

Addis Ababa University

School of Psychology

“Psychological Treatments” Provided to Mental Health Patients in  
Torhailoch Specialized Hospital: Situation Analysis

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Addis Ababa University

School of Psychology

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A Thesis Submitted to School of Psychology of Addis Ababa University in Partial Fulfillment of the Requirements for the Degree of Master of Arts in Counseling Psychology

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### Abstract

A qualitative research of explanatory case study type was applied to investigate the situation of psychological treatments that are provided to mental health patients in Torhailoch Hospital. Six psychiatric nurses and three psychiatric patients were involved in the study by using purposive sampling method. Interviews, observations and document analysis were also applied to collect data. Four points were identified as findings. The psychiatric nurses who were delivering the psychological service in the hospital had inadequate trainings regarding psychological therapies; the psychiatric nurses did not make use of any theory of psychotherapy while they were conducting group or individual therapy; the prominent psychological service that was given in the hospital was group therapy which comprised of every psychiatric patient in a single group, and focusing on providing psychoeducation; the hospital gave little attention to the use psychological means for the treatment of psychiatric patients. However, it found that the psychiatric nurses and the mental health patients had positive attitudes toward the usefulness of psychological therapies for the wellbeing of patients. Moreover, the psychiatric nurses had high interest to help patients using psychological method.

## Chapter One

### 1. Introduction

#### 1.1. Background of the Study

One of the cultures of Ethio-telecom is sending text messages to its mobile phone customers. The messages can be any kind, which are believed to be essential for the good of the public or the government. One of the text messages, which were sent in the month of September, 2017, was about the commitment of the Ethiopian government to combat and prevent mental illnesses as it is very important for the development and growth of the nation. In its plan to deal with mental illnesses, the document of the National Mental Health Strategy for Ethiopia reveals its agreement with the declaration or motto of the World Health Organization (WHO, 2005)). WHO declaration states, 'There is no health without mental health' (WHO, 2005).

The World Health Organization (WHO) defines mental health as a state of wellness where an individual realizes his or her own abilities; interacts positively, copes with stressors of life, works productively and fruitfully, and he or she contributes to his or her family and community. Most of the terms used in the definition do indicate psychological attribution. The inverse of the definition indicates deficits and that deficits show illness. As a result, the absence of mental health shows mental illness.

According to American Psychological Association (2012), mental illnesses or mental disorders are classified as psychological conditions, which are marked by sufficient disorganizations of personality, mind and emotions that seriously impair the normal psychological and social functioning of individuals. Barlow (2004) maintains that mental disorders or illnesses can consist of a combination of affective, behavioral, cognitive and

perceptual components. Gaudiano (2005) also explained that mental health problems can affect the way an individual thinks, feels and behaves.

In order to combat mental illnesses of many kinds, different treatments can be used in ways that can help the individuals. Two of the treatments that are expected to be used in mental health hospitals or clinics or units are pharmacology and non-pharmacology.

Pharmacology, or medication, is the kind of treatment which is common in psychiatric units. Some mental illnesses like schizophrenia, bipolar, major depression need the use of medication so that the individual can get the relief from the symptoms that have suffered him or her. But it does not necessarily mean it can bring back the patient to his or her normal health condition in the way he or she can lead his or her life appropriately after they are discharged from the hospitals or clinics. In the study that Getnet and Bereket (2017) conducted in St Amanuel Mental Specialized Hospital, patients with schizophrenia and bipolar disorder experienced relapses and thus a number of re-hospitalizations after being treated pharmacologically. This is one kind of evidence that can show that depending totally on medication to treat severe mental illnesses is not a wise decision.

The other treatment is non-pharmacological. That is, the treatment becomes psychological. A psychological treatment, or psychotherapy, is a form of treatment for many mental disorders. Psychological treatments together with medications in psychiatric units give positive outcomes compared with medications with no psychotherapy according to a lot of research evidence. For example, compared to medication for the treatment of bipolar disorder, combining psychotherapy with medication leads to a better patient functioning and lower relapses (Cook, & O'Donnell, 2005). Besides Eells et al (2005) pointed out that the most common treatment for patients of schizophrenia is a combination of prescription of antipsychotic

medications and some form of individual psychotherapy. So, psychological treatments are very important for the positive outcomes of psychiatric patients.

This study tries to investigate the kinds of “psychological treatments” that are delivered at psychiatric unit of Torhailoch Specialized Hospital.

## 1.2. Statement of the Problem

Mental illness has a high prevalence in Ethiopia according to the document of the National Mental Health Strategy for Ethiopia (2012/13 – 2015/16). This document also implies, ‘mental illness is not a luxury of the West’. This is to inform that its availability cannot necessarily be related to the lifestyle that has resulted in high income living. The level of mental illness in the nation is found to be very similar to the levels that would be expected in the Western settings according to mental health gap action plan (mhGAP) working group 2010.

In order to address these mental problems, there need to be a number of hospitals and clinics. However, the nation has only a few of them. Torhailoch Specialized Hospital is one of the places where problems of mental health are treated. The hospital in its psychiatric unit gives the services of medication and psychotherapy, which is a kind of psychological treatment, so that patients will able to gain their wellness.

According to the observation of the researcher while he was assigned there as an intern and according to the reports he has heard from patients and other individuals the ways mentally ill people are treated in psychiatric clinics and hospitals in the city that very high attention has been given for the treatment of symptoms using psychopharmacology and very little attention has been given for the use of psychotherapy which is a psychological intervention. In this study

the researcher tries to investigate the situations in which psychological treatments are delivered to the psychiatric patients in Torhailoch Specialized Hospital.

### 1.3. Research Questions

The study will attempt to address the following research questions.

1. How professional are the practitioners who deliver the psychological treatments for the mental health patients?
2. What kinds of psychological treatments are delivered in the psychiatric unit of the hospital?
3. Which approaches or theories of psychotherapy are frequently used in the unit?
4. How do the practitioners and the patients perceive the importance of psychological treatment for the wellbeing of patients?

### 1.4. Objective of the Study

#### 1.4.1. General Objective

The general aim of this study is to investigate and assess the ways psychological treatments are provided at the psychiatric unit of Torhailoch Specialized Hospital.

#### 1.4.2. Specific Objective

\* To identify whether psychological professionals or professionals who have had the courses, trainings and supervisions of psychotherapy or psychological principles give the treatments.

\* To identify whether individual and group therapy are provided to the patients in the psychiatric unit.

\* To identify whether any theories of psychotherapy or psychological interventions are included in the treatments.

- To investigate the perspectives of psychiatric patients and mental health patients toward psychological therapy for the wellbeing of patients.

### 1.5. Significance of the Study

This study is very important for the following reasons.

- It gives information to the hospital what has been done to help those who have been mentally ill and what needs to be done for the good of the patients in terms of psychological intervention.
- It also gives some valuable information to any concerned body including the ministry of Health regarding the ways mental health problems are treated in this specific psychiatric unit and it can also be instrumental to get some idea that how less attention is given for the non pharmacological interventions even though they are very essential for wellbeing of patients.
- It can provide valuable evidence for those who need a kind of literature about psychological intervention which are provided for mental health problems in the Ethiopian context.

### 1.6. Limitation of the Study

The study has the limitation in terms of gathering data because of time constraint and unavailability of some data.

### 1.7. Delimitation of the Study

The study was conducted only in the psychiatric unit of Torhailoch Hospital, and only psychiatric nurses and mental health inpatients were included.

### 1.8. Operational Definitions

The phrase “psychological treatments” is enclosed in the quotation marks to indicate that the treatments are assumed as psychological treatments by the psychiatric nurses and other medical personnel in the hospital.

Psychological treatments in this study includes every attempt that is applied to help the mental health patients that is not pharmacological and that uses talk to help patients understand their illnesses and get some kind of emotional relief.

## Chapter Two

## Review of the Related Literature

This section of the paper consists of the reviews about points that are related to the study. The points are psychological disorders, psychological treatments, professionals who provide psychological therapies, effectiveness of psychological treatments and the nature of group therapy.

### 2.1. Psychological Disorders

What are psychological disorders? Wikipedia defines psychological disorders as mental disorders or psychiatric disorders; they are ‘patterns of behavioral or psychological symptoms that impact multiple areas of life.’ It further explains that the disorders bring distress for the person who is experiencing the disorders.

Szasz (1974) defined psychological problems as abnormal behaviors that are usually ‘problems in living rather than medical problems.’ According to Rathus, psychological disorders are behaviors or mental processes that are connected with various kinds of distress or significant impairment in functioning (Rathus, 2014).

Weiten (2005) argued that there must be indicators to label illnesses to be psychological disorders. The indicators he listed are deviance, maladaptive behavior and personal distress. He continued explaining what deviance means. He pointed out that when a person can be said to have psychological disorder, his or her behavior needs to deviate from what the society considers to be acceptable. Szasz (1974) seemed to have similar understanding when he argued that as “all cultures have norms and when a person violates those norms which are standards and expectations of that society, the person may be labeled to be mentally ill,” or psychologically disordered.

Deviance is not the only indicator to label an illness to be a disorder. Maladaptive behaviors also help for indentifying whether it is a psychological disorder or not. Weiten(2005) included the maladaptive behavior as an indicator when people have the difficulty in everyday life or when their everyday life is impaired. Rathus (2014) also explained maladaptive behaviors as becoming dangerous. In other words, the individuals' "behaviors or mental processes become hazardous to self or others"; this can be an indicator for being psychologically disordered. He further explained that people who" threaten or attempt suicide or threaten or attack others may be considered to have psychological disorders."

Personal distress is the other indicator that a person can have a kind of personal disorder (Szasz, 1974). Weiten (2005) also showed that the diagnosis of psychological disorder is based on an individual's report of personal distress. He added that personal distress is usually the criterion met by people who are troubled by depression and anxiety. According to Rathus, those people who have psychological disorders are likely to exhibit "self defeating behaviors." These behaviors or mental disorders cause "misery rather than happiness and fulfillment". Hence, these behaviors may suggest that the people have psychological disorders.

### 2.1. 1. Kinds of Psychological Disorders

There are a number of psychological disorders that are recognized by mental health professionals and psychologists. The Diagnostic and Statistical Manual of Mental Disorders (DSM) lists more than four hundred mental disorders.

This literature review tries to list a few of them based on their commonality in psychiatry hospitals, clinics or units. The disorders to be included in this review are anxiety disorders, depressive disorders, bipolar disorders, schizophrenia, and substance use disorders.

#### 2.1.1. 1.Anxiety Disorders

Before discussing about anxiety disorders, it is appropriate to define what anxiety is. What is anxiety? The Cambridge English Dictionary defines anxiety as an uncountable noun it means that “an uncomfortable feeling of nervousness or worry about something that is happening or might happen in the future” and as a countable noun it means that “something that causes a feeling of fear or worry”. Clinical definition of anxiety is “the presence of fear or apprehension that is out of proportion to the context of life situation”. In other words, anxiety can be understood as a kind of extreme fear which can be inappropriate developmentally or in an individual’s life situations.

Rathus (2014) also defined anxiety as an inappropriate response to a real threat, but anxiety becomes a problem or abnormal when it becomes excessive and when it controls the person’s life and when it prevents the person from doing important things in life; again it becomes abnormal when the anxiety comes out of nowhere - which means when events do not seem to “warrant it”. According to DSM 5, anxiety is defined as “excessive fear”. Additionally, it tries to show the difference between fear and anxiety. Fear is defined as “the emotional response to real or perceived imminent threat”, but anxiety is “anticipation of future threat”.

What are Anxiety Disorders?

According to DSM, anxiety disorders are disorders that “share features of excessive fear and anxiety and related behavioral disturbances”. The disorders that are included under anxiety disorders are separation anxiety disorder, panic disorder, phobic disorder, general anxiety disorder, obsessive compulsive disorder, posttraumatic stress disorder.

Generalized Anxiety Disorder

People with generalized anxiety disorder feel anxious most of the time. They worry excessively about routine events or circumstances in their lives. Their worries often relate to

finances, family, personal health, and relationships with others. Although they recognize their anxiety as irrational or out of proportion to actual events, they feel unable to control their worrying. For example, they may worry uncontrollably and intensely about money despite evidence that their financial situation is stable (Plewa, 2009).

People with generalized anxiety disorder often find that their worries interfere with their ability to function at work or concentrate on tasks. Physical symptoms, such as disturbed sleep, irritability, muscle aches, and tension, may accompany the anxiety. To receive a diagnosis of this disorder, individuals must have experienced its symptoms for at least six months (DSM IV TR). Generalized anxiety disorder affects about 3 percent of people in the general population in any given year. From 55 to 66 percent of people with this disorder are female.

### Phobia

A phobia is an excessive, enduring fear of clearly defined objects or situations that interferes with a person's normal functioning. Although they know their fear is irrational, people with phobias always try to avoid the source of their fear. Common phobias include fear of heights that is acrophobia, fear of enclosed places that is claustrophobia, fear of insects, snakes, or other animals, and fear of air travel. Social phobias involve a fear of performing, of critical evaluation, or of being embarrassed in front of other people (Morison, 2001).

Phobia is intense and persistent fear of a specific object, situation, or activity. Because of this intense and persistent fear, the phobic person often leads a constricted life. The anxiety is typically out of proportion to the real situation, and the victim is fully aware that the fear is irrational. Phobic anxiety is distinguishable from other forms of anxiety only in that it occurs specifically in relation to a certain object or situation. This anxiety is characterized by physiological symptoms such as a rapid, pounding heartbeat, stomach disorders, nausea,

diarrhea, frequent urination, and choking feelings, flushing of the face, perspiration, tremulousness, and faintness. Some phobic people are able to confront their fears. More commonly, however, they avoid the situation or object that causes the fear, an avoidance that impairs the sufferer's freedom (Morison, 2001).

### Panic Disorder

Panic Disorder is a mental illness in which a person experiences repeated, unexpected panic attacks and persistent anxiety about the possibility that the panic attacks will recur. A panic attack is a period of intense fear, apprehension, or discomfort. In panic disorder, the attacks usually occur without warning. Symptoms include a racing heart, shortness of breath, trembling, choking or smothering sensations, and fears of 'going crazy', losing control, or dying from a heart attack. Panic attacks may last from a few seconds to several hours. Most panic attacks peak within 10 minutes and end within 20 or 30 minutes (Kessler et al, 1998).

This illness affects more than twice as many women as men. People with panic disorder may experience panic attacks frequently, such as daily or weekly, or more sporadically. Additionally, panic attacks may occur as part of other anxiety disorders, such as phobias—in which a specific object or situation triggers the attack—and, more rarely, post-traumatic stress disorder (Kessler et al, 1998).

People with panic disorder frequently develop agoraphobia - a fear of being in places or situations from which escape might be difficult if a panic attack occurs. People with agoraphobia typically fear situations such as traveling in a bus, train, car, or airplane, shopping at malls, going to theaters, crossing over bridges or through tunnels, and being alone in unfamiliar places. Therefore, they avoid these situations and may eventually become reluctant to leave their home. In addition, people with panic disorder appear to have an increased risk of alcoholism and drug

dependence. Some studies indicate they also have a higher risk of depression and suicide

(Kendler et al, 1992).

Panic disorder, both with and without agoraphobia, results from a combination of biological and psychological factors. Some individuals may inherit a vulnerability to stress and anxiety and an increased risk of experiencing panic attacks. In addition, certain physiological cues may trigger a panic attack.

#### Treatments of Anxiety Disorders

Mental health professionals use a variety of methods to help people overcome anxiety disorders. These include psychoactive drugs and psychotherapy, particularly behavior therapy. Other techniques, such as exercise, hypnosis, meditation, and biofeedback, may also prove helpful.

#### Psychotherapy

Therapists who attribute the cause of anxiety to unconscious, internal conflicts may use psychoanalysis to help people understand and resolve their conflicts. Other types of psychotherapy, such as cognitive-behavioral therapy, have proven effective in treating anxiety disorders. In cognitive-behavioral therapy, the therapist often educates the person about the nature of his or her particular anxiety disorder. Then, the therapist may help the person challenge irrational thoughts that lead to anxiety.

Research has shown psychotherapy to be as effective as or more effective than medications in treating many anxiety disorders. Psychotherapy may also provide more lasting benefits than medications when patients discontinue treatment.

#### 2.1.1.2. Depression

Welsh (2009) describes depression to be a syndrome with a cluster of emotional, physical and behavioral symptoms which are characterized by sadness, low self esteem, loss of pleasure and sometimes difficulty in functioning (Welsh, 2009). She also emphasized that a feeling of hopelessness is one of the most common symptoms of depression.

A fact sheet which was prepared by World Health Organization (WHO), and which was also updated in February, 2017 and which is also available in the internet, describes depression as a common mental illness worldwide. This illness has affected more than 300 million people in the world and that depression is the leading cause of disability worldwide and a major contributor to the overall global burden of disease. Again, it is shown in the document that more women are affected by depression than men are. Nolen- Hoeksema (2002) has also shown in her study that the prevalence of depression is twice as high in women as it is in men.

Although depression may appear anytime from childhood to old age, it usually begins during a person's 20s or 30s. Additionally, this mental disorder can lead patients to suicide. Nearly 800 000 people die due to suicide every year globally according to World Health Organization fact sheet.

The fact sheet also states that depression is different from usual mood fluctuations and short-lived emotional responses to challenges in everyday life. Especially when long-lasting and with moderate or severe intensity, depression may become a serious health condition. It can cause the affected person to suffer greatly and function poorly at work, at school and in the family.

Although there are known, effective treatments for depression, fewer than half of those affected receive such treatments - in many countries they are fewer than 10% the people who are affected. The burden of depression and other mental health conditions is on the rise globally.

A study which was published in 2015 under mhGAP, depressive disorder is found to be a highly prevalent and disabling disorder whose relative disease burden is significant both in high and low in-come countries. The study also indicates that depression is a major cause of disease burden in low in-come countries.

### Kinds of Depression

#### Major Depressive Disorder (MDD)

Major depression has other names like unipolar affective disorder, clinical depression and melancholia, which is the most ancient term used for major depression. The word melancholia comes from Greek and it has the meaning of black bile.

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR, 2000) describes major depressive disorder with the following characteristics. The patient can exhibit depressed mood or irritable most of the day, decreased interest or pleasure in most activities in most of each day, significant weight change of 5 % or change in appetite, change in sleep – either insomnia or hypersomnia, change in activity either psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or excessive or inappropriate guilt, diminished ability to think or concentrate or more indecisiveness, suicidality which means thoughts of death or suicide or the plan to suicide.

#### Persistent Depressive Disorder (PDD)

According to healthline website, persistent depressive disorder (PDD) is a form of chronic depression, and it is a relatively new diagnosis that combines the two earlier diagnoses dysthymia and chronic major depressive disorder. Like other types of depression, persistent depressive disorder (PDD) causes continuous feelings of deep sadness and hopelessness. These feelings can affect the individual's mood and behavior as well as physical functions, including

appetite and sleep. As a result, people with the disorder often lose interest in doing activities they once enjoyed and have difficulty finishing daily tasks.

The website also reminds readers that these symptoms are seen in all forms of depression. In PDD, however, the symptoms are less severe and longer lasting. They can persist for years and may interfere with school, work, and personal relationships. The chronic nature of persistent depressive disorder (PDD) can also make it more challenging to cope with the symptoms.

It has also been pointed out in website that the symptoms of persistent depressive disorder (PDD) often begin to appear during childhood or adolescence. Children and teens with persistent depressive disorder (PDD) may appear to be irritable, moody, or pessimistic over an extended period. They may also display behavioral problems, poor performance at school, and difficulty interacting with other children in social situations. Their symptoms may come and go over several years, and the severity of them may vary over time.

### Symptoms of Depression

Symptoms of depression can vary by age. In younger children, depression may include physical complaints, such as stomach aches and headaches, as well as irritability, “moping around,” social withdrawal, and changes in eating habits. They may feel unenthusiastic about school and other activities. In adolescents, common symptoms include sad mood, sleep disturbances, and lack of energy. Elderly people with depression usually complain of physical rather than emotional problems (Jamison, 1995).

Symptoms of depression can also vary by culture. In some cultures, depressed people may not experience sadness or guilt but may complain of physical problems. In Mediterranean cultures, for example, depressed people may complain of headaches or nerves. In Asian cultures they may complain of weakness, fatigue, or imbalance (Jamison, 1995).

Depression usually alters a person's appetite, sometimes increasing it, but usually reducing it. Sleep habits often change as well. People with depression may oversleep or, more commonly, sleep for fewer hours. A depressed person might go to sleep at midnight, sleep restlessly, then wake up at 5 AM feeling tired and blue. For many depressed people, early morning is the saddest time of the day (Hollon et al, 2000).

Depression also changes one's energy level. Some depressed people may be restless and agitated, engaging in fidgety movements and pacing. Others may feel sluggish and inactive, experiencing great fatigue, lack of energy, and a feeling of being worn out or carrying a heavy burden. Depressed people may also have difficulty thinking, poor concentration, and problems with memory.

People with depression often experience feelings of worthlessness, helplessness, guilt, and self-blame. They may interpret a minor failing on their part as a sign of incompetence or interpret minor criticism as condemnation. Some depressed people complain of being spiritually or morally dead. The mirror seems to reflect someone ugly and repulsive. Even a competent and decent person may feel deficient, cruel, stupid, phony, or guilty of having deceived others. People with major depression may experience such extreme emotional pain that they consider or attempt suicide. At least 15 percent of seriously depressed people commit suicide, and many more attempt it (Cui & Vaillant, 1996).

In some cases, people with depression may experience psychotic symptoms, such as delusions which are false beliefs, and hallucinations which are false sensory perceptions. Psychotic symptoms indicate an especially severe illness. Compared to other depressed people, those with psychotic symptoms have longer hospital stays, and after leaving, they are more likely to be moody and unhappy. They are also more likely to commit suicide (Bhalla et al, 2009).

## Causes of Depressive Disorders

Some depressions seem to come out of the blue, even when things are going well. Others seem to have an obvious cause like a marital conflict, financial difficulty, or some personal failure. Yet many people with these problems do not become deeply depressed. Most psychologists believe depression results from an interaction between stressful life events and a person's biological and psychological vulnerabilities (Schimtt et al, 2008).

### Biological Factors

Depression runs in families. By studying twins, researchers have found evidence of a strong genetic influence in depression. Genetically identical twins raised in the same environment are three times more likely to have depression in common than fraternal twins, who have only about half of their genes in common. In addition, identical twins are five times more likely to have bipolar disorder in common. These findings suggest that vulnerability to depression and bipolar disorder can be inherited. Adoption studies have provided more evidence of a genetic role in depression. These studies show that children of depressed people are vulnerable to depression even when raised by adoptive parents.

Genes may influence depression by causing abnormal activity in the brain. Studies have shown that certain brain chemicals called neurotransmitters play an important role in regulating moods and emotions. Neurotransmitters involved in depression include norepinephrine, dopamine, and serotonin. Research suggested that depression results from lower than normal levels of these neurotransmitters in parts of the brain. Support for this theory came from the effects of antidepressant drugs, which work by increasing the levels of neurotransmitters involved in depression. However, later studies have discredited this simple explanation and have suggested a more complex relationship between neurotransmitter levels and depression.

An imbalance of hormones may also play a role in depression. Many depressed people have higher than normal levels of hydrocortisone, a hormone secreted by the adrenal gland in response to stress. In addition, an underactive or overactive thyroid gland can lead to depression.

A variety of medical conditions can cause depression. These include dietary deficiencies in vitamin B<sub>6</sub>, vitamin B<sub>12</sub>, and folic acid; degenerative neurological disorders, such as Alzheimer's disease and Huntington's disease; strokes in the frontal part of the brain; and certain viral infections, such as hepatitis and mononucleosis. Certain medications, such as steroids, may also cause depression.

### Psychological Factors

Psychological theories of depression focus on the way people think and behave. In a 1917 essay, Austrian psychoanalyst Sigmund Freud explained melancholia, or major depression, as a response to loss - either real loss, such as the death of a spouse, or symbolic loss, such as the failure to achieve an important goal. Freud believed that a person's unconscious anger over loss weakens the ego, resulting in self-hate and self-destructive behavior.

Cognitive theories of depression emphasize the role of irrational thought processes. Aaron Beck proposed that depressed people tend to view themselves, their environment, and the future in a negative light because of errors in thinking. These errors include focusing on the negative aspects of any situation, misinterpreting facts in negative ways, and blaming themselves for any misfortune. In Beck's view, people learn these self-defeating ways of looking at the world during early childhood. This negative thinking makes situations seem much worse than they really are and increases the risk of depression, especially in stressful situations.

In support of this cognitive view, people with depressive personality traits appear to be more vulnerable than others to actual depression. Examples of depressive personality traits

include gloominess, pessimism, introversion, self-criticism, excessive skepticism and criticism of others, deep feelings of inadequacy, and excessive brooding and worrying. In addition, people who regularly behave in dependent, hostile, and impulsive ways appear at greater risk for depression.

### Stressful Events

Stressful experiences can trigger depression in people who are predisposed to the illness. For example, the death of a loved one may trigger depression. The Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR, 2000) usually distinguishes true depression from grief, a normal process of mourning a loved one who has died. Other stressful experiences may include divorce, pregnancy, the loss of a job, and even childbirth. People who experience child abuse appear more vulnerable to depression than others. So, too, do people living under chronically stressful conditions, such as single mothers with many children and little or no support from friends or relatives (Welsh, 2009).

### Treatments of Depressive Disorders

Depression can be treated effectively with antidepressant drugs, psychotherapy, or a combination of both.

Despite the availability of effective treatment, most depressive disorders go untreated and undiagnosed. Studies indicate that general physicians fail to recognize depression in their patients at least half of the time.

### Psychotherapy

Studies have shown that short-term psychotherapy can relieve mild to moderate depression as effectively as antidepressant drugs. Unlike medication, psychotherapy produces no physiological side effects. In addition, depressed people treated with psychotherapy appear less

likely to experience a relapse than those treated only with antidepressant medication. However, psychotherapy usually takes longer to produce benefits (Akiskai, 2004).

Cognitive-behavioral therapy assumes that depression stems from negative, often irrational thinking about oneself and one's future. In this type of therapy, a person learns to understand and eventually eliminate those habits of negative thinking. In interpersonal therapy, the therapist helps a person resolve problems in relationships with others that may have caused the depression. The subsequent improvement in social relationships and support helps alleviate the depression. Psychodynamic therapy views depression as the result of internal, unconscious conflicts. Psychodynamic therapists focus on a person's past experiences and the resolution of childhood conflicts (Akiskai, 2004).

#### 2.1.1.3. Bipolar Disorder

The website named HELPGUIDE.ORG describes bipolar disorder to be a kind of mental illness that causes serious shifts in mood, energy, thinking and behavior. It further explained that this mental disorder causes the individual to experience mood changes from "the highs of mania on one extreme to the lows of depression on the other". According to the website, the mood changes of the disorder are so intense that they interfere with the individual's ability of functioning. Additionally, the cycle of bipolar disorder lasts for days, weeks and months.

Rathus (2014) mentioned that bipolar disorder was formerly known as manic depressive disorder before the third edition of The Diagnostic and Statistical Manual of Mental Disorders – this term was used to indicate that a person who is affected by bipolar disorder experiences both mania and depression. He also showed that individuals who have bipolar disorders exhibit mood swings from ecstatic elation to deep depression. In the elated or manic phase of the illness the patient may show excessive excitement or silliness, carrying jokes too far; in this episode the

individual may have the tendency of being argumentative, showing poor judgment, destroying properties, making huge contribution to charity or giving away expensive possessions (Jamison, 2000). Furthermore, people with this mental disorder often speak rapidly with showing pressured speech and they jump from topic to topic – which could mean rapid flight of ideas (Rathus, 2014). In the depression phase people with bipolar disorder often sleep more than usual and become lethargic or tired with no cause for the tiresome. They also exhibit social withdrawal and irritability; there could be the possibility of attempting suicide when the mood shifts from elated phase toward depression; also, individuals with bipolar disorders may do almost anything to escape from the depths of depression that lie ahead of them; during the episode of depression, they experience painful sadness, negative thinking, and indifference to things that used to bring them happiness (Jamison, 2000).

#### The signs and symptoms of bipolar disorders

Although symptoms of bipolar disorders vary from person to person, there are common symptoms and signs that help to identify the disorders. The website of Mayo Clinic lists the signs and symptoms that people with bipolar disorders can show.

During the episodes of mania or hypomania, the following signs and symptoms can be observed: being jumpy or wired; an increase in activity, energy or agitation; exaggerated sense of well-being and self-confidence which is euphoria; decreased need for sleep; unusual talkativeness; racing thoughts; distractibility and poor decision making like taking sexual risks or making foolish investments.

During depressive episode, the following signs and symptoms may be seen: feeling sad, empty, hopeless or tearful and irritability in the case of children and teens; marked loss of interest or feelings of no pleasure in all or almost all activities including those activities which

were enjoyable before; significant weight loss or weight gain with the presence of increase or decrease in appetite; either insomnia or sleeping too much – hypersomnia; fatigue or loss of energy, either restlessness or slowed behavior; feelings of worthlessness or excessive or inappropriate guilt; decreased ability to think or concentrate, or being indecisive; thinking about or planning or attempting suicide.

### Types of Bipolar Disorders

Only the two types of bipolar disorders are to be discussed in this review of literature.

They are bipolar I disorder and bipolar II disorder.

### Bipolar I disorder

What is bipolar I disorder? The website named healthline describes bipolar I disorder as a type of bipolar disorder which is characterized by the presence of at least one manic episode and one major depressive episode, and the depressive episode must occur either before or after the manic episode. According this website, the symptoms of a manic of may be so severe during bipolar type one that the patient requires hospital care.

The Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR, 2000) gives lists of symptoms for manic and the depressive episodes of bipolar I disorder. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR, 2000) , the symptoms of manic phase of bipolar I are: a distinct period of abnormally and persistently elevated, expansive, or irritable mood and abnormally and persistently increased goal directed activity or energy which lasts one week and present most of the day or nearly every day; inflated self esteem or grandiosity; decreased need for sleep; more talkative than usual or pressure to keep talking; flight of ideas or subjective experience that thoughts are racing, distractibility – attention easily drawn to unimportant or irrelevant external stimuli; increase in goal directed activity either socially, at

work or at school ,or sexually or increase in psychomotor agitation – purposeless non-goal directed activity; excessive involvement in activities that have a high potential for painful consequences like engaging in unrestrained buying sprees, sexual indiscretions, or foolish business investment.

### Bipolar II Disorder

What is bipolar II disorder?

The website healthline describes bipolar II disorder as a bipolar disorder which involves a major depressive episode that lasts at least two weeks and also comprising at least one hypomanic episode. However, bipolar II disorder doesn't have manic episodes intense enough to require hospitalization. It was further explained that bipolar II disorder can sometimes be misdiagnosed as depression because there are no manic episodes to suggest the illness to be bipolar and the depressive symptoms become more identifiable vividly. The Diagnostic and Statistical Manual of Mental Disorders (DSM IV TR, 2000) describes bipolar II disorder to have at least one hypomanic episode and at least one depressive episode.

The hypomanic episode is a period of mania that is less severe than a full blown manic episode.

### Causes of Bipolar Disorder

The exact causes of bipolar disorder are not yet fully understood. However, it is believed that the illness is primarily biological. Also, there are a number of factors that are also believed to play a role in the development of bipolar disorders. Few of the factors include genetics, brain chemicals and stressful environment (Akiskai, 2004).

### Genetics

Bipolar disorder is frequently inherited, with genetic factors accounting for approximately 80% of the cause of the condition. If one parent has bipolar disorder, there is a 10% chance that his or her child will develop the illness. If both parents have bipolar disorder the likelihood of their child developing the illness rises to 40%. Mood Disorder Association of British Columbia indicated that children with a parent or sibling who has bipolar disorder are four to six times more likely to develop the illness than children who do not have a family history of bipolar disorder. However, just because one family member has the illness, it is not necessarily the case that other family members will also develop the illness according to Mood Disorder Association of British Columbia.

#### Brain chemicals

Researchers have also looked at what might be the activities in the brain that cause these extremes in mood and impaired ability to function. There is evidence to suggest that bipolar disorder is the result of abnormalities in the way some of the nerve cells in our brain communicate among one another. Nerve cells communicate with each other through chemical messengers called neurotransmitters. When there are problems in the functioning of these neurotransmitters, the communication system in the brain can be disrupted according to the Mood Disorder Association of British Columbia.

This Association explained that researchers have known for decades that a link exists between neurotransmitters and mood disorders, as specific medications which alter these transmitters can also relieve mood disorders. The association concluded that researchers are quite certain that the neurotransmitter system is at least part of the cause of bipolar disorder.

Another study has revealed a theory about the cause of bipolar disorder is that it is related to abnormal serotonin chemistry in the brain. Serotonin is one of the neurotransmitters in the

brain, and it is believed to be the one that strongly affects a person's mood. It is thought that the abnormal levels of serotonin cause mood swings because of their feedback effects on other brain chemicals. It is, however, unlikely to conclude that serotonin is the only neurotransmitter involved for the cause or development of the illness; other neurotransmitters are also likely to play a role.

#### Environmental Factors

While the onset of bipolar disorder may be linked to stressful life events, it is difficult to make it responsible as its cause. Despite this, people who suffer from bipolar disorder often find it beneficial to discover ways of managing and reducing stress in their lives as emotional pressure is often a trigger for relapse.

Seasonal factors appear to play a role in the onset of bipolar disorder, with the likelihood of onset increasing in spring. The rapid increase in hours of bright sunshine is thought to trigger depression and mania or hypomania by affecting the pineal gland which is responsible for the release of melatonin.

#### Treatments of Bipolar Disorders

The National Institute of Mental Health of the United States of America on its document states that "there is no cure for bipolar disorder", but proper treatment helps most people with bipolar disorder gain control their mood swings and related symptoms. The document also emphasizes that as bipolar is a lifelong recurrent illness, people who are affected with this illness need long term treatment to maintain the symptoms of the disorder.

Medication and psychological treatments are recommended for the prevention of relapse and reduction of symptom severity.

#### Psychological Treatments

Psychological therapies such as counseling, psychotherapy, like cognitive behavioral therapy (CBT) and family focused therapy are important additions to medications in the treatment of bipolar disorder. However, when used by themselves which means without medication, they can be ineffective.

Combining physical treatments and psychological therapies has been clearly demonstrated to be better than using physical treatments alone.

#### 2.1.1.4. Schizophrenia

The National Institute of Mental Health of the United States describes schizophrenia as a serious mental disorder that affects how a person thinks, feels, and behaves. People with schizophrenia may seem like they have lost touch with reality. They may hear voices other people don't hear. They may think other people are trying to hurt them. Sometimes they don't make any sense when they talk. It is also mentioned in the document that the symptoms of the disorder can make it hard for a person to interact with people, go to school, keep a job, or take care of day-to-day tasks. According to the institute of mental health, the symptoms can be very disabling, but with effective treatment many people with schizophrenia experience recovery. Rathus (2014) defines schizophrenia to be a severe psychological disorder that touches every aspect of a person's life. He added that it is characterized by disturbances in thought and language, perception and attention, motor activity, and mood as well as withdrawal and absorption in daydreams and fantasy. This disorder is referred to as the worst psychological disorder affecting human beings.

The encyclopaedia of Microsoft Encarta begins defining the word schizophrenia to be "split mind" and the term comes from Greek even though the illness doesn't show the characteristics having split mind. The encyclopaedia added that a person with schizophrenia may

have difficulty telling the difference between real and unreal experiences, logical and illogical thoughts, or appropriate and inappropriate behavior. It further explains that schizophrenia seriously impairs a person's ability to work, go to school, enjoy relationships with others, or take care of oneself. In addition, people with schizophrenia frequently require hospitalization because they pose a danger to themselves. About 10 percent of people with schizophrenia commit suicide, and many others attempt suicide.

Schizophrenia occurs in slightly more men than women and affects all ethnic groups. Symptoms usually start between the ages of 16 and 30 and its adverse effects tend to endure. It afflicts nearly 1 % of the population of the world (Rathus, 2014).

#### Symptoms of Schizophrenia

What are the symptoms of schizophrenia? The National Institute of Mental Health of the United States classified the symptoms of schizophrenia into three categories – positive, negative and cognitive symptoms.

Positive symptoms are psychotic experiences that are not generally seen in healthy people. People with these symptoms are sometimes unable to tell what's real from what is imagined. These symptoms can be severe, and at other times, hardly noticeable. Positive symptoms include hallucinations, delusions, thought disorders and movement disorders. Hallucination is when a person sees, hears, smells, tastes, or feels things that are not real. "Hearing voices" is common for people with schizophrenia. People who hear voices may hear them for a long time before family or friends notice a problem. Delusion is when a person believes things that are not true. For example, a person may believe that people on the radio and television are talking directly to him or her. Thought disorder is when a person has ways of thinking that are odd or illogical. People with thought disorders may have trouble organizing

their thoughts. Sometimes a person will stop talking in the middle of a thought or make up words that have no meaning. Movement disorder is when a person has or may appear as agitated body movements. A person may repeat certain motions over and over. In the other extreme, a person may stop moving or talking for a while, which is a rare condition called catatonia.

Negative symptoms refer to social withdrawal, difficulty showing emotions, or difficulty functioning normally. People with negative symptoms may need help with everyday tasks. Negative symptoms include: talking in a dull voice; showing no facial expression, such as a smile or frown; having trouble experiencing happiness; having trouble planning and sticking with an activity, such as grocery shopping; talking very little to other people, even when it is important.

Cognitive symptoms are not easy to see, but they can make it hard for people to have a job or take care of themselves. Often, these symptoms are detected only when specific tests are performed. Cognitive symptoms include: Difficulty using information to make decisions, problems using information immediately after learning it and trouble paying attention.

### Types of Schizophrenia

The Diagnostic and Statistical Manual of Mental Disorder identifies five types of schizophrenia – paranoid, disorganized, catatonic, undifferentiated and residual types.

Paranoid schizophrenia is widely regarded as the most common type of schizophrenia. People with paranoid schizophrenia can have complex delusions hallucinations in the form of voices. They usually have delusions of grandeur and persecution, but they may also have delusions of jealousy. They may show agitation, confusion, and fear, and they may experience vivid hallucinations that are consistent with their delusions.

This is widely regarded as the most common type of schizophrenia. Among individuals with the paranoid-type, they commonly experience delusions and hallucinations in the form of “voices.” The delusions may involve the fact that other people are conspiring against them and or plotting their demise. They may hear voices that say mean things, curse them, and make life difficult.

In this particular subtype, individuals tend to respond very well to treatment with an antipsychotic medication. Despite the symptoms that are experienced, the people with this subtype may not appear to act bizarre or out of the ordinary – they may seem pretty normal.

People with paranoid-type tend to live pretty normal lives once their symptoms are treated. They do not experience the cognitive decline to the degree of the other subtypes and tend to be higher functioning. In general, individuals with this subtype tend to have a good prognosis as long as they take time to properly treat their symptoms.

#### Disorganized Schizophrenia

In this particular subtype, the dominant symptoms revolve around disorganization. The person will experience disorganized behavior, speech, and thinking. In other words, they will act odd, make no sense when they talk, and their thinking will be highly unfocused, nonsensical, and completely random. Individuals with this subtype tend to have difficulties performing basic tasks that are part of daily living.

They may neglect their personal hygiene and not understand that they need to take care of themselves. In many cases there is also an emotional impairment in the person in which they exhibit odd emotional responses. For example, the person may laugh or smile in a very serious situation. In other words, the emotion that they show and/or express doesn't usually fit the given situation.

It is pretty easy to tell when someone has the disorganized subtype. They may have a disheveled appearance, behave oddly, and speak in such a disorganized manner that it makes almost no sense to the listener. They may jump topics mid-sentence or every other sentence leading to completely nonsensical speech.

This particular subtype tends to have an early onset between the ages of 15 and 25 and is often referred to as “hebephrenic” which means “during adolescence.” Unfortunately the prognosis for this subtype is pretty poor compared to some of the others.

### Catatonic Schizophrenia

In this subtype, the symptoms involve motor disturbances, disturbances in movement, and “catatonia.” Usually individuals with this subtype will experience a major reduction in overall activity to the point that they stop moving, and may appear “frozen.” This frozen state with a complete lack of movement is called a “catatonic stupor.” They also may significantly increase movement and appear to be hyperactive – this is known as “catatonic excitement.”

In other words, individuals jump back and forth between purposeless excitement and a major stupor. Individuals may also experience other movement disturbances such as engaging in stereotypes – or ritualistic, repetitive movements such as body rocking. When the individual is in an excited state, they do not engage in any sort of productive activity. During the state of catatonic stupor, the person may appear completely immobile and highly resistant to people that try to help them move.

They may stay stuck in one position for hours at a time. This subtype is also characterized by the symptom of “waxy flexibility” in which another person may move the person’s arm and they hold it locked in the position that it was moved into. In other words, they can be molded like a “wax” figure. Other patients exhibit a strong “rigidity” (i.e. negativism) to

the point that it is impossible to move any of their limbs. It is also common to witness mimicking speech and movements of other people.

### Undifferentiated Schizophrenia

The undifferentiated subtype is diagnosed when individuals exhibit general symptoms of schizophrenia, but do not meet specific diagnostic criteria for another subtype. Individuals with the undifferentiated subtypes may have symptoms that fall into multiple categories of other subtypes. For example, a person may have disorganized thinking, paranoia, hallucinations, low energy, and cognitive deficits.

Sometimes people that are diagnosed with the undifferentiated subtype have symptoms that fluctuate over a period of time. For example, they may experience symptoms that fit the paranoid subtype for awhile, and then they may experience symptoms that better fit the disorganized subtype for a period of time. When the set of symptoms is difficult to classify, “undifferentiated” is typically diagnosed.

Some have used the term “mixed clinical syndrome” to describe this diagnosis because there is essentially a “mix” of symptoms.

### Residual Schizophrenia

This subtype is diagnosed when a person with schizophrenia has gone for an extended period of time without any symptoms. In other words, the patient has been in remission and symptom free for up to a full year (12 months). In cases of residual schizophrenia, the symptoms may be completely non-existent or have lessened in severity to the point that they do not interfere with the daily functioning of the individual.

A person with residual schizophrenia may still have hallucinations, delusions, or other unusual behaviors, but they do not have as profound of affect as they did when the patient was

initially diagnosed. A person with any given subtype can be diagnosed as having “residual” schizophrenia as long as they are symptom-free or have low-grade symptoms for an extended period of time.

With the residual subtype, some people feel completely recovered from their condition once it is properly treated. In order to make sure that the symptoms stay in remission, it is important to make sure that the individual continues treatment, therapy, and makes healthy lifestyle choices. Most people experience a relapse of symptoms every once in awhile. This subtype is characterized by a “waxing” and “waning” of schizophrenic symptoms.

During the “waxing” phase, symptoms increase in intensity, and during the “waning” phase, they decrease and may become non-existent. Most people will have some hospitalizations with this subtype, but their overall prognosis with this subtype is pretty good. Individuals with the residual type can be productive members of society while their illness is in the “waning” phase.

### Causes of Schizophrenia

Experts believe that schizophrenia can be caused by different factors (Kim et al, 2000). It is also believed that schizophrenia to be a biological disease which is caused by genetic factors, imbalance of chemicals in the brain, structural brain abnormalities, or abnormalities in the prenatal environment. In addition, stressful life events may contribute to the development of schizophrenia in those who are presupposed to the illness. These five factors can be the possible causes of the illness, and each is discussed in this review of literature.

### Genetic Factors

Research suggests that the genes one inherits strongly influence one’s risk of developing schizophrenia. Studies of families have shown that the more closely one is related to someone

with schizophrenia, the greater the risk one has of developing the illness. For example, the children of one parent with schizophrenia have about a 13 percent chance of developing the illness, and children of two parents with schizophrenia have about a 46 percent chance of eventually developing schizophrenia. This increased risk occurs even when such children are adopted and raised by mentally healthy parents. In comparison, children in the general population have only about a 1 percent chance of developing schizophrenia (Gordon, 2016).

### Chemical Imbalance

Some evidence suggests that schizophrenia may result from an imbalance of chemicals in the brain called neurotransmitters. These chemicals enable neurons, which are brain cells, to communicate with each other. Some scientists suggest that schizophrenia results from excess activity of the neurotransmitter dopamine in certain parts of the brain or from an abnormal sensitivity to dopamine. Support for this hypothesis comes from antipsychotic drugs, which reduce psychotic symptoms in schizophrenia by blocking brain receptors for dopamine. In addition, amphetamines, which increase dopamine activity, intensify psychotic symptoms in people with schizophrenia (Shim et al, 2008). Structural Brain Abnormalities

Brain imaging techniques, such as magnetic resonance imaging and positron-emission tomography, have led researchers to discover specific structural abnormalities in the brains of people with schizophrenia. For example, people with chronic schizophrenia tend to have enlarged brain ventricles, which are cavities in the brain that contain cerebrospinal fluid. They also have a smaller overall volume of brain tissue compared to mentally healthy people. Other people with schizophrenia show abnormally low activity in the frontal lobe of the brain, which governs abstract thought, planning, and judgment. Research has identified possible abnormalities

in many other parts of the brain, including the temporal lobes, basal ganglia, thalamus, hippocampus, and superior temporal gyrus.

### Stressful Events

Although scientists favor a biological cause of schizophrenia, stress in the environment may affect the onset and course of the illness. Stressful life circumstances can increase the chances of schizophrenia in a person biologically predisposed to the disease. These circumstances are like growing up and living in poverty, the death of a loved one, an important change in jobs or relationships, or chronic tension and hostility at home. In addition, stressful events can trigger a relapse of symptoms in a person who already has the illness. Individuals who have effective skills for managing stress may be less susceptible to its negative effects (Shim et al, 2008).

### Treatments of Schizophrenia

Although there is no cure for schizophrenia, effective treatment exists that can improve the long-term course of the illness. With many years of treatment and rehabilitation, significant numbers of people with schizophrenia experience partial or full remission of their symptoms.

Treatment of schizophrenia usually involves a combination of medication, rehabilitation, and treatment of other problems the person may have. Antipsychotic drugs, which are also called neuroleptics, are the most frequently used medications for the treatment of schizophrenia.

Psychological and social rehabilitation programs may help people with schizophrenia function in the community and reduce stress related to their symptoms. Treatment of secondary problems, such as substance abuse and infectious diseases, is also an important part of an overall treatment program.

## 2.2. Psychological Treatments

What are psychological treatments? What are psychological treatments like?

Wikipedia gives the explanation of psychological treatments in the following manner. Psychological treatments are 'talking therapies. They can help people change their thinking patterns and improve their coping skills so they are better equipped to deal with life stresses and conflict.' This encyclopedia also states that a psychological treatment as a healing process that takes place between the therapist and the client.

Psychological treatments are non pharmacological therapies that need to be provided in mental health clinics and hospitals. The two major therapies which are applied for treating mental disorders are biomedical and psychological. The psychological therapy, which is most commonly psychotherapy, is a form of treatment for mental disorders (Cook & O'Donnell, 2005). Hunsely et al (2014) explained that psychotherapy is an interpersonal intervention usually provided by a mental health professional that employs any range of specific psychological techniques. According to the American Psychological Association, psychotherapy is a kind of psychological intervention which applies a systematic interaction between a client and a therapist. The association also emphasizes that psychological interventions use psychological principles to affect the client's thoughts, feelings or behaviors to help the client or patient.

The site named Psychology Today clarifies psychological treatments or interventions as actions that are performed to bring about changes in people. The site again emphasizes that psychological treatments mean any activities used to modify behaviors, emotional states or feelings or thoughts.

### 2.2.1. Psychodynamic Therapy

Psychodynamic therapy is a therapeutic approach that embraces all analytic therapies. Its roots lies predominantly in Freud's psychoanalysis approach, but Carl Jung, Alfred Adler, Otto

Rank and Melanie Klein are all widely recognized the further development and application of psychodynamic therapy (McLeod, 2017).

The aim of psychodynamic therapy is to bring unconscious mind into consciousness. That is, it focuses on helping individuals to unravel experiences and understand their true deep rooted feelings in order to resolve them. According to psychodynamic approach view, the unconscious holds onto painful feelings and memories, which one too difficult for the conscious mind to process. In order to ensure these memories and experiences not to surface, many individuals will develop defenses such as denial and projections. These defenses will often do more harm than good according to the view of psychodynamic approach (Haggerty, 2016 ).

Psychodynamic therapy, which is also known for its being insight oriented therapy focuses on unconscious processes as they are manifested in the person's behavior (Haggerty, 2016).

Haggerty (2016) states the goals of this therapy to help clients come to their self-awareness state and to help them understand the influences of past on present behavior. This therapy approach tries to enable clients to examine unresolved conflicts and symptoms that arise from past dysfunctional relationships and manifest themselves in the need and desire to abuse substances (Haggerty, 2016).

#### 2.2.1.1. Key Concepts of Psychodynamic Therapy

##### Structures of the Mind

Sigmund Freud proposed that the human mind is composed of three components- the id, the ego and the superego.

The id is the part of the mind where the basis of the unconscious is formed and the instinct is found. It is a biological component. According to Freud's assumption, at birth a person is all Id. He further added that the id is the primary source of psychic energy and the seat of the instincts. This system or components lacks organization. It is also blind, demanding and insistent. As it is ruled by pleasure principle, it cannot tolerate tension and it functions to discharge tension immediately. This system doesn't have the capability for maturity as it doesn't think but it only wishes or acts. The id is largely unconscious, which means it is out of awareness (Corey, 2013).

The second system or component of the mind is the ego. The ego is the psychological component. This component has contact with the external world of reality. The ego is the kind of system of the mind, which governs controls and regulates personality. It does mediation between the instinct and the surrounding and exercises censorship. As the ego is ruled by reality principle, it does realistic and logical thinking and formulates plans of action for satisfying needs. The ego which is the seat of intelligence and rationality, it checks and controls the blind impulses of the id, which is the seat of instinct (Corey, 2013).

The superego is the third system of the mind according to Freud. The superego is neither a biological nor psychological component. Rather it is the social component. It is also the judicial branch of personality. Whether actions are right or wrong, good or bad are checked in this system of the mind. The superego strives for perfection instead of pleasure which is the commitment of the id. According to psychodynamic approach, the superego functions to inhibit the impulses of the id by persuading the ego to substitute realistic goals for realistic ones for the purpose of perfection (Corey, 2013).

Levels of the Mind

Haggerty (2016) presented three levels of the mind in the psychodynamic perspective – the conscious, the sub-conscious and the unconscious. The concepts of the conscious and levels of consciousness are the keys to understanding behavior and the problems of personality.

The unconscious mind is the level in which instincts, deeply held beliefs and many patterns of thought and behavior reside (Haggerty, 2016). The person is not consciously aware of anything at this level of the mind. But there is an assumption that the contents of the unconscious mind make up the vast majority of what a person is, what the individual wants, how the person behaves in order to get what she/he wants.

The subconscious or the pre-conscious is the second level of the mind. This level is found between the conscious and the unconscious. The contents of the preconscious can be called to consciousness with the purposeful concept from the individuals as the contents of this level are just below the surface of consciousness.

The third level of the mind is the consciousness this level of the mind the individual is in a state of awareness. According to Freud (1899), this is the level with the least defining content, and this level makes up a very tiny part of who the individual is.

The aim of psychodynamic therapy is to make the unconscious motives conscious for the purpose of helping the client have the chance to make choice.

#### 2.2.1.2. Theory of Therapeutic Actions of Psychodynamic Therapy

Cananiss et al. (2011) state the theory of therapeutic actions of psychodynamic approach tries to explain how psychotherapy works under the psychodynamic approach. According to Cananiss and colleagues three actions are implemented to help patients – making the unconscious conscious, supporting weakened ego functions and reactivating development.

The first action is bringing the unconscious to conscious state thoughts and feelings that are out of awareness can affect and motivate people often lead to habitual but maladaptive ways of thinking and behaving. Clients in psychodynamic therapy become aware of these thoughts and feelings.

In order to help the client understand what their unconscious disturbances, are and how their mind works, some techniques are applied in the psycho-dynamic therapy – free association, therapeutic transference and interpretation.

Free association is a central technique in psychodynamic therapy. In free association, clients are encouraged to say whatever comes to mind regardless of how painful silly, trivial, illogical or irrelevant of may be. There must be no attempt to shape ideas before they are not said nor do clients tell things in a linear story structure. Clients flow with any feelings or thoughts by reporting them immediately without censorship. The spontaneity allows true thoughts and feelings to emerge without any concern.

Free association is one of the basic tools used to open the doors to unconscious wishes, fantasies, conflicts and motivations.

During free association process, the therapist needs to identify repressed material that is locked in the unconscious. The sequence of associations guides the therapist in understanding the connections clients make among events. The therapist then interprets the material to clients for the purpose of guiding them toward increased insight into the underlying dynamics.

Supporting weakened ego functions is the second action applied in the psychodynamic therapy. During therapy the therapist works to help clients to strengthen their ego functions. As mentioned earlier, the ego is responsible for the management of the person's inner mental life and his/her relationships to the world. In order to do this, the ego relies on many essential

functions such as impulse control, internal and external regulations the capacity for tolerating anxiety and strong feelings and mobilization of defense mechanisms.

If these ego functions become weak, people can suffer in many ways. Intermittent stress, trauma and physical illnesses can weaken ego functions chronically.

Supporting or strengthening ego functions becomes very essential part of therapy in the psychodynamic approach. Patients can be helped to internalize new ways of thinking and behaving so as to strengthen ego functioning on a more permanent basis.

The third action which is taken in psychodynamic therapy is the action of reactivating development. This treatment can reactivate mental and emotional development in the purpose of fostering new healthier growth. The rationale behind this treatment is that there is the assumption that there are aspects of mental and emotional development which can be arrested or stunted. Because of this, people can become unable to move forward as adults. This can lead to a variety of problems such as maladaptive coping mechanisms, unpaired relationships with other people and problems in maintaining self-esteem. Abuse, neglect emotional departures, lack of parental attachment or overstimulation could be the reason for the problems.

In order to resolve the problems, psychodynamic therapy helps clients to reactivate development in the context of the new relationship with the therapist. As a result, development of new ways of thinking about oneself and regulating self-esteem, development of new ways of relating others, and development of more flexible, adaptive coping mechanism, can be achieved (Westend,2002).

### 2.2.2. Behavioral Therapy

Behavioral therapies differ dramatically from psychodynamic and humanistic therapies. Behavioral therapists do not explore an individual's thoughts, feelings, dreams, or past

experiences. Rather, they focus on the behavior that is causing distress for their clients. They believe that behavior of all kinds, both normal and abnormal, is the product of learning. By applying the principles of learning, they help individuals replace distressing behaviors with more appropriate ones (Bellack & Herson, 1985). Bellack and colleague further explained that behavioral therapists begin treatment by finding out as much as they can about the client's problem and the circumstances surrounding it. They do not infer causes or look for hidden meanings, but rather focus on observable and measurable behaviors. Therapists may use a number of specific techniques to alter behavior. These techniques include relaxation training, systematic desensitization, exposure and response prevention, aversive conditioning, and social skills training (Bellack & Herson, 1985).

Wood et al (2011) tried to show that behavior therapists view maladaptive behavior as a behavior which is a disorder itself rather than taking the behavior a symptom of some underlying disorder. Because of this, the goal of behavioral therapy is to change troublesome behaviors or is to teach clients new behaviors to minimize or eliminate the issue. Old learning led to the development of a problem and so the idea is that new learning can fix it. They do not do anything to change the individual's personality structure or to search for the origin of the problem behavior. Thus, this therapy is referred to as action based therapy. The therapists are focused on using the same learning strategies that led to the formation of unwanted behaviors.

#### 2.2.2.1. The Foundation of Behavioral Therapy

In order to understand how behavioral therapy works, Cherry (2017) insists that it is essential to explore the two basic principles that contribute to behavioral therapy: classical conditioning and operant conditioning.

Classical Conditioning involves forming associations between stimuli. Previously neutral stimuli are paired with a stimulus that naturally and automatically evokes a response. After repeated pairings, an association is formed and the previously neutral stimulus will come to evoke the response on its own.

Operant conditioning focuses on how reinforcement and punishment can be utilized to either increase or decrease the frequency of a behavior. Behaviors followed by desirable consequences are more likely to occur again in the future, while those followed by negative consequences become less likely to occur.

#### Behavior Therapy Based on Classical Conditioning

Classical conditioning is one way to alter behavior, and a number of techniques exist that can produce such change according to Cherry (2017). Originally known as behavior modification, this type of therapy is often referred to today as applied behavior analysis. Some of the techniques and strategies used in this approach to therapy include flooding, systematic desensitization and aversive therapy.

**Flooding:** This is a technique of classical conditioning where a person is exposed or flooded with anxiety provoking stimulus until the anxiety is extinguished. Kassin (1997) indicated that flooding can occur by guiding the client to imagine the dreaded stimulus, or it can also be the experience of first hand by getting exposed to the real object that the client fears to confront. The procedure of getting exposed to the feared stimulus is repeated several times until anxiety is completely diminished. Kassin (1997) made it clear that flooding is sometimes effective, but success is not guaranteed. It is often used to treat phobia, anxiety and other stress-related disorders. During the process, the individual is prevented from escaping or avoiding the situation.

According to Wolpe (1982), for example, flooding might be used to help a client who is suffering from an intense fear of dogs. At first, the client might be exposed to a small friendly dog for an extended period of time during which he or she cannot leave. After repeated exposures to the dog during which nothing bad happens, the fear response begins to fade.

**Systematic Desensitization:** This technique involves having a client make a list of fears and then teaching the individual to relax while concentrating on these fears. The use of this process began with psychologist John B. Watson and his famous Little Albert experiment in which he conditioned a young child to fear a white rat. Later, Mary Cover Jones replicated Watson's results and utilized counterconditioning techniques to desensitize and eliminate the fear response (Bellack & Herson, 1985).

Systematic desensitization is often used to treat phobias. The process follows three basic steps. First, the client is taught relaxation techniques. Next, the individual creates a ranked list of fear-invoking situations. Starting with the least fear-inducing item and working their way up to the most fear-inducing item, the client confronts these fears under the guidance of the therapist while maintaining a relaxed state.

Cherry(2017) explains that, for instance, an individual with a fear of the dark might start by looking at an image of a dark room before moving on to thinking about being in a dark room and then actually confronting his fear by sitting in a dark room. By pairing the old fear-producing stimulus with the newly learned relaxation behavior, the phobic response can be reduced or even eliminated.

**Aversive Therapy:** This process involves pairing an undesirable behavior with an aversive stimulus in the hope that the unwanted behavior will eventually be reduced. Cherry (2017) gives explanation by taking someone who suffers from alcoholism, and the person might

utilize a drug known as disulfiram, which causes severe symptoms such as headaches, nausea, anxiety and vomiting when combined with alcohol. Because the person becomes extremely ill when they drink, the drinking behavior may be eliminated.

#### Behavior Therapy Based on Operant Conditioning

Many behavior techniques rely on the principles of operant conditioning, which means that they utilize reinforcement, punishment, shaping, modeling and related techniques to alter behavior. These methods have the benefit of being highly focused, which means that they can produce fast and effective results. Some of the techniques and strategies used in this approach to behavioral therapy include token economy, contingency management, modeling and extinction (Rimm & Master, 1974).

**Token Economies:** This type of behavioral strategy relies on reinforcement to modify behavior. Clients are allowed to earn tokens that can be exchanged for special privileges or desired items. Parents and teachers often use token economies to reinforce good behavior. Kids earn tokens for engaging in preferred behaviors and may even lose tokens for displaying undesirable behaviors. These tokens can then be traded for things such as candy, toys, or extra time playing with a favorite toy.

**Contingency Management:** This approach utilizes a formal written contract between the client and the therapist that outlines the behavior change goals, reinforcements and rewards that will be given and the penalties for failing to meet the demands of the agreement. These types of agreements aren't just used by therapists, but teachers and parents also often use them with students and children in the form of behavior contracts. Contingency contracts can be very effective in producing behavior changes since the rules are spelled out clearly in black-and-white, preventing both parties from backing down on their promises (Cherry, 2017).

**Modeling:** This technique involves learning through observation and modeling the behavior of others. The process is based on Albert Bandura's social learning theory, which emphasizes the social components of the learning process. Rather than relying simply on reinforcement or punishment, modeling allows individuals to learn new skills or acceptable behaviors by watching someone else perform those desired skills. In some cases, the therapist might model the desired behavior. In other instances, watching peers engage in the sought after behaviors can also be helpful.

**Extinction:** Another way to produce behavior change is to stop reinforcing a behavior in order to eliminate the response. Time-outs are a perfect example of the extinction process. During a time-out, a person is removed from a situation that provides reinforcement. For example, a child who starts yelling or striking other children would be removed from the play activity and required to sit quietly in a corner or another room where there are no opportunities for attention and reinforcement. By taking away the attention that the child found rewarding, the unwanted behavior is eventually extinguished.

### How Well Does Behavioral Therapy Work?

When it comes to treating specific behavioral issues, behavioral therapy can sometimes be more effective than other approaches. Phobias, panic disorder, and obsessive compulsive disorder are examples of problems that respond well to behavioral treatments (Cherry, 2017). Behavioral therapy might be effective at helping clients manage or cope with certain aspects of the psychiatric conditions, but they should be used in conjunction with other medical and therapeutic treatments recommended by a medical doctor, psychologist or psychiatrist.

### 2.2.3. Cognitive Therapy

McMullan (2000) explains that cognitive therapy is a form of treatment which is designed to alter the maladaptive ways in which people interpret significant events in their lives. There are different brands of cognitive therapy and many techniques which they use. But only two kinds of cognitive therapies are included in this review – rational emotive behavioral therapy and cognitive therapy of Aaron Beck.

#### 2.2.3.1. Rational Emotive Behavioral Therapy (REBT)

Rational emotive behavioral therapy (REBT) is a type of cognitive behavioral therapy which was developed by the psychologist Albert Ellis. This therapy bases itself on the assumption that human beings are born with a potential for both rational thinking and irrational thinking. Rational thinking can be understood as straight thinking, whereas irrational thinking as crooked thinking (Corey, 2013). Irrational thinking can include becoming demanding, inflexible or rigid, all-or-nothing thinking and personalizing events.

#### Source of Emotional Disturbance

According to Ellis, "People are not disturbed by things but rather by their view of things." The fundamental assumption of the rational emotive behavioral therapy is that the way people feel is largely influenced by how they think (Ellis & Dryden, 1997). Although human beings originally learn irrational beliefs from significant others during childhood, but the individual themselves create dogmas by themselves. These irrational dogmas occur by actively reinforcing self defeating beliefs by the process of auto suggestions and self repetition and by behaving as if they were useful (Corey, 2013). Hence, it is largely, humans own repetition of early indoctrinated irrational thoughts that keep dysfunctional attitudes alive and operative with the individuals.

The Rational emotive behavioral therapy(REBT) takes the stance that blame is at the core of most emotional disturbances. Blaming oneself and others contributes for high emotional disturbances. It was also indicated that humans have a strong tendency to make and keep themselves emotionally disturbed by internalizing self defeating beliefs (Spiegler, 2008).

Fraggatt (2005) suggests that human beings disturb themselves in two main ways. The first is named ego disturbance which happens when the individual holds irrational beliefs about himself or herself. The second kind of disturbance is called discomfort disturbance according to Wayne Fraggatt. This disturbance occurs when the person holds irrational beliefs about his or her emotional or physical comfort. He also added that frequently the two go together. That is, people may think irrationally about both themselves and their circumstances even though one or the other of the two will usually predominate.

#### The A-B-C Model of the rational motive behavioral therapy(REBT)

Cherry (2017) indicates that the rational motive behavioral therapy(REBT) has the A-B-C model in order to explain how people's mistakenly blaming external events for the occurrence of their emotional disturbance. The A-B-C model tries to depict the interpretation of events that brings the disturbance in the part of the client rather than the event itself. This model is central for REBT theory and practice. The model is developed to help understand the clients' feelings, thoughts, events, and behavior. The letter -A- stands for the existence of a fact, an activating agent, or the behavior or attitude of an individual. Generally, A refers to the activating agent which can be anything that happens in the environment around the person. The letter B stands for the belief of the individual about the event or the situation. The letter C represents the emotional and the behavioral consequences or reactions of the individual to the activating agent, which is referred to as A.

According to the rational motive behavioral therapy(REBT) therapy, the activating agent -A- does not cause the emotional consequence – C. Instead, it is the person’s belief about the event -B – that largely causes the emotional reaction or behavior – C.

#### Techniques of the rational motive behavioral therapy(REBT)

The central technique of the rational motive behavioral therapy(REBT) is cognitive restructuring. This technique helps the therapist to teach clients how to improve themselves by replacing faulty cognitions with constructive beliefs. Restructuring involves helping clients learn to monitor their self talk, identify maladaptive self talk, and substitute adaptive self talk for their negative self talk (Spiegler, 2008).

During therapy, the therapist invites the client to examine, challenge, modify and uproot B- which is the irrational belief the person has about the activating agent – A. A new and effective belief system consists of replacing unhealthy thoughts with healthy ones. When healthy thoughts take the place of unhealthy ones, a new set of feelings will arrive consequently (Good Therapy, 2015). As a result, instead of feeling seriously anxious and depressed, the person begins to feel healthy sorry and disappointed in accordance with the situation (Corey, 2013).

In addition to restructuring, different other techniques are applied in the REBT, such as modeling, cognitive homework, bibliography, recording sessions, reframing, rational emotive imagery, role playing, humor, encouraging the client, reinforcing, skill training, relapse prevention and others (Good Therapy, 2015).

#### Goals of Therapy

The general goal of the rational motive behavioral therapy (REBT) is to help clients minimize emotional disturbances, decrease self-defeating behaviors and become happier (Tompkins, 2006). To teach clients to separate the evaluation of their behaviors from the

evaluation of themselves is also the goal of this therapy. This means that they are taught how to accept themselves in spite of their anticipated perfection (Weishaar, 1993).

The basic goals are to teach clients how to change dysfunctional emotions and behaviors into healthy ones, and to teach clients differentiate between realistic and unrealistic goals and to help them differentiate between self defeating and self enhancing goals. Moreover, the therapy aims to dispute clients' irrational beliefs, to encourage them to engage in activities that will counter their self defeating beliefs and to help them replace their rigid musts with preferences.

#### 2.2.3.2. Cognitive Therapy of Aaron Beck

Cognitive therapy is a type of psychotherapy which was developed by American Psychiatrist Aaron Beck in the 1960s. Cognitive therapy seeks to help the patient to overcome difficulties by identifying and changing dysfunctional thinking, behavior and emotional responses. This involves helping patients develop skills for modifying beliefs, identifying distorted thinking, relating to others in different ways and changing behaviors. Cognitive therapy is based on an information process model of human behavior and psychotherapy.

This therapy is active, directive, time limited, present centered, problem oriented, collaborative, structured and it makes use of home works.

McLeod (2008) emphasizes that the human mind is not a passive receptacle of environmental and biological influences and sensations, but rather individuals are actively involved in constructing their realities. This view is also at the very core of cognitive therapy.

#### Basic Principles of Cognitive Therapy

This therapy holds the stand that clients exhibited a negative bias in their interpretation of thinking. People with emotional difficulties tend to commit characteristic logical errors that tilt

objective realities in the direction of self deprecation (Corey, 2013). The focus of cognitive therapy is often on distorted thinking.

Dattilio & Freeman (1992) point out that cognitive distortions are the systematic errors in reasoning that lead to faulty assumptions and misconceptions. They listed seven cognitive distortions. These distortions are arbitrary inferring, selective abstraction, overgeneralization, labeling and mislabeling, and dichotomous thinking.

Arbitrary inferences refer to making conclusions without supporting and relevant evidence. This includes catastrophizing or thinking of the absolute worst scenario and outcome for most situations.

Selective abstraction consists of forming conclusions based on an isolated detail of event. In this process other information is ignored and significance of the total context is missed. The assumption is that the events that matter are those dealings with failure and deprivation

Overgeneralization is a process of holding extreme beliefs on the basis of a single incident and applying them inappropriately to dissimilar events or settings.

Magnification and minimization is a kind of cognitive distortion which consists of perceiving a case or situation in a greater or lesser light than it truly deserves. Personalization is a tendency for individuals to relate external events to themselves, even when there is no basis for making this connection.

Labeling and mislabeling is a cognitive distortion that involves portraying one's identity on the basis of perfections and mistakes made in the past and allowing them to define one's true identity.

Dichotomous thinking refers to categorizing experiences into two extremes. With such polarized thinking, events are labeled in black and white.

The cognitive therapist operates on the assumption that the most direct way to change dysfunctional emotions and behaviors is to modify inaccurate and dysfunctional thinking. The cognitive therapist teaches clients how to identify these distorted and dysfunctional cognitions through a process of evaluation. Through a collaborative effort, clients learn the influence that cognition has on their feelings and behaviors and even on environmental events. In cognitive therapy, clients learn to engage in more realistic thinking, especially if they consistently notice times when they tend to get caught up in catastrophic thinking. After they have gained insight into how their unrealistically negative thoughts are affecting them, clients are trained to test these automatic thoughts against reality by examining and weighing the evidence for and against them.

They can begin to monitor the frequency with which these beliefs intrude in situations in everyday life.

This process of critically examining their core beliefs involves empirically testing them by actively engaging in a Socratic dialogue with the therapist. The clients also carry out homework assignments; they gather data on assumptions they make; they keep a record of activities, and form alternative interpretations (Dattilio & Freeman, 2007; Tompkins, 2004). Clients form hypotheses about their behavior and eventually learn to employ specific problem-solving and coping skills. Through a process of guided discovery, clients acquire insight about the connection between their thinking and the ways they act and feel.

#### Levels of Cognition

Cognitive therapy recognizes three levels of cognition. The levels are core beliefs, dysfunctional assumptions, and negative automatic thoughts. These levels of cognition are fundamental to the cognitive model.

Core beliefs which are also called schemas are deeply held beliefs about self, others and the world. Core beliefs are generally learned early in life and are influenced by childhood experiences, and they are seen as absolute. The negative triad negative core beliefs capture how they relate to the self, the world or others and the future. Negative views about the world or others, like viewing that everybody hates the individual because he or she feels worthless causes negative views about the future, like the individual will think that he or she will never be good at anything because everybody hates him or her. This negative about the future influences the person's view of himself or herself negatively like he is worthless. This in turn contributes for the formation of negative views about the world or others. This is the cognitive triad of negative core beliefs according to Beck (1976).

The second level of cognition is dysfunctional assumptions. Dysfunctional assumptions are rigid conditional rules for living that people adopt. They may be unrealistic and therefore maladaptive. Living by the rule of never trying anything for the purpose of not risking failing can be an example of dysfunctional assumption.

Negative automatic thoughts are the third level of cognition. Negative automatic thoughts are thoughts that are involuntarily activated in certain situations. In depression, negative automatic thoughts typically center on themes of negativity, low self esteem and uselessness. In cognitive therapy, the cognition model is used as a framework which helps to understand a person's mental distress or presenting problem.

### Goals of Therapy

Cognitive therapy aims to teach patients to be their own therapists by helping them to understand their current ways of thinking and behaving and by equipping them with tools to

change their maladaptive cognitive and behavioral patterns. Therapists try to get people to open their minds, challenge their assumptions, and think old problems in new ways (Jamison, 1995).

#### 2.2.4. Person centered therapy

Person center therapy was developed by Carl Rogers in 1940's and 50's. The basic principles of this therapy is that people are trustworthy, resourceful, capable of self - understanding and self- direction, able to make constructive changes and able to live effective and production lives, (Corey, 2013). According to McLeod (2008), person center therapists have deep conviction that humans are essentially forward moving organisms drawn to the fulfillment of their own creative natives and to the pursuit of truth and social responsiveness. In other words, there is a belief that people will move toward health of the way seems open for them to move that direction. Wilson (2018) supported this idea by writing that people have the potential to strive toward realization, fulfillment, autonomy, self- determination and perfection. This growth force within people provides an internal healing. It can be noted that the person centered therapy has the stand that individuals have inherent capacity to move away from maladjustment, and to move toward psychological health. It is also indicated that peoples' natural growth is blocked; because of this they can have a feeling of basic helplessness, powerlessness and an inability to make decisions or effectively direct their own lives.

Person centered therapy requires three therapist attributes to create a growth promoting climate in which clients can move forward and become what they are capable of becoming. The three therapist attributes are congruence, unconditional positive regard and accurate emphatic understanding for clients to experience their tendency of growth to health or healing themselves.

Congruence implies that therapists are real, that is, they are genuine, integrated and authentic during the therapy hours. In other words, their inner experience and outer expressions

of that experience need to match. Cherry (2017) explained that the quality of the real presence of the therapist for the client during therapy is the heart of effective the therapy.

Unconditional positive regard refers to the attitude of the therapist to communicate with the client in deep and genuine ear. Garrett and Garrett (2013) describe unconditional positive regard as the experiencing and offering of a consistently, non-judgmental and valuing attitude toward a client. For Essays (2013) unconditional positive regard is considered as a form of non-possessive level, a warm acceptance of the client as he\she is. In other words, nothing is required of a client for him or her to be viewed in a positively regarded manner.

Accurate empathic understanding refers to the attitude of a therapist to understand clients' experience and feelings sensitively and accurately as they are revealed in the as they are revealed in the moment to moment interaction during the therapy sessions (Corey, 2013) Empathy is a deep and subjective understanding of another person as the person experiences it at any given moment (Ackerman, 2017). According to Rogers (1980), empathy is an attitude through which the therapist strives to "enter the client's private perceptual world." This means that empathy is the experience of trying to fully understand another person's world.

The basic goal of person centered therapy is encouraging clients to become open to experiences, to have trust in them, to have an internal source of evaluation and to be willing to continue growing as people who are in the journey of actualization possessing these characteristics (Rogers, 1980). The person centered approach aims to ward the client achieving a great degree of independence and integration. This therapy focuses on the person, but not on the person's presenting problem. The aim of person centered therapy is not to solve problems, but to assist clients in their growth process so that they could better cope with their current and future problems.

The role of the therapists is rooted in their ways of being and attitudes. No techniques are designed and opted to get the clients to do something during therapy or out of therapy (Corey, 2013). Therapists use themselves as an instrument of change.

### 2.3. Group Therapy

What is group therapy?

According to American Psychology Association, group therapy is a kind of psychotherapy where five to fifteen people meet face to face with one or more trained group therapists, and they talk about things that are troubling them. Weiten (2005) states a group therapy typically consists of four to fifteen people, but a group with the size of about eight participants is regarded as ideal. Members of the group also give feedback to each other by expressing their own feelings about what someone says or does. This interaction gives group therapy members an opportunity to try out new ways of behaving and to learn more about the way they interact with others. The contents of the group sessions need to be confidential, which means that what members talk about or disclose is not to be discussed outside the group. Woods et al (2011) indicated that group therapy gives the individuals a sense of belonging and opportunities to express feelings, to get feedbacks from other members and to give and receive help and emotional support. It was also indicated that learning that others also share their problems helps people feel less alone and ashamed.

Weiten (2005) explains that group treatments have proven particularly helpful when members share similar problems such as alcoholism, overeating or sexually abused as a child. He added that many approaches that were originally designed for individuals have been adapted for treatment of groups. Supportive, behavioral, cognitive, person centered, and psychodynamic approaches may be applied to the treatment of group patients.

It was noted that under the direction of a group therapist the group is able to give support, offer alternatives or gently confront the person. In group therapy, people begin to see that they are not alone. Many people feel they are unique because of their problems and it is encouraging to hear that other people have similar difficulties. But American Group Psychotherapy Association is interested to remind that group therapy can be a threat for self disclosing in front of strangers and it can also make members fear the criticism and the rejection that they might experience later.

### 2.3.1. Roles of the Therapists

Koukourikos et al (2014) pointed out the roles of the group therapists in the psychiatric ward. According to them, the mental health nurses are more responsible than any other mental health professionals because of the short duration of inpatient groups. The roles that the nurses as therapists play are to actively structure the discussion in a way that encourages the group members to stay in a topic, to be quiet and allow the patients to feel a sense of mastery when members interact spontaneously around an appropriate issue, to try to include all members in the group discussion by asking each one to express their views and feelings, to assist silent members to speak and understand their reason for being silence, not to take sides rather encourage each member discuss issues in a way that leads them to understand why conflict has arisen when a conflict happens, and to help the group develop into a cohesive unit with an atmosphere of conducive to the operation of curative factors and where confidentiality and non judgmental approach can be communicated.

### 2.3.2. The Therapeutic Principles of Group Therapy

Koukourikos et al (2014) listed eleven key therapeutic principles that have been outlined by Irvin D. Yalom. Yalom proposed these therapeutic principles which were originally termed as curative factors.

**Universality:**The recognition of shared experiences and feelings among group members and that these may be widespread or universal human concerns, serves to remove a group member's sense of isolation, validate their experiences, and raise self-esteem.

**Altruism:**The group is a place where members can help each other, and the experience of being able to give something to another person can lift the member's self esteem and help develop more adaptive coping styles and interpersonal skills.

**Instillation of Hope:** In a mixed group which has members at various stages of development or recovery, a member can be inspired and encouraged by another member, who has overcome the problems with which they are still struggling.

**Imparting Information:**While this is not strictly speaking a psychotherapeutic process, members often report that it has been very helpful to learn factual information from other members in the group.

**Corrective Recapitulation of the Primary Family Experience:**Members often unconsciously identify the group therapist and other group members with their own parents and siblings in a process that is a form of transference specific to group psychotherapy. The therapist's interpretations can help group members to gain understanding of the impact of childhood experiences on their personality, and they may learn to avoid unconsciously repeating unhelpful past interactive patterns in present-day relationships.

**Development of Socializing Techniques:** The group setting provides a safe and supportive environment for members to take risks by extending their repertoire of interpersonal behavior and improving their social skills.

**Imitative Behavior:** One way in which group members can develop social skills is through a modeling process, observing and imitating the therapist and other group members.

**Cohesiveness:** It has been suggested that this is the primary therapeutic factor from which all others flow. Humans are herd animals with an instinctive need to belong to groups, and personal development can only take place in an interpersonal context. A cohesive group is one in which all members feel a sense of belonging, acceptance, and validation.

**Existential Factors:** While working within a group offers support and guidance, group therapy helps member realize that they are responsible for their own lives, actions, and choices.

**Catharsis:** Catharsis is the experience of relief from emotional distress through the free and uninhibited expression of emotion. When members tell their story to a supportive audience, they can obtain relief from chronic feelings of shame and guilt.

**Interpersonal learning:** Group members achieve a greater level of self-awareness through the process of interacting with others in the group, who give feedback on the member's behavior and impact on others.

**Self-understanding:** This factor overlaps with interpersonal learning but refers to the achievement of greater levels of insight into the genesis of one's problems and the unconscious motivations that underlie one's behavior.

### 2.3.3. Benefits of Group Therapy

For participants, there are many reasons why **group therapy** is a treatment worth considering. The main advantages include are listed underneath.

- It allows participants to receive support and encouragement from other members of the group, helping them to feel less alone or isolated.
- Group therapy provides an opportunity for group members to act as role models for other members, especially when the group is composed of participants at different stages of treatment. Even if all participants are at the same stage, some participants will naturally be more successful at managing certain types of problems than others; and group members can share their experiences and learn from each other.
- It is usually more affordable than individual treatment, since the therapist's time is shared with other clients.
- Group therapy provides a safe environment for group members to practice new behaviors without fear of judgment.
- Interacting with others in group therapy will help the therapist to see first-hand how a client interacts with others and behaves in a social situation, allowing the therapist to provide targeted feedback and suggestions to each client (Cherry, 2017).

#### 2.4. Effectiveness of Psychological Treatments

The expressions 'psychological treatments' and 'psychotherapy' are interchangeable to express non pharmacological treatments in the psychiatric context. So, there is the use of both to mean the same idea. This section of the literature review tries to show how effective is psychotherapy to help those who have mental illnesses.

Psychotherapy is very essential for the treatment of mental disorders. There are a number of items of evidence that can indicate its being beneficial and effective.

Gilman (2001) indicated that in controlled trials and clinical practice psychotherapy was found to be healing. Markowitz (2008) also presented that psychotherapy is a legitimate and

beneficial treatment for mental disorders in the United States. According to Jerome Frank (1971, 1991), psychotherapy works for most psychopathology.

From hundreds of meta-analysis studies, a conclusion was made to show that psychotherapy to be very beneficial for a wide range of disorders (Grawe et al, 1994; Lambert, 2013). Some other conducted studies revealed that the results of psychotherapy tend to last longer and less likely to require additional treatment courses than psychopharmacological treatments (Hollon, Stewart & Strunk, 2006; Sheldler, 2010). After numerous meta-analyses, Beutler (2009) confirmed that CBT, which is one kind of psychotherapy, is found to be the most effective psychological treatment for a wide range of psychotic disorders that include depression, bipolar disorder, obsessive compulsive disorder, and anxiety disorder.

Another research finding has also indicated that those who received psychotherapy for their mental health problems achieved much better outcomes compared with the times they had not received any psychological treatments (Lambert & Ogles, 2004; Wampold, 2001, 2007). According to the American Group Psychotherapy Association, there is research evidence that shows individual, group and family psychotherapies are effective for a broad range of disorders. Again another research finding clearly reveals that early mental health treatments that include psychotherapy improves the patient's treatment seeking attitudes and behaviors (Alexandra, Arnkoff, & Glass, 2010; Felker et al, 2004).

To come to a common understanding, different research findings and evidence urge professionals and non professionals to accept the usefulness, benefits and effectiveness of psychotherapy or psychological treatments for the positive outcome of patients of mental illness.

## 2.5. Professionals Who Can Provide Psychological Treatments

Sharf (2008) stated that psychotherapists and counselors come principally from fields of psychology, psychiatry, social work and psychiatric nursing. Mental Health America (2015) also explains that there are actually a number of different people who are able to provide psychotherapy services to clients suffering from mental illness and psychological distress. It also indicated that while each of the mental health professionals deals first-hand with the practice of psychotherapy, they often utilize different techniques and approaches. It was also emphasized each profession has its own unique educational and training requirements. Cherry (2016) seemed interested to show that professionals who provide psychotherapy and other mental health services often hold a number of different titles, credential or licenses.

Psychologists, counselors, clinical social workers, psychiatrists, psychiatric or mental health nurse practitioners and members of the clergy are able to provide psychological treatments for people with mental health problems.

#### 2.5.1. Psychiatrists

Psychiatrists are medical doctors who have graduated from medical school and then participated in a resident program in psychiatric care. They specialize in the diagnosis and treatment of mental illnesses and have the ability to prescribe medications. Some psychiatrists are board-certified, indicating they have passed written and oral board exams after completing medical school and psychiatric residency. Most psychiatrists do not offer counseling services, but will recommend treatment and give referrals to therapists.

#### 2.5.2. Psychologists

Psychologists are another major group of professionals providing psychotherapy. Psychologists who practice psychotherapy have received specialized training in clinical or counseling psychology. They are usually trained in psychopathology, psychotherapy and

counseling. In North America they typically have a doctorate degree, although in other jurisdictions one can register as psychologist with a master's degree. Many psychologists are also trained in psychological assessment or the administration of psychological tests.

### 2.5.3. Counselors

Licensed counselors typically have two to three years of graduate training in counseling methods. Specialty areas include marriage and family counseling, school counseling, community counseling and substance abuse counseling.

### 2.5.4. Psychiatric Nurses

Psychiatric nurses are registered nurses who usually have a master's degree in psychiatric nursing. These professionals are able to assess patients, diagnose disorders, provide psychotherapy and prescribe medications in some states. They often work in a hospital setting conducting individual or group therapy with patients under the supervision of a psychiatrist. Nurses in this area receive specific training in psychological therapies, building a therapeutic alliance, dealing with challenging behaviour, and the administration of psychiatric medication.

### 2.5.5. Psychiatric Social Workers

Psychiatric social workers have a master's degree in social work, usually requiring two years of graduate study. They may work in mental health agencies or medical settings practicing individual therapy or family and marital therapy. Psychiatric social workers make up the single largest group of mental health professionals.

### 2.5.6. Members of the Clergy

Members of the clergy—priests, ministers, and rabbis—usually take courses in counseling and psychology as part of their seminary training. Some ministers specialize in pastoral counseling, working with members of a congregation who are in distress.

## Chapter Three

## Methodology

## 3.1. Research Design

A qualitative research of an explanatory case study method was chosen to conduct the study. Specifically, a situation analysis was applied to figure out the nature of psychological interventions that are implemented and the professionals who provide the intervention for the patients.

## 3.2. Participants

There are ten psychiatric nurses, one psychiatrist at the master's level and one part time psychiatric doctor who provide the service twice a week for half days.

The participants of the study were the psychiatric nurses who were involved in delivering the psychological services to the psychiatric patients in the psychiatric unit of Torhailoch Specialized Hospital, and inpatient of the psychiatric ward were also included.

## 3.3. Sampling and Sampling Techniques

As a qualitative method which is suitable for this study was used, a qualitative sampling method works very well in order to collect the needed data. Because of this, a non probability sampling was applied. From the non probability sampling techniques, purposive sampling method was chosen for the sake of gathering the data in depth and because this technique allowed the researcher to gather the data from those who were selected.

## 3.4. Instruments

Qualitative research methods need instruments that must permit the researcher to collect data in depth. Keeping this in mind, the three instruments were applied. The instruments were interview, observation and document analysis.

### 3.5. Ethical Consideration

The researcher used a consent form that requests the permission of the participants to get involved in the study, and all the participants agreed to give their interview and they showed their agreement by signing on the letter. Each participant was given a copy of the consent for to confirm this agreement to be in the study.

## Chapter Four

## Result

The data was collected using the tools of interview, observation and document analysis. The interview was semi-structured. Each practitioner gave an average of thirty five minutes of interview, and each patient took an average of ten minutes to give the interview. The researcher did the observation as a participant because he was also an intern in the hospital for three months. Document was analyzed, interview was conducted and observation was made for the purpose of gathering data for the study.

Nine participants were involved in the study. Six of the participants were psychiatric nurses and the remaining three were psychiatric patients.

The abbreviation Pr. is used to stand for practitioner participant, who is the psychiatric nurse. The abbreviation PP is used to refer to patient participant, who was the psychiatric inpatient in the hospital during the time of data collection.

#### 4.1. Document Analysis

The document analysis showed the number of psychiatric patients that were admitted and the kinds of illnesses diagnosed in the psychiatric unit within six months' period (from Tikimt 21, 2010 to Miaizia 15, 2010 Ethiopian Calendar). The total number of patients admitted during this six-month period as one hundred and two. On average 17 patients were admitted per month. Ninety of them were males (around 88.2 %), and the remaining twelve were females (comprising 11.8 %).

Out of the total number of patients, 38 of them (around 37.2%) were diagnosed to have schizophrenia; 33 patients (around 32.3%) were found to be people with mood disorders –

depression and bipolar disorder; those with substance use disorder were 28 patients (around 27.4%); epilepsy and other unspecified mental illnesses had a share of 3 patients (around 2%).

The paragraph describes the psychiatric patients who were in the hospital who got pharmacotherapy and psychotherapy in the hospital during the period the data were being collected.

#### 4.2. Data from Interviews and Observations

The interviews were analyzed based on the research questions of the study, and themes were identified.

##### 4.2.1. The Psychiatric Nurses' Trainings

All of the practitioner participants were trained in psychiatry or psychiatric nursing in Bachelor of Science. Each of them took a single psychology course within which a topic of psychotherapy was included.

All of the courses of psychiatry had their own practice periods for one month or two after the classroom sessions ended. But when it comes to the course of psychotherapy, the trend did not go as it was in the psychiatry courses.

“We took a psychology course with three credit hours. We also took a course of psychotherapy in four credit hours. But the courses of psychiatry took 47 credit hours.”

This practitioner also added,

We had practice at St Amanuel Hospital, St. Paul Hospital and Torhailoch Hospital. We went to these hospitals for psychiatric courses practice. When it comes to psychotherapy, we did only the observational practice in St. Paul Hospital. Actually, we did not have its practice schedule. During the time we went to St. Paul Hospital for psychiatric courses practice, we included the observations of how psychotherapy was delivered in that hospital. We had the opportunity to get five observations. The group therapy was provided only once a week.(Pr.2)

Practitioner four had similar idea with practitioner two. She stated,

We went to St Paul for practicing psychotherapy. The group psychotherapy of St. Paul Hospital was for people with substance use problems. We were observing how the therapy was being delivered to the patients. We were also given chances to reflect our ideas about the way the group therapy and we forwarded some ideas.(Pr.5)

As a result, the practitioners did not get the opportunity of translating what they learned in the classroom into practice. Instead they had only the experience of observing how group therapy was delivered in St. Paul Hospital for an average of three sessions. The group therapy of St. Paul Hospital was designed only for patients of substance use disorders. The observations which they had didn't include other groups which should comprise other mental health patients. The participant practitioners' training condition is similar with the rest of the practitioners in the unit because they had similar trainings in the same institution.

The practices of psychiatry courses included supervision; however, supervision did not have a place in psychotherapy, which is very essential for a professional to be a successful therapist.

#### 4.2.2.The Kinds of Psychological Treatments

Three types of psychological treatments were mentioned by the practitioners. The treatments they provided to the mental health patients were group psychotherapy, individual therapy and family therapy. The researcher had the opportunity to observe only the group therapy while it was being conducted when he was an intern practitioner and as an observer.

The data are presented under the themes of group therapy, individual therapy and family therapy.

##### A. Group Therapy

All of the interviewees indicated that group therapy is the main kind of psychological treatment that is available in the psychiatric unit for the mental patients.

The observation of the researcher confirmed the presence of the group therapy in the unit, and he also attended the therapy a number of times when he was an intern in the hospital for three months and as a participant observer during the time of collecting data.

Almost all of the practitioner participants and the patient participants informed that all kinds of mental patients are included in the group therapy. But patients who have insight problems and communication problems may not be included in the therapy because they do not have the attention, and sometimes they disturb the group members and the therapy itself.

Even though a single practitioner participant explained that there are different groups based on their cases in the unit, the remaining practitioners and all the patients reported that there was only a single group which comprised all kinds of psychiatric patients. The researcher was also able to observe the presence of only one open group.

The group therapy is conducted twice a week. The days are Tuesday and Thursday afternoons. A single session could take from thirty minutes to an hour. Despite the fact that the duration of the session needs to be fixed according to the schedule of the unit, the duration of the single session of the therapy varied based on the situations and the practitioners.

The researcher was able to observe that during the group therapy the assigned practitioners brought topics for discussion and after the discussion the practitioners gave explanations in order to conclude the sessions.

The responses of practitioner one, practitioner two and practitioner three can confirm this situation.

“During the group therapy, each patient gets a lesson when another patient shares his experience.”(Pr.2)

“During the group therapy the practitioner introduces the topic of the day, but the practitioner does not do a lot of things. He or she gives the opportunity to the patients to discuss and they keep on discussing.”(Pr.3)

The topics which were brought into discussion were only two kinds. They were 'what mental illnesses are' and 'what an addiction is.' After the practitioners introduced the topics of the day, they gave patients the opportunity to forward what they believed or what they know about the raised topics.

Those patients who raised their hands were given the chance and they forwarded what they understood and believed. But those patients who never participated in the discussion were frequently asked by the practitioners to remind the group what were being discussed during the sessions. While some of the patients tried to explain, some others said nothing.

One of the patients explained the situation in the following way:

"The nurse sits in the middle and encourages patients to speak. Patients who raise their hands are given the chances to tell the members or the nurses his idea that he believes it is related to raised topic."(PP.1)

The second patient participant seemed to say similar things with the first patient participant and the observation of the researcher.

"The doctors encourage every patient to participate or say something about the point which is raised. They ask us patients what we learned from the discussion or the lesson delivered; they also ask us patients if there is anything which disturbs us or anything which we want to share to the group; during the time we are together, we exchange ideas one another."(PP.2)

The response that one of the practitioners gave was in consistent with the patient participants said. He stated,

The patients learn from each other in the group therapy. When each patient shares his or her experience, the others listen to the speaker with a lot of wonder and attention because they get amazed by the life experience of the other patient. Instead of teaching them, we usually allow the patients to discuss and share their unique experiences. (Pr.4)

The group therapy had the nature of encouraging patients to participate in the discussion that patients are doing. The practitioners are also teaching patients about the general nature of mental illnesses and addictions in the manner and language that the patients can understand.

### B. Family Therapy

All of the practitioner participants indicated that family therapy is delivered in the unit when they believe including family members becomes essential for the wellbeing of the patient in some ways.

According to the participants, the purpose of family therapy is that family members of the patients need to be aware of the natures of the illnesses, and that the family members need to provide the necessary support to the patients. The other aim of the family therapy is to inform family members of patients to help and follow up the patients closely so that their adherence of medication might not be interrupted, which is very crucial for their wellness and relapse prevention.

The family therapy does not have a regular schedule. As a result, the researcher was not able to observe how it was conducted and how long it took in terms of duration of sessions and number of sessions.

The responses of three practitioners are listed below. The third practitioner participant focuses on the need to inform family members about psychotic illness so that they could be better understand their loved one who suffered from the illness. The practitioners explained,

“Our family therapy is not in a formal form. But when for example a family member will be informed about the patient’s psychotic nature and they will be told what cares need to be taken for the good of the patient.”(Pr.3)

The fourth participant included the need of raising the awareness of family members how their support is essential for the recovery of the patient. The participant stated,

“Patients need the support of their family members. Because of this, we sometimes call family members and educate them the nature of mental illnesses and the need of their support for wellbeing of the patients.”(Pr.4)

The fourth participant also added to show the importance of including family members when treating psychotic and mood disorders. He said,

“Including the family members is very important in the case of psychotic illnesses and mood disorders because the patients do not have the insight that they have mental health problems. But the treatment of medication must be done before the family therapy begins. (Pr.4)

The first practitioner also stressed what the other two practitioners said. He kept on saying,

“Sometimes after assessing the nature of patients we call family members and we inform about the illness of the patients and the importance of their support for the patients.”(Pr.1)

The practitioners seemed to show that family therapy can be one of the therapies which are delivered when they want to include family members for the purpose of helping patients in the case of psychotic illnesses and mood disorder.

### C. Individual Therapy

Three ideas were reflected by the interviewees when individual therapy was raised. One idea was that there is individual therapy on daily basis. The other idea was that individual therapy is conducted when the practitioner believes that it is essential for the patient he or she encounters. The third idea tells that there is no individual therapy in the unit at all.

The practitioner who indicated the presence of individual therapy on daily basis reported that convincing patients about their illness and the medicines that they take is important when practitioners meet the patients. So, this participant believed what they were discussing with

patients every day is a kind of individual therapy. The pieces of advice given to patients are the individual therapies in the unit.

This practitioner stated,

“We deliver individual therapy on daily basis. We usually go to the bedrooms of the patients, and we tell them what they must do to get better when it comes to the medication or their behaviors. We give them advice about their illness, the medicines or behavioral issues...For a single patient we can take a day or two for ten minutes.”(Pr.1)

The practitioner who indicated that individual therapy is delivered only when the need of delivering the therapy convinces the practitioners. He also indicated there can be no individual therapy when there is no case to conduct individual therapy. That is, there is the possibility of no delivery of individual therapy for the patients.

The second practitioner presented his response in this manner,  
“We conduct individual therapy when there is a patient who has a different case that cannot be treated in the group. Or else we don’t conduct any kind of individual therapy.” (Pr.2)

The third practitioner explained that no practitioner gives individual therapy in the way individual therapy is to be conducted. The main reason is lack of knowledge, skill and practice of delivering individual therapy. This is what the practitioner said,

“There is no formal individual therapy in our unit. It is better to call it a friendly talk rather than taking it to be individual therapy. That is what I believe what we are doing.” (Pr.3)

The length of sessions of their individual therapy is only a single session of ten to twenty minutes. During the meeting, the practitioners ask, give advice and comment.

Two practitioners gave responses how long their individual therapy lasts. Practitioner one says, “Our individual therapy is for ten or twenty minutes.” (Pr.1)

Practitioner two seemed he took a little more time than practitioner one was using. He indicated, “When it is individual therapy, we can use twenty minutes to discuss with the patient.”(Pr.2)

The so-called individual therapy which is being provided to the mental health patients takes not more than twenty minutes. The hospital also does not have a room for the purpose of delivering the therapy, so the practitioners are using the bedroom of the patients or any corner of the compound.

#### 4.2.3. The Approaches of the Therapies

##### A. The use of psycho-education and psychosocial education

Two things are happening in the group therapy. The first is sharing experiences among patients, and the second is educating the mental health patients about mental illnesses and addictions with their causes, symptoms and effects on patients.

The practitioner participants and the patient participants indicated these two points. “According to our program, we select topics and teach the patients accordingly. (Pr.1) “The patients discuss their concerns when the practitioners facilitate the environment.” (Pr.3)

“The purpose of the group therapy is to help our patients discuss their ideas related to the topics raised during the therapy.” (Pr. 3)

“When each patient shares his or her experiences and struggles, the others listen attentively and get a different kind of understanding.” (Pr.4)

“Each patient gets the opportunity to learn from the other patients during the discussion sessions. (Pr.4)

##### B. Absence of the Use of Theories of Psychotherapy

It was noted that the practitioners did not use any theories of psychotherapy when they were delivering the therapy whether it was in a group, family or individual format. They delivered the group therapy only in the way they observed their seniors did and in the way they

had observed during their practice period at St. Paul Hospital. Some of the practitioners also indicated that they did not use theories because they did not have the practice after taking the course about psychotherapy, and they have almost forgotten the theories of psychotherapy.

“We took psychotherapy course, and we use cognitive behavioral therapy in the unit most of the time.” (Pr.3)

When a question of which techniques of cognitive behavioral therapy that they frequently used was raised, the practitioner replied that they brought topics and allowed the patients to discuss.

“We tell the patients we brought topics for discussion. After the discussion is completed, next we practitioners always explain what to be done, and some other patients also give advice the other patients.” (Pr.3)

When a question of whether the possibility of not using theories of psychotherapy was raised, this practitioner replied that lack of knowledge made them not use theories.

Another practitioner participant believed that she used behavioral therapy to help her patients change their maladaptive behaviors.

“I prefer to use behavioral therapy. Most of the time, the patients we meet have behavioral problems. As a result, I tend to do something on their behavior.” (Pr.4)

This practitioner replied that harmful habits were raised and discussed to help patients change their habits when a question of techniques was raised.

“Habits that are harmful for the patients are discussed in detail, and we try to convince them change these bad habits.” (Pr.4)

Though the practitioner focused on changing harmful behaviors of patients, it could be inferred that behavioral therapy was not applied during the group therapy sessions. Actually, educating the patients about the harmful behaviors did take place.

The response of another participant showed that using theories or approaches of psychotherapy is foreign for the practitioners in the unit.

“Mostly we use group therapy. The therapies you mentioned as cognitive therapy and the other therapies are unlikely to be applied here. But what we frequently do is giving group therapy. In the future, I think we might use them.” (Pr. 5)

Another practitioner emphasized that the practitioners in the ward are not using any theory of psychotherapy even though they learned the theories in the classroom sessions. He stated,

We don't do psychotherapy using theories in our unit. As far as psychotherapy is concerned, none of us can say that we are using cognitive therapy or behavioral therapy or whatever therapy. What we are doing is that based on our turn of the schedule, we select topics and then we teach the patients. (Pr.1)

The second practitioner gave his support to the response of practitioner one. This was what he said, “Our delivery of psychotherapy does not have any theoretical ground. We lack the experience of preparing ourselves for the therapy we deliver.” (Pr.2)

Both of the practitioners agreed that applying the theories is very important for the good of the patients.

“Personally, I believe it is good to recognize the theories very well and apply them in our therapy sessions.” (Pr.1)

“In my opinion we have to get to know the theories very well and make use of the ones which fit our circumstances.”(Pr.)

The practitioners indicated that they are delivering group therapy, family therapy and individual therapy. But they also agreed that they do not use any kind of theory while they are conducting the therapies.

#### 4.2.4. Perspectives of Nurses and Patients

All the participants, patients and practitioners, indicated that psychological treatments are very important for the wellbeing of patients. The psychological treatment they were referring to was the group therapy that the practitioners were delivering and the patients were receiving. Three themes emerged from the interview sessions regarding the importance of psychological treatment. The themes are important for sharing and getting experiences, important for raising awareness for adherence of medication and important for emotional relief. These things contributed directly and indirectly to the wellbeing of patients.

#### A. Important for sharing and getting experiences

The group therapy gave patients the opportunity to see themselves and their problems when they were with other patients in the group discussion. Some of the patients were able to understand that what they were experiencing was similar with others were experiencing. This understanding could lessen their confusion and disturbance.

The response of the participants showed these ideas. Two patient participants shared their experience with the research in the following manner.

The usefulness of group therapy is paramount. For example, when one individual explained what he used to solve his problem, a problem of substance use, I got amazed. I never thought problems can be solved using the way he used. Discussions of such kinds give you different ways of solving problems.”(PP1.)

This same patient also added,

In the therapy, I could observe that when somebody becomes under the total influence of some kind of substance, the person can attempt suicide or commit suicide. The discussion we had shed light what will happen to my life if I continue in addiction. The thought scares me so much. Thus, I have decided to quit taking substances permanently. (PP.1)

The other patient made it clear that what the other patients who were in the therapy discussed after the session ended and when they were together after the therapy. He stated,

“I heard patients discuss that they would face the same suffering as the one who shared his story if they kept on doing things the way the storyteller did.” (PP.3)

The practitioners also explained the group therapy how helpful it is for patients to share experiences and to understand that they are not the only ones who have those problems.

Practitioner two explained this in this way:

“When one patient tells his or her problems and its effects on his or her life, the others get information about that problem in other’s patient life. This is very useful.” (Pr.2)

Practitioner one seemed to share the same idea. He also explained,

Group therapy is a kind of situation where patients become aware that their problem is not their own only. This experience causes them to understand that others have similar experiences. It is very important kind of treatment for mental health patients. (Pr.1)

Practitioner five said the same thing as the other two practitioners mention. He stated,

Psychotherapy gives awareness for those people who have problems in substance use. Each patient after group therapy can have a clear awareness of the effects of substance they are taking, and they, in turn, can also teach the members of the society. (Pr.5)

The practitioners and the patient participants indicated that group therapy is helpful and essential for the patients so that they share experiences and get a lot of information about the illness that they have and this helps the patients.

#### B. Important for adherence to medication

The practitioners indicated that the group psychotherapy helped them to make patients aware of using medicines that were prescribed for their wellbeing. The discussion they had during the therapy made it clear that the proper use of medication was very instrumental for being cured and for the prevention of relapses.

Practitioner one explained how helpful the group therapy is to make patients change their negative attitudes to take medicines and to convince them to adhere the usage of medication.

This what he said: “Counseling service is very essential in our unit because it helps us to convince patients to have adherence of medication.” (Pr.1)

He also added the nature of mental health patients that challenges the practitioners and how the group therapy helped them to overcome the challenges they faced.

When most patients are brought to this hospital, they always try to convince the nurses and others that they are healthy and they do not know why they are here. But after attending the group therapies for some sessions, they begin to realize that they have mental health problems and they begin to cooperate with the practitioners to take medicines. (Pr.1)

Practitioner three explained how the group therapy helped the practitioners to make the patients recognize the side effects of the medicines they are taking. Because of the adverse effects of some medicines, some patients resist to take the medicines. But after attending the therapy, the practitioner has seen changes in the attitudes of patients in the positive side. To explain this situation, she said,

Our patients are more concerned about side effects of the medicines they are taking because of the discomfort they are experiencing. As a result, they show the tendency to quit medicines or make an argument not to take the medication. But after attending the group psychotherapy, they become aware of the adherence of medication and they also become less resistant despite the adverse side effects. Do without the inclusion of psychotherapy, medication can't help so much. I can say that only focusing on medication makes your effort less fruitful. (Pr.3)

She also emphasized that it is not only mental health patients who need psychological therapies. She believed that any kind of medical treatment needs to include psychological treatment for more effectiveness and for better outcome.

Any kind of medical treatment needs to include psychological treatments for more effectiveness. Unless the patient gets convinced and becomes cooperative, I think, using medicines only will become less likely to cure patients. When it comes to psychiatric patients, psychotherapy is much

more important than medication. I strongly believe that psychological treatments are very important for mental health patients' wellness." (Pr.3)

The perspective of practitioner one is very amazing. Even though he was more trained for helping patients in medication, his attitude for psychological treatment seemed very positive. He confidently said, "Psychotherapy is more than medication. So we give both medication and psychotherapy together for our patients." (Pr.1)

One of the patient participants indicated that he was objecting taking medicines, which means the medicines that is taken orally. Because of this he was given injections even though he resisted this also. But after attending some therapy sessions he agreed to take the oral medicine willfully. He explained his recent stand in this way,

"Now I am in the position of following what the practitioners informed us, and I have to take the medicines with no interruption as it is important for my wellness."(PP.2)

The responses which are collected from the practitioners and the patient made it clear that the group therapy has become helpful to raise the awareness of patients so that they continue taking their medicines while they are in the hospital and after they are discharged from the hospital.

### C. Important for patients' emotional relief

All participants tried to show that psychological treatment is useful for the positive emotional experience for patients. Patient's feelings vividly have differences before and after the therapy. According to the patients and the practitioners, during the start of the group therapy many of the patients looked tired, bored, sleepy and sick. But after the therapy ended those, feelings and emotions got rid of the lives of patients and almost everybody looked refreshed and energetic.

One of the practitioners shared what he regularly observed patients before and after the group therapy. He stated, “The patients feel unburdened when they share what worries them. They get relief after even only attending the group therapy. (Pr.5)

All of the patient participants expressed how good they felt after they attended the group therapies. They also indicated that they had emotional difficulties to attend the meeting, but after having participated in the therapies, they never had the earlier feelings that distressed them.

Patient participant one related not only his experiences, he also related the other patients as well.

The problem that brought me to this hospital is addiction. I was injecting myself with drugs to feel good. This became my usual life. But I worried about my life how long I would keep on this way, and finally I decided to quit abusing the substance and I got admitted to this hospital with my own willingness. During the group therapy, I realized that how dangerous it is depending oneself on drugs when one patient explained that he attempted suicide a number of times because of feeling worthless and hopelessness. I had also those feelings, too. But after hearing what he was going to do, I thought that I would do the same thing if I continued in this kind of life style. Getting the chance to hear this unique experience of the person led me to praise God that I am alive. I have also become glad that I am in this hospital to quit depending on the drug which I was abusing.(PP.1)

The patient also added what the other patients felt after the therapy, “Many patients are eager to listen to the experience of other patients, and they feel good after listening to the stories of others.” (PP.1)

Patient participant two shared his experiences how he felt after the end of the group therapy session.

”During the beginning of the discussion or the lesson we found it confused what to say or what to do. But after the discussion and the delivery of the lesson we get something, even we feel happy at the end of the sessions.” (PP.2)

Patient participant three expressed what he experienced during the days he participated the group therapy in this way:

“The discussion we had in the therapy gave us internal satisfaction. I personally experienced positive feelings after I attended the lesson the practitioners gave.” (PP.3)

He was also willing to tell what the other patients were feeling. He kept on saying,

“When each patient speaks what they feel, the feeling of depression that suppresses the person departs from him. So, the discussion is very good to scare away our bad feelings.” (PP.3)

The practitioner and the patients themselves pointed out that the group therapy helped the patients to listen to the experiences of other patients and began to have emotional changes to the positive.

### Discussion

This section of the paper discusses the findings of the result based on the research questions of the study.

#### **5.1. How professional are the practitioners who deliver the psychological treatments for the mental health patients?**

The Findings of the current study showed that the practitioners are psychiatric nurses. Three of the nurses affirmed that they took a psychology course (course title: Introduction to Psychology) with three credit hours within which a topic of psychotherapy was included. The other three practitioners took a psychology course (course title: General Psychology) with three credit hours and a psychotherapy course with four credit hours.

All of the practitioners had only observational practice of group therapy which was being conducted at St. Paul Hospital. They had on average four observations. Their observations of the group therapy were limited to an open therapy group which was designed only for patients with substance use problem. Their observational practice did not have its own supervision. The reason for not being supervised was shortage of professionals of psychology in the college. The college was giving the courses using part time teachers, who were teaching in other colleges. This was the main reason not to allow the psychiatric nurses to gain supervised practices or observations. But full psychotherapeutic training needs to cover a theory, self-experience, and practice under supervision (Ward, 2011). Abuhashem et al (2015) have indicated that there is a relationship between practicing psychological therapies and nurses' level of education and setting of work. They also indicated that in the study they conducted they found that psychiatric nurses had poor knowledge and little basic practice regarding psychological therapy.

Rydon (2005) has shown that psychiatric nurses receive specific training in psychological therapies and building a therapeutic alliance. Sharf (2008) also indicated that psychiatric nurses are registered nurses who usually have a master's degree in psychiatric nursing; and they often work in hospital settings conducting individual or group therapy with patients under the supervision of a psychiatrist.

Based on the above perspectives, one can judge that the psychiatric nurses of the hospital had inadequate training to deliver psychological therapies for mental health patients in the way it has to be delivered.

## **5.2. What kinds of psychological treatments are delivered in the psychiatric unit of the hospital?**

### **A. Group Therapy**

The hospital has only a single group for the purpose of delivering therapy for the mental health inpatients. The group has a heterogeneous nature which means that the members of the group were diagnosed with different mental illnesses, such as schizophrenia, depression, bipolar disorder and substance use problems. Every patient who is admitted to the ward is expected to attend the group therapy. This can indicate that little preparation is made to select members of the group therapy in order to form the group.

Even though the majority of the patients who attended the group therapies were diagnosed with schizophrenia, depression and bipolar disorder within the six month period, the topic of addiction dominates the discussion in the group therapies. The response of one of the practitioners indicated this.

When we have twenty or fifteen patients in the group therapy and if seven or eight of the members are people with substance use problem, then we will teach the whole group about addiction together with its causes, symptoms and effects on the mental health of patients. Even though the other members

of the group do not have this problem, we encourage them to participate in the discussion. (Pr.1)

It can be suggested that this can prevent the majority of the group members to get involved in the discussion openly; and it can indicate that the therapists fail to emphasize the commonalities among members to install a sense of group identity. Installation of a sense of group identity is one of the principles that need to take place in group therapy (Yalom, 1983). It can also be the result of inadequate training how to conduct therapy.

Instead of using heterogeneous group, using homogenous group could be more beneficial for encouraging members to participate because they can have common issues (Yalom, 1983)

The other things that were observed about group therapy were the size of the group, the length of the single session and the setting in which it was being conducted. The size of the group therapy varies depending on the number of patients who are admitted to the ward. It can be small, medium, large or very large. There are no minimum numbers of participants to be allowed and no maximum numbers of participants to form the group. Ten to thirty patients can be involved in the therapy.

The duration of the single session is believed to be thirty minutes. The decision of the duration has come from the administration of the ward and it is taken as a norm. The practitioners had the following to say when justifying the very brief session. One of them said, "We use from twenty to thirty minutes. The reason for this is that the patients must not get bored. To avoid boredom of patients we have decided to make the duration shorter." (Pr.5)

The other practitioner agreed with the idea of practitioner 5 and stated that "Because the patients must not get tired and stressed, thirty minutes becomes enough to conduct the group therapy." (Pr.1)

But the patients did not seem happy with the duration of the session. They thought that the duration is not enough to get each member the chance to express their ideas in the way they want.

“I believe the duration of the session is short. Each member needs to be given enough time to finish speaking what he or she has in mind. Everybody is eager to listen to the experience of the other patients.” (PP.1)

“According to my evaluation, the duration of the session is shorter than I expect it to be. I think we use thirty minutes, but making it an hour seem enough to me because it gives the opportunity each member to speak and participate actively.”(PP.3)

Koukourikos et al (2014) advised therapists to use the duration of 60-90 minutes so as to increase patients' awareness of themselves through interaction with other group members, to provide patients with improved interpersonal social skills and decrease isolation for those who are psychotic.

When it comes to the setting, Gladding (1994) stresses that the meeting room should be quiet and inviting, and the room must be away from other activities. He further explains that groups work best when chairs are arranged in circles where everyone feels a sense of equality with one another and the flow of communication to get enhanced. But the psychiatric unit of Torhailoch Hospital does not have a room or a place which is devoted for the purpose of therapy. The room where the group therapy is conducted is the room which is used for a dining room for the patients, and the room which is also used as a TV room. The room also serves as a corridor through which people pass to reach the other offices of the ward and the women's bedrooms. During the group therapy, it was common that some other individuals were passing through the room to reach the other offices. This condition was sometimes disturbing the therapy and

distracting some patients who were in the therapy sessions. Thus, it can be concluded that the group therapy hasn't been given the attention it needs to help patients.

### **B. Individual Therapy**

The practitioners indicated that they conduct individual therapy in the ward. One of the practitioners believed he conducted individual therapy on daily basis.

“We deliver individual therapy on daily basis. We usually go to the bedrooms of the patients, and we tell them what they must do to get better when it comes to the medication or their behaviors. We give them advice about their illness, the medicines or behavioral issues...For a single patient we can take a day or two for ten minutes.”(Pr.1)

Another practitioner indicated that “Individual therapy takes a maximum of twenty minutes. We haven't gone more than this duration. We don't have time because we are expected to perform other psychiatric obligations.”(Pr.2)

It can be noted from the responses of the practitioners that there is a misunderstanding of what individual therapy is all about. They seem to confuse “giving advice” with “individual therapy.” Lioi (2015) makes it clear that advice is different from therapy. She further explains that the goal of most advice giver is to provide the individual an answer. But the goal of therapy is not providing answers; it is helping clients answer their own questions (Camepes, 2015). Lioi (2015) emphasizes that telling a client what to do is a kind of advice that goes against the nature of therapy. Kolmes (2010) also stresses that giving advice is not psychotherapy. Campese (2015) clarifies the difference between advice and therapy. Therapy, however, takes time and requires the person seeking the therapy to put in a lot of work. He also explained that a therapist does not need to give out advice because the point of therapy is to empower individuals to make their own decisions. Lioi (2015) added that advice rarely satisfies people and people do not come to therapy to get advice. She emphasizes that it is a relationship that heals. It is interaction between a patient and a therapist that provides the most healing and growth (Lioi, 2015). According to

Campe (2015), a professional therapist will never tell clients what they should do rather the therapist will help the individuals identify what they should do, or what they will choose to do.

It can be concluded that the practitioners can't identify the difference between advice and therapy. This can also be the result of inadequate training concerning psychological therapy. In brief, it appears safe to say that individual therapy, in strictest sense of the phrase, is not practiced in the hospital.

### **5.3. Which approaches or theories of psychotherapy are frequently used in the unit?**

#### **A. Absence of using theories of psychotherapy**

Counseling and psychotherapy have different theories and techniques by which therapists and counselors help their clients. Using theories or models of psychotherapy is very important for any professional who is engaged to deliver the psychotherapy service. In this connection, Myers (2013) stated that a theory presents a systematic way of understanding events, behaviors and situations. She further added that a theory is a set of interrelated concepts, definitions and propositions that explains or predicts events or situations by specifying relations among variables. It was also noted that establishing a theoretical orientation as a counselor is vital in working with clients in the mental health profession. This is common knowledge in the field because any well grounded professional needs a basis by which to operate. Aliriano and Wendell (2014) further mentioned how important theories are in conducting psychotherapy. They tried to depict that theories logically consist of concepts, assumptions and generalization. According to them, the main function of theory is to describe, explain and predict behavior. Boy and Pine (1983) also confirmed the importance of using theories by saying, "Theories are important to counseling as they are the foundation of effective counseling." This means that theories provide directions and ensure therapists to be effective with clients. In addition, Karen (2005) explains

that a growing body of evidence suggests that interventions developed with an explicit theoretical foundation or foundations are more effective than those interventions which lack a theoretical base. Thus, using theories or models of psychotherapy is very essential for anybody who is delivering psychotherapy or counseling.

The practitioners in the hospital, however, do not seem to have any experience of basing their psychological treatments on any of the theories or approaches of psychotherapy. The absence of using theories in their therapies was vivid when they replied that they are delivering the group therapy only in the way they observed their seniors did and in the way they had observed during their practice period at St. Paul Hospital, which had only a single group therapy for people with substance use problems.

It can be suggested that the neglect of using theories of psychotherapy has stemmed from the inadequate trainings they received during the time they were in college. Evidence from the practitioners supports this point. One of the practitioners pointed out the reason why she was not able to use theories or approaches of psychotherapy.

Lack of knowledge. We learned the theories in the classroom, but we did not have the appropriate practice during the training time. If I am asked about psychodynamic, psychoanalysis, or the others, I can't say anything now. I cannot remember them now, because we did not have the practice to get to know how to use them. I think this is not only my problem. It is the problem of every practitioner in this unit.(Pr.3)

According to the this practitioner, practice of psychotherapy was not given the attention it needs so as to be able to master the way therapy needs to be delivered using the theories which can be considered as a "road map" to show the destination of the therapy. The practitioner did not imply it was just her problem, but she also indicated that this was the problem of every practitioner in the unit as they had similar trainings and similar exposures. The responses of two other practitioners seem to agree with her idea.

We never have had the experience of delivering psychotherapy using any kind of theory of psychotherapy...What we are doing is delivering group psychotherapy based on the way our seniors were doing. They are our models to deliver psychotherapy... We learned theories of psychotherapy and how they must be used, but we learned only in a course level, no more than that. We are not applying them in our unit. Each practitioner has a program when to deliver the therapy, so the practitioner brings a topic and invites patients to discuss or he teaches the patients based on the topic he has brought.(Pr.1)

There is the practice of not using theories of psychotherapy in this unit. There is a lack or absence of preparing oneself to deliver the therapy in the part of the practitioners. We deliver the therapy in the way we want to do it rather than getting led by theories.(Pr.2)

The other reason for not using theories of psychotherapy must be the practitioners' attitude. They believe they are trained to treat patients pharmacologically. Psychological treatments are not their concern as far as they are not psychological professionals. The belief that they are doing the job of psychological professionals has contributed for not using theories and approaches of psychotherapy. They did little to update themselves how to give the therapy in the manner of applying the theories. They also feel that they are doing what psychologists should have done because there is no psychological professional in the unit. The responses of the practitioners may clarify this point.

I think we are doing both the jobs of psychiatrists and psychologists. Instead of my doing psychotherapy if a person who is professional in the area delivers the therapy, I think there will be more effectiveness... We should have at least one psychologist. Things need to be done with their own professionals. The knowledge which they have is missing when it comes to me as a psychiatric nurse. What I am giving is limited because of my limited knowledge. But the psychological professionals have sufficient knowledge to help patients using psychological means. I have also limited resource and time to update myself. I am more focused on helping patients with medication.(Pr.1)

Another practitioner stated that "Psychological treatments did not have enough focus when we were being trained. Most of the focus is on how to help patients using

medication.”(Pr.5)In the same manner, another practitioner explained his opinion as follows.

We need psychologists to be hired in our ward. Even though psychotherapy is a very essential treatment for psychiatric patients, we do not have any psychological professionals. It is very difficult for me as a psychiatric professional to deliver psychotherapy in the proper manner because I am not well trained in that direction. I fear I may lead the patients to wrong directions instead of helping them... Updating oneself is one of the things which I love very much, but I can't say I am doing a lot in that direction. I read only few things concerning psychotherapy. It is not at the level to help patients.(Pr.3)

It has become evident that the practitioners are doing the therapy without giving any concern for the theories of psychotherapy, and this can imply that they are giving the service with no map where to go and what to give to their patients. This practice of delivering therapy with no theoretical foundation brings less effectiveness compared to therapy with the help of theory (Karen, 2005).

### **B. The use of psycho-education**

The group therapy and the family therapy which are delivered in the psychiatric ward seem to have some nature of psycho-education in some ways. Before discussing the way it is being delivered in the psychiatric unit, it is essential to explain what psycho-education is.

Bhattacharjee and colleagues (2011) gave the explanation of psycho-education as an educative method which aims to provide necessary information and training to people with mental health problems and their family members or caregivers. They further explained that psycho-education has become an effective adjective treatment which can significantly improve the level of understanding of people about mental disorders, ensuring active participation of both patients and their caregivers. Xia et al. (2011) defines psycho-education as a therapist intervention for patients and their family members, and it provides information and support to

better understand and cope with illness. He further tried to indicate that psycho-education is most often associated with serious mental illness including dementia, schizophrenia, psychotic disorder, clinical depression, anxiety disorders and others they also stress that psycho-education can take place in one to one discussion or in groups, and it can be delivered by any qualified health educators as well as health professionals such as nurses, social workers, occupational therapists, psychologists and physicians. When used in groups, several patients are informed about their illness at once. Also, exchanges of experience between concerned patients and mutual support play a role in the healing process. Hagarty, et al (1986), however, proposed that psycho-education cannot be taken as an approach to treatment in itself, but it represents an important early step in treatment as it involves offering information on both how to offer support and how to maintain their own emotional health and overall wellbeing, and it provides the patients and family members or caregivers the opportunity to develop a thorough understanding of the mental health concerns affecting individuals. He also added that participating in psycho-education may have a positive impact on quality of life.

Stanford and Colom (2013) categorized psycho-educational models into four groups: information model, the skill training model, the support model and comprehensive model. The information model emphasizes the provision of knowledge about psychiatric illness and its management. The skill training is directed at systematically developing specific behaviors so that the patients can cope with challenges and family members can enhance their capability to assist the patients.

Psycho-education can include a therapist's explanation to a person in therapy the ways a mental health condition might impact function, a psychiatrist's description about how a prescribed medication counteract symptoms of a mental health condition, a psychiatric hospital's

provision of support and education to family members of those receiving treatment. Furthermore, when people who have been diagnosed with a mental health condition are able to understand what diagnosis means, they are more likely to view their illnesses as treatable conditions rather than an illness that can remain with them till the end of their day on earth.

Based on these explanations about the nature, benefits and models of psycho-education, the therapy of psychiatric unit of Torhailoch Hospital is discussed.

The therapy has the nature of using psychoeducation. The reason for this is that the practitioners were educating patients about mental illnesses and addictions. Causes, symptoms and effects of mental illnesses and addictions were generally presented to inform patients in the group sessions every time they met. It can be noted that the psycho-education seems to be an information model. But specific disorders were not raised and discussed. In other words, disorders like schizophrenia, bipolar disorders, depression, and anxiety disorders were not brought as topics to inform patients as to what the disorders are, their symptoms and how to cope with the symptoms of the disorders. This can show that the psycho-education lacked a well organized preparation. It can be suggested that the use of the same topics every session is an indication of less preparation and their inadequate training. One of the practitioners pointed out this idea when he said, "There is a lack or absence of preparing oneself to deliver the therapy on the part of the practitioners. We deliver the therapy in the way we want to do it rather than getting led by theories."(Pr.2)

The other point is the nature of the group. The group therapy is an open group, which means that on every session new members can join the group. The group therapy also has a heterogeneous nature where every patient of every kind of disorder gets involved in the group. For more effectiveness of group therapy, especially in psychiatric hospitals, homogenous group

is the one which is advisable to apply (Michael, 1995). When mental illnesses are presented which focus on psychotic types, those patients with substance use problems felt that the discussion did not concern them. Sometimes some patients were laughing at those who were explaining experiences in disorganized manner. Some members replied nothing when they were asked what were being discussed and explained in the therapy.

Including patients with every kind of disorder in the same group can also be taken as the indication of the practitioners' inadequate training in how to deliver psycho-education for groups, and their poor preparation for the therapy only for the sake of discharging the assigned duty as another practitioner mentioned it. The practitioner stated that "Each practitioner has a program when to deliver the therapy, so the practitioner brings a topic and invites patients to discuss or he teaches the patients based on the topic he has brought."(Pr.1)

To summarize, the research question tried to explore what kind of theories were frequently used by the practitioners in the psychiatric unit as therapy has been delivered there. Where there is psychotherapy, the use of theories and techniques are expected from professionals. However, it was noted that no theory or model or approach of psychotherapy was applied by any of the practitioners in the hospital, where a number of military personnel and civilians are admitted and treated. The method they used and are using is psycho-education. The psycho-education itself has not been delivered in the manner it has to be applied, especially not using homogenous group and not teaching specific disorders' natures, causes, symptoms and coping strategies.

**5.4. How do the practitioners and the patients perceive the importance of psychological treatment for the wellbeing of patients?**

The findings from the interview can show that the practitioners and the patients have positive attitudes toward the usefulness of psychological therapies for the wellbeing of mental health patients.

It was indicated that psychological therapies could give patients the opportunity to look at themselves and their behaviors when they were with other patient in the group discussion. Those who had similar problems could exchange experiences with the others who were listening. This is one of the benefits of getting involved in the group therapy (Yalom, 2013).

The practitioners also indicated that the group therapy was instrumental to make patients change their attitudes toward the adherence medication. Those who refused and resisted to take medicines, especially the oral medicines, became willing to take the medication for their wellbeing. Moreover, the practitioners have a positive perspective that psychotherapy in conjunction with medication helps patients experience wellness. This perspective of the practitioners is consistent with different research findings (Koster et al, 2006; Lambert & Ogles, 2004; Walpole, 2007 & Moyer, 2004).

Both the practitioners and the patients witnessed that psychotherapy give emotional relief or healing for those who participate. Gilman (2010) indicated that psychotherapy was found to be healing. Thus, what the practitioners and the patients witnessed seems to be consistent with Gilman's finding.

### **Summary**

Four research questions were initially formulated to guide the investigation pertaining to explain the nature of the psychological treatments which were delivered to mental health patients in Torhailoch Specialized Hospital. Four major points were identified.

The first is that the psychiatric nurses had inadequate trainings regarding psychological therapies. The second is that there was only a single group therapy in the hospital which had heterogeneous nature in which all mental health patients were expected to participate. The third is that the practitioners did not make use of any theory of psychotherapy at all, and they had a little knowledge about the theories, but they were able to use psycho-education in some forms to help patients. The fourth and last point is that regardless of the practitioners' inadequate trainings the practitioners had positive attitude toward the usefulness of psychological therapies for the wellbeing of the mental health patients; and that they had high interest to help patients in psychological ways.

In addition to the practitioners, it was noted that patients themselves had positive attitude toward the usefulness of psychological therapies for their wellbeing.

## Chapter Six

## Conclusion and Recommendations

## 6.1. Conclusion

The findings could show that the psychiatric nurses had inadequate trainings regarding psychological therapies; there was no use of theories or approaches of psychotherapy when the therapy was being delivered; the group therapy was a heterogeneous type which included every patient with any kind of mental illness and that the group therapy focused on educating patients about mental illness and addiction. Despite these conditions, the psychiatric nurses had positive perspective for the usefulness of psychological therapies especially when they are used in combination with medication. Moreover, the nurses were observed to have the willingness to help patients using psychological means.

The psychiatric patients also found to have positive attitude toward the usefulness of psychological therapies to their mental wellness. However, treating patients using psychological methods has been given little attention in the hospital. But different research findings reveal that using psychotherapy alone for mild and moderate depression and anxiety is effective; and psychotherapy is found to be effective when it is used in conjunction with medication to treat a wide range mental illness.

## 6.2. Recommendations

The researcher believed the following recommendations should be applied so that there could more effectiveness in the use of psychological ways to help mental health patients.

1. The training should include a period of supervised practice so that the practitioners become more knowledgeable and skilful in the use of psychotherapy.

2. The hospital should arrange programs for the purpose of providing in-service trainings and workshops so that the psychiatric nurses of the hospital can help the mental patients in more professional ways.
3. The hospital should find ways to prepare a room which needs to be devoted for psychotherapy.
4. The hospital should employ a psychological professional who can arrange the psychological help for the patients and organize things for the better delivery of the psychological service.
5. The psychiatric nurses should be provided reading materials and videos in order that they can update themselves to provide the psychotherapy service in a better way.

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**Declaration**

I, the undersigned, declare that this thesis is my original work, and it has not been presented for a degree in any other university, and that all sources of materials used in this thesis have been duly acknowledged.

Name: Debebe Tiruneh

Signature: \_\_\_\_\_

Date of Approval: June, 2018

**Appendix 1****Addis Ababa University****School of Psychology****Interview Questions**

This interview is a semi-structured interview so that the participants can express their ideas in detail. The first part of the interview is designed to assess the professional standing of the practitioners whether they have the training that the therapy needs. The second part is designed to assess the kinds of psychotherapy formats the practitioners are using. Third part is designed to assess the approaches or the theories they are applying during they are doing the counseling. The fourth part is to assess the frequency of the therapy and the settings.

1. Educational Level \_\_\_\_\_ Field of Specialization \_\_\_\_\_
2. What relevant training did you take before you hold your current position? What about on-the-job training that helps you keep abreast of new developments in the field? (Please tell me all the training you received)

S. No.	Type of Training (Content/Specialty)	Duration of Training (in days and/or hours)	Is it a pre-service training? On-the-job training? Or what?
1			
2			
3			
4			
5			
6			

3. Tell me in detail about the practice after the training? What were the most interesting and most challenging experiences you encountered during the time?

4. What kinds of formats do you use to provide the psychotherapy? Tell me in detail. What is the response of your patients about the formats you use?

5. Can you tell me about your choice of psychotherapeutic theory? What about your colleagues?

**Probing Questions:** Do you subscribe to one theory? If so, what? If not, what can you tell me about using a theory? What about your colleagues? Which theory do you think is most frequently used? What do you think is the reason?

6. How long do you usually take between beginning and ending the client-therapist relationship?

**Probing Questions:** What factor determines the duration of the relationship most? How long does each session last? Is the duration of the session fixed or flexible? Is there any reason for this? Do you have any special experience you would like to share with me regarding an abrupt discontinuation of the treatment you started or something similar? What happened?

7. Would you explain the goals which you frequently set for the therapy?

8. What do you do to make the therapy be understood by different patients who come from different cultural and language settings?

9. What do you say about your belief about the usefulness and importance of psychotherapy for mental health patients? Do you believe psychotherapy helps the patients? If you agree, in what way? If you disagree, why can't it help?

**Probing Questions:** What about the clients/ Do they come to you wholeheartedly believing that they will be cured? What about the community at large?

10. What do you feel about establishing rapport between yourself and your client?

**Probing Questions:** If you believe building a rapport is very important, how important is it in your experience? Do your colleagues have the same belief with you? If not, what causes the difference? How do you think the reaction of the patients based on good rapport? Tell me whatever you observed.

11. Have you had any training or workshop after you have become a practitioner in the hospital? How many times? How do workshops help your delivering the therapy?

12. Is there anything you do keep yourself abreast of new developments in the field? Tell me the things you do to update yourself with new development of therapy. How about your colleagues? How about its effect on the delivery of the therapy?

13. What do you and your colleagues think is the most important element you are lacking as a practitioner that you would like to have if possible?

**Probing Questions:** Can you tell me about the elements that are essential for your work that you need the most and least? Is there any plan in the hospital to improve the condition? If so, what are they?

14. Finally, is there any remaining point that you would like to raise before we end this session?

Appendix 2

ለአእምሮ ህመምን የተዘጋጀ የቃለ መጠይቅ መመሪያ

1. በሆስፒታሉ ውስጥ ለአእምሮ ህመምን ስለሚሰጠው የስነልቦና አገልግሎት ምን የሚሉት ነገር አለ?

- ለህመማችሁ ጥቅም ካለው ፤ በምን ሁኔታ ነው አየጠቀመ ያለው ?
- ጥቅም ከሌለው ጥቅም እንዳይኖረው ያደረገው ነገር ምንድነው ይላሉ?

2. የስነ ልቦና አገልግሎቱን ስለሚሰጡት ባለሙያዎች አቀራረብ ምን የሚሉት ነገር አለ?

- አቀራረባቸው እንዴት ሲሆን ነው ለህመማችሁ ጤንነት መልካም የሚሆነው?
- መሆን የሌለበት ነገር አለ ብለው የሚያምኑ ከሆነ መሆን የሌለበትን ነገር ከነምክንያቱ ቢዘረዝሩልኝ?

3. የትኞቹ ህመምን ናቸው አገልግሎቱን የሚያገኙት?

- ይህን አገልግሎት የማይካፈል ህመምተኛ ካለ የማይካፈልበት ምክንያቱ ምንድነው?
- አገልግሎቱን ካገኙ በኋላ የህመማችሁ ስሜት ምን ይመስላል? የእርሶስ ስሜት ምን ይመስላል ? በጥሩውም ሆነ በመጥፎው የተገነዘቡት ለውጥ ካለ ቢያብራሩልኝ::
- በጤንነት ላይስ የታየ ለውጥ ካለ ቢያብራሩልኝ::
- በባህሪና በአስተሳሰብ የመጣ ለውጥ ካለ በደንብ በምሳሌ ቢዘረዝሩልኝ::

4. አገልግሎቱ የሚሰጠው በሳምንት ለምን ያህል ቀን ነው?

- ምን ያህል ሰአት ወይም ደቂቃ ይወስዳል?
- ስለሚወስደው የጊዜ መጠን ምን የሚሉት ነገር ይኖራል? ምንስ መሆን አለበት ይላሉ?

5. ቃለመጠይቁን ከማጠናቀቃችን በፊት ማንሳት የሚፈልጉት ነገር ካለ እድሉን ልስጥዎት::

**Appendix 3****Addis Ababa University****School of Psychology****Consent Form**

I, Ato Debebe Tiruneh, am a graduate student of Counseling Psychology at Addis Ababa University. I am currently doing my thesis on "Psychological Treatments Provided to Mental Health Patients in Torhailoch Comprehensive Specialized Hospital: Situation Analysis" for the fulfillment of MA degree. I kindly request your consent to take part on this research. Your contribution is very important. Participation in this study is voluntary and if you do not feel any comfort to answer any individual question, you have the right to stop at any time and your participation will not have any negative consequences. The information that you provide will be kept confidentially and will not be shared with other persons without your consent. I hope that you will be willing to participate in this study.

Thank you in advance for your cooperation!

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

አዲስ አበባ ዩኒቨርሲቲ የሳይኮሎጂ ት/በት  
የሰምምነት ቅጽ

እኔ አቶ ደበበ ጥሩነህ የአዲስ አበባ ዩኒቨርሲቲ የካውንስሊንግ ሳይኮሎጂ የድህረመረቃ ትምህርት ክፍል ተማሪ ስሆን ለመመረቅያ በማዘጋጀው ጥናትና ምርምር ላይ የእርሶዎ ተሳትፎ አስፈላጊ ነው። እርሶዎ የሚሰጡት ምላሽ ለጥናቱ ስኬት ወሳኝ ስለሆነ ለቃለመጠይቅ የእርሶዎን ፈቃደኝነት በትህትና እጠይቃለሁ። በጥናቱ ላይ ተሳታፊ መሆን በፈቃደኝነት ላይ የተመሰረተ ጉዳይ ። እርሶዎ መመለስ የማይፈልጉትን ጥያቄ ያለመመለስ መብትዎ የተጠበቀ ነው ። መልሶች ሚስጥሩን በጠበቀና በተገቢው ቦታ የሚቀመጥ እና ለሌላ ሦስተኛ ወገን የማይገለጽ ነው ። በጥናቱ ላይ ተሳታፊ ለመሆን ፈቃደኛ ከሆኑ በፊርማዎ እንዲያረጋግጡልኝ በአክብሮት እጠይቃለሁ።

ለሚያደርጉት ትብብር ታላቅ ምስጋና አቀርባለሁ!

ስም:-----

ፊርማ -----

ቀን -----