud, Foster, Zheutlin, Gerhard, Roy, Koutsouleris, and Krystal (2018) conveyed that social stigma can cause deterrence to an individual's wellbeing, yielding profound and extensive outcomes, such as an increase of psychological symptoms, denial and social isolation. The mentally ill face the double challenge of having to tackle their chronic symptoms as well as damaging misconceptions. Stigmatization has various adverse effects for mentally ill individuals such as lower self- image, dismal quality of life and impaired social interaction. Nonetheless, the efficacy of social stigma as an incentive is highly subjective as it could prove to be an incentive which propels a client to participate in psychotherapy or could conversely demotivate a client.

Social stigma can hinder clients from accessing mental health resources due to shame over socially unacceptable diagnoses. According to a study in the Spanish Journal of psychology, social stigma is linked to negative consequences in psychotherapy by promoting client withdrawal (Alonso, Guillen & Munoz, 2019). Hassan *et al.,* (2021) conciliated this view, stating that stigma around addiction is an issue which pervades its victims. Individuals suffering from substance use disorders often resist receiving therapy for addiction as it is not a diagnosis which is deemed as culturally acceptable. Furthermore, social stigma often deters the basic human need for social connection and Palmer, Murphy, Piselli, and Ball (2009) sustain that social stigma can reduce

motivation for psychotherapy due to a lack of social support. This implies that social stigma can act as a barrier against a clients' innate need for social connection.

It is important to note that social stigma can also be present within psychotherapy, with therapists discriminating against clients. Institutional stigma can inhibit the connection between staff and patient, thereby severing any chance of a working alliance. Palmer *et al.*, (2009) found that American clients who when presented with issues of a moral nature would endure volatile or negative remarks from therapists while attempting to acquire helpful interventions. By negatively altering the therapeutic alliance, clients are less likely to engage in therapy (Jacobsen, 2013). Institutional stigma also affects mental health professionals who need psychotherapy as part of the requirements of the profession. Edwards and Crisp, (2017) surmised in their study that Australian Mental health professionals resisted attending psychotherapy due to fear of being stigmatized by fellow colleagues. These findings suggest that although mental health professionals are more equipped with mental health literacy, resisting therapy on the basis of stigma is still a present concern.

Social stigma can elicit a need for social connection which can act as motivation to comply in therapy. For instance, in their study Bozdağ and Çuhadar (2022) provided that stigma had positive effects on the therapeutic process, with stigmatized Turkish clients being more driven to adhere to psychotherapy. These findings could be equated to clients' feeling the need to eradicate the symptoms that led to requiring therapy, thereby eradicating stigma. Similarly, a study by Owen, Thomas, and Rodolfa (2013) examined the effect of self and social stigma on engagement and therapeutic outcomes. It was found that client perception of social stigma actually led to positive therapeutic outcomes. The authors argued that social stigma may interfere with a client's sense of social support, and in turn ally the client with therapists as a way to meet that need for social support. Moreover, it was identified that psychotherapy can act as a chance for a client to find ways to improve their social relationships, leading to compliance in therapy. However, the study was limited as it only encapsulated university students, suggesting a need for further research in other mental health settings.

Stigma is endorsed by cultural and communal attitudes making it a global phenomenon; however, developing countries are more plagued by social stigma in comparison to their developed counterparts. Notably, African communities have more stigmatizing attitudes towards the mentally ill (Ndetei, Mutiso, Maraj, Anderson, Musyimi, & McKenzie, 2016). According to research, Africans continually neglect the pervasive effects of mental illness, and this is linked to a negative attitude towards the mentally ill (Aguwa, Carrasco, Odongo, & Riblet, 2023). Locally, stigmatizing attitudes towards mental illness are tied to shame, contributing to non-engagement in psychotherapy. To confirm this, Kaimunyu, Ndungo, and Wango (2010) evidenced that university students tended to resist psychotherapy in Kenya due to fear of being judged by fellow peers. The characteristics of this resistance were distrusting mental health professionals, and denying the need for therapeutic care and these factors both deterred students from receiving care and from openly participating in therapy.

As a type of extrinsic motivation, social stigma has varying effects engagement in psychotherapy among clients. Subu *et al.* (2021) elucidated that social stigma can act as a hindrance to client engagement. Wasil, Osborn, Venturo-Conerly, Wasanga, and Weisz (2021) also provided that locally, pathologizing clients can lead to non-engagement in therapy due to stigmatizing attitudes in regards to mental illness. Conversely, Bozdağ and Çuhadar (2022) denoted that social stigma can be an effective incentive for client adherence and participation. The findings in the above reviewed literature show diverging outcomes of social stigma as an incentive to engage in psychotherapy. Therefore, addressing social stigma as a determinant of client engagement requires an investigation in order to examine its efficacy in developing nations.

2.4. Psycho-Education as a Determinant of Engagement in psychotherapy

Psycho-education can be identified as the identified regulation and integrated regulation forms of extrinsic motivation. It is an extrinsic motivator whereby a client can perceive psycho-education as something of value and also internalize this value (Bell, 2010). Psycho-education has become a foundational part of the therapeutic process, with mental health professionals using it to enhance mental health literacy among clients.

Russell, D'Aniello, Tambling, and Stekler (2023) state that individuals who have received psycho-education understand that mental illness can and should be treated. Ideally, adequate psycho-education fosters help seeking behavior among clients. As such, psycho-education could be used as an extrinsic motivator that helps clients understand the importance of active participation in psychotherapy. As Ryan and Deci (2017) note, extrinsic motivation that aligns with one's values is likely to promote more positive outcomes. It is with this viewpoint that psycho-education can be investigated to understand its role as a determinant of engagement in therapy.

Psycho-education has been utilized in countries where clients often do not perceive a need for therapy, which is associated with little understanding of the therapeutic process and its efficacy. To illustrate this, Prins, Meadows, Bobevski, Graham, Verhaak, van der Meer, and Bensing (2011) denoted that Australian participants in their study had negative viewpoints towards the benefit of psychotherapy and these perceptions acted as a barrier to receiving adequate mental health-care. These findings suggest that by incorrectly comprehending the value of therapy, clients are often resistant to seeking mental health care or to engaging in the service. Due to lack of perceived need for psychotherapy, clinicians encourage psycho-education initiatives in an aim to promote client engagement. Indian scholars have noted in their research that psycho-education can work well among clients as it gives clients a direction on the stages and importance of therapy (Srivastava, & Panday, 2016). By presenting psychotherapy as a systematic and structured approach, clients are able to identify the importance of engaging in the psychotherapeutic process.

Psycho-education involves the comprehension of psychology, psychological disorders and psychological interventions. As an extrinsic motivator, psycho-education can act as an augmenting element in psychotherapy as it helps the client to identify the cause of their mental distress and work to alleviate it. In this context, psycho-education can be utilized to elicit a sense of rapport between a mental health provider and a client, allowing a client to gain clarity on therapy and facilitate consistent attendance in therapy (Becker, Boustani, Gellatly, & Chorpita, 2018). In this way, psycho-education can be viewed as consistent in its promotion of engagement as a dynamic process (Russell, D'Aniello, Tambling, & Stekler, 2023). In general, psycho-education provides an explanation on the mechanisms of therapy and has effectively been found

to encourage treatment adherence (Tursi *et al.*, 2013). This aligns with Erdoğan, and Demir (2022) who provide that psycho-education works as an aid in promoting adherence by enabling clients to have a heightened positive sense of recovery in therapy. This subjective sense of improvement in psychotherapy is seen as an enhancing element in therapy, working to improve active participation in therapy.

Africans are able to identify the symptoms of mental illnesses, but do not always have knowledge on formal diagnoses and this leads to a preference for alternative healing methods over psychotherapeutic interventions. In the African context, psycho-education could then work to enlighten individuals on the importance of therapy, however this intervention is still not being utilized. In a Nigeria study it was found that although women were the primary caretakers of the mentally ill, the community preferred to utilize traditional methods in addressing mental illness (Okafor *et al.*, 2022). Wadende, and Sodi (2023) studied the understanding of mental illness among North Turkana adolescents and found that although the community possessed an understanding of mental symptoms, they believed these symptoms were as a result of curses. The preferred solutions in this study were to confide in friends and family rather consulting than mental health professionals. Indeed, it is difficult to foster engagement between therapists and clients if there is little education and trust in the effectiveness of psychotherapy.

Challenges arise on identifying the efficacy of psycho-education in regions such as Kenya, which has reportedly low mental health literacy (Marangu *et al.*, 2021) and high rates of stigmatizing attitudes against mental illness. For instance, Wasil, Osborn, Venturo-Conerly, Wasanga, and Weisz (2021) suggest that pathologizing clients by using terms like ‘mental illness’, and ‘’depression’ may be detrimental when working with Kenyan clients who harbor stigmatizing attitudes towards mental illness. This points to the contextual relevance of factors used to promote engagement and Hassan *et al.*, (2021) concur in their study that culturally relevant psycho-education initiatives can act as more efficacious enhancers of client engagement. These nuances encourage a local investigation on if psycho-education interventions determine engagement among clients in Kenya.

Psycho-education can serve as a potent extrinsic motivator, encouraging active participation and promoting positive outcomes in therapy; however, it is imperative to recognize the need for culturally relevant interventions (Hassan *et al.*, 2021). Challenges of engagement persist in regions with low mental health literacy and high stigma, necessitating tailored approaches to disseminate psycho-education effectively (Marangu *et al.*, 2021). It is ideal for clients who receive knowledge on the nuances of mental diagnosis and prognosis, to participate actively in therapy, but this is not always the outcome. In Kenya, providing psycho-education initiatives that focus on diagnoses could be ineffective as mental disorders are highly stigmatized (Wasil *et al.*, 2021); however, this could be a speculative stance. Furthermore, in urban Nairobi where mental health resources are more available (Masambia, 2014), psycho-education may be more effective due to a clearer societal understanding of mental health. Hence, further research, particularly within local contexts such as Kenya, is warranted to explore the efficacy of psycho-education interventions in promoting client engagement.

2.5. Theoretical Framework

This study was steered by the Self Determination theory developed in 1985 by Edward Deci and Richard Ryan and by the Rational Emotive Behavior theory, conceptualized by Albert Ellis in 1955.

2.5.1 The Self Determination Theory

The first theory used in this study was the Self Determination Theory (SDT) developed by Edward Deci and Richard Ryan in 1985. This theory informed extrinsic motivation which is the independent variable in this study and the theory has been used to examine what contributes to learning behavior, and lasting behavior change. At its foundation, SDT explains the impact of one's social environment on either aiding or obstructing essential psychological needs (Legault, 2020). Self Determination Theory is founded on the humanistic premise that humans generally work to achieve growth and self-development (Ryan & Deci, 2017). The theory states that given the right environment, humans will innately work towards the betterment of their lives.

SDT identifies extrinsic motivation as working in order to attain a desired external outcome or working because of the presence of an external stimulus (Ryan & Deci, 2017). Extrinsic motivation is fundamental in behavior change as it provides incentives to individuals when an internal drive is lacking. Ryan and Deci (2022) establish that as not all activities promote an independent drive for participation, and as non-engagement implies a lack of an internal drive to adhere to psychotherapy, extrinsic motivation plays a critical role in its context.

Client engagement is a primary factor in the effectiveness of any therapeutic treatment. Many clients begin psychotherapy with ambivalence and resistance to the process and by skillfully encouraging engagement, the client can embrace therapeutic interventions. This theory informs the study by stating that extrinsic motivators are used to elicit behavioral change and therefore a crucial step in determining engagement could be through the use of extrinsic motivators. As elucidated by White and Miller (2007), coercion has been utilized as an incentive to engage in psychotherapy, and furthermore, social stigma (Owen *et al.*, 2013) and psycho-education (Srivastava, & Panday, 2016) are stimuli utilized as incentives to engage in therapy. Upon the premise that given the right environment, clients will be able to work towards the betterment of their lives, it can be implied that those who use coercion, social stigma and psycho-education as extrinsic motivators may do so in an effort to foster engagement among clients. Therefore, an environment which utilizes coercion, social stigma and psycho-education as extrinsic motivators, has the capacity to determine engagement in psychotherapy among clients.

2.5.2 The Rational Emotive Behavior Theory

Rational Emotive Behavior Theory (REBT) was formulated by Dr Albert Ellis, a psychologist in the 1950s. REBT became a foundational part of therapy, formulating the notion that individuals react to events on the basis of internal belief systems (Şahin, & Acar, 2019). REBT informed engagement in psychotherapy, which is the dependent variable in this study. This theory is hinged on the ABC model which proposes a three-tier step by which individuals evaluate and respond to life circumstances (Ellis & Harper, 1961). The ABC model conforms to the belief that humans have an innate capacity to evaluate information from the subjective basis of

emotions and perceptions. In essence, REBT states that an individual's actions are dependent upon their belief systems.

Throughout REBT, it is alleged that there are a series of thought patterns which directly affect consequences and these are generally depicted as irrational and irrational beliefs. Irrational beliefs tend to be absolute systems which declare that a situation 'must' be a certain way, and entail catastrophizing beliefs about an activating event, a low tolerance for frustrating situations and black and white thinking (David, Matu, Pintea, Cotet, & Nagy, 2014). Irrational beliefs are notions which are set in stone and which demand that life function in a certain way, lest an individual suffers greatly. Rational beliefs however, maintain that life is not so absolute, and that individuals have the capacity to acknowledge and accept reality without perfectionistic views or awfulization (Szentagotai & Jones, 2010).

This theory aligns with this study from the basis that individuals evaluate events on the basis of their flexible or inflexible beliefs; and these beliefs produce observable outcomes (Szentagotai & Jones, 2010). The REBT theory is applicable in this study as it explores the nature of the dependent variable and informs the notion that if a client has rigid or flexible beliefs concerning extrinsic motivators, those beliefs could determine the outcome of engagement in psychotherapy. This lends an explanation to engagement in psychotherapy in relation to extrinsic motivation by supposing that engagement is dependent upon the client's beliefs in regards to the extrinsic motivators present within the therapeutic environment. REBT offers room to investigate how extrinsic motivators, acting as driving events steered by clients' belief systems, determine the formulation of engagement in therapy.

2.6. Conceptual Framework

A conceptual framework provides an illustration of the relationship between the independent, dependent and intervening variables. This framework represents an integrated way of examining the study (Imenda, 2014).

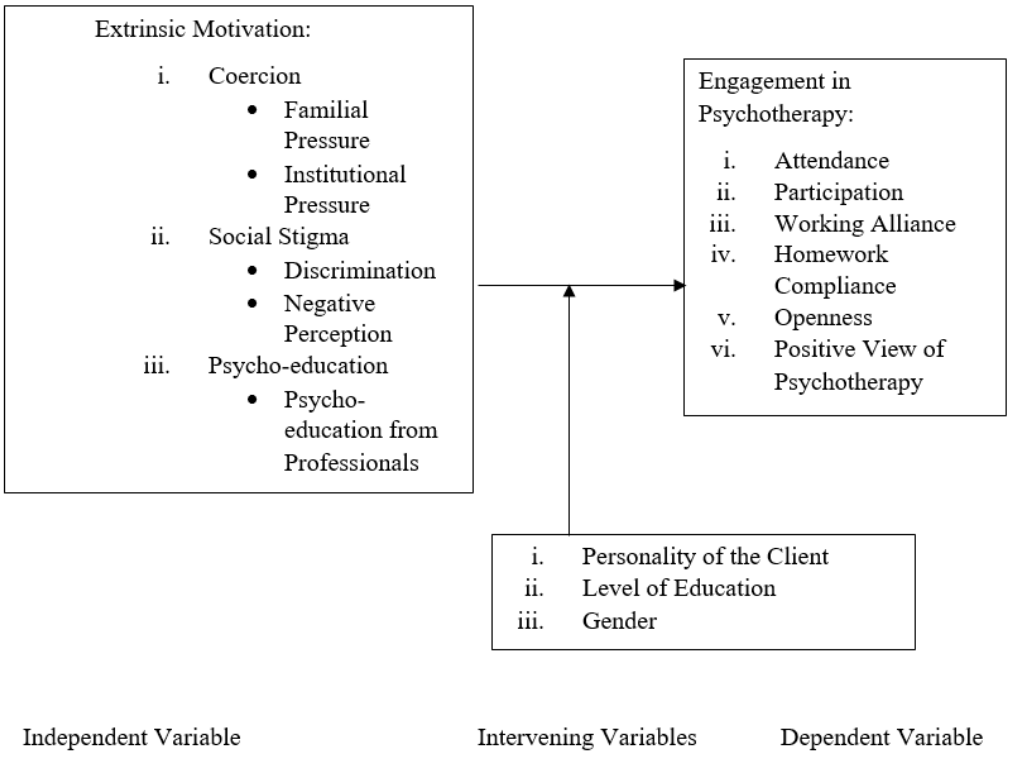

Figure 1: Relationship among Study Variables

The independent variable in this present study was extrinsic motivation and the key indicators of extrinsic motivation were coercion, social stigma, and psycho-education. Coercion is this study was depicted in ways such as familial pressure and institutional pressure. Social stigma was depicted as discrimination and a negative perception against the mentally ill. Finally, psycho-education was depicted as psycho-education from mental health professionals. The dependent variable in the study was engagement in psychotherapy which encapsulates attendance, client participation, a strong therapeutic alliance, homework compliance, openness and a positive view of psychotherapy. The intervening variables which likely influenced the independent and dependent variables were the personality of the client, level of education and gender. The intervening variables were not controlled in the study.

CHAPTER THREE

METHODOLOGY

3.1. Location of the Study

The study was undertaken in Mathari National Teaching and Referral Hospital, a government institution offering psychotherapy for mental and substance use disorders. This is a government institution which first provided rich ground for data from diverse cultural, social and economic groups. As a government facility, the resources provided are also affordable leading to more clients having access to this institution. Mathari National Teaching and Referral Hospital was also the preferred location for this study because it is known to have instances of non-engagement among clients (Falkenström *et al.*, 2017) as well as high relapse rates due to client non-adherence (Gathaiya, 2011). These factors tied into a problem with engagement in psychotherapy by providing the relevant contexts for this study.

3.2. Research Design

The study utilized a descriptive research design which provided a more detailed description on the variables in the study (Nassaji, 2015). This research design was used because it gave an accurate portrayal of the variables without manipulating the variables in any way. This allowed for a clear elaboration of the findings of the study.

3.3. Population of the Study

The total population for this study were 200 respondents, which included patients undertaking psychotherapy and psychologists within Mathari National Teaching and Referral Hospital. According to the mental health professionals from the institution, Mathari National Teaching and Referral Hospital have 180 clients undergoing outpatient psychotherapy and 20 professional psychologists in its institution.

3.4. Sample Size and Sampling Procedure

According to Krejcie and Morgan (1970) a sample size of 132 respondents adequately represented the population for this study (Appendix 4). Proportionate sampling was used to determine the number of clients and psychologists who would participate in the study, which gave a sample size constituting of clients and psychologists as shown in Table 1 which provides that 119 clients and 13 psychologists were an appropriate

sample. Purposive sampling was employed to select the clients and psychologists who would participate, with clients who are undergoing psychotherapy and their psychologists being deemed as relevant respondents. An exclusion criterion was used in order to establish the clients who would be able to provide relevant feedback to the research instruments. Clients suffering from emotional or cognitive deregulation at the time of collection were excluded from this study.

Table 1: Proportionate sample = category population/total population x sample size

Category	Population	Proportionate Sample
Clients	180	119
Psychologists	20	13
Total	200	132

Source: Information from the Mental Health Professionals of Mathari National Teaching and Referral Hospital

3.5. Research Instruments

The research instruments for this study were a questionnaire for the clients, and an interview guide for therapists. This form of triangulation was essential in gathering comprehensive, non-biased information (Creswell, 2003) on extrinsic motivation as determinants of engagement in psychotherapy.

3.5.1. Questionnaire

A questionnaire (Appendix 2) was administered to the clients undergoing psychotherapy who were selected to participate in this study. The questionnaire utilized a Likert scale to determine extrinsic motivation as a determinant of engagement in psychotherapy among clients. The questionnaire had four sections consisting of a section gathering demographic information and three sections aligned with the study objectives. Section A of the questionnaire gathered demographic information and had six questions. Section B, C, and D solicited information on coercion as a determinant of engagement among clients, social stigma as a determinant of engagement among clients, and psycho-education as a determinant of engagement among clients. Section B, C and D had seven questions each to determine the relationship between the independent and dependent variables.

3.5.2. Interview Guide

An interview guide (Appendix 3) was utilized to gather information from therapists on extrinsic motivation as a determinant of engagement in therapy among clients. As a flexible and expansive research instrument, an interview guide allows the respondent room to offer precise feedback, thereby enriching the study (Smulowitz, 2017). Turner and Hagstrom-Schmidt (2022) maintained that interview guides enable the collection of consistent and adaptable information by giving the researcher control while maintaining flexibility based on its prompts. The interview guide therefore offered a structured and flexible approach to the study. The interview guide incorporated a summary of the questions presented in the questionnaires which directly relate to the study objectives. The interview guide had two sections. Section A collected general demographic information and had five questions. Section B had four questions used to gather insight from mental health professionals on coercion as a determinant of engagement among clients, social stigma as a determinant of engagement among clients, and psycho-education as a determinant of engagement among clients.

3.6. Piloting

Piloting was undertaken to refine the research instruments and ensure representativeness of data. A pilot study functions as a necessary phase in a study offering a roadmap for the subsequent stages in a study. These investigations play a vital role in the study by refining the research instruments prior to embarking on the main study (Hazzi, & Maldaon, 2015). According to Mugenda and Mugenda (2003) a pilot study should encompass ten percent of the sample population. Moreover, it is important that the location selected for the pilot study is a representative of the established study location. The pilot study was conducted on 11 respondents (9 patients and 2 psychologists) in Diamonds Refined Recovery Center, a psychological facility specializing in mental illness and addiction in Kiambu County.

3.6.1. Validity of the Research Instruments

As articulated by Creswell (2003), the validity of a study examines the extent to which it accurately measures what is intended. In this study, expert opinion of supervisors and professors from Chuka University was sought to validate the study instrument. This step critically scrutinized the tools employed for data collection in order to ensure precision within the study.

3.6.2. Reliability of the Research Instruments

Rigorously addressing reliability is vital when evaluating the quality of a study as it ensures that when a participant is involved in a study, the responses gathered remain similar each time questions are answered (Heale & Twycross, 2015). In order to assess the reliability of the study, the statistical technique Cronbach Alpha Coefficient was adopted and a correlation coefficient of 0.86 was found. This tool assessed the internal consistency of the scales employed in the research, providing a precise indicator of the dependability of the data. Cronbach Alpha Coefficient is essential in research as it looks at the internal consistency of the items within the research instruments.

3.7. Data Collection Procedure

The data collection Procedure involved the following stages: The Chuka University Institutional Ethics Review Committee provided an introduction letter in regards to the clearance of any ethical issues pertaining to the study. This letter was then submitted to the National Commission for Science, Technology and Innovation (NACOSTI) in order to get a research permit. Thereafter, a letter was acquired from the County Commissioner to allow for data collection in the selected facilities. A permit from the Directors of the facility selected was acquired in order to enter the premises. The study respondents were then met, the purpose of the study was explained, and confidentiality was established. Finally, responses were collected from both clients and therapists through the research instruments. These responses were finally be collected for analysis.

3.8. Data Analysis

The data analysis procedure involved going through the research instruments and data was recorded and cleaned to eradicate outliers and incomplete responses which involved editing and tabulation. The instruments were coded and the coded data was be entered into the Statistical Package for Social Science (SPSS) version 27. As a software, SPSS offers features which extracts accurate insight from the data (Kathiresan, 2021). The responses from the questionnaire were analyzed through descriptive statistics using frequencies and percentages. The responses from the interview guide were analyzed using thematic analysis.

3.9. Ethical Considerations

All pertinent permits were attained to ensure ethical data collection. Ethical approval from NACOSTI (Appendix 8) was sought to ensure that the study complies with ethical standards and regulations. In the domain of informed consent, all participants received information on the study's objectives, methodologies, as well as potential advantages and risks. The participation of the respondents was contingent upon voluntary and informed consent and anonymity. The participants in the interview guide remained confidential. To mitigate any coercion, participants had the freedom to withdraw or exit from the study at any juncture. The collection process was non-intrusive and clients were given the choice of where to fill the instruments. During data collection there was no bias, regardless of factors such as gender, ethnicity, or socioeconomic status. Confidentiality was maintained at all stages of the research, inclusive of the report writing stage.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Response Rate

This study utilized both descriptive statistics for the questionnaire and a thematic analysis for the interview guide. Questionnaires were distributed to patients undergoing psychotherapy at Mathari National Teaching and Referral Hospital, achieving a response rate of 100%. An interview guide was distributed to mental health professionals and garnered a 76.9% response rate. Both response rates align with the adequate threshold of 70% as suggested by Mugenda and Mugenda (2003).

4.2 Demographic characteristics of respondents

This section provided an overview of the demographic data of the respondents who participated in the questionnaire and the interview guide. The data showed the demographic characteristics in relation to age, gender, employment status, educational background and marital status. Demographic characteristics are important in providing representative data on the participants in the study as this information can influence the responses to the research instruments.

Table 2: Age of Clients

Age of Clients	Frequency	Percentages
Under 18	41	34.5
18-24	16	13.4
25-34	30	25.2
35-44	14	11.8
45-54	13	10.9
55 and over	5	4.2
Total	119	100

The table provided a breakdown of the age distribution of the sample of the 119 clients. This data was categorized into various age groups, with the frequencies and percentages for each group illustrating the composition of the sample. The largest category was those "Under 18," representing 34.5% of the total respondents. The second-largest group was the "25 - 34" age bracket, representing 25.2% of the population. The "35 - 44" and "45 - 54" age groups had smaller representations, with 14 respondents (11.8%) and 13 respondents (10.9%), respectively. The "55 and Over" category was the smallest category, being 4.2% of the sample. This indicated that older individuals were less represented in the study while very young respondents

who were under 18 were the most represented in the study. This implies that the data was more representative of a younger perspective.

Table 3: Age of Psychotherapists

Age of the Psychotherapists	Frequency	Percentages
18-24	1	10
25-34	5	50
35-44	3	30
45-54	1	10
Total	10	100

The table provided a breakdown of the age distribution of the sample of the 10 mental health professionals in this study. From the data it was evident that the largest represented sample were between the ages of 25-34, making up 50% of these respondents. The second largest population were those 35-44 who made up 30% of the respondents. The least represented mental health professionals were 18-24 and 45-54, implying that these responses were limited in the data collection process.

Table 4: Gender of the Clients

Gender of the Clients	Frequency	Percentages
Female	68	57.1
Male	51	42.9
Total	119	100

The gender distribution among the clients revealed that the total respondents, 57.1% of the sample were female and 42.9% of the total, were male. This showcased a relatively balanced distribution of genders in the study. This implies that both gender responses were adequately represented in the study.

Table 5: Gender of the Psychotherapists

Gender of the Psychotherapists	Frequency	Percentages
Female	7	70
Male	3	30
Total	10	100

The table showcased the gender distribution of the psychotherapists within this study. It revealed a predominantly female demographic, making up 70% of the responses. Male psychotherapists made up 30% of the respondents, supplying a smaller representation to the study.

Table 6: Level of Education of the Clients

Level of Education of the Clients	Frequency	Percentages
Bachelor's Degree	39	32.8
High School Graduate	21	17.6
High School Student	32	26.9
Other	13	10.9
Post Graduate Degree	11	9.2
Prefer not to say	3	2.5
Total	119	100

The educational data of the clients revealed diverse educational levels. The largest group comprised respondents with a Bachelor's Degree, reaching 32.8% of the total. Following this, the "High School Student" represented 26.9% of the sample. The "High School Graduate" made up 17.6% of the sample. The "Other" category, encompassed 10.9% of the sample, including individuals whose educational background did not fit into the otherwise specified categories. Respondents with a Post Graduate Degree accounted for 9.2% of the total. Finally, the "Prefer not to say" category, encompassed 2.5%, indicating a small portion of individuals who did not wish to disclose their educational background.

Table 7: Level of Education of the Psychotherapists

Level of Education of the Psychotherapists	Frequency	Percentages
Bachelor's Degree	7	70
Graduate Degree	2	20
Other	1	10
Total	10	100

The educational data of the psychotherapists revealed that a majority of respondents had a Bachelor's degree which encompassed 70% of the sample. Those with a Graduate degree made up 20% where-as the psychotherapists with a Doctorate Degree made up 10% of the respondents. This implied that data was a representation of the perceptions of psychologists with an Undergraduate Degree. There were no responses who did not wish to disclose their educational background, implying a level of transparency.

Table 8: Employment status of Clients

Employment status of Clients	Frequency	Percentages
Employed	41	34.5
Other	31	26.1
Prefer not to say	5	4.2
Retired	7	5.9
Unemployed	35	29.4
Total	119	100

The employment status data revealed that the largest group comprised individuals who were currently "Employed," totaling 34.5% of the sample. Following this 29.4% of the total, were classified as "Unemployed" while the "Other" category represented 26.1% of the total. The "Retired" category, was a relatively small group with 7 respondents (5.9%). Finally, 4.2% of the respondents, chose "Prefer not to say," indicating that they opted not to disclose their status of employment.

Table 9: Employment status of Psychotherapists

Employment status of Psychotherapists	Frequency	Percentages
Counseling Psychologist	4	40
Clinical Psychologist	3	30
Other	3	30
Total	10	100

The employment status data of the psychologist revealed that the largest group comprised individuals who were currently "Counseling Psychologists," totaling 40% of the sample. Following this 30% of the total, were classified as "Clinical Psychologists" while the "Other" category represented 30% of the total indicating that some professionals did not fit the specified categories.

Table 10: Marital Status of Clients

Marital Status of Clients	Frequency	Percentages
Divorced	9	7.6
Married	18	15.1
Other	5	4.2
Prefer not to say	3	2.5
Single	80	67.2
Widowed	4	3.4
Total	119	100

The marital status data revealed that the sample were predominantly single. The single "Single," comprised 67.2% of the total sample and the next largest category was "Married," representing 15.1% of the sample. The "Divorced" category accounted for 7.6% of the total and 4.2% fit the "Other" category, which encompassed marital statuses not explicitly listed in the standard provided classifications. A small percentage of respondents, 2.5%, chose "Prefer not to say," reflecting a minor level of privacy regarding their marital status. The "Widowed" category had the smallest representation, representing only 3.4% of the sample.

Table 11: Marital Status of the Psychotherapists

Marital Status of the Psychotherapists	Frequency	Percentages
Married	5	50
Single	5	50
Total	10	100

The marital status data of the psychologists revealed that the sample were equally single or married. The single "Single," comprised 50% of the total sample and the next largest category was "Married," representing 50% of the sample. The practitioners did not fit into any of the other specified categories.

Table 12: Religious Affiliation of the Clients

Religious Affiliation of Clients	Frequency	Percentages
Christian	65	54.6
Muslim	12	10.1
Other	26	21.8
Prefer not to say	16	13.4
Total	119	100

The data on religious affiliation of the clients revealed 54.6% of the sample were Christian. The "Muslim" category represented 10.1% of the total sample and the "Other" category encompassed 21.8% of the total. A percentage of 13.4%, chose "Prefer not to say." indicating a notable minority of participants who withheld their religious affiliation. This implies that this study has a majorly Christian demographic, without diversified representation from other religious groups.

Table 13: Religious Affiliation of the Psychotherapists

Religious Affiliation of Psychotherapists	Frequency	Percentages
Christian	8	80
Muslim	1	10
Other	1	10
Total	10	100

The data on religious affiliation of the psychologists revealed 80% of the sample were Christian. The "Muslim" category represented 10.1% of the total sample and the "Other" category encompassed 10% of the total. No percentage chose "Prefer not to say." indicating that none of the practitioners withheld their religious affiliation. This implies that this study has a majorly Christian demographic of psychology professionals.

4.3 Coercion as a determinant of engagement in Psychotherapy among clients

This section discusses how coercion determines engagement in therapy among clients. The data in the table provides the distribution of responses on coercion as a determinant of engagement in psychotherapy among clients. The results below confirm that coercion is a nuanced determinant of engagement in psychotherapy. As affirmed by Ng and Ng (2015) every individual can be determined by extrinsic motivation in different ways. This proves a need for context when utilizing coercion as an incentive to engage in psychotherapy.

Table 14: Coercion as a determinant of Engagement in Psychotherapy among Clients

Variable	N%	P%	U%	VN%	VP%
How does being pressured to attend psychotherapy sessions determine your attendance in therapy?	39(32.8%)	19(16.0%)	13(10.9%)	18(15.1%)	30(25.2%)
How does being required to go to therapy determine your active participation in therapy activities?	37(31.1%)	28(23.5%)	16(13.4%)	22(18.5%)	16(13.4%)
How do social pressures to comply in therapy determine your relationship with my therapist?	46(38.7%)	21(17.6%)	16(13.4%)	25(21.0%)	11(9.2%)

How does outside influence on my decisions during therapy determine your completion of assigned therapeutic tasks?	40(33.6%)	38(31.9%)	9(7.6%)	26(21.8%)	4(4.2%)
How does being required to participate in therapy sessions determine your openness in therapy?	34(28.6%)	28(23.5%)	16(13.4%)	18(15.1%)	23(19.3%)
How do you view forced therapy in regards to promoting engagement in therapy?	56(47.1%)	14(11.8%)	2(1.7%)	37(31.1%)	10(8.4%)
If you understood that being required to go to therapy was necessary, how would that determine your engagement?	37(31.1%)	25(21.0%)	16(13.4%)	14(11.8%)	23(19.3%)

VN: *Very Negatively,* ***N:*** *Negatively,* ***U:*** *Undecided,* ***P:*** *Positively* ***VP:*** *Very positively*

A total of 18 respondents (15.1%) stated that pressure was a very negative determinant of their attendance, potentially indicating resistance to attend therapy when pressured. 39 respondents (32.8%) reported that being pressured to attend psychotherapy sessions was a negative determinant on their attendance. This was the largest group, indicating that for one-third of the respondents, external pressure negatively determined their attendance. A total of 13 respondents (10.9%) were undecided or felt neutral about how pressure determined their attendance in therapy. 19 respondents (16.0%) indicated that pressure to attend psychotherapy was a positive determinant of their attendance. Finally, 30 respondents (25.2%) reported that pressure to attend psychotherapy was a very positive determinant on their attendance. This group likely viewed external pressure as a factor which enhanced their commitment to therapy.

A total of 22 respondents (18.5%) stated that being required to go to therapy was a very negative determinant of their active participation in therapy activities This suggests that for these individuals, being required to go to therapy might deduct their motivation to participate in therapy activities. 37 respondents (31.1%) reported that

being required to go to therapy was a negative determinant of their active participation in therapy activities This was the largest group, suggesting that for a large percentage of the respondents, being required to go to therapy negatively affected their decision to actively participate in therapy activities. 16 respondents (13.4%) were undecided or neutral about how being required to go to therapy determined their attendance. 28 respondents (23.5%) indicated that being required to go to therapy was a positive determinant on their active participation in therapy activities. Finally, 16 respondents (13.4%) reported that being required to go to therapy was a very positive determinant of their active participation in therapy activities seeing the requirement to attend therapy as a strong motivator for active participation.

A total of 25 respondents (21.0%) stated that social pressures to comply in therapy was a very negative determinant on their relationship with a therapist. 46 respondents (38.7%) reported that social pressures to comply in therapy was a negative determinant of their relationship with therapists. This is the largest group, indicating that for nearly 40% of respondents, social pressures to comply in therapy negatively determined their therapeutic alliance. 16 respondents (13.4%) were undecided or neutral about how social pressures determines their therapeutic relationship. 21 respondents (17.6%) indicated that social pressures to comply in therapy was a positive determinant of their therapeutic relationships. Finally, 11 respondents (9.2%) reported that social pressures to comply in therapy was a very positive determinant of their relationship with a therapist. This indicated that a small portion sees social pressures to comply in therapy as a positive motivator for a strong therapeutic relationship.

A total of 26 respondents (21.8%) stated that outside influences on decisions during therapy was a very negative determinant of their completion of therapeutic tasks. This suggests that for these individuals, outside influences on decisions may dissuade their motivation to complete therapy assignments. 40 respondents (33.6%) reported that outside influences on decisions during therapy was a negative determinant of their completion of therapeutic tasks. This is the largest group, indicating that for approximately one-third of respondents, outside influences on decisions negatively determined their decision to complete therapy homework. 9 respondents (7.6%) were

undecided or neutral about how outside influences on decisions during therapy determined their completion of therapeutic tasks. 38 respondents (31.9%) indicated that outside influences on decisions during therapy was a positive determinant of their completion of therapeutic tasks. Finally, 5 respondents (4.2%) reported that outside influences on decisions during therapy was a very positive determinant of their completion of therapeutic tasks. This indicated that only a small portion sees outside influences on decisions as a positive motivator for their completion of therapeutic tasks.

A total of 18 respondents (15.1%) stated that the requirement was a very negative determinant of their openness. This suggests that for these individuals, being required to attend therapy might discourage them from being open during the sessions. 34 respondents (28.6%) indicated that being required to participate in therapy sessions was a negative determinant of their openness, suggesting that for these respondents, the requirement to participate negatively determines their openness. 16 respondents (13.4%) were undecided or neutral about how required participation determined their openness. 28 respondents (23.5%) reported that the requirement was a positive determinant of their openness. Finally, 23 respondents (19.3%) reported that the requirement to participate in therapy was a very positive determinant on their openness. These respondents felt that the requirement to participate strongly encouraged their openness during therapy.

A total of 37 respondents (31.1%) stated that forced therapy was a very negative determinant of their engagement. 56 respondents (47.1%) indicated that forced therapy does was a negative determinant of engagement in therapy. This was the largest group, suggesting that nearly half of the respondents believed that being forced into therapy negatively determined their engagement in therapy sessions. 2 respondents (1.7%) were undecided or neutral about how forced therapy determined their engagement. This indicated that very few respondents are unsure about how forced therapy determined their willingness to engage. 14 respondents (11.8%) reported that forced therapy positively determined their engagement in therapy. Finally, 10 respondents (8.4%) reported that forced therapy was a very positive

determinant of their engagement, indicating that only a small portion of respondents felt positively determined to engage in forced therapy.

A total of 14 respondents (11.8%) stated that understanding the necessity of therapy would be a very negative determinant of their engagement suggesting that for these individuals, the necessity of therapy might discourage them from being engaged during sessions. 37 respondents (31.1%) indicated that understanding the necessity of therapy would negatively determine their engagement. This was the largest group of responses, indicating that knowing that attending therapy is necessary negatively affects how engaged clients are during the sessions. 16 respondents (13.4%) were undecided or neutral about how understanding the necessity of therapy determined their engagement. 25 respondents (21.0%) reported that understanding the necessity of therapy positively determined their engagement in therapy. Finally, 23 respondents (19.3%) reported that understanding the necessity of therapy was a very positive determinant of their engagement.

The results of this variable showcased a mixed response on coercion as a determinant of engagement in psychotherapy among clients. This is in alignment with Wolfe, *et al.,* (2013) who conciliated that it is important not to generalize on the negative outcome nor perception of coercion in psychotherapy. Coercion can indeed be viewed positively as purported by the respondents from Mathari National Teaching and Referral Hospital. This aligns with Hachtel *et al.,* (2019) who noted that coercion as an extrinsic motivator is not inherently detrimental. The general findings from clients was a consensus that coercion negatively determined their engagement, with an apparent deviation towards it being a positive determinant. This presents a nuanced understanding of coercion, providing the need for individualized approaches to evoke engagement among clients based on their specific needs.

The thematic analysis brought forward a clear perspective of the psychotherapeutic perspective on coercion as a determinant of engagement among clients. In regards to a prevalence of coercion as a means of eliciting engagement in therapy, the responses indicate that coercion in therapy is a common practice. Therapists reported witnessing various forms of coercion, including forced institutionalization and familial pressure. One respondent noted, "*At a certain mental health facility, some of the patients*

claimed that they were brought to the facility by force by their friends and family." This aligns with the notion that coercion is a common practice in the mental health context. It also corroborates the notion that individuals are coerced under the assumption that this will facilitate positive behavioral change (White & Miller, 2007).

Another therapist shared an experience "*While working in a mental health clinic that primarily served youth-aged individuals, I bore witness to a number of cases involving coercion. One such case involved a college student who was pressured by his family into attending therapy sessions (they told him he would be going for a toxicology, only for him to end up in a mental health institution). According to the family members, they resorted to the use of coercion because the client did not manifest an understanding of the grave impact of prolonged marijuana use. They committed to accompany him to all his sessions, merely to ensure that he is faithfully attending; this according to them, was the greatest favour they could offer to their loved one."* This aligns with the Self Determination theory (Ryan & Deci, 2017) which lays the assumption that it can be implied that those who use coercion, may do so in an effort to foster engagement among clients.

In relation to the how coercion determines client engagement there was a general consensus that coercion often negatively determines client engagement in therapy. As one therapist stated, " *In my perspective, the use of coercion negatively affects clients in therapeutic activities. More often than not, it results in resistance and a consistent lack of cooperation on the client's part. Posing as potential hindrance to the development of a therapeutic alliance between the client and therapist, it is highly likely that the therapeutic process will not yield much fruit."* This was echoed by another respondent who observed, " *Many clients do not want to be in therapy if they are forced into it. Also depending on the educational level of the patient, they may not even understand the purpose of therapy so why engage? If they are inpatients they can sit there and just wait for the session to end and if they are outpatients they might engage if they are the ones paying for the session but if not, they come as a courtesy."* These findings align with Bukhari *et al.*, (2021) who stated that coercion can be perceived as an intrusion on the lives of clients, leading to resentment. This resentment can foster a lack of a therapeutic alliance and resistance in therapy, further inhibiting client engagement.

The responses also suggest that the impact of coercion is not universally negative with data revealing that outcomes of coerced therapy can vary. Some therapists reported instances where coercion led to positive outcomes such as one respondent who supplied, "*Some of the recovered clients state that if they had not been coerced, they would not have sought treatment for their poor mental health,"* suggesting that in some cases, coercion can lead to beneficial outcomes. As depicted by (Egunjobi *et al.*, 2021), Kenyan clients are able to see the value of coercion. This internalization can in turn allow clients to reap the benefits of psychotherapeutic intervention.

The responses highlight several factors that may determine whether coerced clients engage in therapy such as client attitude, their perception of therapy's value, and the therapeutic alliance. As one therapist provided, *"The ones who can engage are those in my opinion who see a value in therapy. Those are the ones who are feeling helped or who feel like their therapist understands them and is not judgmental*." A caution was noted on the ethical implications of coercion in therapy. While some therapists acknowledge its necessity, there's a clear preference for voluntary participation. One respondent stated*, "While I believe that it is necessary in few cases, I also think that voluntary therapy has the best results. Such clients will put in the work as opposed to those who are forced or coerced."* This provides an ethical perspective illustrating that as sustained by White and Miller (2007), coercion is fundamentally of ethical concern in psychotherapeutic contexts.

The findings align with Bukhari *et al.*, (2021) who sustained that coercion is a predominantly negative determinant of engagement in psychotherapy. This provides a different perspective to client feedback which was nuanced on the nature of coercion as a determinant of engagement in psychotherapy. This implies that clients and psychologists in Mathari are not in implicit agreement on the influence of coercion on engagement in psychotherapy. However, there is therapist allowance for the fact that clients can benefit from coercion, although this practice is not perceived as ethical. This concurs with Rosen *et al.*, (2004) who concluded in their study that clients can engage in therapy when there is a present understanding of the value of therapy. While it's generally seen as detrimental to client engagement and the therapeutic process, there are instances where coercion can lead to positive outcomes. The general

consensus is that coercion is an overall negative determinant of engagement in psychotherapy among clients.

4.4 Social Stigma as a Determinant of Engagement in Psychotherapy among clients

This section provides insight on how clients perceive social stigma as a determinant of engagement in psychotherapy. The table presents the distribution of responses which examined how social stigma determines engagement in psychotherapy among clients. The results depict social stigma as a predominantly negative determinant of engagement in psychotherapy with a slight deviation towards it being a positive determinant of engagement. This is in tandem with Alonso *et al.* (2019) who sustained that social stigma is linked to negative consequences in psychotherapy by promoting client resistance.

Table 15: Social Stigma as a determinant of Engagement in Psychotherapy

Variable	N%	P%	U%	VN%	VP%
How do negative comments about your condition determine my attendance in therapy?	31(26.1%)	19(16.0%)	9(7.6%)	37(31.1%)	23(19.3%)
How does using shame as a reason for seeking therapy determine your participation in therapy?	40(33.6%)	26(21.8%)	4(3.4%)	40(33.6%)	9(7.6%)
How does social rejection due to your condition determine my relationship with my therapist?	42(35.3%)	19(16.0%)	11(9.2%)	36(30.3%)	11(9.2%)
How does discrimination based on your diagnosis determine my completion of assigned therapeutic tasks?	49(41.2%)	16(13.4%)	5(4.2%)	38(31.9%)	11(9.2%)
How does prejudice against your mental condition determine my openness in therapy?	53(44.5%)	19(16.0%)	10(8.4%)	27(22.7%)	10(8.4%)
How do you view social stigma in regards to promoting engagement in therapy?	38(31.9%)	14(11.8%)	10(8.4%)	40(33.6%)	17(14.3%)
If you understood that using shame, social stigma or rejection was necessary for you to go to therapy, how would it determine my engagement?	37(31.1%)	23(19.3%)	7(5.9%)	38(31.9%)	14(11.8%)

VN: Very Negatively, N: Negatively, U: Undecided, P: Positively VP: Very positively

A total of 37 respondents (31.1%) indicated that negative comments were a very negative determinant of their attendance. This was the largest group of responses, which suggests that for many, negative comments may discourage them from attending therapy. 31 respondents (26.1%) indicated that negative comments about their condition was a negative determinant of their attendance in therapy, suggesting that for over a quarter of the respondents, comments negatively determined their attendance in therapy. 9 respondents (7.6%) were undecided or neutral about how negative comments determine their attendance. 19 respondents (16.0%) reported that negative comments positively determined their attendance. 23 respondents (19.3%) reported that negative comments very positively determined their attendance. This group likely felt motivated to attend therapy more regularly when faced with negative comments based on their diagnosis.

A total of 40 respondents (33.6%) indicated that shame was a very negative determinant of their participation in therapy. 40 respondents (33.6%) indicated that using shame as a reason for seeking therapy was a negative determinant of their participation. These group, equally suggest that shame may act as a barrier to active participation in therapy sessions. 4 respondents (3.4%) were undecided or neutral about the how shame determines their participation. 26 respondents (21.8%) reported that shame was a positive determinant of their participation in therapy while 9 respondents (7.6%) reported that shame was a very positive determinant of their participation. These respondents may use shame as a positive determinant to engage in therapy.

A total of 36 respondents (30.3%) indicated that social rejection was a very negative determinant of their relationship with their therapist. This suggests that social rejection creates a barrier to building a positive therapeutic relationship. 42 respondents (35.3%) indicated that social rejection was a negative determinant of their relationship with their therapist. This group represents the largest portion of respondents, suggesting that for over a third, social rejection negatively affects how they relate to their therapist. 11 respondents (9.2%) were undecided or neutral about how social rejection determines their relationship. 19 respondents (16.0%) reported that social rejection was a positive determinant of their relationship with their

therapist while 11 respondents (9.2%) reported that social rejection was a very positive determinant of their relationship with their therapist. These group may view the therapist as a crucial source of support, reinforcing a strong, positive connection due to the external social challenges caused by social stigma.

38 respondents (31.9%) indicated that discrimination was a very negative determinant of their task completion indicating discrimination hinders the completion of therapeutic tasks. 49 respondents (41.2%) represented the largest group of respondents, who stated that discrimination based on their diagnosis negatively determined their completion of therapeutic tasks. 5 respondents (4.2%) were undecided or neutral how discrimination determines their task completion. 16 respondents (13.4%) reported that discrimination positively determines their completion of therapeutic tasks while 11 respondents (9.2%) reported that discrimination was a very positive determinant of their task completion. These groups might use discrimination as a positive determinant to complete therapy tasks.

A total of 27 respondents (22.7%) which represents nearly a quarter of the respondents, indicated that prejudice was a very negative determinant of their openness in therapy. 53 respondents (44.5%) which were the largest group, indicated that prejudice against their mental condition negatively determined their openness in therapy. 10 respondents (8.4%) were undecided or neutral about how prejudice determines their openness in therapy. 19 respondents (16.0%) reported that prejudice positively determines their openness in therapy while 10 respondents (8.4%) reported that prejudice was a very positive determinant of their openness in therapy.

A total of 40 respondents (33.6%) representing the largest segment, indicated that social stigma was a very negative determinant of their engagement in therapy. 38 respondents (31.9%) representing nearly a third of the respondents, indicated that social stigma negatively determined their engagement in therapy.10 respondents (8.4%) were undecided or neutral about how social stigma determines their engagement in therapy. 14 respondents (11.8%) reported that social stigma positively determines their engagement in therapy while 17 respondents (14.3%) reported that social stigma was a very positive determinant of their engagement in therapy. These

individuals might view stigma as a positive driving force to engage more actively in therapy.

A total 38 respondents (31.9%) representing the largest segment, indicated that understanding shame, social stigma, or rejection as necessary for therapy would be a very negative determinant of their engagement. 37 respondents (31.1%) who were a significant portion of the respondents indicated that understanding shame, social stigma, or rejection as necessary for therapy would be a negative determinant of their engagement. 7 respondents (5.9%) were undecided or neutral about the impact of these factors on their engagement. 23 respondents (19.3%) reported that this understanding would positively determine their engagement while 14 respondents (11.8%) reported that this understanding would be a very positive determinant of their engagement.

The results provided ally with Alonso *et al.* (2019) who found that social stigma is detrimental to psychotherapy as it exacerbates client withdrawal. This is reflected in the survey results, where a majority of respondents indicated that social stigma was a negative determinant of engagement in psychotherapy. These respondents could likely harbor the shame associated with social stigma as a barrier to seeking mental health intervention. Survey participants who had a more positive outlook on stigma were a slight deviation. However, these respondents present an essential viewpoint as they may believe that stigma is a necessary incentive to participate in therapy. Moreover, such respondents may actively participate in therapy in a bid to consequently eliminate their undesirable illness. This aligns with Bozdağ and Çuhadar, (2022) who provided that social stigma could positively influence clients into participating in therapy. This can be as a result of allying with therapists in order to eradicate seemingly unwanted symptoms. The general consensus from the findings above is that social stigma is an overall negative determinant of engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital.

As per the thematic analysis of the interview guide, prominent theme noted by mental health professionals was a prevalence of stigma and its various manifestations in regards to mental illness. This is exemplified by one respondent who stated, *"Absolutely, almost everyday I witness some sort of stigma against the mentally ill. If they are not outwardly distressed maybe they will not face stigma but those who clearly look mentally ill are often viewed as dirty, incompetent and even dangerous."* As provided by another mental health professional, *"I have heard patients being called 'mwenda wazimu' and other such terms. Even sometimes a patient can be volatile to another patient if they do not like the look of them. This is very common in Kenya although I would hope the trend is shifting somewhat."* This supports Ndetei (2016), who surmised that African communities have more stigmatizing attitudes towards the mentally ill. Respondents consistently reported observing explicit stigma towards individuals with mental health issues.

Another significant theme observed was that many respondents noted that stigma often acts as a barrier to help seeking behavior and engagement in therapy. One therapist stated, *"People tend to stigmatize those who seek for mental health treatments and those who do seek help will not disclose that they are receiving treatment."* This reluctance to seek or disclose treatment highlights the powerful influence of social perceptions on individual behavior regarding mental health. Furthermore, cultural and societal factors also played a significant role in shaping attitudes towards engaging in therapy. One respondent highlighted that, *"The fear of being vulnerable especially for men in African society discourages engagement in therapy."* This corroborates Kaimunyu *et al.* (2010) who evidenced that Kenyan participants in their study resisted psychotherapy due to fear of being judged by fellow peers. This points to the impact of external perception on client engagement.

Aguwa *et al.* (2023) concurred that the negative attitudes towards mental illness is linked to neglect of one's mental health, a potential barrier to help seeking behavior. Furthermore, stigmatizing attitudes in regards to mental illness, discourage engagement due to fear of external judgment. Conversely, some responses suggested that stigma can, in certain cases, positively influence individuals to engage in therapy. One respondent observed, *"I have seen patients being shamed by family when they exhibit symptoms which are classified as weird. And this can be used as a reason to*

go to therapy, like a promise that therapy will fix their odd nature." This suggest that social stigma can in certain cases promote positive therapeutic outcomes, highlighting the complex ways in which stigma can determine therapy engagement.

In regards to if social stigma, contributes to or impede client engagement in therapy, the findings suggest that some therapists believe stigma to be an impediment to engagement. For instance, one respondent noted that stigma *"makes the client resistant and the lack of vulnerability affects the sessions."* However, this was negated by another response which claimed that social stigma can in fact positively determine engagement as seen by the response that, *"If the shame is profound, like something the client has a hard time accepting they could comply in therapy in hopes that they will change. Actually, as much as it is not kind to watch, shamed clients can stay in therapy because they no longer want to be associated with that shame."* This corresponds with Bozdağ and Çuhadar (2022) who provided that stigma had positive effects on the therapeutic process where clients' felt the need to eradicate the symptoms that led to requiring therapy, thereby eradicating stigma.

Finally, the responses revealed that some clients are able to engage in therapy despite societal stigma, with one respondent suggesting, *"The ones who can engage after being stigmatized I believe are those who are fed up of the stigma and so they want a change."* In terms of what differentiates clients who can engage in therapy and those who cannot it was denoted that the differences are, *"Awareness: some clients are aware of the true benefits of therapy. This may outweigh the impact of social stigma on their lives. Others lack awareness which causes them to hesitate. Upbringing: some clients may have been brought up in an environment that allowed vulnerability while others may have not."*

The responses from both clients and mental health professionals provided that social stigma is an overall negative determinant of engagement in psychotherapy. However, some nuance is brought out by psychologists who contend that social stigma can have a positive outcome on engagement in some instances. Bozdağ and Çuhadar, (2022) suggested that social stigma can be an effective incentive for client adherence and participation. Conversely, Subu *et al.* (2021) elucidated that social stigma can act as a hindrance to client engagement. This conflict is illustrated in the findings provided

above with a common theme emerging; that clients engage when tired of the stigma associated with their mental health condition. This fact is in alignment with Owen *et al.* (2013) who stipulated that social stigma may interfere with a client's sense of social support, and in turn ally the client with the therapeutic process. However, as per therapist insight stigmatizing attitudes in this case do not generally foster engagement but rather act as a hindrance towards it. In conclusion, this thematic analysis reveals an overall theme that social stigma negatively determines client engagement.

4.5 Psycho-education as a Determinant of Engagement in Psychotherapy among Clients

This segment reviews client responses on how psycho-education determines their engagement in psychotherapy. The table below provides the distribution of data on the questions which explored how psycho-education determines engagement in psychotherapy among clients. The results surmise that psycho-education is a positive determinant of engagement in psychotherapy. This allies with Srivastava and Panday (2016) who contended that by presenting psychotherapy as a systematic and structured approach, clients are able to identify the importance of engaging in the psychotherapeutic process. This is presented by the responses which predominantly denoted a positive association between psycho-education and engagement in psychotherapy.

Table 16: Psycho-education as a determinant of Engagement in Psychotherapy

Variable	N%	P%	U%	VN%	VP%
How does getting education about your diagnosis influence your attendance in therapy?	7(5.9%)	37(31.1%)	4(3.4%)	16(13.4%)	55(46.2%)
How does homework on the importance of therapy influence your participation in therapy?	26(21.8%)	37(31.1%)	6(5%)	18(15.1%)	32(26.9%)
How does receiving education about your diagnosis in therapy influence your relationship with my therapist?	7(5.9%)	45(37.8%)	5(4.2%)	13(10.9%)	49(41.2%)
How does getting educated about therapy influence your completion of therapy homework?	4(3.4%)	37(31.1%)	7(5.9%)	31(26.1%)	40(33.6%)
How does understanding your diagnosis influence my openness in therapy?	29(24.4%)	35(29.4%)	6(5%)	8(6.7%)	41(34.5%)
How do you view psycho-education in regards to promoting engagement in therapy?	12(10.1%)	32(26.9%)	5(4.2%)	10(8.4%)	60(50.4%)
If you understood that getting educated about your mental diagnosis was necessary for you to go to therapy, how would it influence your engagement?	2(1.7%)	48(40.3%)	3(2.5%)	26(21.8%)	40(33.6%)

VN: Very Negatively, N: Negatively, U: Undecided, P: Positively VP: Very positively

A total 16 respondents (13.4%) though a small group, indicated that receiving education about their diagnosis would be a very negative determinant of their attendance. 7 respondents (5.9%) which was a small minority, indicated that getting education about their diagnosis would be a negative determinant of their attendance in therapy. 4 respondents (3.4%) were undecided or neutral how education determines their attendance. 37 respondents (31.1%) who were a significant portion of respondents reported that education about their diagnosis would positively determine their attendance. 55 respondents (46.2%) representing the largest group reported that education about their diagnosis would be a very positive determinant of their attendance.

A total of 18 respondents (15.1%) felt that homework on the importance of therapy was a very negative determinant of their participation. 26 respondents (21.8%) who were a significant portion of respondents, indicated that homework on the importance of therapy negatively determines their participation. 6 respondents (5.0%) were neutral or undecided about how homework determines their participation in therapy. 37 respondents (31.1%), the largest group of respondents reported that such homework was a positive determinant of their participation. Finally, 32 respondents (26.9%) indicated that such homework was a very positive determinant of their participation. This group views the homework as a positive determinant, thereby likely enhancing their engagement in therapy.

A total of 13 respondents (10.9%) felt that receiving education about their diagnosis in therapy was a very negative determinant of their relationship with their therapist. 7 respondents (5.9%) who represented a small percentage indicated that receiving education about their diagnosis in therapy negatively determines their relationship with their therapist. Only 5 respondents (4.2%) were undecided or neutral about how education determines relationship with their therapist. 45 respondents (37.8%), who were a substantial portion of respondents reported that education in therapy positively determines their relationship with their therapist. 49 respondents (41.2%) who represented the largest group, indicated that education in therapy was a very positive determinant of their relationship with their therapist.

A total 31 respondents (26.1%) felt that getting educated about therapy was a very negative determinant of their completion of therapy homework. 4 respondents (3.4%) indicated that getting educated about therapy was a negative determinant of their completion of therapy homework. 7 respondents (5.9%) were undecided or neutral about how therapy education determines their homework completion. 37 respondents (31.1%), who depict a substantial portion of respondents, reported that education about therapy positively determines their completion of therapy homework. 40 respondents (33.6%), who represented the largest group, indicated that education about therapy was a very positive determinant of their completion of therapy homework.

A total of 8 respondents (6.7%) felt that understanding their diagnosis was a very negative determinant of their openness in therapy. 29 respondents (24.4%) who were a moderate percentage indicated that understanding their diagnosis negatively determined their openness in therapy. 6 respondents (5.0%) were undecided or neutral on how understanding their diagnosis determines their openness in therapy. 35 respondents (29.4%) reported that understanding their diagnosis positively determines their openness in therapy. Finally, the largest group of 41 respondents (34.5%) indicated that understanding their diagnosis was a very positive determinant of their openness in therapy.

A total of 10 respondents (8.4%) felt that psycho-education was a very negative determinant of their engagement in therapy. 12 respondents (10.1%) found psycho-education as being a negative determinant of their engagement in therapy. 5 respondents (4.2%) were neutral on how psycho-education determined their engagement. Finally, 32 respondents (26.9%) perceived that psycho-education positively determined their engagement in therapy while 60 respondents (50.4%) perceived psycho-education as a very positive determinant of engagement in therapy.

A total of 26 respondents (21.8%) felt that understanding the necessity of education would be a very negative determinant of their engagement. 2 respondents (1.7%) indicated that understanding the necessity of education for therapy would negatively determine their engagement. 3 respondents (2.5%) were neutral on how understanding the necessity of education would determine their engagement. 48 respondents (40.3%), reported that understanding the necessity of education would positively determine their engagement in therapy. Finally, 33.6% of the total believed that this understanding would very positively determine their engagement.

The results above strongly support psycho-education as a positive determinant of patient's involvement in therapy. A large majority of respondents indicated that receiving education about their diagnosis would positively or very positively determine their participation in therapy as supported by Becker *et al.* (2018). However, respondents held a negative perception towards homework on their diagnosis as a determinant of engagement in psychotherapy. Perhaps therapy

homework takes autonomy away from the patients if not collaboratively assigned, thereby leading to resistance. This corroborates the view of Ryan and Deci (2022) who sustained that autonomy was essential for fostering motivation. There were also negative responses on how understanding mental diagnosis determines engagement in psychotherapy. This could be tied to educational material which use words tied to stigma like "mental illness" or "depression" that could turn some people away from therapy (Wasil *et al.*, 2021). While psycho-education is typically beneficial, the mode of application thought about carefully, especially with populations who hold stigmatizing attitudes towards mental health.

As per the responses in the interview guide on the use of psycho-education in therapy, there was a theme among the respondents that psycho-education is widely used and generally effective as a therapeutic intervention. Many therapists report personally utilizing psycho-education in their practice, with one stating, *"In my field I always use psycho-education to explain to my clients why they are in therapy, what their condition is and why therapy is important."* As an extrinsic motivator, psycho-education can act as an augmenting element in psychotherapy as it helps the client to identify the cause of their mental distress and work to alleviate it (Srivastava & Panday, 2016). This indicates that psycho-education is seen as a fundamental tool in therapy.

In regards to whether psycho-education encourages client participation: psycho-education appears to be crucial in encouraging client engagement. One respondent noted, *"By encouraging a client, they were able to understand that therapy is for the benefit of their mental wellbeing*." Another therapist explained how psycho-education helps boost client participation: *"For example a client who has never heard of therapy or bipolar may know they are struggling but not know what to do about it. By being educated about bipolar, medication and the benefits of therapy they can learn that there is something that can be done to help them."* Furthermore, psycho-education serves to demystify mental health challenges and normalize clients' experiences. As one therapist put it, "*I have used psycho-education to demystify the challenges the client is grappling with, normalize and validate the client's experiences and relay feedback on the possibility of healing and restoration."* This process can help reduce stigma and create an open environment for clients to engage. This is in alignment with

Becker *et al.* (2018) who purported that psycho-education can be utilized to elicit a sense of rapport between a mental health provider and a client, allowing a client to gain clarity on therapy and facilitate consistent attendance in therapy.

On whether psycho-education bolsters engagement in psychotherapy it was reported that while psycho-education is generally seen as beneficial, not all clients engage equally after receiving it. One therapist observed, *"Those who are able to engage in therapy are the ones who feel like they now see what their issue is and believe that counselling will help them. Those who do not benefit are the few who do not want to be there in the first place and it is hard to get them on board, they can even exit the facility before they are supposed to."* The findings demonstrate that clients who do not wish to be in therapy may not benefit from it regardless of psychotherapy. This illustrates a possible interaction between psycho-education and coercion, corresponding with Wasil *et al.* (2021) who denoted that a negative perception of psychotherapy hinders engagement.

Some responses indicated potential drawbacks to psycho-education. One therapist cautioned, "*Psycho-education is good, to some extent especially when used in moderation. Too much psycho-education takes the autonomy away from the client who is the one supposed to be doing more of the sharing. A bit of psycho-education and more of psychodynamic therapy works better in some illnesses like adverse childhood experiences and trauma."* Another noted that for certain diagnoses, like schizophrenia, psycho-education might sometimes be demoralizing for clients. These insights suggest that the use of psycho-education should be balanced and tailored to individual client needs. This is in correspondence with (Ryan & Deci, 2022) who conciliated that a lack of autonomy inhibits motivation in individuals, which could limit the efficacy of psycho-education on clients.

The responses hint at the influence of mental health literacy on the effectiveness of psycho-education. One respondent mentioned, *"Psychotherapy is still not understood, they say 'enda uongeleshwe' hence someone feels like they can talk to one another or relative instead of paying to 'kuongeleshwa'."* This indicates that cultural comprehension on psychotherapy can determine how clients engage with psycho-education in therapy. Wadende and Sodi (2023) stated that low mental health literacy

can lead to a preference to confide in friends and family rather consulting than mental health professionals. Indeed, it is difficult to foster engagement between therapists and clients if there is little education and trust in the effectiveness of psychotherapy. Challenges of engagement persist in regions with low mental health literacy and high stigma, necessitating tailored approaches to disseminate psycho-education effectively (Marangu *et al.*, 2021).

The responses suggest that psycho-education, when used appropriately, can significantly enhance client engagement in psychotherapy. This is tandem with the responses from clients. These responses are parallel with Russell *et al.* (2023) who stated that individuals who have received psycho-education comprehend the prognosis of mental illness and that it can and should be treated. This leads to a normalization of the client's symptoms and therefore more rational help seeking behavior. Psycho-education provides clients with clarity on therapy and facilitates consistent attendance and engagement in therapy (Becker *et al.*, 2018).

CHAPTER FIVE

SUMMARY, CONCLUSION AND RECOMMENDATIONS

5.1. Summary

This section provides a comprehensive summary of the demographic data and findings of the study. This summary is vital in providing an elaborate conclusion on extrinsic motivation as a determinant of engagement in psychotherapy among clients. From the conclusion, subsequent recommendations and areas of further study can be garnered to further examine factors in relation to engagement in psychotherapy.

The background of the study focused on the significance of psychotherapy as a talking intervention between a client and a psychotherapist. Literature provided that psychotherapy is known to promote positive behavioral outcomes for clients but this is contingent upon client participation and adherence (Miller *et al.*, 2010). This chapter provided context to the significance of utilizing psychotherapy as a mental health intervention in that a substantial population require mental health care. However, although there is a definite need, psychotherapy is underutilized and those who do access this intervention lack adherence to treatment protocol (Cenci 2017).

This chapter emphasized the need for clients to engage in psychotherapy in order to achieve therapeutic goals. It took a global approach by identifying countries in the West who attempt to foster engagement through means such as improving the therapeutic alliance (Daniels, Holdsworth, & Tramontano, 2017). The discussion then shifted to the African context, whereby engagement is an apparent issue caused by varying factors. Africans are depicted to resist Western psychotherapy. This is majorly as a result of poor mental health literacy and a lack of a perceived need for therapy.

In Kenya particularly, it was sustained that mental health care is underutilized leading to common rates of symptom relapse. This resistance to therapy is a culmination of social factors lending to unsuccessful therapeutic outcomes (Gathaiya, 2011). In Nairobi, the rate of client non-engagement is notably high with many depictions of resistance by clients. These forms of non-engagement include denying diagnoses, missing appointments and avoiding talk therapy altogether. Falkenström *et al.*, (2017)

provide further that clients in mental health facilities in Nairobi showed significantly low attendance rates due to attrition, confirming a problem with non-engagement in therapy. This points to a need for incentives in order to elicit engagement in psychotherapy; tying in the study premise which is to examine how certain extrinsic motivators determine engagement in psychotherapy among clients.

The chapter identified the potential role of extrinsic motivation as a determinant of engagement in psychotherapy. Coercion, social stigma and psycho-education can act as extrinsic motivators in relation to psychotherapy in the Kenyan context as they are a predominant part of the nation's psychotherapeutic environment (de Menil *et al.*, 2014; Kamunyu *et al.*, 2010; Ongeri, 2021). As these motivators interact with each other, their outcome on engagement in psychotherapy is complex, providing the gap for this study. The chapter proposed that understanding how these factors interact and determine engagement is essential for improving therapeutic outcomes in settings like Kenya.

The second chapter of this study provided a comprehensive review on literature on extrinsic motivation, engagement in psychotherapy, the theoretical frameworks which steered this study and the conceptual framework of the study. The chapter began with an overview of extrinsic motivation and engagement in psychotherapy. It was established that as per Ryan and Deci (2022), there are four types of extrinsic motivation. These forms of extrinsic motivation work in a continuum from having the least to most autonomy. Simply put, an individual who is extrinsically motivated, depending on the type may feel in control and thus internalize the value of the motivator (Bell, 2010) or may feel no control. It is sustained that autonomy is paramount to successful motivation (Legault, 2020) but this stance is contentious. The overall notion was that extrinsic motivation can have individually or contextually specific outcomes.

The literature identified engagement as active or avid participation in an act. Specifically, engagement is maintained as observable client behavior such as client attendance, client participation in psychotherapy, compliance with therapeutic homework or assignments, and establishing a positive therapeutic relationship

(Holdsworth *et al.*, 2014). It was established that engagement in therapy is key to client success in psychotherapy a fact which has been long understood by mental health professionals. As such in contexts where there is a challenge with engagement, extrinsic factors can positively veer a client towards active involvement (Legault, 2020).

The review explored three types of extrinsic motivators which are relevant to the Kenyan mental health context, as they are common features of the therapy environment. These extrinsic motivators; coercion, social stigma and psycho-education all can facilitate or impede engagement. The evident complexity of these independent variables in relation to engagement in therapy was evident by literature which held no consensus on their efficacy. In contrast, these variables were viewed as dependent upon context, with caution to avoid assumption on their outcomes (Wolfe *et al.*, 2013). Particularly, the cultural context presented as a specific influence on the outcome.

The theoretical frameworks which steered this study were the Self-Determination Theory (SDT) and the Rational Emotive Behavior Therapy (REBT) Theory. SDT steered the independent variable and provided the specific definition of extrinsic motivation utilized in this study. This definition provided a distinction of extrinsic motivation as not only extrinsic incentives but also external stimuli present which elicit behavior change (Ryan & Deci, 2017). REBT is the second theory which steers the dependent variable and provides perspective on clients' beliefs and how these beliefs might determine their engagement in therapy (Szentagotai & Jones, 2010). This chapter presented the review of extrinsic motivation as a determinant of engagement in psychotherapy, and established the theoretical frameworks for this study.

The third chapter presented the methodology of the study. The study was conducted at Mathari National Teaching and Referral Hospital, Nairobi Kenya. This was case study research design which allowed for deeper insights into complex situations and individual responses (Starman, 2013). The study population was a total of 200 respondents, constituting a total of 180 clients undergoing psychotherapy and 20 mental health professionals. By using proportionate sampling, a sample size of 132

respondents were selected. The sample size comprised of 119 clients and 13 psychologists. The research instruments employed in this study were a questionnaire for the patients undergoing psychotherapy and an interview guide for the professional psychologists. This form of triangulation was deemed pertinent to avoid bias and to gain a broader perspective on the study premise.

A pilot study was conducted with 11 respondents at Diamonds Refined Recovery Center in Kiambu County. The reliability of the study was assessed using the Cronbach Alpha Coefficient, which yielded a correlation coefficient of 0.86. Validity was ensured through expert feedback from supervisors at Chuka University. The data collection procedure involved obtaining all the necessary permits for ethical clearance before conducting the study. Data was analyzed using the Statistical Package for Social Science (SPSS) version 27 for the questionnaire whereas the interview guide was analyzed using thematic analysis. Ethical considerations were thoroughly addressed, including ensuring informed consent, and confidentiality in order to gather comprehensive data.

The fourth chapter presented the results and discussion on the three key determinants of client engagement in psychotherapy in this study: coercion, social stigma, and psycho-education. The responses were divided into those of the clients who participated in the questionnaire and the psychotherapists who answered the interview guide. The questionnaire responses were illustrated by tables which utilized in frequencies and percentages. The interview guide responses were provided through a comprehensive thematic analysis.

In regards to coercion as a determinant of engagement in psychotherapy, it was determined that coercion is an overall negative determinant on engagement among clients. This was in alignment with the studies reviewed in chapter two. Social stigma was determined as a negative determinant of engagement in psychotherapy, a fact which showed an overall theme against stigmatizing attitudes towards the mentally ill. Finally, psycho-education was determined as an overall positive determinant of engagement in psychotherapy. Psycho-education was deemed instrumental in

demystifying mental illness and providing clients with an understanding of their conditions.

5.2 Conclusion

From the view of clients, coercion emerged as a nuanced determinant of engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital with responses deviating towards it being a predominantly negative determinant of engagement. As per the responses from mental health professionals, coercion was a negative determinant of engagement in psychotherapy. Although the general theme was that coercion negatively determined client engagement, there was a notable understanding that it was of some benefits to some clients. These responses could have been influenced by the age of clients who were predominantly under 18 years of age. Data from a more diversified or older age group could have presented a different perspective. Furthermore, although coercion was viewed as a possible positive determinant of engagement, the lack of autonomy created an overall negative theme on the ethics and efficacy of this practice.

Responses on social stigma presented it as a negative determinant of engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital with clients depicting it as a deterrence to attendance and active participation. Therapists noted that stigma is particularly present in the Kenyan mental health context and can be damaging to clients on a mental and emotional level. Both clients and psychotherapists were in consensus on social stigma as a negative determinant of engagement in psychotherapy. Although there was some admission that stigma could bolster engagement, this was from the point of trying to eradicate unwanted symptoms. In this case social stigma boosts a negative comprehension of mental conditions which could lead to resentment for psychotherapy overtime.

Lastly, psycho-education was viewed as an overall positive determinant of engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital. This viewpoint was echoed by clients as well as psychologists but there was a slight caution by mental health low mental health literacy may deter the positive effects of psycho-education and that it can reduce autonomy in a setting where clients should be doing the most disclosure. This was allied by findings from

clients who held a negative perception towards the association between understanding their diagnosis and engagement in psychotherapy. The findings of this study portray a need for personalized and culturally approaches in psychotherapy which are individualized to meet the proclivities of clients. In general coercion is an overall negative determinant of engagement in psychotherapy, social stigma is an overall negative determinant of engagement in psychotherapy while psycho-education is an overall positive determinant of engagement in psychotherapy among clients in Mathari National Teaching and Referral Hospital.

5.3 Recommendations

The following were the recommendations derived from this study which when implemented can foster more efficacious and inclusive therapeutic environments:

i. Policy makers in the Kenyan Board of Mental Health can develop policies which minimize practices such as coercion and social stigma while encouraging more collaborative, transparent and open sessions in order to enhance a strong therapeutic alliance.
ii. Therapists can develop individualized therapy plans that consider each client's unique needs and background as a means to foster engagement in therapy. Mental health professionals can also provide interactive psycho-education practices, to promote participation, based on client backgrounds and needs in order to enhance relevance.
iii. Caregivers can promote autonomy regardless of the presence of any extrinsic motivation in order to bolster client engagement in psychotherapy.
iv. Clients can be empowered to advocate for their individualized and specific therapeutic needs in order to promote a working alliance with mental health professionals.

5.4 Suggestions for further studies

For further studies, this study proposed the following:

i. A qualitative analysis to further elaborate on the viewpoints of clients on how extrinsic motivators determines engagement in psychotherapy.
ii. Conduct a nationwide study which also has the perspective of guardians and staff as a focus group to get a more in-depth analysis on the variables.

iii. A study on various mental health facilities on extrinsic motivation as a determinant of engagement in psychotherapy to gain a broader perspective on the interactions between the study variables.

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APPENDICES

APPENDIX I : LETTER OF INTRODUCTION

Dear Sir/Madam,

RE: LETTER OF INTRODUCTION

I am writing this letter to inform you of a study which you have the option to participate in. The purpose of this study is to examine **"Selected Extrinsic Motivation Factors as determinants of engagement in psychotherapy among clients"**. The study objective is to comprehend this topic in psychotherapeutic contexts so as to promote a positive therapeutic environment for clients. By answering this question, therapists can be equipped with valuable insights which can promote evidence-based practices to promote engagement in psychotherapy among clients.

Participation in this study involves asking questions in regards to factors determining engagement in therapy and information on this topic will be gathered through questionnaires and interview guides. It is important to emphasize that the choice to participate in this study is completely voluntary. Confidentiality will be maintained in the entire research process and you have the option to decide to participate or not. Furthermore, any participant is allowed to leave or withdraw from the study at any point without consequence. Just as well, you can answer the research instruments at your discretion and are not obliged to answer all questions presented to you. Your contribution will be greatly appreciated.

Kind Regards,

Meek Lio

APPENDIX II : QUESTIONNAIRE

INFORMED CONSENT ON PARTICIPATING IN THE STUDY: SELECTED EXTRINSIC MOTIVATION FACTORS AS DETERMINANTS OF ENGAGEMENT IN PSYCHOTHERAPY AMONG CLIENTS

PURPOSE OF THE STUDY

I am writing to inform you about a study you may participate in. The study examines "Selected Extrinsic Motivation Factors as Determinants of Engagement in Psychotherapy among Clients." Its goal is to understand how external stimuli or incentives affects participation in therapy so as to encourage positive therapeutic environments.

STUDY PROCEDURE

Participation involves answering questions about factors that affect therapy engagement through questionnaires and this should not take longer than 10 to 20 minutes

RISKS

There are no foreseeable risks for participating in this study however the topic may be sensitive to some participants. There is assurance that all information gathered will be confidential and as a participant you can withdraw at any point from the study

BENEFITS

The insights gained will help therapists use evidence-based practices to improve client engagement. Just as well, clients may be able to gain better access to conducive environments that encourages active participation in therapy.

PARTICIPATION

Your participation in this study is voluntary. It is up to you to decide whether or not to take part in this study. If you decide to take part in this study, you will be asked to sign the consent section below. Your contribution will be greatly appreciated.

CONSENT

I have read and I understand the provided information and have had the opportunity to ask questions. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I voluntarily agree to take part in this study.

Participant's signature _____ Date _____

Section A:

Demographic Information:

1. Age:
    a) Under 18
    b) 18-24
    c) 25-34
    d) 35-44
    e) 45-54
    f) 55 and over
2. Gender:
    a) Male
    b) Female
3. Level of Education:
    a) High School Graduate
    b) Bachelor's Degree
    c) Post graduate Degree
    d) Other
    e) Prefer not to say
4. Employment Status:
    a) Employed
    b) Unemployed
    c) Retired
    d) Other
    e) Prefer not to say
5. Marital Status:
    a) Single
    b) Married
    c) Divorced
    d) Widowed
    e) Other
    f) Prefer not to say
6. Religious Affiliation:
    a)Christian
    b)Muslim
    c) Other

d) Prefer not to say

SECTION B: Coercion as a Determinant of Engagement in psychotherapy

For the following statements, please tick (√) the category that corresponds with your view using the scale below:

VN: Very Negatively, **N:** Negatively, **U:** Undecided, **P:** Positively **VP:** Very Positively

	Statement	**VN**	**N**	**U**	**P**	**VP**
7.	How does being pressured to attend psychotherapy sessions determine my attendance in therapy?					
8.	How does being required to go to therapy determine my active participation in therapy activities?					
9.	How do social pressures to comply in therapy determine my relationship with my therapist?					
10.	How does outside influence on my decisions during therapy determine my completion of assigned therapeutic tasks?					
11.	How does being required to participate in therapy sessions determine my openness in therapy?					
12.	How do I view forced therapy in regards to promoting engagement in therapy?					
13.	If I understood that being required to go to therapy was necessary for me to attend therapy, how would it determine my engagement?					

SECTION C: Social Stigma as a Determinant of Engagement in psychotherapy

For the following statements, please tick (√) the category that corresponds with your view using the scale below:

VN: Very Negatively, **N:** Negatively, **U:** Undecided, **P:** Positively **VP:** Very Positively

	Statement	**VN**	**N**	**U**	**P**	**VP**
14.	How do negative comments about my condition determine my attendance in therapy?					
15.	How does using shame as a reason for seeking therapy determine my participation in therapy?					
16.	How does social rejection due to my condition determine my relationship with my therapist?					

17.	How does discrimination based on my diagnosis determine my completion of assigned therapeutic tasks?					
19.	How does prejudice against my mental condition determine my openness in therapy?					
20.	How do I view social stigma in regards to promoting engagement in therapy?					
21.	If I understood that using shame, social stigma or rejection was necessary for me to go to therapy, how would it determine my engagement?					

SECTION D: Psycho-education as a Determinant of Engagement in psychotherapy

For the following statements, please tick (√) the category that corresponds with your view using the scale below:

VN: Very Negatively, **N:** Negatively, **U:** Undecided, **P:** Positively **VP:** Very Positively

	Statement	**VN**	**N**	**U**	**P**	**VP**
22.	How does getting education about my diagnosis determine my attendance in therapy?					
23.	How does homework on the importance of therapy determine my participation in therapy?					
24.	How does receiving education about my diagnosis in therapy determine my relationship with my therapist?					
25.	How does getting educated about therapy determine my completion of therapy homework?					
26.	How does understanding my diagnosis determine my openness in therapy?					
27.	How do I view psycho-education in regards to promoting engagement in therapy?					
28.	If I understood that getting educated about my mental diagnosis was necessary for me to go to therapy, how would it determine my engagement?					

APPENDIX III: INTERVIEW GUIDE
Section A: Demographic Information:

1. Age:
    a)18-24
    b)25-34
    c)35-44
    d)45-54
    e) 55 and over

2. Gender:
    a) Male
    b) Female

3.Level of Education:
    a) Bachelor's Degree
    b) Graduate Degree
    c) Doctorate Degree

4. Employment Status:
    a) Counseling Psychologist
    b) Clinical Psychologist
    c) Director
    d) Other

5. Marital Status:
    a) Single
    b) Married
    c) Divorced
    d) Widowed
    e) Prefer not to say

6. Religious Affiliation:
    a)Christian
    b)Muslim
    c) Other
    d) Prefer not to say

7. Coercion as a Determinant of Engagement in psychotherapy:

Probes:

- Can you share instances where you've witnessed the use of coercion, such as forced institutionalization or familial pressure in therapy?
- From your professional perspective, how does the use of coercion influence client engagement in therapy activities?
- In your interactions with clients, have you observed instances when coercion was a positive or negative determinant of engagement in therapy? Please share examples of this observation
- Why do you think some clients are able to engage after being coerced while others are not able to do so?

8. Social Stigma as a Determinant of Engagement in psychotherapy

Probes:

- Drawing from your professional experiences, how have you observed social stigma, such as negative remarks, stereotypes, discrimination and prejudice in the context of mental illness and therapy? Can you provide examples of this?
- In your interactions with clients, have you witnessed instances where social stigma has been used as a means of inducing engagement in therapy? Please share specific examples to illustrate these occurrences if any.
- From your perspective, how does social stigma, contribute to or impede client engagement in therapy?
- Why do you think some clients are able to engage in therapy while being socially stigmatized while others are not able to do so?

9. Psycho-education as a Determinant of Engagement in psychotherapy Probes:

- As a therapist, have you utilized or witnessed the use of psycho-education as an intervention in therapy?
- In your experience, has psycho-education been used as a means to encourage client participation? Please share examples of these occurrences if any
- Please share how psycho-education has positively influenced or hindered engagement in therapy among clients
- Why do you think some clients are able to engage in therapy after receiving psycho-education while others are not able to do so?

APPENDIX IV: TABLE FOR DETERMINING SAMPLE SIZE

N	S	N	S	N	S
10	10	220	140	1200	291
15	14	230	144	1300	297
20	19	240	148	1400	302
25	24	250	152	1500	306
30	28	260	155	1600	310
35	32	270	159	1700	313
40	36	280	162	1800	317
45	40	290	165	1900	320
50	44	300	169	2000	322
55	48	320	175	2200	327
60	52	340	181	2400	331
65	56	360	186	2600	335
70	59	380	191	2800	338
75	63	400	196	3000	341
80	66	420	201	3500	346
85	70	440	205	4000	351
90	73	460	210	4500	354
95	76	480	214	5000	357
100	80	500	217	6000	361
110	86	550	226	7000	364
120	92	600	234	8000	367
130	97	650	241	9000	368
140	103	700	248	10000	370
150	108	750	254	15000	375
160	113	800	260	20000	377
170	118	850	265	30000	379

180	123	900	269	40000	380
190	127	960	274	50000	381
200	132	1000	278	75000	382
210	136	1100	285	100000	384

N = population; S = Sample Size

Adapted from Krejcie and Morgan (1970)

APPENDIX V: ETHICS COMMITTEE LETTER

CHUKA UNIVERSITY

Knowledge is Wealth *(Sapientia divitia est)* Akili ni Mali

OFFICE OF THE DIRECTOR
BOARD OF POSTGRADUATE STUDIES

Telephones: 020-2310512/18
Direct Line: 020-268 7625
postgraduate@chuka.ac.ke
P. O. Box 109-60400, Chuka
Website: www.chuka.ac.ke

REF: AM23/40019/19 **27th May, 2024**

Director
National Commission for Science Technology and Innovation
Off Waiyaki Way, Upper Kabete
P O Box 30623, 00100
Nairobi.

Dear Sir / Madam,

MEEK MUTHEU LIO

The above-named person is a *bona fide* student of Chuka University pursuing MA in Counselling Psychology proposal titled: **Extrinsic Motivation as a Determinant of Engagement in Psychotherapy Among Clients: A Case of Chiromo Medical Lane, Nairobi, Kenya.**

Ms. Mutheu has defended at the Faculty level and is now expected to conduct research.
Any assistance accorded will be highly appreciated.

Yours sincerely,

27 MAY 2024

Prof. Moses Muraya, Ph.D.

DIRECTOR
BOARD OF POSTGRADUATE STUDIES

APPENDIX VI: CHUKA UNIVERSITY INTRODUCTION LETTER

CHUKA UNIVERSITY

Knowledge is Wealth *(Sapientia divitia est)* Akili ni Mali

CHUKA UNIVERSITY INSTITUTIONAL ETHICS REVIEW COMMITTEE

Telephones: 020-2310512/18 **P. O. Box 109-60400, Chuka**
Direct Line: 0772894438 **Email: info@chuka.ac.ke,** **Website: www.chuka.ac.ke**

8th May, 2024

REF: CUIERC/ NACOSTI/522
TO: **Meek Mutheu Lio**

RE: Extrinsic Motivation as a Determinant of Engagement in Psychotherapy Among Clients: A Case of Chiromo Medical Lane, Nairobi, Kenya

This is to inform you that *Chuka University IERC* has reviewed and approved your above research proposal. Your application approval number is *NACOSTI/NBC/AC-0812*. The approval period is 8th May, 2024 – 8th May, 2025.

This approval is subject to compliance with the following requirements;

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

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

Yours sincerely

Dr. Benjamin Kanga
SECRETARY

APPENDIX VIII: NACOSTI PERMIT

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **849644**

Date of Issue: **21/June/2024**

RESEARCH LICENSE

This is to Certify that Miss.. MEEK MUTHEU LIO of Chuka University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nairobi on the topic: EXTRINSIC MOTIVATION AS A DETERMINANT OF ENGAGEMENT IN PSYCHOTHERAPY AMONG CLIENTS: A CASE OF MATHARI NATIONAL TEACHING AND REFERRAL HOSPITAL NAIROBI, KENYA for the period ending : 21/June/2025.

License No: **NACOSTI/P/24/36600**

849644

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

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