UNIVERSITY OF EDUCATION, WINNEBA

PORTFOLIO - A COMPILATION OF THE LEARNING JOURNEY TO BECOMING A GLOBAL PRACTITIONER

SPECIALIZATION IN COMMUNITY SERVICE

SILATU ZEBA ABUBAKAR

MASTER OF EDUCATION

2023

UNIVERSITY OF EDUCATION, WINNEBA

PORTFOLIO - A COMPILATION OF THE LEARNING JOURNEY TO BECOMING A GLOBAL PRACTITIONER

SILATU ZEBA ABUBAKAR
220034843

A Portfolio of Professional Learning in the Department of Counselling Psychology, Faculty of Applied Behavioural Sciences in Education, submitted to the School of Graduate Studies in partial fulfillment of the requirement for the award of the degree of Master of Education (Counselling Psychology) in the University of Education, Winneba

DECEMBER, 2023

DECLARATION

Student's Declaration

I, **SILATU ZEBA ABUBAKAR**, hereby declare that except for references made to other people's work which have been duly cited, this project is the result of my own research, professional learning and efforts. It has neither in whole nor part been presented for a degree in this institution or elsewhere.

…… …….

DATE **SIGNATURE**

Supervisor's Declaration

I hereby declare that the preparation and presentation of this work was supervised in accordance with the guidelines for supervision of thesis as laid down by the University of Education, Winneba, as well as professional requirements for counselling and related fields.

Supervisor's Name: Prof. Matthew Namale (PhD)

Signature: ……..

Date:……..

DEDICATION

I dedicated this work to my lovely Husband and my caring mother and I will never forget my boss at work place Mr. Davide Osie Senu who consistently encourages me. I also dedicated this work to the memory of my late father Mr. Abubakar Zeba.

ACKNOWLEDGEMENT

My sincere appreciation goes to God Almighty Allah for his love, care, provision, protection and favor enjoyed from the beginning of this journey to the end. Indeed, great is thy faithfulness.

My profound gratitude goes to my supervisor, Prof. Matthew Namale (PhD), whom I described as a father and a mentor for guiding me through this journey. God bless you and grant you good health to continue impacting lives. My regard again goes to my lecturers of the Department of Counselling Psychology Dr. Theresa Antwi, Mrs. Christina Ammah, Dr. Patricia Amos and the rest for adding value to my life.

My special and sincere thanks go to my lovely husband, and my family for their moral support and assistance offered me. My boss MR. Davide Oise Senu thank you for your encouragement you have been a father to me .

and the others for your prayers and support in diverse ways.

My gratitude also goes to all my congregants in AL- Aziz Mosque Burma Camp

Finally, to the management and staff of forces senior high technical school especially, Col John Aqua the Headmaster and school counsel. sincere gratitude to everybody.

TABLE OF CONTENTS

ABSTRACT

This document is a compilation of all the learnings I have acquired in the 2-year Master of Education program in Guidance and Counselling specializing in family system . In this document, one will come across my growth journey, how my family connects with my choice of program and profession as illustrated with a genogram. Also, my curriculum vitae, reference letters and flower exercise that display my goals and mission in life are in this document. The unique components from each of the core courses I studied in the program as well as my specialization area in counselling, family system and group counselling broaden my knowledge about the social and psychological issues in our communities. I specifically, connected my personality to one traditional theory which is Rational Emotional Behavioral. Therapy and one post-modern theory which is Solution-Focus Brief Therapy, and then display my knowledge of ethics in the document that guides the client counsellor relationship. Later, I reflected on my overall experience and knowledge gained throughout the learning journey and in the compilation process.

CHAPTER ONE

INTRODUCTION AND PERSONAL JOURNEY

1.0 Agenda for Oral Defense

Date for the defense: 15th December, 2023

Presentation: 15 minutes per presenter

Questions and Answers: 15 minutes per presenter

Order of Appearance: Candidates were called in order of registration

1.1 Introduction and Background

This chapter consists of some elements of

my own comprehension that related me to this course of study. As detailed in my learning journey statement, the process leading to the choice of this course was planned. I acknowledged the fact that I have been aided by a number of people to cope up till now. I see this as a good opportunity for me to also give back to my family, congregants, students and the society as a whole.

1.2 Learning Journey Statement

The world is moving fast in terms of knowledge and skills acquisition in all fields of endeavor. Becoming relevant in one's field of discipline or career requires upgrading and value addiction. This is the underlying factor for me to pursue Guidance and Counselling in the University of Education Winneba in order to gain the needed knowledge and skills to assist me in the discharge of my 'malama' meaning female who teaches Arabic lesson and teaching duties effectively and efficiently.

I could recall vividly the excitement which I could not hide on the 23rd September, 202 when I received a message announcing my admission into this program. I said wow! Thank you, ALLAHA. Immediately, I noticed that WhatsApp platforms were

created where relevant information was channeled to all of us who gained admission into the program.

My experiences to study via virtual class media like V class and Google meeting were amazing though I was completely lost in the first encounter. The feeling was so great and memorable. Kudos to Dr. Patricia Mawusi Amos. Dr. Theresa Antwi,and the rest lecturers for bringing learning to my home during those periods. Though network challenges sometimes took me off the virtual class, it was a fulfilling moment to me.

Coming down for a four-week face-to-face encounter was another amazing experience after leaving the lecture theatre for seven years in UEW. I arrived at Winneba on 24th October 2022 in the company of two colleagues who are Emmanuel Obeng and Mable Amoah -Tenewaah. Lectures began immediately the following day. Lecturers who came to the lecture hall warmly welcomed everybody. The face-to-face encounter was a vigorous and rigorous academic encounter coupled with assignments, group works and presentations among others. It was an intense moment of academics, research work and pressure.

Studying a course like Human Life Span had given me a deeper understanding of human development.

Exposure to Theories of Counselling and Applications, and Techniques in the Helping Profession was so amazing.

Undertaking practicum as part of my practical course is quite refreshing as well. Numerous seminars and webinars attended have given me a lot of insight into the counselling profession. My supervisor has been great in assisting me acquire the relevant skills. The practicum has exposed me to a lot of challenges people are going through. The psychoeducation carried out were so much patronized and appreciated. The results of tests administered were so much revealing. My greatest challenge,

however, was with the individual or one-on-one counselling. People came to the session but after intake you would not see them again.

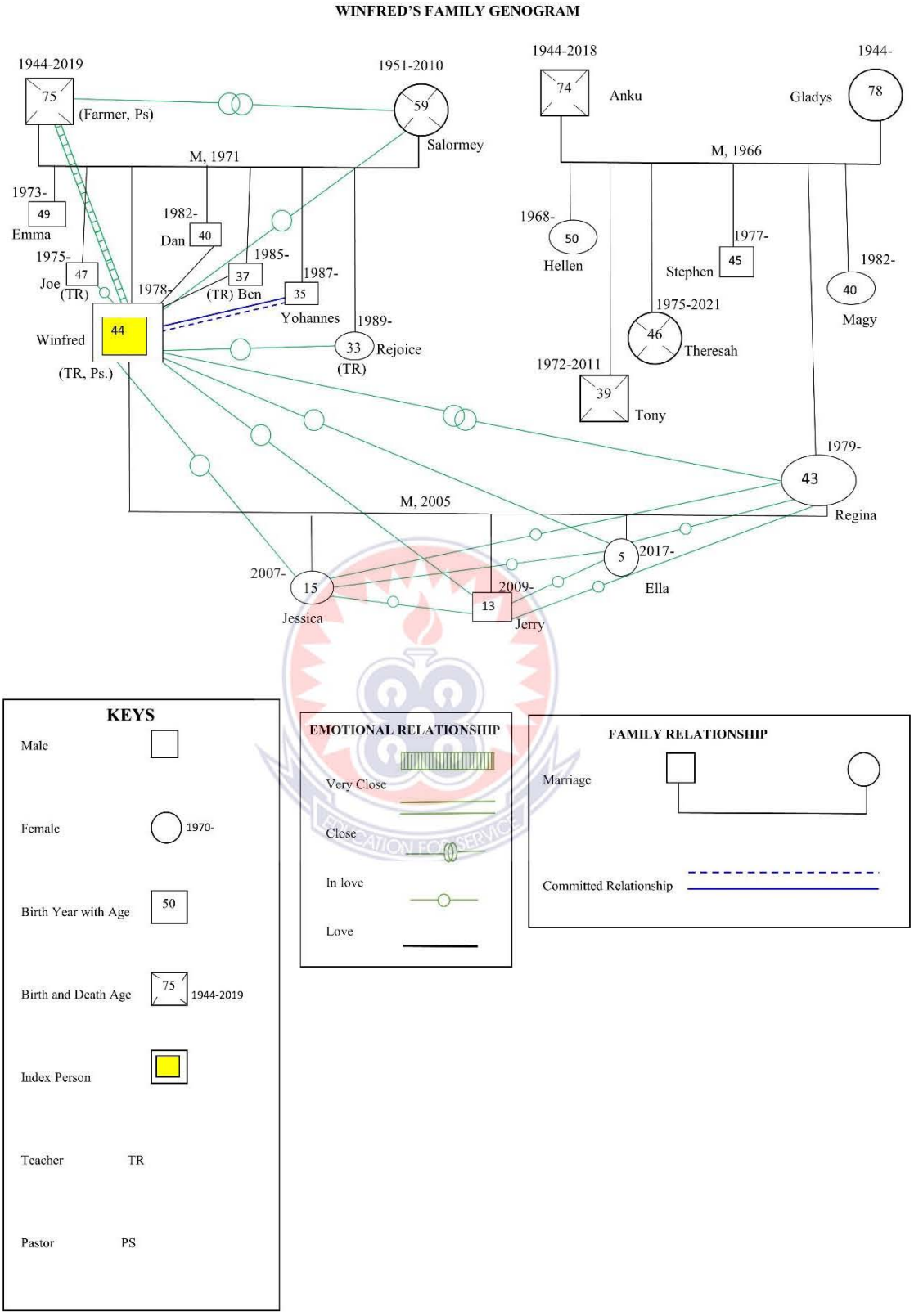
Coming back to school for the second session was a challenging one to me. The present economic crises coupled with increased in school fees at the last hour traumatized me a lot. Due to this I could not report to school in the first week.

I came back to school in the second week by which time lectures had already begun. Meeting friends and my lecturers were moments of excitement to me. However, this excitement was short lived as lecturers began bombarding us with a lot of assignments, group works, and presentations. In fact, anxiety have immediately taken the better part of me and I felt stressed up. Thank God, two of my lecturers noticed it and put the necessary interventions in place to distress those of us who were getting worn out. Really, they are psychologists and I applaud them for such a wonderful step taken.

In this session, I chose to take one elective course which is Family System. Learning about this course is self-revealing and healing to me. Writing a reflection paper on my trauma history and sharing my past trauma experience with colleagues in a lecture was a moment of emotional pain to me and healing. However, the Family System learning have made me a strong person emotionally than ever before.

To draw the curtain to a close, I can confidently say, my learning journey in University of Education, Winneba has not been easy but the exciting moment had overshadowed the difficult times. Counselling has impacted my life positively and I feel that I am a transformed being by the help of my lecturers.

1.3 Family Systems and its effect on my current choice of profession



This is two generational family genogram which illustrates my relationship with other members in the family. On the genogram, I am the index person or the person of interest whom everything revolves around. My father Mallam Shaibu Abubakar was born in 1944 and died in 2019 at the age of 95. My mother was born in 1945 and still alive. They got married in 1971 and gave birth to seven children five female and two male who are all alive.

My relationship with my late father and mother was very close and lovely respectively. I have love relationship with Sawda, my elder brother and Aminu my only sister, committed relationship with Hassana my younger brother, and normal relationship with the rest of them.

On the part of my nuclear family, I was born in 1981 and 41 years now. Aminu was born in 1978 and 45 years. We got married in 2019 and I love my husband. I have love relationship with my Husband, the relationship among my siblings also love and nothing else.

The effect of the relationship I have with my late father and siblings is the underlying factor for the kind of relationship that exists in my nuclear family. Also, connecting the genogram to my profession, I know my late father taught briefly before he became a Imam and a farmer. Currently, three of my siblings are teachers including me. Besides, two of my siblings are also Imams including me just like our late father. The genogram above is the exact reflection of my family background.

CHAPTER TWO

CAREER-RELATED ACQUISITION

2.0 Introduction to the Career-Related Acquisition Chapter

This chapter deals with issues with regards to my career as a Global Practitioner. The Curriculum Vitae concerns my story, identity, biodata, academic history, work experiences, seminars, conferences attended, and personal accomplishments. Letters of recommendation from accomplished personality who have recommended me to be accepted to study this course. The following exercise reflects my personality and aspiration in life from the broader world perspective. The above gave reasons why I was considered capable to be enrolled in this course.

2.1 Curriculum Vitae

BIODATA

Name:	ZEBA ABUBAKAR
Address:	Forces Senior High Technical School, P. O. Box 299. Burma camp
Religion	Islam
Region:	Accra
Email:	Fashzeba32@gmail.com
Telephone Number:	+233244612131 / +556192651
Nationality:	Ghanaian
Date of Birth:	25-05-1981
Gender:	Female
Marital Status:	Married

PROFESSIONAL SUMMARY: I am a self-motivated teacher and a malama with 12 years experiences in these fields respectively. Offering expertise in impacting knowledge, malama care, coaching and providing transformational leadership. Very creative and team builder able to navigate high-stress situations. Highly self-discipline and carry out duties accurately. In addition to my competencies, I have also acquired formal training in Master of Education, Guidance and counselling which will enable me to fit well into the highly competitive professional environment. I have the zeal to bring to bear my experience in counselling on the society.

EDUCATION

INSTITUTION	YEAR	CERTIFICATE
University of Education, Winneba	2022- 2023	Master of Education Guidance and Counselling
University of Education, Winneba	2015-2017	BED Guidance and Guidance
University of Ghana Legon	2013-2015	Diploma in Adult in Education
Presbyterian vocational institute	1998-200	SSSCE
Nuriya Islamic JHS	1991-1994	BECE

SKILLS

- Team Building and team player
- Leadership
- Creative
- Communicating Effectively

- Decision Making
- Empathy

WORK HISTORY AND POSITIONS HELD

1. Teacher Forces Senior High Technical School
2. School Counsellor, Forces Senior High School
3. School Committee Member for Sanitation, Forces Senior High School
4. Member for SHS Counsellors, La Dede-Kotoopon Municipal Education Office (LaDMEO)
5. Vice Present, Muslim Women in Teaching, Accra Branch
6. Islamic Facilitator, Al Aziz Women Organization, Burma Camp, Accra

SEMINARS AND WORKSHOPS

ORGANISERS	**TOPIC**	**YEAR**
Family Services	Staying Resilience in the Face of Challenges	2022
Mental Health Authority	Examining Sexual Anxiety in Male and Females and its Implications on Mental Health. Developing Current Effective Coping Strategies.	2022
Exam Ethics	Evaluation of Effective Teaching for Class Room Management	2022
Forces Senior High Technical School	Sensitization on time management	2022
Muslim women in Teaching	The Role of Economics Teacher in	2020

Teachers Association	Nation Building	
University of Education, Winneba (CETDAR)	Workshop On Mentoring	2017
AL-Aziz Women Association	Coping Strategies with family members	2017
International Leadership Foundation, International Leadership University	Transformation Leadership	

LANGUAGES SPOKEN

- English
- Bissa
- Twi
- Hausa

HOBBIES/ INTERESTS

- Reading
- Listening to Quran
- Watching Movies

REFEREES

1. **David Osei Senu**

   Forces Senior High Technical School

   P.O.Box 299 Burma Comp.

   E-mail Address. naedoh-torgah@uew.edu.gh

   Phone number; 0244982713

2. **Maj Mohammed Hassan**

   Imam of Armed forces musq

   Burma Camp P.O. Box 98, Nima Accra

   Telephone number. 0249220158

3. **FLT Moucharoudine Siddique**

   Burma Camp P.O. Box 98,Nima Accra

   Telephone number. 0244069631

2.2 Reference Letter(s)

KADJEBI ASATO SENIOR HIGH SCHOOL

In case of reply number and date of this letter should be quoted

Our Ref: GES/OR/KSS/VOL.3/81

Your Ref:.....

Post Office Box 57
Kadjebi V/R

Tel:

Date: 6th DECEMBER, 2022

REFERENCE LETTER

WINFRED YAO MENSAH; STAFF ID: 267075

Winfred Yao Mensah, was posted to Kadjebi-Asato Senior High School in the year 2010 to teach Economics, after completion of his tertiary education.

In less than five 5 years, he was appointed as the Head of Economics department due to his work.

Winfred is very passionate with his work both in class and outside class. He was appointed Assistant House Master between 2011 and 2012. A year later in 2013, he was appointed the substantive House Master till 2017.

As the Assistant Headmaster in charge of Academic Affairs, I have enjoyed a nice working relationship with. He was later appointed the Head of Social Science Department in 2020.

Winfred Mensah, is a man of many parts, he assists the school when it comes to planting of tress and other projects that benefit the school.

Winfred was later appointed as the chaplain of the school in the year 2022.

As the chaplain of the school, he supports the school in shaping the lives of our students as well as other students within the Kadjebi District. He is simply a workaholic.

On Fridays, he engages the students on motivational talks that seek to make our students well informed.

Through his love and care for students has helped shaped the moral lives of the students.

I am unable to comment of any weakness of his because I do not know of any.

I therefore recommend him to be considered to successfully complete his course of study.

CEPHAS ADANUVOR

ASSIST HEAD, ACADEMIC

ASST. HEADMASTER (ACADEMIC)
KADJEBI-ASATO SNR. HIGH SCH.
KADJEBI

GLOBAL EVANGELICAL CHURCH
Jasikan Presbytery
P.O. Box 98 Jasikan, Tel.0208208147/0249220158, jasikan@gecgh.org
Our Ref. GEC/JP/22/01
18th November, 2022

TO WHOM IT MAY CONCERN

REFERENCE LETTER OF
RE: WINFRED YAO MENSAH (REV.)

Rev. Winfred Yao Mensah was commissioned and ordained in the Global Evangelical Church. He works directly under me as the District Pastor of the Church in the Papase District of the Jasikan Presbytery in Oti Region. He has been the District Pastor from the year 2015 to date and he is the current Presbytery Clerk.

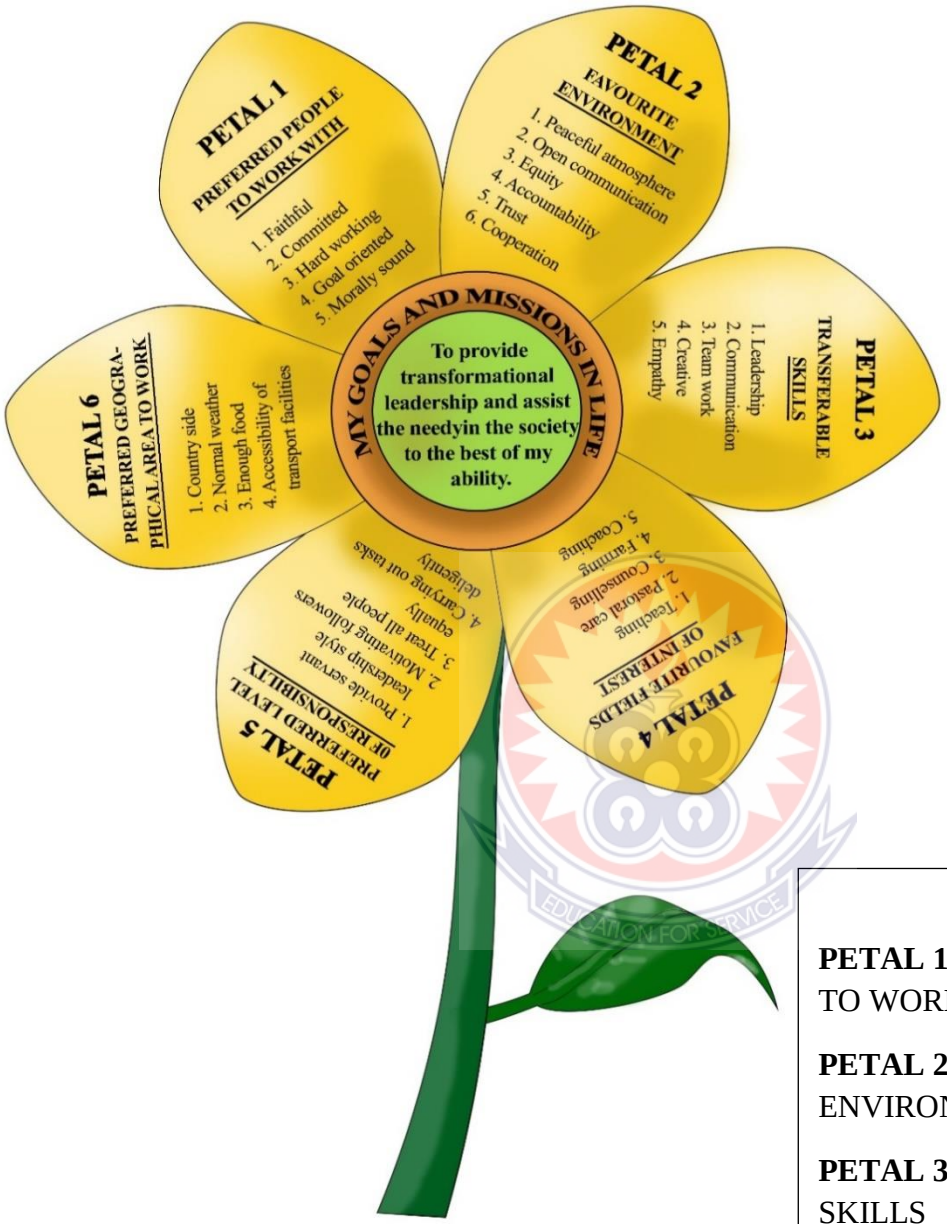
Having offered a course in Counselling Psychology, and as part of his pastoral duties, he offers counseling services to his Church members, as well as other people in his community. It is therefore, prudent for him to sharpen his competences in that field, to enable him offer better services in his Pastoral Ministry.

Rev. Winfred is very dedicated to duty; a man, who does not play with his work. He is a team player, who is ever ready to learn. He is sharp in reasoning, focused and can be relied on to carry out various assignments given to him.
Therefore, I have no doubt, whatsoever in mind, about the ability of Rev. Winfred Yao Mensah in the pursuit of further studies in his current field of study.
Thank you.

REV. ANTHONY KWAMENA NKPEDZI

(CHAIRMAN)

2.3 Flower Exercise. The flower exercise illustrates my goals and mission in



KEYS

PETAL 1 - PREFERRED PEOPLE TO WORK WITH

PETAL 2 -FAVOURITE ENVIRONMENT TO WORK

PETAL 3 – TRANSFERABLE SKILLS

PETAL 4- FOVOURITE FIELDS OF INTEREST

PETAL 5- PREFERRED LEVEL OF RESPONSIBILTY

PETAL 6- PREFERRED GEOGRAPHICAL AREA OF WORK

The pictorial flower illustrates my goals and missions in life. Each of the petal represent a goal and a mission I intend to achieve. Petal 1 talks about preferred people to work who should be faithful, committed, hardworking, goal oriented, and morally sound. Petal 2 talks about the preferred working environment which should be peaceful, where there is open communication, equity, and accountability among others. Petal 3 looks at the transferrable skills such as leadership, team work, communication and being creative. Teaching, my Islamic lesson care, counselling, coaching, and farming constitute my favorite fields of interest in petal 4. Petal 5 shows my preferred level of responsibility such as providing servant leadership, motivating my followers, treating all people equally, and carrying out my tasks diligently. Working at the country side, with normal weather, enough food, and accessing transportation facilities constitute my preferred geographical area of work as noted in petal 6.

CHAPTER THREE

CORE GUIDANCE AND COUNSELLING COMPETENCIES

3.0 Introduction to the Core Guidance and Counselling Chapter

The Core Guidance Counselling chapter talks about the courses that make up the core Guidance and counselling program. These core competencies include the nature of humankind, techniques and applications in counselling, and family system statement. All these exhibited my professional orientation and the heart I demonstrate for the profession and for my clients.

3.1 Nature of Huma\nkind

I see myself connected with Rational Emotive Behavioral Therapy (REBT) which is one of the Behavioralists Theory grounded on the fact that I have a dual nature. I have both rational and irrational beliefs that can be modified through disputation. I stand not being controlled by my instincts but by reasoning. As human, I am disposing to happiness, self-actualization and growth. On the other hand, I have the propensity for self-disturbance and self-blame as well. In this case I can figure out myself stand at the center of therapy through self-help, self-control, personal security, personal liberation, and personal healing. In therapy clients will be viewed in this light

Solution Focused Brief Therapy is the Post-Modern Theory I see myself incline to. I see myself and clients as competent and capable of developing solution to our problems. I am able to identify what behaviors and actions are working and develop goals towards change.

3.2 Techniques and Applications

Connecting oneself or learning towards a particular theory alone is not an end to itself in counselling. A theory becomes relevant when blended or combined effectively with

techniques. As a result, I intend to employ relevant techniques and skills such as active listening, attending, cognitive restructuring, unconditional acceptance, use of humor, homework, reinforcement, questioning, exception questions, reflection of meaning, feeling and content, paraphrasing and summarizing with the theories stated in 3.2 in my counselling service. These techniques may be employed in both individual counselling, group counselling and family counselling.

3.3 Cultural and Diversity Competency Statement

Cultural diversity is the quality of diverse or different cultures, as opposed to monoculture, the global monoculture, or a homogenization of cultures, akin to cultural evolution. The term cultural diversity can also refer to having different cultures respect each other's differences (Wikipedia).

I appreciate my personal beliefs and values and how they differ from other people's beliefs and values. Cultural and Diversity competency enables me as a counsellor to work with individuals, groups and communities in ways that are appropriate and responsive without any bias. It is attached on eliminating cultural biases, foster a culture that encourages an openness in counselling. It again enables me accept and respect clients irrespective of their beliefs, backgrounds, values, culture, race, ethnicity, socioeconomic status, sex and sexual orientation.

I have been adequately equipped to be tactful to clients' own inborn race-related or cultural identity and privilege, ethnocentrism, bias, stereotypes and uphold the dignity and rights of clients in the performance of my professional duties.

CHAPTER FOUR

ETHICS AND VALUES ACQUISITION

4.0 Introduction to the Ethics and Values Acquisition

The chapter deals with part of my ethical and legal class issues. This includes my advocacy statement, my ethics statement for practice, professional goal statement, and clients' bill of rights. These are ethical and legal records of my profession that I need to exhibit to clients or to showcase in my place of practice.

4.1 Advocacy Position Statement

Advocacy can be considered as an ethical obligation of every counsellor. It is very important for promoting and protecting the right of people with mental, physical and psychological impairment or problem and for establishing quality of life they desire.

According to American Counselling Association (2020), professional counsellor advocacy involves taking action to promote the profession, with emphasis on removing or minimizing barriers to counsellor's ability to provide services. Advocacy in counselling is for advancing the wellbeing of individuals, groups and the counselling profession. I do firmly belief that without strong advocacy at all levels, people will be disadvantaged in our society.

Advocacy intends to find solution to any limitation that might hinder the growth, well-being and development of certain individuals being age, gender, social life or race. It is a medium for the less privilege in the society who may not be able to talk for themselves or articulate or express their needs and concerns to be heard.

My advocacy position seeks to offer assistance to children who are abused in our society. My practicum exercise carried out over the period brought to the fore how children are abused in all forms. Surprisingly, parents abusing their daughters

sexually is becoming a common scenario. Realizing the severity of the situation, I seek to be a mouth piece for these poor children in our society. As a Graduate Trainee Counsellor, I intend to speak to this issue in public gatherings, churches, mosques and our community radio stations. I will also collaborate with relevant bodies such as Commission on Human Right and Administrative Justice (CHRAJ), Social Welfare Department, Domestic Violence and Victim Support Unit (DVVSU) of Ghana Police Service and many more to address this thorny issue. My hope is to prevent this social ill from happening and assist victims who were traumatized as a result of abuse. I will empower the victims to advocate on this issue in the society soliciting for the necessary resources they might need to perform their advocacy role.

4.2 Ethics Statement for Practice

Ethical issues are important and sensitive in the counselling profession. Counsellor's actions and inactions in circumstances involving ethics will affect all parties engaged, therefore the basic principles of counselling must be sticked to ethically.

As a professional therapist I shall at all times uphold the code of ethics of Ghana Psychology Council (GPC), Ghana Psychological Association (GPA) as well as international code of ethics like American Counselling Association guidelines that promotes respect, dignity and fair treatment of clients.

Attention will be given to client's autonomy, non-maleficence, beneficence, justice, and fidelity, as explained below.

Autonomy: I shall motivate and enable clients to take control of the direction of their own lives wherever possible.

Non-maleficence: my action or inaction should never deliberately cause harm to my client.

Beneficence: mental health and wellbeing shall be paramount for the good of the individual and for society at large.

Justice: I will treat all people fairly and equitably

Fidelity: I shall honor all personal and professional obligations, promises and responsibilities.

This ethical statement I pledge to uphold and implement as I perform my duties as a malama, teacher and professional counsellor.

4.3 Professional Goal Statement

As a trained teacher in the Senior High School, and MED Guidance and Counselling Student Trainee of the University of Education Winneba, my profession as a malama, teacher and to be a profession counsellor is already determined; which is in tune with my purpose and aspirations in life. My training as counsellor is to equip me with the relevant knowledge and skills in the helping profession. It is my desire to work diligently to build a portfolio in this field by attending seminars and workshops, conferences and reading books and other relevant materials to help sharpen my leadership skills and counselling abilities. I deem it necessary to ensure that I remain consequential in this field and make meaningful contribution in practice.

4.4 Professional Disclosure Statement with Client's Bill of Right

Zeba Abubakar Silatu

Graduate Student Trainee Counsellor

Department of Counselling Psychology, University of Education, Winneba.

fatashzeba32@gmail.com

Tel. 0244924990/0207246990

Education: I am currently a second year MED Guidance and Counselling student of the University of Education, Winneba. I had my first degree in BED in Guidance and Counselling from this same University. I also hold Diploma in Adult Education from university Ghana Legon and as part of my course, I should have a practicum of 600 hours' experience in individual counselling, crisis counselling, group counselling and psychoeducation on various topics in Senior High Schools, Junior High Schools, Mosques, Muslim women in teaching center and AL-Aziz women Association. I also had the opportunity during the practicum to participate in webinars and seminars where various topics or themes were discussed and certificates awarded to me.

Professional affiliation: Currently, I am a member of Guidance and counsellors' Coordinators in La – Dadekotopon District Assembly and Islamic tutor at AL-Aziz Mosque Burma Camp.

Services provided: I am Community Counsellor providing services in individual counselling. and psychoeducation on issues.

Counselling is a therapeutic relationship between a professional (counsellor) and someone who needs or wants help (client). This relationship rides on some established rules and responsibilities for both parties (counsellor and client). As a client, you need to know your rights as well as limitations to those rights. Similarly, I have the following responsibilities towards you:

1. **Confidentiality** – I shall hold your information confidential as part of my legal ethical standards except in the few instances listed below:

a. If there is the indication of you harming another person, I will attempt to warn that person, so he/she gets secured.

b. If there is the indication that you are abusing or neglecting a child or the aged, or you inform me about someone else doing same, I must reach the appropriate bodies involved to provide safety for that person.

c. If there is the impending danger of you causing harm to yourself, I may lawfully break confidentiality to provide protection for you.

d. If the court, for some reason, subpoena me to release information about this professional relationship, I may have to break confidentiality.

2. Treatment with dignity and respect

3. Give or withhold informed consent

4. Autonomy or independence self-respect

5. **Record keeping**: I keep brief records of our sessions, noting the interventions and topics we address, as well as dates and times of our sessions. These records are for professional use only, and to guide our sessions as we journey on.

6. **Diagnosis:** I provide some tentative diagnosis from a professional manual known as the DSM-5 to help guide the treatment I provide for you if need be.

7. **Other rights:** Clients have the right to ask questions about what happens in therapy and receive responses to these questions. I am willing to discuss how and why I use specific interventions for your mental wellness.

8. **Approach to Therapy** – My counselling philosophy and therapeutic approach is incline to Rational Emotive Behavioral Therapy (REBT) to help clients address irrational thoughts or beliefs, and Solution Focus Brief Therapy (SFBT) to assist clients identifies resources and strengths to bring the desire change. Integrated techniques and interventions from the approaches will be employed to achieve a holistic wellness.

9. **Risks:** Counselling could have risks in terms of evoking painful memories. Sometimes, you are asked to make certain changes or modifications in behavior that may be scary or disruptive to present relationships. It is important to think through these risks to be sure the benefits therein are worth the changes or modifications required of you. People who take these risks mostly find it worthwhile and counselling helpful.
10. **Responsibilities:** You are responsible for coming for your sessions on time at our schedule appointments. Sessions last between 30-45 minutes. Please inform me at least 24 hours prior if you will not be able to make any of our scheduled appointments. Pay bills in accordance with the billing agreement, follow agreed - upon goals and strategies established in sessions and, avoid placing the counsellor in ethical dilemma.

What to Do in case You Are Dissatisfied: Remember that a counsellor who meets the needs of one client might not meet the needs of another client. Therefore, if you are not satisfied with the services of your counsellor.

- ❖ Express concerns directly to the counsellor, if possible.
- ❖ Seek the advice of the counsellor's supervisor if the counsellor is practicing in a setting, where he or she receives direct supervision.
- ❖ Terminate the counselling relationship if the situation remains unresolved.
- ❖ Contact the appropriate regulatory bodies, if you believe the counsellor's conduct was unethical.

Having read the above rights, responsibilities, and what to do in case you are dissatisfied, if you agree, please append your signature, date, and your name(s) accordingly in the spaces provided below. Thank you!!

Signed ———————————————— Date ————————————

Name of client's ———————————————————————————————

Signed ———————————————— Date ————————————

Counsellor's name _____ _____

CHAPTER FIVE

PERSONAL REFLECTIONS & COUNSELLOR COMPETENCIES

5.0 Introduction to the Counsellor Competencies

This chapter intends to focus on the counselling process, the theories, techniques and how to effectively apply them in my professional practice.

5.1 Counsellor Competencies

The role of the care profession over the years cannot be underestimated. It is required of a counsellor to demonstrate competency in the performance of their responsibility. Accordingly, a professional counsellor must gain satisfactory knowledge with the needed experiences that positions him/her to practice efficiently and effectively. The various areas of my competencies are discussed in this chapter.

I am a final year MED Student of Guidance and Counselling of the University of\Education Winneba. For me to be trained holistically by the University, I was assigned to do a practical work under the supervision of experienced and competent counsellor as my supervisor. I engaged in activities such as attending conferences, seminars, webinars, outreach programs, and one-on-one counselling with client under the supervision.

During the practicum, I had the opportunity to practice the theories and techniques studied to show forth my competence and mastery of the theories and techniques. The 600 practicum hours form the basis for me to be licensed by Ghana Psychology Council, a state regulatory body and also a student member of Ghana Psychological Association; whose code of ethics will direct the performance of my responsibilities professionally.

5.2 Human Lifespan Development

The course outlined the full process of human lifespan development from birth to death. The course exposed me to the holistic point of view to understanding the physiological, cognitive, emotional and the social changes that people go through. The lifespan developmental psychology assesses the patterns of change in psychological characteristics across the life course of human being.

Artifact 1 **OBSERVATION OF INFANCY (0-2YEARS)**

Name: Daniel Battah

Date: 20th November, 2023

Age: 9 months

Venue: Home

Observation topic: Developmental characteristics of 9 months old boy.

Objectives: By the end of the 3 hours' observation, student/counselor will be able to;

i) Notice 4 physical development characteristics of the boy.

ii) Observe 4 cognitive/language development characteristics of the boy.

iii) See 3 psychosocial development characteristics of the boy.

OBSERVATION FORMAT

Physical development activities observed	**Responses**	
	Yes	No
1. Sits without help	√	
2. Begins to crawl	√	
3. Try to stand	√	
4. Moves objects between hands	√	

Cognitive development	**Responses**	
	Yes	No
1. Babbles and imitates sounds	√	
2. Begins to say "mama" or "dad"		√
3. Drop objects and then look for them	√	
4. Bangs objects together	√	

Psychosocial development	**Responses**	
	Yes	No
1. Recognizes familiar faces	√	
2. Have stranger anxiety	√	
3. Misses' caregivers when they have	√	

OBSERVATION EQUIPMENT: Writing materials (pen, pencils, paper etc.) clip board, laptop, phone, toys etc.

SUMMARY OF THE OBSERVATION: From the observation, all the activities carried out on the child's Physical and Psychosocial Development indicated that the child had no developmental defects in these two areas. However, under Cognitive Development 3 out of the 4 activities observed were normal, except that the child cannot mention "mama" or "dada". I have observed that the mother does not talk much when playing with the child.

CONCLUSION: The child's Physical, Cognitive and Psychosocial developments are on course. The parents must continue to give proper attention and care for the child to develop well.

However, much talking must be done in the presence of the child by the mother or anybody playing with him. Parents need not to be worried because he is not even a year old.

Artifact 2 **MIDDLE CHILDHOOD (6-10YEARS)**

Name: Jerry Mensah

Date: 22nd November, 2023

Age: 10years

Venue: School

Observation topic: Developmental characteristics of 10years old boy.

Objectives: By the end of the observation, Student/Counsellor will be able to;

1. Observe the physical development characteristics of the boy.
2. Notice the cognitive development characteristics of the boy.
3. See the psychosocial development characteristics of the boy.

OBSERVATION FORMAT

Physical development activities observed	**Responses**	
	Yes	No
1. Enjoyment of rough-and-tumble games with peers.	√	
2. Increased stamina (running up and down).	√	
3. Refinement of finger control like throwing a ball and catching.		√
4. Self-care	√	

Cognitive development activities observed.	**Responses**	
	Yes	No
1. Ability to learn and apply.	√	
2. Interpretative ability development.	√	
3. Ability to answer who, what, where, and when questions.	√	

Psychosocial/emotional development activities observed.	**Responses**	
	Yes	No
1. Ability to interact with peers.	√	
2. Strong group identity	√	
3. Temperament in relation with friends	√	
4. Feel concern about outward appearance. (Care)	√	

OBSERVATION EQUIPMENT: Writing materials (pen, paper, pencil, exercise, etc.) clip board, balls, laptop, deck, textbook, phone.

SUMMARY OF THE OBSERVATION: From the observation chart, 4 activities each were carried out under physical and psychosocial development domains of the child. In respect of the cognitive development 3 activities were carried out. The observation indicated that all activities under cognitive and psychosocial development were performed by the child without any hitches. However, refine finger control activities like throwing and catching ball which is fine motor skill could not be executed by the child.

CONCLUSION: Though the child's development in all the 3 domains is progressing well, the child needs to be helped to develop his fine motor skill in this area of deficiency**.**

5.3 Theories of Counselling

This course exposed me to the theories used in counselling. The theories are categorized into traditional and post-modern theories. It helps me to connect myself with one theory from the traditional theories which is Rational Emotive Behavioral Therapy and Solution Focused Brief, Therapy which is post-modern theory that forms the basis of my theoretical orientation in counselling.

Artifact 1 **Rational Emotive Behavior Therapy (REBT)**

The REBT was developed by Albert Ellis in 1950s. REBT is an action-oriented approach that focus on helping people deal with their irrational beliefs and learn how to manage their emotions, thoughts, and behaviors in a healthier and more realistic way (Guy-Evans, 2022). People are disturbed not by things but by their view of things.

REBT sees man as potentially rational and irrational in thinking and behaviors. Man is disposed to happiness, love, self-actualization and growth. In the same vein, man has the drive for self-disturbance, avoidance of thoughts, and self-blame (Buk & Agordzo Edoh-Torgah, 2021). This explain the dual nature of man as rational and irrational being.

The goal of the REBT aims at showing clients how their misinterpretations of events are causing them problems, and to teach them to see things in a more rational way and assist them in the process of adjustments (Buku & Agordzo Edoh-Torgah, 2021). This

ensures unconditional self-acceptance, unconditional other acceptance and unconditional acceptance of life.

REBT is a based-on model call A-B-C model. The theory maintains that when we have an emotional reaction at point C (the emotional consequences), after some activating event that occurred at point A, it is not the event itself (A) that causes the emotional state (C), although it may contribute to it. It is the belief system (B) we have about the event, that mainly create C (Corey, 2016).

The therapeutic process involves, the therapist helping the clients to learn to apply the A-B-C model to their daily life. The therapist will use techniques such as assertiveness training disputing irrational beliefs, reframing, homework, humor, mindfulness, relaxation, guided imagery and visualization, unconditional and self-acceptance, unconditional other acceptance, and unconditional life acceptance to assist the client (Guy-Evans, 2022).

The REBT can be helpful in the treatment of people living with a variety of issues such as depression, anxiety, addictive behaviors phobias among others. It can be used in both individual and group counselling.

Strengths of REBT.

i. It helps clients to identify their problem and then to fined a goal to overcome them ex.
ii. It also helps people to learn to identify and challenge their irrational thoughts

Weakness of REBT.

i. It is easy to practice poorly
ii. REBT practitioners often employ or rapid-fire active-directive-persuasive methodology.

Artifact 2 **Solution Focused Brief Therapy (SFBT).**

Solution-Focused Briefs Therapy (SFBT) was created in the late 1970s and early 1980s in the brief Family Therapy Center in Milwaukee, by De Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich and Weiner-Davis (1986). SFBT is a form of therapy which focuses on solutions to problems or issues and discovering the resources and strengths a person has, rather than focusing on the problem like most traditional talking therapies do (Murray, 2021). Instead of analyzing how the issue arose and why it is there and what it really means for the person, SEBT instead focuses on the issue in the here and now, how to move forward with a solution for it (De Shazer & Dolan, 2012).

The SFBT sees humankind as competent and capable of developing solution to his/her problems. People are able to identify what behaviors and actions are working and develop goals towards change to happen. Every human being is unique and have resources and strengths to bring change they desire.

The goal of SFBT is to assist the client develops tools and skills, based on his/her strengths that he/she can use moving forward. The tools and skills may help him/her change harmful behaviors, achieve his/her life goals and manage difficult situations (Moore & Silva, 2022).

The therapeutic process in SFBT session involves, the counsellor and client work collaboratively to set goals and find solution together, to overcome the problem or issue. The counsellor will ask questions to gain an understanding of the client's strengths and inner resources that they might not have noticed before. The therapist using SFBT depends much on questioning techniques. The practitioner begins a first session with a goal development questions, pre-session change question, looking for

exceptions, present and future focused questions, and compliments. In SFBT miracle questions, scaling, questions, coping questions, exception questions are used effectively as techniques.

The SFBT is used for most emotional and mental health problems that other forms of counselling are used to treat. These include; depression, anxiety, self-esteem, substance addiction, and relationship problems.

Strengths of SFBT

1. It helps clients to identify their problems and then find a goal to overcome them
2. It is future oriented, so it helps to motivate the client to move forward in life and not to feel stuck in their past.

Weaknesses of SFBT.

1. The theory places less importance in past traumas, giving less room during sessions to explore these significant events.
2. Because it is good for short term interventions, it is not a good fit for everyone. For example, clients with more severe problems need more time.

5.4 Research Methods

This course exposed me to the steps involved in writing a research proposal. This entails the main idea, the reason why research needs to be conducted and the methodology that will be used. It also equipped me with knowledge to research into questioning technique in counselling and how to apply it.

Artifact 1 **Research Proposal**

TOPIC: ***EXPLORING ADOLESCENTS' PERCEPTION ON SEXUAL EXPERIENCES IN SENIOR HIGH SCHOOLS IN THE forces FORCES SENIOUR HIGH TECHNICAL SCHOOL, ACCRA REGION-GHANA.***

5.4.0 Background of the study

Adolescence is a time where individuals are increasingly likely to be concerned with figuring out who they are (Nassar-McMillan & Casnwell, 1997). Curiosity about sex in adolescence lead to exposure to viewing pornographic materials and increased risk of sexual assaults. In recent years, the internet has made a difference in the minds and perspectives of young people concerning sex (Kanuga & Rosenfeld, 2004)). Adolescents gain in-depth knowledge that has to do with sex, which can be misleading and potentially have negative influence on sexual behavior. Sexual behavior is complex and caused by factors such as physical appearance, psychological, social and cultural history. Sexually experienced adolescents in Ghana remains higher than sexually experienced adolescents in developed countries over the past 2 decades (Smith, Hunt, McVay & McConnell, 2007). In Ghana, there has been some social campaign about adolescent sex desires and other related issues. However, a search by the researcher revealed that studies on adolescent perception toward sexual experiences appears scanty hence the need for this study.

5.4.1 Statement of the problem: Globally, about 16 million girls between the ages of 15 to 19 and some 1 million girls below the age of 15 give birth every year especially in low- and middle-income countries. This has resulted in hitches during pregnancy and childbirth as the second cause of demise for 15-19 years old girls worldwide (WHO, 2014). In many developing countries, including Ghana, cultural elements have

hindered the youth, especially the adolescents to discuss about sexuality with their parents. But information about sex, is not and must not be a taboo in our current dispensation Most of these adolescents seek sexuality "education" from external influence such as from friends, social media, as well as from print media. I have also observed with dismay, several of our female students in the district got pregnant, especially during their final examination periods. It is against this backdrop that I want to study the sexual perceptions, sexual experiences and sexual behaviors of these students.

5.4.2 Purpose of the study: The purpose of the study is to explore sexual perceptions, experiences and behaviors among adolescents in senior high school.

5.4.3 Objective of the study

The study seeks to explore the perception adolescents have toward sexual experience. Specifically, the study will;

1. Explore the factors that inform the perceptions of adolescent toward sexual experience.
2. Identify the perceptions adolescents have regarding sex.
3. Identify some challenges that adolescent goes through in handling perceptions toward sexual experiences.

5.4.4 Research Questions

The study will be guided by the following research questions;

1. What is the nature of sexual perception and experience among senior high school students in La-Dadekotopon district?
2. How do sexual perceptions and experiences influence the behavior of senior high school students in La-Dadekotopon district?

3. How do senior high school students handle their sexual perceptions and experiences in La-Dadekotopon district?

5.4.5 Significance of the study

- The findings of the study will be of great assistance to the various stakeholders (adolescents, parents, teachers, policy makers and academia)
- The findings will enlighten the understanding of the adolescents on some factors that lead to sexual experience, perceptions and how to handle them.
- The study will assist teachers and parent on how to counsel and handle children entering into adolescence to help them deal with perceptions towards sexual experiences.
- The government will also find this study useful such that it will aid the government in designing the curricula for schools and how to inculcate sex education in the curricula.

5.4.6 Delimitations: Although there are private senior high schools in the district, the study will only focus on adolescents between the ages of 12 and 19 years in Forces senior high schools in La-Dadekotopon district;

The choice of the population is justified due to inadequate research on the phenomenon of adolescent sexual perceptions, experiences and behavior, especially in the senior high schools and most particularly in in the greater Accra region of Ghana.

5.4.7 Theoretical framework

The study is underpinned by two theoretical models. The Social Cognitive Theory (SCP) and the Theory Planned Behavior (TPB).

Social Cognitive Theory: Social Cognitive Theory (SCT) is one of the social theories that blends components of psychology, sociology, and political science. The theory emphasizes the role of observation and cognition to appreciate and forecast

learning and behavior (Glanz, Rimer & Viswanath, 2015). The theory identifies that human behavior is the product of interactions between personal, cognitive, behavioral, and environmental factors. The theory places particular emphasis on the potential of people to modify an environment suitable for individual and mutual purposes. The Social Cognitive Theory is relevant to this study because, it will not only help to identify the influence of peers but also explain the role the environment plays in the occurrence of the phenomenon under study.

Theory of Planned Behavior: The Theory of Planned Behavior (TPB) was developed by Ajzen, 1975. This theory predicts individual's intention to engage in a behavior at a specific time and place. It posits that individual behavior is driven by behavior intentions, where behavior intentions are a function of three determinants: an individual's attitude toward behavior (how the person thinks positively or negatively about the behavior), subjective norms (how the person perceives what significant others or social environment will react to his/her behavior) and perceived behavioral control (the person's confidence of succeeding in the planned behavior or otherwise). This theory is also considered relevant to the study because it will enable the researcher to appreciate and explain the intentions and considerations of adolescents regarding their sexual behaviors

5.4.8 Literature Review

Scholarly books and articles that are related to the research questions and objectives will be reviewed. Most importantly, the researcher will solicit for scholarly materials on challenges of adolescents regarding their sexuality, sexual perceptions sexual experiences, differences in their sexual perspectives, misconceptions on sexual experiences sexual behaviours and coping strategies to handle sexual experiences. The data for this study will be solicited from both secondary and primary sources. To

start with, primary sources of data will include the adolescents in public senior high schools in the LaDMEO District of the Accra Region. On the other hand, secondary data will be solicited from books, articles, reports, earlier studies conducted on this phenomenon, and any other relevant scholarly material that the researcher will come across.

5.4.9 Methodology

The research method for this study will be qualitative method. Ambrose Huston & Norman (2005), qualitative method refers to a research approach which focuses on obtaining data through open-ended questions and conversational communication. Kumar (2011) argues that a study is classified as qualitative if the purpose of the study is primarily to describe a situation, phenomenon, problem or event. Specifically, qualitative research enables the researcher to solicit data that answers not only "what" participants think but also "why" they think so. Qualitative approach is selected for the study because of its ability to enable the researcher to have deeper interactions with the participants to explore, ascertain and interpret the views and actions of the participants and the reasons why they share those views and actions. The qualitative method is therefore the most suitable method to carry out a study as it seeks to explore and ascertain the perceptions, experiences and behaviours of adolescents and the counselling mechanisms that can be used to help them develop coping strategies. Qualitative research approach enhances in-depth understanding of how people in specific environments come to understand, behave, and handle their day-to-day situations Kemparaj and Chavan (2013). And to the extent that human behaviours, attitudes and perspectives will be studied, this method is considered more suitable.

Research Population: Population is defined by Saunders et al. (2007) as the full set of cases from which a sample is obtained. The study population is made up all adolescents in three senior high schools in the minicipal.

Sampling Technique: The sampling method that the study will use is the purposive sampling. According to Palinkas, Horwitz, Green, Wisdom, Duan and Hoagwood (2015)

purposive sampling refers to the sampling technique that a researcher chooses based on who he or she thinks would be appropriate for the study. Since the phenomenon under study is related adolescents between the ages of 12 and 19 years, the researcher will intentionally identify, select and interview students who fall within the age bracket who are readily available to provide responses that can be used to address the objectives of the study.

Sample Size: Sampling is the process of selecting a few (a sample) from a bigger group (the sampling population) to become the basis for estimating or predicting the prevalence of an unknown piece of information, situation or outcome regarding the bigger group (Kumar, 2011). Thirty (30) students will be selected out of the total population. These will be purposively selected due to the participants' sexual perception, sexual experiences and sexual behaviors.

Instrumentation: The study will employ semi- structured interview to obtain data for the study. The interview guide will be structured into three sections taken into consideration the research objectives, which will be self-developed by the researcher collect the needed primary data from the participants.

Data Collection Process and Data Management: The researcher will take an introductory letter from the Department of Counseling Psychology at University of

Education, Winneba to inform the selected respondents and assured them about the fact that their views will solely be used for academic purpose. Thereafter, the researcher will, in line with the ethics of qualitative research, inform the respondents that the semi-structured interview will be recorded electronically for transcription purposes. After the respondents give their verbal consent for the researcher to continue with the interview, the researcher will go ahead to conduct the interview and record them electronically. The recorded interviews will transcribe onto a word document and kept as transcripts.

5.4.10 Data Analysis

Thematic analysis will be used to analyze the responses to achieve the objectives of the study. Thematic analysis is a method of analysis that enable researchers to analyze responses based on specific themes which are usually derive from the research questions or objectives. The researcher will code and group the transcribed data into major themes; using each research objective as a theme. Related themes generated from the coded transcripts will then be analyzed in line with the research objectives using thematic analysis.

5.4.11 General Layout of the Research.

There are six chapters to this study. The constituents of the specific chapters include the following.

Chapter one will be the introduction to the research.

Chapter two will focus on literature review.

Chapter three will focus on the research methodology.

Chapter four will focus on presentation of results of the study.

Chapter five will focus on the discussion of the results.

Chapter six, the final chapter, will outline summary of the research findings, conclusions and recommendations.

Artifact 2: **Questioning techniques in counselling**.

Questioning is an act or expression of inquiry that calls for a reply. It is one technique of counselling which therapists employ so much irrespective of their theoretical orientation. Questioning indicates the counsellor's intent to seek further information from clients or requires clients to elaborate on a point (Shertzer & Stone,1980).

There are different types of question and their purpose in counselling. Open-ended and close-ended questions are important tools in the counselling. They can help a person to open up or close down (Buku, Noi-Okwei & Wilson, 2012). Shertzer and Stone (1980), argue that questions used by counsellors are open-ended and require more than 'yes' or 'no' response; otherwise, they get nowhere and only stifle discussion. An opened question has no correct answer and requires an explanation of sorts; the who, what, why and how questions are used. On the other hand, open-ended questions are those that can easily be answered with a "yes" or a "no" or brief response. For instance, what is your name and date of birth?

Other types of questions are affective questions which help clients to look more closely at their feelings. They facilitate the identification and expression of feelings. They stimulate reflection and thought (Kankam & Onivehu, 2000). Example of affective question is "what was the relationship all about?"

Also, a leading question is type of question which invites or encourages the client to respond to open communication. They are asked in order to elicit a particular response. "Please tell me why you are here" is an example

Direct leading questions help to focus on the topic more specifically. It enables the client to elaborate or clarify what he has been saying. For instance, “what do you mean?” (Kankam & Onivehu, 2000)

Finally, probing question refers to the counsellor’s ability to help client identify and explore experiences, behaviors and feelings that will help them engage more constructively in any of the steps of the helping process. This helps the client to think beyond the obvious which they have started.

Questioning in counselling is very important. It is used for clarification, obtaining specific information, direct the client’s conversation to more fruitful channels, and assist the client open up and get the session to start.

Questioning in counselling can be problematic if not well handled. Use of questions by a counsellor in a counselling session can open up communication and also extensive questioning draws the client into a passive position in which they wait for the counsellor to solve the problems (Shertez & Stone, 1980).

To conclude, questioning techniques can be employed in all the stages of counselling; thus, the initial stage, middle stage and the termination stage.

5.5 Techniques in the Helping Profession

This course unveiled the various techniques that can be employed in counselling sessions and how the techniques can be combined with the theories effectively. The relevance of the rapport creation in counselling was highlighted. It was obvious that without techniques, theories alone cannot strive.

Artifact 1. **Transcript of Role Play in Counselling Session. "A Worried Wife"**

Rev Mensah: Mrs. Ayi you're welcome.

Mrs. Ayi: Thank you sir.

Rev. Mensah: Have a sit.

Mrs. Ayi: Thank you.

Mrs. Ayi: Good Afternoon

Rev. Mensah: Good Afternoon, how may I help you?

Mrs. Ayi: Is about my marriage.

Rev. Mensah: Okay!

Mrs. Ayi: About ten years now I got married to my husband with two kids and they are girls.

Rev. Mensah: Okay!

Mrs. Ayi: Yes, two beautiful girls.

Rev. Mensah: Waoo!

Mrs. Ayi: The last one is 3 years of age now.

Rev. Mensah: That's good.

Mrs. Ayi: And we live happy at home. Everything goes on smoothly; nobody hears of us.

Rev. Mensah: Okay!

Mrs. Ayi: We have never picked any quarrel before sir!

Rev. Mensah: Mm!

Mrs. Ayi: But of late, my husband mood in the house, I can't just understand him. He frowns his face to me, shout at me at the very least thing.

Rev. Mensah: Oh! You mean, he is angry with you in the house?

Mrs. Ayi: Yes, yes, he is angry with me sir.

Rev. Mensah: Ooh!

Mrs. Ayi: Because of that he even comes home late in the evening. I have never felt happy this time again.

Rev. Mensah: It means you're worried?

Mrs. Ayi: Very worried sir. Yes, I'm worried. Even when I cook this time, he doesn't take my meal. Sir, could you believe that he has even denied his marital bed?

Rev. Mensah: You mean there is nothing like sex between you any longer?

Mrs. Ayi: Yes! there is nothing like that.

Rev. Mensah: Oh! I see

Mrs. Ayi: Yes! Yes!

Mrs. Ayi: Sir, the comment he has being passing these days is while other women are giving birth to male children, me I continue given birth to female children. What would he use female children for?

Rev. Mensah: You mean he is angry because you are not giving him male children?

Mrs. Ayi: Yes sir! Yes! Yes!

Rev. Mensah: Oh! Mrs. Ayi, Okay! I see.

Mrs. Ayi: Yes! Please help me. I need a help from you.

Rev. Mensah: Mrs. Ayi, what I'll say now is, you be patient with him. Don't get angry with him as well, be calm. Continue to discharge your marital duties, and show him much love and care. We'll schedule another meeting next week Tuesday this same time, we'll meet.

Mrs. Ayi: I'll be very glad.

Rev. Mensah: Thanks for coming.

Mrs. Ayi: Thank you

Rev. Mensah: Greeting to the family.

Mrs. Ayi: They'll hear.

Rev. Mensah: Bye! Bye!

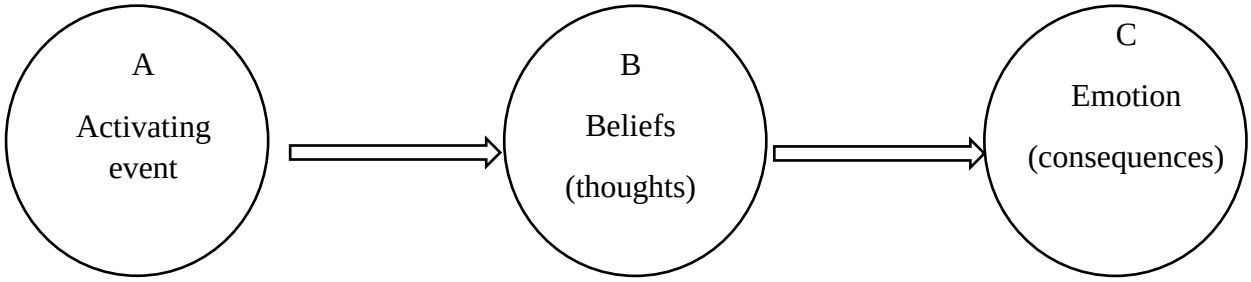
Mrs. Ayi: Bye!

I am reflecting on the content, feeling and meaning of my dialogue with Mrs. Ayi as a counsellor.

Artifact 2 Cognitive Restructuring Technique

Cognitive restructuring or reframing techniques is the process of learning to refute cognitive distortions or faulty thinking with the aim of replacing one's irrational, distorted thoughts or beliefs with more accurate, beneficial and adaptive ones (Ellis & Harper, 1975). Emotions have little to do with actual events and that in between the event and the emotion is the unrealistic self-talk. The emotions actually come from what you say to yourself (beliefs) and not from the event itself, these unrealistic beliefs and thoughts are directly responsible for generating dysfunctional emotions and their resultant behaviors like stress, depression, anxiety, anger and many more. We can get rid of such emotions and their effects by dismantling the beliefs that give them life (Buku, et.al, 2012)

Ellis uses the "ABC" model to explain how it works. The "A" represents the activating event, the "B" represents the beliefs-thoughts, assumptions and "C" represents the consequences-feelings/emotions, behaviors, and actions.



For instance, “I will score 100% in all the courses”

A- activating event	B. beliefs	C. consequences
I will score 100% in all the course	Fear of failure to score the 100% in all the course	Anxiety

There are five steps to changing the way you think and eliminating irrational ideas.

A- Write down the facts of the event as they occurred at the time. (facts)

B- Write down your self-talk about the events. (beliefs)

C- Focus on your emotional response (consequence)

D- Dispute and change the irrational self-talk identified at step B.

E- Alternative thought or emotions.

This distorted thinking may be in the form of filtering, personalization, being right among others. In using this technique activity such as reading, journaling and self-help activities may be employed.

Grounding Technique

Grounding is a practice that can help clients pull away from flash backs, unwanted memories and negative or challenging emotions (Raypole, 2022). The exercises involve in grounding techniques help the clients refocus in the present moment to distract him/her from anxious feelings. This technique is helpful in the treatment of anxiety, depression, stress, post-traumatic stress disorder etc. In this technique, all the five senses are involved.

Putting one’s hands in water is one of the exercises in grounding. Client focuses on the water temperature and how it feels on his fingertips, palms, and the backs of his hands. Does it feel the same in each part of his hand? Use warm water first, then cold.

Next, try cold water first, then warm. Does it feel different to switch from cold to warm water versus warm to cold?

Breathe deeply is also an exercise in grounding techniques, slowly inhale, then exhale. If it helps the client can say or think “in” and “out” with each breath. Feel each breath filling his lungs and note how it feels to push it back out.

Finally, client can take a short walk as a grounding exercise. The client concentrates on his steps. He can even count them. Notice the rhythm of his footsteps and how it feels to put his foot on the ground and then lift it again.

5.6 Group Counselling

The course revealed to me how to start a group, membership composition, principles, and development of socializing techniques in group counselling. Various group development models, theories and techniques applicable in group counselling were brought to the fore. Resolving conflict that might arise in group counselling session is very in important for the group life.

Artifact 1 **Proposal for Group Counselling to Increase Self-Esteem in Adolescents in The Senior High Schools**

Rationale for using Group Counselling to Increase Adolescent Self-Esteem in Senior High Schools

Adolescence is a time where individuals are increasingly likely to be concerned with figuring out who they are (Nassar-McMillan & Cashwell, 1997). According to Searcy (2007), a main avenue through which youth explore their self-concept and develop self-esteem or lack thereof, is through interactions with their peers. Self-esteem is then developed through associations with others, activities one engages in, and the things that one hears about themselves (Searcy, 2007). Based on this information,

work with adolescents aimed at fostering a high level of self-esteem often occurs in group counselling settings (Nassar-McMillan & Cashwell, 1997).

According to Gumaer (as cited in Margot & Warren, 1996), there is no better environment for youth to learn in than within their peer group, and as such, counsellors working in the school settings can maximize student's learning through group experiences. Nassar-McMillan and Cashwell (1997) stated that many different types of group counselling interventions have been successfully utilized with adolescents with a higher likelihood of experiencing low self-esteem. To support this assertion, Margot and Warren (1996) compared the effectiveness of individual versus group therapy focused on increasing self-esteem for 37, 12 to 15 years old male and female adolescents who had experienced verbal abuse. They found significantly higher levels of self-esteem among participants in the group counselling condition, when compared to the individual counselling condition one week after the counselling sessions had ended. In another such study, Hong, Lin, Wang, Chin, and Yu (2012) tested the effectiveness of a functional group counselling intervention on 43 low achieving students' self-worth and self-efficacy. They found that group counselling in a school setting was found to be enjoyable to students and provided an atmosphere that had the ability to promote positive student-to-student learning. More importantly, Hong and colleagues (2012) found that the 43 students that participated in the functional group counselling intervention had significantly improved levels of self-worth and self-efficacy when compared to their peers that did not complete the functional group counselling.

To get a bigger picture of the effectiveness of group counselling interventions in increasing self-esteem in adolescents, Haney and Durlak (1998) conducted a meta-analytic review of 116 studies focused on different therapeutic modalities to increase

children and adolescent self-esteem. Of these studies, 84.5% were delivered to groups of children or adolescents. Haney and Durlack (1998) concluded from their review that: (a) significant improvements were not likely to happen if the intervention was not focused specifically on increasing self-esteem; (b) although the majority of participants appeared to benefit from intervention focused directly on increasing self-esteem, there were differences found in types of presenting problem; and (c) intervention programs guided by a specific theoretical background and using evidence-based interventions were more likely to demonstrate successful outcomes.

This information is essential to the development of group counselling aimed to increase self- esteem in 15-18 years old, as it demonstrates the success of group therapy modalities, calls for a direct focus on self-esteem, and denotes the importance of anchoring this group program within a specific therapeutic background, utilizing evidence-based interventions.

Core Objectives

1. Develop an improved sense of self-esteem
2. Develop stress management and coping strategies for self-esteem
3. Identify personal positive attributes and strengths
4. Recognize the power in personal choices

Practical Considerations: The group will consist of approximately 6-8 male and female student of Senior High School, aged 15-18 years old. The group will be facilitated by a male therapist. The group will meet each Wednesday during after school 4:30 pm to 5:30 pm in the counseling department. The group will commence during the second week of the first semester. This schedule will allow for 10 sessions. The group will be a closed one. Termination session will be announced to the participants 4 weeks to the time.

Procedures: Interested students will participate in a short (30 minutes) screening process. Potential participants will be given an opportunity to discuss their expectations of such a group, including any issues or concerns. The counselor will disclose the intended nature of the group. The screening process is important for both the participant and the counselor. It allows participants to make an informed choice in deciding whether or not to join the group. It also provides the counselor with a chance to control group dynamics to some extent. The counselor will assemble a group composed of members whose needs are compatible with the group and whose well-being will not be jeopardized by the group experience. In addition, the counselor may seek members with varying degrees of personality (extroverted and introverted). Chosen members will be asked to consent to join the group. The counsellor will utilize individual consent forms.

The counselor will attempt to create a balanced partnership between group process and content. The group will begin with a pre-group preparation meeting. It is during the pre-group meeting that the leader and members will clarify expectations of the group and discuss therapeutic groups in general. The leader will also use this period to explain basic ground rules (respecting members, importance of confidentiality, not becoming intimately involved with other members, etc.) and allow members an opportunity to discuss group norms they would like to establish. Finally, the leader will administer a brief pre-group written evaluation pertaining to members' current self-reported attitudes and social interactions.

The initial group sessions will focus on establishing cohesion among the group members. Group norms and expectations will be reviewed. Warm-up activities, such as "checking in", singing songs, and getting to know one another activities will be utilized in an effort to become acquainted, develop trust, and link group members

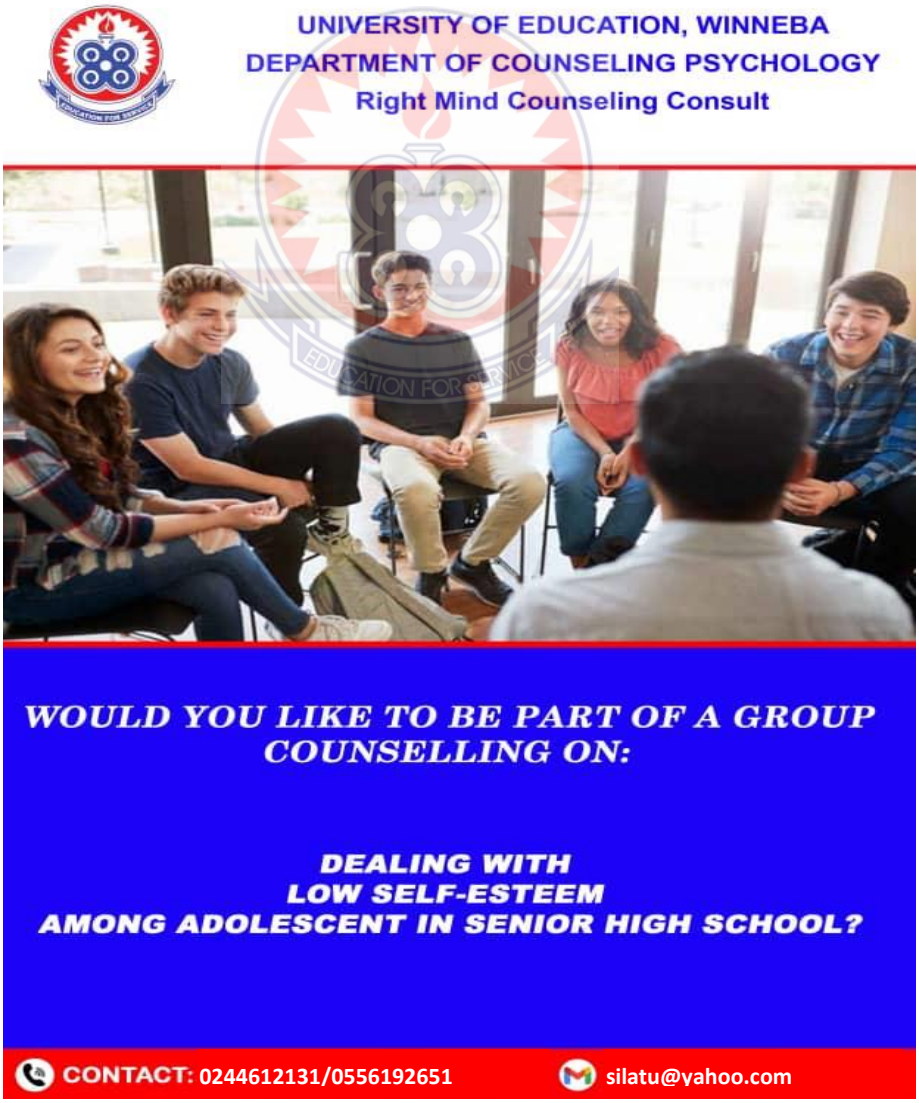
together. The leader will encourage participation and model appropriate behavior to group members. These behaviors will include actively listening, respecting all members, exhibiting empathy, authenticity, appropriate self-disclosure, and giving or receiving feedback when appropriate. The leader will also help members to define personal goals they hope to accomplish during the course of the group experience.

As group members transition into the action phase, they take responsibility to actively address common concerns and issues of low self-esteem. The group leader will continue to open and close sessions. However, members will be primarily responsible for generating the focus of group discussions. Anticipated topics may include issues such as causes, effects, and coping strategies for low self-esteem. The leader may also utilize Rational Emotive Behavior Therapy – teaching REBT A-B-C, teaching coping self-statements, active disputation of irrational beliefs, and home works. The group leader will attend to the here-and-now and facilitate the appropriate expression of self-disclosure, caring, confrontation and feedback as members address important issues.

Several sessions will be devoted to the termination of the group. The central goals of the termination phase are to allow members an opportunity to honor and reflect on their group experience and the gains they have made during the course of the school semester. Group tasks will include giving support, addressing unfinished business, and discussing group and individual growth. In saying goodbye during the final session, the leader and members will engage in disclosing any regrets, resentments and appreciations of themselves and fellow group members. Members will also complete a post-test identical to the written evaluation administered during the pre-group session.

Evaluation: Terminating the group four weeks prior to the end of the semester will allow sufficient time to conduct individual 20 minutes' follow-up interviews and observation on each group member. The post group interview will be used to assist the leader in determining the types and degrees of benefits the support-therapy group has provided to participants. The individual's pre and post evaluation will be discussed. Members will discuss the degree to which they have accomplished their stated goals, whether the group met their expectations, and what the group has meant to them personally.

Artifact 2 **Group Counselling Advertisement Poster**



5.7 Practicum

This course gave me the opportunity to practice what I have learnt in both individual and group counselling and applying the theories and the techniques. Various stages in counselling were highlighted. I was exposed to more techniques and qualities of a good counsellor. Note taking and confidentiality are very important in counselling, and also ensuring how good rapport is created in every session.

Artifact 1 **INTAKE FORM**

Counsellor's Name: Mrs. Aminu

Client's Name: musah

Gender: male

Marital Status: Married

Major Language: English

General Appearance: Client was well dressed and slim in nature. The client is about 1.70 meters tall.

Presenting Problem: Client started his narration by saying "its hurts but I kept it to myself for sometimes now" client met the wife and just a year, they got married. Prior to the marriage client said I realized "the mother feels uncomfortable around me. She doesn't like me". He noted that they dated for one year and married for 4 years now. He knows the mother-in law for 3 or 4 months to their marriage but knew the wife earlier because they stay in the same town. Client mentioned that the in-laws were no longer together as spouse, and as a result the mother in-law has not married for the past 20 years, probably more than. "She doesn't like the marriage, she doesn't have a good relationship with me, she feels I have taken the daughter from her". Some sort of "jealousy" between us and sees one as a "rival". Client stated that he doesn't think financial issue is the source of the problem because the mother-in-law is working and

the three children she has, are grownups. He said the problem might be the wife's inability to visit her mother very often as she used to do because she is closer to her mother. The client said that after their marriage the mother-in-law planned to stay with them which he objected to, citing a reason of privacy and the marriage being too young for that. He stopped her by renting one-bedroom apartment. Client said her mother-in law has shown her dislike for him even in public and said all manner of things about him to other family members. Her attitude got me "worried and is a bit hurting". Client said he has tried not to get into conversation about this issue with the wife to avoid creating any problem. Likewise, he has never discussed the issue with the mother-in law herself, though he discussed it with the father-in law whom he has a very good relationship with. Client noted, "my fear for not taking any step is that she might have come with the proposal of staying with us again". The clients have pledged to take the necessary step to talk to the wife on the issue and if possible, the mother-in law.

Artifact 2 Group Work in a Practicum Class

5.8 The Brain

This course exposed me to various mental disorders that people suffered from. It also gave me fair understanding of their classifications, symptoms, comorbidity, etiology of these disorders, cultural and gender differential, and how they can be treated. I infer from this course that everybody has one mental disorder or the other.

Artifact 1 **SCHIZOPHRENIA SPECTRUM**

SCHIZOPHRENIA PATIENT

Introduction to Psychopathology

Derived from the Greek words 'schizo' (splitting) and 'phren' (mind) with the term first coined by Eugen Bleuler in 1908, schizophrenia is a psychotic disorder characterized by the presence of delusional beliefs, hallucinations, and disturbances in thought, perception, and behavior. These disorders are serious mental disorder in which people interpret reality abnormally. Psychotic disorders may result in some

combination of hallucinations, delusions, and extremely disordered thinking and behavior that impairs daily functioning, and can be disabling. People with schizophrenia spectrum require lifelong treatment. Early treatment may help get symptoms under control before serious complications develop and may help improve the long-term outlook.

Symptoms

Traditionally, schizophrenia symptoms have been divided into two main categories:

1. Positive Symptoms
2. Negative Symptoms

Positive Symptoms

- Hallucinations,
- Delusions
- Grossly disorganized or abnormal motor behavior (including catatonia)

Delusions: These are false beliefs that are not based in reality. For example, you think that you're being harmed or harassed; certain gestures or comments are directed at you; you have exceptional ability or fame; another person is in love with you; or a major catastrophe is about to occur. Delusions occur in most people with schizophrenia.

Hallucinations: These usually involve seeing or hearing things that don't exist. Yet for the person with schizophrenia, they have the full force and impact of a normal experience. Hallucinations can be in any of the senses, but hearing voices is the most common hallucination.

Disorganized thinking (speech): Disorganized thinking is inferred from disorganized speech. Effective communication can be impaired, and answers to questions may be

partially or completely unrelated. Rarely, speech may include putting together meaningless words that can't be understood, sometimes known as word salad.

Extremely disorganized or abnormal motor behavior: This may show in a number of ways, from childlike silliness to unpredictable agitation. Behavior is not focused on a goal, so it is hard to do tasks. Behavior can include resistance to instructions, inappropriate or bizarre posture, a complete lack of response, or useless and excessive movement.

Negative symptoms: Negative symptoms account for a substantial portion of the morbidity associated with schizophrenia but are less prominent in other psychotic disorders. Two negative symptoms are particularly prominent in schizophrenia:

- diminished emotional expression
- avolition.

- **Diminished emotional expression:** It is reductions in the expression of emotions in the face, eye contact, intonation of speech (prosody), and movements of the hand, head, and face that normally give an emotional emphasis to speech.

- **Avolition**: This is a decrease in motivated self-initiated purposeful activities. The individual may sit for long periods of time and show little interest in participating in work or social activities.

Other negative symptoms include;

- alogia,
- Anhedonia
- Asociality

The diagnosis of schizophrenia spectrum is clinical, made exclusively after obtaining a full psychiatric history and excluding other causes of psychosis.

Classification

- Schizotypal(personality) Disorder
- Delusional Disorder
- Brief Psychotic Disorder
- Schizophreniform Disorder
- Schizophrenia
- Schizoaffective Disorder
- Substance Induced Psychotic Disorder
- Catatonia With Another Medical Disorder
- Catatonic Disorder Due to Another Medical Condition

Schizotypal Disorder 301.22 (F21)**:** A pervasive pattern of social and interpersonal deficits marked by acute discomfort with, and reduced capacity for, close relationships as well as by cognitive or perceptual distortions and eccentricities of behavior, beginning by early adulthood and present in a variety of contexts, as indicated by five (or more) of the following:

1. Ideas of reference (excluding delusions of reference).

2. Odd beliefs or magical thinking that influences behavior and is inconsistent with subcultural norms (e.g., belief in clairvoyance, telepathy, or "sixth sense"; in children and adolescents, bizarre fantasies or preoccupations).

3. Unusual perceptual experiences, including bodily illusions.

4. Odd thinking and speech (e.g., vague, circumstantial, metaphorical, overelaborate, or stereotyped).

5. Suspiciousness or paranoid ideation.

Delusional Disorders: The presence of one (or more) delusions with a duration of ONE (1) month or longer.

The disturbance is not attributable to the physiological effects of a substance or another medical condition and is not better explained by another mental disorder, such as body dysmorphic disorder or obsessive-compulsive disorder.

Types of schizophrenia

Erotomanic type: This subtype applies when the central theme of the delusion is that another person is in love with the individual.

Grandiose type: This subtype applies when the central theme of the delusion is the conviction of having some great (but unrecognized) talent or insight or having made some important discovery.

Jealous type: This subtype applies when the central theme of the individual's delusion is that his or her spouse or lover is unfaithful

Persecutory type: This subtype applies when the central theme of the delusion involves the individual's belief that he or she is being conspired against, cheated, spied on, followed, poisoned or drugged, maliciously maligned, harassed, or obstructed in the pursuit of long-term goals. **Somatic type:** This subtype applies when the central theme of the delusion involves bodily functions or sensations.

Brief Psychotic Disorder

Presence of one (or more) of the following symptoms. At least one of these must be (1), (2), or (3):

1. Delusions.
2. Hallucinations.
3. Disorganized speech (e.g., frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior

Duration of an episode of the disturbance is at least 1 day but less than 1 month, with eventual full return to premorbid level of functioning.

Schizophreniform

Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be (1), (2), or (3):

1. Delusions.
2. Hallucinations.
3. Disorganized speech (e.g., frequent derailment or incoherence).
4. Grossly disorganized or catatonic behavior.
5. Negative symptoms (i.e., diminished emotional expression or avolition)

- An episode of the disorder lasts at least 1 month but less than 6 months.
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug of abuse, a medication) or another medical condition

Schizophrenia

Two (or more) of the following, each present for a significant portion of time during a 1-month period (or less if successfully treated). At least one of these must be

(1), (2), or (3):

1. Delusions.

2. Hallucinations.

3. Disorganized speech (e.g., frequent derailment or incoherence).

4. Grossly disorganized or catatonic behavior.

5. Negative symptoms (i.e., diminished emotional expression or avolition)

Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least:

- Continuous signs of the disturbance persist for at least 6 months. This 6-month period must include at least 1 month of symptoms
- The disturbance is not attributable to the physiological effects of a substance (e.g., a drug abuse, a medication) or another medical condition.

Individuals with schizophrenia may display inappropriate affect (e.g., laughing in the absence of an appropriate stimulus); a dysphoric mood that can take the form of depression, anxiety, or anger; a disturbed sleep pattern (e.g., daytime sleeping and nighttime activity); and a lack of interest in eating or food refusal. Depersonalization, derealization, and somatic concerns may occur and sometimes reach delusional proportions.

Schizoaffective Disorder: An uninterrupted period of illness during which there is a major mood episode (major depressive or manic) concurrent with Criterion A of schizophrenia.

Delusions or hallucinations for 2 or more weeks in the absence of a major mood episode (depressive or manic) during the lifetime duration of the illness.

Specify whether: 295.70 (F25.0) Bipolar type: This subtype applies if a manic episode is part of the presentation.

Major depressive episodes may also occur.

295.70 (F25.1) Depressive type: This subtype applies if only major depressive episodes are part of the presentation.

Substance/Medication-Induced Psychotic Disorder

Presence of one or both of the following symptoms:

1. Delusions.

2. Hallucinations.

There is evidence from the history, physical examination, or laboratory findings of both (1) and (2):

The disturbance is not better explained by a psychotic disorder that is not substance/ medication-induced. Such evidence of an independent psychotic disorder could include the following:

The symptoms preceded the onset of the substance/medication use; the symptoms persist for a substantial period of time (e.g., about 1 month) after the cessation of acute withdrawal or severe intoxication; or there is other evidence of an independent non-substance/medication-induced psychotic disorder (e.g., a history of recurrent non-substance/medication-related episodes).

Psychotic Disorder Due to Another Medical Condition

Prominent hallucinations or delusions.

There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.

- The disturbance is not better explained by another mental disorder.
- The disturbance does not occur exclusively during the course of a delirium.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Catatonia Associated with another Mental Disorder (Catatonia Specifier)

Catatonia is defined by the presence of three or more of 12 psychomotor features in the diagnostic criteria for catatonia associated with another mental disorder and catatonic disorder due to another medical condition.

The clinical picture is dominated by three (or more) of the following symptoms:

1. Stupor (no psychomotor activity; not actively relating to environment).

2. Catalepsy (passive induction of a posture held against gravity).

3. Waxy flexibility (slight, even resistance to positioning by examiner).

4. Mutism (no, or very little, verbal response [exclude if known aphasia]).

5. Negativism (opposition or no response to instructions or external stimuli). 6. Posturing (spontaneous and active maintenance of a posture against gravity).

6. Posturing (spontaneous and active maintenance of a posture against gravity).

7. Mannerism (odd, circumstantial caricature of normal actions).

8. Stereotypy (repetitive, abnormally frequent, non-goal-directed movements).

9. Agitation, not influenced by external stimuli.

10. Grimacing (an ugly twisted on a person's face)

11. Echolalia (mimicking another's speech).

12. Echopraxia (mimicking another's movements).

Catatonic Disorder Due to another Medical Condition

The clinical picture is dominated by three (or more) of the following symptoms:

1. Stupor (no psychomotor activity; not actively relating to environment).

2. Catalepsy (passive induction of a posture held against gravity).

3. Waxy flexibility (slight, even resistance to positioning by examiner).

4. Mutism (no, or very little, verbal response [Note: not applicable if there is an established aphasia]).

5. Negativism (opposition or no response to instructions or external stimuli).

6. Posturing (spontaneous and active maintenance of a posture against gravity).

7. Mannerism (odd, circumstantial caricature of normal actions).

8. Stereotypy (repetitive, abnormally frequent, non-goal-directed movements).

9. Agitation, not influenced by external stimuli.

10. Grimacing.

11. Echolalia (mimicking another's speech).

12. Echopraxia (mimicking another's movements)

- There is evidence from the history, physical examination, or laboratory findings that the disturbance is the direct pathophysiological consequence of another medical condition.
- The disturbance is not better explained by another mental disorder (e.g., a manic episode).
- The disturbance does not occur exclusively during the course of a delirium.
- The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Etiology

The cause of schizophrenia is unknown, but it is usually a combination of the following factors:

- Genetics
- Brain chemistry
- Complications at birth
- Some people develop schizophrenia following a stressful event, such as the death of a loved one or the loss of a job.

Genetics

- Schizophrenia spectrum tends to run in families, but no single gene is thought to be responsible.
- It is more likely that different combinations of genes make people more vulnerable to the condition. However, having these genes does not necessarily mean you'll develop any of the disorders.

Brain Chemistry

- Studies of people with schizophrenia spectrum have shown there are subtle differences in the structure of their brains.
- These changes are not seen in everyone with schizophrenia and can occur in people who do not have a mental illness. But they suggest schizophrenia spectrum may partly be a disorder of the brain.

Birth complications

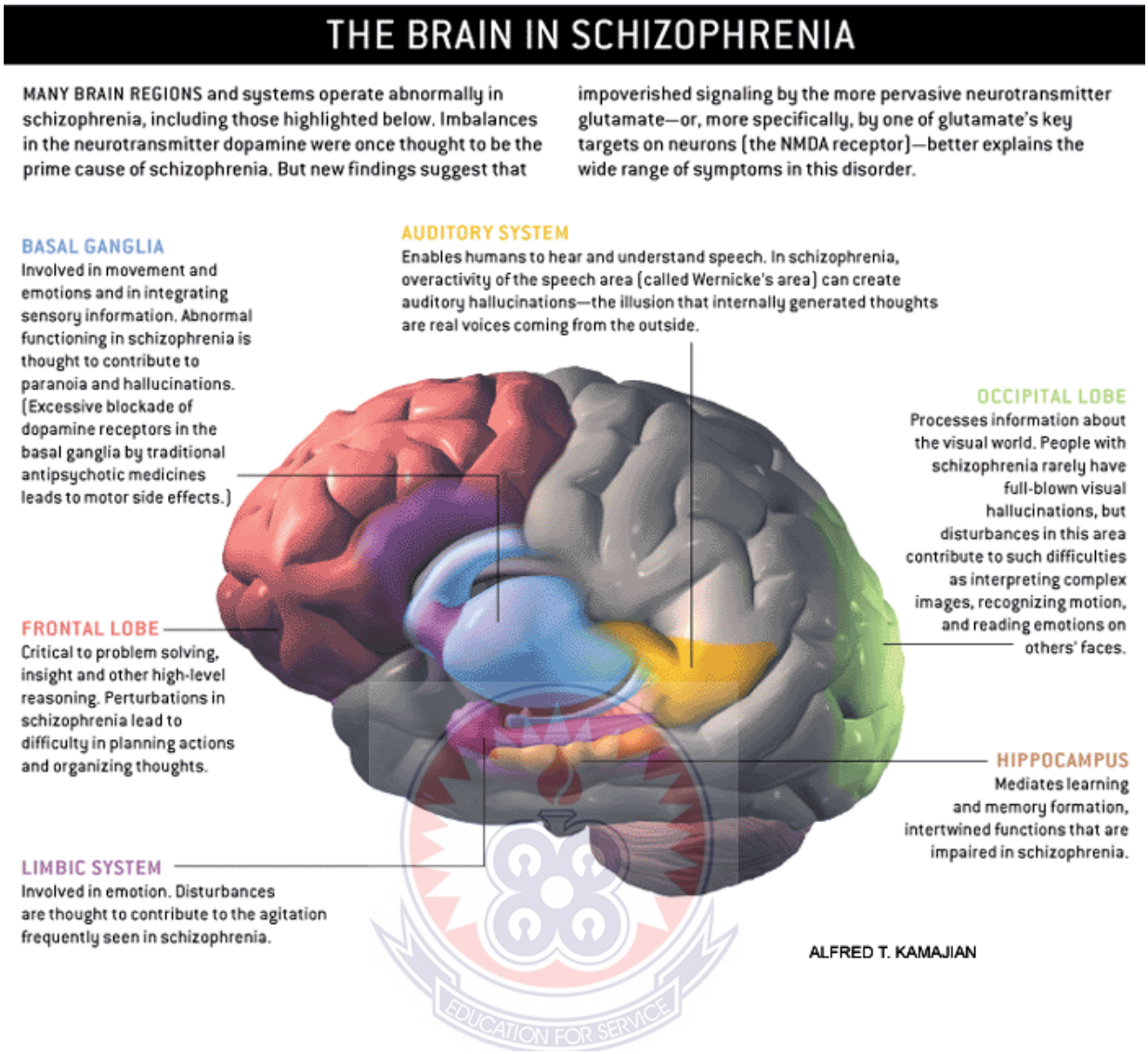
Research has shown that people who develop schizophrenia are more likely to have experienced complications before and during their birth, such as:

- a low birthweight
- premature labour
- a lack of oxygen (asphyxia) during birth

It may be that these things have a subtle effect on brain development.

Experiences like growing up in a town or city, stressful life events and moving to a new town or country can also trigger symptoms of any of the disorders.

There’s also a strong link between the use of strong cannabis and the development of some schizophrenia spectrum.



COMORBIDITY

- Anxiety
- personality disorder
- Mood disorders
- Obsessive-compulsive disorder
- Panic disorder

Deferential Diagnosis

- Obsessive-compulsive disorder and body dysmorphic disorder
- Posttraumatic stress disorder
- Substance-related disorders

- Malingering and factitious disorders.
- Depressive and bipolar disorders

Gender Consideration

- A number of features distinguish the clinical expression of schizophrenia spectrum in females and males. The general incidence of schizophrenia spectrum tends to be slightly lower in females, particularly among treated cases. The age at onset is later in females, with a second mid-life peak as described.
- Symptoms tend to be more affect-laden among females, and there are more psychotic symptoms, as well as a greater propensity for psychotic symptoms to worsen in later life.
- Symptoms can vary in type and severity over time, with periods of worsening and remission of symptoms. Some symptoms may always be present.
- In men, schizophrenia spectrum symptoms typically start in the early to mid-20s. In women, symptoms typically begin in the late 20s. It's uncommon for children to be diagnosed with schizophrenia and rare for those older than age 45.
- Cultural and socioeconomic factors must be considered, particularly when the individual and the clinician do not share the same cultural and socioeconomic background. Ideas that appear to be delusional in one culture (e.g., witchcraft) may be commonly held in another. In some cultures, visual or auditory hallucinations with a religious content (e.g., hearing God's voice) are a normal part of religious experience.
- In addition, the assessment of disorganized speech may be made difficult by linguistic variation in narrative styles across cultures.

- The assessment of affect requires sensitivity to differences in styles of emotional expression, eye contact, and body language, which vary across cultures.
- If the assessment is conducted in a language that is different from the individual's primary language, care must be taken to ensure that alogia is not related to linguistic barriers.
- In certain cultures, distress may take the form of hallucinations or pseudo-hallucinations and overvalued ideas that may present clinically similar to true psychosis but are normative to the patient's subgroup

Treatment

- There is no cure for this disorder, but with the right treatment, it is possible to limit symptoms and reduce the chances of further episodes.
- Everyone's experience of schizophrenia is different. It may become better before worsening, you may have episodes of being unwell, or its effects may be more constant.

Medication

- A psychiatrist may offer you antipsychotic medications to treat some of the disorders.
- These help to reduce the symptoms, but will not cure it.
- Some of the medications may include but not limited to;
- Aripiprazole (Abilify)
- Asenapine (Saphris)
- Brexpiprazole (Rexulti)
- Cariprazine (Vraylar)

- Clozapine (Clozaril, Versacloz)
- Iloperidone (Fanapt)
- Lurasidone (Latuda)

Psychosocial interventions: Once psychosis recedes, in addition to continuing on medication, psychological and social (psychosocial) interventions are important. These may include:

- **Individual therapy.** Psychotherapy may help to normalize thought patterns. Also, learning to cope with stress and identify early warning signs of relapse can help people with schizophrenia manage their illness.
- **Social skills training.** This focuses on improving communication and social interactions and improving the ability to participate in daily activities.
- **Family therapy.** This provides support and education to families dealing with schizophrenia.
- **Vocational rehabilitation and supported employment.** This focuses on helping people with schizophrenia prepare for, find and keep jobs.

Arts therapies

- Art therapy can help learn new ways of relating to other people, show how you are feeling, accept your feelings, and understand your feelings.

Cognitive behavioural therapy (CBT)

CBT aims to help you understand links between your thoughts, feeling and actions. CBT will look at your symptoms and how they affect your life, and also at your perceptions and beliefs. CBT improves awareness of your episodes and gives you ways of coping with stress and other symptoms.

Self-care: Self-care and management skills can help you to understand and overcome symptoms of schizophrenia.

- **Self-care focuses on:**
- Exercise
- Diet
- Relationships
- Daily routines
- Taking medication

Conclusion

- Schizophrenia spectrum is a complex, heterogeneous, and disabling psychiatric disorders that disrupts cognitive, perceptual, and emotional functioning. The clinical, pharmacological, and neurobiological profiles of comorbid conditions in schizophrenia spectrum have been extensively explored in recent years. However, the diagnostic and treatment issues of coexisting or overlapping psychiatric symptoms and disorders in schizophrenia spectrum remain poorly understood and clinically challenging.

Artifact 2 **Interview Transcription of Psychological Distress Market Woman**

Interviewer: How older are you?

Interviewer: I'm 79 years

Interviewer: Oh! We thank God.

Interviewer: Please, are you female

Interviewer: Please, are a female?

Interviewee: Yes.

Interviewer: Where do you come?

Interviewer: I'm a Krabo from Somanya Eastern Region

Interviewer: Please have you married?

Interviewer: I have married but I've lost my husband.

Interviewer: So, are you alone now?

Interviewee: Yes.

Interviewer: Please, how many children do you have?

Interviewee: I've lost two children, left with two

Interviewer: Whatever about your grandchildren?

Interviewee: I've six grandchildren.

Interviewer: Please, do you have any health challenge?

Interviewee: Yes. I've high blood pressure and diabetes.

Interviewer: Please, for how many years now you have been with these challenges?

Interviewee: For the B.P is 10 years, and the diabetes 1 year

Interviewer: please, what do you sell?

Interviewee: I sell yam and oil but now we don't get the oil, so I sell yam and onion now.

Interviewer: What causes much stress in this market?

Interviewee: Is money issue.

Interviewer: Do other market women cause you stress?

Interviewee: No. I don't stress anybody, so nobody stress

Interviewer: So, do the market queen give you stress?

Interviewee: No. The market queen passed on and somebody have been appointed to be holding the fort until substantive is appointed.

Interviewer: So, the one in charge has she being giving you stress?

Interviewee: No.

Interviewer: Do your customers give you stress?

Interviewee: No. The only thing is when they ask of the price and you mentioned it, they will be asking for price reduction.

Interviewer: So, do some people buy the yam and refuse to pay?

Interviewee: As for this, is only some students. I was there when a student came that he has nothing to eat so I should give him a yam and he'll come and pay later but never came back. I was there, then another one also came, and I don't know whether they've planned it. He said, ma, we are four and we've no money on us. I looked through and gave him two (2) big tubers of yam. He went and never came back. This is what I can say.

Interviewer: Okay

Interviewer: Are you saying money issue is a problem?

Interviewee: Yes.

Interviewer: Please, is somebody in the family giving you stress?

Interviewee: No.

Interviewer: Do any spiritual issue give you stress?

Interviewee: Spiritual issue like what?

Interviewer: Somebody put charm at where you sell.

Interviewee: No. I don't think evil about anybody so I don't think somebody will think evil about me.

Interviewer: Thank God.

Interviewer: I hope you said earlier that you have BP and diabetes as a health challenge?

Interviewee: Yes.

Interviewer: Do your health challenge give you emotional pain?

Interviewee: No. The issue is I visit the hospital regularly. When they prescribe drugs for me, I make sure I find money to buy it.

Interviewer: When you sleep, do you sleep well?

Interviewee: Not always I sleep well, because of my sickness. At times the BP worries me.

Interviewer: Do you suffer depression as a result of these sickness?

Interviewee: No. I don't think about it because I'm not alone in this situation and the only thing I do is pray to God and ask for grace.

Interviewer: Mummy thank you! Thank God.

Interviewer: Do lack concentration?

Interviewee: Yes. For lack of concentration is there. I can put something down right now and forget.

Interviewer: Please do experience so much fatigue on the work?

Interviewee: Yes. The work actual involves so much fatigue. When you go to market and buy goods, carrying and packing it on truck involves a lot of fatigue. At time when I come back, I will be tired.

Interviewer: Do you shed tear at time looking at situation?

Interviewee: No. I've never thought of it before.

Interviewer: Do you breathe well?

Interviewee: Yes, I do.

Interviewer: Do you have appetite when eating?

Interviewee: I eat well except maybe I'm attacked by malaria.

Interviewer: Do you visit the hospital frequently?

Interviewee: Yes, I do.

Interviewer: Do experience anxiety or panic attacks?

Interviewee: No. only once when someone shouted when I'm not aware.

Interviewer: Do you experience dizziness?

Interviewee: Sometimes. But when I went to the hospital it was attributed to the BP.

Interviewer: How do you assist or support other market women or men who are going through stress like financial difficulty so that they can be mentally healthy?

Interviewee: If somebody comes to me, I do give the person advice so that his heart will be peace. If is debt I encourage the person to be paying a bit by bit as he or she sells.

Interviewer: Do you know some market women or men going through stress?

Interviewee: Because of the money problem, a lot of people are going through stress.

Interviewer: How do this people cope? Do they talk to someone in the market or at home?

Interviewee: Some may talk to their friends and relatives. Others also keep it to themselves. Some also talk to the market queen.

Interviewer: Do you have a counsellor in the market when someone is going through stress, he/she can be directed to him or her?

Interviewee: Is only the market queen that issues are directed to. These issues are also market related issues

Interviewer: Do you want a counsellor in the market here?

Interviewee: Yes. We want one.

Interviewer: Ma, thank you, God bless you and give you long life.

Interview Analysis of Psychological Distress Market Woman

A. Age: 79years

B. Gender: female

C. Marital status: single (widow)

D. Number of children: 2

E. What she sells: yam, oil and onion

F. How long she has been selling in the market: over 30 years.

G. Health related problem: high blood pressure and diabetes.

H. Sources of stress

   i. Health related problem

   ii. Issue of finance for her business and fatigue

I. Effects of the stress: Insomnia, mild neurocognitive disorder and anxiety. “Not always I sleep well, because of my sickness. At times the BP worries me. “Yes. For lack of concentration is there. I can put something down right now and forget”. “Yes. The work actual involves so much fatigue. When you go to market and buy goods, carrying and packing it on truck involves a lot of fatigue. At time when I come back, I will be so much tired”.

J. Coping mechanism

   Client has a strong positive self-talk as a strategy for handling her present condition. She is also taking her medication and go for regular check-up. “No. I don’t think about it because I’m not alone in this situation and the only thing I do is pray to God and ask for grace”.

5.9 Crisis-Suicide, Abuse and Trauma Counselling.

This course revealed the various crisis and abuses people suffered that can result in trauma. It also helps me to explore my childhood trauma and its effects in adulthood through a reflection paper on my trauma history. I was exposed to trauma theories and intervention modalities, and relevance of self-care in trauma counselling.

Artifact 1 **Reflection Paper on My Personal Trauma History**

Abstract

Exposure to dead bodies in any form can be very traumatic when not handled properly. Victims of this circumstances may suffer significant psychological stressors or post-traumatic stress disorders. Reflecting on my personal trauma history is aimed at helping me identified my post-traumatic stress disorders which include flash back, nightmare, fright and many more. The reflection is also aimed at unmasking how I handle my traumatic experience in the past. Furthermore, it is aimed at determining how my past experience had affected me presently and the implication on my future profession as counsellor. The reflection will also reveal the appropriate psychotherapy that might have been used to assist me in case I were to be in therapy.

Self-Reflection on My Personal Trauma History

I can recall my personal trauma experience dated back to my childhood period when I was 11 years old. During that period, taking corpse or dead body to the mortuary was not common as it is today. Traditionally, when someone dies and cannot be buried immediately, some herbs are usually grinded and smeared on the dead body. The body is then put in a corner in a room for preservation for some few days before burial because he was imam and chief.

There was an uncle of mine who died, and was preserved this way and put in a corner in particular room which I did not know. I was looking for something and went to open that door. Seeing the dead body in the corner caused me to shout loudly and became unconscious, I felt so frightened to the extent that I became ill. Sleeping had become a challenge to me because anytime I closed my eyes, my dead uncle's dead body would appear. My mind was re-experiencing trauma events with negative thoughts, I was feeling removed from my own body, and re-experiencing that seeing in my mind, nightmare had become part of me anytime I sleep.

In fact, this traumatic experience had been with me until few years ago. As result of this, I don't see corpse or dead body during those periods. Hearing that somebody is dead alone would even put me off and fear would take a better part of me. For more than 20 years I have not seen a dead body until my father died in 2019 where I have no choice than to get closer to his dead body.

The Impact of My Trauma History on My Present Life

Initially, I found it very difficult to overcome my phobia and the other forms of disorders that I was going through. I gradually overcome this traumatic experience when I became a were of myself or fully Matured person and being an Islamic tutor . Burial of dead bodies is core mandate of any muslim who had knowledge about the religion my duties. At the initial stage, I couldn't find it easy but as I continue to perform burial services time and again, I became used to dead bodies without much phobia and anxiety. However, the scene always flashed my mind when I am carrying out burial exercise but do not give me any mental imbalance. Presently, I can say I am more mentally stable.

Impact on My Experimental Practice

This reflection had revealed to me that anybody can suffer from trauma and post-traumatic disorders if not treated early. This also mean that client's present traumatic experience can be traced to his/her childhood period. It is important to note that, though I was not taken through therapy deliberately, my continuous exposure to dead bodies because of my obligation as malama had helped me. Connecting it to my knowledge gained so far in guidance and counselling revealed to me that I was going through healing gradually any time I'm exposed to dead body. This is a therapy in counselling known as prolonged exposure therapy which is a form of cognitive behavior therapy that can be used to treat traumatic problems.

It is important to acknowledge the fact that, my post-traumatic stress disorders suffered would have been avoided if I were exposed to psychotherapy. Prolonged exposure therapy which is a form of cognitive behavioral therapy would have assisted me to gradually approach my trauma memories and feelings better than I did.

Artifact 2 **How to Use Somatic Experiencing Therapy Focus Intervention Modalities to Treat Trauma Associated with Sexual Dysfunction in Men**

Definitional Issues of the Therapy Focus Intervention Modality

Somatic experiencing is a method of alternative therapy for treating trauma and stressor-related disorders like PTSD. The primary goal of SE is to modify the trauma-related stress response through bottom-up processing (Wikipedia).

Somatic Experiencing sessions involve the introduction of small amounts of traumatic material and the observation of a client's physical responses to that material, such as shallow breathing or a shift in posture.

In somatic therapy, these sensations, along with things like crying, shaking, or shivering, are considered to be a discharge of the energy trapped in your body. Your therapist might also help you use specific breathing or relaxation techniques to help you process and release the trauma (Legg T. J, 2020)

We have found that the trauma recovery model developed by Dr. Peter A. Levine called Somatic Experiencing (SE) is one of the most effective tools for the healing of traumatic life events. SE is a relatively short-term, somatically based approach to the healing and resolution of trauma. (Heller D. P, Heller L 2004). SE is based on a generalized psychobiological model of resilience (Levine, 1997). According to SE, post-traumatic stress symptoms originate from a permanent overreaction of the innate

stress system due to the overwhelming character of the traumatic event. In the traumatic situation, people are unable to complete the initiated psychological and physiological defensive reaction (e.g., prolonged freeze instead of fight or flight; Levine, 1997). This leads to a persistent somatic and emotional dysregulation of the nervous system and results in the chronically increased stress reaction that is observed in clients with PTSD. Therefore, the primary goal of SE is to modify the trauma-related stress response (Ogden & Minton, 2000).

To achieve this, its major interventional strategy builds on bottom-up processing. Clients' attention is directed to internal sensations, both visceral (interception) and musculoskeletal (proprioception and kinaesthesis), rather than to primarily cognitive or emotional experiences. This is an important divergence from cognitive-behavioral therapy that focusses primarily on the cognitive and emotional experience associated with the trauma. In doing this, clients are trained to gradually reduce the arousal associated with the trauma by increasingly tolerating and accepting the inner physical sensations and related emotions and by activating internal and external resources, such as identifying parts of the body or memories that are associated with a positive and reassuring feeling. The resulting increase in interoceptive and proprioceptive awareness leads to a 'discharge process' after which the trauma-related activation is resolved (Brom et al., 2017; Payne et al., 2015).

What is sexual dysfunction in males?

Sexual dysfunction is any physical or psychological problem that prevents you or your partner from getting sexual satisfaction. Sexual dysfunction in men can be classified as sexual desire disorders, sexual arousal disorders, organism disorders, sexual pain disorders.

Trauma and Issues of Sexual Dysfunction

Traumatized individuals may develop a sexual desire disorder with hypo-, hyper- or asexuality. Hypo sexuality is evidenced by low initiatory behavior, while hyper sexuality employs frequent sexual initiation as a means of dealing with most negative affective states, including loneliness, fear and sadness. Asexuality typically results from extreme fear of bonding with others, extreme narcissism which results in an inability to genuinely care for or empathize with others and/or severe repudiation of one's genitals, sexual arousal or gender. Often individuals with hypo-, hyper- and asexuality's will utilize imagery to distance themselves from others and thereby deal with fears of intimacy. Frequently hypersexual individuals will become hyposexual as their alexithymia is reversed, and they consciously experience fears related to bonding (Schwartz et al., 1995). Individuals with a history of sexual assault often experience subsequent sexual dysfunction.

Theory of Origin

Dr. Peter Levine developed Somatic Experience from his observations of how wild animals recover from repeated traumatic experiences like attacks by predators (imagine gazelles eluding a cheetah). What he noticed was, after a threat was gone, the animals experienced a physical release of their fight-or-flight energy by shaking, trembling, or sometimes running. He also saw that with completion of the physical release, they quickly returned to their normal state.

Dr. Levine believed that humans also possess the same ability to release physical energy from stress but often thwart it by "keeping it together" following trauma. We all probably have direct experience "keeping it together" through a difficult experience. Our ability to override what is an innate mechanism for self-care is for many of us what sets the stage for PTSD. By stopping this natural cycle of release, the

energy becomes stuck, in effect keeping us in a perpetual state of fight-or-flight so that we are unable to return to our relaxed, balanced state.

Somatic therapy techniques

A somatic therapist can use a few different techniques to help release trauma or negative emotions from the body. Here are some of the more common ones.

- **Grounding.** This is the act of connecting deeply to your body and the earth Grounding involves sensing the body, feeling your feet on the ground, and calming your nervous system. This is one of the first steps in learning to release tension from the body. The client learns to recognize and identify areas of tension in the body, as well as calming thoughts and feelings.
- **Resourcing.** This involves recalling resources in your life that make you feel safe, such as your relationships, personality strengths, or even a favourite vacation spot. It can include anything that makes you feel calm. You then recall the good feelings and sensations associated with your resources, which act as an emotional anchor.
- **Titration.** In this technique, the therapist guides you through a traumatic memory. You will be asked to observe any changes in your body that appear as you describe the memory. If you experience any physical sensations, the therapist will help you address them as they occur.
- **Pendulation.** In this technique, a therapist guides you from a relaxed state to one that feels similar to your traumatic experience. This may repeat several times, allowing you to release the pent-up energy. While the energy is released, you may feel uncomfortable or anxious. Each time, you will be

guided back to a relaxed state. Over time, you will learn to get into a relaxed state on your own.

- **Sequencing.** This involves paying close attention to the order in which sensations of tension leave your body. For instance, first you might feel a tightening in your chest and then in your throat. Then there may be a sensation of trembling as the tension leaves your body.

How The (TFIM) is used with The Associated Population

The somatic experience therapy can be employed with a combination of techniques in the treatment of trauma associated with sexual dysfunction in men. Body awareness or grounding is the commonest technique to begin with. This is where the counselor assists the client learn more about his automatic nervous system and the part it plays in his trauma response. This helps the client who feel confused about his response during the traumatic event of sexual dysfunction or believe he should have reacted differently. The therapist uses the following exercises or activities in grounding to help solve sexual dysfunction in men as a result of post-traumatic stress disorder. This includes put your hands in water, pick up or touch items near you, breathe deeply, take a short walk, savor a scent, move your body, feel your body, play a memory game, make yourself laugh, visualize a lovely task you enjoy, practice self-kindness, list favorites and visualize your favorites place.

In addition, resourcing technique is can also be applied. The counsellor will help the client access his innate strength, resilience and a sense of people. In this technique the client draws on his positive memories of a place, person or something he loves when he feels distressed or encounter something triggering. This will help the client stay calm and present the issues as he/she encounters trauma sensations or memories of the event.

Once the client is taken through resourcing, the counsellor will begin slowly revisiting the trauma and related sensations. It is a gradual process that allows the client to come to terms with and integrate each aspect of the event. It slows down the trauma to allow the client to handle it. As he begins slowly revisiting the trauma the therapist will track his response and the bodily sensations the trauma brings up. This is determined by watching client breathing or shift in tone of voice. This process is known as titration.

The client's body sensations go along with things like crying, shaking or shivering is considered to be a discharge of the energy trapped in his body. The counsellor in this case will help the client with breathing or relaxation exercises like pursed lip breathing, diaphragmatic breathing, breath focus, wins breath, alternate nostril breathing, equal breathing and deep breathing to help this process and release the trauma. The counsellor will help the client move from this aroused state to a calmer one using resourcing or other techniques. This process is known as pendulation.

How is it Relevant in Our Ghanaian Context?

Between January and April 2010, a cross-sectional study was conducted among subjects with various medical conditions in the Kumasi metropolis, Ghana. The study's age group consisted of people aged between 19 and 66. The prevalence of SD among study participants was 59.8%. Patients with ulcers had the highest prevalence of SD (100%), followed by patients who had undergone surgery (75%), diabetes (70%), hypertension (50%), STD (50%), and migraine patients (41.7%) (Amidu et al., 2010)

Sexual dysfunction is a public health issue that affects the overall quality of life of patients and their sexual partners (SD). In Ghana, this results in a loss of physical and

emotional intimacy, as well as, at times, divorce. Traditionally, male SD has been attributed to psychogenic factors; however, advances in pathophysiology research show that the majority of patients have vascular dysfunction. The vascular dysfunction could be caused by atherosclerotic lesions in the penile arteries, which result in decreased blood flow (Amidu et al., 2010).

Sexual dysfunction is common among Ghanaian men with medical conditions (about 60%) and men of advanced age. The highest prevalence of SD was found in ulcer patients (100%), followed by patients who had surgery (75%), diabetes (70%), hypertension (50%), STD (50%), and migraine patients (41.7%) (Amidu et al., 2010) Patients with Post-Trauma Stress Disorder were more likely to develop sexual dysfunction than those who did not have Post-Trauma Stress Disorder (Psychiatry, 2021).

From the literature it is obvious that men who suffer from post trauma stress disorder are also likely to experience sexual dysfunction. On this note, one can conclude that the trauma focused modality intervention which is somatic experience can equally be applied to clients with this problem in Ghana.

Conclusion

In conclusion it is obvious that Somatic Experience Therapy can be effectively used on the treatment of sexual dysfunction on men as a result of post trauma stress disorder. In using the therapy, techniques such as grounding, resourcing titration and pendulation can be applied to assist the client. It is worth noting also that some sexual dysfunction among men in Ghana came as result of post-traumatic stress disorder. Therefore, patients or clients must see therapist for assistance

5.10 Personal Reflections

Every journey in life has a begin and an end. Besides, every journey in life has ups and downs. This is the exact scenario that confronts me in my journey on MED guidance and counselling. Pursuing this course has not been easy for me financially, academically and psychologically. Paying fees, buying relevant course materials for study and meeting the financial obligations to my family was burdensome to me. Academically, I find it quite challenging to get the understanding in some of the courses and cope because I lack the foundation in some courses in counselling programmed. Also, I felt overwhelmed at times with the workload in terms of assignments, group works and presentations. As a result, my anxiety level increased and I felt stress up. During these periods, insomnia took over the better part of me.

In spite of the above challenges enumerated, I can confidently announce with boldness that guidance and counselling has impacted my life positively. The courses have not only exposed me to the psychosocial and emotional issues in my communities but also enabled me to get a deep understanding of humanity and why people behave the way they do. Walking through the entire course I came to appreciate the fact that counselling really is a helping profession. It is human centered and nothing more. has unmasked to me a lot of disorders that are associated with human beings. From this course I have realized that everyone has one or two disorders and I can figure out my disorder as well. Additionally, I have come to appreciate the fact that when people go through trauma and they have not been taking through therapy properly its consequences can be dire (PTSD).

Putting this portfolio together was like dream come true for me. From the begin, I could not figure out where to start from and where to end. One thing that kept me going over the period is perseverance to overcome every challenge no matter how it

seems to be insurmountable. I have learned to adjust and face life's challenges whenever they come my way with this quote "It's always too soon to quit!". Drawing my own family genogram and connecting it to my career was an amazing moment for me to behold.

To conclude, I can say I am leaving University of Education, Winneba better off than I came. I have a renewed mind to see things in different perspective. I am proud to be taught and mentored by world class men and women in academia. Blending my counselling knowledge with my career as a noble malama and a teacher, I am better place to impact lives positively.

5.11 Summary and Closing Remarks

I did not realize how much growth I would gain from being in this programme. If I had not come into the programme, I would have missed out a lot. Specifically, I have learned more about myself than I ever thought possible. I have also gained amazing friends in the programme who, hopefully, will become friends for life as well as professional colleagues. This Portfolio has indeed been a compilation of all the learnings I have acquired in this programme.

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