

# Psychotherapeutic Practice Experience In Yaba Psychiatric Hospital, Lagos

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## Abstract

Review of previous studies shows that psychotherapy helps people make positive changes in their lives. In psychotherapy, psychological principle and scientifically validated procedures help people develop healthier, more effective habits and positive coping skills. In Yaba, referral for psychotherapy ranges from 50-60 clients, for both in and out clients, in the hospital per week. Clinical experiences validate previous scientific reports of psychotherapeutic efficacy in managing behaviour disorders. Hospital based psychotherapy is a collaborative management that builds on the relationship between client(s) and the therapist and it provides a supportive environment for both the therapist and the clients. There are different approaches to psychotherapy, in the hospital, with different and unique theoretical perspectives. Each theoretical perspective acts as a roadmap to help the therapist understand their clients, their problems and develop solutions. It could also take various forms, including individual, family, marital and group. This paper is an attempt to present the psychotherapeutic approaches and practice experiences in Yaba Psychiatric Hospital. Sharing our experiences with other professional colleagues will not only serve as scientific information that have the potential for practice adjustment to professional colleagues in other centres but may also provide some ingredients of improvement to our centre's clinical practice. This paper is an attempt to present the psychotherapeutic approaches and practice experiences in Yaba Psychiatric Hospital. Sharing our experiences with other professional colleagues will not only serve as scientific information that has the potential for practice adjustment to professional colleagues in other centres, but may also provide some ingredients of improvement to our centre's clinical practice.

**Key words:** Psychotherapy, Hospital, Federal Neuropsychiatric Hospital, Yaba, Psychotherapeutic Practice

## Psychotherapy in Hospitals: Yaba Experience

Psychotherapy in hospitals has been linked to the onset of the application of hospital psychology which started as far back as the late 19<sup>th</sup> century in Massachusetts, United

States. This was established at the McLean Hospital by a team of mental health professionals which included a psychologist (Ismael, 2007). Generally, psychotherapy in hospitals associated with the diverse forms of interaction between the therapists,

clients/patients and their relatives with an aim to support and manage the various problems presented by clients/patients who are in dire need of resolution to these problems. Several studies have discovered that psychotherapy has been found to be effective in the improvement of symptom relief among the variety of mental illnesses (Janssen, 2015; Tasca, Sylvestre, Balfour, Chyurlia, Evans, Fortin-Langelier, et. al., 2014). This versatile function popularized psychotherapy as a treatment in hospitals.

Psychotherapy has been utilized in the area of institutional care especially mental health facilities where an individualized treatment plan is executed, after a team of mental health professionals which includes the psychologist holistically review all the factors which has mutually or exclusively precipitated or is maintaining the mental condition of the client/patient. At the centre of every session of psychotherapy in the hospitals, there is a caring, empathetic and understanding relationship between the psychotherapist and his/her client/patient; the theoretical perspective of the therapist and the trending psychological research that can effectively manage the presenting complaints (Alberti, Nicolau & Moretto, 2016).

Due to the encouragement of clients/patients to ensure transference occurs naturally in a mental health or psychiatric facility's outpatient setting, the significance of having a one-on-one interaction cannot be understated. However, in the inpatient setting, as a result of the multidisciplinary approach, the patients encounter different styles of management but the most commonly adopted mode is the one-on-one relationship (Janssen, 2015; Alberti, et. al., 2016).

In hospitals, psychotherapy has been found not just to be helpful to clients/patients who have difficulties in dealing with their everyday functioning; but

it has been found to be effective in managing burden of care in family members and caregivers (Alberti, et. al., 2016). Psychotherapeutic treatments were developed to help couples, families or groups to improve on existing dysfunctional patterns of relationships with the mentally ill client/patient, and induce less stress and anxiety.

A review of previous studies has shown that psychotherapy as an intervention for mental illness and emotional distress helps people make positive changes in their lives (Hunsley, Elliot & Therrien, 2013; American Psychological Association, 2013). The APA (2013) posited that psychotherapies were established to focus on a wide range of interventions for mental and medical conditions using diverse psychological principles and scientifically validated procedures and techniques to help in the development of healthier, more adaptive habits and positive coping skills. Given the range of procedures and techniques that are intricate in conducting psychotherapy in hospitals; attaining an accurate definition of psychotherapy is complex. The importance the diverse schools of thought on psychotherapy placed on specific additives determines the differences in application.

Nonetheless, psychotherapy can cautiously be defined as an interpersonal, relational intervention by trained psychotherapists to patients who help them increase their sense of well-being and reduce discomfort/distress. It can also be specified as a technique an expertly trained personnel in the psychotherapeutic specialty handles the psychological issues experienced by an individual, be it male or female through communication (Herkov, 2016). Parekh (2016) indicated that it is an intervention that deals with a broad range of mental illnesses and emotional disturbances; eliminates or controls the distressing

symptoms to enhance the daily functioning and quality of life of the distressed individual. The mental illnesses and emotional disturbances could include major depression, bipolar affective disorder, schizophrenia, phobias and anxiety disorders e.t.c.

Although, majority of the psychotherapies centers on the communication between the psychotherapist and the client/patient, there are intricacies involved in administering psychotherapy. The relationship between the expert and client/patient is a professional affiliation grounded on therapeutic techniques, principles and structure (Gurman & Messer, 1995). The range of techniques is based on relationship building, communication and behaviour change designed to improve the mental state of individual client/patient or group (APA, 2016). According to Nevid (2007), in psychotherapy, there are four features which are of utmost importance. These include:

- Systematic interaction: this involves the structured interaction between the therapist and his/her client/patient in a way that reflects the therapist's theoretical school of thought.
- Psychological principles: In the practice of a psychotherapist, s/he must utilize psychological theories, principles, research
- Thoughts, feelings, behaviours: The three domains (cognitive, emotional and behavioural) that may be affected are the focus of psychotherapists. Psychotherapy aids the client/patient to ameliorate the psychological distress that arises from the malfunctioning of the domains to achieve a more satisfactory everyday functioning.
- Maladaptive behavior, problem solving, and personal growth: Psychotherapy handles the

management of three categories of problems that clients/patients face. These include, abnormal or maladaptive behavioural problems manifested in schizophrenia, anxiety disorders, or affective disorders; problems that are not considered as psychiatric illnesses such as uncertainty in career selection or timidity in social gatherings; and personal growth in terms of development goals at work or the home front. For the individuals who fall in these three categories, psychotherapy assists them in attaining their full potentials. While some therapies focus on changing current maladaptive behavior patterns (Nevid, 2007), others emphasize understanding past critical issues (Gurman & Messer, 1995), and some therapies combine changing behaviors with understanding motivation (Ryan & Deci, 2008).

The nature of the psychotherapist-client relationship is unique in the sense that it is an austere professional interaction and exists exclusively with the intent to help the client/patient. Confidentiality and anonymity are essential requirements of psychotherapy and these must be strictly adhered to. This adherence prevents the client/patient from getting scared of their problems getting divulged without his/her consent (Gurman & Messer, 1995). In a therapeutic relationship, while the clients/patients divulge thoughts and personal feelings, an intimate physical contact with the psychotherapist is considered in appropriate. Psychotherapists disclose little to no information about themselves to their clients/patients to ensure that the manner in which clients present is not influenced by trying to create a

favorable impression of themselves (Herkov, 2016).

In Federal Neuropsychiatric Hospital, Yaba, (FNPHY) Lagos State, henceforth to be referred to as Yaba, referral for psychotherapies ranges from 50-60 clients/patients weekly, for both the hospital in- and outpatient settings. Clinical experiences validate previous scientific reports of psychotherapeutic efficacy in managing behaviour disorders. In Yaba, hospital based psychotherapy over the years has been a collaborative management that builds on the relationship between client(s) and the therapist and it provides a supportive environment for both the psychotherapists and the clients. There are different approaches to psychotherapy, in the hospital, with different and unique theoretical perspectives. Each theoretical perspective acts as a roadmap to help the therapist understand their clients, their problems and develop solutions. It could also take various forms, including individual, family, marital and group.

### **Theoretical Perspectives in Psychotherapy**

#### ***Psychodynamic Therapy***

The first psychological model of abnormal behaviour was theorized by Sigmund Freud and was called the Psychodynamic model. This led to the development of a model of psychotherapy for the abnormal behaviours or psychological disorders he treated in the form of Psychoanalysis. He posited that the psychodynamic therapy helped clients/patients with psychological disorders gain insight into their unconscious conflicts which was at the root of their disorders and hence resolves them through the psychoanalysis psychotherapy. By effectively managing this conflict, the ego would not require the use of defence mechanisms such as denials, rationalization,

and phobia e.t.c to protect itself from recognising inner conflicts. Freud suggested that with psychoanalysis, the client/patient becomes more self-aware of the inner workings of the pleasure principle (id). By confronting these inner turmoil and the resultant conflicts, the client/patient will learnt to resolve their feelings and develop a more constructive and socially tolerant way of conducting his/her wishes and impulses; which frees the ego to concentrate on more positive interests. The main techniques used during psychoanalysis include dream analysis, analysis of transference relationship and free association.

Contemporary psychodynamic therapies which are briefer and less intense compared to Freud's traditional psychoanalysis are currently being used. This is practiced in Yaba as clients/patients seek briefer and less expensive forms of intervention on a once or twice weekly basis (Gross, 2003). The intent of these modern approaches is to reveal the unconscious motives, break down psychological defenses and resistances; yet focus on the clients' present relationships by encouraging them to modify their maladaptive behaviours. The major techniques in this approach are establishing a more open dialogue and precise exploration of defenses and transference in relationships (Messer, 2001b).

#### ***Behaviour Therapy***

This adopts the systematic utilization of the principles of learning in treatment of mental illnesses and psychological distresses. Since the attention is on changing behaviour and not the change in personality or the in-depth probing of past events, this treatment is brief and limited to a period of few weeks to months. Although behaviour therapists develop an empathic therapeutic relationship with the client/patient, their orientation is rooted in the belief that treatment is

effective due to the impact of the learning-based techniques used in therapy rather than the empathic relationship.

This therapy gained therapeutic ground when its principles and techniques were effectively used in the treatment of fears, phobias as well as other dysfunction that has proven resistant to insight-oriented therapies. Some of the techniques used include modeling, systematic desensitization and gradual exposure. From the behaviourist school of orientation, treatment focuses on the use of reinforcement techniques derived from operant conditioning to shape the desired behaviour. In Yaba, token economy is used as reinforcement to seek an increase in the adaptive behaviours. For instance to increase activities of daily living such as making of beds, bathing, the tokens are given which would later be substituted for a desired reward. This technique is used in the child and adolescent unit to treat conduct disorder.

### ***Humanistic Therapy***

Humanistic psychotherapists focus on the present than on the past like the behaviourists. These therapists like the psychodynamic therapists assume that past events affect present feelings and behaviours, hence they strive to work on the self-insight of clients/patients. This therapy mainly focuses on the person-centred therapy developed by Carl Rogers. Person-centred therapies believe that humans naturally tend to be self-motivated towards good health, fulfilment and growth. Therapists who use this perspective believe that psychological disorders are developed majorly from obstacles to self-actualization. As humans, when others around us selectively approve of our childhood behaviours and feelings, we grow up disowning these criticized feelings and behaviours; consequently to earn approval, we adopt a “be seen and not heard”

behaviour, donning social facades and deafen our inner voices (Nevid,2007). This develops into a distorted self-concept not our own making, which is consistent with the perception of others about us over years and which eventually leads to an individual who is poorly adjusted, is confused and unhappy.

In the management of this kind of client/patient, person-centred therapists establish a warm and acceptable environment in which the client/patient can become more self-aware and accepting of his/her true nature. This condition encourages self-exploration and self-expression which is paramount in this form of therapy. In Yaba, clinical psychologists who practice person-centred therapy do not impose their own goals and values on the client/patient. The focus is on the client/patient and non-directive. The client/patient takes the lead in therapy and directs the course. Four basic qualities must be possessed by a person-centred therapist for an effective treatment and these are unconditional positive regard, empathy, genuineness, and congruence.

### ***Cognitive therapy***

Cognitive therapists believe that the way distressing events are interpreted can enhance or lessen a client/patient's discomfort and influence the way they cope with the event. The role of these therapists is to help the client/patient identify and modify any cognitive distortion and self-defeatist attitude that create or maintain emotional problems. Cognitive therapists foster the recognition and modification of errors in thoughts such as the predisposition to magnify negative events and minimize personal achievements that affect moods and lead to maladaptive behaviour and functioning. In Yaba, the therapists encourage the client/patient to record thoughts prompted by distressing events and

note the link between these thoughts and the consequent emotions. They thereafter assist the client/patient to challenge these cognitive distortions and substitute with rational thoughts.

In Yaba, psychotherapy is conducted with individual, couple, family or group of unrelated members who share common issues. In Yaba parlance, it is usually done mostly for patients who are on medications and are on a level plane ground to be engaged psychologically. Patients who are referred for psychotherapy could be; children (with behavioural, school, family issues), adolescents (with behavioural, school, family issues, issues of separation, peer relationships, depression and substance abuse), young adults (with behavioural, school, family issues, issues of separation, peer relationships, depression, substance abuse and career issues), mature adults: (with behavioural, family issues, issues of separation, depression and substance abuse plus issues of changing relationships, family alignments, health, work and social status) and older adults (with behavioural, family issues, issues of separation, depression and substance abuse, family alignments, health plus end of life issues).

In Yaba psychiatric hospital, psychotherapy is majorly done by clinical psychologists who by their training and experience understand the techniques of modifying behaviour. Factors to consider selecting a therapy to utilize will include the diagnosis as well as the presence of co-morbidity, the intellectual functioning of the client/patient, the readiness and willingness of the client/patient to invest. The client/patient must possess adequate psychological and emotional strength to endure exploration. Long term therapy is a large commitment of time, energy and money. Some patients are very fearful of treatments that do not feel structured and

may do better with a Cognitive Behavioural Therapy approach.

Therapy session entails the initial assessment where psychological and psychodynamic issues are explored. The aim of the assessment is to collect relevant information upon which psychological intervention can be planned. However, before any assessment, rapport building is crucial for effective therapeutic alliance.

The domains usually assessed include the bio-data, presenting complaints, physical description, background history of presenting complaints, family history, personal history, educational history, psychosexual and psychosocial history, forensic history, psychoactive substance use history, suicidal ideations, pre-morbid personality and mental state examination.

Besides the clinical interview, psychological tests are usually administered to the patients before treatments. Such tests include Minnesota Multiphasic Personality Inventory, Second Edition (MMPI-2), Draw A Person (DAP), Incomplete Sentences Blank-College Form (ISBC), Incomplete Sentences Blank – Adult Form (ISBA), Wechsler Adult Intelligence Scale, Fourth Edition (WAIS-IV), Wechsler Intelligence Scale for Children, Third Edition (WISC-111), Beck Depression Inventory, Second Edition (BDI-11) e.t.c.

## **Types of Psychotherapies**

### ***Individual psychotherapy***

This form of psychotherapy covers a broad range of psychotherapeutic techniques which are usually done individually - single therapist working with a single patient. Under this we have:

#### ***1. Insight oriented psychotherapy***

This is based on psychodynamic concept focused on interpersonal relationship - here and now situation. The patients are encouraged to achieve an intellectual

understanding of the mainspring of their behavior that will assist in changing it as needed.

## 2. *Supportive psychotherapy*

This deals with the lessening of anxiety through reassurance, advice, modifications of social factor (it helps patients to get through difficult situations). It offers support to patients and their caregivers during period of illness, turmoil, temporary decompensation.

This is usually done for patients with chronic health conditions such as dementia, hypertension etc., and it enhance the expression of emotion.

## 3. *Cognitive behavioral therapies*

These therapies are derived from the cognitive and behavioral psychological models of human behavior including theories of normal and abnormal development and theories of emotion and psychopathology. They utilize the cognitive model, operant conditioning and classical conditioning to conceptualize and treat a patient's problems. These therapies attempt to integrate therapeutic techniques that help clients/patients to change not only their underlying distorted thoughts, beliefs and attitudes but also the overt maladaptive behaviours. They draw on the assumption that the thinking pattern and belief affect behaviours and modification of these cognitive distortions produce desirable emotional and behavioural changes.

### **General Features:**

Manualized

Time limited,

The therapists are more directive and sometimes "coach-like"

Approach focuses on problems in the here and now

Treatment is empowering: focus on gaining psychological and practical skills

Patient puts what they have learnt into practice between sessions by doing "homework"

**Techniques:** identify cognitive distortions, test automatic thoughts, and identify maladaptive assumptions

The therapist takes an active, problem-oriented, directive stance.

The therapies are used in a wide range of mental health problems: depression, anxiety disorders, bulimia, anger management, adjustment to physical health problems, substance abuse, phobias and chronic pain.

### **Examples of these therapies include:**

#### **A. *Interpersonal psychotherapy (IPT)***

This therapy was developed in the 1970's and assumes that there is a connection between onset mood disorder and the interpersonal context in which they occur. It is based on view that mental illness may reflect and be expressed in problems with relationship and emphasizes working on improving interpersonal relationships during the process of therapy.

It is used for a variety of depressed populations: geriatric, adolescent, HIV-infected, people with marital discord.

#### **General Features**

Time-limited treatment for major depressive disorder

Can be combined with medication

Duration: 12 – 16 weeks

#### **B. *Dialectical behavioral therapy (DBT)***

This therapy was developed to treat borderline personality disorder. It focuses on the self-destructive behaviours of people with this personality disorders especially their suicidality. The intervention is based largely on the elements of behaviorist and cognitive theories. Studies have shown that DBT as a combination of these two theories is superior as an intervention to "treatment as usual" in the reduction of para-suicidality, medical severity of para-suicide, treatment drop-out rate and number of inpatients hospitalization days.

### **General Features**

Therapists are specially trained  
Incorporates Mindfulness (from Zen) as a central component

Patient has individual and group sessions

**Skills learned:** core mindfulness, emotion regulation, interpersonal effectiveness and distress tolerance

### **C. Behavior therapy**

This treatment was derived from British empiricism, Pavlov's studies of conditioning, research on stimulus response relationship conducted by behaviorists (such as Skinner, Wolpe, Eysenck). It works with objective, observable phenomena, referred to as behaviour, including physical activities (drinking, eating, talking, completing sequential activities) that lead to habit formations and social interaction. Behavioural problems managed with this therapy emerge from inappropriate behavioural regulation such as weak, strong or inappropriate stimulus control or motivational conditions that alter the effects of given consequences (Gurman & Messer, 1995).

### **General Features**

Work on the overt behaviour of the patient

Aim is to change maladaptive behaviours.

**Examples of Behaviour therapy include:**

Relaxation training

Systematic desensitization

Flooding

### **Relaxation training**

It is used to teach patient to gain control over their bodies and achieve voluntary control over their feeling of tension. The training instruct the patients to move through the muscle groups of the body that are tensed and achieve relaxation.

### **Systematic desensitization**

In this session, the patient is taught how to reduce or control the fear elicited by a specific stimuli.

This helps to reduce tense and anxious response to feared stimuli. For instance, the therapist may ask an agoraphobic patient to imagine a visit to the shopping mall where the patient typically develops panic on a normal day, but the patient who is in session is encouraged to use relaxation techniques to diminish panic and place it under voluntary control.

### **Flooding**

The aim is to extinguish anxiety produced by feared stimuli.

The patient is placed in continuous contact with the stimulus and the therapist helps them to learn that stimulus does not lead to any feared consequences.

### **D. Cognitive therapy**

Cognitive structures or schemata shape the way people react and adapt to a variety of situations that they encounter in their lives

The aim is to abolish negative thoughts which allow symptoms to persist (our moods and feelings are influenced by our thoughts and the psychological disturbances are caused by habitual errors in thinking). By correcting these distorted ways of thinking, the therapist restructure patients views of themselves.

Aaron Beck observed three major cognitive patterns in depression

- a negative view of oneself

- a negative interpretation of experience

- a negative view of future

In the treatment of depression, the schema that lead to negative interpretations are identified, challenged and altered.

The goal of therapy is to identify and restructure those negative schemata (that shape misperceptions)

### **Forms of Psychotherapy Done In Yaba**

#### **Group psychotherapy**

In Yaba, the group therapy session is conducted by a therapist or a pair of

therapists. Group therapy has some advantages over the one-on-one therapies. For instance, group therapy is less costly compared with individual therapies because a number of clients/patients are treated at once. Several therapists believe that treating clients/patients with a similar condition such as anxiety, psychoactive substance use, depression, lack of social skills and adjustment to stressful life conditions in a group is more effective compared to their counterparts in individual therapy sessions. These clients/patients also learn how individuals with similar conditions resolved or coped with their conditions in a group hence they receive more social support from the groups.

Group therapy in Yaba is mostly done for patients with psychoactive substance dependence. It is usually done 3 times in a week.

Carefully selected participants meet in group guided by a trained leader or facilitator

The leader directs members' interactions to bring about changes

Participants get immediate feedback

Patients may also have outside individual therapy

Self-help groups enable members to give up patterns of unwanted behavior; therapy groups help patients understand why these unwanted behaviour manifest.

### **Family therapy**

This is an intervention to alter interactions among family members and improve family functioning.

In family therapy, the focus is on the family as a unit and not the client/patient alone. This form of therapy is focused on help the troubled family resolve any conflict and problems arose as a result of the client/patient's illness so the family can better function as a unit and less stress is experienced by the individual members of

the family. It is also aimed at teasing out any precipitating factor in a dysfunctional family that is maintaining client/patient's condition. Better and effective communication is encouraged in the family when disagreements are aired constructively in therapy. The therapy interrupts rigid patterns that cause distre

### **Couple's therapy**

This is designed to modify interactions of persons in conflict. It restructures couples' interaction.

Couple therapy concentrates on the resolution of conflict between a distressed couple. This can be done for both the married and unmarried couple. Couple's therapy aids in the improvement of communication between a couple and analyzes the roles in the relationships. For instance, a partner who is more dominant in the relationship might refuse to share power transition with the other leading to conflicts. The aim of the therapist will be to help bring these role relationships to the fore so that the couple can explore other better ways of interacting with each other leading to a satisfied relationship.

"Marriage counseling" is different from therapy. As it is more limited in scope of treatment. Can be with couple or in group with couples present. It is indicated when individual therapy fails to resolve relationship difficulty.

Therapy is geared toward enabling each partner to see each other realistically.

Over the years, psychotherapy among patients in Yaba has been resulted-oriented and is an indispensable treatment in the management of mental patients.

The case of M.K is a typical example to illustrate the efficacy of CBT as an adjoint treatment of depression. After about 3 months on admission, M.K was still experiencing negative thoughts about self,

others and the future despite using the medications which has eliminated the auditory hallucination and poor sleep he presented with. Following rapport building and administration of BDI -11, the patient scored a total score of 39, indicating severe depression.

Patient was now exposed to the ingredients of CBT which included psycho-education; exploration of the thought patterns of the depressed patient; relationship among the thoughts, feelings and behavior; social skill training; homework assignment etc. After about a month of intensive sessions, the patient's post-test score on BDI-11, dropped to a total score 11, indicating mild depression. Similarly, there was significant improvement in his social interaction and quality of life even before discharge.

**STATISTICAL TABLE SHOWING THE PSYCHOLOGICAL INTERVENTIONS FOR PATIENTS IN YABA BETWEEN JANUARY – SEPTEMBER, 2016**

**PSYCHOLOGICAL INTERVENTION AND NUMBER OF PATIENTS SEEN (JANUARY – SEPTEMBER 2016)**

Intervention Type	No Of Patients Seen
Individual (unspecified)	242
Cognitive behavioural therapy	459
Insight oriented therapy	350
Couples' therapy	127
Family therapy	177

**PSYCHOLOGICAL INTERVENTIONS BY GENDER (JANUARY – SEPTEMBER 2016)**

	Male	Female
Individual	112	130
Cognitive behavioural therapy	295	164
Insight oriented therapy	186	164
Couples' therapy	59	68
Family therapy	72	105

**GENDER AND GROUP THERAPY (JANUARY – SEPTEMBER 2016)**

Group therapy	Male	Female
	2290	170

**SUMMARY OF ALL PSYCHOLOGICAL INTERVENTIONS (JANUARY – SEPTEMBER 2016)**

	Psychological Interventions	Group therapy	Relapse prevention
First quarter	299	865	554
Second quarter	248	816	488
Third quarter	799	779	357
Total	1346	2460	1399

**CASE ILLUSTRATIONS**

**Report On Sessions Of Cognitive Behavioural Therapy (CBT) Session With Miss C.I.**

Miss C.I. is a twenty-nine years old single, female copywriter, who presently works with an advertising agency and undertaking a master's program in Public Administration. She was referred for Cognitive Behavioural Therapy (CBT) on 31<sup>st</sup> March, 2016.

She is an old patient of the hospital, index episode was in August, 1996 and she had since been managed as a case of Paranoid Schizophrenia on outpatient basis. She had relapses in June, 2009 and September 2014, but was hospitalized for the first time in 2014 for a period of two months.

She however presented in the hospital for this episode before referral on 6<sup>th</sup> March, 2016 on account of undue restlessness, weepy spells, shouting spontaneously and repeatedly, and hearing of strange voices of about a week duration prior to treatment

**FIRST SESSION:** She was seen for her first session on 31<sup>st</sup> March. 2016

**Mental State examination:** During interaction she was neatly and appropriately

dressed in a multi-coloured blouse, on a black skirt. She was conscious, alert, calm and cooperative. She was well oriented to time, place and person. Her attention was aroused, and concentration well sustained. Her speech was spontaneous, in normal tone and volume, coherent and relevant in response to questions asked, though she had hearing impairment and some questions needed to be repeated before she could understand what was being said. Her immediate recall, short and long term memories were good. Her mood was happy; she indicated being happy because she had been able to go back to her job. Her affect was dull. Her judgment was good. She had insight into her present condition. She indicated that her perceptual abnormalities had resolved. There was no thought abnormality detected.

**Introduction:** The session started with brief orientation of the patient to the essence, procedure, and expectations from both parties for the intervention.

**Goal of treatment:** The initial part of the session focused on trying to assess the treatment goal of the patient. This, she put as amelioration of symptoms, having a better understanding of the condition to forestall future reoccurrence, and enhancing her social interaction.

**Initial Interaction:** The initial interaction focused on exploring patient's beliefs, thought patterns, about the illness and herself; and the various stressors that could probably be contributing to her present condition.

**Issues from the Initial Assessment:** Some of the issues elicited from the initial interaction that could be contributing to the condition are as follows;

(i) She had been managing the condition for a period of about twenty years (from the age of ten). This had been a bit frustrating for her and any time she

remembers this fact she is not usually happy about it.

- (ii) She also did not find it interesting using pills for such a long part of her life, and therefore decided stopping her medication because this was actually frustrating to her. This decision led to her last relapse and this had always been the pattern.
- (iii) She has a comorbid hearing impairment which had been a major source of concern as she had been on hearing aid which was presently non-functional and had to be returned to its manufacturers abroad.
- (iv) She had issues with the side effects from the medication she was using-amenorrhea, and weight gain. This had made her uncomfortable with the medications and one of the reasons why she defaulted from medication use. She claimed that after her previous medication was changed the last time she was reviewed, the new medication seemingly has no effect on her.
- (v) Her job is also a bit stressful, as she had to work on tight schedule and deliver on target; though this would not had been an issue. However, she is also running a master's degree program in the evenings and weekends, which had made the condition a bit more stressful coupled with the fact that she had to be on medications that makes her a bit drowsy.
- (vi) At her age she is not in any heterosexual relationship, and she also had not been able to sustain relationships in the past. She also considered herself not having good interpersonal skills.

**Intervention:** She was educated about her condition- symptoms, some related issues,

the need for medication adherence in the context of the illness. She was given assignment to read more about her diagnosis.

## **SECOND SESSION**

Date: 19/04/2016

She presented for her second session on the above date. She was stable, insightful, and calm. Most of her symptoms had resolved at this stage.

**Feedback:** The session started with review of her activities and feedback on her performance, functioning and level of improvement. She indicated most of her symptoms had resolved and she is trying to cope with her new medications' side effect – drowsiness.

She gave a recap of the activities of the previous session.

**Intervention:** The session focus started with her assignment on Psychoeducation about her diagnosis. She gave her submission about her findings and tried linking it with her various symptoms and experiences. This was further fine-tuned for her to have a good understanding of her condition.

Her past heterosexual relationships was a major focus which were explored. A pattern of very short, non-involved relationships was observed. This was further explored and a major factor responsible was her inability to commit herself to any form of relationship because of her subtle fear of having a failed relationship or being disappointed. She admitted to being pre-emptive and judgmental as a factor responsible for this outcome.

Other forms of interpersonal relationships were also explored. She is observed to be relatively more secured in other forms of relationships once she does not need to make so much commitment. Though, she is not so intimate with most people, she has a pattern of a few intimate friends who know her on a personal level; on the other hand,

she still maintains a limited level of self-disclosure, and her friends rather prefer to disclose more to her because they perceive her as someone who does not really interact and therefore believe that whatever they tell her would be kept close.

The possible implications of her fears and approach to issues were discussed and the possible consequences.

**Closing:** The need to work on her self-perception was obvious from the session. She was given assignment on self-discovery (strength and weaknesses), and self-perception.

## **THIRD SESSION**

Date: 28/04/2016

The third session was held on the above date. She was stable, calm and insightful.

**Feedback:** The session started with review of her activities and feedback on her performance, functioning and level of improvement. She indicated maintaining remission of symptoms, though she still has issues with side effect of the medication-drowsiness, which affects her job (she sometimes sleep in the office which she does not like). She was able to give a brief recap of the last session.

**Intervention:** The session focused on issues on self-discovery. She was taken through the various dimensions of self-discovery to identify her strength, weaknesses, who she is, her ideal and real self, her perception about herself, and those of others about her.

Her views about herself and those of others about her were explored to ascertain how they affect her and her activities. She had a positive self and other perception, she is quite altruistic, believes in looking out for the good and interest of others in her dealings with them. She admitted her health condition had always been a source of concern (having a psychiatric illness that she had been living with and treating for about

twenty years, with a hearing impairment which necessitated his use of the hearing aid). Though, she added that she does not feel discriminated against, but she is usually self-conscious and always exercise restraints in relationships so people would not stigmatize or embarrass her because of her condition. This makes her less interactive, and cautious in starting any form of interaction with anyone she is meeting for the first time and rather prefers keeping to herself.

The need for self-acceptance and how to better manage her altruistic stance in her relationship with others was jointly considered. The essence of this and the probable consequences were considered in the course of the interaction. The implication of her views on her relationship with others and the possibility of her beliefs affecting her expectations and also being the factor responsible for her short mostly uninvolved relationships. The need to be less self conscious was emphasized.

**Closing:** She was given assignment to read on assertiveness and self esteem.

#### **FOURTH SESSION**

Date: 17/05/2016

She was seen for the fourth session on the above date. She was stable and maintaining remission of symptoms.

**Feedback:** The session started with review of her activities and feedback on her performance, functioning and level of improvement in the last two months. She indicated maintaining remission of symptoms, though she still has issues with side effect of the medication- drowsiness, which affects her job. She was informed of the need to discuss the issue with her psychiatrist due to the fact that it was affecting her job. She was able to give a vivid recap of the last session and how she had been able to relate to the issues discussed.

**Intervention:** The session focused on teaching on self-esteem, the factors responsible, indications, and how to build good self-esteem. The various issues related to self-esteem were looked into and how this could affect individual's perception of themselves and those of people around them. The relationship of self-esteem to self-efficacy, and other self-concept were explored and the way it affects the patients relationships and functioning.

Also, the issue of assertiveness was considered, as it relates to self-esteem. The need to delineate between being passive/aggression as against being assertive was discussed in details. The issues of avoidance and confrontation in assertiveness were discussed at length with its implication in various scenarios.

The ways the above issues relates to her relationships were explored and the various scenarios clarified. The need to do things differently as it relates to her interpersonal relationships were considered (especially heterosexual relationships). The need for affiliation to groups, right emotional and cognitive management when in such interaction was discussed.

**Closing:** She was given assignment to read up some of the ingredients and techniques for assertiveness. She was to explore her dynamics of interaction to check if they are more of avoidance or confrontation. She is to review scenarios in her previous interactions, and evaluate the good and not so good in her pattern of interaction.

#### **FIFTH SESSION**

Date: 25/06/2016

She was seen for her fifth session on the above date. She was stable, calm, and maintaining remission of symptoms.

**Feedback:** The session started with review of her activities and feedback on her performance, functioning and level of improvement since the beginning of the

session. A review of the various benefits she had been able to draw from the interaction and the various ways this had helped her psychological improvement/recovery. She indicated maintaining remission of symptoms. She also discussed the issue of side effect with her doctor who assured her that with time she may be able to adapt to the medications or the dosage may be reduced with time. She was taken through the need for medication adherence and the ways of dealing with side effects.

**Intervention:** The session focused on exploring her relational styles (to check in the light of previous discussion whether it was predominated by confrontation or avoidance). The various scenarios were evaluated based on whether they fall into the passive, aggressive or assertive styles and these were jointly explored for what were the good and not so good in her pattern of interaction.

She indicated being more passive, though she could be assertive when need be, especially on her job. But more passive when involved in a group or some other interpersonal relationship because she is usually altruistic and prefers to be on the receiving end. The consequences of being on the receiving end were also explored. She admitted to sometimes feeling bad for not being assertive on some occasion, but most times prefer to allow people have their way. But she distances herself from those who may want to take undue advantage of her because of her disposition.

She however reported not being afraid to make her opinion known when necessary. She does not pretend to accept whatever she deemed unacceptable to her, though she most times deal with issues in a subtle and non-confrontational style. The import of her style of interaction was reviewed to see its impact on her thought and feeling through guided discovery.

The various issues from her relational style were reviewed and evaluated in the light of her strength and weaknesses, the good and not so good and how to better resolve such situations in the future.

**Closing:** She was given assignment read about interpersonal skills and social intelligence. She is to write about her social interactions, assess/ critique it and look at ways of improving them.

## **SIXTH SESSION**

Date: 19/07/2016

She was seen for her sixth session on the above date. She was calm and stable. She had been asymptomatic for over three months.

**Feedback:** The session started with review of her activities and feedback on her performance, functioning and level of improvement. She indicated maintaining remission of symptoms, and better able to cope with the issue of side effect of the medication- drowsiness. She reported that the dosage of her medication was reduced which had made the side effect more bearable. She was able to give a recap of the last session, the ways she had benefitted and how she had been able to relate to the issues discussed.

**Intervention:** The session focused on teachings on interpersonal skills. She read and discussed the various domains of the skill, and related it to its relevance to her functioning and performance.

The various components of interpersonal skill were considered and she was reviewed on the basis of these skills to see if she possessed them and to what level. She indicated possessing verbal and non-verbal communication, and her greatest strength was in the area of listening skills followed by assertiveness skill. She claimed not having any issue with problem solving and decision making skills. The only skill she

feels she may not have so much of grasp with is the negotiation skill.

The import of all these skills to her socialization was explored. She discussed how she thinks possessing these skills will improve her social interaction, especially working on her assertiveness and negotiation skills.

The various skills were discussed in perspective to review areas where and when she had functioned well using these skill and when she had not been on top of her game. She admitted the display of her strengths when she is in a one on one relationship than when in a group setting. The difference in the display of these skills at individual and group level was explored and the major factor responsible for her inability to function effectively in the later case was her self-consciousness or fear related to social anxiety.

The issues of her social anxiety and self-consciousness were emphatically addressed in the course of the session.

**Closing:** She was given assignment to go back and consider how this fear/social anxiety had been a hindrance to her interpersonal relationships and how it has affected her functioning in the social sphere. She is also look at ways she feels she can improve her performance in the social setting.

## SEVENTH SESSION

Date: 16/08/2016

She was seen for her seventh session on the above date. She was calm and stable. She indicated being symptoms free and free of distress in the period between the last session and today.

**Feedback:** The session started with review of her activities and feedback on her performance, functioning and level of improvement. She indicated maintaining remission of symptoms, and better able to cope with the issue of side effect of the

medication- drowsiness. Though, she acknowledged that sometimes she still doze in the office, but she is better able to cope because she knows her medication use is not an option for debate but she has to use them.

She gave a recap of the last session, the ways she had benefitted and how she had been able to relate to the issues discussed. Being the penultimate session she was able to also articulate some of the skills she had been able to learn and started practicing. But more important for her was the fact that the sessions had afforded her the opportunity to review her activities and see more didactically the reasons for some of her behaviours and the consequences of these. She also indicated that this knowledge about herself had been the greatest outcome of the therapy that had helped her understand the reasons for her actions and beliefs which invariably affect her behaviour. She was asked to comment on other areas she would appreciate the therapy addressing. However, she claimed she was satisfied with the present outcome and cannot readily think of any now.

**Intervention:** The session started with a review of her assignment and focused more on concluding the issues on interpersonal skills and social interaction.

The ways social anxiety/fear had affected her effective functioning in all the interpersonal skills domain were considered. The various components of the interpersonal skills were explored to consider how she's been functioning with these skills, scenarios that she believed she was on top of her game and areas when she had it not so good.

She had an altruistic approach to interpersonal relationship which had affected her level of assertiveness and negotiation skills. It also affects the other domains and the issue of a win-win approach to interaction was discussed. The fact that she was not interested in a

relationship for personal gain but to add value to the other party was explored. Much as she was not interested in being dependent on people, it was also considered in the course of the session that if all her interaction do not add value to her, the probability of feeling spent and lacking motivation to go on. The various consequences of these approaches were also explored to make her see some of its implications, how it had affected her relationships and probable ways of improving on this.

Similarly, she indicated being cautious in relationships, this was explored for possible paranoid ideation. She seems to have a very balanced opinion about herself and her environment, though; she has more of the dispositions of an introverted person. However, her cautions were more of self-consciousness (which had been addressed earlier). She is usually comfortable being around very few intimate friends, rather than being with a crowd or strangers.

She believes that trust is a major consideration for in any relationship. Therefore, getting intimate with anyone, she needs to be sure that the issue of trust is not compromised. This had been her reason for not getting involved with strangers and sometimes not comfortable with people she is not familiar with. The issue of trust and reasons for not being able to trust were explored. However, these issues were also discovered to be related to her self-consciousness - she does not like her issues being discussed by strangers especially in a negative perspective. The need for self-confidence (related to her self-esteem and self-perception).

**Closing:** The need to talk about social and emotional intelligence was more evident, she was given assignment to read around it and also consider some of scenarios that she had been self-conscious, looking at how this can be worked on. Positive affirmations

were jointly agreed on to correct the negative cognitions responsible for the self-consciousness.

## **EIGHT SESSION**

Date: 20/9/2016

She was seen for her eight session on the above date. She was calm and stable. She indicated maintaining remission of symptoms.

**Feedback:** The session being the final one, started with review of her activities and feedback on her performance, functioning, and level of improvement from the beginning of the session. She indicated maintaining remission of symptoms, and better able to cope with the issue of side effect of the medication- drowsiness. Though, she is not planning to stop her medication as she knows the reasons for using them. She had also put plans in place to ensure its not possible for her to attempt this, as she agreed with her siblings and mother to check on her medication from time to time.

She gave a recap of the last session, the ways she had benefitted and how she had been able to relate to the issues discussed. She agreed that she is gradually working on her social interaction which she realized from the session had been really defective. She now knows why she had preferred a life of isolation and why she feels the way she does about strangers and people who come around (even male friends interested in relationship with her).

**Intervention:** She initially took a review of scenarios that she had been self conscious, and how she can be work on this issue. Her positive affirmations were taken and its effectiveness in correcting the negative cognitions responsible for self-consciousness assessed.

The session focused on her pending assignments on social and emotional intelligence. The relationship between them

and interpersonal skill domains were discussed. The various domains of this intelligence were considered in relation to her specific issue especially being self-conscious. The benefits of the intelligence and how they help improve her interactional skills and invariably productivity and functioning were explored. The similarities between the two and some differences were considered.

**Closing:** She was allowed to speak about her level of fulfillment with the outcome of the therapy, and the ways she feels the body of knowledge she had gained so far will affect her beliefs and lead to change of behaviour.

### **Case study of a family therapy session**

JD a 40yr old single, unemployed man was referred to the department for family therapy. He had been on admission 3 times with each admission characterized with history of physical and verbal aggression with family members, non medication adherence, poor sleep and social withdrawal. During interaction, he was neatly and appropriately dressed. He was conscious, alert, agitated but cooperative. He was well oriented to time place and person. His speech was of high tone and volume, coherent and relevant in response to questions asked. He maintained good eye contact during the interaction. His immediate recall, short term and long term memories were good, because he was able to remember major significant events in his life with dates. His judgement and insight was poor. He denied any perceptual abnormality. He believes that his family does not love him hence their negative behaviour towards him.

The session started by exploring the presenting complaint. During interaction, it was discovered that he was having conflict with his adult siblings and parents. They seem to fight constantly whenever they are

together, and he feels that his parents call him daily to “criticize” and “put me down.” It was also discovered that since his initial mental illness 15 years ago, he feels he had been relegated to the background without being given the due respect to her deserves as the first born.

During the session, his parents reported that they were only trying to check up on him to use his medications and do the things that he should do. His parents stated that they feel bad that he seems to be wasting away.

From the interaction, it was discovered that, his parents uses high expressed emotion with him -critical comments and they seems to be over involved in his life. This makes JD to feel “criticised” and “put down”.

From his own part, he feels that he is “a nobody” as his siblings are doing very well with their lifestyle which he was not doing. Since the onset of the illness and due to his poor insight, he had not being able to hold down a job or get married.

Goals of therapy were set at improving communicating, improving self-care skills (such as eating right, relaxation, medication adherence, and positive internal messages), improved interpersonal relationship and boundary-setting.

The session then focused on Psychoeducation- this aims to help the family to understand the nature of his illness. Equally, the effect of expressed emotional- critical comments- was explained to them. Also ways of dealing with his family and his own emotions were explained during the session.

His siblings were invited for the second session.

### **Session 2**

JD was seen for the second session alongside his siblings and parents.

A brief review of the previous session was done which patient and parents were able to do effectively.

During interaction, he was neatly and appropriately dressed. He was conscious, alert, calm and cooperative. He was well oriented to time place and person. His speech was of normal tone and volume, coherent and relevant in response to questions asked. He maintained good eye contact during the interaction. His immediate recall, short term and long term memories were good, because he was able to remember major significant events in his life with dates. His judgement is good and insight partial. He denied any perceptual abnormality. He seems to be coming to terms with his illness and his family.

The session started by exploring all the issues he had with his siblings. Equally, they attributed their reaction to him to the fact that they perceived him to be lazy and just using the illness as cover up.

They were psychoeducated on the nature of the illness and some of the degenerative process that had taken place. The concept of a motivational symptoms as it tends to affect individuals with schizophrenia was explained to them. Equally they were counselled on insight and its implication on recovery.

The need to understand his illness was emphasised and ways of dealing with the associated symptoms were counselled.

Other issues that came up were the fact that he feels inferior to his siblings. He was counselled to be positive in his thinking and attitude. The issue of medication adherence was emphasised so as to help him get well and settle down.

Ways of effective communication was taught during the session as well as good interpersonal relationship skills.

### **Session 3**

JD had his third session with his family members

A review of the previous session was done. The family reported significant improvement in the family interaction. JD indicated that he now use his medication regularly and enjoys quality interaction with his siblings.

During interaction, he was neatly and appropriately dressed. He was conscious, alert, calm and cooperative. He was well oriented to time place and person. His speech was of normal tone and volume, coherent and relevant in response to questions asked. He maintained good eye contact during the interaction. His immediate recall, short term and long term memories were good, because he was able to remember major significant events in his life with dates. His judgement is good and has insight into his illness. He denied any perceptual abnormality. No form of thought disorder was detected.

The session focused on reviewing the goals of the therapy and significant improvement made.

Other areas that needed to be addressed were done.

### **Session ends.**

In conclusion, psychotherapeutic practices in Yaba follows the tenets of best clinical practices, although in some cases, the therapist is adapted to meet both the culture of the people and their individual or group needs.

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