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BEHAVIOUR THERAPY IN THE MANAGEMENT OF CLINICAL DEPRESSION IN NIGERIA

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Introduction

Depression is a universal experience and is said to be the common cold of psychopathology in Europe and America. For a long time, though, depressive illness was thought to be rare or even non-existent in sub-saharan Africans. Recent investigations by practitioners in these regions have proved that position untenable. Studies describing the clinical picture of depression in African patients (e.g. Leighton et al., 1963) have led to a better understanding of the differences in manifestation — a major explanation for its being missed. Though exact figures are presently not available, depression in its various forms have been found to be high on the list of prevalent problems in psychiatric clinics and hospitals in Africa (German, 1988; Ebie, 1972).

Considered a unitary phenomenon for a long time, depression has recently been divided into different subgroups that presumably have different aetiologies (Winokur, 1974). Hill (1968) proposed that the distinctions between endogenous and exogenous depression, as well as between neurotic and psychotic depression, are not clinically useful in terms of treatment planning. Depression can thus be viewed in three separate ways — as a biological disease, as a reaction to life situations, and as a means of interpersonal communication.

In psychiatry, pharmacotherapy has been, as is still regarded, as the treatment of choice for all types of depression. Despite the advances in the chemotherapy of depression, review of various-controlled studies indicate that only about 60 to 65% show definite improvement as a result of common tricyclic drug (Beck, 1973). It thus became necessary to develop methods to help the 45 to 40% who were not helped by antidepressant drug. It was also observed that many patients who respond to drugs refuse to take medication either because of personal objections or sho...
effects from the drugs. The role of effective psychotherapy in 
the overall management of the depressed patient was further 
highlighted by the high relapse rate of patients previously treated 
with drugs. As high as 50% in the year following termination 
of drug treatment has been observed (Beck et al., 1979). 
Social-psychological research indicates that effective management 
must ensure that patients develop and draw on their own coping 
mechanisms to deal with the depression.

In recent years, a variety of new and innovative models of 
depression have been proposed (Lewinsohn et al., 1969; 
Beck, 1972; Perrier, 1973; Seligman, 1975). These authors analyse 
depression from a social learning or behavioural point of view. 
The various symptoms of clinical depression are seen as maladaptive 
behaviours, to a considerable degree acquired through learning 
and could therefore be modified by using learning principles. 
Emphasis is on the roles of environmental antecedents and 
consequences of depressed behaviour and faulty patterns of thinking 
in the development and maintenance of depression.

Behavioural Classification of Symptoms of Depression

Within the behavioural framework, the symptoms of depression 
are classified by their mode of expression into the physiological, 
vor- motor and verbal-cognitive categories (Lang, 1968).

Among the physiological symptoms are sleep disturbance, 
loss of appetite, weight loss, constipation, aches and pains, menstrual 
changes and loss of libido.

In the overt-motor area, depression includes:

1) behaviour of depressive typographical, such as sad dénouement 
   head hanging and crying,
2) deceleration of activity level, which includes a variety of 
   measures of motoric and speech activity related to work 
   recreation, eating, sex etc.

Overt-motor indications of depression is useful since a 
deceleration of a wide variety of responses in the person's repertoire 
and the accelerated occurrence of a few specifically depressive 
behaviours, especially crying.
In the verbal-cognitive area, depression is considered to include:

(a) sad affect;
(b) reports of decelerated behaviour and lack of motivation to perform a variety of activities;
(c) hypochondriacal complaints;
(d) distortions of experience in the form of guilt, negative self-evaluations, pessimism about the world and the future, etc.

Cognitive distortion is held to be important by various authors (Ferster, 1973; Lewinsohn, 1975). In fact, the cognitive theory of depression proposed by Beck (1967, 1970a & b, 1973) assigns a primary role to the cognitive manifestations of depression. The treatment procedure involves the identification and modification of depressive's inappropriate and inaccurate cognitions.

The main advantage of the behavioural observation of depression is in the fact that components of the depressive syndrome can be reliably observed, the frequencies recorded and measured.

The behavioural analysis of depression also emphasizes the need to elucidate the precipitating and maintaining factors in the environment which are functionally related to the depressive behaviour. Several hypothetical mechanisms by which depression, especially those diagnosed as reactive (exogenous), can occur are described (Bibring, 1953; Ferster, 1966; Liberman & Raskin, 1971; Beck, 1970c, 1974; Seligman, 1974). It is assumed that the major feature of depression is a reduced frequency of adaptive behaviour which the patient formerly possessed. On the other hand, the depressed individual with his complaints and somatic symptoms generates definite reaction-concern, sympathy, attention – from his interpersonal environment which serve as reinforcement for the symptoms and make the depressive behaviour more likely to occur in future - process of operant conditioning.

Behavioural Management of Depression

A number of case reports describing the application of learning theory to the treatment of depression have appeared in the literature (Lazarus, 1968, 1974; Lewinsohn & Atwood, 1969; Lewinsohn
Behavioural Management of depression usually proceeds through a number of identifiable stages (Lewinsohn, 1975; Cobb, 1987);

A. Diagnostic Functional Analysis of Depressed Individuals

A careful diagnostic evaluation is always needed because of the wide differences in the types of symptoms and problems manifested by depressed individuals.

The diagnostic evaluation aims at:

(a) evaluating the intensity of the depression including suicidal risk;
(b) pin-pointing specific behavioural excesses and deficits;
(c) formulating a “behavioural diagnosis” in regard to causation and maintenance of the patient’s depression;
(d) generating a treatment plan that includes specific behavioural goals and appropriate treatment procedures.

The beginning phase of treatment is clearly defined as a diagnostic phase, usually about 2 weeks. The first interview identifies major problem areas for further exploration in future interviews. As much information as possible are obtained as regard the fluctuating mood ratings, activity levels, interests, etc. A number of psychological tests have been designed to help in identifying behaviour problems and in measuring behaviour change.

One or more review sessions conclude the diagnostic phase. The therapist presents the findings and conclusions to the patient. Behavioural terms, graphs and other visual aids are used to present the “behavioural diagnosis” as clearly as possible. The end product is a mutually acceptable “contract” or undertaking as to the patient’s difficulties and the desirable treatment goals and procedures.

B. The Behavioural Treatment

Following the information gathering diagnostic phase, specific treatment techniques are employed. These fall into four categories:
(i) **Techniques Aimed at Increasing the Patient’s Activity Level**

Depressed individuals as a group engage in relatively few activities, especially those considered to be pleasant and rewarding by them.

To increase the patient’s rate for certain behaviours the Premack principle is applied. According to the Premack’s Principle, the occurrence of high frequency behaviours would have reinforcing value for other low frequency behaviours. For example, Homme (1965) used high frequency behaviours like smoking and drinking coffee to reinforce low frequency behaviours such as thinking self-confident thoughts. Sentz (1971) and Todd (1972) had their patients generate a list of positive thoughts and then instructed them to think about one or more items on the list before lighting a cigarette (a high frequency behaviour).

Social reinforcement is often used to increase constructive behaviours in depressed patients. The patient is first told to emit some simple behaviour, like making a telephone call. Task requirements are then increased (graded task assignment procedure). Patients are socially reinforced upon successful completion of each step.

Reinforcement contingencies are applied even in the context of family interaction for the modification of depressed behaviours. Liberman and Raskin (1971) taught family members to change their focus of attention and interest from “depressed” behaviours to more “constructive and productive” behaviours (cooking, cleaning house etc.) The family members were to pay instant and frequent attention to coping behaviour, but ignore depressed behaviour like verbal statements of dysphoria.

(ii) **Techniques Aimed at Reduction of Behavioural Excesses and Changing Patients’ Cognitions**

Depressed individuals manifest a series of “behavioural excesses” in the form of obsessive ruminating or verbalizations about negative aspects of the self, the past, somatic complaints.
etc. The frequency of such behavior can be reduced in different ways.

The therapist can ignore them (Burgess, 1969). People in the social environment can be taught to ignore them (Liberman & Raskin, 1971). Using the “thought stopping” procedures (Wolpe, 1969) the patient can be taught to control them.

As regards the cognitive manifestations, patient is taught to focus upon and to identify depression-generating cognition which Beck (1970) labelled “automatic thoughts”. A subsequent goal is to increase the patient’s objectivity towards these depressive cognitions — “distancing”. Distancing is accomplished by applying rules of logic to these cognitions, by having the patient check the observations on which the cognitions are based. The patient needs to see that his/her depressive cognitions distort reality. The last stage of therapy is directed at “neutralization” of the depressive cognitions by having the patient recite the reasons that some of the cognitions are invalid, thus reducing the intensity frequency and affect of such cognitions.

(iii) Techniques Aimed at the Induction of Affects that are Incompatible with Depression

It has been suggested that there are affects which are incompatible with feeling depressed. Lazarus (1968) proposed that the deliberate stimulation of feelings of amusement, affection, sexual excitement, or anxiety tend to break the depressive cycle. Relaxation training has been found useful especially with patients who are obsessively ruminating about their problems or have difficulty in falling asleep at night.

(iv) Techniques Aimed at Enhancing the Patient’s Instrumental Skill

Depressed individuals often lack the skills necessary to deal effectively with their environment. The use of social skill training as part of the treatment is often suggested as depressed patients often have few friends and engage in very few
interaction when they are with people (Lewinsohn et al., 1970). Exercises are designed to aid the development of communication skills and solve specific interpersonal problems. Some depressed individuals have difficulty asserting themselves. The need for assertive training is ascertained during the diagnostic phase.

To the extent that marital problems exist and are felt to be contributory to the patient’s depression, marital therapy is indicated. The joint sessions with husband and wife aim at maximizing positive interchange between the spouses. Where necessary, contingency contracting is used (Liberman, 1970).

The information obtained from a vocational interest scale is often useful in assisting depressed individuals to make decisions and take appropriate action in regard to their occupational or academic career.

C. Evaluation of Intervention

A complete program would involve developing multiple techniques for the patient concerned.

A general strategy in the behavioural management of depression involve setting a time limit for treatment for each individual patient based on treatment goals. Published case reports involve short treatment periods. Lewinsohn et al (1969) usually set a 3-month time limit which starts at the end of the diagnostic phase. The effectiveness of the treatment strategies techniques are then assessed to see if significant reduction in depression has been effected.

Measuring instruments – checklists, rating scales are again used to assess therapeutic progress.

The Nigerian Experience of Depression

In trying to apply the behavioural paradigm to the treatment of depression in this environment, certain issues have to be taken into cognisance.

The first issue concerns the presentation of problems in the Nigerian patients. For a long time, depressive illness was thought
to be rare or even non-existent in sub-saharan Africans. Psychiatrists have drawn attention to the problems involved in the diagnosis of depression in Nigeria. It has been shown that depression in Nigerians is characterized mainly by hypochondriasis and somatic complaints. The predominance of somatic symptoms and signs have been confirmed in clinical studies (Biniite, 1975; Morakinyo, 1983). Symptoms commonly reported by such patients include sensation of movement or crawling in parts of the body; heat in the head; internal body heat; “fever”; fatigue; inability to concentrate, remember or assimilate; headache; sleep disturbance.

Morakinyo (1983) discusses the various explanations for the somatisation like the one proposed by Birkmayer which says that the deficiency of biogenic amines in depressive illness involves both the brain and peripheral nervous system and account for some of the somatic features of the illness. Another explanation from the social anthropologists’ collectivism – individualism construct for classifying various cultures was proposed by Leff. He suggested that the predominance of somatic symptoms could be due to difficulty in differentiating between the emotions. Leff sees the differentiation of emotional feelings as being comparable to differentiation of the self from the society (i.e. individualism).

An alternative explanation was derived from the study of cultural perceptions of body-mind relationships among Yoruba-Nigerians (Morakinyo and Akiwowo, 1981). This study established that the concept of the person was a unitary one to the Yoruba man-woman. Thus, it is possible that the feeling state which the depressive patient in Western societies experience is the same as the one experienced by his Nigerian counterpart, but that there would be linguistic differences in the description of that state based on the cultural perception or conception of the human being.

Many practitioners in the Nigerian environment prefer to see the somatisation as the contribution of socio-cultural factors. As Morakinyo (1983) points out, in a culture in which it is a stigma to suffer mental illness, one would expect mental symptoms to be repressed and substituted with somatic ones. The illness
would then be perceived as a physical one and would thus attract sympathy and understanding and remain acceptable for the society.

Another striking feature of depression in Nigerians is the relative absence of guilt feelings or self-accusation. Binitie (1975) contrasted this finding to the finding on a British sample. In Nigerians, however, a high prevalence of ideas of persecution is observed.

As recent publications show (e.g., Morakina, 1984), practitioners are now convinced that although witchcraft, sorcery and other supernatural phenomena are no longer of major concern in Western society, they are still of very vital importance in the life of African peoples.

**Implications for the Application of the Behavioural Paradigm in the Management of Depression in Nigeria**

The behaviour modification techniques, discussed above, have been shown to be effective in producing observable behaviour change. The behaviour approach encourages and promotes constructive moves to overcome depressive reactions.

Conflict areas in the patient's life are identified, explored and resolved through active intervention techniques based on testable laws between the environment and behaviour.

Objective goals of behaviour change are set and assessed periodically. Reliable methods of measuring behaviour based on observation rather than inference are used. Specific and direct attention is paid to the correction of maladaptive behaviours, negative feelings and sensations, intrusive images, irrational beliefs and stressful relationships.

Thus a wholesome approach to depression is embarked on - covering the physical, emotional, social, work, personal and cognitive aspects. In implementing the programmes for individual patients, realistic goals are chosen; natural, community-based reinforcers and social feedback are held important.

The need to modify the existing forms of psychotherapeutic methods in the Nigerian has been highlighted by practitioners (Binitie, 1982; Uzoka, 1982; Laosebikan, 1982; Odebunmi, 1985; Oladimeji, 1989). The experience shared by authors stress that
the Nigerian patient expects benevolent authoritarian treatment, along with the attributes of empathy, genuineness and non-possession warmth proposed by Frank (1973).

Like all approaches, the behavioural formulations of depression have its limitations. Even proponents have pointed to the need for systematic studies of the efficacy of behavioural techniques with appropriate controls and follow-up data (Lewinsoln, 1975; Liberman & Raskin, 1971; Burgess, 1969; Beck, 1974).

In trying to apply the behavioural paradigm to depression in the Nigerian context, one encounters some difficulties. One such is in relation to data collection through record-keeping, one of the main advantages of the behavioural approaches. It is well known that the Nigerian clinic population is an illiterate or a semi-literate population, only a few can keep systematic records for functional analysis. Again, many of the assessment instruments currently in use need to be modified and standardized to suit this culture. List of pleasant activities or the reinforcement survey schedule compiled for Americans and Europeans are definitely not wholly appropriate in the Nigerian environment. However, the author has found that material generated from the use of other traditional approaches to personality assessment like the Eysenck Personality Questionnaire and the Rotter Incomplete Sentences Blank often generate useful background information about the patient.

In the experience of the author it has often been helpful to combine pure behavioural techniques with dream analysis, a technique of psycho-analysis. Many patients readily take to this assignment - keeping daily records of their dreams, even when they can't write it out in details. This experience has also been shared by other practitioners/Akinbode (1984) recommended an eclectic approach to patient management in African contexts.

The observed difficulties notwithstanding, the behavioural formulation of depression offer a relatively simple framework within which to understand and manage depression more effectively. The combination of techniques has been found to be as effective as drug therapy of depression especially in cases of chronic neurotic depression. They definitely prove to be invaluable addition to the
management of even psychotic depressive illness common in Nigerian clinics.

References


