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# The Evolution of Mental Health Understanding and Practice in Uganda

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**ABSTRACT:** *This paper examines the milestones in the process of building interventions in mental health to alleviate human suffering in Uganda. The objectives of the paper are to trace the kind of mental health services provided in Uganda at different periods, identify the different activities that have influenced the building of the counselling industry in Uganda, analyze the challenges facing the counselling industry in Uganda, and develop coping strategies to address existing challenges in the counselling field of in the country. Initially professional mental health services were provided to people described by society as ‘mad’ persons. However, the perception has gone on changing from time to time as the need to research deeper into counselling and mental health issues arise. Counselling services that are restricted to normal persons are a recent occurrence in Uganda. It is just recently that counselling is taking on a different twist in society but with great challenges.*

**Keywords:** *Counselling, Mental health, Mental illness, Uganda*

## INTRODUCTION

Professional counseling/ mental health services refer to the interventions given by a professional mental health worker to individuals or a group of people facing adjustment /psychological/ mental health problems in order to restore effective functioning (McLeod, 2003).

Historical trends in mental health have indicated that every culture has described its people’s mental problems with its own definition to reflect its general social and logical concerns. Among these are the Greeks, the Egyptians, medieval England and the present day states. African societies likewise, have also described people suffering from psychological disorders in their own views which were closely associated with their environment and philosophy of life (Sedgwick, 1973; Nsereko, 2014).

A number of factors have shaped the prevailing attitudes, understanding of causes and treatment of mental health problems. These included: ignorance, fear, cultural contexts, superstition, religion and now science. These have caused mental health to be characterized as being either a forward or backward enterprise depending on the given moment of time (Carson, Butcher, & Mineka, 1996; Nsereko, 2014).

In Uganda the predominant understanding of the etiology and intervention in mental health was mainly rooted in the concepts of the spirit world, supernatural possession, and the role of the living dead, witchcraft and divination and traditional medicine. The traditional healers, time immemorial were considered as the vanguard, experts in illnesses and their treatment. They played an important role in the treatment of mental health illnesses (Abbo et al., 2009).

They claimed different sources of ability to recognize health issues ranging from spirit possession, experiences and heredity (Ovuga, Boardman, & Oluka, 1999). They could however recognize mental illness by very cogent behaviours exhibited by the patients. These included: “bizarre content of speech, picking and hoarding rubbish, running away or being restless, removing clothes, a suspicious attitude, having an unkempt appearance or being withdrawn, having red, unsteady or glittering eyes, a frightened look and other strange actions or behaviours” p.277.

By and large, the availability and accessibility to mental health services in Uganda have been confined to the traditional conventional approach (Achieng, 2006). This practice involved the participation of elders, the wise person, parents, friends and the extended family system in providing the services. It was only when a family member’s mental illness had reached a critical level that a traditional healer’s services were sought to intervene in the ailment or other trusted outsiders were consulted. The stigma associated with mental illness played a role in keeping issues of mental disturbances within the family circles.

As society advanced in medicine and technology, modern means of interventions and understanding of mental health issues were added to the existing structures of dealing with people with adjustment and mental health problems (Nsereko, 2014).

## Professional Intervention in Mental Illness in Uganda: A Historical Perspective

Professional mental health services started with the creation of institutionalized infrastructure in Uganda way back in the 1920’s. The promulgation of the different Ordinances and Acts e.g. the Mental Treatment Ordinance of 1938 and the Mental Treatment Act of 1964 added a vibrant input in giving a steady leap into modern mental health practice.

The first mental health services were started in Hoima prison about 320 km from the capital city in the 1920’s. But as the number of mental health patients grew, coupled with insufficient facilities within the prison, humanitarian concerns about the deplorable conditions rose from the general public. Eventually a mental health ward at Old Mulago hospital a suburb of Kampala was constructed. It was opened between, 1934-36 to receive the influx of mental health patients from Hoima prison. In 1940, the remaining batch of patients in Hoima was transferred to Mulago in the legendary mental health ward 16.

In 1955 a mental health hospital, located at Butabika on the shores of Lake Victoria, was started as a mental asylum for psychotic patients and serving the whole of East and Central Africa. It catered for both civil and forensic cases. The latter were criminal psychotics who could not be contained by just the prison services. The location at Butabika Hospital was considered because it was more spacious than Mulago hospital where patients would often be a nuisance to passers-by in the densely populated Mulago city suburb.

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In the early years of provision of professional mental health services, expatriate psychiatric workers manned the mental health facilities right from Hoima, Mulago and Butabika hospitals. The first indigenous mental health workers learnt on the job as far back as 1956. Some were sent abroad for specialized training in psychiatry. Notable among the indigenous psychiatrists included Professor Bbosa, Dr. Kitumba, Dr. Muhangi, Dr. Fred Kigozi, Prof. Seggane Musisi etc.

In the early 1960's a Nursing Training School was opened at Butabika hospital to train enrolled mental health nurses. In the subsequent years more advanced courses were included in the training program. The Medical School, at Mulago Hospital, also began a course in psychiatry.

The mental health personnel were trained to handle what the general public commonly referred to as the "mad people" who had been confined to mental asylums. Mental health services have since then been synonymously associated with the mad person (Annual Report, 2008).

The main stay approach in the provision of mental health services in Uganda since the inception of the modern mental health infrastructure has been at the tertiary level of intervention and it is primarily reactive and not proactive. This can be deduced from the philosophy underlying the budgeting and the perceived core challenges facing a 'rehabilitated and remodeled new Butabika mental health referral Hospital' (Annual Report, 2008). For instance, drugs and medical sundries, and patients' welfare constituted 42% and 33% respectively of the main referral hospital budget. The core challenges mentioned in the report included: (1) Inadequate nursing coverage on wards/units. (2) Too many patients. (3) Inadequate materials, supplies and equipment to the user units. (4) Inadequate computer and internet services to wards/units.

The usual practice of invention is that the mental health patients are brought to the hospital, mainly suffering from bipolar affective disorders, epilepsy and schizophrenia (Annual Report, 2008). They are received, assessed and case management follows. The most common initial management is the use of biochemical intervention to 'cool' down the patient who quite often had depicted violent behaviours. Other methods like occupational therapy, counselling have been recently introduced in the treatment modality and applied at a later stage depending on the condition of the patient.

However it is still a daunting task to think and offer mental health services outside this medical model regardless of any given group of people experiencing mental health difficulties in the different life settings in Uganda. Currently it is the medical model which is at the helm of mental health service provision in the country despite a persistent remarkable deficit of providers for mental health disorders service delivery (Collins, Musisi, Frehywot & Patel, 2015).

All the mental health patients from all over the country have been mainly referred to for psychiatric intervention in Mulago and Butabika mental health facilities. It is just recently that a mental health policy has been considered to have a psychiatric ward at regional referral hospitals and the opening of out-reach clinics for training community mental health workers and for continued supervision of the patients under treatment (Kigozi et al., 2011).

## **Counselling Services in Institutions of Learning in Uganda**

A study by German and Arya (1969) indicated prevalence of psychiatric morbidity among Makerere University students. The findings indicated 10.8% were deemed to be suffering from a psychiatric illness for both male and female students. However, for the male students alone it was 11.5% a figure comparable to figures from British Universities. Bennet (1967) quoted in German and

Arya (1969) had drawn attention to the likely factors causing stress among undergraduate students at Makerere University. Nevertheless there was no available literature to show any attempt to introduce a counselling program and such services in the university by that time.

The most available documented 'counselling services' in Uganda were about career guidance. These service were started in 1965 under the Ministry of Education. Those who were working as career personnel obtained the skills from seminars organized by the Ministry of education and not from a university program for training career guidance counsellors.

Ejulun, E. in her paper to the school participants in a seminar on Careers and Guidance organized by the Ministry of Education in 1973 made the following remarks. "That there is lack of a sufficient number of trained personnel [guidance counselors] and funds to carry out these services [in schools]" (Ministry of Education, 1973). She continued to note that teachers and administrators in schools had to stand in for guidance counselors because of the lack of enough trained counselors to carry out the counseling duties (Nsereko, 2012).

The Ministry of Education organized materials for use in career guidance. In his speech, the Permanent Secretary in the Ministry of Education, Mr. A.B. Adimola, while opening the "Careers and Guidance Seminar" in 1973 said:

*"I notice from previous records that many of you have been interested in career guidance for quite a long time. You have been attending meetings like this one to gain the basic tools and ideas on how to go about guiding the young people in your care since 1965"* (Ministry of Education, 1973).

To date the Ministry of Education and Sports has a Department of Guidance and Counselling at the headquarters. The Department is the voice for the promotion of counselling services in schools. It has recently launched a guidance and counseling journal to disseminate information about its activities and other useful guidance information. In its current operations, it sends career information to schools and it carries out placement services for students entering tertiary and university education (Nsereko, 2012).

The Department may have to take cognizance of the fact that practically in all the schools in Uganda there are no assigned/appointed guidance counsellors. This creates an uphill task for the department to oversee the execution of counselling services in schools without the rightful resource persons available. Notwithstanding, however, the Kajubi Education Review Commission of 1987, among other things, recommended the establishment of guidance services in all schools.

## **Volunteers in Counseling Services**

Although Makerere was the only university in Uganda by 1987, it did not have a counselling program to train counselors and to avail counselling services to its community. It was only later that a guidance and counselling clinic was attached to the university sick bay.

In the early 1970's, Rev. Fr. Peter C. Matovu, Mrs. Abzaid a psychiatric nurse, Mr. Kyeyune and Mr. Sengendo, with a specialty in community development; started a privately run program named Volunteer Counselling Services. It trained counsellor volunteers who had graduated in Social Works and Social Administration, plus other interested individuals at the university sick bay. This program did not turn them into professional counselors. Instead, the trainees would give counselling services to their communities as para-professionals.

By 1978, when the precursors of the program dispersed, the Volunteers Counselling Services died a natural death. And there was no empirical evidence that the graduates of the program went any further to offer formal counselling services or pursue training programs in the field.

## Counseling Programs at University Level

Makerere University started a formal training for guidance counsellors in 1994 at Masters' degree level with the purpose of creating resource people for schools. Those who were recruited for the program were teachers in secondary schools. The program was scrapped shortly afterwards in favour of the clinical psychology program.

With the opening of private universities from 1988, the guidance and counselling program was started to be taught in some public and private universities. Among these universities included, Kyambogo University, Nkumba University, Mbarara University of Science and Technology etc. Other post-secondary institutions have since then started training programs in counselling.

## Need for Counseling Services

Counselling services or mental health intervention are highly needed in Uganda. Research has indicated a rise and severity in non-communicable diseases, such as mental, neurological, and substance use (MNS) disorders which have resulted in premature mortality and disability globally and a general compromised mental health status among the general public (Kasoro et al., 2002; Collins, Musisi, Frehywot & Patel, 2015). A study on University students in Uganda indicated that 37% had psychosocial problems and while at the same time they were significantly related to the development of psychopathology (Nsereko, Musisi, Nakigudde & Ssekiwu, 2014).

A number of factors have exacerbated the ongoing states of mental illness. For the general population, the stressful prevailing political environment, stressful war experiences and childhood adversities (Okello et al., 2014), unhealthy life styles, HIV/AIDS, social and economic hardships the people grapple with on a daily basis take centre stage.

Working with students, one often listens to the torment they experience, which often ends at the very least, in intensified and compounded mental health problems. It is not uncommon to hear their experiences touching issues around poverty, prejudice, divorce and separation, abuse of all kinds, examination and parental pressure on the student, and addiction which all contribute to their mental health problems. And besides, other sources like the records from the disciplinary committees in schools document incidents depicting how students may be suffering from a mental health problem at any one time.

Research done by Nsereko (1997) indicated that depression was a phenomenon among senior secondary students in Uganda. And there was a significant relationship between depression and a student's motivation, affiliation and life events. Also Nalugya-Sserunjogi, Rukundo, Ovuga, Kiwuwa, Musisi and Nakimuli-Mpungu (2016) found significant depression symptoms prevalent in adolescent students in four secondary schools in Mukono district, Uganda. Yet recent research on university students has shown that emotional problems, academic problems, traumatic experiences and antisocial behavior have been identified as being among the leading predictors of university students' psychopathology (Nsereko, Musisi, Nakigudde & Holtzman, 2014).

The question is, do we have adequate counseling/mental health infrastructure to meet the growing cases of mental health challenges in society?

## Encouraging Signs for the Profession of Counseling

Counselling as a course has gained a lot of enthusiasm among counselor trainees and in training institutions. In almost every post-secondary institution of learning there is a program of guidance and

counselling being taught. Some institutions boast about hundreds of students recruited for the program. On a daily basis, adverts about counselling services run on radios calling for clients. In some other areas adverts about short courses in guidance and counselling are all over the place.

## CHALLENGES IN THE COUNSELLING PROFESSION IN UGANDA

### *Counselling At Its Infancy*

Uganda could be counted as one of the countries which has just recently opened up training opportunities for counsellors. Apart from the counsellors who had received training from abroad, the locally trained counselors are still young in the profession and they are a product of institutions that are just opening up to the realities and demands of training a counsellor. So counselling in Uganda that offers services to normal and functioning people is yet to develop in terms of personnel, experience, infrastructure, policy, professionalism and research.

### *Mental Health Literacy*

Mental health literacy which refers to

*“Knowledge and beliefs about mental disorders that aid their recognition, management or prevention. It also includes the ability to recognize specific disorders, known risk factors and causes, know self-treatments and available professional help, and it is an attitude that promotes recognition and appropriate help-seeking”* (Jorm, 2000) is still low among the general public as depicted by the following observations.

The phenomenon of HIV and AIDS has been a major factor for the public awareness about counselling in Uganda for worse or for better. Achieng (2006) observed that counselling had gained prominence with the onset of HIV/AIDS in Uganda in the early 1990's. However, she also noted that some people still thought that only people with HIV/AIDS needed counselling services and that is why they resisted going for them in spite of their apparent counselling needs.

From the author's experience, there is a growing myth in schools, families etc. of associating counselling services with people with disruptive behaviors. Administrators, teachers, students are caught in this unfortunate inference when they tell whoever is misbehaving that he/ she needed to be sent to a counselor. Such a scenario only compounds the problem making those who needed the services for other concerns inhibitive least they were seen as having behavioral problems.

It is therefore crucial to increase the public's knowledge about mental health and mental diseases since it is a prerequisite for early recognition and intervention in mental disorders.

### *Quality of Trainees*

The quality of counsellor trainees leaves a lot to be desired. Some are recruited without demonstrated aptitude, ability, interest, value and personality requirements for this profession. Counseling should be equated in recruitment requirements to the medical profession (Fuster, 1998). Medicine is largely to do with the physical health of an individual and conversely counselling to the mental health and adjustment problems.

### *Quack Practitioners*

There are very many “counsellors” in the field offering counselling services without proper credentials and demanding hefty fees. There are some who have had a brief training for 6 months from whoever announces a counselling program. Unfortunately

counselling services training and intervention are being compromised for monetary aspects diverting away from a service- oriented drive for the most vulnerable members of society.

## **Regulation of Services**

In order for the counselling services to reflect professionalism in Uganda, the services ought to be regulated by any regulatory scheme whether on a voluntary basis by professional organizations or on statutory basis by an Act of Parliament. It is not very clear which scheme has taken full responsibility of counselling in Uganda. What is clear is that The Uganda Counselling Association which ought to be a professional organization is not yet a regulatory body to ensure professional development of counselling. So far it is the National Council of Higher Education (NCHE) which regulates one aspect of professionalism. It is concerned with accrediting the counselling courses taught at universities and other training institutions.

The gap still abounds in the development of counselling to a professional level in Uganda because certain features are yet to be identified in the profession. These include as observed by Bond and Baron (1998).

- Accreditation of counsellors to affirm that they have reached a minimum requirement of training and experience,
- Accreditation of counselling courses to affirm that they are able to satisfy the training requirements to be an accredited counsellor,
- Registration to identify adequately qualified counsellors who may be listed with the list freely available to members of the public and other professions,
- Licensing as being currently authorized to work as a professional counselor.

## **Generic Approaches to Counselling Training**

Uganda faces the challenge of ensuring adequate counsellor education training. There are a number of challenges in the training curriculum of the training institutions. The majority of the available programs in universities are tailored around the western curriculum. There is a need to develop programs to train our own counsellors based on the needs of our country and our people.

Another notable issue in the training, is the teaching methodology factor. Counsellor trainees undertake their course at various levels of the institutions. Some attend, certificate, diploma and degree and post graduate awarding institutions. The common approach is the generic style approach in the training which has its own flaws in the preparation of competence required in the field of counselling.

The generic approach is generalist in comparison to specialization commonly and generally followed in Western countries. The generic approach tackles almost all areas of specialty in counselling in a little time. This results in giving bits and pieces of knowledge to a trainee which is not adequate enough to address a client with a specific problem.

For instance a student on a counselling degree program in Uganda, (e.g. Bachelor of Arts) must offer thirty six course units before graduation (regulatory demand by the National Council of Higher Education). In the arrangement to meet the requirement, the local training institution organizes course units to reflect the teaching material appropriate to the counselling field. This may include in one semester of approximately 24 weeks covering six course units, for example marriage and family counseling, grief counselling, child and adolescent counseling, stress and trauma counseling, substance abuse counseling and school counseling.

All these aspects of training constitute specialty which need to take more time to study and research in order to gain adequate competence to help any client with a problem in any of these areas. Really how prepared is a trainee to handle a problem e.g. of school in nature or marriage with a training of just three months? Counsellors trained in western countries specialize exclusively under a specialist in any of the areas mentioned above for at least two years and complemented by research project and internship training in the area of study. The implication in practice is that counselors will attend to clients whose needs fall within the counselor's competence. And it is an ethical obligation for counselor not to claim competence they do not have.

## **Supervision of Interns and Practicing Counsellors**

Another equally challenging aspect of development to professionalism in counselling is the supervision and opportunities available at internship sites. It could be a horrible and less wholesome experience at some internship sites. Quite often the trainees choose sites with very little relevancy to the duties assigned in regard to counseling practice and skills. Some do their internship as a come-in to a records attendant on leave. Others are assigned activities of being in charge of a site ambulance transporting critically ill patients to referral hospitals!

Anecdotal evidences shows that the site supervisors and the training institutions' supervisors do not have any competence in supervision of counseling practice, theory and skills. And due to logistical problems they fail even to check on their supervisees. Successful completion of internship is gauged from the responsiveness of the trainee to those who 'put an eye on him/her'. Really this exercise is far from the requirements of counseling supervision.

The practicing counsellors from day one operate without supervisors. It is not publically known whether registered members with the Uganda Counseling Association have qualified supervisors or whether the Association resources from other areas to meet the mandatory ethical requirement of licensed, accredited counsellors to practice under supervision. Really how would you guarantee that they are practicing ethically and legally/ and to know as whether they are practicing from the professional trade-offs (application of the counselling theories in conceptualizing and determining the right treatment plan in the session).

Without application or referring to a counselling theory in practice is tantamount to a medical worker operating without a microscope. It is also tantamount to practicing witchcraft in counseling. Cottone (2007) actually puts his weight behind the importance of application of theories by counselors in similar emphasis. He argues:

*"A theory raises the level of discourse to that of a meta-theoretical analysis. Counsellors can make judgments about their approaches in a way that allows for assessment not only on utility (the approach appears or has been shown to be useful), but on philosophical coherence. Counselling practiced outside of philosophy is not counselling practice. Anyone can pretend to know what he or she is doing in advising others, but implicit in professionalism is an intellectual attitude-an attitude that communicates to clients that the professional is educated and analyzes problems beyond commonplace distinctions" (p.10).*

## **Taking The Bull By The Horns: The Way Forward**

There is a need to make counselling professional and offer evidence based services to at risk populations in Uganda. The Uganda Counselling Association or any program regulatory body and others must come in to arrest the situation before it gets out of control.

## **Intervention in Schools**

Given the mental health vulnerability incidents among the student population (Nsereko, Musisi, Nakigudde & Holtzman, 2014; Nsereko, 1997) and the paucity of available interventions, there is an urgent need to address the rights of students' mental health. This is contained in the national health policy of the country.

In pursuance of the policy, the Uganda Counselling Association should be involved in lobbying policy makers to make counselling a reality in all schools so that the most vulnerable members of society-the children are availed the services.

Schools should be asked to place mental health and emotional well-being of their members at their core concern. Good schools should have effective special educational needs provision whose influence permeates all aspects of school life. Counselling intervention in schools should be a priority area in the country's modernization efforts of all sectors of society. The future of the country is at stake if the mental health situation in schools is just left to take its course without appropriate interventions. Every school with a population of not more than 350 students should have at least one qualified counselor besides other service team personnel like psychologist, social worker, psychiatrist nurse.

Evidence based interventions for the mental health, social, personal, career and educational needs of students must be encouraged. This calls for the development of assessment instruments and interventions which are culturally sensitive (Nalugya-Sserunjogi et al., 2016) and to inform our research and practices on existing theories like the University student psychosocial problems development theory (USPPDT) (Nsereko & Musisi, 2014). This is a big challenge in service delivery and in the research agenda of most renowned researchers in mental health in Uganda. The few existing assessment tools, like the University Student Evaluation of Psychosocial Problems (USEPP) (Nsereko, Musisi, & Holtzman, 2014; Nsereko, 2015) ought to be a handy tool for counsellors working with students, the university establishment, counsellor training institutions let alone the government medical, and education ministries. This instrument has sound psychometric properties and it has been empirically tested to assess students' psychosocial mental status by looking at their emotional, traumatic experiences, academic problems and antisocial behaviour (Nsereko, Musisi & Holtzman, 2014; Nsereko, 2015).

## **Training Programs**

There are still very few trained and qualified human resource let alone the appropriate infrastructure needed in the training of counsellors. For most institutions counselling is taught like any other liberal arts without putting into consideration the numbers of trainees per trainer, qualified counsellor trainers or the availability of equipment, placement sites, and qualified supervisors. In the short and long run many students will get certificates but they will be poorly trained and may not be effective and competent counsellors.

The Uganda Counselling Association must coordinate and monitor the training programs offered in the institutions that train counsellors. The basic areas in the body of knowledge in counselling must be seen to be included on the training program. Prospective counsellor trainees must fulfill the recruitment requirements for the course.

## **Titles and Qualifications**

There is a lot to be desired in designing our training programs and to determine what constitutes competence to practice. I would suggest that at graduate level a counselor trainee should acquire specialty in a given area of counselling because there are clients who need such competence and services.

The title counsellor or any other should be designated only to a trainee who has undergone both generic training and a specialty in counseling. Those who may not have had such grounding in the field of counseling they ought to be referred to as counselor paraprofessionals. This title would imply that they have acquired some basics of general counseling and can offer basic help as they organize for a referral to more competent personnel.

## **Practical Necessities**

The Uganda Counselling Association has to make aggressive drives towards counselling services awareness among the general public because the public has a scanty and sometimes an incomplete picture about counselling. It must expedite the efforts to disseminate the code of ethics to the public. All practicing counsellors should be licensed and accredited to ensure compliance with the code. There must be supervision of the counselling activities carried out in the country.

The Association must venture into a drive to address the human rights issues in the country. Without addressing these issues vulnerability to mental health problems will be on the increase in society. In fact it should make human rights and counselling an obligatory study unit in the training institutions.

Given the fact the Uganda Counselling Association has an NGO status, other counselling professionals ought to come up and start other related counselling professional associations to mitigate in the demand to professionalize counselling services in Uganda.

## **Team Work**

The regulatory body on counseling education, training and practice should incorporate on their team experienced counselor trainers. This may help to give some technical advice on basic minimum generic body of knowledge to counselling training programs and the validity of course units that are reminiscent on many training programs in the country.

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