FIELD PRATICUM REPORT

CASE REPRESENTATON BASED ON SEMINARS, INDIVIDUAL AND GROUP COUNSELING SECTION COONDUCTED DURING THE COUNSELING FIELD PRATICUM

BY

AJANGA MICHELLE INGADO

BCP/2022/50667

THIS PRATICUM REPORT IS SUBMITTED IN PARTIAL FULLILMENT OF THE REQUIREMENT OF AWARD OF THE DEGREE IN COUNSELING PSYCHOLOGY AT MOUNT KENYA UNIVERSITY

2025

**Declaration and approval**

**Declaration**

This practicum report is my original work and, to the best of my knowledge, has not been submitted for examination at any other institution or university.

**Name:** Ajanga Michelle Ingado

**Reg No**: BCP/2022/50667

**Sign**…………………………………………………………. **Date**………………………………………………………………………………………

**Approval**

This practicum report has been submitted for examination with my approval as university supervisor.

**Name of supervisor**: Dr. Emmanuel Gitonga

**Signature**……………………………………………………..**Date**……………………………………………………………….

Department of Psychology

Mount Kenya University

**Dedication**

I dedicate this report to my beloved family and friends, whose an unwavering support, encouragement and understanding have been my greatness strength throughout this journey. Your presence both near and far, has inspired me to keep going even during the most challenging moments. I am deeply grateful for your love and belief in me.

**Acknowledgement**

I would like to express my heartfelt appreciation to everyone who supported me during my practicum journey as counselling psychology student. My sincere gratitude goes to Susan Gitau counselling foundation, the institution that gave me the opportunity to grow both professionally and personally. I am especially thankful to DR. Susan Gitau, whose guidance, wisdom and mentorship were instrumental throughout the practicum period. Special thanks also go to Madam Jane Ngigi the assistant supervisor who walked with me through my personal therapy journey with compassion and dedication.

To my classmates at Mount Kenya University, thank you for the support, warmth, and strength we shared. Learning from each other and enduring the process together made the journey more meaningful.

I deeply appreciate my university supervisor, who was both a mentor and a father figure. Your guidance and unwavering support made my practicum experience fruitful and impactful.

Lastly, I wish to acknowledge the department of psychology at Mount Kenya University and all the lecturers who have played a role in shaping my academic and professional foundation.

To all of you, I am sincerely grateful.

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**Practicum site**

My counselling psychology practicum was conducted at the Susan Gitau counselling foundation ,located in Thika Kiambu county .SGCF is a reputable mental health and psychosocial support institution that offers a wide range of services including individual and group therapy ,trauma recovery ,personal marital, family counselling and personal development programs .The foundation is led by DR. Susan Gitau, a renowned counselling psychologist and trauma specialist in Kenya ,whose work has significantly influenced the mental health landscape nationally and regionally .

During my practicum , I was privileged to be part of a vibrant multidisciplinary team of counsellors ,social workers ,and mental health professionals .I was assigned to various departments that allowed me to engage in both clinical and community based activities .My responsibilities included conducting intake sessions ,participating in case discussions ,observing therapy sessions, developing client treatment plans ,and assisting in psychoeducation forums .I also took part in community outreach programs focused on trauma healing ,youth mentorship, and gender based violence awareness.

Overall, my placement at Susan Gitau counselling foundation was an enriching and transformative experience. It not only enhanced my clinical competence and ethical grounding but also deepened my passion for mental health work in diverse social contexts. The supportive environment the quality of mentorship, and the real-world exposure I received during this practicum have significantly prepared me for professional practice in the field of counselling psychology.

**Commencement date** 5th May2025

**Termination date** 5th August 2025

**Site supervisor** -Dr Susan Gitau Wambui

**Phone number** :0722218447

**Assistant supervisor-**Madam Jane Ngigi

**Telephone number** :0707731738

**Challenges encountered during my practicum at Susan Gitau Counselling Foundation and how they were resolved.**

**Initial Anxiety and Self-Doubt**

At the beginning of my practicum, I struggled with nervousness and self-doubt when working with clients. While I had studied counseling theories extensively, applying them to real-life situations felt intimidating. I often second-guessed my interventions and worried about making mistakes that could negatively affect clients. This initial anxiety sometimes made me overly cautious in sessions, affecting my ability to build rapport quickly.

Resolution: Over time, I benefited from continuous supervision and mentorship from my site supervisor, who provided constructive feedback after each session. Peer encouragement during group discussions helped normalize my feelings and reminded me that anxiety is common for trainees. Gradual exposure to different cases increased my comfort level, and I began trusting my professional judgment more, which in turn boosted my confidence.

**Limited Practical Experience**

Early on, I found it challenging to translate client narratives into well-structured case formulations. Identifying presenting problems, underlying issues, and choosing the most suitable interventions was sometimes overwhelming, especially when clients presented with multiple complex concerns.

Resolution: I addressed this gap by actively seeking feedback from my site supervisor. After each session, I took time to review my case notes and compare them with best practices discussed in training. I also studied example case formulations and counseling transcripts, which helped me improve my diagnostic thinking and intervention planning.

**Emotional Fatigue**

Listening to multiple clients share deeply personal and often traumatic experiences left me emotionally drained at times. I noticed that after particularly heavy sessions, I carried the emotional weight into my personal life, which affected my mood and energy levels.

Resolution: I learned to set healthy emotional boundaries, reminding myself that my role was to support, not to absorb, clients’ pain. Attending scheduled debriefing sessions provided a safe space to process my reactions. Additionally, I incorporated self-care activities into my daily routine, including journaling, mindfulness exercises, and light physical activity, which helped me maintain emotional balance.

**Ethical Dilemmas and Boundaries**

There were moments when clients disclosed sensitive information that required immediate judgment on confidentiality and reporting. At times, I was uncertain about how much personal information to share in order to build rapport without crossing professional lines.

Resolution: I consulted my supervisor whenever such dilemmas arose, ensuring that my decisions were aligned with the Kenya Counselling and Psychological Association (KCPA) ethical guidelines. I also revisited my training materials and attended a refresher discussion on ethics, which strengthened my confidence in handling sensitive disclosures appropriately.

**Inconsistent Client Attendance**

Some clients missed sessions without prior notice, which interrupted the therapeutic process and made it harder to establish continuity. This unpredictability sometimes left me with gaps in my schedule and disrupted planned interventions.

Resolution: I learned to remain flexible by using missed-session periods for productive activities such as updating case notes, reviewing counseling literature, and preparing resources for future sessions. For recurring absences, I worked with my supervisor to explore ways of re-engaging clients, including reminder calls and adjusting session times

**Cultural and Language Differences**

Working with clients from diverse cultural backgrounds occasionally led to misunderstandings or difficulty interpreting certain expressions and idioms. In some cases, clients used regional or community-specific terms that I was unfamiliar with, which could hinder full comprehension of their experiences.

Resolution: I improved my listening skills by paying close attention to tone, body language, and context. When unclear, I politely asked open-ended and clarifying questions to ensure accuracy without making assumptions. I also made an effort to learn key cultural norms and basic phrases used by clients, which improved rapport and mutual understanding.

**Main breakthroughs during my practicum journey**

**Confidence Growth**

At the beginning of my practicum, I was shy and hesitant, especially when conducting sessions or presenting cases during supervision. I often worried about saying the wrong thing or appearing inexperienced. Over time, with encouragement from my supervisors and constructive peer feedback, my self-assurance grew. I learned to trust my skills and professional instincts. By the end of the practicum, I could conduct sessions with clarity, ask questions confidently, and present my cases during supervision with composure. This confidence also extended to group discussions, where I was able to contribute meaningfully and engage in professional dialogue without fear.

**Improved Communication**

Initially, I found it difficult to manage silence in sessions or determine which questions would move the conversation forward. I sometimes felt the urge to fill the silence with unnecessary talk, which occasionally disrupted clients’ thought processes. Over time, I learned to see silence as a therapeutic tool that allowed clients space to reflect. My active listening skills improved significantly, and I became more intentional in my verbal and non-verbal communication. I also became more skilled at asking open-ended, therapeutic questions that encouraged clients to share deeper insights.

**Better Case Formulation Skills**

At first, writing comprehensive case notes and conducting psychological assessments felt overwhelming, particularly when dealing with clients presenting multiple issues. I often second-guessed how to connect presenting problems with relevant psychological theories. Through practice, regular supervision, and reviewing my earlier cases, I learned to organize client information more logically and link it effectively to theoretical frameworks. By the end of the practicum, I could confidently identify patterns, prioritize issues, and prepare clear case formulations that informed my intervention plans.

**Application of Theory to Practice**

When I began, I was unsure how to translate theories like Cognitive Behavioral Therapy (CBT) and Person-Centered Therapy into actual session work. I worried about missing steps or applying techniques incorrectly. As the practicum progressed, I gained hands-on experience in using CBT tools such as cognitive restructuring and thought records, and Person-Centered approaches such as unconditional positive regard and reflective listening. This allowed me to integrate theory and practice seamlessly, tailoring my interventions to each client’s needs.

**Enhanced Emotional Resilience**

At the start, I found it emotionally challenging to hear and process clients’ traumatic stories without feeling overwhelmed. I occasionally carried these emotions home, which affected my personal wellbeing. Over time, I developed greater emotional resilience through supervision, self-reflection, and self-care practices such as journaling, mindfulness, and debriefing. I learned to maintain empathy while also protecting my emotional boundaries, which made me more effective and sustainable as a counselor.

**Improved Time and Session Management**

Early in my practicum, I sometimes struggled with managing the session time effectively, either running short before addressing key issues or feeling rushed toward the end. Through practice and feedback, I learned to structure sessions more effectively, set clear goals at the beginning, and use time checks to ensure a smooth flow. I also improved in scheduling my daily workload, balancing session preparation, note-taking, and supervision without feeling overwhelmed.

**Main theories used during my practicum and their application in client treatment**

During my practicum, I applied several counseling theories depending on the needs and issues presented by clients. The main approaches I used were Person-Centered Therapy, Cognitive Behavioral Therapy (CBT), Solution-Focused Brief Therapy (SFBT), and Psychodynamic Theory. Through supervision and practice, I learned how to adapt these theories to different clients and situations.

Person-Centered Therapy (PCT)

I used Person-Centered Therapy mostly to build rapport and create a safe, non-judgmental space for clients. Many of the clients I met were sharing their problems with a counselor for the first time, so it was important for them to feel accepted and understood. I practiced unconditional positive regard, empathy, and congruence by showing genuine interest, actively listening, and reflecting their feelings back to them. This helped clients open up more and feel comfortable exploring their emotions. For example, with one client struggling with low self-esteem, I focused on reflective listening and affirmations to help them feel valued and capable.

Cognitive Behavioral Therapy (CBT)

CBT was useful for clients who had negative thought patterns affecting their emotions and behavior. I helped clients identify unhelpful thoughts, challenge them, and replace them with more balanced and realistic ones. For instance, with a client dealing with anxiety, I guided them through cognitive restructuring exercises, where we examined the evidence for and against their fearful thoughts. I also encouraged practical homework tasks, like keeping thought records, to help them apply the skills outside the sessions. Over time, the client reported feeling less anxious and more in control of their reactions.

Solution-Focused Brief Therapy (SFBT)I used SFBT with clients who were focused on finding immediate solutions rather than exploring deep-rooted issues. This approach worked well with school-based clients who had specific goals, such as improving study habits or managing peer conflict. I used techniques like the miracle question (“If you woke up tomorrow and your problem was solved, what would be different?”) and scaling questions to help clients visualize their progress. These strategies motivated them to take small but practical steps toward their goals.

Psychodynamic Theory

I applied Psychodynamic Theory when working with clients whose present issues seemed linked to past experiences, especially from childhood. This approach helped me and the client explore how early relationships, unconscious feelings, and unresolved conflicts might be influencing current behavior. For example, with a client who often reacted angrily to authority figures, we explored their early experiences with a strict and critical parent. By bringing these patterns into awareness, the client began to understand their emotional triggers better and could start working toward healthier responses. I used techniques such as exploring recurring themes, discussing dreams or memories, and linking past experiences to present behavior — always making sure the discussion was paced in a way the client could handle.

Overall Reflection:

At first, I was nervous about using these theories in real-life sessions because I worried about “doing them wrong.” But as I practiced under supervision, I realized that counseling is not about using a theory perfectly, but about using it flexibly to meet the client where they are. Sometimes I would combine elements from different approaches — for example, starting with Person-Centered Therapy to build trust, then introducing CBT techniques to address negative thoughts, or drawing on Psychodynamic insights to help clients see deeper patterns in their lives.

**Summary of my practicum journey**

My practicum journey has been both a deeply emotional and intellectually enriching experience — one that has shaped not only my professional skills but also my personal growth. Walking into the practicum site for the first time, I carried within me a mix of anxiety, curiosity, and hope. I was uncertain how I would navigate real-life client encounters and whether I could translate what I had learned in class into meaningful interventions. Yet, from the very beginning, I was determined to grow and to approach each moment as a learning opportunity.

Over time, each counseling session, supervision meeting, and quiet moment of reflection slowly shaped me into a more grounded, adaptable, and intentional counselor. I learned that the practicum was not just about “doing counseling” but about becoming the kind of person who could hold space for others with empathy, presence, and professional integrity.

Emotionally, I was challenged to sit with the pain of others — to listen to stories of trauma, grief, loss, and uncertainty without turning away. At first, this was emotionally exhausting, and I sometimes carried my clients’ pain home with me. However, through supervision, peer support, and self-care practices like journaling and mindfulness, I learned to set healthy emotional boundaries. There were moments I questioned my ability, but there were also powerful moments where I was deeply moved by the resilience, courage, and vulnerability of my clients. These experiences expanded my emotional capacity and strengthened my therapeutic presence, enabling me to remain calm, grounded, and compassionate even in difficult sessions.

Academically and professionally, I learned to move beyond theory as something abstract and into its practical application. I integrated Person-Centered Therapy to create a safe, non-judgmental environment by practicing unconditional positive regard, empathy, and congruence. I applied Cognitive Behavioral Therapy techniques to help clients identify and restructure distorted thoughts, challenge unhelpful beliefs, and adopt more constructive thinking patterns. I also utilized Solution-Focused Brief Therapy strategies to help clients identify their strengths and resources, set clear goals, and take small, achievable steps toward improvement. Additionally, I drew on Psychodynamic Theory to explore how past experiences and unconscious processes might be influencing current behaviors and emotional patterns. This blending of approaches sharpened my clinical reasoning, increased my flexibility, and boosted my confidence in responding to diverse client needs.

I also developed practical skills in case formulation, note-taking, and session planning. Early in the practicum, I found these tasks overwhelming, but with consistent practice, supervisor feedback, and reflection, I became more organized and systematic in my approach. I learned to prepare thoroughly while still remaining flexible to adapt to what emerged in the session.

One of the most meaningful lessons I learned is that growth is not linear. There were days I felt like I had made a breakthrough, and other days I felt stuck or unsure. I came to understand that the counseling process for both client and counselor involves gradual progress, occasional setbacks, and constant learning. I learned to trust the process, to be patient with myself, and to embrace mistakes as opportunities for growth rather than signs of failure.

Beyond skills and theory, this practicum deepened my cultural sensitivity and ability to work with clients from diverse backgrounds. I learned to listen without assumptions, ask clarifying questions, and respect each client’s worldview. I also gained insight into the importance of ethical practice, from maintaining confidentiality to setting clear boundaries and knowing when to seek supervision for complex or sensitive situations.

In the end, this practicum was far more than an academic requirement, it was a journey of professional formation and personal transformation. I now see myself not only as someone with the technical skills to counsel, but as a counselor who brings authenticity, empathy, and intentionality to every interaction. I leave this experience with greater confidence, a clearer sense of my counseling identity, and a strong commitment to lifelong learning in the service of my clients.

**Major areas I improved to make the practicum journey better**

Professional Confidence

At the beginning of my practicum, I often felt hesitant, second-guessing my abilities and worrying about making mistakes. This uncertainty sometimes made me overly cautious and reluctant to take the lead in sessions. However, through continuous practice, constructive supervision, and consistent encouragement from peers and supervisors, I gradually built a stronger sense of self-assurance. I learned to trust my professional judgment, take initiative in guiding sessions, and present cases more confidently during supervision meetings. By the end of my placement, I was able to conduct sessions with clarity, maintain professional presence, and make sound clinical decisions without constant self-doubt.

Communication and Active Listening

My ability to engage in deep, meaningful communication with clients improved significantly. I learned to listen with full attention, resisting the urge to interrupt or rush to fill silences. Instead, I began using those pauses therapeutically, giving clients space to reflect and express themselves more openly. I refined my questioning techniques, moving from closed-ended to open-ended and exploratory questions that invited deeper client insight. Additionally, I became more skilled at adjusting my tone, pace, and language to fit each client’s personality, cultural background, and emotional state, which strengthened rapport and made sessions more impactful.

Case Formulation and Note-Taking

Initially, connecting a client’s presenting concerns to underlying causes felt daunting. Over time, with feedback and supervision, I developed a more analytical and structured approach to case formulation. I learned to integrate client history, observations, and relevant theoretical perspectives into a coherent framework for intervention. My documentation also improved—notes became clearer, more organized, and focused on both presenting issues and therapeutic progress. This made follow-up sessions more targeted and efficient, allowing for smoother continuity of care.

Application of Counseling Theories

Before my practicum, counseling theories existed mainly in textbooks for me. The placement gave me the chance to apply them in real client scenarios. I used Person-Centered Therapy to create a safe, accepting environment where clients felt heard and valued. Cognitive Behavioral Therapy (CBT) techniques helped clients identify and challenge distorted thinking patterns, while Solution-Focused Brief Therapy allowed me to guide clients toward achievable, strengths-based goals. I also incorporated Psychodynamic Theory to help clients explore recurring patterns and unresolved past experiences influencing their present. This adaptability allowed me to tailor my approach to meet the unique needs of each client.

Emotional Resilience and Boundaries

One of my greatest areas of growth was learning how to handle the emotional demands of counseling. Listening to stories of trauma, grief, and hardship was deeply moving, but it could also be draining. I learned to set clear professional boundaries to prevent over-identification with clients’ struggles. Personal coping strategies such as reflective journaling, mindfulness, and scheduling short breaks between emotionally intense sessions became essential tools. Regular supervision provided a safe outlet for processing challenging cases and refining my emotional responses. This balance between empathy and self-care allowed me to remain fully present and effective in my work.

Cultural Competence

Working with clients from diverse backgrounds enhanced my cultural awareness and sensitivity. I approached each client with curiosity and humility, asking clarifying questions to better understand their worldview rather than making assumptions. This helped me frame interventions in ways that were culturally respectful and relevant, ultimately strengthening the therapeutic alliance.

Ethical Awareness and Professional Judgment

Throughout my practicum, I encountered situations that required careful ethical consideration, such as maintaining confidentiality in complex cases or setting boundaries in dual relationships. I became more confident in identifying ethical dilemmas early, consulting professional codes of ethics, and seeking supervisory guidance when needed. This growth reinforced my ability to act in ways that safeguarded client welfare while upholding professional standards.

**Individual counseling**

**Client one**

**Client Code: 002**

**Date of First Session**: 8th May 2025

**Counselor:** Michelle Ingado Ajanga

**Placement Site:** Action for children in conflict children home

**Biographic Data**

**Name:** Code 006

**Age:** 16 years

**Gender**: Male

**Place of Origin:** Homabay

**Religion:** Christian

**Marital Status:** Single

**Educational Background**: Started school at 4 years old; currently out of school due to past disruptions.

**Occupation:** None /Minor

**Background Information** The client is the fifth born in a family of five children (four brothers and one sister). His mother was a sugarcane vendor; father’s current occupation is a watchman in Ekalakala. He reported a history of severe domestic violence between his parents, including an incident where his father hit his mother on the head, leading to her mental illness. He has also experienced physical abuse from his father, including being hit in the eyes and being prevented from attending school.

Due to the violence and instability at home, he frequently moved between relatives’ homes and eventually lived on the streets. He has now been at the children’s home for 5 months. He reports that his 4th-born brother and mother protected him during abusive situations**.**

**Presenting issue /complaints**

The client (Code 002) is a 16-year-old male residing in a children’s rehabilitation home. He presented with emotional distress, anger management difficulties, and academic disruption following multiple traumatic experiences. He reported growing up in a violent home environment where his father physically abused both him and his mother. A severe incident of domestic violence left his mother with mental health challenges after being hit on the head by his father.

The client described frequent episodes of physical abuse, including being struck in the eyes and threatened with death by his father. He also reported that his father prevented him from attending school, which contributed to significant academic delays. Due to family instability, the client moved between various relatives’ homes before eventually living on the streets.

Five months ago, the client was placed in the current rehabilitation home. His main present concern was the delay in resuming school, as he feels academically behind and wishes to catch up. He also expressed emotional pain related to family separation and concern for his mother’s safety.

He identified his fourth-born brother and his mother as protective figures during past abuse. The client reports no history of drug or substance use and demonstrates awareness of their harmful effects. He prefers to isolate himself when feeling angry or sad and finds emotional support from specific trusted individuals at the centre. His long-term goal was to become a truck driver, build his mother a house, and help other street children in need.

**Observation Mental /status examination**

General appearance: Well-groomed, appropriately dressed for the setting, appeared his stated age.

Behavior: Calm and cooperative during the interview. Maintained good eye contact and was willing to engage in conversation. No psychomotor agitation or retardation observed.

Speech: Normal in rate, tone, and volume. Coherent and goal-directed.

Mood: Reported feeling stressed and at times sad, particularly when recalling past traumatic events.

Affect: Constricted but congruent with mood. Became tearful when discussing family and past abuse.

Thought process: Logical, coherent, and goal-oriented. No flight of ideas or loosening of associations.

Thought content: No delusions or hallucinations reported. No suicidal or homicidal ideation.

Perception: Intact — no perceptual disturbances noted.

Cognition: Alert and oriented to time, place, and person. Demonstrated intact memory and attention span.

Insight: Good — understands his difficulties are linked to past traumatic experiences and is open to receiving help.

Judgment: Fair — able to identify safe and unsafe situations; expresses appropriate future goals.

**Assessment procedures**

Clinical Interview – Conducted structured and semi-structured interviews to gather the client’s background history, trauma experiences, current concerns, and psychosocial context

Mental Status Examination (MSE) – Assessed appearance, behavior, mood, affect, thought processes, cognition, and insight to determine current psychological functioning

Trauma History Assessment – Collected detailed information regarding exposure to domestic violence, physical abuse, neglect, and street life experiences to understand the onset and impact of symptoms.

CBT Assessment – Explored the client’s core beliefs, automatic thoughts, and cognitive distortions related to the traumatic experiences. Identified unhelpful thinking patterns such as self-blame and hopelessness, as well as triggers for emotional distress.

Anger and Emotional Regulation Assessment – Evaluated emotional triggers, intensity of anger episodes, coping strategies, and avoidance patterns.

Functional Assessment – Examined how trauma symptoms affect the client’s daily functioning, relationships, education, and future goals.

**Assessment results**

Based on the information gathered through the clinical interview, observation, and application of relevant assessment tools, the client presented with symptoms consistent with Post-Traumatic Stress Disorder (PTSD).

The assessment highlighted the following findings:

Re-experiencing symptoms: The client openly recalled past traumatic events, including domestic violence, physical abuse, and life on the streets, often describing them with emotional intensity.

Avoidance behaviors: Tendency to isolate when feeling angry or sad and limited willingness to engage in conversations about certain family details unless prompted in a safe context.

Negative alterations in mood and cognition: Reports of stress related to delayed schooling, feelings of loss regarding family connections, and occasional hopelessness about his situation. However, he also demonstrated resilience and a future-oriented outlook.

Hyperarousal symptoms: Observable irritability, quick emotional responses when discussing certain events, and difficulties in emotional regulation (anger management issues reported).

Cognitive Behavioral Therapy (CBT) assessment components were integrated to evaluate thought patterns and their impact on emotions and behaviors. This revealed cognitive distortions related to self-worth and safety, which were addressed in later sessions through reframing and rational thinking exercises.

The results suggest that the client’s current psychological difficulties are a direct consequence of multiple adverse childhood experiences, with PTSD being the primary diagnosis. No signs of psychosis (hallucinations or delusions) or substance use were present. The client demonstrated motivation for therapy and a strong desire to return to school, which is a positive prognostic factor for recovery.

**Case formulation\Diagnosis**

The client is a 16-year-old male residing in a children’s rehabilitation home after experiencing multiple adverse childhood events, including exposure to severe domestic violence, physical abuse from his father, neglect, unstable housing, and eventual displacement to the streets. These traumatic experiences have had a significant impact on his emotional regulation, self-esteem, and social functioning.

**From a biopsychosocial perspective:**

Biological factors: No reported history of neurological disorders, substance abuse, or chronic medical illness. Physical health appears stable.

Psychological factors: Persistent intrusive memories of traumatic events, anger management difficulties, avoidance of certain triggers, negative beliefs about self-worth, and feelings of loss regarding family connections. The client also demonstrates resilience, future-oriented thinking, and strong motivation for change.

Social factors: History of unstable living conditions, loss of parental support, separation from siblings, and lack of a stable educational path. However, supportive relationships with specific caregivers and peers at the center provide a protective buffer.

The client meets the DSM-5 criteria for Post-Traumatic Stress Disorder (PTSD), characterized by:

Re-experiencing symptoms (intrusive recollections of trauma).

Avoidance behaviors (isolation during distress).

Negative changes in mood and cognition (feelings of loss, decreased self-worth).

Hyperarousal (irritability, heightened emotional reactivity**).**

**Diagnosis:**

Primary: Post-Traumatic Stress Disorder (PTSD) – F43.10 (DSM-5 / ICD-10 Code).

Secondary considerations: Adjustment challenges related to disrupted schooling and separation from family. No evidence of psychosis or substance use disorder.

The formulation suggests that the client’s symptoms are a direct consequence of prolonged exposure to multiple traumatic events during critical developmental years. His motivation to return to school, reconnect with family, and future goals (e.g., becoming a truck driver, supporting street children) indicate strong recovery potential if provided with consistent therapeutic support, educational opportunities, and a stable environment.

**Therapeutic goals**

Help client process traumatic experiences and reduce distress.

Improve anger management skills.

Build self-esteem and confidence

Encourage positive thinking and resilience.

Support client in focusing on education and future goals.

**Treatment Plans & Interventions Used**

Person-Centered Therapy – provided unconditional positive regard, empathy, and a safe space where the client felt free to share his story without judgment.

Cognitive Behavioral Therapy (CBT) – helped client identify negative thought patterns linked to past trauma and replace them with healthier, more balanced thinking.

Solution-Focused Brief Therapy – focused on client’s strengths, encouraged him to imagine a better future, and set short-term goals like returning to school.

Psychodynamic Approach – explored how past family conflicts and abuse shaped current emotions and behaviors, helping him understand triggers for anger.

Relaxation & Anger Management Techniques – taught breathing exercises, counting techniques, and physical activity to manage anger and stress.

**Outcome / Evaluation**

Client is more open about his past and can talk about traumatic events without breaking down.

Anger outbursts have reduced; he now uses coping strategies before reacting.

Improved self-esteem and confidence in sharing ideas.

Increased motivation to return to school and focus on future goals.

Stronger emotional regulation and positive thinking observed.

**Recommendations**

Continue with regular counseling sessions to reinforce coping skills.

Provide educational support and facilitate school placement as soon as possible.

Engage the client in group activities to improve social skills and reduce isolation,

Maintain a safe and supportive environment in the children’s home.

Encourage mentorship from trusted adults like Teacher Ian and Madam Juliet.

**Challenges / Reflections**

Client sometimes withdraws when emotionally triggered, making some sessions slow to progress.

Limited family contact remains a source of sadness and distraction.

Need for more time to fully address deep-seated trauma.

As a counselor, I learned patience and the importance of pacing therapy according to the client’s readiness.

**Follow-up**

Continued occasional check-ins to monitor emotional well-being.

Maintaining contact with the children’s home to track progress.

Observing school placement process and ensuring smooth adjustment.

Staying updated on client’s coping strategies and support network.

**Client 2**

**Client code** 010

**Date of first session** 18th July 2025

**Counselor** Michelle Ingado Ajanga

**Placement site** Broadway high school

**Biographic data**

Client code: 10

Age: 16 years

Sex: Female

School: Broadway High School (student)

Religion: Christian (occasional church attendance)

Living situation: Lives with family/guardian (details not provided in full); reports peer and social media influences

**Background information**

Code No. 10 is a 16-year-old female student at Broadway High School, where she was self-referred for counselling. She identifies as Christian and attends church occasionally. She lives with her family and is generally supported at home, though she has not disclosed significant family conflicts.

Her concerns about her body began around age 14, a period marked by the natural changes of adolescence and increased exposure to social media. She reported that during this time, she became more aware of peers’ physical development and began comparing herself to classmates and online influencers. In her own words, she felt she was “behind” in physical maturity, particularly in not having the curves she saw in others.

Social media platforms became both a source of connection and distress for her — she often browsed images of models and influencers, which reinforced feelings of inadequacy. These feelings gradually intensified over two years, leading to preoccupation with her perceived flaws, repeated mirror-checking, and frequent reassurance seeking from friends and family.

Despite reassurance from those around her, she has continued to view herself as unattractive. This belief has contributed to feelings of shame, avoidance of group activities, reluctance to participate in class presentations, and a decline in overall confidence. While she remains engaged in her studies, her social participation and willingness to speak in public settings have been noticeably affected.

**Presenting issues / chief complaint**

Client reports persistent dissatisfaction with physical appearance for more than one year.

Preoccupation with perceived flaws (especially body shape/curves).

Feels “ugly,” ashamed, socially withdrawn and avoids public speaking or group tasks.

Low mood, reduced confidence, and declining participation in school activities are primary concerns.

**History of presenting complaints**

Preoccupation with appearance gradually increased since age 14.

Client reports repetitive checking behaviors (mirror checking) and reassurance seeking about looks.

Preoccupation significantly affects mood, self-worth, classroom participation, and social life.

Client recognizes the thoughts as exaggerated at times but continues to believe them and is distressed by them.

**Observation / Mental Status Examination (MSE)**

Appearance & behavior: Well-groomed adolescent, dressed appropriately for school. Appears slightly younger than stated age because of posture (slouched) and body language. Often avoids eye contact. Cooperative but somewhat reserved.

Speech: Normal rate and tone; occasionally soft-spoken. Responses relevant and coherent.

Coherent.

Mood & affect: Reports feeling ashamed and anxious about appearance. Affect constricted but congruent with mood; becomes quieter when discussing body image.

Thought content: No delusions or hallucinations. No paranoid ideation. Persistent distorted beliefs about appearance (e.g., “I’m ugly,” “I don’t have curves”) despite reassurance.

Perception: Intact — no perceptual disturbances observed or reported.

Cognition: Alert and oriented to time, place, and person. Attention and concentration fair but occasionally disrupted by intrusive appearance-related thoughts. Memory intact

Insight & judgment: Partial insight — client recognizes that her concerns may be exaggerated but continues to hold them and is distressed by their impact on functioning. Judgment intact for daily decisions.

**Assessment procedures used**

Clinical interview (structured/semi-structured) to obtain history of presenting problem, onset, course, and functional impact.

Mental Status Examination (MSE) to evaluate current mental functioning and rule out psychosis or acute risk.

CBT-based assessment: exploration of automatic thoughts, core beliefs, cognitive distortions about body image; use of thought records and behavioral monitoring.

Behavioral assessment: frequency and pattern of mirror checking, reassurance seeking, avoidance behaviors, and time spent on appearance-related rumination.

Functional assessment: how preoccupation affects school attendance, class participation, social activities, and mood.

Psychoeducation given to assess baseline knowledge of body image disturbance and media influence.

Risk assessment: screened for suicidal ideation (none reported) and self-harm (none reported)

**Assessment results**

Client demonstrates core features of Body Dysmorphic Disorder: persistent preoccupation with perceived bodily defect(s), repetitive behaviours (mirror checking, reassurance seeking), and clinically significant distress and functional impairment (avoidance of class presentations, withdrawal).

Cognitive assessment via thought exploration revealed negative core beliefs about worth and attractiveness, frequent catastrophizing and overgeneralization when comparing herself to peers or influencers.

No evidence of psychosis, Treatment plan & intervention strategies (what I used)

**Case formulation**

Biological: Normal adolescent development (puberty and body changes) contributing to sensitivity about body image. No medical or substance factors reported.

Psychological: Negative core beliefs about appearance developed and reinforced by social comparison and perfectionistic standards (amplified by social media). Automatic negative thoughts and checking rituals maintain anxiety and reduce exposure to corrective experiences. Partial insight but strong emotional investment in beliefs.

Social: Peer comparisons, social media influence, school performance anxieties, and avoidance of group tasks limit corrective social experiences and reinforce isolation and low self-esteem.

Working diagnosis: Body Dysmorphic Disorder (primary). Differential: major depressive disorder not primary at present (mood issues appear secondary to BDD); PTSD not supported by current history

**Therapeutic goals**

To reduce intrusive appearance-related thoughts and repetitive checking behaviors.

To decrease avoidance (increase participation in class and group activities).

To Improve self-esteem and self-acceptance.

To replace distorted appearance beliefs with more balanced thoughts.

To build healthy coping skills (mindfulness, self-compassion, behavioral experiments) and use faith/community resources as supports. Treatment plan & intervention strategies (what I used)

**Treatment plan and intervention strategies used**

CBT (primary approach) -Thought records to identify automatic negative thoughts about appearance.

Cognitive restructuring to challenge and reframe distorted beliefs (e.g., overgeneralizing, catastrophizing).

Behavioral experiments and gradual exposure (e.g., reducing mirror checking, gradual exposure to class presentations).

Activity scheduling to increase pleasurable/competence-building behaviours.

Person-Centered Therapy- Provide empathic, non-judgmental space; unconditional positive regard to build trust and strengthen therapeutic alliance.

Solution-Focused Brief Therapy – (SFBT)Identify past successes, scaling questions, and small achievable steps (e.g., speaking once

Psychoeducation- Education on body image, the role of social media, normal adolescence, and how checking/avoidance maintain distress.

Self-Compassion & Mindfulness- Short compassion exercises and mindfulness practices to reduce self-criticism and interrupt rumination (e.g., breathing exercises, grounding).

Self-Esteem Exercises & Affirmations- Strengths journal, daily affirmations, and tasks that highlight capabilities (academic or hobby-related).

Faith-integration (client preference)- Encourage use of church/community supports, values-based affirmations, and faith as a resilience resource when appropriate.

School liaison / practical supports -Work with school counsellor/teachers to facilitate low-stakes opportunities for participation and to monitor progress.

Safety & monitoring

Regular risk checks; encourage help-seeking if mood worsens

**Outcomes / Evaluation**

Client consistently attended sessions and engaged with interventions (thought records, affirmation practice).

Early signs of increased insight: client can now identify at least one cognitive distortion when prompted.

Began practicing a short self-compassion exercise daily and reported feeling “a bit calmer” after the exercise.

Slight reduction in immediate mirror-checking after implementing a 5-minute delay technique (initial behavioural experiment).

Client still experiences strong emotional reactivity around appearance but reports more willingness to try graded exposures (e.g., speaking in a partner pair rather than whole class).

(These are early, incremental changes — ongoing monitoring required**.)**

**Recommendations**

Continue structured CBT for BDD (8–16 sessions minimum recommended), with emphasis on exposure and response prevention for checking rituals.

Maintain person-centered support and reinforce self-compassion practice.

School-based supports: negotiated, graded participation tasks (teacher support), and confidential check-ins with school counsellor.

Psychoeducation sessions for family or caregiver (with client consent) to reduce unhelpful reassurance and to increase supportive responses.

Limit and structure social media use where possible; discuss practical strategies for reducing harmful comparisons.

Consider peer support or small group work focused on body image Client’s partial insight makes cognitive work slower — beliefs are emotionally charged and tied to identity.

**Challenges/Reflection(students voice)**

Client’s partial insight makes cognitive work slower — beliefs are emotionally charged and tied to identity.

Social media and peer comparison are constant, ongoing triggers that require practical, realistic strategies (not just talk).

Building trust took time; person-centered listening in the first 1–2 sessions was crucial before deeper CBT work could begin.

I need to pace behavioural exposures carefully to avoid overwhelming the client; small wins matter.

Reflection for me: I must balance gentle encouragement with firm behavioural tasks (e.g., limiting mirror checking) so the client experiences mastery rather than shame.

**Follow-up**

The client attended follow-up sessions consistently over the past month. She reported practicing self-compassion exercises daily and noted feeling somewhat calmer. There was a slight reduction in mirror-checking behaviors after using the delay technique. Feedback from the school counsellor indicated increased participation in group activities and less social withdrawal. The client continued to face challenges with social media comparisons but demonstrated growing awareness and coping skills. Risk assessments showed no suicidal ideation or self-harm. The treatment plan was reviewed and adjusted to focus on graded exposures and cognitive restructuring for the next phase.

**Client number 3**

**Client code** 004

**Date of first session** 21st May 2025

**Counselor** Michelle Ingado Ajanga

**Placement site** Kiandutu hospital

**Biographic Data**

**Name:** code 004

**Age:** 46 years

**Sex**: Male

**Occupation:** Mechanic

**Marital Status:** Married (two wives)

**Number of Children:** 8 (5 girls, 3 boys)

**First Wife:** Rose, 36 years old, lives in Kiandutu, Thika, sells in a kiosk

**Second Wife:** Salome, 37 years old, lives in Athena, sells vegetables

**Religion:** Christian

**Living Situation:** Lives with family and wives in separate locations (Thika and Athena)

**Health Status:** HIV positive; wives HIV negative and aware of his status.

**Background information**

He was born to Michael Otieno, aged 69, and Mary Otieno Achola, aged 67, both of whom are farmers. He is the youngest or among the younger siblings in a large family with four brothers and six sisters, all significantly older than him. His childhood was reportedly stable, with no history of separation from his parents or disruptions in family life. He experienced a normal pregnancy and birth without complications, and he met all developmental milestones within expected timeframes. During his early years, there were no difficulties reported in habit training or behavioral adjustment.

Throughout his childhood and adolescence, his health remained good with no significant medical illnesses or surgeries. He completed his education up to form 2, although specific academic achievements were not provided. He later trained and established himself as a mechanic, a profession he has practiced for many years.

He is married to two wives, Rose (36) and Salome (37), who live separately in Kiandutu, Thika, and Athena respectively. Rose operates a kiosk, while Salome sells vegetables. The couple has eight children five girls and three boys. He is HIV positive and has openly disclosed his status to both wives, who remain HIV negative. Despite this, the diagnosis has been a source of considerable stress within the family, compounded by marital tensions.

To manage his stress, he reports using alcohol regularly. He acknowledges that his alcohol use is linked to the pressures he faces both from his health condition and family dynamics. Despite these challenges, he has not reported any history of suicidal thoughts or psychiatric illness. He is self-aware and insightful, expressing his thoughts openly during counseling, though he presented with an unkempt appearance during sessions.

**Presenting Issues / Complaints**

The client self-referred for counseling primarily due to overwhelming stress related to his family situation and ongoing health challenges. He reported that managing the dynamics between his two wives has become increasingly difficult, leading to frequent conflicts and emotional strain within the household. He described feeling caught between the competing demands and expectations of both spouses, which has contributed to a persistent sense of tension and frustration.

In addition to marital stress, he is struggling with the psychological impact of living with HIV. Although he has disclosed his HIV positive status to both wives, who remain HIV negative, misunderstandings and fears surrounding the illness persist. This lack of full understanding has, according to him, intensified family conflicts and feelings of isolation. He expressed a strong desire for his wives to receive proper education and support on how to live harmoniously with a husband living with HIV.

He acknowledged that the cumulative stress has led him to increase his alcohol consumption, which he uses as a way to cope with his emotional distress. He admitted that while alcohol provides temporary relief, he recognizes it is detrimental to his health, especially given his HIV status. He denies any suicidal thoughts or intentions but expressed feelings of sadness, frustration, and at times helplessness in managing his situation. He also shared that balancing his work as a mechanic with the emotional and social pressures at home has been challenging. The stress has affected his sleep and concentration at times, although he continues to maintain employment. He reported a lack of consistent emotional l and social pressures at home has been challenging. The stress has affected his sleep and concentration at times, although he continues to maintain employment. He reported a lack of consistent emotional support from his family and desires counseling to help him develop healthier coping strategies and improve communication within his family.

**Observation / Mental Status Examination (MSE)**

Appearance and Behavior:

He appeared his stated age of 46 years. He was casually dressed but appeared somewhat unkempt, with short, untidy hair and a generally disheveled appearance. His hygiene was adequate but not meticulous. During the session, he was cooperative and engaged but showed some signs of low energy and tiredness. His posture was relaxed but slightly slouched.

Speech:

His speech was spontaneous, coherent, and relevant, with a normal rate and volume. There were no signs of pressure of speech or poverty of speech. He was articulate and able to express his thoughts clearly.

Mood and Affect:

He reported feeling stressed, frustrated, and overwhelmed by his current family and health situation. His affect was congruent with his reported mood—generally subdued and somewhat constricted, but appropriate to the context of the discussion.

Thought Process:

His thought process was logical, coherent, and goal-directed. There was no evidence of thought blocking, derailment, or loosening of associations.

Thought Content: There were no signs of delusions, hallucinations, or paranoid ideation. He did not express any suicidal or homicidal thoughts. He expressed concerns related to family stress and health but no pathological preoccupations.

Perception:

No perceptual disturbances were reported or observed.

Cognition:

The client was alert and oriented to time, place, and person. His attention and concentration were fair but occasionally disrupted when discussing stressful topics. Memory appeared intact for recent and remote events.

Insight and Judgment:

He demonstrated good insight into his current difficulties, acknowledging the role of stress and alcohol in his condition. His judgment appeared intact, and he showed motivation for counseling and behavioral change.

**Assessment Procedures**

Clinical Interview: A structured and semi-structured clinical interview was conducted to gather comprehensive information about his personal history, family dynamics, health status (including HIV diagnosis), substance use, and current psychosocial stressors.

Mental Status Examination (MSE): Performed to evaluate his current cognitive, emotional, and behavioral functioning, rule out psychiatric symptoms such as psychosis, and assess mood, thought processes, and insight.

Risk Assessment: Screening for suicidal ideation, self-harm, and potential harm to others was carried out, with no risk factors identified during sessions.

Psychoeducation: Provided regarding the effects of alcohol on health, particularly considering his HIV positive status, and the importance of medication adherence and healthy coping mechanisms.

Family System Exploration: Informal exploration of family dynamics and communication patterns was conducted to understand the stressors related to his relationships with his two wives.

Behavioral Assessment: Assessment of alcohol use patterns as a coping mechanism for stress, including frequency and impact on daily functioning.

Motivational Assessment: Evaluated his readiness and motivation to engage in counseling and make behavioral changes, noting good insight and self-awareness.

**Assessment Results**

The assessment process revealed that the client is experiencing significant psychological distress manifesting as symptoms consistent with adjustment disorder with Mixed Disturbance of Emotions and Conduct. He reported persistent feelings of stress, frustration, and low mood directly linked to psychosocial stressors, particularly his HIV positive status and complex marital dynamics involving his two wives.

During the clinical interview and Mental Status Examination, he appeared alert and oriented, with coherent and goal-directed thought processes. No psychotic symptoms or cognitive impairments were evident. His mood was notably distressed, with a constricted but appropriate affect. He denied suicidal or homicidal ideation, and no immediate safety risks were identified.

Behaviorally, he reported increased use of alcohol as a maladaptive coping strategy to manage his emotional distress and familial conflicts. This increased alcohol consumption has contributed to difficulties in maintaining harmonious relationships with his wives and may pose risks to his physical health given his HIV status.

Family exploration revealed ongoing communication breakdowns and emotional tensions exacerbated by misunderstandings about his illness. Despite these challenges, he demonstrated a strong motivation to engage in psychoeducation and counseling interventions aimed at improving family support and managing stress.

He maintains steady employment as a mechanic, indicating functional capacity in occupational domains despite psychosocial difficulties. His insight into his condition and willingness to participate in therapy are positive prognostic factors.

**Case Formulation**

Biological Factors:

The client is a 46-year-old male living with HIV, a chronic medical condition requiring ongoing management. His physical health is potentially compromised by his reported alcohol use, which may interfere with medication adherence and immune system functioning. There is no history of psychiatric illness or neurological conditions.

Psychological Factors:

The client experiences significant emotional distress manifested as stress, frustration, and low mood. He uses alcohol as a maladaptive coping mechanism to manage his psychological discomfort and familial pressures. Despite this, he demonstrates good insight into his condition and motivation for change. Cognitive patterns include worry about family relationships, feelings of helplessness, and concerns about his health status.

Social Factors:

His complex family dynamics being married to two wives living separately create ongoing interpersonal stressors. Communication difficulties and misunderstandings about his HIV status exacerbate marital tensions. His occupational role as a mechanic provides some stability, but balancing work and family responsibilities adds to his stress load. Social support appears limited, with expressed needs for psychoeducation and improved familial support.

Summary:

The clients emotional and behavioral symptoms are clearly linked to identifiable psychosocial stressors, particularly his health status and marital conflicts. His alcohol use reflects a conduct disturbance secondary to these stressors. His motivation and insight are strengths that can facilitate therapeutic progress.

**Diagnosis**

Adjustment Disorder with Mixed Disturbance of Emotions and Conduct (F43.25)

His symptoms of emotional distress (stress, low mood) combined with behavioral issues (increased alcohol use) following the onset of significant psychosocial stressors namely, his HIV diagnosis and complex marital relationships meet the DSM-5 criteria for this diagnosis. There is no evidence of a primary mood disorder, psychotic disorder, or substance use disorder, though alcohol misuse contributes to the overall clinical picture

**Therapeutic goals**

To Reduce stress and emotional distress related to family dynamics and living with HIV.

To decrease alcohol consumption by developing healthier coping mechanisms for managing stress.

To Improve communication and relationship skills to foster better understanding and support between him and his wives.

To Increase knowledge and acceptance of HIV within the family through psychoeducation.

To enhance his emotional regulation and problem-solving abilities to better manage daily stressors.

To strengthen his motivation and adherence to medical treatment and counseling recommendations.

To promote overall psychological well-being and improve quality of life.

**Treatment Plan and Intervention Strategies**

Stress Management and Emotional Support Cognitive-behavioral therapy (CBT) techniques were used to help him identify and challenge negative thoughts related to his stress and health condition.

Relaxation techniques such as deep breathing and mindfulness were introduced to reduce physiological stress responses. He was encouraged to use journaling and other expressive activities to process his emotions.

Alcohol Use Reduction -Motivational interviewing was employed to explore his ambivalence about alcohol use and strengthen his commitment to reduce consumption. A relapse prevention plan was developed, identifying triggers and alternative coping strategies. Psychoeducation on the effects of alcohol on HIV and overall health was provided.

Family and Marital Counseling Sessions were facilitated with him and his wives (with their consent) to improve communication, address misunderstandings about HIV, and build supportive relationships. Communication skills, conflict resolution, and empathy development were taught to reduce marital tensions.

Psychoeducation about HIV transmission, treatment, and living positively was incorporated to reduce stigma. Ongoing education about HIV management, medication adherence, and health maintenance was provided. Resources and referrals for support groups for people living with HIV were offered.

Enhancing Coping and Problem-Solving Skills

CBT-based problem-solving techniques were introduced to equip him with tools to manage daily stressors effectively. Support was provided to develop healthy routines balancing work, family, and self-care.

Monitoring and Risk Assessment

Mood, alcohol use, and any emerging risk factors, including suicidal ideation, were regularly assessed.

The treatment plan was adjusted based on his progress and feedback.

Referral Considerations

Referral to medical professionals or psychiatrists was planned if pharmacological intervention became necessary. Community resources such as peer support groups and HIV counseling services were recommended.

**Outcome / Evaluation**

The client consistently attended counseling sessions and actively engaged in the therapeutic process. He demonstrated increased insight into the relationship between his stress, alcohol use, and health status. Over time, he reported a gradual reduction in alcohol consumption, supported by the relapse prevention strategies introduced.

He began to practice relaxation and stress management techniques, such as deep breathing and mindfulness, which he reported helped to decrease feelings of anxiety and frustration. Communication within the family showed some improvement as the client applied skills learned during marital counseling sessions, though challenges remained.

The client expressed appreciation for the psychoeducation provided on HIV management, which helped reduce some anxieties related to the illness and improved his willingness to discuss his condition openly with his wives.

Risk assessments conducted throughout the intervention period showed no emergence of suicidal ideation or self-harm behaviors. The client maintained his work as a mechanic, indicating functional stability in occupational areas despite ongoing stressors.

Overall, progress was noted in emotional regulation, coping strategies, and family interactions. Continued support and follow-up were recommended to sustain and build upon these gains.

**Recommendations**

Continued engagement in structured counseling focusing on stress management, alcohol reduction, and family communication is recommended to support ongoing emotional and behavioral improvements.

Further psychoeducation sessions for the client and his wives should be facilitated to enhance understanding of HIV management and reduce stigma within the family.

Regular monitoring of alcohol use and mental health symptoms is advised to promptly identify and address any relapse or emerging psychological concerns.

Collaboration with healthcare providers is important to ensure adherence to HIV treatment and address any physical health complications.

Referral to peer support groups for people living with HIV may provide additional social support and promote coping.

Encourage the client to develop and maintain healthy lifestyle routines balancing work, family, and self-care.

In case of significant deterioration or persistent symptoms despite counseling, consider referral for psychiatric evaluation and possible pharmacological intervention.

**Challenges and Reflections**

During the counseling process, several challenges were encountered. The client’s use of alcohol as a coping mechanism complicated the therapeutic work, requiring careful pacing and motivational strategies to address substance use without overwhelming him. Balancing respect for his cultural and family context with the need to challenge maladaptive behaviors demanded sensitivity and patience.

Family dynamics involving two wives living separately presented ongoing stressors that limited the immediate impact of counseling on relational harmony. Building trust with the client took time, especially as he navigated feelings of vulnerability related to his HIV status and marital conflicts.

From a personal perspective, I reflected on the importance of providing a nonjudgmental and supportive space to facilitate openness. It was clear that psychoeducation played a key role in reducing misconceptions about HIV and improving communication. Moving forward, I recognized the need to integrate behavioral and emotional interventions carefully to support sustainable change.

This experience highlighted the complexity of addressing adjustment difficulties within a multifaceted social and health context and underscored the value of client-centered approaches in fostering resilience and insight.

**Follow-up**

Regular follow-up sessions were scheduled to monitor the client’s progress in managing stress, reducing alcohol use, and improving family communication. The client’s adherence to coping strategies and homework assignments, such as relaxation exercises and relapse prevention plans, was reviewed during these meetings.

Collaboration with the school counsellor and healthcare providers was maintained informally to track changes in the client’s occupational functioning and physical health. Any emerging concerns, including mood fluctuations or increased alcohol use, were promptly addressed.

Reassessments were conducted every four to six weeks to evaluate symptom severity and adjust the treatment plan as needed. The client was kept informed about the possibility of additional referrals for family psychoeducation or psychiatric evaluation, which would only be pursued with his consent and appropriate guardian involvement if required.

**Client number 4**

**Client code** 012

**Date of first session** 12th June 2025

**Counselor** Michelle Ingado Ajanga

**Placement site** Broadway High School

**Biographic Data**

**Client Code**: 012

**Age:** 15 years

**Gender**: Female

**School**: Broadway High School

**Class/Form**: Form 2

**Marital Status:** Single

**Occupation:** Student

**Religion:** Christian

**Background data**

The client is a 15-year-old female Form 2 student at Broadway High School who self-referred for counseling. She reported experiencing persistent discomfort in social situations, which began in late primary school after a few peers made negative comments about her weight. These experiences were reinforced at home, where her mother and sisters often made jokes about her appearance.

Over time, these remarks contributed to the development of low self-esteem, heightened self-consciousness, and avoidance of social interactions. The client expressed a strong desire to understand why she feels uncomfortable in social settings and tends to avoid interacting with peers. She reported that she frequently checks her reflection, compares herself to others, and sometimes skips meals in an attempt to improve her appearance.

The client has no known history of medical illness, psychiatric treatment, or substance use. She maintains regular school attendance but reports limited participation in group activities. Her relationship with peers is restricted, and she prefers to keep to herself to avoid potential judgment. She has a supportive teacher who encouraged her to seek counseling

**Presenting Issues / Complaints**

The client reported persistent feelings of discomfort and anxiety in social settings, often avoiding interaction with peers due to fear of negative judgment or embarrassment. She expressed feelings of shame about her body, particularly her weight, and admitted to frequently checking her reflection and comparing her appearance to others. She described episodes of low mood, sadness, and crying, as well as skipping meals in an attempt to lose weight. These difficulties are compounded by repeated teasing and comments from her mother and sisters about her appearance, which have contributed to heightened self-consciousness. The symptoms have persisted for more than six months, have increased in severity over time, and interfere significantly with her daily functioning and school life.

**Observations**

The client appeared her stated age and was neatly dressed in her school uniform, maintaining good personal hygiene. Her posture was slightly withdrawn, with limited eye contact at the beginning of the session, though she became more relaxed as rapport developed. She was cooperative and engaged appropriately throughout. Her speech was coherent, relevant, and spontaneous, with a soft tone and low but audible volume. Speech was goal-directed, though she occasionally became slightly insistent when discussing emotionally distressing topics. No evidence of pressured speech was noted

**Mental State Examination (MSE)**

Appearance: Neatly dressed in school uniform; well-groomed; appeared stated age.

Behavior: Initially withdrawn with limited eye contact; became more comfortable as session progressed; cooperative and responsive.

Speech: Coherent, relevant, spontaneous; soft tone, low but audible volume; goal-directed; no pressured speech.

Mood and Affect: Reported low mood, shame, and anxiety related to body image; affect congruent with mood

Thought Processes: Logical and goal-directed; no loosening of associations.

Thought Content: Cognitive distortions present, especially around self-image (“not good enough”); no delusions or psychotic features.

Perception: No hallucinations or perceptual disturbances noted.

Cognition: Alert and oriented to time, place, and person; attention span and concentration intact; memory adequate.

Insight and Judgment: Fair insight into her difficulties; judgment intact.

**Assessment procedures**

Clinical Interview -A semi-structured clinical interview was conducted to gather detailed information about the client’s presenting concerns, personal history, family background, academic life, and the onset and course of symptoms. The interview explored triggers, maintaining factors, coping strategies, and the client’s subjective experience of her difficulties. This process allowed for rapport building and provided qualitative data on her emotional state, thought patterns, and social functioning.

Behavioral Observation -The client’s non-verbal behavior, posture, eye contact, and emotional expressions were closely observed during the session. Special attention was given to changes in comfort level as rapport developed, speech characteristics, and anxiety-related behaviors such as fidgeting or topic avoidance. Observations were used to corroborate self-reported information with visible indicators of distress.

Social Anxiety Scale for Adolescents (SASA) -This standardized tool was administered to measure the intensity of fears in social and performance situations. It assessed avoidance patterns, physiological symptoms in social contexts, and the degree to which these symptoms interfered with daily functioning. Results were compared with normative data to determine severity.

Body Dysmorphic Disorder Questionnaire (BDDQ) – Selected questions from the BDDQ were used to assess the presence and severity of preoccupation with perceived flaws in physical appearance, particularly weight-related questions from the BDDQ were used to assess the presence and severity of concerns. The tool explored the extent of distress, the amount of time spent on appearance-related thoughts, and behaviors such as mirror checking and social avoidance.

Mental State Examination (MSE) – A detailed MSE was conducted to evaluate the client’s appearance, behavior, speech, mood, affect, thought processes, thought content, perception, cognition, insight, and judgment. This helped in identifying cognitive distortions related to self-image and ruling out psychotic symptoms such as hallucinations or delusions.

**Assessment Results**

Clinical Interview

Revealed persistent social anxiety symptoms, including fear of negative judgment, avoidance of peer interactions, and emotional distress in social settings. Identified significant preoccupation with body image, especially weight, which has been ongoing for more than six months and interferes with academic and social functioning.

Behavioral Observation

The client initially displayed a withdrawn posture, limited eye contact, and a soft tone of voice. She became more engaged as rapport developed but showed signs of anxiety such as fidgeting and hesitation when discussing her appearance.

Social Anxiety Scale for Adolescents (SASA)

Scores indicated moderate-to-severe levels of social anxiety. Showed high avoidance behaviors, intense distress in anticipation of social situations, and strong fear of being judged.

Body Dysmorphic Disorder Questionnaire (BDDQ) – Responses showed high preoccupation with perceived physical flaws, primarily body weight. Client reported frequent mirror checking, comparing herself to others, and meal skipping as weight-control measures. The preoccupation caused emotional distress and social avoidance.

Mental State Examination (MSE) – Client was alert, oriented, and cognitively intact. Mood was low with affect congruent to mood. No hallucinations, delusions, or other psychotic symptoms were observed. Thought content showed cognitive distortions related to self-worth and appearance. Insight was fair, and judgment intact.

**Case formulation& diagnosis**

**Case Formulation**

Client Code 0012 is a 15-year-old female Form 2 student who self-referred for counseling due to persistent discomfort in social settings, fear of negative judgment, and preoccupation with her body image, particularly weight. Her symptoms began in late primary school following teasing from peers, which was later reinforced by repeated comments from her mother and sisters. These experiences contributed to low self-esteem, cognitive distortions around self-worth, and avoidance of social situations. Assessment findings indicate that her social anxiety and body image concerns are interconnected – preoccupation with her appearance intensifies her fear of judgment, while social avoidance reinforces her negative self-perception. The combination of these factors has led to functional impairment in both academic and social domains, with emotional distress characterized by low mood, shame, and self-consciousness.

**Primary Diagnosis (DSM-5):**

**Social Anxiety Disorder (F40.10)**

Marked fear of social situations where there is potential for scrutiny.

Fear of embarrassment or negative evaluation by others.

Avoidance of social interactions or enduring them with intense anxiety.

Duration of symptoms for more than six months.

Significant distress and impairment in functioning.

Not attributable to the effects of a substance or another medical condition.

**Secondary/Co-occurring Symptoms:**

**Symptoms consistent with Body Dysmorphic Disorder (F45.22)**

Preoccupation with perceived flaws in physical appearance, especially body weight.

Repetitive behaviors (e.g., mirror checking, comparing appearance to others).

Avoidance of social situations due to appearance concerns.

Emotional distress and functional impairment resulting from preoccupation.

**Therapeutic Goals**

The therapy process for Code 0012 is aimed at addressing both her emotional and behavioral challenges, while building resilience and improving her self-image. The specific goals include:

To reduce social anxiety symptoms for example, decreasing avoidance of social situations and reducing physical manifestations of anxiety, such as restlessness or rapid heartbeat, during peer interactions.

To improve self-esteem and body image for example, fostering a positive self-perception, encouraging self-acceptance, and challenging negative self-talk related to her physical appearance.

To reduce safety behaviors, such as excessive mirror checking for example, replacing compulsive appearance-checking habits with healthier coping mechanisms like mindfulness or grounding exercises.

To enhance emotional regulation and social skills for example, increasing her ability to manage distressing emotions, initiate conversations, and maintain healthy peer relationships.

To strengthen family understanding and support — for example, facilitating psychoeducation sessions with her parents/siblings to improve empathy, communication, and supportive interactions within the family.

**Treatment Plan & Interventions**

The treatment approach for Code 0012 integrates Cognitive Behavioral Therapy (CBT) and Person-Centered Therapy (PCT), with additional focus on self-compassion and self-care techniques. The plan is structured as follows:

Psychoeducation

Provide education about social anxiety, body image concerns, and the role of thoughts in shaping emotions and behaviors. Share information about healthy body diversity and the impact of unrealistic beauty standards.

Cognitive Behavioral Therapy (CBT) Techniques

Cognitive restructuring: Identify and challenge distorted thoughts about her appearance and perceived social judgment.

Behavioral experiments: Gradually reduce avoidance behaviors (e.g., skipping social activities) and mirror-checking through exposure tasks.

Thought records: Encourage regular journaling of situations, thoughts, emotions, and alternative balanced thoughts.

Person-Centered Therapy (PCT) Approach

Provide a non-judgmental, empathetic, and accepting environment to enhance self-expression. Encourage the client to explore her feelings about herself and her relationships, fostering self-awareness and self-acceptance.

Self-Compassion Practices

Introduce mindfulness-based self-kindness exercises to replace harsh self-criticism with understanding and patience.

Use guided imagery to promote positive body image and self-worth.

Self-Care Strategies

Promote engagement in enjoyable activities, such as hobbies, sports, or creative arts.

Encourage balanced nutrition, adequate rest, and regular physical activity for emotional and physical well-being.

Family Involvement

Conduct family sessions to educate parents/siblings on the harmful effects of teasing and to encourage supportive communication.

Relapse Prevention

Teach coping strategies for future triggers, such as grounding techniques, positive self-affirmations, and problem-solving skills.

**Outcome/Evaluation**

Reduction in social anxiety symptoms – Client showed decreased avoidance of social situations and improved comfort in interacting with peers.

Decrease in compulsive mirror checking – Frequency reduced significantly, with less distress over perceived flaws.

Improved self-esteem – Client expressed greater self-acceptance and reduced negative self-talk.

Enhanced emotional regulation – Began using relaxation techniques such as deep breathing and positive affirmations effectively.

Family psychoeducation impact – Family members demonstrated increased awareness of body image issues, though communication challenges persisted.

Overall coping improvement – Client became more confident in applying learned coping skills outside sessions.

Need for continued follow-up – Recommended periodic check-ins to reinforce gains and address remaining challenges.

**Recommendations**

Continued individual counseling – Maintain regular therapy sessions to reinforce progress in self-esteem and social confidence.

Family counseling sessions – Engage family members to improve communication and reduce negative remarks about appearance.

Peer support group participation – Encourage joining a safe, supportive group for adolescents dealing with body image concerns.

Ongoing psychoeducation – Provide further education on healthy body image, self-care, and resilience skills.

School collaboration – Work with teachers and the school counselor to monitor academic performance and social engagement.

Skill-building activities – Encourage involvement in hobbies and extracurricular activities that promote self-worth.

Periodic follow-up – Schedule check-ins every 2–3 months to assess progress and prevent relapse.

**Challenges**

Limited time for sessions due to the client’s school schedule, which sometimes interrupted therapeutic continuity.

Resistance in initial sessions, as the client was hesitant to share personal experiences openly.

Minimal family cooperation, with caregivers showing limited understanding of the impact of their comments on the client’s self-esteem.

Emotional sensitivity during discussions on body image, requiring careful pacing and emotional regulation strategies.

Balancing confidentiality with the need to involve school staff in supporting the client.

**Reflections**

The case highlighted the importance of creating a safe and non-judgmental environment for adolescents to open up about sensitive issues like body image.

Building rapport through empathy, active listening, and consistent validation was crucial in breaking initial resistance.

Family involvement, even if challenging, remains a key factor in sustaining long-term change for adolescent clients.

Incorporating creative interventions, such as art therapy and journaling, proved effective in helping the client express emotions indirectly.

**Follow-Up**

A follow-up session was scheduled after 4–6 weeks to monitor progress in self-esteem, social engagement, and emotional regulation.

Communication was maintained with the school counselor/teacher to track behavioral and academic changes.

Booster psychoeducation sessions on body image and coping strategies were provided to reinforce skills learned.

The client was assessed for any relapse in avoidance behaviors or negative self-talk, and these were addressed promptly.

The client continued journaling and participated in positive peer activities to sustain confidence building. The experience reinforced the need for continuous psychoeducation for both clients and families to address deep-seated beliefs about beauty and self-worth.

**Client number 5**

**Client code** 009

**Date of first session** 16th July 2025

**Counselor** Michelle Ingado Ajanga

**Placement site** Broadway High School

**Biographic data**

**Client Code:** 009

**Age:** 17 years

**Gender**: Male

**School:** Broadway High School

**Marital Status:** Single

**Referral Source**: Self-referred

**Religion** Christian

**Background Information**

The client reported that the habit of masturbation began at approximately age 14, initially occurring frequently. Over time, the behavior gradually increased, becoming more habitual, particularly during idle moments or when watching movies unsupervised. He identified boredom and certain movie scenes as primary triggers.

The client stated that although he has a girlfriend, they are not sexually active. He clarified that his concerns were not due to unmet sexual needs but rather poor impulse control. He denied any history of trauma, sexual abuse, or psychiatric illness. There was no history of substance use or any significant medical conditions.

**Presenting Issues / Complaints**

The client voluntarily sought counselling support to address persistent difficulties with excessive masturbation and frequent consumption of pornographic material. He reported that these behaviors had become increasingly problematic, occurring predominantly during idle periods, moments of unsupervised leisure, or while watching movies containing sexual content.

He expressed significant emotional distress associated with the behavior, describing recurrent feelings of guilt, anxiety, and self-disappointment due to a perceived failure to meet personal values, family expectations, and spiritual beliefs. Despite being in a relationship, he stated that the issue was unrelated to unmet sexual needs, emphasizing that his primary challenge was poor impulse control.

The client’s motivation for seeking help was rooted in a desire to reduce or eliminate the behaviors, adopt healthier coping strategies, and strengthen his sense of self-control, thereby maintaining personal integrity and avoiding parental disappointment.

**Observation / Mental State Examination**

General Appearance and Behavior:

The client presented as neatly groomed, clean, and appropriately dressed for his age and school environment. His attire was in line with the school’s standards and gave an impression of self-care. Posture was upright, and motor activity appeared within normal limits, with no observable signs of psychomotor agitation or retardation. He maintained appropriate eye contact, displayed open body language, and remained seated comfortably throughout the session. The client demonstrated cooperative behavior, willingly engaging in the counselling process without resistance or defensiveness.

Attitude and Engagement:

He exhibited a respectful and receptive attitude toward the counsellor, appearing motivated to discuss his concerns openly. He responded thoughtfully to questions, often reflecting before answering, and did not display signs of guardedness or avoidance. His engagement was consistent throughout the session, and there were no signs of distraction, fidgeting, or withdrawal.

Speech:

Speech was spontaneous, coherent, and goal-directed. The tone and volume were appropriate, with a moderate pace that was neither pressured nor excessively slow. There was no evidence of tangentiality, circumstantiality, or flight of ideas. Language use was age-appropriate, and articulation was clear.

Mood and Affect:

The client’s mood appeared mildly anxious, particularly when discussing the frequency of the behaviors and the associated feelings of guilt. His affect was congruent with his reported mood, displaying seriousness when addressing sensitive topics and slight relief when discussing potential solutions. There were no signs of emotional blunting, lability, or inappropriate affect.

Thought Processes and Content:

Thought processes were logical, linear, and well-organized. There was no evidence of thought disorder, loosening of associations, or derailment. Thought content revealed preoccupation with the problem behaviors and concern about their moral, personal, and relational implications. There were no delusions, hallucinations, or paranoid ideations noted.

Perceptions:

No perceptual disturbances were reported or observed during the session.

Cognition:

The client was alert and fully oriented to time, place, person, and situation. His memory (both recent and remote) appeared intact, as did his attention span and concentration. He demonstrated sound reasoning skills and was able to understand and process abstract concepts presented during the discussion.

Insight and Judgment:

Insight was fair; the client demonstrated an understanding of the nature of his behaviors, their triggers, and their potential consequences. He acknowledged that the behaviors conflicted with his values and expressed a desire for change. Judgment was generally intact, though he noted occasional susceptibility to peer influence and media exposure.

Risk Assessment:

No evidence of suicidal ideation, self-harm tendencies, or risk to others was observed or disclosed.

**Assessment Procedures**

Clinical Interview

A semi-structured interview was conducted to explore the onset, frequency, triggers, and impact of masturbation and pornography use. The interview also covered developmental, family, academic, social, and sexual health history.

Mental State Examination (MSE)

The client was neatly groomed, appropriately dressed, alert, and oriented to time, place, and person. Speech was coherent and goal-directed. Mood appeared mildly anxious, with congruent affect. Thought processes were logical, with no evidence of hallucinations, delusions, or paranoia. Memory, concentration, and reasoning were intact. Insight was fair, and judgment was generally appropriate.

Functional Behavioral Analysis

Applied the Antecedent–Behavior–Consequence (ABC) model to identify triggers (boredom, unsupervised screen time, sexualized media) and reinforcing factors (short-term relief, pleasure). Mapped behavior sequences to identify intervention points.

Self-Monitoring Diary

The client recorded instances of masturbation and pornography use, noting time, place, emotional state, and triggers. This helped establish baseline frequency and identify high-risk periods.

Screening Tools

Brief adolescent screeners for anxiety, depression, and impulse control were administered to rule out comorbid conditions. No significant symptoms of mood disorders, obsessive-compulsive disorder, or substance use were found.

Risk and Safeguarding Assessment

Evaluated for suicidal ideation, self-harm, exposure to illegal content, and coercive sexual behavior. No acute risks were identified. Discussed internet safety and healthy screen habits.

**Assessment Results**

Behavioral Pattern

The client reported engaging in masturbation and pornography use multiple times per week, with some weeks showing daily episodes. The behavior typically occurred during periods of unstructured time, especially when alone at home or in his room. Evening and late-night hours were the most common times, often following prolonged screen use.

Identified Triggers

Boredom was the most frequently cited trigger, particularly during school holidays or free afternoons. Other strong triggers included watching movies containing sexualized content, having unrestricted access to a phone or laptop, and being in a private setting without the possibility of interruption.

Emotional Impact

The client consistently reported feelings of guilt, self-disappointment, and mild anxiety following the behaviors. These emotions were tied to perceived failure to uphold personal values, religious beliefs, and parental expectations. He also expressed concern that the behavior could affect his self-control and long-term personal development.

Impulse Control

Although aware of the consequences and motivated to stop, the client described difficulty resisting urges once they began. Attempts to distract himself were sometimes successful but often short-lived. This suggested a struggle with sustained impulse regulation rather than lack of awareness.

Comorbidities

Screening and interview data indicated no history of trauma, sexual abuse, psychiatric illness, or substance use. Mood and anxiety screening tools revealed no clinical levels of depression or generalized anxiety. There were no indicators of obsessive-compulsive disorder or psychosis.

Protective Factors

The client demonstrated good insight into his behavior, a high level of motivation for change, and a willingness to participate in counselling. He had a supportive school environment, no engagement in risky or coercive sexual behavior, and maintained generally stable relationships at home and with peers. His absence of comorbid psychiatric or medical conditions provided a favorable prognosis for therapeutic intervention.

**Case Formulation**

Client 009 is a male adolescent student at Broadway High School who voluntarily sought counselling due to persistent engagement in masturbation and frequent consumption of pornography. The behavior began around age 14 and gradually increased in frequency, eventually becoming habitual. He reported that the behaviors typically occur during idle periods, particularly when unsupervised, or after exposure to sexual content in movies. Despite being in a non-sexually active relationship, he emphasized that his difficulties are related to impulse control rather than unmet sexual needs.

The behavior is distressing to the client because it conflicts with his personal values, family expectations, and spiritual beliefs, resulting in guilt, anxiety, and lowered self-esteem. He has expressed a strong desire to change, reflecting insight into the problematic nature of the behaviors and motivation to engage in therapeutic intervention.

From a biopsychosocial perspective:

Biological Factors: Adolescence is characterized by hormonal changes that increase sexual drive. These biological processes may amplify susceptibility to habitual sexual behaviors.

Psychological Factors: The client demonstrates difficulties with impulse control, cognitive distortions regarding urges, and reliance on masturbation as a coping mechanism for boredom and emotional regulation. There is no evidence of underlying psychiatric illness, trauma, or substance use.

Social Factors: Unstructured and unsupervised free time, exposure to sexualized media, and limited engagement in alternative recreational or social activities perpetuate the behavior. Family and school environments are generally stable, serving as protective factors, but the client’s awareness of parental expectations contributes to guilt and internal conflict.

The interaction of these factors has resulted in a pattern of compulsive sexual behavior that causes significant distress, interferes with the client’s emotional wellbeing, and challenges his sense of self-control. Protective factors include the client’s insight, motivation for change, cooperation with counselling, stable school and home environment, and absence of psychiatric comorbidities.

Diagnosis

**DSM-5: Other Specified Obsessive-Compulsive and Related Disorder – Compulsive Sexual Behavior Pattern**

Rationale: The client exhibits persistent, repetitive sexual behaviors that are difficult to control, cause marked emotional distress, and interfere with daily functioning. The behavior is not better explained by substance use, psychotic disorders, or another medical condition

**ICD-10: F52.7 – Excessive Sexual Drive (Hypersexuality, Non-paraphilic)**

Rationale: The client demonstrates an elevated sexual drive with repetitive sexual behaviors, distress, and interference in daily functioning, without paraphilic features.

**Therapeutic Goals**

To reduce the frequency of masturbation and pornography consumption

To develop effective coping strategies for managing sexual urges

To enhance impulse control and self-regulation skills

To address feelings of guilt, anxiety, and self-disappointment

To clarify personal values and align behavior with them

To increase awareness of triggers and high-risk situations

To strengthen support systems and communication skills

**Treatment Plan & Intervention Strategies**

Cognitive Behavioral Therapy (CBT)

The client participated in CBT sessions aimed at identifying and restructuring maladaptive thoughts related to masturbation and pornography use.

Cognitive restructuring exercises helped him challenge beliefs such as “I cannot resist urges” and replace them with adaptive, self-affirming thoughts.

Behavioral experiments and role-playing were used to practice coping with triggers in controlled settings.

Person-Centered Therapy (PCT)

The client engaged in person-centered sessions that provided a non-judgmental, empathetic environment to explore emotions of guilt, anxiety, and self-disappointment.

He reflected on his experiences, values, and personal goals, which facilitated self-awareness and promoted intrinsic motivation for change.

Psychoeducation

The client received age-appropriate education on adolescent sexual development, the impact of pornography on brain and behavior, and healthy sexual expression.

Discussions focused on the physiological, psychological, and social consequences of compulsive sexual behaviors, reinforcing awareness without shaming.

Values Clarification & Identity Work

The client engaged in exercises to clarify personal, familial, and spiritual values.

He connected these values to behavioral choices, enhancing alignment between his actions and his sense of self.

Functional Analysis & Self-Monitoring

The client maintained a behavioral diary to track instances of masturbation, pornography use, triggers, and emotional states.

Functional analysis was used to identify antecedents and consequences of behavior, guiding targeted interventions and helping him develop alternative coping strategies.

Impulse Control & Coping Skills Training

The client learned strategies to delay or redirect urges, including deep-breathing exercises, mindfulness techniques, and engaging in alternative rewarding activities.

Sessions included rehearsal of coping strategies to improve self-regulation during high-risk situations.

Support & Environmental Modification

Recommendations were provided to increase structured daily routines, reduce unmonitored screen time, and enhance supportive communication with parents or school staff.

The client identified safe and trusted adults to consult when experiencing intense urges or emotional distress.

**Outcomes/Evaluation**

Reduction in Frequency of Behavior

The client demonstrated a noticeable decrease in the frequency of masturbation and pornography consumption over the course of the sessions. Self-monitoring diaries indicated fewer episodes and shorter durations, particularly during previously high-risk periods such as evenings and unsupervised leisure time.

Improved Coping and Impulse Control

The client successfully implemented alternative coping strategies, including engaging in physical activity, creative hobbies, and mindfulness exercises. He reported feeling more able to pause and reflect before responding to sexual urges, indicating enhanced impulse control.

Emotional Regulation and Self-Acceptance

Through person-centered therapy and cognitive restructuring, the client reported reduced feelings of guilt, anxiety, and self-disappointment. He demonstrated improved emotional awareness and expressed greater self-compassion regarding past behaviors.

Increased Insight and Self-Awareness

The client exhibited stronger insight into the triggers and maintaining factors of his behaviors. He was able to identify patterns, anticipate high-risk situations, and apply learned strategies to manage urges effectively.

Alignment with Personal Values

The client showed progress in aligning his behaviors with his personal, family, and spiritual values. He expressed increased confidence in making decisions consistent with his goals and values, contributing to improved self-esteem and personal integrity.

Enhanced Support Utilization

The client successfully engaged his support system by identifying trusted adults at home and school to consult when experiencing strong urges or emotional distress. This increased his sense of safety and accountability.

Overall Evaluation:

The client demonstrated measurable improvement across behavioral, emotional, and cognitive domains. He actively engaged in all interventions, showed motivation for change, and successfully applied coping strategies in real-life situations. While occasional lapses occurred, they decreased over time, indicating progress towards sustainable behavioral change. The interventions were effective in enhancing self-control, reducing distress, and supporting value-consistent behavior.

**Recommendations**

Continued Counselling Support

I recommended that the client continue with periodic follow-up sessions to reinforce the coping strategies learned, monitor progress, and address any emerging challenges related to masturbation and pornography use.

Structured Routine and Time Management

I advised the client to maintain a structured daily routine, including scheduled academic, recreational, and social activities, to reduce idle time and minimize opportunities for high-risk behavior.

Ongoing Self-Monitoring

I encouraged the client to continue maintaining a behavioral diary to track urges, triggers, and coping responses, as this would reinforce self-awareness and accountability.

Parental Involvement and Communication

I recommended that the client maintain open, age-appropriate communication with his parents or guardians about his progress, while preserving confidentiality regarding sensitive details, to enhance support and guidance.

Engagement in Healthy Coping Mechanisms

I guided the client to actively engage in alternative, value-consistent activities such as sports, creative hobbies, mindfulness, and relaxation exercises to manage boredom and sexual urges effectively.

Psychoeducation Reinforcement

I advised the client to periodically review age-appropriate sexual health and emotional regulation information to reinforce healthy attitudes toward sexuality and strengthen knowledge of triggers and coping strategies.

School Support and Monitoring

I recommended that teachers and the school counsellor continue providing a supportive environment, monitor high-risk periods (e.g., free periods, unsupervised access to devices), and facilitate structured engagement in school activities.

**Challenges and Reflections**

Client Hesitation to Disclose

The client initially hesitated to share details about his masturbation and pornography use due to embarrassment. This required consistent reassurance and building of trust to encourage honest disclosure.

Environmental Triggers

The client’s behavior was strongly influenced by boredom, unsupervised time, and exposure to sexualized media. Addressing these triggers required repeated guidance and practical strategies to manage high-risk situations.

Balancing Psychoeducation and Sensitivity

It was challenging to provide age-appropriate and culturally sensitive information about sexual behavior without causing shame. Careful choice of language and examples was necessary to ensure understanding and acceptance.

Implementing Behavioral Change

Encouraging the client to consistently apply coping strategies and diary-keeping was sometimes difficult, as habitual behaviors are deeply ingrained. Continuous monitoring and reinforcement were needed.

Professional Reflection

I reflected on the importance of combining CBT, person-centered therapy, and values clarification. The client’s motivation and insight facilitated progress, and the case highlighted areas for my professional growth in managing adolescent sexual behaviors.

**Follow-Up**

Monitoring Progress

I scheduled follow-up sessions to review the client’s diary entries, assess the frequency of masturbation and pornography use, and evaluate the effectiveness of coping strategies. This allowed for adjustments to interventions as needed.

Reinforcing Coping Strategies

During follow-up, I reinforced previously taught coping skills such as mindfulness, alternative activities, and stimulus-control techniques to ensure the client continued to apply them effectively.

Reviewing Values and Goals

I revisited the client’s personal, familial, and spiritual values to maintain motivation and ensure behavior remained aligned with his long-term goals.

Parental and School Support

I maintained communication with parents and school staff, with the client’s consent, to provide guidance on supportive monitoring, structured routines, and safe access to devices.

Evaluation of Emotional Wellbeing

Follow-up sessions included discussion of the client’s emotional state, self-esteem, and anxiety levels to monitor improvement and address any emerging distress.

Planning for Long-Term Maintenance

I guided the client in developing a long-term plan to sustain behavioral change, prevent relapse, and reinforce healthy coping mechanisms beyond the counselling period.

**Client number 6**

**Client code** 013

**Date of first session** 10th June 2025

**Counselor** Michelle Ingado Ajanga

**Placement site** Broadway High School

**Biographic data**

**Client Code:** 013

**Name:** Michelle Ingado Ajanga

**Age:** 15 years

**Gender:** Male

**Marital Status:** Single

**School:** Broadway High School

**Grade/Form:** 2

**Background information**

The client’s emotional and behavioral challenges began approximately seven months ago, around two months after his parents separated. Initially, he stayed with his mother, but he was later sent to live with his father and stepmother. He reported that his stepmother was strict and closely monitored his activities, which he found stressful.

Since relocating, he exhibited declining academic performance, emotional withdrawal, irritability, disturbed sleep patterns, and growing confusion regarding his identity and sense of belonging. He avoided social interactions, lost interest in class and group activities, and demonstrated occasional anger outbursts, including shouting at a teacher.

The client was raised in a Christian home and occasionally prayed, though he reported feeling spiritually disconnected, stating, “I ask God why this is happening to me.” He showed little concern for his physical appearance and often appeared unkempt. He denied any history of psychiatric illness, trauma, substance abuse, or major medical conditions. His upbringing prior to parental separation appeared generally stable, and he demonstrated fair insight into his current emotional struggles.

**Presenting Issues / Complaints:**

The client was referred by his class teacher due to concerns regarding academic decline, withdrawal from class participation and extracurricular activities, and observable changes in behavior. He voluntarily acknowledged feeling persistently low, overwhelmed, and emotionally detached since relocating to live with his father and stepmother following parental separation. He described experiencing frequent episodes of anger and frustration, sometimes resulting in verbal outbursts, such as shouting at a teacher.

The client reported difficulty concentrating on academic tasks, diminished interest in subjects he previously enjoyed, and avoidance of social interactions with peers. He expressed confusion regarding his sense of identity and belonging, stating, “I don’t belong anywhere.” Additionally, he noted disturbed sleep patterns and low energy, contributing to his sense of fatigue and detachment. He described feeling unsupported and emotionally neglected at home, which appeared to exacerbate feelings of sadness, irritability, and emotional withdrawal.

Emotionally, the client reported feeling spiritually disconnected, despite being raised in a Christian home. He occasionally prayed but often questioned why he was experiencing his current struggles, saying, “I ask God why this is happening to me.” He also exhibited diminished concern for his physical appearance and personal care, often appearing unkempt. Overall, the client’s complaints reflect a combination of emotional distress, adjustment difficulties related to family changes, and impairment in academic and social functioning.

**Observation / Mental Status Examination (MSE):**

Appearance and Behavior: The client appeared casually dressed and somewhat unkempt, showing limited concern for personal hygiene and grooming. His posture was slouched, and he demonstrated minimal eye contact throughout the session. He was cooperative but appeared fatigued and emotionally withdrawn.

Speech: Speech was coherent, relevant, soft-spoken, and monotone, with occasional long pauses. There were no signs of pressured, disorganized, or tangential speech.

Mood and Affect: The client’s mood appeared low, and his affect was subdued and constricted. He expressed sadness, frustration, and emotional detachment.

Thought Processes and Content: Thought processes were logical, goal-directed, and coherent. He did not express any delusional thoughts, hallucinations, or bizarre beliefs. He occasionally voiced feelings of being unwanted and unvalued.

Cognition: The client was alert and oriented to time, place, and person. Memory appeared intact, and attention and concentration were average. He demonstrated fair insight into his emotional challenges, particularly regarding the impact of parental separation and changes in living arrangements.

Risk Assessment: The client did not express suicidal ideation, self-harm thoughts, or risk to others. However, moderate risk was noted due to emotional neglect at home and frequent emotional distress.

Spirituality: The client reported being raised in a Christian home and occasionally praying. However, he felt spiritually disconnected and questioned why he was experiencing his current difficulties, stating, “I ask God why this is happening to me.”

Overall Impression: The client presented as emotionally distressed, fatigued, and withdrawn, with signs of adjustment difficulties related to family transition. He demonstrated fair insight and motivation to engage in counseling to improve his emotional well-being and academic focus.

**Assessment Procedures:**

Clinical Interview: A structured and semi-structured clinical interview was conducted to gather comprehensive information about the client’s presenting concerns, emotional state, behavioral changes, academic functioning, family background, and psychosocial stressors. The client’s responses were noted for coherence, insight, and emotional expression.

Observation: Behavioral observations were made during the session, including appearance, grooming, posture, eye contact, speech patterns, and level of engagement. Observations also focused on affect, mood, and signs of emotional withdrawal or distress.

Mental Status Examination (MSE): A detailed MSE was conducted to assess the client’s appearance, behavior, speech, mood, affect, thought processes and content, cognition, insight, and risk factors.

Psychosocial History Assessment: Information regarding family dynamics, living arrangements, parental separation, peer relationships, spiritual beliefs, and academic performance was gathered to understand contextual factors contributing to the client’s emotional and behavioral difficulties.

Symptom Checklist / Behavioral Assessment: The client’s reported symptoms, including persistent sadness, irritability, withdrawal, difficulty concentrating, and loss of interest in previously enjoyed activities, were systematically recorded and analyzed to identify patterns consistent with adjustment difficulties.

Risk Assessment: Although no suicidal or homicidal ideation was reported, an evaluation of emotional neglect and stress-related risk factors was conducted to determine potential vulnerability.

**Assessment Results:**

Emotional and Behavioral Functioning: The client reported persistent low mood, feelings of being overwhelmed, emotional detachment, and frequent anger outbursts. He expressed a pervasive sense of not belonging and confusion regarding his personal identity. Behavioral observations confirmed withdrawal from social interactions, lack of interest in class and group activities, and occasional verbal aggression.

Cognitive Functioning: The client was alert and oriented to time, place, and person. His memory appeared intact, and attention and concentration were average. Thought processes were logical, goal-directed, and coherent. He did not exhibit delusional thoughts, hallucinations, or bizarre beliefs. He occasionally expressed feelings of being unwanted.

Insight and Judgment: The client demonstrated fair insight into his current emotional challenges. He understood that his distress was linked to family changes, particularly the parental separation and the shift to living with his father and stepmother. He expressed motivation to engage in counseling to improve his emotional well-being and academic performance.

Spirituality: Raised in a Christian home, the client occasionally prayed but reported feeling spiritually disconnected. He questioned why he was experiencing his current difficulties, stating, “I ask God why this is happening to me.”

Risk Assessment: The client did not express suicidal or homicidal ideation, and no self-harm behaviors were reported. Moderate risk was noted due to emotional neglect at and persistent emotional distress.

Diagnostic Considerations: Based on reported symptoms and psychosocial stressors, and aligned with DSM-5 criteria, the client exhibited:

Persistent sadness and low mood

Difficulty concentrating in school

Withdrawal from social interactions

Loss of interest in previously enjoyed activities

These findings were consistent with adjustment difficulties secondary to familial changes.

**Provisional Diagnosis: Adjustment Disorder with Depressed Mood (F43.21)**

**Case Formulation & Diagnosis:**

**Formulation:**

Client 013, a 15-year-old male student, presented with emotional and behavioral difficulties following his parents’ separation seven months ago. Initially residing with his mother, he was later relocated to live with his father and stepmother, whose strict and closely monitored household contributed to heightened stress. Since the transition, he exhibited persistent sadness, emotional withdrawal, irritability, anger outbursts, difficulty concentrating, and a diminished sense of belonging.

The client’s challenges appeared to be influenced by multiple factors:

Family / Environmental Factors: Parental separation, inconsistent parental attention, adjustment to a new home, and emotional neglect contributed to feelings of abandonment and identity confusion.

Psychosocial Factors: Loss of previously enjoyed social and academic activities, reduced peer interaction, and a sense of isolation intensified emotional distress.

Emotional and Cognitive Factors: The client held negative self-perceptions, such as feeling unwanted, which reinforced low mood, irritability, and social withdrawal.

The client demonstrated fair insight, recognizing the link between his emotional state and family circumstances, and expressed motivation to improve his situation and academic engagement.

Theoretical Alignment: Cognitive Behavioral Therapy (CBT) was applied to address negative thoughts, such as “I am unwanted,” while Person-Centered Therapy provided unconditional positive regard and support. Attachment theory informed understanding of relational and familial dynamics. Interventions also included emotional regulation strategies, grounding exercises, deep breathing, and self-esteem and identity rebuilding techniques.

**Diagnosis:**

Based on DSM-5 criteria, the client met the criteria for Adjustment Disorder with Depressed Mood (F43.21), characterized by persistent sadness, withdrawal, difficulty concentrating, and loss of interest in previously enjoyed activities, arising in response to identifiable psychosocial stressors.

**Therapeutic Goals:**

To help the client develop healthier coping mechanisms to manage stress, anger, and emotional distress.

To improve emotional regulation and reduce the frequency and intensity of anger episodes.

To enhance attention, concentration, and engagement in academic tasks.

To rebuild the client’s self-esteem and personal identity.

To increase social interaction and participation in group and extracurricular activities.

To strengthen the client’s insight into family dynamics and adjustment to parental separation.

To foster a sense of belonging and emotional connectedness both at home and in school.

**Treatment plan and intervention strategies**

The client did not express suicidal ideation or risk to others but was considered at moderate risk due to emotional neglect at home .The counseling approach integrated cognitive behavioral therapy ,person centered therapy, and attachment theory alongside practical strategies for emotional regulation and self esteem rebuilding .

**Interventions implemented:**

Cognitive behavioral therapy**:** The client identified and challenged negative thoughts, such as aim unwanted, and learnt to rephrase them in to more positive and realistic cognitions.

Person centered therapy: sessions focused on providing-on-providing unconditional positive regard, empathy, and supportive listening, fostering self-acceptance and emotional expression.

Attachment based strategies: The client explored feelings of abandonment and inconsistency in parental attention, helping him understand relational patterns and attachment needs.

Emotional regulation and copings: Techniques such as deep breathing, grounding exercises, and mindfulness were employed to help manage anger, anxiety and emotional distress

Self-esteem and identity rebuilding : Discussion and activities aimed at enhancing personal identity, confidence and a sense of worth, particularly in academic and social contexts.

Academic and social support: The client was encouraged to engage in class participation and peer interaction gradually, reinforcing social skills and school engagement.

Overall plan: Interventions were structured to address the client emotional distress, adjustment difficulties and academic challenges while supporting the development of coping strategies, resilience, and a stronger sense of self-worth. Progress was monitored through regular counselling sessions, feedback from the client, and observations of behavioral changes in school and home settings.

**Outcomes / Evaluation:**

Improved Emotional Regulation: The client reported a decrease in the frequency and intensity of anger episodes. He was able to identify triggers and apply coping strategies such as deep breathing and grounding exercises, which helped him manage stress more effectively.

Enhanced Cognitive Awareness: The client demonstrated increased awareness of negative thoughts, particularly feelings of being unwanted, and began reframing these thoughts into more positive and realistic perspectives, reflecting progress in CBT interventions.

Better Academic Engagement: There was noticeable improvement in the client’s concentration, attention, and participation in class activities. Although some difficulties persisted, he showed greater willingness to engage with academic tasks.

Increased Social Interaction: The client gradually began participating in group activities and interacting more with peers, indicating progress in rebuilding social confidence and reducing emotional withdrawal.

Strengthened Insight: The client showed improved understanding of the relationship between his family dynamics, parental separation, and his emotional responses. He expressed motivation to continue working on his emotional well-being and academic performance.

Rebuilding Self-Esteem and Identity: The client demonstrated early signs of improvement in self-confidence and a developing sense of personal identity. Discussions and activities helped him recognize his strengths and value, though continued support was recommended for sustained development.

Overall Evaluation: Overall, the client showed positive progress in emotional, cognitive, social, and academic domains. Interventions integrating CBT, Person-Centered Therapy, Attachment-Based approaches, and coping skills training were effective. Continued support and reinforcement of strategies were necessary to consolidate gains and ensure long-term improvement.

**Recommendations**

Continued Counseling: The client was advised to continue regular counseling sessions to reinforce coping skills, emotional regulation, and self-esteem, ensuring ongoing support for adjustment and emotional challenges.

Parental Engagement: Collaboration with his father and stepmother was recommended to improve understanding, communication, and emotional support at home. Guidance on providing consistent reassurance and appropriate monitoring was suggested.

Academic Support: Engagement with teachers and school counselors was encouraged to monitor academic progress, provide additional support for concentration, and facilitate reintegration into class and group activities.

Social Skills Development: Participation in structured group activities, peer support programs, or school clubs was suggested to enhance social interaction, sense of belonging, and confidence in peer relationships.

Spiritual Support: The client was encouraged to explore spiritual practices or seek guidance if meaningful, to address feelings of spiritual disconnection and promote holistic well-being.

Monitoring Emotional Well-being: Ongoing observation of mood, anger episodes, and social withdrawal was recommended to identify early signs of distress and provide timely support.

Reinforcement of Coping Strategies: Continued practice of deep breathing, grounding exercises, and mindfulness techniques was advised to maintain gains in emotional regulation and stress management.

**Challenges and Reflections:**

Adjustment to New Home Environment: The client initially struggled to adapt to living with his father and stepmother, whose strict rules and close monitoring contributed to stress and emotional withdrawal.

Emotional Withdrawal and Fatigue: At the start of counseling, the client exhibited low motivation, fatigue, and emotional detachment, which slowed engagement and progress in sessions.

Anger Management Difficulties: Frequent anger episodes, including verbal outbursts, required consistent intervention and monitoring to prevent escalation and to teach alternative coping strategies.

Insight Development: While the client showed fair insight into his emotional challenges, reinforcing understanding of the relationship between family dynamics, parental separation, and emotional responses was an ongoing process.

Self-Esteem and Identity Challenges: The client struggled with feelings of being unwanted and confusion regarding personal identity, requiring structured interventions to rebuild self-esteem and foster a sense of belonging.

Reflection on Counseling Practice: The counselor reflected on the importance of patience, active listening, and combining Cognitive Behavioral Therapy, Person-Centered Therapy, and Attachment-Based strategies. Building trust and rapport was critical in supporting the client’s gradual progress and engagement.

**Follow-Up:**

The client was scheduled for ongoing counseling sessions to reinforce emotional regulation, coping skills, and self-esteem development.

Progress was to be monitored through regular feedback from the client, observations at school, and input from teachers regarding academic performance and social engagement.

Collaboration with the client’s family was planned to ensure a supportive home environment and continuity of care.

The counselor intended to review and adjust interventions as needed, based on the client’s progress and emerging needs, to sustain improvements in emotional, social, and academic functioning.

**Group counselling**

**Biographical Data**

**Group Name:** Healthy Minds Support Group

**Group Issues:** Compulsive masturbation and pornography use

**Number of Participants**: 8–12 boys

**Age Range**: 16–20 years

**Number of Sessions:** 11

**Date of First Session:** 10th June 2025

**Venue:** Broadway High School

**Facilitator:** Michelle Ingado Ajanga

**Placement Site:** Susan Gitau Counselling Foundation (in partnership with Broadway High School)

**Duration per Session:** 1 hour 30 minutes

**Background Information & Group Context**

The Healthy Minds Support Group was established to support 8–12 male students at Broadway High School, aged between 16 and 20 years, who were struggling with compulsive masturbation and frequent consumption of pornography. These issues were affecting their concentration in class, academic performance, self-esteem, and personal values.

Most participants reported that the behaviors began during early adolescence and had developed into habitual patterns, often triggered by boredom, peer influence, or exposure to sexual content in media. Some had tried to stop individually but found it difficult due to strong urges and lack of alternative coping skills.

The group was referred by the school’s guidance and counseling department after concerns were raised by teachers and through self-disclosure by some students. The main goal was to provide a safe, non-judgmental environment where members could openly discuss their challenges, gain psychoeducation, and learn healthier coping strategies to manage their urges.

Sessions were held weekly for eleven weeks, each lasting 1 hour and 30 minutes, at Broadway High School. The facilitation approach combined psychoeducation, cognitive-behavioral strategies, group discussions, peer accountability, and practical behavioral change techniques. The group was designed to encourage openness, trust, and mutual respect while promoting self-control and positive lifestyle adjustments.

**Group member selection process**

I identified the group members through referrals from the school’s guidance and counseling department, based on teacher observations and self-disclosures from students struggling with masturbation and pornography use. I worked closely with class teachers to spot boys who showed behavioral signs such as reduced class participation, academic decline, frequent isolation, and distraction due to sexual content.

Participation in the group was voluntary. Once identified, I privately approached each student and explained the purpose, objectives, and confidentiality of the group. Those who agreed to participate provided verbal consent, and we scheduled weekly meetings within the school premises. The final group consisted of 8–12 male students aged 16–20 years who met the criteria and were willing to actively engage in the counseling process.

**Therapeutic Goals**

To provide a safe and confidential environment for members to openly discuss their struggles with masturbation and pornography without fear of judgment.

To increase members’ awareness of the psychological, emotional, social, and spiritual impacts of pornography and compulsive masturbation.

To help members identify personal triggers and high-risk situations that lead to the behavior.

To equip members with practical cognitive-behavioral strategies for managing sexual urges and reducing reliance on pornography and masturbation.

To develop healthier coping mechanisms for managing boredom, loneliness, and stress.

To strengthen self-control, self-esteem, and alignment of behavior with personal values.

To encourage peer accountability and ongoing mutual support beyond the group session

To reduce the frequency of pornography consumption and masturbation among members over the course of the sessions.

**Theoretical Perspective**

The facilitation of the group was guided by a combination of Person-Centered Therapy (PCT) and Cognitive Behavioral Therapy (CBT).

Person-Centered Therapy (PCT): This approach emphasized creating a safe, non-judgmental environment where members felt valued, understood, and accepted. By practicing empathy, unconditional positive regard, and congruence, members were encouraged to openly share their experiences without fear of criticism, fostering self-awareness and personal growth.

Cognitive Behavioral Therapy (CBT): This approach was used to help members identify, evaluate, and challenge irrational or negative thoughts contributing to their distress. Through guided discussions, thought-challenging exercises, and practical coping strategies, members learned to reframe maladaptive thinking and develop healthier behavioral patterns.

**Management Plan & Intervention Strategies**

The group management plan integrated principles from both theoretical approaches, ensuring members received emotional support alongside practical skills training. Key intervention strategies included:

Establishing group rules and structure to provide consistency and psychological safety.

Facilitating open sharing using PCT principles, allowing members to express themselves freely.

Cognitive restructuring exercises to help members challenge distorted thoughts and replace them with realistic alternatives.

Role-playing and problem-solving tasks to practice new coping behaviors in a supportive environment.

Homework assignments such as reflective journaling to reinforce learning between sessions.

Peer feedback sessions to build social support and accountability.

Monitoring progress through regular check-ins and encouraging self-evaluation by members.

**Group therapy**

**Forming – 2 Sessions (1 hour 30 minutes each)**

The first two sessions focused on building rapport, creating a safe atmosphere, and helping members become familiar with one another. I began by welcoming the boys and explaining the purpose of the group, emphasizing that it was a confidential and judgment-free space. Each participant introduced themselves, shared their age, and mentioned one reason they joined the group.

We discussed and agreed on group rules, including respect, active listening, maintaining confidentiality, allowing one person to speak at a time, and avoiding judgment or ridicule. I used icebreakers to ease tension and help members feel comfortable, such as sharing something unique about themselves or discussing a non-threatening topic before moving into deeper issues.

I introduced the main theme of the group — struggles with masturbation and pornography — and briefly explained the goals: to understand the behavior, learn healthy coping skills, and support one another in making positive changes. In these sessions, I also set expectations for attendance, participation, and respect for personal boundaries.

By the end of the forming stage, members were more relaxed, had a clear understanding of the group’s purpose, and began showing willingness to open up in later sessions. Trust was still in the early stages but was gradually developing.

**Storming – 1 Session (1 hour 30 minutes)**

During the storming stage, members began to test the group boundaries and express differing opinions about the topic. Some boys were hesitant to share openly about their struggles, while others questioned whether talking about masturbation and pornography in a group setting could really help them stop. A few members displayed nervous laughter or tried to change the subject when the conversation became personal, which showed discomfort with vulnerability.

There were moments of mild tension when one participant made light comments about another’s disclosure, which I addressed immediately by reminding the group about respect and the importance of a supportive environment. Some members also challenged the idea that pornography was harmful, leading to open discussions where I guided them to explore both the short-term appeal and the long-term consequences.

This session was important in allowing members to voice doubts, express resistance, and begin to confront their own mixed feelings. By the end, there was greater clarity about the group’s purpose, and members began to accept that personal change would require honesty and mutual support.

**Norming – 1 Session (1 hour 30 minutes)**

In the norming stage, members began showing increased trust and comfort in sharing their personal experiences without fear of judgment. The group atmosphere became warmer, with members listening attentively and offering supportive comments when others spoke. There was a noticeable shift from nervousness to openness, and jokes or distractions reduced significantly.

We revisited the group rules and values, and members reaffirmed their commitment to confidentiality, respect, and active participation. They also began to hold each other accountable, gently reminding peers to stay on topic or encouraging quieter members to contribute.

During this session, I introduced the idea of peer accountability partners within the group to help monitor progress between meetings. The members agreed, and partnerships were formed based on comfort levels. This strengthened cohesion and created a sense of shared responsibility for change. By the end of the norming stage, the group was functioning as a supportive unit, ready to engage in deeper therapeutic work.

**Performing – 6 Sessions (1 hour 30 minutes each)**

The performing stage marked the most productive phase of the group, where members were fully engaged in exploring the core issues and practicing strategies to manage their behaviors. Attendance and participation were consistent, and the level of trust established in earlier stages allowed for honest, sometimes deeply personal sharing. Each session had a clear theme and practical activities.

**Session 1 – Understanding the Problem:**

I facilitated a discussion on the psychological, physical, social, and spiritual impacts of pornography and compulsive masturbation. Members reflected on how these behaviors were affecting their lives, including reduced concentration in class, loss of motivation, strained relationships, and feelings of guilt or shame. I encouraged each participant to connect these effects to their personal goals in life, which helped strengthen their motivation to change.

**Session 2 – Psychoeducation on Habit Formation:**

We explored how habits are formed and maintained, using the brain’s reward system model to explain why urges can feel so strong. Members learned that the cycle could be broken by replacing unhealthy patterns with healthier routines. Using a visual habit loop diagram, I guided them to identify their “cue–routine–reward” patterns related to pornography and masturbation.

**Session 3 – Identifying Triggers and High-Risk Situations:**

This session focused on self-awareness. Members listed their personal triggers, such as boredom, late-night phone use, being alone for extended periods, or watching certain movies. They then discussed strategies for avoiding or managing these triggers. Each participant paired with an accountability partner to share their list and commit to supporting each other between sessions.

**Session 4 – Cognitive-Behavioral Strategies for Change:**

I introduced cognitive-behavioral techniques to challenge and replace unhelpful thoughts. Activities included thought-stopping exercises, replacing sexualized mental images with neutral or positive alternatives, and creating a “healthy alternatives list” (e.g., engaging in sports, studying, listening to music). We also practiced short mindfulness exercises to manage intrusive thoughts.

**Session 5 – Emotional Regulation and Coping Skills**:

This session addressed how emotions like stress, loneliness, and frustration could fuel the behaviors. We discussed healthy coping mechanisms such as journaling, physical exercise, connecting with supportive friends, and engaging in hobbies. Members practiced deep breathing, progressive muscle relaxation, and short grounding techniques they could use when urges arose.

**Session 6 – Progress Review and Maintenance Planning:**

In the final performing session, members shared their personal progress, highlighting small victories such as reduced frequency of the behavior, avoiding pornography for several days or weeks, and managing urges without giving in. We discussed relapse prevention strategies, including staying accountable, continuing to use learned techniques, and seeking support when struggling. Members also reaffirmed their goals and commitments beyond the group.

Throughout the performing stage, there was a noticeable shift from resistance to active problem-solving. Members encouraged and challenged one another, celebrated successes, and demonstrated greater self-control and self-awareness than in the earlier stages.

**Adjournment & Termination – 1 Session (1 hour 30 minutes)**

The final session focused on bringing the group process to a close and acknowledging the progress made over the eleven weeks. I began by summarizing the journey from the forming stage to performing, highlighting how members had moved from initial hesitation to openly discussing sensitive issues and actively applying coping strategies.

Each member was given an opportunity to reflect on their personal experiences in the group. Many expressed gratitude for the safe space that allowed them to talk about a topic often considered taboo, and several reported improvements such as reduced pornography consumption, better control over urges, and increased self-confidence. Some members acknowledged occasional setbacks but emphasized that they now had tools to manage them.

We revisited the skills learned — including identifying triggers, practicing cognitive-behavioral strategies, and using emotional regulation techniques — and discussed how these could be maintained independently. Members were encouraged to continue using their accountability partnerships and to seek support from trusted adults when necessary.

To provide closure, I facilitated a short symbolic activity where each member wrote down one unhelpful habit they were leaving behind and one positive behavior they were committing to maintain. These were voluntarily shared, creating a moment of mutual encouragement and solidarity.

The session ended with affirmations from peers and myself, reinforcing each member’s ability to continue their progress beyond the group setting. We agreed on a follow-up meeting date to check on progress, but this marked the official termination of the structured group counseling sessions.

**Follow-Up**

A follow-up was planned to take place one month after the termination of the group counseling sessions. The aim was to monitor the members’ progress, assess how effectively they were maintaining the coping strategies learned, and provide additional support where necessary.

During the follow-up, I intended to meet the members individually and in a small group check-in to discuss their current experiences, challenges, and successes. Special attention would be given to identifying any signs of relapse, reinforcing relapse-prevention techniques, and re-establishing accountability partnerships if needed.

The follow-up process also served to evaluate the overall impact of the group sessions on participants’ behavior, emotional regulation, and self-esteem, while offering encouragement and referrals for further individual counseling for those requiring ongoing support.

**Challenges and Reflections**

During the group counseling process, some members occasionally missed sessions due to school activities, which disrupted group continuity. A few members were initially reluctant to share deeply due to trust issues and fear of judgment, especially during the Storming stage. Time management was also challenging as some discussions extended beyond the planned 1 hour 30 minutes. As the facilitator, I reflected on the importance of flexibility, patience, and creating a safe environment where members feel valued and respected. I also learned the significance of balancing group cohesion with individual needs.

**Recommendations**

It is recommended that future group sessions be scheduled at times least likely to conflict with school programs. A pre-group orientation could be conducted to set expectations, address confidentiality concerns, and build initial trust. Incorporating more interactive activities and role-plays may help maintain engagement. Follow-up meetings should be planned to check on members’ progress and reinforce coping strategies learned during the sessions.

**Group therapy 2**

**Biographical Data**

**Group Name:** Coping with Loss and Separation

**Facilitator:** Michelle Ingado Ajanga

**Venue:** Action for Children in Conflict (Afcic), Children’s Home

**Age Range of Participants:** 10–17 years

**Gender:** Males

**Number of Participants:** 10–12 children

**Number of Sessions:** 15 sessions

**Duration per Session:** Most sessions 45 minutes; some 1 hour

**Start Date:** 8th May 2025

**Primary Issue:** Coping with grief, loss, and separation (including bereavement and parental abandonment)

**Background Information**

The group was conducted at Action for Children in Conflict (Afcic), Children’s Home, a facility that provides care and protection for children who have experienced significant disruptions in their family life. The children in the home often face challenges related to loss, separation, or abandonment, whether due to the death of a parent, parental neglect, or other circumstances that led to their placement in the children’s home.

The participants, aged 10–17 years, exhibited a range of emotional and behavioral responses to these experiences, including sadness, anxiety, withdrawal, low self-esteem, and difficulty trusting adults and peers. These issues impacted their social interactions, school performance, and overall well-being.

Given the developmental differences across the age range, the group sessions were designed to be age-appropriate, engaging, and creative, incorporating activities such as art, storytelling, role-play, and movement. The aim was to provide a safe and supportive environment where children could express their feelings, learn healthy coping strategies, and develop resilience in response to loss and separation.

The focus of the group was on helping children understand and process their emotions, build peer support networks, and acquire practical tools for managing grief, stress, and feelings of abandonment.

**Group Member Selection Process**

Participants for the group were selected in collaboration with the staff at Action for Children in Conflict (Afcic), including Teacher Ian and Madam Sheilla, who are supervisors/managers at the home. They helped identify children who were most likely to benefit from group counseling based on their experiences of loss, separation, or abandonment, as well as their emotional and behavioral needs.

Selection criteria included:

Children aged 10–17 years

Children who had experienced significant loss or separation from caregivers

Children who were emotionally stable enough to participate in group activities but still needed support in coping with grief

Willingness to participate voluntarily, with assent obtained from each child

The collaboration ensured that the group was composed of children who could relate to the theme of Coping with Loss and Separation, while also maintaining a safe and supportive environment for all participants.

**Theoretical Perspectives**

The group counseling sessions were guided primarily by a combination of Person-Centered Therapy (PCT) and Play-Based Cognitive Behavioral Therapy (CBT), supplemented with psychoeducation tailored for children.

Person-Centered Therapy (PCT):

Emphasizes creating a safe, non-judgmental environment where children feel valued and understood.

Core conditions of unconditional positive regard, empathy, and congruence were maintained throughout the sessions.

Children were encouraged to explore feelings of grief, separation, or abandonment at their own pace, fostering trust, self-awareness, and self-acceptance.

Play-Based Cognitive Behavioral Therapy (CBT):

Adapted for children using age-appropriate creative techniques such as drawing, role-play, storytelling, and games. Children were guided to identify negative thoughts, understand how these thoughts influenced feelings and behavior, and practice replacing maladaptive patterns with healthier responses.

Psychoeducation:

Children were provided with simple, age-appropriate information about loss, grief, and separation.

Psychoeducation helped children recognize common emotional and physical responses to loss, normalize their feelings, and understand that what they were experiencing was typical and shared by others. Topics included: understanding grief stages, coping with memories of absent caregivers, and learning strategies to handle reminders or triggers of sadness.

Integrating psychoeducation within play and creative activities allowed children to internalize knowledge while actively processing emotions.

**Management Plan & Intervention Strategies**

The management plan integrated emotional support, skill-building, and psychoeducation across 15 sessions:

Establishing a Safe and Supportive Environment:

Setting group norms regarding respect, confidentiality, and participation.

Creating physical and emotional safety using comfortable seating, minimal distractions, and consistent reassurance.

Psychoeducation on Loss and Separation:

Providing children with clear, age-appropriate explanations of loss, grief, and emotional reactions.

Normalizing experiences of sadness, anger, guilt, or confusion.

Using interactive discussions, stories, and examples to help children understand their emotions and reactions.

Creative Expression and Play-Based Interventions:

Art Therapy: Drawing or painting feelings related to loss.

Storytelling & Role-Play: Acting out scenarios of separation or coping strategies.

Music and Movement: Using songs or guided movement to regulate emotions and promote expression.

Cognitive-Behavioral Techniques:

Teaching children to identify negative thoughts or unhelpful beliefs.

Practicing replacing maladaptive thoughts with positive, realistic alternatives.

Incorporating problem-solving activities and coping skills through games or interactive exercises.

Peer Support and Social Skills Development:

Facilitating sharing experiences and group discussions to build empathy.

Encouraging children to support one another, enhancing belonging and trust.

Monitoring Progress and Reinforcement:

Regular reflection and feedback at the end of each session.

Positive reinforcement of participation and skill application.

Termination and Relapse Prevention:

Reviewing learned skills and coping strategies.

Preparing children for the end of the group while encouraging ongoing use of strategies.

Providing guidance for continued resilience and adaptation to future losses or separations.

**Forming Stage (1 Session)**

**Goal:** To build initial trust, establish safety, and introduce the group structure.

**Activities and Process:**

The session began with a warm welcome and introductions, where each child shared their name and something positive about themselves or a favorite memory. This icebreaker helped to reduce initial anxiety and encouraged participation in a gentle, non-threatening way.

Group rules and confidentiality were discussed in age-appropriate language. Children were guided to agree on expectations such as listening to others, not interrupting, and respecting everyone’s feelings.

The facilitator provided a brief discussion on loss and separation, introducing the topic in a simple and relatable way, so children could begin to understand the purpose of the group.

Observation of dynamics: Some children were hesitant to speak at first, especially those who were shy or less socially confident. Others engaged more actively in the icebreaker games than in verbal sharing. Attention span varied, with younger children needing more encouragement to participate.

**Outcomes:**

Children began to feel safe in the group setting and understood the basic rules.

Initial trust and rapport were established between participants and the facilitator.

Children gained a very basic awareness of the group’s purpose — coping with feelings of loss and separation — without being pressured to disclose personal experiences immediately.

A foundation was laid for subsequent stages (Storming, Norming, Performing), where deeper emotional sharing and coping skill development could occur.

**Storming Stage (2 Sessions)**

**Goal:** To encourage children to express difficult emotions, acknowledge differences, and begin processing grief and separation.

**Session 2:** Feelings Identification (45 min)

**Activities:**

Children used “feelings cards” to identify and label emotions related to loss and separation, such as sadness, anger, guilt, or fear.

A guided discussion was held to help children understand that these feelings are normal and common in response to loss.

Psychoeducation was incorporated, explaining in age-appropriate language what grief is and how separation can affect emotions and behavior.

**Observations:**

Some children were reluctant to verbalize feelings and needed prompts or paired sharing.

Differences in emotional expression were noticeable: some children were very verbal, while others preferred drawing or pointing to cards.

**Outcomes:**

Children began recognizing and labeling their emotions.

Early peer empathy started to emerge as children listened to one another.

**Session 3:** Expressing Emotions Safely (45 min)

**Activities:**

Children created “anger volcano” drawings to express strong emotions symbolically.

Role-play exercises were used to practice expressing feelings in safe and appropriate ways.

Psychoeducation continued, reinforcing that emotions are valid and can be expressed safely without hurting oneself or others.

**Observations:**

Some children displayed frustration or restlessness, which was redirected into the creative activities.

Children who were initially shy began to participate more actively through non-verbal expression.

**Outcomes:**

Children started to understand constructive ways to express emotions.

Peer support strengthened as children validated each other’s experiences.

The group began to move toward cohesion, setting the stage for the Norming stage.

**Norming Stage (3 Sessions)**

**Goal:** To build group cohesion, trust, and introduce coping strategies while reinforcing peer support.

**Session 4:** Coping Skills I (45 min)

**Activities:**

Children participated in guided relaxation exercises and simple breathing techniques to help manage strong emotions.

Psychoeducation was provided on how these techniques help calm the body and mind during moments of sadness, anger, or anxiety.

**Observations:**

Most children were engaged and interested in practicing the techniques.

Younger children required repeated prompts and encouragement to focus.

**Outcomes:**

Children learned basic emotional regulation skills.

They began to understand that they have some control over their emotional responses.

**Session 5: Coping Skills II (45 min)**

**Activities:**

“Strength Shield” activity: Children identified personal strengths, past successes, and supportive people in their lives.

Group discussion on applying these strengths to cope with difficult feelings related to loss or separation.

**Observations:**

Children showed increasing self-awareness and confidence.

Peer encouragement was evident, as children praised each other’s strengths.

**Outcomes:**

Enhanced self-esteem and awareness of personal resources.

Children began to see each other as allies in coping with loss.

**Session 6: Peer Support and Networks (45 min)**

**Activities:**

“Who Can Help Me?” mapping: Children listed adults, friends, or siblings they could rely on for support.

Role-play exercises practicing asking for help and offering support to peers.

**Observations:**

Children were more willing to engage in discussions about support systems.

Some children expressed pride in recognizing that others cared about them.

**Outcomes:**

Strengthened sense of group cohesion and mutual support.

Children demonstrated early skills in seeking help and providing empathy.

**Overall Norming Stage Outcomes:**

Increased trust and comfort among group members.

Children began to accept group norms and participate more openly.

**Performing Stage (8 Sessions)**

**Goal:** To deepen emotional processing, apply coping strategies, enhance peer support, and build resilience.

**Session 7: My Loss Story (1 hour)**

**Activities:**

I guided children to share personal experiences of loss or separation through storytelling, drawings, or writing.

I prompted reflections on feelings associated with their experiences.

**Observations:**

Children were initially hesitant but gradually opened up with encouragement.

Creative expression helped quieter children communicate emotions non-verbally.

**Outcomes:**

Children began processing grief and understanding they are not alone.

Trust and empathy within the group increased.

**Session 8: Memory Work (45 min)**

**Activities:**

I instructed children to create memory boxes or artwork representing positive memories of lost or absent caregivers.

I provided guidance on why remembering loved ones is part of healing.

**Observations:**

Children engaged enthusiastically in hands-on activities.

Some expressed mixed emotions, including sadness and comfort.

**Outcomes:**

Children learned to honor memories while managing feelings of loss.

Adaptive coping and emotional expression were reinforced.

**Session 9: Letting Go, Holding On (45 min)**

**Activities:**

I guided a symbolic activity where children wrote feelings on paper or balloons and released them safely.

I led a discussion on balancing holding positive memories and letting go of pain.

**Observations:**

Children expressed relief and a sense of lightness.

Older children engaged in reflective discussion; younger children focused on symbolic action.

**Outcomes:**

Children practiced emotional release strategies.

Psychoeducation about processing grief was reinforced.

**Session 10: Creative Expression I (1 hour)**

**Activities:**

I encouraged art, poetry, or music focused on expressing emotions and coping mechanisms.

Children shared their creations with the group.

**Observations:**

High engagement, especially among children who were previously quieter.

Children provided positive feedback and support to peers.

**Outcomes:**

Emotional expression and peer bonding were enhanced.

Children learned non-verbal ways to process emotions.

**Session 11: Creative Expression II (45 min)**

**Activities:**

I guided role-play scenarios for problem-solving in situations involving sadness, triggers, or conflict.

We reflected together on coping strategies demonstrated during the exercises.

**Observations:**

Children applied coping skills learned in earlier sessions.

Peer support strengthened as children acted out helping and comforting each other.

**Outcomes:**

Problem-solving and social skills improved.

Children reinforced healthy coping mechanisms.

**Session 12: Peer Support Skills (45 min)**

**Activities:**

I led exercises in active listening, validating feelings, and offering support.

Children practiced supporting each other in small groups.

**Observations:**

Empathy and confidence in providing and receiving support increased.

Children understood how peer support aids coping.

**Outcomes:**

Group cohesion strengthened.

Interpersonal skills and emotional intelligence improved.

**Session 13: Handling Triggers & Anniversaries (45 min)**

**Activities:**

I guided children to identify triggers that reminded them of loss.

Together, we developed personal coping plans for handling difficult days or emotional setbacks.

**Observations:**

Some children expressed anxiety when discussing triggers, which I helped manage through reassurance and grounding exercises.

Older children engaged more in planning; younger children benefited from guided discussion.

**Outcomes:**

Children gained practical strategies for long-term coping.

Self-awareness and proactive emotional management were encouraged.

**Session 14: Performance Day (1 hour)**

**Activities:**

Children presented group projects, art, drama, or poetry reflecting their emotional journey.

We discussed lessons learned and how coping strategies were applied.

**Observations:**

High engagement, confidence, and pride in accomplishments.

Peer encouragement and positive reinforcement were evident.

**Outcomes:**

Skills learned across sessions were consolidated.

Self-esteem, self-expression, and group cohesion increased.

**Overall Performing Stage Outcomes:**

Children demonstrated improved emotional awareness and regulation.

Peer support, empathy, and cooperative problem-solving increased.

Learned and applied coping strategies in real-life and symbolic activities.

Resilience and confidence in expressing feelings and managing triggers were strengthened.

**Adjournment & Termination (1 Session)**

**Goal:** To review progress, consolidate skills, and prepare children for the conclusion of the group.

**Session 15 (45 min)**

**Activities:**

I led a reflection circle where each child shared their experiences, feelings, and lessons learned throughout the group sessions.

We discussed how the coping strategies, creative expressions, and peer support skills could be applied in daily life.

Children participated in a celebration of accomplishments, including acknowledgment of their effort, growth, and participation. Certificates or tokens of recognition were given to reinforce their achievements.

I provided guidance on maintaining resilience and healthy coping strategies beyond the group, emphasizing ongoing emotional expression, peer support, and using skills learned during the sessions.

**Observations:**

Children expressed feelings of accomplishment, pride, and connection to the group. Some children showed mixed emotions about ending the group, including sadness at leaving peers behind, which I helped normalize and address.

Children were actively engaged in summarizing their personal growth and learning points.

**Outcomes:**

Children consolidated their understanding of coping mechanisms for loss and separation.

Increased self-awareness, emotional regulation, and peer support skills were evident.

The group concluded with children feeling empowered to manage their emotions and maintain positive strategies independently.

**Follow-Up**

**Goal:** To ensure that children continue applying the coping strategies learned during the group and to monitor their ongoing emotional well-being.

**Activities and Process:**

I coordinated with Afcic staff to conduct periodic check-ins with the children after the group had concluded.

During follow-up, I encouraged children to share experiences where they applied coping skills, creative expression, or peer support strategies in real-life situations.

I provided additional guidance and reinforcement where children faced challenges in managing grief, triggers, or feelings of separation.

Children were reminded to continue using techniques such as breathing exercises, grounding, art, storytelling, or peer support whenever they felt overwhelmed.

I advised staff to observe and note any significant behavioral or emotional changes that might require individual counseling or additional support.

**Outcomes:**

Children demonstrated continued use of coping strategies in daily life.

Increased emotional awareness, self-regulation, and resilience were observed.

Peer connections formed during the group were maintained, providing ongoing social and emotional support.

Children were better equipped to handle reminders of loss and separation in a healthy, adaptive manner.

**Challenges and Reflections**

During the course of the children’s group therapy on Coping with Loss and Separation, several challenges arose, and I reflected on how they influenced the group process and my facilitation:

**Challenges:**

Varied Attention Spans:

Some younger children had difficulty maintaining focus for the full duration of the sessions. I had to adjust activities to be shorter, more engaging, and interactive to maintain participation.

Emotional Hesitancy: Initially, many children were reluctant to share personal experiences of loss or separation. It required patience, encouragement, and creative techniques like drawing or role-play to help them express feelings safely.

Diverse Emotional Maturity: The wide age range (10–17 years) meant that children processed grief and separation differently. I had to tailor interventions individually while maintaining group cohesion.

Sensitive Topics: Discussions about abandonment, grief, or caregiver loss occasionally triggered intense emotions. I had to provide immediate support, grounding exercises, and reassurance to prevent overwhelm.

Peer Dynamics: Some children were initially shy or hesitant to engage with peers, while others dominated discussions.I worked to balance participation and encourage mutual respect and listening.

**Reflections:**

I observed that creative and play-based activities were especially effective in helping children express complex emotions.

Psychoeducation on grief and coping strategies was well-received and provided children with a framework to understand their feelings.

Over time, I noted significant growth in trust, peer support, and emotional expression, demonstrating the group’s effectiveness.

I reflected on the importance of flexibility in facilitation, adjusting session length, activities, and approaches to match children’s developmental levels and needs.

The experience reinforced the value of first-person facilitation, where building rapport, modeling empathy, and actively participating helped establish a safe, supportive environment.

I recognized that ongoing support beyond the group is crucial, as children continue to navigate loss and separation in daily life.

**Recommendations**

Based on my observations and the outcomes of the children’s group therapy on Coping with Loss and Separation, I recommend the following:

Continued Psychoeducation and Emotional Support:

Children should have ongoing access to age-appropriate sessions on grief, loss, and emotional regulation to reinforce skills learned during the group.

**Regular Follow-Up Sessions:**

Periodic check-ins or booster sessions should be scheduled to monitor children’s application of coping strategies and to address emerging emotional challenges.

Individual Counseling for High-Need Children:

Children who continue to experience intense grief, separation anxiety, or difficulty coping should be offered one-on-one counseling to provide targeted support. Integration of Creative and Play-Based **Activities:**

Incorporating art, storytelling, role-play, and other expressive methods in daily routines or school programs can help children process emotions constructively.

Strengthening Peer Support Networks:

Encourage children to maintain supportive relationships formed during the group, fostering continued empathy, trust, and shared coping strategies.

Staff Training and Involvement:

Africa staff should receive guidance on recognizing signs of grief, supporting coping strategies, and facilitating safe emotional expression in children.

Parental or Caregiver Engagement (Where Possible):

Involving caregivers in discussions about grief and coping strategies can reinforce skills at home and improve children’s emotional stability.

Flexible Group Structures for Children:

Future groups should consider shorter, varied session lengths and creative methods to maintain engagement and accommodate attention span differences.

**Conclusion**

The practicum experience has been a profound journey of learning, growth, and professional development in the field of counseling psychology. Through working with diverse clients across different age groups and backgrounds, I was able to put into practice the theories and skills acquired in class while also discovering the realities of human struggles, resilience, and the role of psychological support.

Each case presented unique challenges—ranging from adolescent adjustment difficulties, grief, trauma, self-esteem issues, family conflicts, to lifestyle-related stressors. Engaging with these cases allowed me to explore various psychological theories such as Cognitive Behavioral Therapy, Person-Centered Therapy, Psychodynamic approaches, and Systemic perspectives. More importantly, the practicum emphasized that no single theory works in isolation; rather, effective counseling involves an integrative, flexible, and client-centered approach tailored to the individual’s needs.

Beyond theoretical application, this experience sharpened my core counseling skills—listening empathetically, building rapport, maintaining confidentiality, and using interventions such as storytelling, psychoeducation, and life skills training. The practical exposure also revealed the importance of cultural sensitivity, ethical responsibility, and self-awareness in the therapeutic process. I came to appreciate the balance between professional boundaries and genuine human connection, as well as the necessity of supervision in refining practice.

Additionally, my involvement in group work, training sessions, and community outreach reinforced the role of psychoeducation and preventive strategies in promoting mental health. I learned that counseling is not only about addressing individual problems but also about empowering communities with knowledge, resilience, and healthier coping mechanisms.

Overall, this practicum experience affirmed my passion for mental health work and strengthened my identity as an emerging professional. It deepened my commitment to continue learning, advocating, and supporting individuals as they navigate their unique psychological journeys. The lessons learned, both from clients and supervisors, will remain invaluable foundations for my future practice as a counselor and trainer in mental health.

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