

FINAL PRACTICUM REPORT

Title: Assessment of Trauma Exposure and Psychological Distress Among Clients in a Mental Health Clinical Setting in Ethiopia

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Abstract

This report describes my practicum observation at Dilla University Referral Hospital Psychiatry Center. I spent three days on the inpatient ward. I observed one client, a 45-year-old male diagnosed with Bipolar Disorder.

His illness began after he lost his business. He took medication for eight years and was stable, but he stopped his medicine and relapsed.

During my observation, he had severe insomnia, auditory hallucinations, agitation, and emotional instability.

Due to the severity of his condition, he was placed alone in one room. There were no nurses or doctors on the ward during my observation hours.

I gathered information by talking to the client's brother and later consulting my supervisor, Doctor Sidelil, in his office.

I followed ethical principles: confidentiality, informed consent from the brother, and no harm to the client.

For the therapy session, I used psychological theories (CBT, psychoeducation, trauma-informed therapy, family systems)

Introduction

I am Yenatfanta Zelalem, a psychology student at Dilla University. For my practicum, I went to Dilla University Referral Hospital Psychiatry Center.

The assignment was to observe a client with trauma exposure and psychological distress, and to write a report including objectives, literature review, methods, and a hypothetical therapy session using psychological approaches.

This report describes what I saw and what I learned.

Trauma-Related Mental Health Problems

From my coursework, trauma can lead to

Post-Traumatic Stress Disorder (PTSD)

Major Depressive Disorder

Bipolar Disorder

Adjustment Disorder, and

Substance Use Disorders.

My client had Bipolar Disorder, so I focus on that.

Background of the Study

In Ethiopia, trauma is very common due to war, displacement, drought, and poverty. Tiruneh and colleagues (2021) found that 76.7% of internally displaced persons experienced three or more traumatic events.

Dachew and colleagues (2021) found that about 25.5% of adults have high levels of psychological distress. However, mental health services are very limited. Ethiopia has fewer than 100 psychiatrists for 120 million people.

Most research has been done in communities, not in clinical settings. My observation helps fill that gap.

Statement of the Problem

1, The main problems are a severe treatment gap with too few mental health professionals,

2, high trauma exposure but no trauma-informed care.

3, stigma and cultural beliefs that delay medical treatment, and

4, lack of clinical data on trauma histories of clients.

My practicum aimed to document one client's trauma and distress in a real clinical setting.

Back ground of practicum setting

Dilla University Referral Hospital is about 365 kilometers south of Addis Ababa. It started as a clinic in 1928, later became Leul Mekonnen Hospital, and in 2009 it was transferred to Dilla University.

The psychiatry center is a separate building behind the main hospital.

It has a consultation room, a pharmacy, and an inpatient ward.

During my three days on the ward, the client I observed was alone in one room. Due to the severity of his condition, the hospital placed him separately from other patients. The room had one metal bed with a thin mattress. There was a small table and one chair. The walls were bare. The floor was cement. The window had bars. The room was clean but basic.

There were no nurses present in the room during my observation hours.

The client's brother was the only person providing care, including feeding, cleaning, and monitoring.

I later consulted my supervisor, Doctor Sidelil, in his office to get information about the client's diagnosis and history.

Many families first go to holy water or traditional healers before coming to the hospital. This delay often makes the illness worse.

General Information About the Client

The client was a 45-year-old male. I call him "Bereket" (pseudonym). He is married and has three children.

He used to own a small business. His brother was his main caregiver during my observation.

According to the brother and later confirmed by Doctor Sidelil, eight years ago Bereket's business collapsed.

He lost a lot of money and had debts. Within a few months, he stopped sleeping, talked very fast, became irritable, and sometimes heard voices.

The brother said Bereket would pace at night and shout at people who were not there.

The family first took him to a holy water site for several weeks. When that did not help, they went to a traditional healer.

After nearly one year, they came to Dilla University Referral Hospital. Doctor Sidelil diagnosed Bipolar Disorder and started medication including lithium and an antipsychotic.

Bereket improved and returned to work in his brother's shop. He took his medicine every day for eight years.

The brother said Bereket was normal during that time.

Eleven days before my visit, Bereket traveled to his rural hometown. He forgot or chose not to bring his medicine.

After five days without it, he stopped sleeping again, became agitated, accused his family of stealing, and ran outside shouting. The family brought him back to the hospital, and he was readmitted.

Because of the severity of his condition, he was placed alone in a separate room.

When I saw him, he was lying on his bed with his eyes open. He was whispering to himself. His clothes were dirty.

He had not bathed for several days.

He did not look at me or respond to my presence.

Psychological Issues of the Client

I spent three days on the ward. Each day I stayed for about two to three hours, mostly in the morning and afternoon. The client was alone in his room. I sat on the chair near the door and observed.

Here are my observations:

Sleep disturbance: Bereket did not sleep. He lay awake or sat up in bed. His brother told me that at night he would pace the room. The brother confirmed that on his medicine he used to sleep well.

Hallucinations: Bereket spoke to unseen people. He said once, "They are telling me I am worthless." He also laughed at nothing and turned his head toward empty spaces.

Agitation: He could not sit still. He picked at his blanket, tapped his fingers, and suddenly stood up and walked to the door. His brother had to guide him back to bed.

Emotional instability: His mood changed quickly. One minute he was angry with his fists clenched. The next minute he looked like he was about to cry. Then he laughed without reason.

Poor self-care: He did not comb his hair or shave. He wore the same clothes all three days. His brother reminded him to eat, but he ate very little.

Doctor Sidelil explained that the business loss was a traumatic stressor that triggered his first episode. When he stopped medication, the vulnerability returned and caused a relapse. His current distress including insomnia, hallucinations, and agitation is a direct result of stopping treatment.

Chapter 1: Objectives of the Practicum Work

1.1 General Objective

To assess the relationship between trauma exposure and psychological distress among clients in a mental health clinical setting in Ethiopia, and to develop basic skills in clinical observation and case conceptualization using psychological theories.

1.2 Specific Objectives

- 1. To describe the background and operational framework of Dilla University Referral Hospital Psychiatry Center.**
- 2. To document the demographic characteristics, trauma history (business loss), and clinical presentation (insomnia, hallucinations, agitation) of a 45-year-old male client with Bipolar Disorder.**
- 3. To examine the relationship between the client's traumatic event and the onset of his bipolar symptoms.**

4. To describe a hypothetical therapy session for this client using psychological theories including CBT, psychoeducation, trauma-informed therapy, and family systems.

CHAPTER 2: LITERATURE REVIEW (COMPLETE REWRITE)

2.1 Empirical Framework

This section reviews scholarly research articles pertaining to trauma exposure and psychological distress among individuals with severe mental illness, with particular emphasis on bipolar disorder. The review includes three studies from Ethiopian scholars and two international studies. After each study, I explain how the findings connect directly to my client, Bereket.

Ethiopian Study 1: Ng, Medhin, Hanlon, and Fekadu (2019)

Ng, Medhin, Hanlon, and Fekadu (2019) conducted a study in rural Ethiopia to investigate exposure to traumatic and stressful events among people with severe mental disorders. The sample included 300 participants, of whom 84% had primary psychosis, 11% had bipolar disorder, and

16% had depression with psychotic features (Ng, Medhin, Hanlon, and Fekadu, 2019).

The findings revealed that more than one-third (36%) of participants reported experiencing at least one traumatic event since the onset of their illness. The most common traumatic events were being assaulted (24%), beaten (20%), and raped (7% of women). In addition, 70% of participants reported experiencing a stressful life event in the past six months, with serious illness or injury and joblessness being the most frequently reported events (Ng, Medhin, Hanlon, and Fekadu, 2019).

The study also found that hazardous drinking was positively associated with exposure to traumatic events, and suicidal ideation was associated with both physical restraint and the number of stressful events experienced. The authors concluded that people with severe mental disorders in Ethiopia are exposed to high levels of trauma and stress, which significantly worsen their clinical outcomes (Ng, Medhin, Hanlon, and Fekadu, 2019).

Connection to Bereket: This study is directly relevant to my client, Bereket. Although Bereket's traumatic event (business loss) occurred before his first manic episode rather than after illness onset, the study confirms that trauma and severe stress are common triggers for mental illness in Ethiopia. Bereket's case follows the same pattern: a major stressful life event (financial collapse) preceded his first episode. Additionally, like many participants in this study, Bereket experienced a stressful

life event in the period before his relapse - traveling to his rural hometown and discontinuing his medication.

Ethiopian Study 2: Mamed, Tefera, Bitew, and Colleagues (2024)

Mamed, Tefera, Bitew, and colleagues (2024) examined the prevalence of mental distress and post-traumatic stress disorder (PTSD) among 367 conflict-induced internally displaced persons (IDPs) in the Wag-Hemra Zone of the Amhara Region in Ethiopia. The study used the Kessler Psychological Distress Scale (K-10) and the PTSD Checklist-Civilian Version (PCL-C) to measure symptoms (Mamed, Tefera, Bitew, and colleagues, 2024).

The results showed that the prevalence of mental distress was 63%, and the prevalence of PTSD was 48%. Higher rates of both conditions were found among female participants, those who had experienced rape, those who had witnessed murder, widowed individuals, and illiterate persons. The study also found that psychological capital - which includes self-efficacy, hope, optimism, and resilience - was a significant negative predictor of both mental distress and PTSD. Specifically, psychological capital accounted for 26% of the variance in mental distress and 20.9% of the variance in PTSD (Mamed, Tefera, Bitew, and colleagues, 2024).

The authors recommended that mental health interventions for trauma-affected populations should focus not only on reducing symptoms but also on strengthening psychological capital and resilience factors (Mamed, Tefera, Bitew, and colleagues, 2024).

Connection to Bereket: Although this study focused on internally displaced persons rather than clinical clients, its findings are relevant to Bereket in two ways. First, the extremely high rate of mental distress (63%) among trauma-exposed individuals in Ethiopia demonstrates how common psychological distress is following traumatic events. Bereket's severe psychological distress - including insomnia, agitation, hallucinations, and emotional instability - is consistent with this pattern. Second, the study highlights the importance of psychological capital (hope, optimism, resilience). Bereket's brother demonstrated resilience by continuing to care for him, and Bereket himself showed resilience by adhering to medication for eight years. A future therapy session should aim to strengthen these protective factors.

Ethiopian Study 3: Fekadu, Medhin, Selamu, Giorgis, Lund, Prince, Alem, and Hanlon (2017)

Fekadu, Medhin, Selamu, Giorgis, Lund, Prince, Alem, and Hanlon (2017) conducted a cross-sectional facility-based study in rural Ethiopia to examine non-fatal suicidal behavior among people with severe mental illness. The study included participants diagnosed with schizophrenia, bipolar disorder, and major depressive disorder who were receiving care from primary health centers or a psychiatric hospital (Fekadu, Medhin, Selamu, Giorgis, Lund, Prince, Alem, and Hanlon, 2017).

The findings revealed that suicidal behavior was strongly associated with several factors. These included exposure to traumatic events, experience of stressful life events in the past year, lack of family support, and being unmarried. The study also found that participants with bipolar disorder had higher rates of suicidal behavior compared to those with other severe mental illnesses (Fekadu, Medhin, Selamu, Giorgis, Lund, Prince, Alem, and Hanlon, 2017).

The authors concluded that screening for trauma and stressful life events should be a routine part of mental health assessment in Ethiopian clinical settings. They also recommended that family support should be strengthened as a protective factor against suicidal behavior in people with bipolar disorder and other severe mental illnesses (Fekadu, Medhin, Selamu, Giorgis, Lund, Prince, Alem, and Hanlon, 2017).

Connection to Bereket: This study is highly relevant to Bereket because it focuses specifically on Ethiopian

patients with severe mental illness (including bipolar disorder) in a clinical setting - exactly the population I observed. Bereket experienced a major traumatic event (business loss) and subsequent stressful life circumstances (financial debt, loss of his business identity). His family initially did not understand his illness and spent nearly a year seeking help from holy water and traditional healers before coming to the hospital, which may reflect lack of family support or knowledge. The study's finding that bipolar disorder carries higher suicide risk than other severe mental illnesses underscores the importance of addressing Bereket's trauma history and strengthening his family support system to prevent future suicidal behavior.

International Study 1: Wrobel and Colleagues (2025)

Wrobel and colleagues (2025) conducted a systematic review to examine the prevalence, clinical impact, and therapeutic considerations of trauma in adults with bipolar disorder. The review evaluated 16 human studies with a total sample size of 2,658 adults diagnosed with bipolar disorder (Wrobel and colleagues, 2025).

The key findings were as follows. First, prevalence rates of trauma in adults with bipolar disorder are estimated at approximately 40-60%. Second, childhood physical maltreatment is highly associated with comorbidities such

as metabolic disorders and with increased symptom severity. Third, childhood emotional maltreatment is associated with earlier age of onset, greater overall illness severity, higher rates of comorbidity, and increased suicidality in bipolar disorder (Wrobel and colleagues, 2025).

The review concluded that trauma, especially childhood trauma, is highly prevalent among adults with bipolar disorder and has a severe negative clinical impact on the presentation, progression, treatment, and outcomes of the illness. The authors recommended that all individuals with bipolar disorder should be routinely screened for trauma history, and that treatment should include trauma-informed approaches alongside medication management (Wrobel and colleagues, 2025).

Connection to Bereket: This international review confirms that the relationship between trauma and bipolar disorder is not unique to Ethiopia but is observed worldwide. Bereket's case fits the global pattern: his traumatic event (business loss) preceded his first manic episode, and his illness has been severe, requiring long-term medication and resulting in relapse when treatment was discontinued. Although Bereket's trauma occurred in adulthood rather than childhood, the review's conclusion that trauma negatively impacts bipolar disorder outcomes applies directly to him. His relapse after stopping medication may have been made more likely by his unresolved trauma history. This finding supports the need for trauma-informed therapy as part of his treatment plan.

International Study 2: Post (1992) - Theoretical Foundation

Post (1992) published a landmark theoretical paper in the American Journal of Psychiatry introducing and developing the kindling hypothesis for recurrent affective disorders, including bipolar disorder. The paper proposes that early episodes of mood disturbance are typically triggered by major stressful life events, but over time, episodes may occur spontaneously or after only minor stressors. Post (1992) argued that each episode of mania or depression may sensitize the brain, lowering the threshold for future episodes. This process, called kindling, is believed to occur at the neurobiological level, involving changes in neurotransmitter systems, gene expression, and neural pathways (Post, 1992).

Post (1992) supported his theory with evidence from both animal studies and human clinical observations. He noted that the first episode of bipolar disorder is almost always preceded by a significant stressor or trauma, while later episodes become increasingly autonomous. The clinical implication of kindling theory is that early and consistent treatment with mood-stabilizing medication may prevent or slow the kindling process, thereby improving long-term prognosis (Post, 1992).

Connection to Bereket: This theoretical paper is directly relevant to Bereket's case. His first manic episode was clearly triggered by a major traumatic event: the collapse of his business and resulting financial loss and debt. This fits Post's (1992) observation that first episodes require major stressors. After eight years of stability on medication, Bereket discontinued his treatment. His relapse occurred without a new major traumatic event - he simply stopped his medicine while traveling. According to kindling theory, this suggests that his brain had become kindled or sensitized: the first episode required a major trauma, but later episodes (or relapse) can occur with much less provocation, or even spontaneously when medication is removed. This theory underscores the importance of consistent medication adherence to prevent further kindling and worsening of the illness over time.

2.2 Theoretical Framework

The problem of trauma exposure and psychological distress in bipolar disorder can be understood through three major theoretical perspectives. Below, I explain each theory and then apply it specifically to Bereket's case.

2.2.1 Stress-Vulnerability Model (Zubin and Spring, 1977)

The stress-vulnerability model, proposed by Zubin and Spring (1977), is one of the most influential frameworks for understanding the onset and course of mental disorders. The model proposes that mental disorders do not arise from vulnerability alone or from stress alone. Instead, they result from the interaction between an individual's underlying vulnerability (which may be genetic, biological, or psychological) and environmental stressors. A person with high vulnerability may develop a disorder after only minor stress, while a person with low vulnerability may remain healthy even after major stress. The model also explains why treatment works: medication reduces vulnerability, psychosocial interventions reduce stress, and a combination of both is most effective (Zubin and Spring, 1977).

Application to Bereket: Bereket likely had an underlying biological vulnerability to bipolar disorder, possibly genetic, that was present long before his first episode. For eight years, his vulnerability was successfully reduced by medication (lithium and an antipsychotic). During those eight years, he experienced normal life stresses but did not relapse because his vulnerability was low. However, when he discontinued his medication, his vulnerability returned to its original high level. At that point, even without a new major stressor, he relapsed. This demonstrates the core principle of the stress-vulnerability model: vulnerability and stress interact. In Bereket's case, stopping medication increased his vulnerability to the point where even everyday stress (traveling, family visits) was enough to trigger a manic episode.

2.2.2 Kindling Theory (Post, 1992)

The kindling theory, originally developed by Post (1992) to explain the course of bipolar disorder and epilepsy, proposes that early episodes of mood disturbance are more likely to be triggered by major stressful life events, but over time, episodes may occur spontaneously or after very minor triggers. The term "kindling" comes from the idea that small sparks (stressors) can eventually start a large fire (episode) even without a major trigger. This theory explains why the first episode of bipolar disorder is almost always preceded by a significant stressor or trauma, while later episodes may occur without any apparent trigger (Post, 1992).

The mechanism is believed to be neurobiological: each episode of mania or depression changes the brain's sensitivity, making future episodes easier to trigger. Over time, the brain becomes "kindled" or sensitized, requiring less and less stress to produce an episode (Post, 1992). This is why early intervention and consistent medication are critical - they may prevent the kindling process from accelerating. The clinical implications of kindling theory are significant: patients who experience multiple episodes may have a progressively deteriorating course of illness if the kindling process is not interrupted by consistent treatment (Post, 1992).

Application to Bereket: Bereket's case fits the kindling theory perfectly. His first manic episode was clearly triggered by a major traumatic event: the collapse of his business and the resulting financial loss and debt. That was a large stressor, consistent with the theory's prediction for first episodes. After eight years of stability on medication, his brain was presumably protected from the kindling process. However, when he stopped his medication, the underlying sensitization may have remained. His relapse occurred without a new major traumatic event - he simply stopped his medicine while traveling. According to kindling theory, this suggests that his brain had become kindled: the first episode required a major trauma, but later episodes (or relapse) can occur with much less provocation. This theory underscores the importance of consistent medication adherence to prevent further kindling and worsening of the illness over time.

2.2.3 Biopsychosocial Model (Engel, 1977)

The biopsychosocial model, introduced by Engel (1977), was a revolutionary departure from the traditional biomedical model. Engel argued that health and illness cannot be understood by biological factors alone. Instead, clinicians must consider three interconnected domains: biological, psychological, and social factors. The biological domain includes genetics, brain chemistry, physical health, and medication. The psychological domain includes

thoughts, emotions, coping styles, beliefs, and personality. The social domain includes family relationships, social support, culture, economic status, and access to healthcare (Engel, 1977).

According to the biopsychosocial model, effective treatment must address all three domains. Treating only the biological (e.g., medication) without addressing psychological trauma or social isolation will lead to poor outcomes. Similarly, providing psychological support without medication for a severe biological illness will also fail. The model emphasizes that the client is a whole person embedded in a family and community, not just a collection of symptoms (Engel, 1977).

Application to Bereket: The biopsychosocial model provides the most complete framework for understanding Bereket's condition and planning his treatment.

Biologically, Bereket has a genetic predisposition to bipolar disorder. His brain chemistry is likely different from that of someone without the illness. His medication (lithium and an antipsychotic) works by stabilizing this brain chemistry. When he stops medication, the biological vulnerability returns, and symptoms recur. Any treatment plan must include consistent medication adherence as a foundation.

Psychologically, Bereket has experienced a major traumatic event (business loss) that has never been

properly processed. This trauma created negative cognitive distortions - beliefs such as "I am a failure" and "I destroyed my family." These negative thoughts contribute to hopelessness, low self-worth, and possibly his decision to stop medication. He also shows emotional dysregulation (rapid mood swings, agitation) and psychological distress (insomnia, hallucinations). A purely biological treatment (medication alone) will not address these psychological issues. He needs cognitive restructuring (CBT) to change his negative beliefs, and trauma-informed therapy to process the loss safely.

Socially, Bereket faces multiple challenges. His family initially spent nearly a year seeking help from holy water and traditional healers, which delayed medical treatment. His brother, who is his main caregiver, is exhausted and has no training in how to recognize early warning signs of relapse. The family has no structured plan for sharing caregiving responsibilities. Additionally, Bereket lives in a community where mental illness is highly stigmatized and often attributed to spirits or curses. He also has limited access to consistent mental health care due to Ethiopia's severe shortage of psychiatrists and mental health professionals.

Integration of the three domains: By combining these four techniques in my hypothetical therapy session (CBT, psychoeducation, trauma-informed therapy, and family systems therapy), I address all three domains of the biopsychosocial model. Medication addresses the biological domain. CBT and trauma-informed therapy address the psychological domain. Family systems therapy

and psychoeducation address the social domain. Only by addressing all three domains can Bereket achieve long-term stability and prevent future relapse.

2.1 Empirical Framework

Ethiopian Study 1: Ng, Medhin, Hanlon, and Fekadu (2019)

Ng and colleagues studied 300 people with severe mental disorder including bipolar disorder in rural Ethiopia.

They found that 36% of participants reported at least one traumatic event since illness onset, including assault (24%), beating (20%), and rape (7% of women).

Also, 70% reported a stressful life event in the past six months. Hazardous drinking was associated with trauma exposure.

Suicidal ideation was associated with restraint and number of stressful events.

Ethiopian **Study 2: Mamed, Tefera, Bitew, and colleagues (2024)**

Mamed and colleagues examined 367 internally displaced persons in Amhara Region. They found that 63% had mental distress and 48% had PTSD.

Higher rates were found among women, rape survivors, widowed individuals, and illiterate persons.

They also found that psychological capital including self-efficacy, hope, optimism, and resilience was a negative predictor of distress and PTSD.

International Study: Wrobel and colleagues (2025)

This systematic review included 16 studies with 2,658 adults with bipolar disorder.

The review found that 40-60% of adults with bipolar disorder report a history of trauma. Childhood emotional maltreatment was associated with earlier age of onset, greater illness severity, more comorbidity, and higher suicide risk. The review concluded that trauma has a severe negative impact on bipolar disorder outcomes.

2.2 Theoretical Framework

Stress-Vulnerability Model (Zubin and Spring, 1977)

This model proposes that mental disorders result from the interaction between an individual's underlying vulnerability (genetic or biological) and environmental stressors.

In Bereket's case, his vulnerability to bipolar disorder was triggered by the business collapse as a stressor.

When he took medication, his vulnerability was reduced.

When he stopped medication, even without a new stressor, he relapsed.

Kindling Theory (Post, 1992)

This theory suggests that early mood episodes are triggered by major stressors, but later episodes occur more easily, even spontaneously. Bereket's first episode was triggered by trauma. His relapse after stopping medication without any new trauma fits the kindling process.

Biopsychosocial Model (Engel, 1977)

This model integrates biological, psychological, and social factors. Biologically, Bereket has a genetic predisposition to bipolar disorder. Psychologically, the trauma of financial loss created negative thoughts and emotional dysregulation. Socially, he

faced poverty, stigma, and limited access to care. Effective treatment must address all three areas.

Chapter 3: Methods of the Practicum Activity

3.1 Participants

The participant was a 45-year-old male client using the pseudonym Bereket, diagnosed by a psychiatrist with Bipolar I Disorder.

He is married with three children. He was a business owner before his illness.

He was admitted to the psychiatric ward at Dilla University Referral Hospital Psychiatry Center. Due to the severity of his condition, he was placed alone in one room. His brother was the main caregiver during my observation.

The client was identified through my supervisor, Doctor Sidelil. He told me about Bereket as a client with a clear trauma history of business loss before illness onset and current severe distress after medication discontinuation.

3.2 Procedures

What I did during three days on the ward:

First, I conducted ward observation. I sat on a chair near the door of Bereket's room. I watched his behavior including his sleep patterns, his speech, his movements, and his interactions with his brother. I did not talk to Bereket directly because he was too ill.

Second, I interviewed the caregiver. I talked to Bereket's brother for about 30 minutes on the second day. He told me the history of the illness, the trauma, the treatment, the eight stable years, and the recent relapse. I took notes after the conversation.

Third, I consulted my supervisor. After my three days on the ward, I met Doctor Sidelil in his office. He confirmed the diagnosis of Bipolar Disorder, the medications including lithium and an antipsychotic, and explained the typical course of bipolar disorder. He also described local cultural beliefs about mental illness.

Fourth, I reviewed medical records. With permission from the brother and the hospital administration, I looked at Bereket's file to confirm dates and medications. I did not record his real name.

Hypothetical Psychotherapy Session: Detailed Therapeutic Techniques

The following is a hypothetical psychotherapy session based on psychological theories.

I assume that this session would take place after Bereket stabilizes, approximately two to three weeks after admission,

when he is calm enough to sit and talk for about 50 minutes.

The session uses four psychological approaches:

- 1,Cognitive Behavioral Therapy (CBT),
- 2,Psychoeducation,
- 3,Trauma-Informed Therapy, and
- 4,Family Systems Therapy.

Below is a detailed explanation of each technique and how I would apply it.

Technique 1: Psychoeducation

What is psychoeducation?

Psychoeducation is a therapeutic technique where the therapist provides factual information to the client and their family about the nature of their illness, its causes, its symptoms, and its treatment.

The goal is to help the client understand what is happening to them, reduce fear and confusion, and increase cooperation with treatment.

Psychoeducation also helps family members understand the illness so they can provide better support.

How I would use psychoeducation with Bereket:

I would sit facing Bereket at a comfortable distance. His brother would also be present for this part. I would speak slowly and use simple words because Bereket may still have some confusion after his manic episode.

I would say something like this:

"Bereket, I want to explain what is happening to you. You have an illness called bipolar disorder. This illness affects two main things: your mood and your sleep. When the illness is active, your mood can go very high, which we call mania. When you are manic, you may feel very excited, talk very fast, have many ideas, and not

need sleep. You may also hear voices or believe things that are not true. Other times, your mood can go very low, which we call depression. When you are depressed, you may feel very sad, tired, and lose interest in everything."

I would then explain the role of trauma:

"The bad experience you had with your business, losing everything, that was a very stressful event. For someone who already has a vulnerability to bipolar disorder, a big stress like that can trigger the first episode. It was not your fault. You did not cause this illness. The business loss was like a match that lit a fire, but the fire was already there inside you."

I would then explain medication:

"The medicine you take, lithium and the antipsychotic, helps put the fire out. It does not cure the illness, but it controls it. When you take your medicine every day, you can live a normal life. You worked for eight years and supported your family. That proves the medicine works. When you stop the medicine, the fire comes back. That is what happened when you traveled to your hometown."

I would use a simple drawing on paper: a line representing the vulnerability, an arrow showing the stressor pushing the line up, and a flat line showing the medicine keeping everything stable. This visual helps the client remember the information.

Why this technique is important for Bereket:

Bereket and his family spent nearly a year going to holy water and traditional healers because they did not understand bipolar disorder as a medical condition. Psychoeducation corrects this misunderstanding. It gives Bereket a clear, non-blaming explanation for his suffering. It also motivates him to stay on medication because he now understands the direct link between stopping medicine and relapse.

Technique 2: Cognitive Restructuring (CBT)

What is cognitive restructuring?

Cognitive restructuring is a core technique of Cognitive Behavioral Therapy (CBT). It is based on the idea that our thoughts (cognitions) affect our feelings and behaviors. When a person has distorted or irrational thoughts, they experience negative emotions and engage in unhelpful behaviors. The therapist helps the client identify these distorted thoughts, challenge their accuracy, and replace them with more realistic, balanced thoughts.

The process has several steps: first, identify the automatic negative thought. Second, examine the evidence for and against that thought. Third, generate a more balanced alternative thought. Fourth, practice the new thought.

How I would use cognitive restructuring with Bereket:

I would start by asking a gentle question:

"Bereket, when you think about losing your business, what thoughts come into your mind? What do you tell yourself?"

I assume he might say something like: "I am a failure" or "I destroyed my family" or "I am worthless."

I would then validate his feeling first: "It makes sense that you feel that way. Losing something you worked hard for is very painful."

Then I would move to challenging the thought. I would ask:

"Bereket, let us look at the evidence. You worked hard for many years to build your business. Is that true?"

He would likely nod or say yes.

I would continue: "Did you choose for the business to collapse? Did you want to lose everything?"

He would likely say no.

I would then say: "So the business loss happened because of things outside your control. The market changed. The economy changed. There may have been other factors. That does not make you a failure. A failure is someone who does not try. You tried. You worked hard."

I would then help him generate a new, balanced thought. I would say:

"Instead of saying 'I am a failure,' what if you said this: 'I suffered a great loss, but I am not worthless. I worked hard for many years. I took my medicine for eight years and supported my family. That is not failure.'"

I would write this new thought on a piece of paper and ask him to read it aloud. I would then ask him to practice saying it to himself three times.

I would also address the thought "I destroyed my family." I would ask:

"Did you destroy your family? Your brother is here with you every day. Your wife and children are waiting for you at home. They have not left you. They brought you to the hospital because they love you. That is not a destroyed family. That is a family that is fighting for you."

I would help him replace that thought with: "My family is suffering because of my illness, but they still love me. I can get better and be with them again."

Why this technique is important for Bereket:

Bereket's negative thoughts about himself as a failure and a burden are likely driving his depression and hopelessness. These thoughts may also make him want to stop medication because he feels "What is the point?" By changing these thoughts, his mood can improve, and he becomes more motivated to stay in treatment. CBT has strong research support for bipolar disorder, especially for reducing residual depressive symptoms and preventing relapse.

Technique 3: Trauma-Informed Therapy

What is trauma-informed therapy?

Trauma-informed therapy is not a specific technique but a way of understanding and responding to clients who have experienced trauma. The therapist recognizes that many psychological symptoms (such as agitation, hypervigilance, sleep disturbance, and emotional outbursts) may be trauma responses.

The therapist avoids any action that could re-traumatize the client, such as forcing them to talk about the trauma before they are ready, using restraints, or being authoritarian.

Instead, the therapist creates safety, gives the client control over the session, and helps the client process the trauma at their own pace.

The core principles are: safety, trustworthiness, peer support, collaboration, empowerment, and cultural sensitivity.

How I would use trauma-informed therapy with Bereket:

First, I would ensure physical safety. I would sit near the door so Bereket does not feel trapped. I would keep my hands visible. I would speak in a calm, low voice. I would not touch him without asking permission.

Second, I would give him control. I would say: "Bereket, we do not have to talk about the business loss today if you are not ready. You decide how much we talk about it. If you feel uncomfortable at any time, just tell me, and we will stop or change the topic."

Third, I would normalize his symptoms as trauma responses. I would say: "The trouble sleeping, the feeling that you need to move all the time, the anger that comes suddenly – these are very common reactions after something terrible happens. Your body and mind are still on alert, even though the danger is gone. That is not a sign of weakness. It is a normal reaction to an abnormal event."

Fourth, I would avoid re-traumatization. I would not ask him to describe the business loss in graphic detail. I would not say "Why didn't you do something different?" or "You should have planned better." I would not compare his trauma to worse traumas (e.g., "At least you were not in a war"). I would simply listen and validate.

Fifth, I would help him reconnect with his body in a safe way. If he becomes agitated during the session, I would say: "Let us take a slow breath together. Breathe in for four seconds, hold for four, breathe out for four. Good. Now feel your

feet on the floor. Feel the chair under you. You are safe here. The business loss happened in the past. Right now, in this room, you are safe."

Why this technique is important for Bereket:

Bereket's trauma has not been processed. His family took him to holy water and traditional healers, but no one ever sat with him and said, "What happened to you was terrible, and your feelings are valid." Without trauma-informed care, he may continue to experience hypervigilance, startle responses, and emotional outbursts even when his mood is stable. Trauma-informed therapy helps him feel safe enough to eventually process the loss, which can reduce the intensity of his trauma responses.

Technique 4: Family Systems Therapy

What is family systems therapy?

Family systems therapy views the client not as an isolated individual but as part of a family system. The family's patterns of communication, roles, rules, and emotional reactions all affect the client's mental health.

When one family member is ill, the entire family is affected. Conversely, when the family changes how they interact with the ill member, the client's symptoms can improve.

The therapist helps the family communicate more clearly, set healthy boundaries, and work together as a team.

How I would use family systems therapy with Bereket and his brother:

I would ask the brother to join the session for the final part. I would start by thanking him:

"Thank you for everything you have done for your brother. You have fed him, cleaned him, stayed with him for three days. That is not easy. You are a good brother."

Then I would assess the family's understanding of the illness. I would ask:

"What do you understand about your brother's illness? What have the doctors told you?"

The brother might say that he does not understand much, or that he thinks it is caused by evil spirits. I would not argue. I would say:

"Many families in our culture believe that. And it is true that spiritual help can be comforting. But the doctors have also found that there is a medical part to this illness. The medicine helps. What do you think about that?"

This approach respects the brother's beliefs while gently introducing the medical model.

Then I would teach the brother the early warning signs of a manic relapse. I would say:

"Bereket, listen to this as well. These are the signs that the illness is coming back. The first sign is usually sleep. If your brother starts sleeping less and does not feel tired, that is a warning. Second, he may start talking faster than normal. Third, he may become irritable or start spending too much money. Fourth, he may have big plans that are not realistic. If you see any of these signs, do not wait. Call the hospital immediately. Early treatment can prevent a full relapse."

I would also address the brother's own stress and burden. I would say:

"You cannot do this alone. Do you have other family members who can help? A sister, an aunt, a cousin? You need to rest too. Burnout helps no one. Let us make a schedule: you take mornings, your wife takes afternoons, another relative takes nights. Everyone shares the load."

Finally, I would facilitate a communication exercise. I would ask the brother to look at Bereket and say one thing he appreciates about him. The brother might say: "I appreciate that you worked hard for eight years and never complained." Then I would ask Bereket to say one thing he appreciates about his brother. Even if Bereket cannot speak much, a nod or a few words is enough. This simple exercise restores dignity and connection.

Why this technique is important for Bereket:

Bereket's brother is exhausted and isolated. Without support, he may burn out and withdraw, leaving Bereket with no caregiver. Family systems therapy strengthens the support network, reduces the brother's burden, and creates a team that can watch for warning signs. It also reduces the shame and secrecy that often surround mental illness in Ethiopian families. When the family understands the illness and works together, the client's prognosis improves significantly.

Summary of Techniques for the Hypothetical Session

Here is how all four techniques fit together in one 50-minute session:

Time Technique Purpose

First 5 minutes Introduction and rapport building Create safety and trust

Next 15 minutes Psychoeducation Explain bipolar disorder, trauma as trigger, medication adherence

Next 15 minutes Cognitive restructuring (CBT) Challenge "I am a failure" thought; replace with balanced thought

Next 10 minutes Medication adherence plan (CBT + Psychoeducation) Create concrete plan to remember pills when traveling

Final 5 minutes Family systems (with brother) Teach warning signs, distribute caregiving burden, restore family connection

Throughout the entire session, Trauma-Informed Therapy principles guide everything I do: I avoid re-traumatization, I give Bereket control, I validate his feelings, and I create physical and emotional safety.

Why These Techniques for Bereket Specifically

Bereket's case requires all four techniques because his problems are multi-layered.

He needs psychoeducation because he and his family have believed for years that his illness was spiritual. Without understanding the medical model, he will likely stop medication again.

He needs cognitive restructuring because his negative self-beliefs ("I am a failure," "I destroyed my family") are driving his hopelessness and may lead to suicidal thoughts.

He needs trauma-informed therapy because his business loss was a genuine trauma that has never been processed. His agitation and hypervigilance are trauma responses, not just mania.

He needs family systems therapy because his brother is exhausted and the family has no structured plan. Without family support, even the best medication will fail.

By combining these four techniques, I address the biological (medication adherence), psychological (negative thoughts, trauma responses), and social (family support) dimensions of his illness. This is the biopsychosocial model in action.

This is a hypothetical session using psychological theories. I never actually conducted this.

3.3 Ethical Standards

I followed the APA Ethics Code (7th edition) as follows:

Informed consent: I explained the purpose of my observation to Bereket's brother. He gave verbal consent. I did not ask Bereket directly because he was too ill to understand.

Confidentiality: I changed the client's name to Bereket. I did not record his real name, his village, or any identifying details.

Non-maleficence (do no harm): I did not touch or disturb Bereket. I stayed at a distance. I did not ask him questions. I did not interfere with any care.

Respect for rights and dignity: I did not judge the family for going to holy water first. I listened without showing negative reactions.

Beneficence: This report has no direct benefit to Bereket, but it may help future clients by educating students about trauma and bipolar disorder.

Case Conceptualization and Analysis

Pseudonym: Bereket

Clinical presentation observed: Bereket is a 45-year-old married Ethiopian male with three children. He was a small business owner. After his business collapsed as a traumatic financial loss, he developed manic symptoms including decreased need for sleep, grandiosity, pressured speech, irritability, and auditory hallucinations. He also had depressive episodes. He was diagnosed by a psychiatrist, Doctor Sidelil, with Bipolar I Disorder. He stabilized on medication for eight years. He discontinued medication while traveling and relapsed into a manic episode with psychotic features, leading to rehospitalization. Due to the severity of his condition, he was placed alone in one room.

Psychological conceptualization (not medical diagnosis):

As a psychology student, I do not provide medical diagnoses. However, using psychological frameworks, I understand Bereket's problems as follows.

Regarding trauma exposure, the business loss was a traumatic event that shattered his identity as a provider and created lasting psychological distress.

Regarding psychological distress symptoms, he presented with insomnia, hallucinations, agitation, emotional instability, and poor self-care.

From a CBT perspective, he likely holds cognitive distortions and negative beliefs such as "I am a failure" or "I destroyed my family."

Regarding behavioral issues, he showed agitation, pacing, social withdrawal, and non-adherence to medication.

Regarding family dynamics, his brother is the main caregiver, but there is no structured family support or psychoeducation.

Therapy approach using psychological theories:

Using CBT, I would challenge the thought "I am a failure" and replace it with "I suffered a loss, but I am not worthless."

Using psychoeducation, I would teach about bipolar disorder, trauma as a trigger, and medication adherence.

Using trauma-informed therapy, I would recognize agitation and hypervigilance as trauma responses and help process the loss safely.

Using family systems approach, I would involve his brother in treatment, teach warning signs, and strengthen communication.

Discussion and Self-Reflection

Integration of theory and practice: The literature confirms that trauma is common in people with severe mental illness as shown by Ng, Medhin, Hanlon, and Fekadu (2019). Bereket's case is a clear example. The stress-vulnerability model explained his first episode. The kindling theory explained his relapse without a new stressor.

Challenges: I could not talk to Bereket directly because he was too ill. I had to rely on his brother and my supervisor. There were no nurses or doctors on the ward during my observation, which meant the brother was doing all the care. Also, the client was alone in a room, which may have increased his distress.

Professional growth: This practicum taught me that trauma is not only about war or rape. Losing a business can be traumatic too. As a future psychologist, I learned to use CBT, psychoeducation, trauma-informed therapy, and family systems approaches rather than medical diagnosis. I also learned to ask every client about trauma history. This experience made me more realistic about what mental health care looks like in Ethiopia with limited resources but dedicated families and staff.

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