Department of Psychiatry, College of Health Sciences, Addis Ababa University

Addis Ababa

Post Graduates Program in Psychiatry

Subjective experiences of clients who attend psychotherapy at Tikur Anebessa Specialized Hospital and Zewditu Memorial Hospital, Ethiopia 2021: Qualitative study

Research paper submitted to the department of psychiatry, in partial fulfillment of the requirements for the specialty certificate in psychiatry

Prepared by: Eshetu Tumiso, MD, Third year resident

November 30, 2021.

Title of the study:

Subjective experiences of clients who have attended psychotherapy at Tikur Anebessa Specialized Hospital and Zewditu Memorial Hospital, Ethiopia 2021: A qualitative study

Principal Investigator: **Eshetu Tumiso**, MD, PGY 3

Cell phone: +251972643265

Email: dreshetutumiso@gmail.com

Advisors:	**Signature**	**Date**
Dr. Filmon Mengesha	--------------------	---------------------
Dr. Ribka Birhanu	---------------------	---------------------
Examiners:		
Dr. Barkot Milkias	----------------------	----------------------
Mr. Getahun Tibebu	-----------------------	----------------------

Table of Contents

Acknowledgment 5
Acronyms 6
Abstract 7
Background 7
Objective 7
Method 7
Findings 7
Conclusion 8
1. Chapter One 9
1.1 Introduction 9
1.1.1 Background 9
1.1.3. Objectives 10
General objective 10
Specific objectives 10
1.1.4. Significance of the study 11
2. Chapter Two 12
2.1. Literature review 12
3. Chapter Three 16
3.1. Methodology 16
3.1.1. Study setting 16
3.1.2. Study design and period 16
3.1.3. Study population and participants 16
3.1.4. Inclusion and exclusion criteria 16
3.1.5. Sampling technique 16
3.1.6. Data collection 17
3.1.7. Data analysis 17
3.1.8. Ethical Consideration 18
3.1.9. Dissemination of result 18

4. Chapter Four 19
4.1. Results 19
Characteristics of the participants 19
Table 1:- Summary of characteristics of study participants 19
4.1.1. Perception of clients about psychotherapy 22
4.1.1.1. Views of clients about the meaning of psychotherapy 22
4.1.1.2. Psychotherapy is different from routine advices 22
4.1.1.3. Concerning the goal of therapy 22
4.1.2. Positive experiences of therapy process 23
4.1.2.1. Impact on the concept of Self 23
4.1.2.2. Influence on social life 24
4.1.2.3. Helped in understanding what has contributed to the illness 24
4.1.2.4. Mechanism of healing 25
4.1.3. Negative experiences and how they have dealt with them 26
4.1.3.1. Factors associated with clinician 27
4.1.3.2. Factors associated with the society 28
4.1.3.3. Factors associated with the therapy 29
4.1.4. Relationship experiences 29
4.1.4.1. The contributions of the clinicians 30
4.1.4.2. The contributions of the clients 30
5. Chapter five 31
5.1. Discussion and analysis 31
5.2. Strengths and limitations 36
5.3. Conclusion and recommendation 36
References 38
58. Annex 42
Annex 1 42
Annex 2 44

Acknowledgment

I would like to express my deepest gratitude to Addis Ababa University College of Health Sciences, Department of Psychiatry for giving me a chance and allocating the budget to conduct a research on an issue that I am curious about. I would like to thank my advisor Dr. Filmon Mengesha, co-advisor Dr. Ribka Birhanu and Dr. Dawit Wondimagegn for their precious contributions on the process of this research paper, for their warm intellectual guidance and support.

Acronyms

AAU- Addis Ababa University

CBT- Cognitive Behavioral Therapy

CMD-Common Mental Disorder

CQR-Consensual Qualitative Research

ERP-Exposure Response Prevention Therapy

HIV/AIDS- Human Immune Virus/Acquired Immune Deficiency Syndrome

GBV-Gender Based Violence

G.C- Gregorian Calendar

IPA- Interpretive Phenomenological Analysis

IPT-E-Interpersonal Psychotherapy adapted for Ethiopia

IPT-G- Interpersonal psychotherapy, Group

IPT-Interpersonal Psychotherapy

ms- Milliseconds

NET-Narrative Exposure Therapy

OPD- Out Patient Department

PGY- Post Graduate Year

PTSD-Post Traumatic Stress Disorder

TASH-Tikur Anebessa Specialized Hospital

WHO- World Health Organization

ZMH- Zewditu Memorial Hospital

Abstract

Background

Psychotherapy, traditionally known as talk therapy is one of the main management modalities used in mental health. It is used to help clients with claimed psychosocial problems to overcome their symptoms and to improve their well being and mental health by applying psychosocial methods. Clients are the reasons why all the psychotherapies are made for and understanding their subjective experiences of the psychotherapies helps us the understanding them, to make psychotherapy meaningful and to design contextual modalities of intervention compatible to a given psychosocial context. This study focuses on assessing the subjective experiences of clients who have attended psychotherapy at TASH and ZMH.

Objective

To explore and understand the subjective experiences of clients who have attended psychotherapy at TASH and ZMH, so that we would learn from how psychotherapy appears for the clients from their perspective.

Method

Qualitative study was conducted on clients who have attended psychotherapy at TASH and ZMH by using in-depth semi-structured interview questions that was prepared after referring different articles on the topic. Participants were recruited using non-probabilistic heterogeneous purposive sampling technique from the hospitals referred above. Participants were those who have attended psychotherapy at least for four sessions, consented to take part, speak Amharic language fluently and on stable mental condition. Sampling proceeded until theoretical saturation was achieved. Eight in-depth interviews were conducted and all were included in the results. The in-depth interviews were audio recorded, transcribed and translated into English. Thematic analysis was used to identify key themes.

Findings

The subjective experiences of clients who have attended psychotherapy were summarized in to four major themes with subordinate subthemes. Firstly, how clients perceived psychotherapy and all of them have defined it as a means of discharging out impacted emotions. They have also differentiated talk therapy from other routine advices based on their experiences and they have had different types of goals set by collaborating with the clinicians. The second theme was their positive experiences and except one all of the participants had helpful experiences which were categorized under how it has impacted their self concept, their social life and their understanding of factors that had contributed to their illnesses. Clients have also described mechanisms at which how psychotherapy has healed them. In the healing process is attributed to clinicians' factors such as empathic listening and clients' factors such as willingness to be healed and their belief on the therapy. The third theme was the negative experiences of clients. They have

experienced it due to different factors like the therapist, the society and the therapy itself. How they had experienced relationships were the fourth theme identified.

Conclusion

Clients have experienced psychotherapy as beneficial in most cases and harmful in some cases. What mattered most for the clients were; an empathic listening, unconditional acceptance and their connection with the therapist who is emotional sensitive and focusing on them as a person not on their problems as priority. Therapists' being not persistent and sensitive had a counterproductive effect on the therapeutic alliance and contributed to the worsening of symptoms. Clients were not comfortable with frequent turnover of clients, being evaluated in front multiple people and long waiting time they spent. Most of the concepts mentioned as healing mechanisms and negative impacts were mainly described in the contexts of identity of clients, interpersonal relationships and social life.

Key words:

Psychotherapy

Subjective experience

Healing mechanism

Clinicians/therapists

Clients/patients

Qualitative study

1. Chapter One

1.1 Introduction

1.1.1 Background

In its history, medicine tried to see mental health problems as caused by unknown physiochemical process and classifying them as functional in contrary to structural problems which claimed to have known causes. There have been trials to identify the hypothesized physiochemical causes of mental disorders and diligently avoiding its psychosocial causes and interventions such as talk therapies. (2, 1) There were deliberate efforts to deprecate any forms of movements that claimed to heal physically via mind, faith or spirituality. A prominent physician John K. Mitchell expressed his convection by saying:

"Most earnestly should we insist that the treatment of a patient, whether it is surgical, medical, or psychic, should for the safety of the public, be in the hands of a doctor" (2)

Incremental efforts of American psychologists, neurologists and psychiatrists have earned acceptability of the idea that talk therapy is different from the religious movements (3). This could be one of the force pushing psychotherapy researches to tackle the negative loading by doing researches that mainly focusing on the acceptability and efficacy of talk therapies rather than the subjective experiences of the clients. This also seems to appear in a few researches done in our context which focuses more on cultural adaptability, acceptability and effectiveness of talk therapies.

Even though the efficacy of psychotherapy is evidence based and not refutable, still there is much positivist emphasis placed on interventions and scientific discovery of universal biological process by ignoring cultures, religions, identities and contexts of the subjects (5). Currently, it is known that there are multiple common factors regardless of the type of psychotherapy, consciously held theoretical foundations or expertise of therapist which are playing major role in the process of talk therapy such as hope, expectation, world view, assumptive base, value, trust, belief and relationship of client and the therapist (6, 7, 8, and 13). These listed common therapeutic factors are experienced by both the client and the person in talk therapy; therefore they need subjective exploration of each individual as a unique culture in depth.

Researches from multiple areas strongly suggests that human connection, whether it is called attachment (16, 17, 18), belongingness (19), social support (20), or the lack of loneliness (21; 22), is necessary for healthy functioning. Lieberman claims that social connection is as basic a need to humans as food or shelter (22).

Most of the researches on psychotherapy are from western set up which is accused of being positivist, colonist and imposing its medicalizing notions of "health" and "illness" by using many means including psychiatry through political pressures, globalization, movement for global mental health (MGMH), promoting its diagnostic standards such as DSM, NGOs and others international organizations. (9) Western talk therapy is said to be an aftereffect of Western culture and psychology itself is a Western science which are designed in response to sociocultural needs and factors of the West. Some researchers consider talk therapy is not only a meeting between to individuals but it is a meeting between two cultures (9, 51). Therefore understanding the subjective experience of given individual opens a new opportunity to learn and understand a new culture. This study tried to understand these issues with open mind from Ethiopian clients.

1.1.2. Statement of the problem

Currently the efficacy and acceptability of talk therapy is not questionable and it is incorporated as one of the main treatment modality of mental health problems as a part of bio-psycho-social model treatment principle. There are researches tried to explore the subjective experiences of clients concerning the talk therapy mainly in the western setup and culture. To my understanding there are no researches that explored the subjective experiences of Ethiopian clients who have attended psychotherapy. This study tried to fill this gap by understanding how talk therapy is experienced by them and how the change has occurred in the clients through psychotherapy from the perspective of Ethiopian clients who have their own rich cultural and spiritual identities, disparate from the western setting

1.1.3. Objectives

General objective

To understand the subjective experiences of the clients who attend psychotherapy at TASH and ZMH

Specific objectives

To explore the subjective experience of clients who attend psychotherapy

To describe what has helped them in the process of talk therapy and how it has helped them

To understand how the talk therapy has impacted their relationships

To investigate their unmet needs and how they have dealt with them

1.1.4. Significance of the study

Humans are predisposed to have a positive orientation toward healing, but only if the healing practices are consistent with their cultural traditions and values. The current psychotherapies and their theoretical bases are originated in the western culture; therefore it's not questionable to understand the subjective experience of Ethiopian clients who has their own interwoven traditions, social values, religions and explanatory models who attend talk therapies which are based on the western set up.

There are few psychotherapy studies done in Ethiopia which are mainly emphasizing on effectiveness, acceptability and cultural adaptations of therapies primarily on IPT and CBT. To my knowledge there are no published researches that explore the subjective experiences of the clients who attend any form of psychotherapy whether structured single therapy or involved mixed principles from different types of therapy. The findings of this study will provide important understanding in this area.

2. Chapter Two

2.1. Literature review

There are different definitions for psychotherapy and therapeutic elements and I have preferred to use the following definitions which I thought are comprehensive, addressing almost all the basic concepts that are mentioned in the second edition of the book called “The Great Psychotherapy Debate” published in 2015 (1).

“Psychotherapy (talk therapy) is a primarily interpersonal treatment that is a) based on psychological principles; b) involves a trained therapist and a client who is seeking help for a mental disorder, problem, or complaint; c) is intended by the therapist to be remedial for the client disorder, problem, or complaint; and d) is adapted or individualized for the particular client and his or her disorder, problem, or complaint.”

“Therapeutic elements denote those constituents that create the benefits of psychotherapy regardless of their status as specific ingredients or common factors.”

In this study we use the concept of subjective experience which is derived from the book of Jft Bugental called “The Art of the Psychotherapist” as:

“Subjectivity is that inner, separate, and private realm in which we live most genuinely. The furnishings or structures of this realm are our perceptions, thoughts, feelings and emotions, values and preferences, anticipations and apprehensions, fantasies and dreams, and all else that goes on endlessly night and day, waking and sleeping, and so determines what we do in the external world and what we make of what happens to us there.” (11)

The first meta-analysis of psychotherapy outcomes, conducted and published by Mary Lee Smith and Gene V. Glass in 1977, changed the nature of the debate about efficacy of talk therapy dramatically. They found that psychotherapy was significantly helpful and that the duels of the different contenders were not evidence based. Despite the criticisms of this particular meta-analysis, its sequel, and meta-analysis as a method, the efficacy of psychotherapy has been firmly established and it is no longer a subject of debate (27, 28, 29, 30, 31, and 35).

By using RCTs for the last decades, researches on talk therapy have focused on elucidating evidence for interventions of given standardized psychopathologies. After decades of such researches, a many psychotherapeutic interventions have been identified as evidence-based and incorporated in formal guidelines to prescribe how to treat multiple psychiatric conditions. They have guided to a conclusion as psychotherapy works generally. Asides from this, predominant

challenge of the researches is that it has not guided to any real advancement in the understanding of what makes talk therapy work. That is summarized by Kazdin as following:

"After decades of psychotherapy research we cannot provide an evidence based explanation for how or why even our most well studied interventions produce change, that is, the mechanism(s) through which they operate" (36)

This study will try to contribute understanding in such mechanisms from client's perspective and embarks opportunity to learn from Ethiopians' perspective having rich cultural and spiritual identities for years which is disparate from the western setting.

In sub-Saharan Africa, talk therapies are poorly distributed at the district and primary care level due to the lack of adequate trained human resources as a major problem and other factors such as lack of appreciation to the contribution of mental disorders to mortality and morbidity, competition within health reforms for limited resources and not perceiving mental illness as amenable to quick solutions (23).

There are evidences from low and middle-income countries (Kenya, Uganda, Pakistan and China) supporting the feasibility and effectiveness of various types of talk therapies and community based psychosocial interventions for depression, anxiety, PTSD, schizophrenia, GBV and other mental distresses irrespective of the specific diagnosis, the level of training and the given types of psychological treatments (39, 41, 42, 45, 46, 47). For example in a study that assessed local perceptions of the impact of group interpersonal psychotherapy in rural Uganda, yielded change in the community related to the IPT-G program, improved school attendance for children, productivity, sanitation in communities, cohesion among community members and reduced conflict in families. The results suggested that applying psychological intervention for depression in communities with high depression prevalence rates may lead to positive changes in a range of non-mental health outcomes (46). But still the subjective experiences of the clients and the mechanism by which how the psychotherapy led to the change was not explored or provided.

Although the practice of western medicine in Ethiopia dates back to the time of King Libne Dengel (1520-1535), organized and sustainable modern medical practice started after the battle of Adwa (1896) (44). According to world bank report, though Ethiopia physicians (per 1,000 people) fluctuated substantially in recent years, it tended to increase through 1988 - 2018 period ending at 0.08 per 1,000 people in 2018 compared to 1.566 physicians per 1,000 people in the world (43). Data from the National Mental Health Strategy (2012–2016) document which is developed by the Ethiopian Ministry of Health and released in 2012 for the first time, shows that there were only 40 practicing psychiatrists, 461 psychiatric nurses, 14 psychologists (not clinical), and three social workers for 85 million Ethiopians in 2012. Throughout the nation, only four universities have programs to train mental health professionals (55). Even though the mental health problems contribute 12% of the burden of diseases in Ethiopia, only 2% of the health budget is allocated to mental health (54, 50, and 52). The limited number of trained helping professionals makes the

country unfavorable and ill-prepared to provide mental health services to those in need amongst its population of nearly 115 million currently.

Despite the fact that scholars all over the world emphasize the need for indigenous psychology, counselling techniques and culture-specific approaches, Western models of therapy are currently used in Ethiopia due to the lack of available local theories and therapy models made by Ethiopians based on the local cultures, belief and traditions. In Ethiopian universities, Western theories and approaches in the field of counselling and psychotherapy are formally taught. (37, 38) The applicability of such theories and approaches in the Ethiopian context is likely questionable. Exploring and understanding these concepts as they appear from the clients side will inform the care and assists to suggest locally based models to understand and help patients.

The first big initiative taken to adapt talk therapy to Ethiopian context was done by Biaber Project, created by psychiatrists from Ethiopia and Canada; Dr. Dawit Wondimagegn, Dr. Paula Ravitz, and Dr. Clare Pain funded by Grand Challenges Canada. It has adapted psychotherapy called Interpersonal Psychotherapy adapted for Ethiopia (IPT-E) (40).

A pilot study was done to evaluate the feasibility and acceptability of IPT-E, among University students and to assess the preliminary outcomes of IPT-E in reducing symptoms of mental distress and in improving functioning. They used Client Satisfaction Questionnaire and semi-structured interview to measure the acceptability of the intervention, self-reporting IPT-E checklist to assess treatment adherence and World Health Organization Disability Assessment and Self-Reporting Questionnaire-20 tools to assess functional impairment and mental distress, respectively. After the delivery of IPT-E, symptoms of mental distress were decreased, functioning was improved and therapist adherence to the treatment model was 100% (i.e. treatment delivered according to the IPT-E guideline). Forty-six percent of the study participants reported that they definitely received the kind of the services they expected and almost all of their needs were met. Even though, what their expectations were not explored in detail. Despite this, most students qualitatively expressed the treatment they received as it was beyond their expectations that fully addressed their mental health care needs. (40, 49) The study tried to assess the satisfaction of the students on the therapy mainly focusing on its acceptability, not explored in detail what their subjective experience was and how the therapy has worked for them.

In a study done on cultural adaptation and implementation of CBT for depression in Ethiopia, which is on the process of publishment, they have assessed the subjective experiences of clients about the CBT by using in-depth interviews. Most clients said that their experience with CBT was very good by attributing the reason behind that to a dedication and empathic nature of their therapists and to the helpful techniques used in CBT. Two patients reported that they were not happy because of lack of improvement in the first client and cognitive intervention made the second client to think a lot about the past and made her feel useless, preferred the behavioral intervention more. The study recommended further adaptations involving several stakeholders and

effectiveness studies. (12) In this study clients have reported different challenges but it was not mentioned how they have tackled them, which will be one of the objectives of our study to learn from their way of dealing with their unmet needs. In addition, the study was about CBT but our study plans to include subjective experiences of other psychotherapies too.

There are also to two studies done by clinical psychology trainees concerning clients' experience of psychotherapy. The first one focusing on exploring perception of people with substance related disorder towards psychotherapy recommended to do further studies in other hospitals because it was limited to Amanuel Specialized Mental Hospital in-patient department. (14) The second one has tried to assess clients' perception of psychotherapy after psychotherapy termination in TASH and ZMH, similar set up with our study. The results were mainly about helpfulness of psychotherapy and their reaction after the termination of therapy (15). The study has limitations such as it has only included clients who have attended psychotherapy with clinical psychological trainees; the interview was done by phone; not mentioned the ways how clients dealt with the challenges despite mentioning the unmet needs of clients and did not reported the mechanisms helped in the process of change. Our study will try to fill these gaps by including clients from all groups of psychotherapy givers at the set up, by doing in-depth interview face-to-face, by exploring ways how they have dealt with the challenges and by learning how change has happened from clients' perspective via understanding how it appears for them subjectively.

Generally, the limited number of researches done concerning talk therapy in Ethiopia mainly focuses on the effectiveness, acceptability and cultural adaptability. To my knowledge there is no published research which has tried to address how clients experience talk therapy and their suggested mechanisms of change in Ethiopia. This study has tried to contribute to understand this issue in depth.

3. Chapter Three

3.1. Methodology

3.1.1. Study setting

The study was conducted on clients who attend psychotherapy at TASH and ZMH. Both of the hospitals are located in Addis Ababa. TASH is the oldest hospital in the country and started to give psychiatric service and a 3-year post-graduate training program of psychiatry in 1995 E.C. There are 5 OPDs in this hospital specifically for psychiatric visits. ZMH also gives psychiatry service at 4 OPDs and one inpatient ward for addiction psychiatry with four beds. In both hospitals the service is run by psychiatrists, clinical psychologists, residents and clinical psychology trainees. This hospitals are the main sights at which psychiatrists, clinical psychologists, psychiatry residents and clinical psychology trainees of AAU provide different types of psychotherapies (IPT-E, CBT,ERP, NET, Supportive, Behavioral modification training).

3.1.2. Study design and period

Qualitative study was conducted to explore and describe the subjective experiences of clients who attend psychotherapy at TASH and ZMH in 2021. Semi-structured in depth interview was used. It was done in time period of July 1, 2021, up to October, 2021.

3.1.3. Study population and participants

The study population included clients who have attended talk therapy in TASH and ZMH.

3.1.4. Inclusion and exclusion criteria

The subjects of this study were clients who attend any form of talk therapy, willing to participate in the study, who have attended at least four sessions of psychotherapy, older than 18 years and can speak Amharic language.

Participants were excluded from the study if they: were acutely unwell and need emergency treatment, were unable to communicate for any reason, did not give consent and were not able to comprehend and communicate their decision to participate in the study.

3.1.5. Sampling technique

The participants were recruited using a non-probabilistic heterogeneous purposive sampling technique by sending emails to psychiatrist, clinical psychologists, clinical psychology students and psychiatry residents to link the clients who were attending psychotherapy and fulfilled the

inclusion criteria after their informed consent. The professionals were orally reminded. Sample size was determined by the saturation of data with eight participants. The interviews were conducted in one of the consulting rooms in the TASH and ZMH, psychiatry clinic after participants' appointment.

3.1.6. Data collection

Data collection took place from August to mid-October. Study participants were communicated the aim and significance of the study earlier and they have scheduled the interview time at their convenience. A semi-structured interview guide consisting of open-ended questions accustomed to collect data during the individual in-depth interview was applied after they have signed on the informed consent sheet. The topic guide was translated into Amharic prior to use. The interview has taken 45-60 minutes per person by using possible precautions to prevent COVID-19 transmission as stated in the national protocol. For the three participants who have exhibited emotional problems during the interview, adequate psychological intervention was provided to prevent secondary psychological harm. The researcher has tried to remain neutral in collecting the knowledge and established good relationships with the participants. Techniques like unconditional acceptance, active listening, and clarification to promote the authenticity of knowledge and to avoid bias were used. The interviews were recorded and transcribed to verbatim to use it for data analysis.

Depending on the participant's responses, more detailed questions were asked to further explore the topics mentioned, or not yet addressed, by the interviewee. As a part of the data collection and analysis process, and to refine the research tool, minor adjustments were made to the interview guide as the interviews progress as needed. We were aware of social desirability/ respondent/ interviewer bias. The interviewer was aware of these biases and was careful while introducing the study and in the wording of questions used. The interviewer has focused on unconditional positive regard and use of indirect questioning to report from the perspective of another person. During data collection the interviewer was also conscious of the bias the interviewer might introduce and in addition to the above things mentioned, the interviewer was also careful of the nonverbal communication styles and the ways of summarization.

3.1.7. Data analysis

The recordings of the interview were transcribed into Amharic and then translated into English. The original Amharic transcripts and the translated version were compared. The materials were reviewed independently by another professional person who is not in the study. After repetitive reading of the material, the themes were formulated.

The analysis has done in months through data collection. Total of 8 participants were included in the result and the two further interviewees were data repeats added to ensure no new information appeared after theoretical saturation was achieved.

The audio recorded in-depth interviews were transcribed in Amharic and translated into English. Selected translations were compared with the original Amharic text by a colleague who is fluent in both Amharic and English languages. A total of 84 pages of translated material resulted from the in-depth interviews. Transcripts were coded and analyzed using thematic analysis**.** Line by line manual coding was conducted and the main topics covered by the interview guide have also contributed in the process of data analysis and developing themes. Four major themes emerged with twelve sub-themes.

3.1.8. Ethical Consideration

Before data collection ethical permission was obtained from the Department of Psychiatry, College of Health Sciences, Addis Ababa University. Participants were informed the purpose and nature of the study, confidentiality, the freedom to opt-out of the study at any stage. Written consent was sought and secured. Participants are denoted by a letter and number like C1, C2: standing for clients. Confidentiality was kept at all levels. During data collection, three clients were tearful and all the necessary psychological support was given.

3.1.9. Dissemination of result

The result will be disseminated to the department of psychiatry, AAU, TASH, ZMH and to the clients who are involved in the study through soft copy, via e-mail or other possible ways. If possible, it will also be published in international journals who are interested in qualitative study in psychotherapy.

4. Chapter Four

4.1. Results

Characteristics of the participants

In this study eight clients who have attended psychotherapy at TASH and ZMH were enrolled. They have an average age of 34 years (23-51) and educational level of 8th grade to masters' degree. Five of them are females and the rest are males. All participants are included in the analysis.

On the process of face to face in depth interview, three of them have developed strong emotional reaction and all the important measures were taken to handle their emotional state. After they have felt comfortable, the interview was continued based on their willingness.

All of the participants were religious: Five orthodox Christians, two Muslims, and one protestant Christian. The minimum duration of psychotherapy is 3 months and maximum duration is four years. They have been meeting in average every one to two weeks.

All participants, except one who was on CBT, didn't know the name of the therapy they had received. They have said that they have been attending talk therapy with different types of professional whom they think they were trained in therapy.

Three of the clients were attending talk therapy with psychiatry residents under supervision, two of them with clinical psychologists and clinical psychology trainees, two of them with psychiatrists and the rest one with psychiatrist and clinical psychologists. The illnesses that have brought them to OPD and psychotherapy were mentioned as depression, anxiety, obsessive compulsive disorder, substance use disorder and comorbid medical problems of HIV and Epilepsy.

With the exception of one, all participants didn't have prior exposure to psychotherapy. It was a fourth round for the exception. Three were married and have children; three were single, and one was widowed.

As both researcher and resident who give psychotherapy, I have tried to be reflective on the understandings that I already hold and actively conscious on the process of bracketing.

Table 1:- Summary of characteristics of study participants

Attributes **C→Client**	C1	C2	C3	C4	C5	C6	C7	C8

Age, years	40	51	33	33	23	23	35	35
Sex	Female	Female	Male	Female	Female	Male	Male	Female
Marital status	Married 3 kids	Widowed 1 son	Married 3 kids	Single	Single	Single	Married 2 kids	Single
Religion	Orthodox	Orthodox	Orthodox	Orthodox	Orthodox	Muslim	Protestant	Muslim
Occupation	House wife	Jobless	Accountant	Nurse	Merchant	Student	Driver	Secretary
Education level	12th grade	8th grade	Masters degree	1st degree	1st degree	1st year university	10+2	Diploma
Diagnosis, Duration	Depression, 1 year	Depression HIV Anxiety, 10 years	Anxiety Loss , 1 month	MDD OCD SUD , 10 years	Anxiety , Depression, 1o months	Depression, 3 year	Depression Epilepsy , 4 years	Depression
Duration of Therapy,	3 months	2 years	4 months	4 years	6 months	1 year	4 months	7 months
Name of therapy	- Don't know	-	-	-	-	CBT	-	-
Visit , Experience	First Counseling program: Radio, TV	First Counseling experience: HIV	First	4th	1st	1st	1st	1st
Referral	Psychiatry OPD	Psychiatry OPD	OPD visit	Psychiatry OPD	Psychiatry OPD	Psychiatry OPD	Psychiatry OPD	Psychiatry OPD
Seen by	Resident	Clinical psychologist Clinical psychology trainees	Resident	Psychologist Psychiatrists Psychologists	Psychiatrist	Resident	Clinical psychologist Clinical psychology trainees	Psychiatrist

In this study subjective experience of clients who have attended psychotherapy at TASH and ZMH was done by using phenomenological method. After analysis was done there are four major themes and total of thirteen subthemes were identified.

1. Perception of Clients about psychotherapy

    1.1 Views of participants about the meaning of psychotherapy
    1.2 Psychotherapy differs from other forms of advices
    1.3 About the goal of therapy

2. Positive experiences of therapy process

    2.1 Impact on the concept of Self
    2.2 Influence on Social life
    2.3 Help in understanding what has contributed to the illness
    2.4 Mechanism of the healing

3. Negative experiences and how they have dealt with them

    3.1 The psychotherapy factors
    3.2 Clinicians' factor
    3.3 Societal factors

4. Relationship experiences

    4.1 Contributions of the "therapists"
    4.2 Contributions of the clients

4.1.1. Perception of clients about psychotherapy

4.1.1.1. Views of clients about the meaning of psychotherapy

Most of the clients have defined psychotherapy as a way of discharging out their negative emotions by talking to an empathic clinician who listened to them attentively. One participant described his therapeutic experience as a way of developing his problem solving skills. Few were also able to describe their experiences using metaphors.

"…For me, psychotherapy is like a valve that deflates an overinflated tire." (C3, 33M, MA degree)

"…Talk therapy is a key that can open tightly closed doors. It has opened those doors inside me and set me free from my own darkness…" (C1, 40F, 12th grade)

"...it's a way of solving problems." (C6, 23M, 2nd year university student)

4.1.1.2. Psychotherapy is different from routine advices

Majority of participants differentiated psychotherapy from other routine advices because it's given by a caring professionals and it has life changing capacity. They have also reasoned that it's a place where they experience things as they are and it's a trustworthy to share their sensitive personal information. It's also different for them because it's a means to understand what has caused their problems and it's reinforced their positive behavior unlike others. One client has also differentiated it because it is an evidence based practice.

"*…it is given by caring trained professional ...directly addressing me…Others don't communicate things as they are because of fear of losing relationship…I couldn't trust others to share my sensitive stories. In addition therapy has a power to change the life style as a whole."* (C1, 40F, 12th grade)

"...It's very structured…it has also a general solution that works for different problems based on some principles and its effectiveness is also derived from some scientific studies..." (C6, 23M, University student)

4.1.1.3. Concerning the goal of therapy

All of the clients disclosed that the goal of psychotherapy was to get rid of their symptoms mainly. Some of them described its goal: to increase their problem solving skills, to understand their conditions, to manage their anger, to improve their relationships and communication skills, to build up their self-esteem and to expose them to the reality at the ground. They have also mentioned that it was a collaborative process between the clinician and the client.

> *"The goal was to get healing from my symptoms, to increase my capacity to deal with different challenges of life, to develop problem solving skills and capacity...to learn and practice how to lead my life properly and independently…how to correct my low self-esteem and testing my belief with realities at the ground…"* (C1, 40F, 12th grade)

> *"…I was in difficult condition and I was wondering to understand what was happening in my life …to deal with my difficulty with the bereavement process…as how I understand and manage my anger and my personality..."* (C3, 33M, MA degree)

4.1.2. Positive experiences of therapy process

4.1.2.1. Impact on the concept of Self

Clients have narrated that psychotherapy has challenged their wrong belief system, helped them to understand their identity, to understand and express their emotions, to lead a meaningful life, to accept things that they can't change and to stop their suicidal ideations.

> *"…it has shaken my lifelong belief system and it has introduced me to myself. It's helped me to understand myself. I was not what I used to think as my identity. The therapy has cleared out that confusion. After I have understood myself, I have developed positive view about myself that has changed my whole world including my problematic relationships which has caused my depression.…"* (C1, 40F, 12th grade)

> *"…I have started to understand myself more and tried to face my fears that I used to avoid…lead life independently…developed accepting attitude to things that I can't change and how to live with my pains…stopped repetitive suicidal thoughts and behaviors…"* (C4, 33F, 1st degree)

> *"…learned that it's okay and health to express my emotions verbally or crying as an Ethiopian male…started to live meaningful life by understanding my behavior and emotions...*" (C3, 33M, MA degree)

One participant revealed that, she's alive due the talk therapy. *"It has helped me to redefine the meaning of life. It's due to the psychotherapy I'm alive, taking the ART medication properly and having effective relationship with other people."* (C2, 51F, 8th grade)

4.1.2.2. Influence on social life

Most of the participants depicted that therapy has positively shaped their social relationships, normalized their symptoms unlike the community, improved their communication skills and empowered them how to impact interpersonal relationships.

> *"…it's helped me not to close my door to others…not to take things personally. For example, initially I used to interpret any talk others talked about HIV was referring to me but on the course of the therapy I have started to understand that the talk is not about me and engaged with the talk freely..."* (C2, 51F, 8th grade)

> "*...It has reformed my interpersonal relationship and my skills to handle social interactions…helped me to avoid victim mentality and to impact relationships for common good, helped me to face the realities I used to fear and avoid in social context.* (C3, 33M, MA degree)

Psychotherapy has helped them to value their life, to hope in the future, to take their medication and to understand that they can have both medical and religious therapy as the same time.

> *"…There was a time I have stopped my medications of epilepsy and depression due the influence of other people and went to holy water places…I had a good control of my symptoms of both depression and epilepsy after I have started the therapy…helped me to understand that I can take the medications and visit holy water places together."* (C7, 35M, 10+2)

One of the clients noticed that there are people who understand her and accepted herself as normal person.

> "*…It's opened my eyes to notice that there are other people other than me who can understand me. I used to think that I was alone and no one understands me. I have also learned that there are many people like me. It has helped me to accept myself as a normal individual.*" (C4, 33F, 1st degree)

4.1.2.3. Helped in understanding what has contributed to the illness

It was reported that psychotherapy has helped clients to understand their symptoms as a normal reaction to a given stressor and how their identity is made of their past experiences.

"…I have understood that my symptoms were normal reactions to my loss... just like a sneezing or runny nose that one develops after acquiring common cold…there were many things accumulated for years that I have closed up on myself which have exhausted me badly…" (C3, 33M, MA degree)

"…I have understood that my self esteem and self-image was built up on my past experiences associated with my development. My self-image was based on the suggestions and recommendations of others including my parents that were in counterpart with the reality at the ground. I was not what I have accepted as I am. I was another person in my daily actions…" (C1, 40F, 12th grade)

4.1.2.4. Mechanism of healing

Almost all of the participants have portrayed the role of the clinician, the client and the relationship between both as a path ways of healing in the process of psychotherapy.

Most of them have mentioned that clinician has healed them by listening to them with all attention and by asking them probing questions.

"*…It seemed to me that the physician was not there at the room i.e. there were no questions or any voices in between, just everything was silent. In that powerful silence I was hearing my own talk and I didn't left any story secret…Throughout this all process the physician has treated me just by listening to me with all his attention…he has focused on me as an individual not in my problems…The questions he asked me have also led me to talk about my pains, then…noticed that it's the past pain causing my current suffering..."* (C1, 40F, 12th grade)

One client expressed how she has attained the healing and the role of clinician on the process as following:

"…The improvement has happened because the clinician has accepted me unconditionally without any judgement…understood me …always tolerated me whenever I fail …has been sensitive to my emotions including my bodily gestures…spent his lunch time as a sacrifice seeing me…never complained why I was coming late and missing sessions…gave me an opportunity to learn from my own mistakes that no one has ever given me…therapist is the main reason that makes therapy to work..." (C4, 33F, 1st degree)

The role of clinician on the healing process was also mentioned as assisting a client to talk about his painful loss, normalizing his experiences and facilitating emotional expressions.

"…The clinician has assisted me to talk about my loss in detail including my relationship with deceased one, my good and bad memories and about the circumstances of the death in detail by probing me to talk and to cry about my loss…" (C3, 33M, MA degree)

Clinicians helped clients to understand and test their wrong thoughts by their own, to put them in ease and validated their painful emotions which have helped clients to trust them and to share their painful stories. They have also helped them by giving them advice to stop things that worsen their illness.

"..It's the therapy where I discuss the issues that I thought as other people not understand me and sometimes I'm shameful of them. The clinician gives me clear direction about the issues and clarifies me some of the meanings of the symptoms and patterns of my behavior…" (C8, 35F, Diploma)

"…They were giving me a clear advice to stop the bad things like chewing chat and drinking alcohol that complicate my illness and to continue with the helpful ones like exercise..." (C7, 35M, 10+2)

In the healing process the client has also a major role of being willing to pay a price that costs to heal, to not to escape painful topics, to be willing to be healed and to believe on the therapy as it works.

"…It didn't happen easily and it has cost me much...there were topics I tried to escape and bound myself with them very tight…What has helped me most is leaving the past ruined things which were attached to me and destroying me by talking them out.. It was like giving birth after labor…I was referring the story by saying "it's was" like that and this with past tenses. Repetitively I was listening myself using a word "it's was". I have noticed that the story was all about the past…it's a past story …I was also eager to be healed and I had a strong belief on the therapy." (C1, 40F, 12th grade)

It was also mentioned that the relationship between the clinician and the client has a healing effect.

"…My relationship with the clinician is like an intimate friend with whom I share my all stories…the relationship by itself has some healing role and I felt free to share all my distressing emotions easily…) (C3, 33M, MA degree)

4.1.3. Negative experiences and how they have dealt with them

The challenges through which the clients have traversed through are categorized under three subthemes of factors associated with the clinicians, with the society and with the therapy.

4.1.3.1. Factors associated with clinician

The role of the clinician in the process of psychotherapy was not only mentioned as a constructive one but it was also described as destructive one that was interrupting the healing process.

Most clients were complaining that they were having their therapy with multiple clinicians who were not staying with them for more than weeks or a month only; sometimes meeting only for one or two sessions.

> *"...It's very tiresome to share my entire story to multiple people who do stay for only short period of time at a clinic. It's also difficult to build trust and develop good working alliance. But it's must for me to accept it because I have no other choice…I had difficult moments at which the working agenda was changing with the clinician that has led me to irritability and distress..."* (C2, 51F, 8th grade)

There were also negative encounters in which clients have experienced as they were being rejected by the clinicians and which has annoyed them.

> *"…clinician had left me suddenly without informing me in a vulnerable moment at which I had started to express my impacted feelings for years. It was a very heart-breaking experience for me. Everything had stacked there and I have lost a direction where to go…not picking up my phone…was not interested to talk with me by claiming as busy. I was in trouble and everything was out of control. I have blamed myself why I had started the therapy... there were also moments in which the clinician was not listening to me with full attention, not giving attention to my physical appearance…"* (C4, 33F, 1st degree)

> *"…there were a moments at which the clinician was touching his phone and destructing me while talking. That made me to think as I was burden on him and seemed to me that he was not interested at me…"* (C1, 40F, 12th grade)

A client who has attended psychotherapy for two years has revealed that there were instants at which the clinician has rejected her traumatic story that has taken her years to disclose. She was tearful while describing the instant.

> *"…After I have told a "therapist" a secret, he has rejected it as not useful thing at the moment because it has happened many years age. He has rushed to another topic. That has broken my heart and I have regretted to share the story. The story was, I have disclosed him that my older brother had assaulted me repetitively for four years since I was a grade one student...I have been living with the wound for all my life…It was a first moment in my life to disclose it... (Tearful) I have told to myself to close the file and not to share it with*

anyone in the future too. Since that day the pain and suffering started to torture me again. I have cried for long time at my house. I have dealt with the challenge by suffering of it…" (C2, 51F, 8th grade)

Clients were not comfortable to be evaluated in front of multiple clinicians and they didn't reveal the stories that they wanted to share.

Another difficulty they have faced at the therapy process was that the clinicians were not accepting the word of praise by clients.

"…clinician was not willing to accept a word of thank from me and I regret that I have never told him how much he has impacted my whole life. It is not fair to not accept a word of an appreciation after changing client's whole life. He has been rejecting it just by saying that he has simply done his job. (Tearful) It might be just a job for him but it's a life changing experience for me..." (C1, 4OF, 12th grade)

4.1.3.2. Factors associated with the society

Participants were revealing that the belief system of society and its expectations have attributed to a negative experience on the process of therapy.

"…While I was suffering with my loss, there were additional burdens imposed by the society such as taking care of the whole family, working and appearing strong before them as a tough Ethiopian male. To not appear as weak, I didn't express my distressing emotions. I have been trying not to cry but I was bleeding inside…" (C3, 33M, MA degree)

The explanatory model of the society had an impact on how a client understands his illness and the process of psychotherapy.

"*… during the worsening of the panic attack people around me were advising me to go to holy water places by claiming that it's due evil spirit's strike because I was visiting tomb place at midday which has worsened my distress and worries…."* (C3, 33M, MA degree)

Some clients have experienced that the society has understood attending psychotherapy as a being crazy and as a trap that leads to insanity. People around the clients have also mocked at them by telling them just talk with them by having fun.

"…When I have told my colleagues at office as I was attending psychotherapy they have warned me to not say a word to other people because others may consider me as a crazy person…who can't function properly and lead his life independently…my friends and relatives were mocking at me…They have recommended me just to talk with them having

fun at coffee time. They have also considered it as I was falling in a trap of making myself crazy…." (C3, 33M, MA degree)

The client has also described that some of the rules of the society were counterproductive.

"…wherever I go everyone was telling me not to cry but that was not what my mind was thinking and feeling. It was very difficult for me to bind for the rule of crying for three times (during the time of death, when they took dead body to the tomb and at the time of burial ceremony) but I was crying repetitively because I couldn't control my strong emotions…after crying I was blaming myself for violating the rules of my religion…they were also telling me that when I mourn and cry repetitively, it will distress the soul of my deceased sibling. Due to all these factors I was blaming and judging myself as sinning against God which has worsened my anxiety…" (C3, 33M, MA degree)

4.1.3.3. Factors associated with the therapy

A Client has reported that some of the principles of the CBT were difficult for him to apply and it didn't help him after one year.

"*…It was very difficult for me to fill the thought-emotion-behavior flow chart. While I was in a state of trouble it's very difficult to think about the solution and to fill it...It's a burden for me to follow and sometimes it's distressing for me. I have tried to deal with it by recording the flow chart every two to three days…I don't fill the chart when I'm in a bad mood rather I fill when I'm in ease…it didn't help me this much… it couldn't prevent me from the recurring of symptoms.. It's as my expectation; it didn't give me a definitive solution …"* (C6, 23M, University student)

Most clients reported that they were exhausted by the waiting time before they enter into psychotherapy session.

"*…there is a scarcity of the clinicians who do psychotherapy. I have been waiting for around two hours in average at the OPD to my turn. It annoys the client and hinders from attending psychotherapy. I have tried to deal with the challenge by being patient and fortunately I'm jobless i.e. nowhere to go. If this had happened at the time when I was working, I wouldn't wait this much i.e. I don't wait for more than thirty minutes... "* (C7, 35M, 10+2)

4.1.4. Relationship experiences

In the process of talk therapy, both clinicians and clients have contributed in the relationship which was categorized as the contributions of the clients and the contributions of the clinicians.

4.1.4.1. The contributions of the clinicians

Clinicians' contributions were experienced as they are compassionately caring and concerned for the clients.

> *"…He has served me with compassion and commitment. He was thoughtful for me, for example he has called me and told me not to come during the day of nation election…was serving me during his lunch time. He helped me with great care…" (C1, 40F, 12th grade)*

> *"…It's like sharing my secrets with a person who is more intimate than my own son or other relatives that puts me in ease…"* (C2, 51F, 8th grade)

One of the clients has described their relationship with the therapist as emotionally sensitive and interested at her as a person.

> *"…she understands me…She is very sensitive to my emotions and she responds with compassion. It is a very friendly and caring relationship. She is a young and approachable physician…she is really a caring person. She is interested at me as a person and she does not forget my stories I had told her weeks back. She gives me attention and makes time to see me even at her lunch time..."* (C5, 23F, 1st degree)

A widowed woman who has only one son has expressed her relationship with the female clinician as follows:

> *"…I used to see her as my daughter and it seemed to me as I'm talking with my real daughter sitting in front of me because she had been asking me questions that I wanted to be asked. I was eager to see her every moment. She had understood me and all my secrets…"* (C2, 51F, 8th grade)

> *"…For me what matters most is not the type of therapy or the level of training, it's a personality and attitude of the individual who gives a therapy that gives a color for the therapy …"* (C4, 33F, 1st degree)

4.1.4.2. The contributions of the clients

In the relationship the clients have different expectations, awareness about the psychotherapy and recommendations that have contributed on the relationship process.

> *"…Actually when I started therapy I didn't expect such a multidimensional life changing experiences rather I was expecting medication as usual. In addition for the first two weeks I used to think as I was spending my time in vain and requested for prescription of medication…*" (C1, 40F, 12th grade)

> *"…I was expecting one to two prescriptive sessions of advises to tell me dos and not to dos…"* (C3, 33M, MA degree)

Another client has described his expectation about psychotherapy as it might not be a definitive solution for his problems.

All the clients have trusted clinicians to share their stories.

"..I have trusted her, shared my all story and cried freely…" (C5, 23F, 1st degree)

"…I believe in a saying that says one should not keep secretes from his/her physician and priest…one who has hidden his illness from the physician will not have a healing …" (C2, 51F, 8th grade)

Almost all the clients have recommended having the therapy with one person and increasing the awareness of society about the talk therapy.

> *"…I recommend having resources about psychotherapy by using local languages via written documents, audios or videos that can increase the awareness of the society. In this age of technology I think we can access people easily via radio, TV, you tube, telegram, face book and instagram."* (C8, 35F, Diploma)

Most clients have recommended psychotherapy to anyone who is sick or healthy person who wants to explore him or herself.

> *"…I wish all people to experience freedom I have experienced. It's suffering to live life without understanding who you are. A person who lives under darkness needs to see light. No one notices when you're living in darkness at mid-day. People didn't understand my suffering because I was talking with them and covering my internal pain with clothes. The good news is that professionals know and understand it. (Intense affect)…"* (C1, 40F, 12th grade)

5. Chapter five

5.1. Discussion and analysis

In this qualitative study, we have explored subjective experiences of 8 clients who have attended psychotherapy by using phenomenological method. Clients were comfortable during the in depth interview. The findings are summarized into four themes. The discussion is going to be presented under the identified themes. The themes were perception of clients about psychotherapy, positive experiences of therapy process, negative experiences and relationship experiences. This study has also tried to figure out how the positive experiences were attained and how the clients have dealt with the negative experiences.

Perception about psychotherapy

Participants have defined talk therapy as a means of discharging negative emotions verbally by working with a trained clinician who listens to them empathically. They have used metaphors to describe the psychotherapy as a key that opens closed doors for years, as a light in the darkness of their life and as a valve that deflates excessively inflated tire. They have also described it as a safe place where clients expose themselves for their own painful realities and as the way of solving their problems. In other local unpublished study psychotherapy was perceived as means of problem solving. (14) Another studies have also described psychotherapy as an interpersonal treatment that involves a trained therapist and client who is seeking help which is similar with our study. (1) What is in contrary is that all the clients in this study were linked or psycho-educated by another clinician to have psychotherapy implying the gap in the awareness about the psychotherapy and its availability. As it's a new practice in our set up, it needs extra clinical efforts to increase the awareness of our society and effort of policy makers to increase the service.

Based on their subjective experiences, clients have listed different reasons that helped them to delineate psychotherapy from routine advices of lay people. The mentioned reasons were: talk therapy is given by trained and caring professionals, it's a means of understanding reasons behind the symptoms of clients, it has reinforced positive behaviors of clients and it's being supported by scientific researches. This is what they have learned from their experiences in the therapy process and it can be used as an exemplar in promoting psychotherapy.

The most common thing identified as a goal of therapy in this study was getting improvement of symptoms. There were also goals of increasing problem solving capacity, boosting self-esteem, understanding symptoms, improving interpersonal and communication skills, managing anger and personality of the clients. The process of goal setting was collaborative process involving both clients and clinicians. Except one, all of the clients have reported as they have relatively attained their goals. Most of the findings about problem solving and improvements of symptoms were consistent with other local studies. (12, 15) According to this study, the major concern of clients was getting healing from their suffering that guides clinician to focus mainly on what has brought clients to the clinic. This helps to connect easily with the client by understanding them and to set collaborative.

All of the clients have reported that the talk therapy was compatible with their own cultural, religious and traditional identities and none of them have found it peculiar for them. That could be due to the factor of therapist who are all Ethiopian and who translate the concepts of therapy written in English to local language i.e. Amharic because there is no local therapy guideline prepared in Amharic. On the process of the translation they might have already contextualized the concepts that need further study.

Positive experiences of therapy process

None of the clients in this study have questioned helpfulness of psychotherapy as it was seen in multiple studies (27, 29, 31 and 35). Some of the participants have recounted that psychotherapy has impacted their understanding of their self image and identity. They have depicted that, it has challenged their belief system. It has also introduced them to their own selves that in turn have opened their eyes to understand others. The therapy has also helped them to understand and identify their own emotions. Understanding their emotions helped them to live harmoniously with their own emotions and selves. It has also helped them to live a meaningful life, face their fears, lead life independently and develop receptive attitude towards things that they can't change. It has assisted them to live a meaningful life and understand the reasons behind their behaviors and emotions. The concepts of living in harmony with self and meaningful life were consistent with other studies focusing on existential issues. (56)

According to this study, psychotherapy has positively impacted clients' social life. They have learned how to manage relationships with other people and developed skills of communication. It helped them to avoid victim mentality in their interpersonal circle that caused of problematic relationships. It has helped clients who take medications (HAART, Antiepileptic and Antidepressants) to be adherent to it. Some clients learned that they can attend both clinical care and religious healing practices together. Some clients figured out that there are people who can understand them easily and there are people suffering of similar conditions. These findings are consistent with other studies done in low and middle-income settings. (39, 42, 46, 47) All of them have described that their experience is compatible with their social and religious identity which is in counterpart with other studies claiming the concept of psychotherapy as western concept (9). This could be explained by different factors such as an effect of common therapeutic factors and clinicians' effect of contextualizing the concept to local setting.

In the process some clients understood what has contributed to their illnesses and the symptoms as normal reaction to the stressors. Few apprehended that their current identity and self image is built up on their past experiences that had created sense of false self that was based on the comments of others. Therapy has helped some to identify the contradiction between what they used to believe as themselves and what they were living in existing reality. The therapy process served as a mirror that reflected themselves and helped them to develop true self by leaving a false self which was not compatible with their own reality. They were able to connect their presenting

symptoms with their past developmental issues that had helped them in understanding and managing themselves accordingly.

In this study, the therapeutic relationship had served as a healing mechanism in the processes of the psychotherapy. In the process, empathic listening of the clinician was described as a major healing factor by all clients. When they were asked how listening has healed them, clients were responding as it has assisted them to listen to their own painful stories by their own words. When the clients were verbalizing their story, they were becoming aware of their own part which was not visible for them before. Most clients were also narrating that clinicians were ways of healing mainly by focusing on them as a person rather than focusing on their problems. There are many studies that have mentioned common therapeutic factors which are consistent with our study (1, 8, 13, and 16). What appeared relatively new in this study was that, an empathic listening by clinicians was mentioned as a healing mechanism and as a means that can take their sufferings. According to this, clinicians can learn that listening has played a role as a healing mechanism in addition to its role of as a means to understand clients.

Clients have described a therapist as a main reason who made a therapy to work. They have narrated ingredients of clinicians in the healing process as an unconditionally accepting the clients, being non-judgmental, understanding the clients, tolerating clients' failures, validating painful emotions, being attentive to non-verbal gestures and giving an opportunity to them to learn from their own mistakes. Clinicians have also played a healing role by guiding them to talk about their painful stories, by normalizing their reactions and by putting clients in ease to express their emotion freely. These findings go with other previous studies in which quality of the client–therapist alliance is a reliable predictor of positive clinical outcome independent of the variety of psychotherapy approaches and outcome measures. (1, 58)

Clients have also a role in the healing process as it is described in this study. It has demanded courage to heal by clients' side. Some clients have taken a responsibility on the process of healing and didn't wait to something to happen from the side of clinician only. They were willing to share their deep pains which kept secret to themselves and other people. One client has described the process as giving birth. Labor is a tiresome process that needs maternal effort and the pain she experiences is the worst pain in her life which is compensated by the joy of having a baby. There is a saying in Ethiopia "ምጡን ርሽው ልጁን አንሽው" which is translated as "Lady, please forget about the labor, just pick up the baby". The healing experienced by the client was described as a baby and the process of therapy especially talking about the past painful experiences is represented as a laboring process that requested the painful active effort of given client.

Two clients have tackled with their own inner sense of struggle to escape the points which are too painful to disclose. It seems that they have some sense of understanding about the resistance that works inside them working against their healing. They have also described their role of being eager to get the healing and having strong belief on the therapy as it works for them. It was also described

in other studies that the belief and willingness of clients have contributed to the healing process. (6, 7 and 8)

It was also revealed that the strong connection between the clinician and the client has by itself a healing effect. It has helped them to think as they were in the heart of the clinician and felt free to share their weaknesses easily with them. This finding is mentioned in many studies to the extent of considering human connectedness as one of basic needs of humans as food and shelter. (17, 18, 19 and 22)

Negative experiences and how they have dealt with them

Frequent turnover of the clinicians have annoyed most of clients and led to a disruption in therapeutic alliance. It has also confused clients due the change in the goal of therapy as clinicians interchange. It is a challenge in our setting because most of the therapies are given by the trainees for academic purpose and the scarcity of therapists. This challenge could be dealt by increasing the number of therapist and keeping the clients under one supervising therapist who stays at the site while trainees rotate.

Few clients have disclosed that clinician has rejected them and stopped the therapy without orienting them. There was also a moment at which clinician has actively ignored a traumatic history of client i.e. sexual assault which has disrupted the therapeutic relationship and worsened the condition of the client. Being evaluated in front many people was embarrassing and hindered them from sharing traumatic stories. Clinician' hesitance to accept the verbal praise from the client has generated a guilty feeling on client because it has stopped them from expressing positive impact of clinician at their life. Mostly the participants have dealt with the negative experiences from the side of clinicians by accepting them because they have no choices. None of them had courage to comment on the disruptive processes. Most of the negative experiences by the side of therapists were also reported in other setups too (1, 31) but the way they have dealt seemed immature in our set-up. Clients faced difficulty to express their resentment to the clinicians directly. It can be improved by: (1) doing therapies under close supervision, (2) helping clinicians to pass through long process of self-reflectiveeness and countertransference management (3) providing contextual opportunity to clients to comment on the challenges attributed by the clinician

Most of the clients have experienced stigma from the society for attending psychotherapy as putting themselves in a trap of making them crazy by their own time. They have also experienced demeaning comments from people around them as it's not worthy to spend that much time and energy for talk. Some have also faced challenges from social norms and religious rules that discouraged expression of emotions openly. They have tackled the negative social impact easily by using their positive experience of psychotherapy as an anchor. The stigma appeared as an extension of stigma in mental illness in which was reported in many local and international studies. (1, 14, 54 and 57)

A client has mentioned CBT has not helped him after attending it for long time and some of its concepts are difficult to understand and practice. The finding is also mentioned in a study done in our setting (12). Waiting for long time at OPDs has exhausted the clients and they have attributed it to the scarcity of clinicians. They have waited for hours because they have no another options. This problem could be also solved by adjusting appointment time of clients at least by appointing them at exact time rather than telling them to come in the morning. In the long run it can also be approached by increasing the quality of the service.

Relationship experiences

Most clinicians were experienced as caring, concerned about them, sensitive to their emotions and interested on them as a person. They have also experienced them as more intimate than their own children and partners. They were also experienced as a guide that clarifies them the meaning of their behaviors and symptoms. Clients had their own expectations concerning psychotherapy like prescription of medications, efficacy and duration of the psychotherapy. Except one client with CBT, others have found therapy as above their expectation and happy of attending it. There were also similar findings mentioning in other studies as multiple common therapeutic factors regardless of the type of psychotherapy, consciously held theoretical foundations or expertise of therapist which are playing major role in the process of talk therapy such as hope, expectation, world view, assumptive base, value, trust, belief and relationship of client and the therapist (6, 7, 8, and 13).

Participants have recommended follow with one constant clinician, to be evaluated by one person, to increase the awareness of the public, to have clean and quit rooms. They have also recommended that the average duration of a session should be one hour.

5.2. Strengths and limitations

The major strength of this study is that it has included clients who have attended psychotherapy with different professions which was identified as gap in the past studies. It has also tried to explore and describe mechanisms of change which is first of its kind for our set up.

The small sample size due to the nature of the study affects it generalisability. There was also huge gap between experiences clients of depending on the duration of psychotherapy they had attended.

5.3. Conclusion and recommendation

Clients have experienced psychotherapy as beneficial in most cases and harmful in some cases. What mattered most for the clients were; an empathic listening, unconditional acceptance and their connection with the therapist who is emotional sensitive and focusing on them as a person not on their problems as priority. Therapists' being not persistent and sensitive had a counterproductive effect on the therapeutic

alliance and contributed to the worsening of symptoms. Clients were not comfortable with frequent turnover of clients, being evaluated in front multiple people and long waiting time they spent. Most of the concepts mentioned as healing mechanisms and negative impacts were mainly described in the contexts of identity of clients, interpersonal relationships and social life.

We recommend to:

- Have a regular therapist to clients
- Increase awareness of psychotherapy in the public and promote it
- Decrease waiting time and appointments management
- Compare different forms of psychotherapies in future researches
- Evaluate clients alone or decrease the number of examiners
- Clinical psychologists and psychiatrists to supervise and manage frequencies of turnover in trainees at different sites
- To do future researches to explore the subjective experiences of therapists

References

1. Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work*. Routledge.
2. Caplan, E. (1998). *Mind games: American culture and the birth of psychotherapy* (Vol. 9). Univ of California Press.
3. Taylor, E. (1999). *Shadow culture: Psychology and spirituality in America.* Washington, DC: Counterpoint
4. Cushman, P. (1992). Psychotherapy to 1992: A historically situated interpretation.
5. Mays, V. M., & Albee, G. W. (1992). Psychotherapy and ethnic minorities.
6. Rosenzweig, S. (1936). Some implicit common factors in diverse methods of psychotherapy. *American journal of Orthopsychiatry*, *6*(3), 412.
7. Frank, J. D., & Frank, J. B. (1991). Persuasion and healing (3rd). *Baltimore: Johns Hopkins*.
8. Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, research & practice*, *16*(3), 252.
9. Fernando, S. (2014). *Mental health worldwide: Culture, globalization and development*. Springer.
10. Dwairy, M. (1999). Toward psycho-cultural approach in middle eastern societies. *Clinical Psychology Review*.
11. Bugental, J. F. (1992). *The art of the psychotherapist*. WW Norton & Company.
12. Filmon, Dawit, Karin: *Cultural adaptation and implementation of Cognitive behavioral therapy (CBT) for depression in Ethiopia* : Unpublished
13. Heppner, P. P., & Claiborn, C. D. (1989). Social influence research in counseling: A review and critique. *Journal of counseling psychology*, *36*(3), 365.
14. Tringo Cheru (2018). *Exploring the subjective perception of people with substance and related disorder towards psychotherapy at Amanuel Specialized Mental Hospital:* Unpublished
15. Amare Alemwork (2020). *Clients' perception of psychotherapy after psychotherapy termination in Tikur Anebessa Specialized Hospital and Zewditu Memorial Hospital*: Unpublished
16. Bowlby, J. (1969). Attachment and loss v. 3 (Vol. 1).
17. Books, B., & Bowlby, J. (1973). Attachment and loss: Vol. 2. *Separation: Anxiety and anger. New*.
18. Bowlby, J. (1980). Loss, vol. 3. Attachment.
19. Baumeister, R. F. (2005). *The cultural animal: Human nature, meaning, and social life*. Oxford University Press.
20. Cohen, S. E., & Syme, S. I. (1985). *Social support and health*. Academic Press.
21. Cacioppo, S., & Cacioppo, J. T. (2012). Decoding the invisible forces of social connections. *Frontiers in integrative neuroscience*, *6*, 51.

22. Lieberman, M. D. (2013). *Social: Why our brains are wired to connect*. OUP Oxford.
23. Jenkins, R., Baingana, F., Belkin, G., Borowitz, M., Daly, A., Francis, P., ... & Sadiq, S. (2010). Mental health and the development agenda in Sub-Saharan Africa. *Psychiatric Services*, *61*(3), 229-234.
24. De Waal, F. B. (2008). Putting the altruism back into altruism: the evolution of empathy. *Annu. Rev. Psychol.*, *59*, 279-300.
25. Niedenthal, P. M., & Brauer, M. (2012). Social functionality of human emotion. *Annual review of psychology*, *63*, 259-285.
26. Preston, S. D., & De Waal, F. B. (2002). Empathy: Its ultimate and proximate bases. *Behavioral and brain sciences*, *25*(1), 1-20.
27. Smith, M. L., & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American psychologist*, *32*(9), 752.
28. Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Johns Hopkins University Press.
29. Eysenck, H. J. (1978). An exercise in mega-silliness.
30. Eysenck, H. J. (1984). Meta-analysis: An abuse of research integration. *The journal of special education*, *18*(1), 41-59.
31. Wilson, G. T., & Rachman, S. J. (1983). Meta-analysis and the evaluation of psychotherapy outcome: Limitations and liabilities. *Journal of Consulting and Clinical Psychology*, *51*(1), 54.
32. Buchholz, M. B., & Kächele, H. (2017). From turn-by-turn to larger chunks of talk: An exploratory study in psychotherapeutic micro-processes using conversation analysis. *Research in Psychotherapy: Psychopathology, Process, and Outcome*, *20*(3).
33. Woolfolk, R. L. (2015). *The value of psychotherapy: The talking cure in an age of clinical science*. Guilford Publications.
34. Wampold, B. E. (2001). The great psychotherapy debate: Models, methods, andfindings Lawrence Erlbaum Associates Publishers. *Mahwah, NJ*.
35. Lambert, M. J. (2013). *Bergin and Garfield's handbook of psychotherapy and behavior change*. John Wiley & Sons.
36. Kazdin, A. E. (2007). Mediators and mechanisms of change in psychotherapy research. *Annu. Rev. Clin. Psychol.*, *3*, 1-27.
37. Mini. T.C. (2008). *An Assessment of Health Care Seeking Behaviour of people in and around Gondar Town*, Paper presented at the 18th Annual Research Conference, University of Gondar, Ethiopia.
38. Janetius, S.T., Alemayehu T. & Mini T.C.(2016). *Traditional world view and culture-specific psychotherapy in Ethiopia*. Amazon CS Publication
39. Bryant, R. A., Schafer, A., Dawson, K. S., Anjuri, D., Mulili, C., Ndogoni, L., ... & Van Ommeren, M. (2017). Effectiveness of a brief behavioural intervention on psychological distress among women with a history of gender-based violence in urban Kenya: a randomised clinical trial. *PLoS medicine*, *14*(8), e1002371.

40. Ravitz, P., Wondimagegn, D., Pain, C., Araya, M., Alem, A., Baheretibeb, Y., ... & Leszcz, M. (2014). Psychotherapy knowledge translation and interpersonal psychotherapy: using best-education practices to transform mental health care in Canada and Ethiopia. *American journal of psychotherapy*, *68*(4), 463-488.
41. Verhey, I. J., Ryan, G. K., Scherer, N., & Magidson, J. F. (2020). Implementation outcomes of cognitive behavioural therapy delivered by non-specialists for common mental disorders and substance-use disorders in low-and middle-income countries: a systematic review. *International Journal of Mental Health Systems*, *14*, 1-14.
42. Khan, M. N., Hamdani, S. U., Chiumento, A., Dawson, K., Bryant, R. A., Sijbrandij, M., ... & Rahman, A. (2019). Evaluating feasibility and acceptability of a group WHO trans-diagnostic intervention for women with common mental disorders in rural Pakistan: a cluster randomised controlled feasibility trial. *Epidemiology and Psychiatric Sciences*, *28*(1), 77-87.
43. https://data.worldbank.org/indicator/SH.MED.PHYS.ZS?locations=ET
44. Berhan, Y. (2008). Medical doctors profile in Ethiopia: production, attrition and retention. In memory of 100-years Ethiopian modern medicine & the new Ethiopian millennium. *Ethiopian medical journal*, *46*, 1-77.
45. Asher, L., Patel, V., & De Silva, M. J. (2017). Community-based psychosocial interventions for people with schizophrenia in low and middle-income countries: systematic review and meta-analysis. *BMC psychiatry*, *17*(1), 1-15.
46. R. E. Lewandowski, P. A. Bolton, A. Feighery (2016). *Local perceptions of the impact of group interpersonal psychotherapy in rural Uganda*. Glob Ment Health (Camb)
47. Kumar, M., Kuria, M. W., Othieno, C. J., & Falkenström, F. (2018). Improving psychotherapies offered in public hospitals in Nairobi, Kenya: extending practice-based research model for LMICs. *International journal of mental health systems*, *12*(1), 1-11.
48. Singla, D. R., Kohrt, B. A., Murray, L. K., Anand, A., Chorpita, B. F., & Patel, V. (2017). Psychological treatments for the world: lessons from low-and middle-income countries. *Annual review of clinical psychology*, *13*, 149-181.
49. NNegash, A., Khan, M. A., Medhin, G., Wondimagegn, D., Pain, C., & Araya, M. (2021). Feasibility and acceptability of brief individual interpersonal psychotherapy among university students with mental distress in Ethiopia. *BMC psychology*, *9*(1), 1-14.
50. Negash, A., Alem, A., Kebede, D., Deyessa, N., Shibre, T., & Kullgren, G. (2005). Prevalence and clinical characteristics of bipolar I disorder in Butajira, Ethiopia: a community-based study. *Journal of affective disorders*, *87*(2-3), 193-201.
51. Marsella, A. J. (1998). Toward a" global-community psychology": Meeting the needs of a changing world. *American psychologist*, *53*(12), 1282.
52. Desta, M. (2008). *Epidemiology of child psychiatric disorders in Addis Ababa, Ethiopia* (Doctoral dissertation, Barn-och ungdomspsykiatri).
53. Giorgis, T. W., & Sime, K. (2013). National Mental Health Strategy. *AddisAbaba: Ministry of Health, Federal Democratic Republic of Ethiopia*, 1-54.

54. Abdulahi, H., Mariam, D. H., & Kebede, D. (2001). Burden of disease analysis in rural Ethiopia. *Ethiopian Medical Journal*, *39*(4), 271-281.
55. Federal Democratic Republic of Ethiopia Ministry of Health (2012). *The National Mental Health Strategies (2012/13–2015/16), Addis Ababa, Ethiopia.*
56. Oliveira, A., Sousa, D., & Pires, A. P. (2012). Significant Events in Existential Psychotherapy: The Client's Perspective. *Existential Analysis: Journal of the Society for Existential Analysis*, *23*(2).
57. Strupp, H. H., Fox, R. E., & Lessler, K. (1969) . Patients view of their psychotherapy. USA: The John Hopkins Press.
58. Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in psychology*, *2*, 270.

Annex

Annex 1

Informed Consent Form

Good morning, my name is Dr. Eshetu Tumiso. I am a final year psychiatry resident at the Addis Ababa University (AAU). As part of my training, I am studying the subjective experience of clients who attend psychotherapy at TASH/ZMH.

You were selected to participate in this study because you are attending psychotherapy in this hospital. I anticipate that this interview will take at least 45 minutes to complete.

Aim: The data collected will provide useful information about the subjective experience of psychotherapy.

Benefit: The study may not have any direct or immediate benefit to you, but your participation is very important for the outcome of the study and gives direction for future study and improvement in the service.

Risk: You do not have to take part in this research if you do not wish to do so, and your decision to participate or not will not have any consequence. All information will remain confidential. I will not record your name. I will only record you as a survey subject C1, C2.

Are you willing to participate in the study?

If yes, I appreciate your willingness to help with my project.

If you have questions later, please contact me at 0972643265 any time.

If you understood the above information, please express your agreement to participate in this study by signing your signature below.

Name ___________________________

Signature _________________________

Amharic version of the informed consent

በመረጃ ላይ የተመሰረተ ስምምነት

ጤና ይስጥልኝ ስሜ ዶ/ር እሸቱ ጡሚሶ ነው ፤ የአዲስ አበባ ዩኒቨርስቲ የመጨረሻ ዓመት የአእምሮ ህክምና ሰልጣኝ ሀኪም ነኝ ፡፡ እንደ የስልጠናው አካል ፣ በጥቁር አንበሳ ስፔሻላይዝድ ሆስፒታል/ ዘዉዲቱ ሆስፒታል የንግግር ህክምና እየተከታተሉ ባሉ ተገልጋዮች ስለ ንግግር ህክምናዉ ያላቸዉን የግል ተሞክሯቸዉን እያጠናሁ ነው ፡፡ በዚህ ጥናት ውስጥ እንዲሳተፉ የተመርጠበት ዋናዉ ምክኒያት በዚሁ ሆስፒታል ህክማናዉን እየተከታተሉ ስላለ ነዉ፡፡ ይህን ቃለ መጠይቅ ለማጠናቀቅ ቢያንስ 45 ደቂቃዎችን ይወስዳል የሚል ግምት አለኝ ፡፡ ይህ ቃለ-መጠይቅ ወደ ፊት ለሚደረገው የጥናቱ ትንተና እንዲያገለግል በድምፅ መቅጃ ይቀዳል፡፡

ዓላማው :- የሚሰበሰበው መረጃ የንግግር ህክምና እየተከታተሉ ስላሉ ተገልጋዮች የግል ተሞክሮና ልምድ በተመለከተ ጠቃሚ መረዳቶችን ይሰጣል፡፡

ጥቅም :- ጥናቱ ለእርስዎ ቀጥተኛ ወይም አሁናዊ ጥቅም ላይኖረው ይችላል ፣ ነገር ግን የእርስዎ ተሳትፎ ለጥናቱ ውጤት በጣም አስፈላጊ ነው፡፡ ጥናቱ ለወደፊቱ ጥናት እና በአገልግሎቱ መሻሻል አቅጣጫ ይሰጣል፡፡

ስጋት:- ይህን ለማድረግ ካልፈለጉ በዚህ ጥናት ውስጥ አለመሳተፍ ይችላሉ፤ ለመሳተፍ ወይም ላለመሳተፍ ያደረጉት ውሳኔ ምንም ዓይነት አሉታዊ ተጽዕኖ አያስከትልም፡፡ የሁሉም መረጃዎች ምስጢራዊነት የሚጠበቁ ይሆናሉ ፣ ስምዎትን አልመዘግብም ፡፡ እኔ የምመዘግብዎ እንደ የዳሰሳ ጥናት ርዕሰ ጉዳይ C1 ፣ C2 እያልኩኝ ነዉ፡፡

በጥናቱ ለመሳተፍ ፈቃደኛ ነዎት?

አዎ ከሆነ ለመሳተፍ ስለፈቀዱ አመስግናለዉ፡፡ በጥናቱ ላይ ጥያቄዎች ካሉዎት በ 0972643265 በፈለጉት ጊዜ መደወል ይችላሉ፡፡

ይህን የስምምነት ቅጽ በትክክል ከተረዱት በጥናቱ ለመሳተፍ ፍቃደኛ መሆንዎን ለማረጋገጥ ከዚህ በታች በተዘጋጀው ቦታ ላይ በመፈረም ፍቃደኛነትዎን ያረጋግጡልኝ ዘንድ በትህትና እጠይቃለሁ፡፡

ስም --------------------------------

ፊርማ --------------------------------

ቀን ----------------------------------

Annex 2

Part 1

Participant information

Age -------------------------------------- Gender------------------------

Marital status ---- ------------------- Level of education------------------

Occupation---------------------------- Religion---------------------------

Duration of the illness ------------- Sessions of the therapy--------

Part 2

Main Questions

1. How did you get in to this process of psychotherapy? How do you recount your experience of the psychotherapy process?
   Have you ever been in psychotherapy before?
   Please tell me your previous understanding about psychotherapy?
2. What was your expectation about the psychotherapy?
3. Please tell me what psychotherapy means to you based on your subjective experiences?
4. Tell me about your experience of the relationship with the psychotherapist?
5. Has being in psychotherapy affected your social relationships?
   How does the psychotherapy integrate into your routine social life?
6. What aspects of the psychotherapy process do you think were most beneficial to you? How it has helped you and impacted your social life?
7. Which aspects of psychotherapy moments were difficult (not beneficial) that you has experienced from your perspective? How did you have dealt with the challenges?
8. What makes this talk therapy different from other routine advises in your context?
9. Is there any difference in the initial phase and later phase therapy?
10. What were the main problems and goals of the therapy? How do you describe your involvement in the process of the psychotherapy?
11. What was the name of psychotherapy that you have attended?

Is there anything else you want to add about your experience of the psychotherapy?

Thank you very much!

የተሳታፊዉ ማንነት

ዕድሜ-------------------   ፆታ------------------------

የጋብቻ------------------   የትምህርት ደረጃ------------

ሥራ--------------------   ሃይማኖት-------------------

ችግሩ ከገጠመዎት ምን ያህል ጊዜ ሆነ ------   የንግግር ህክምናዉን ከጀመሩ ምን ያህል ጊዜ ሆንዎት------

<u>ዋናዎቹ ጥያቄዎች</u>

1. የንግግር ህክምናዉን እንዴት ጀመሩ፤ በራስዎት ነዉ ወይስ በሌላ ሰዉ ምክኒያት? በህክምናዉ ሂደት የነበሮትን ቆይታ እንዴት ያስታዉሱታል?
   ከዚህ በፊት የንግግር ህክምና የመተከታተል ልምድ ነበሮት እንዴ?
   ከአሁኑ የንግግር ህክምና በፊት ስለ ንግግር ህክምና በአጠቃላይ የነበሮትን ግንዛቤ ቢያስረደዱኝ?
2. ስለ ንግግር ህክምናዉ ምን ዓይነት ግምት ነበርዎት?
   እንዴት አገኙት ታዲያ?
3. ከነበሮት ልምድ በመነሳት ለእርሶ የንግግር ህክምና ማለት ምን ማለት እንደሆነ ቢያስረዱኝ?
4. የንግግር ህክምናዉን ከሚሰጦት ሰዉ ጋር ስላሎት ግንኙነት ቢነግሩኝ ?
5. የንግግር ህክምናዉ በማህበራዊ ህይዎቶት ላይ ምን ዓይነት ተጽዕኖ አመጣ?
   የንግግር ህክምናዉን ከዕለት ተዕለት ህይዎቶት ጋር እንዴት ይዋሃዳል (አብሮ ይሄዳል)?
6. በእርሶ እይታ ከንግግር ህክምናዉ በጣም የረዳዎት ነገር ምንድር ነዉ?
   እንዴትስ ሰራሎት? ለምን ይመስሎታል?
7. በንግግር ህክማናዉ ወቅት ምን ዓይነት አሉታዊ ነገር / ተግዳሮት/ ከባዱ ጊዜ የሚሉት ገጠሞት?
   እንዴትስ አለፉት/ተወጡት?
8. በእርሶ እይታ ይህንን የንግግር ህክምና ከሎሎቹ ከተለመዱት ምክሮች ምን ይለየዋል?
9. ገና ህክምናዉን ሲጀምሩትና ከጀመሩት በኋላ ለእርሶ ያለዉን ልዩነት ያስረዱኝ?
10. የንግግር ህክምናዉን ሲጀምሩ የህክምናዉ ዓላማዉ ምን ነበር?
    የተስማማችሁበት የትኩረት አቅጣጫ ወይም ችግር ምን ነበር ?
    ዕቅዱ የማን ነበር? በዕቅዱም ሆነ በህክምናዉ ሂደት የእርሶ ተሳትፎ እንዴት ይገለጻል?
11. ሲከታተሉት የነበረዉ የንግግር ህክምናዉ ስም ምን ይሰኛል?
    ካሎት ልምድ በመነሳት የንግግር ህክምናን በተመለከተ መጨመር የሚፈልጉት ነገር ካለ?

ስለ ነበረን ቆይታ በጣም አመሰግናለዉ !