**PRACTICUM REPORT DONE AT MOI TEACHING AND REFERRAL HOSPITAL**

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REG. NO: CP/30/19

**A REPORT SUBMITTED IN PARTIAL FULFILMENT OF**

**THE REQUIREMENT FOR THE AWARD IN**

**BACHELOR OF SCIENCE,**

**COUNSELLING PSYCHOLOGY,**

**DEPARTMENT OF SOCIOLOGY AND PSYCHOLOGY**

**MOI UNIVERSITY**

**March 2024**

**INTRODUCTION**

Embarking on an eight-week practicum at a Level 6 hospital has been a transformative journey as a Counselling psychology student. Throughout this experience, I have had the privilege of rotating through various clinical departments, each presenting unique challenges and learning opportunities. From providing psychological support to patients grappling with mental health issues to assisting individuals in their recovery from substance abuse, the practicum has offered a comprehensive immersion into the intersection of psychology and healthcare.

This report serves as a reflection on my experiences, observations, and insights gained during the practicum. It delves into the diverse departments visited, the types of patients encountered, the psychological challenges they face, and the professional growth and skills acquired throughout the practicum. Additionally, it highlights the challenges encountered, activities participated in, and suggestions for improving service delivery within the hospital setting.

As a emerging Counselling psychologist, this practicum has been instrumental in shaping my understanding of the complexities inherent in providing holistic care to individuals across various stages of life and health conditions. It is my hope that the insights shared in this report will contribute to ongoing dialogue and efforts aimed at enhancing patient-centred care and promoting psychological well-being within healthcare settings.

*Nature of the Practicum*

The practicum is a rigorous program where students get hand-on experience by working closely and under strict supervision by professional Counsellors and psychologists. As students, we were required to report to the hospital from 8:00 am-5:00pm, Monday to Friday. Each week we were assigned to a different department where we would do our rotations.

A personal development session was scheduled for every Thursday from 8.00 am-9.00am. Debriefing and presentations were the main activities.

*Objectives of the Practicum*

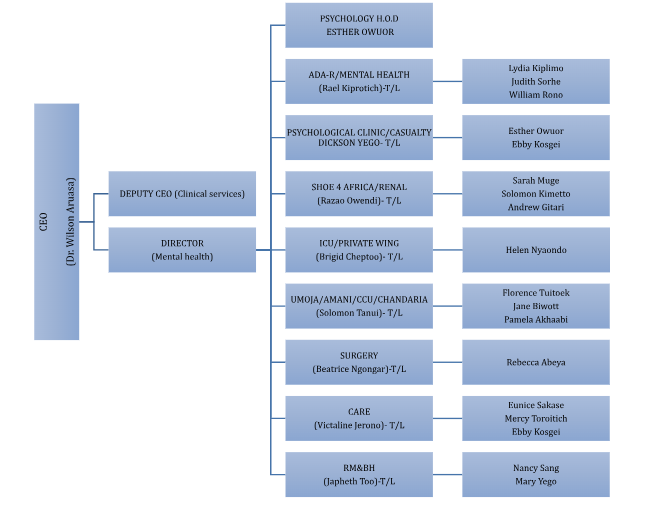
1. Learn how to apply the theoretical knowledge learnt in class into practice of Counselling.  
2. Document 100 hours of Counselling sessions: 60 hours of individual sessions and 40 hours of group sessions

*Orientation*

On the first day of my practicum, I had the opportunity to be introduced and shown around the hospital by Counsellors Benard Nguma. He took me fall the departments of the hospital in an attempt to familiarize me with my new settings.

**ORGANIZATIONAL STRUCTURE**

The organization, Moi Teaching and Referral Hospital together with Moi University, devised the course to run smoothly for the students. The departments involved were the Mental Health department/ Psychological department of MTRH as well as the Behavioral Science department of Moi University.



**OVERVIEW OF THE HOSPITAL DEPARTMENTS**

The specific department I rotated in during the Practicum include:

1. **Psychological Counselling Department**

This is the official unit designated to offering Counselling services in the hospital. It servers as the headquarters for all Counsellors and psychologists.

**Population served** are mainly Out-Patient Clients and Emergency Ward Patients.

Other activities include: conducting debriefing and personal development to all Counselling staff in the hospital.

1. **Alcohol And Drug Abuse Rehabilitation Unit**

This unit is dedicated to offering rehabilitation services to substance abuse patients. It is a recovery centre where patients commit to full 90-day recovery camp.

Services offered include: individual sessions, group therapy, family therapy and psycho-education.

**Population served** are mainly substance abuse patients and their families(in the case of family therapy)

Other services include: detoxification of patients, equipping patients with necessary life skills and job skills.

1. **Mental Health Unit**

This unit mainly offers clinical services like detoxification and stabilisation of patients with chronic mental illnesses like : schizophrenia, bipolar, psychosis not to mention but a few. Patients in this unit are closely supervised to ensure they take their medication so they can be stable. After stabilisation, patients undergo counselling to help them understand the challenges they’re going through.

**Population served** are mainly mentally ill patients and chronic substance users.

1. **Paediatrics Unit**

The Paeds unit deals with all children related cases. From cancer to renal issues to burns to emergencies/casualties. In addition to treating acute illnesses and managing chronic conditions, the Paediatrics Unit also emphasizes preventive care and health promotion. This includes routine well-child visits, immunizations, developmental screenings, and guidance on healthy lifestyle habits.

**Population served** are mainly children and in some cases their parents too.

1. **Intensive Care Unit**
2. **Internal Medicine Unit**
3. **New Born Unit**
4. **Surgical Wards**

**ACTIVITIES PERFORMED**

Throughout my 8-week course at the hospital, I actively participated in a range of activities tailored to meet my objectives. They include:

**1. Conducting Counselling Sessions under Supervision:**

I actively engaged in one-on-one Counselling sessions with patients under the guidance and supervision of experienced Counsellors or psychologists. The supervision ensured that I adhered to ethical standards, confidentiality protocols, and evidence-based Counselling techniques.

I had the opportunity to apply theoretical knowledge in real-life Counselling scenarios, receive feedback on my skills, and learn how to establish therapeutic rapport with clients.

**2. Attending Counselling Sessions and Observing the Counselling Process:**

I was present in Counselling sessions as an observer, where I could witness the dynamics between the Counselling and the client. Observing the Counselling process allowed me to learn various Counselling approaches, communication strategies, and intervention techniques in action.

I observed how Counsellors built trust, explored client issues, facilitated emotional expression, and collaborated with clients to set goals and develop coping strategies.

**3. Attending and Participating in Ward Rounds:**

I participated in ward rounds, where healthcare professionals visited patients in hospital wards to assess their condition, discuss treatment plans, and address any concerns. As a participant in ward rounds, I had the opportunity to observe patient care from a multidisciplinary perspective, interacting with doctors, nurses, and other healthcare team members. I gained insights into patient assessment, treatment planning, medication management, and discharge planning, contributing to a comprehensive understanding of healthcare delivery in a hospital setting.

**4. Offering Bedside Counselling to Patients in Critical Conditions:**

I provided Counselling support to patients who were in critical condition or experiencing acute distress due to their medical condition. Bedside Counselling aimed to address patients' emotional, psychological, and spiritual needs, offering comfort, reassurance, and coping strategies during challenging times. I learned how to adapt Counselling techniques to the unique needs and circumstances of patients in acute care settings, fostering resilience and promoting holistic healing.

**5. Joining Group Sessions:**

I participated in group Counselling sessions, which brought together multiple individuals facing similar challenges or sharing common goals for therapeutic support and mutual learning.

By participating in group sessions, I gained insights into group dynamics, leadership skills, and facilitation techniques. I learned how to create a safe and supportive environment, encourage active participation, facilitate group discussions, and manage conflicts effectively.

**6. Attending Debriefing and Personal Development Sessions:**

I attended debriefing sessions, which provided opportunities for reflection, processing emotional experiences, and discussing challenging cases or situations encountered during clinical practice.

Personal development sessions focused on enhancing self-awareness, self-care practices, professional identity, and career development. These sessions promoted ongoing learning, self-reflection, and growth as a Counselling professional, nurturing resilience and fostering a culture of continuous improvement.

**ICU**

Duties: attend ward rounds, identify patients that required psychological Counselling, recognize new patients so as to give their relatives baseline Counselling, receive referrals from the other health care professionals e.g. Nurses and Doctors. Attending psychotherapy sessions and conducting them.

Site supervisors: Mrs. Obala, Helen Nyaondo and Bridged Cheptoo – Psychological Counsellors

Goals: equipped in performing supportive therapy, baseline Counselling (psychoeducation), and grief/loss therapy.

**ADA-R**

Duties: attend and participate in outpatient clinic services, in-patient ward rounds, group therapy, family therapy, and individual therapy sessions. Others included the social activities set aside for the in-patients by the Occupational therapist and Social worker.

Site supervisors: Judith Sorhe and William Rono - Psychological Counsellors

Goals: being able to lead in family therapy session, perform Motivational Interviewing, and assess patients’ progress and Mental Health disorders using psychological assessment tools. Work in cooperation with all the other healthcare professionals in the patient’s recovery. Write psychological notes on the sessions attended.

**MENTAL HEALTH UNIT**

Duties: attend ward rounds, see patients individual sessions both in-patient and out-patients, attend and observe family sessions, uses appropriate assessment tools to identify the degree of insight for patients.

Site supervisors: Rael Kiprotitch - Psychological Counselling

Goals: conduct sessions without supervision, master the therapeutic skills needed in a therapy session, learn how to diagnose and treat patients with severe mental health conditions.

**RILEY MOTHER AND BABY**

Duties: identify patients referred for psychological Counselling by the doctor, use the appropriate psychological assessment tools to inform the treatment the patient gets.

Site supervisors: Nancy Sang, Japheth Too – Psychological Counsellors.

Goals; provide psychological services to the referred patients, identify and observe the effect pre-partum, peripartum and postpartum condition affect the women’s mental health.

**POPULATIONS SERVED**

ICU: the population served had a wide range since people of all ages were admitted in the unit

ADA-R: All in-patients were male with their age ranging between 18-60 years. Most of the Out patients were Male too.

Mental Health Unit: the population was mostly males and an approximation of 1/3 of the population were female. The ages ranged between 18-60 years for males and 15-35 years for the females.

Riley Mother and Baby: 100% of the population were female with an age range of 15-45 years.

* These are my own approximations based on the Patients I offered services to during the Practicum.

On the next page is the organizational structure for the MTRH hospital

**Activities Performed during the Practicum**

* **Participated in family/ group sessions:** this was mainly done in the ICU, ADA-R and MHU. We would join the supervisors in the sessions, observe the group and family dynamics as well as learn the basics of conducting such session. This included the general rules such sitting arrangements, timings of the session, the introductions, expectations and other therapeutic skills used. I participated in several family therapy sessions as well as group sessions. I offered psychoeducation and support during the sessions as my contributions among others. *The sessions would last between 1-3 hours.*
* **Performed bedside individual therapy:** in my last 2 weeks, I rotated in the Riley Mother and Baby unit, majority of the sessions I conducted were bedside for obvious reasons such as the patients were unable to stand after having surgery performed. The bedside sessions were dynamic depending on the patient, I offered techniques such as, cognitive restructuring, psychoeducation, support and performed different assessment tools*. These sessions would last between 45minutes to 1 hour.*
* **Performed individual sessions**: in the mental health Unit, I performed several individual sessions especially when patients were being discharged during ward rounds thus we discussed with patients about their Exit plan and their coping strategies with the family member that was present. *These sessions would last between 45minutes to 1 hour.*
* **Attending and participating in Ward Rounds:** in all the units. During the rounds, we were able to identify patients who were in need for psychological Counselling as well as get recommendations about the type of treatment they needed from their Doctors. We would even receive referrals from the Nurses and Nutritionists based on their interaction with the patients.*These sessions would last 4 hours.*
* **Diagnosing Patients using The DSM:** after conducting an intake interview, we would sit and discuss the patient’s diagnosis, rule out the differentials as well as document them in our logbook**.**
* **Assessment tools were used to solidify our preferential diagnosis during follow up:** these included the PHQ-9, GAD7, and MMSE as the main ones.  *These sessions would last maximum 45min.*
* **Attended a debriefing sessions:** we would often have debriefing sessions especially in the ICU as well as a class on 26th of March. The session took 2 hours.We discussed about our different experiences in the Wards and offered support to one another.

**Number of Patients: *I have seen a total of around 45 patients during the 6 weeks and one psychoeducation session for outpatients in ADA-R clinic.***

***Psychological issues/ disorders handled*:**

***ICU:***

* Anxious and Depressed symptoms patients’ relatives had.
* Grief and loss
* Negative thought/ beliefs

***ADA-R:***

* Substance Use Disorders: Alcohol, Bhang, Nicotine, Marijuana, and Cocaine.
* Substance induced Bipolar, Psychosis, and Depression.
* Personality Disorders: Obsessive compulsive, Avoidant personality disorder

***MHU:***

* Bipolar disorders
* Schizophrenia and other psychotic disorders: schizoaffective
* Major Depressive Disorders
* Substance use and substance induced bipolar and psychosis

***Riley:***

* Depressive disorders; Major Depression, Postpartum depression, psychosis.
* Anxiety disorders: GAD or due to a medical condition
* Grief and Loss

**Management**

I found that the most frequently used therapy was Supportive therapy and Psychoeducation. Most of our managements were Eclectic: using cognitive restructurings, unconditional positive regard and behavioral techniques among others.

In the MHU and ADA-R we had a variety of management strategies such as Motivational interviewing, insight orientation therapy and CBT among others.

The hospital, being a unique set up, psychotherapy was one of the forms of treatment and not the main one. Therefore, most we had one session with most of our patients.

**Observations**

I observed patients’ behavior/ attitudes on mental health treatment especially when shadowing the Supervisors. Similarly, I observed the attitudes of the other healthcare workers to mental health. From my observations, I find that there is a positive atmosphere about psychotherapy but there is room for improvement. We seem to be in the system of the hospital yet in some areas especially in none mental health wards/ clinics, there is little that has been done for the patients to receive a complete and comprehensive care with psychotherapy included. In the field, the mental health professionals are spread out scarcely such that most are overworked or unable to attend to all the patients. At this rate, most of them will experience a burn out which is not ideal for anyone let alone a therapist.

**What I have learnt**

I have definitely learnt a lot and appreciated that symptoms of the same disorder would manifest differently in different individuals because of their different and unique characteristics. I learnt the different therapeutic skills a therapist should have and how to perfect my listening and questioning skills among others. I learnt that to appreciate the different approaches people had to therapy as they were all unique to the person conducting the session. Similarly, I learnt how to acknowledge patients’ feelings and validate them as well as pick out the stressors that were not being openly communicated. I have also learnt to appreciate that the outcomes of a session are not always immediate, some are subtle but nevertheless present.

***SELF- EVALUATION***

Practical and theoretical value of the practicum: I was able to have a real life experience of the different disorders and the various psychotherapies that would help manage them. I saw how different disorders manifested in individuals and the various factors that affected the severity of the conditions. I was also able to apply the concepts I had acquired into practice which enabled be to develop a deeper understanding of mental illnesses.

Comparing practicum and the theory I learn in class, I would say it has enabled me to solidify the content and information I had. However, being in a hospital set up some of the ideal concepts of psychotherapy had to be revised. It was definitely a unique environment to learn from. Another thing I noticed was that depending on the therapeutic orientation a professional has and their personality, the approach of the therapy differed. It was something interesting to note, my colleagues and I had different approaches to therapy e.g. some were more directive than others.

I had an open mind towards the practicum expecting to meet as many patients as I did and to also learn from the different professionals in the field. I took me a few weeks to build the courage and talk to patients individually but towards the end of the 6 weeks I have gotten comfortable in approaching patients by myself. That was my greatest expectation and achievement for my first practicum. Moreover, I can comfortably say that I have gotten better at collecting patients’ histories and acquired some of the important therapeutic skills. With more practice, I will perfect them.

**Recommendations**

**ICU:** I found that since the place is already a highly traumatic environment, having a separate ward for children would be reduce the symptoms of trauma. For example when a child in a wakeful state is placed next to an old man with a serious condition, they have a full view of the latter developing complications and other symptoms, it will only increase anxiety and fear for that child. If having a separate ward is far-fetched, then they can place a partition, religiously, between patients so that those awake are not haunted or exposed to the others who are unconscious.

The place is in need for an entertainment team. Patients who are awake and Counsellors are at high risk of developing mental illnesses such as depression especially when they have little social support and nothing but the annoying beeping of the machines as a constant reminder of their reality. Liaising with the relatives to bring items that will entertain their patients as well as be there with them during visiting hours will help reduce the feelings of hopelessness and worthlessness.  These include, books radio with earphones and even reading to them. This will help take their mind off of their problems even for a short while.

**ADA-R:** I suggest that, if the in-patients could be taught how to take care or have responsibility over other by tending to a potted plant. Each patient would have a plant they would take care of during the 3 months as well as take it home once they have recovered. The plant can be a symbol of the decision they have made to change, a reminder of why they chose to go to rehab and how far they have progressed. Another way to enact this can be on that mini garden they have in the ADA-R compound. Each patient or they can work in pairs would take good care of their plant that will be named after them. This will not only enhance their ability to cooperate but also develop healthy relationships while learning to share responsibilities. At first I had suggested having a pet in the compound as research has shown the benefits pet have with regards to mental health, however, it may not be easy to maintain a pet in the hospital.

**MHU:** Here I found that our services were needed the most but there were very few psychotherapists. I recommend adding another so that they can share the bulk of work that includes individual sessions, group and family sessions.

**Riley:** I did not find the therapist in charge of that unit since he was reported ill therefore we conducted some sessions on our own. My recommendation is that, there should be at least one therapist covering 2 units at any point and when there is need for a psychological review for patients, the nurses in the wards should call/ inform that therapist. Otherwise most will experience burnouts as mentioned earlier.

Finally, the practicum experience has been an eye opening experience for both my academic and professional goals. I have not yet pinpointed the exact areas I would like to specialize in. However, I find the field of research rich in treasures that are yet to be unearthed especially with regards to East Africa and our country.  The more information and statistics we gather, the more reliable and successful our services will be in the future.

**CONCLUSION**

This report is based on the first Practical experience I have had in MTRH. It was a 6-week course rotating for 2 weeks in different units around the hospital. We were to observe the on ground works, gain skills and information as well as have an exposure to real life situations. We were also encouraged to participate and perform therapy sessions individually so as to improve and build the confidence. Finally, we were encouraged to be creative in developing solutions/ recommendations that would help facilitate the services better.

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