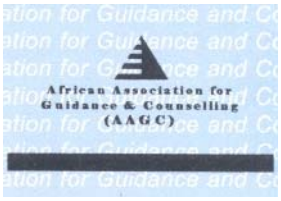

THE 2nd INTERNATIONAL CONFERENCE ON GUIDANCE AND COUNSELLING

Abstract Book

August 2nd to 4th 2005,
Intercontinental *Kigali, Rwanda*

THE 2nd INTERNATIONAL CONFERENCE ON GUIDANCE AND COUNSELLING

Abstract Book

TABLE OF CONTENTS
2

THE RECTOR'S SPEECH……..……4

THE SPEECH OF AAGC PRESIDENT 5

Abstract 2: Le Counselling et Religion..... 8

Abstract 3: Réflexion sur orientation et conseils auprès de la jeunesse rwandaise scolarisée (enjeux et perspectives) 9

Abstract 4: Everybody Rides the Carousel-A Developmental Intervention with Young Adults in an Identity Crisis. 10

Abstract 5: Realities, challenges and issues faced by different types of professional counsellors in Uganda. 10

Abstract 6: Not a Pretty Picture ... Abuse, Shunning & Societal Acceptance - A Comparison of America & Sub-Saharan Africa 11

Abstract 7: The Enigma of Specific Learning Disabilities and the African School Child: Need for a Programme Of Counselling. 14

Abstract 8: Counselor Education/Training and Curriculum in Africa..... 15

Abstract 9 : Les troubles psychosomatiques, un langage à décoder 15

Abstract 10: Introducing Electronic counselling in Nigeria: Implication for counsellor Education. 19

Abstract 11: An Investigation of Teachers' Knowledge of ADHD: Implications for Counselling at CJSS. 20

Abstract 12: Challenges of Counselling Training in Zimbabwe 20

Abstract 13: Secondary school students' knowledge, attitudes and risk behaviors in relation to HIV/AIDS as a basis for youth counseling in Rwanda. 22

Abstract 14: Positive Prevention Activities For PLWHA - Training in Basic Counselling and Communication skill 23

Abstract 15: Counselling People Living With HIV/AIDS (PLWHA): Principles and Practice..... 24

Abstract 16: HIV/AIDS intervention strategies in Africa: case of Maseru - Lesotho 25

Abstract 17: The Quality of Pre and Post HIV-Test Counselling at Sinikithemba HIV/AIDS Christian Care Centre in Durban 25

Abstract 18: Causes and Consequences of Examination among Secondary School Students. 26

THE RECTOR'S SPEECH

Rector, KHI

Kigali Health Institute is a higher learning institution that collaborates with the African Association for Guidance and Counselling in general and this conference in particular. The collaboration is based on KHI mandate of developing a human resource that is competent and sufficient to provide preventive, curative, rehabilitative and promotive health. The graduates are ultimately responsible for providing holistic health care and community empowering to ensure physical, mental and social well being of individuals, families and communities. It is on this basis that KHI in partnership with AAGC is greatly honoured to host this conference to which you are most welcome.

Honourable Minister and distinguished delegates, this conference provides an opportunity to take a closer look at the guidance and counselling challenges in the African context. As you are aware, guidance, counselling, human development and culture are continuously intersecting phenomenon in our lives. They have a relationship with culture, multi-cultural and cross-cultural issues in relation to policies, mobilization of necessary resources, interventions and accessibility by the beneficiaries.

Ladies and gentlemen, I am hopeful that during these three days, we will in a participatory manner share experience on the actual situation and identify strategies to strengthen the guidance and counselling in our countries. It is on this point that I once again welcome you sincerely and invite your active participation to ensure effective sharing of different experiences that eventually results into realistic outputs and reinforce the existing networking that is beneficial to our respective countries.

Enjoy your stay in Rwanda. Thank you for your attention. I now take this opportunity of inviting our Guest of honour, The Honourable, Minister of Education, Science, Technology and Scientific Research to officially open the conference.

Dr NDUSHABANDI Desire
Rector, KHI

THE SPEECH OF AAGC PRESIDENT

President, AAGC

It is with great pleasure to welcome you all to this Annual Conference on Guidance and Counselling, organized under the auspices of the African Association for Guidance and Counselling (AAGC) and hosted by the Kigali Health Institute (KHI).

This historic conference marks a new era in the development of the Guidance and Counselling services and programmes in Africa in the sense that it focuses on the most critical issues and challenges facing counsellors and mental health professionals today. More specifically, issues of cultural relevance and appropriateness of the contemporary intervention strategies are the focus of most deliberations at this conference. Issues of counsellor training, policy implementation, inadequate resources, and other related challenges would also be addressed during this conference.

Unlike previous conferences, this one brings together counsellor educators and counsellors, or helping professionals, policy-makers, experts and students from various parts of Africa and the world to take a closer look at the challenges, experiences and realities facing counselling in Africa. Further, the conference creates an opportunity for counsellors in Africa to share their knowledge and experiences on some of the daunting realities and issues that continue to affect the delivery and development of the counselling services in Africa. National and international experiences in addressing some of the current threats and possible interventions to development of counselling will be explored at this conference.

The AAGC, which was launched on the 26th April 2002 in Nairobi, Kenya at the 1st International Conference on Guidance, Counselling and Youth Development, will continue to support countries, groups or organisations, and individuals engaged in developing and providing guidance and counselling in Africa. It is our goal as an association to help all those who are involved in efforts that promote counselling in Africa. More specifically, the AAGC is committed to:

1. Promoting the development and establishment of guidance and counselling in Africa through advocacy, networking, development of professional training programs and research;

2. Organizing and coordinating international congresses, conferences, and other fora aimed at facilitating of experiences and research within the African context and experience;

3. Facilitating the establishment of standards and professional ethics, monitoring and evaluation mechanisms among the members;

4. Creating and coordinating formal links with other international associations, agencies, and national associations in facilitating development and establishment of guidance and counselling services and programs to address the experiences and realities of the different populations and groups in Africa;

5. Encouraging the establishment of a society that is caring and responsive to all needs and realities of the youths, children and their families, especially girls, victims of disasters and wars, and disadvantaged groups

On behalf of the AAGC I would like to take this opportunity to thank the Board of Governors for the Guidance, Counselling and Youth Development Centre for Africa (GCYDCA) for its relentless efforts and commitment to the promotion of counselling services in Africa. I wish to convey our sincere gratitude to UNESCO, National Board for Certified Counsellors (NBCC), and other partners who have shown their unwavering support to our efforts to promote counselling as a profession in Africa. I wish to point out that AAGC will continue to work collaboratively and cooperatively with you at all times.

I would like to thank all those who managed to attend this conference. I am aware there are many who wanted to attend but due to limited resources and other circumstances beyond control could not make it. Amongst you there are those who had to finance their travel to this conference despite the fact that it is very expensive to travel by air from one part of Africa to another. I commend you for your commitment to promoting counselling in the African continent. I hope your participation in this conference will benefit you in many ways. I call upon all of you to become active members of the AAGC so that you can help it grow into a powerful and effective professional body that can serve your interests. I am happy that there are many who have now registered as members of AAGC. I encourage you to talk to other counsellors and helping professionals in your countries to join the AAGC. Your participation and expertise will help it grow into a very effective organisation.

I would like to thank Honourable Minister of Education, Science, Technology & Scientific Research, Professor Romain Murenzi, senior government officials, and representatives of various local and international organisations present at this conference for taking your precious time to grace this important occasion. My special appreciation goes to the Rector of Kigali Health Institute (KHI), Dr Ndushabandi Desire and his staff for hosting this conference. Your support encourages us to continue to work hard in order to succeed in helping those who need our assistance in developing guidance and counselling services. I would like to thank the local organising committee, coordinated by Mr. Desire Kamanzi, for making it possible for this

conference to take place. Despite the challenges the committee continued to show courage and dedication to make the conference a success. The people of Rwanda should be proud of you. We need people like you who are dedicated to serving their nation and Africa as a whole. It would have been impossible any member of the executive to travel back and forth to make preparations for this conference. Because of your dedication as people representing your beloved country, AAGC will never give up on Rwanda. We will continue to support all your efforts in addressing some of the daunting challenges you are grappling with. You have shown us all that it takes to face the challenges faced by counsellors in Africa. Difficulties in communication, limited resources, and other related problems need people like you who show determination to succeed in spite of all the hurdles faced by most helping professionals in Africa.

I would like to recognise the presence of Dr Thomas Clawson, President of the National Board of Certified Counsellors (NBCC) and his colleague Jolie Long, who found it necessary to attend this conference despite their busy schedule this week. AAGC recognises NBCC as an important partner in promoting standards in counselling in Africa. We appreciate NBCC's support in helping in facilitating the establishment of standards and certification in Africa. I would also like to recognise the participation of the Acting Director of GCYDCA, Mr. Kenneth Hamweka. The AAGC will continue to work very closely with the GCYDCA. On behalf of the AAGC executive members I would like to appreciate the efforts and contribution made by every one of you in promoting our association.

Dan-Bush Bhusumane President, AAGC

Abstract 1: L'importance de la culture et son utilité dans l'intervention psychothérapeutique. Comment renouer les liens générationnels?

By **Dr. Naasson Munyandamutsa**, Psychiatre-Psychothérapeute, Institute of Research and Dialogue for Peace, B.P 7109 Kigali Rwanda, Tel +250 (08300883)

La souffrance est souvent révélatrice de l'échec de communication et peut-être mieux, de la rupture des liens avec l'univers relationnel de la personne. II s'agit aussi de la rupture des liens générationnels qui rend inabordable la possibilité d'envisager l'avenir. L'univers relationnel et le fil générationnel constituent le dispositif d'appartenance sans lequel vivre n'est pas possible. Or on appartient a une famille, on appartient a un groupe et surtout on appartient a une culture.

L'accompagnement ou le counselling de la personne souffrant de traumatisme psychique dans ses diverses facettes exige qu'on apprenne a décoder le langage de la souffrance, qu'on maîtrise les vecteurs fonctionnels de ce langage. On le sait, le langage trouve ses constituants dans la culture et l'engagement dans un lien thérapeutique trouve ses assises dans diverses croyances culturelles. Je tacherai de montrer, a travers une vignette clinique, comment la question de l'appartenance mérite d'être posée et a quel point la réponse exige de renouer les liens générationnels pour se réinscrire dans la culture a laquelle on appartient.

Abstract 2: Le Counselling et Religion

By **Benoît RURATOTOYE**, Etudiant Doctorat, Université de Paris 8 St. Denis, Psychologie Clinique et Psychopathologie (Lecturer - Kigali Health Institute) B.P 3286 Kigali - Rwanda, Tel +250 (08866828), e-mai: rutabenoit@yahoo.fr

La religion est toujours sensible à la souffrance de l'être humain et elle contribue à soulager les chrétiens. Les chrétiens viennent régulièrement demander conseil au pasteur, ou ce dernier leur explique tel verset de la Bible qu'il n'ont pas compris, les aide à sortir chrétiennement d'une situation difficile et pleine de tentation.

Les devoirs du curé ou de pasteur envers les chrétiens seront entre autres de les ramener dans le droit chemin, de l'aider à exprime leurs peines et à trouver la solution à leurs problèmes. La connaissance de la Bible du langage, le partage d'un code, implique une pensée commune et une série d'attitudes envers les fidèles et le monde. Cette multitude de signes partages permet une interaction souple ou s'échangent du sens et du lien grâce a une immense processus de communication. Le religieux, aussi appelé le pasteur ou le prêtre, est un être élu, un personnage digne de respect. Les fidèles consultent le pasteur pour divers problèmes surgissant dans leur foyers, aussi bien en ce qui concerne les problèmes de relations sociales que leur vie de relation avec Dieu. Le pasteur a le devoir d'écouter ses chrétiens de les laisser parler, en veillant à avoir une dose suffisante d'empathie. Et le langage des religieux, est une parole liturgique et thérapeutique qui libère, qui réconcilie, et qui socialise l'être malade et déconnecte. Je chercherai a montrer comment la question de la croyance doit être prise

en compte lorsqu'on a affaire à un malade. Ce qui sépare la médecine moderne de la religion est que l'une s'applique aux symptômes, elle est mécaniciste; l'autre se réfère au Principe, a l'Absolu, elle est causale. Par ailleurs, la relation de confiance entre le conseille et le patient devrait être le fil conducteur du chemin du counselling, du traitement et de la guérison des maladies. Elle semble malheureusement, dans le monde marchand de l'heure, avoir été remplacée par les progrès techniques et la rigueur scientifique qui sont cependant deux excellentes choses. II s'ensuit une remise en cause de la compétence des soignants (conseillés) par ceux de leurs malades qui sont le plus dépossèdes de leurs corps sur un plan symbolique. Cette fuite de désespoir est une des explication du recours a la religion. C'est cette écoute empathique qui rassure les fidèles par le fait qu'il est enfin écouté par quelqu'un qui a une autorité. La fonction symbolique de la religion dans le counselling est alors essentielle dans la résolution de certains conflits ou problèmes au delà du monde visible.

Abstract 3: Réflexion sur orientation et conseils auprès de la jeunesse rwandaise scolarisée (enjeux et perspectives)

By **Kagemanyi Léonard,** Psychopédagogue, Kigali Health Institute, B P 3286 Kigali Rwanda, Tel +250 (08350230), e-mail: Kagemanyi@yahoo.fr

L'inexistence du service d'orientation et conseils au cours de I'histoire du système éducatif rwandais ne veut pas dire que les éducateurs spécialises ignorent les avantages combien louables de l'orientation et conseils mais les intérêts des responsables du système éducatif au cours de la période coloniale et directement après les années de l'indépendance étaient focalises ailleurs c.a.d. les intérêts professionnels du système et non sur les besoins et les goûts des apprenants. Un tel système éducatif élitiste était base sur les emplois existants, seul mobile profond qui guidait les décideurs éducatifs depuis la période coloniale jusqu'en 1994. C'est pourquoi, d'ailleurs I'école rwandaise en un moment donne, était le facteur de division ethnique ou régionale au lieu d'être milieu d'épanouissement des apprenants. Apres 1994, le système éducatif rwandais connaît un dynamisme agissant au sein duquel la dimension éducative d'orientation et conseils ne doit plus être négligée. L'encadrement des jeunes rescapes du génocide, celui des orphelins de VIH/SIDA, les enfants chefs de ménage enfants adultisés par les événements de 1994 tous ces groupes ont des réalités psychosociales et pscho-educatives multiformes. Ils ne seront efficacement aides que grâce aux services d'orientation et conseils de qualité Services pilotes par des spécialistes en métier d'aide. II faut alors une mutualisation des compétences, dans ce domaine et les apports de tous les intervenants nationaux que internationaux sont à solliciter.

Abstract 4: Everybody Rides the Carousel-A Developmental Intervention with Young Adults in an Identity Crisis.

By **Dr Callie Hugo**, Practical Theology Pastoral Care and Counselling, University of South Africa, UNISA, Pretoria South Africa e-mail: hugocj@unisa.ac.za

The identities of South Africa and its citizens have been undergoing crucial changes since 1994 when the first democratic election; resulted in the demise of statutory apartheid. Although changes in South African society are clearly visible in increased social mobility migration, access to jobs, training and education and general reform in the country, the nature and influence of the identities being formed in response is as yet less clear - Abebe Zegeye. The research question for this presentation is as follows: - IS A DEVELOPMENTAL EXPLANATION AND INTERVENTION A VIABLE SOLUTION FOR AN IDENTITY CRISIS? A developmental view of identity diffusion/ confusion will be contrasted with a social constructivist view to address the question of an identity in crisis. Effective intervention with young adults in identity crisis emphasize psychosocial identity development with special focus on ego epigenesis and the lifecycle Empirical research reports the outcomes of a field intervention with young adults in South Africa. The MPD developed by Gwen A Hawley was used in the research. The outcomes confirm the importance of maturation for identity in a changing world for young adults.

Abstract 5: Realities, challenges and issues faced by different types of professional counsellors in Uganda.

By **Lois Achieng Ochieng,** Counselling Psychologist in private practice in Kampala, Uganda

Professional counselling is still a new phenomenon in most Africa countries although it has been in practice under different names, intervention techniques and methods time immemorial. With the onset of HIV/AIDS in Uganda, trained, organised and near professional counselling came on the forefront. In Uganda and probably on the African countries, counselling became synonymous with HIV/AIDS to the extent that when people are asked to seek counselling services, they respond that they are not suffering from AIDS. This paper will attempt to discuss the different types of 'counsellors' in Uganda and the challenges they face. The different types are brought about by duration of training, contents and certificate awarded. There are counsellors who are trained to deal with the issues of HIV/AIDS only and those who are trained to handle various psychosocial issues. The paper will also attempt to look for solutions to some of the problems, challenges and issues. A qualitative research will be carried out to find the challenges different types of counsellors face and what could be done to reduce or eliminate them. A purposive sampling will be done in and around Kampala.

Abstract 6: Not a Pretty Picture ... Abuse, Shunning & Societal Acceptance - A Comparison of America & Sub-Saharan Africa

By **Kay Rutherford**, PhD, LPC, NCC, RN, P.O Box 33, La Crosse, WI 54602, 608 782 0710 Ext. 219 or 507 895 4427,
e-mail: kmrutherford@viterbo.edu

Kay Rutherford has a PhD in Counselor Education and teaches Racial Ethnics and Abnormal Psychology at Viterbo University. She also counsels at a private agency. Dr. Rutherford's special areas of research and consultation are in infidelity, holistic therapies, wellness, humor, and the healing emotions.

Men have controlled women since time began. Very few societies exhibit an equalitarian relationship between men and women. Neurophysican Bleier (1984) told us that the most effective way for men to control women is through sex-sexual power and control. She tells of the medical field being mostly controlled by men and how that, in turn, means control of women in childbirth, hormone replacement, abortion or menopause-with each seen as illness rather than normal stages of life. She says that the legal system also puts men at the head of the family and that it is the woman's job to stay within that family system, regardless of what her husband may do. Such patriarchal values put women at great risk. Bassoff (1991) tells us the sexual exploitation of girls and women is a long-standing tradition. My research on infidelity includes an extensive reference list, interviews with the infideled, and the knowledge from my two adult daughters: one who has spent the last year in AmeriCorps teaching AIDS education in the inner city schools of Washington DC and the other who has spent the last year in Mozambique teaching AIDS education. As a psychotherapist I work with many infideled clients. I now share the concepts of infidelity, infidelity's PTSD symptoms, why infidelity is abuse, society's acceptance of the infidel and its shunning of the infideled, and I list several suggestions for counselors. I speak in the female voice as I am a woman.

Concepts of Infidelity

1. Infidelity is not expected; most expect their love to be faithful.

2. Infidelity is not simple: it is a planned pattern of behaviors that it infinitely dangerous to all involved.

3. Infidelity includes massive deception, seduction and lying. Author Lerner (1993) tells us that our bodies seek the truth and we often get physically sick during deception. The infidel cannot relate to those he is deceiving and his partner can do no right.

The Trauma of Infidelity

The infideled experiences PTSD symptoms including incessant, recurring thoughts of her love with another. She often loses weight, becomes a detective sleuthing for details, and suffers from insomnia, extreme low self-esteem and shock. Bloomfield, et. al., tell us "This longing may shorten her life."

The infideled must grieve for her losses of faithfulness and security. Eisenberger (2003) says a rejected heart physically hurts and the body is affected like with a physical injury. The world, as she knows it, has stopped. Glass & Wright (1997) say the victim's trauma parallels that of other forms of abuse.

The Abuse of Infidelity

1. The characteristics of the infidel are like those of a batterer: he exhibits a sense of entitlement with a pattern of behaviors that rarely hit home for him, or as to the damage that he potentially puts his partner/s in. He blames her.

2. Societal patriarchal acceptance of the infidel is amazing - he wasn't "getting enough," she is hard to get along with, he had to do what he did. The family often rallies for the infidel as they do for the batterer (one of the reasons he gets by with it). He is narcissistically entitled.

3. Society most often disregards the infideled; she is scorned and shunned. She becomes a detective because others will not tell her the truth about the infidel. She is often shunned for being a strong, self-made, wise woman. The infideled is heart broken and feels shame and guilt from his actions. Battered women often say that infidelity's lasting damage is often worse than physical assault

The Schneiders (1991) say the sexual addict numbs out with sex and that his bedroom is usually a nightmare, not letting her sleep until his needs are satisfied. Bancroft (2002) tells us that chronic infidelity is abuse and that 25% of abusers cheat on their partners. He also says that infidelity is not sexual compulsion or addiction; it is sexual abuse. Sexual indiscretion is not just self-soothing behaviors but dangerous-physically, emotionally and spiritually. Exposure to AIDS or other sexually transmitted diseases is abuse. Pitts, his article entitled *On AIDS, Silence Is not an Option: Black America Where is your Sense of Urgency?* asks us to awaken to the problem of Africa's AIDS, especially after Mandela's announcement of his son's death and proclaiming, "Let us give publicity to HIV/AIDS and not hide from it.

Counseling suggestions:

1. Listen to her story for the many times she will need to tell it.

2. Believe her story. Patriarchy and society rarely support her; her self-esteem will be all but gone and shame takes its place.

3. Tell her not to sleep with him-very directive but necessary-for safety. She will want to sleep with him to keep him; he will have convinced her it was lack of sex that made him do it.

4. Suggest a Clarissa Pinkola Estes's wolf pack of solid supporters who know and understand-whose cunning, wary, feral, observant.

5. Respect her grief-she cannot make it smaller than what it is to her.

6. Encourage unforgiveness to keep her safe at first. Wade and Washington (2003) say forgiveness is not always the answer-dignity and self-respect must come first.

7. Let her anger be her strength, for it says, "Stay away from me."

8. Remind her that infidelity is not simple; it is dangerous and it is abusive.

Senegalese author Marima Ba (1989) tells of her husband taking a second wife, "For the sake of variety?" she asks. "When I have carried his child twelve times over?" She shares her grief and how she cannot leave him, though advised to do so. But Ba's best friend leaves when her husband takes a second wife; clothed in her dignity she walks away."

Infidelity is complex, traumatic, dangerous patriarchal institution and it contributes to the spread of AIDS worldwide. We must deal with it as such, with both the infidel and the infideled. When safety is threatened, abuse must be considered.

Abstract 7: The Enigma of Specific Learning Disabilities and the African School Child: Need for a Programme Of Counselling.

By **Dr Sylvester OKENYI**, Senior Lecturer and Head of the Psychology of Education Department, Kigali Institute of Education (KIE), Kigali.

Dr Sylvester OKENYI holds a Ph.D degree in Educational Psychology, and specialized in Specific Learning Disabilities (SLD), M.Ed in Guidance and Counselling, both obtained from the University of Nigeria (UNN), Nsukka - one of the foremost universities in Nigeria. He has also two first degrees: B.Ed (Language Arts-English) and LL.B (Law). He has been lecturing in higher institutions in Nigeria and Rwanda since 1985.

Specific learning disability (SLD) is a problem that affects the perceptual processes involved in learning. A major symptom of SLD in a child is the existence of a discrepancy between the child's learning potentiality/capacity and his/her actual learning performance. Because there is usually no observable difference in the child's physical and at times behavioral appearances from that of his/her other peers, his or her condition is usually neglected by planners of special education programmes in Africa. In this paper, an attempt has been made to examine contemporary definitions of the phenomenon of specific learning disabilities with a view to delineating which of the definitions is more amenable to the current practices of intervention applied to similar learning problems in African primary and secondary schools. Based on this, two basic approaches to the formulation of intervention programmes were highlighted: neurological and behavioural.

Suggestions were made, based on practical considerations, on intervention strategies that can be adapted to suit contemporary educational practices in public schools in Africa. Lay out of the paper: Introduction: Here the author discussed the various approaches to the definition of learning. The aim is to show how all the known theories of learning tended to emphasize "normal" learning without giving a clue to the understanding of the phenomenon that gives rise to such abnormal situations as "learning disability". Definitions of Learning Disability: Various approaches to the definition of the phenomenon were examined with a view providing a guide for a search for workable intervention strategy. Learning disability and Mental retardation: Efforts were made to differentiate the two phenomena which are often misunderstood to mean the same thing. Characteristics associated with children with specific learning disabilities: Here the author highlights those characteristics that tend to interfere with school learning focusing on areas that intervention strategies can be directed at Remedial approaches to specific learning disabilities. Here the author examines such conventional remedial approaches to SLD as: Visual, multi-sensory and remedial reading methods. The idea here is to equip a special educator with tools with which to organize specific strategies for identified specific learning disabilities Special education services in Africa: Traditional special education services in most countries in Africa are examined and reasons are preferred as to why they are not suitable for children identified with specific learning disabilities. Special education services for children with specific learning disabilities: An attempt is made to examine contemporary special education services which serve as intervention strategies for children with specific learning disabilities. These include Consultation to regular

educators, Itinerant special education services, Resource room assistance, and Partially self-contained classroom. The author briefly discusses the strengths and weaknesses of each of these and pointed out that each of these can be adapted to fit into mainstreaming/inclusive education practices in conventional public schools in Africa. This however depends on the status and availability of the relevant personnel to provide some or all the above-mentioned intervention strategies.

Abstract 8: Counselor Education/Training and Curriculum in Africa

By **Julie Angitso,** Kigali Institute of Education, Rwanda,
e-mail: angitsoj2002@yahoo.co.uk

The present paper discusses counselor education / training and curriculum in Africa. It focuses specifically on four broad areas: Personal, social, academic, curriculum and vocational problems that face African society today and how the counselor responds to them. Wide spread numbers of displaced people due to wars and other natural disasters, drug and substance abuse, the adolescences growth and psychological needs amongst many others. On Academic issues like study skills, coping with exam stress and the use of PQ4R study methods and other related issues in education call for counselor education training. In the area of vocational / career guidance, vocational adjustment and orientation are imperative to the counselor, the curriculum at present needs to be revisited with a view to making it more functional. The expected outcome will be a citizen that is educated, courageous, and well trained who will set goals and achieve them. These will also participate in the democratic initiatives of their various countries and will help in protecting the territorial integrity of the African continent.

Abstract 9 : Les troubles psychosomatiques, un langage à décoder

Dr. RUTAKAYIRE BIZOZA, Medecin-Psychiatre. Kigali Health Institute.
e-mail : rutekayirebizoza@yahoo.fr

Notre corps parle. II est intimement lie à notre âme, communément appelé psyché, ainsi qu'à notre Esprit, communément appèle subconscient. Et chaque fois que notre âme ainsi que notre Esprit souffre, le corps commence à parler. A chaque fois notre vie est confrontée au stress à divers problèmes notamment les problèmes de foyer, notre corps parle. II parle en se plaignant qu'il y a quelque chose qui ne va pas et qu'il faut corriger assez rapidement. Et ces plaintes s'expriment souvent sous forme des maux de tête chroniques résistants aux traitements antalgiques et sans étiologies organiques bien identifiées. Parfois ces plaintes corporelles prennent I'aspect des lombalgies et des maux de bas - ventre chronique surtout chez les femmes. En effet, les plaintes se localisent plus fréquemment dans le bas ventre et le dos chez la femme. Et au niveau épigastrique et abdominal chez I'homme, sous forme de gastrite, d'ulcère gastrique et de colopathie fonctionnelle. Et ce attentes psychiques peuvent être consécutives a I'anxiété ou a I'état

dépressif. Dans tous les cas, ces signes ou ces maladies somatique sont des signes d'alarme d'un mal être et d'un malaise existentiel conjugal, professionnel etc. Et en ce sens c'est un phénomène positif car les symptômes nous interpellent à opérer des changements dans notre vie pour restaurer l'harmonie, assurant ainsi la prévention en santé mentale.

En tant que soignants, nous devons apprendre à décoder le langage du corps de nos patients pour éviter que les symptôme somatiques, ainsi que les maladies psychosomatiques n'évoluent vers des maladies mentales plus graves telles que la psychose.

En effet dans un monde moderne domine par le stress, le difficultés conjugales et les difficultés économiques, notre corps reste le baromètre essentiel qui nous avertit qu'il y a par exemple un excès de travail et qu'il faut se reposer suffisamment, même si nous voulons gagner beaucoup d'argent au détriment de notre santé. Notre corps nous avertit qu'il y a des difficultés conjugales à régler pour notre mieux être notamment au travers d'une thérapie de couple... Tout cela fait partie de la prévention en santé mentale.

Les troubles psychosomatiques en général notamment les céphalées chroniques sont le plus fréquemment motif de consultation ambulatoire à l'hôpital psychiatrique de Ndera, l'épilepsie et les manifestations épileptiformes des états de stress post-traumatiques occupant la seconde place. Comme le montre le tableau N°1, les céphalées chroniques sont les troubles psychosomatiques les plus fréquemment observes a l'hôpital psychiatrique de Ndera ou nous avons fait ce travail de recherche. Les céphalées chroniques sont observes dans 70% des cas psychosomatiques. Par contre les palpitations, les vertiges, la fatigue chronique et les douleurs abdominales sont observées avec une fréquence également élevée mais moindre que celle des céphalées allant de 30 a 40% des cas psychosomatiques.

Tableau N°1: FREQUENCE DES TROUBLES PSYCHOSOMATIQUES

Signes	***Effectifl/30***	**%**
Palpitation	12	40
Amnésie	3	10
Lombalgiesies	7	23.3
Vertigies	11	36.6
Gastrite ou ulcère gastrique	6	20
Brûlures au niveau des membres inférieurs	3	10
Fatigue chronique	10	33.3
Céphalées chroniques	21	70
Troubles sensitives	4	13.3
Troubles sensoriels	6	20
Problèmes sexuels dyspareunie	1	3.3
Douleurs abdominales	9	30

Les céphalées chroniques de type psychosomatique sont souvent à type de brûlures et se localisent fréquemment au niveau du cortex, au sommet du crâne. Ces céphalées ainsi que les autres troubles psychosomatiques sont souvent secondaires à des pensées négatives ainsi que des sentiments négatifs entretenus pendant longtemps, notamment les sentiments de peur, de tristesse profonds, de colère, de jalousie et de vengeance ou de rancœur. Mais c'est l'humeur dépressive et l'anxiété qui sont les facteurs causals les fréquents comme le démontre le tableau N°2 illustrant les liens très étroits qui existent entre les sentiments négatifs, les comportements négatifs et les troubles psychosomatiques.

Tableau N°2 : FREQUENCE DES TROUBLES COMPORTEMENTAUX ET SENTIMENTAUX ASSOCIES AUX TROUBLES PSYCHOSOMATIQUES

Grille de réponses	Effectif / 30	%
Manque de volonté	4	13.3
Manque d'appétit	5	16.6
Humeur dépressive	12	40
Insomnie	8	26.6
Colère	3	10
Agressivité	1	3.3
Anxiété	6	20
Flash-back	10	33.3

Ces troubles psychosomatiques doivent impérativement pris en charge car ils ont un impact négatif scolaire académique professionnel important comme l' illustre le tableau N° 3.

Tableau N°3: IMPACT DE LA MALADIE SUR LES ETUDES ET LA VIE PROFESSIONNELLE

Consequences	Effectif/30	%
Arrête les études	3	10
licencie de leur travail	5	16.6
Changement du travail	4	13.3
Démission	6	20

Notre recherche a constate que 33.3% des cas des troubles psychosomatiques sont dus aux conflits conjugaux, que l'appelle conjuguopathies ou les maladies du foyer. Et ces troubles affecte plus souvent la femme que l'homme a cause de sa grande sensibilité et quand ces troubles psychosomatiques ainsi que ces conjugaupathie ne sont pas soignes a temps, ils évoluent vers la forme de malade mentale la plus grave appelée PSYCHOSE. C'est la forme la plus grave car elle s'accompagne d'une dislocation de la personnalité sujet. 40% des cas de psychose réactionnelle brève observées salle de crise de l'hôpital psychiatrique de Ndera sont en rapport avec des difficultés conjugales. D'où l'importance de ces journée sensibilisation en santé mentale qui devraient être multipliée. En effet, il y a trop d'ignorance dans le domaine de la santé mentale au niveau de la population

Rwandaise. Or le plus grand ennemi développement et de la santé intégrale, c'est l'ignorance. Surtout dans un pays qui a été affecté par le génocide, beaucoup de personnes soufrent moralement, mais malheuresement elles ne savent pas le type de maladie dont elles souffrent ni la cause réelle. Ce qui augmente le malaise individuel et la souffrance morale ou psychique. Le tableau No.4 nous montre les facteurs psychosociaux qui sont souvent à base des troubles psychosomatiques.

Tableau N^{o} 4: FREQUENCE DES ETIOLOGIES PSYCHOSOCIALES DES TROUBLES PSYCHOSOMATIQUES

Difficultés	**VA 30**	**VR%**
Conflits conjugaux	10	33.3
Mésententes au travail	5	16.6
Isolement social	1	3.3
Problèmes économiques	6	20
Difficultés sociales	1	3.3
N'ont rien révèle	7	23.3
Total	30	100

Le traitement des états anxiodepressifs sous jacents fait souvent recours à un traitement antidépresseur sédatif tel que l'anafranil 25 : 1 comp x 3/j parfois associé au stugeron 75 1 cp matin et soir pendant au moins 6 mois en associant avec le psychothérapie.

LES VIGNETTES CLINIQUES

1. CAS CLINIQUE N°1

II s'agit d'un cas clinique illustrant comment un trouble psychosomatique peut être un cri d'alarme voile d'une conjuguopathies cache et qu'il faut décoder. C'est une dame qui est venue me voir en consultation pour des céphalées chroniques qui avaient résistes a tous les traitements reçus jusqu'a alors. En prenant le temps d'écouter cette patiente en train de verbaliser sa souffrance, je me suis rendu compte que ses céphalées associes aux cervicalgies étant l'expression d'un fardeau psychique. Exactement comme quelqu'un qui a porté un lourd fardeau toute la journée et qui se retrouve avec des céphalées et des cervicalgies le soir. Avec la différence ici que le fardeau étant psychique. Et ce fardeau n'étant rien d'autre que des conflits conjugaux incessants.

Ces conflits ont débute un soir, quand un de ses collègues travail I'a appelle a 22h, pour savoir comment elle se portait. Et son mari s'est mi en colère a cause de ce coup de fil tardif et il est devenu méfiant a l'égard de sa femme depuis ce jour la. Cette crise de confiance a déclenché chez la dame des céphalées interminables, qui n'ont pas pu disparaître qu'au travers d'une thérapie de couple que nous avons instauré. Cette thérapie de couple a travaille surtout sur la restauration de la communication dans le couple, la restauration de la confiance mutuelle ainsi que la bonne gestion de I'émotion de la colère et du budget conjugal.

2. CAS CLINIQUE N°2

II s'agit d'un couple dont le mari étant d'ethnie différente de celle de son épouse. Apres leur mariage, le mari éjaculait hors de I'organe féminin lors des rapports sexuels, et cela a intrigue la dame. Plus tard le monsieur était oblige de révéler la raison de son comportement : il ne voulait avoir avec elle un enfant dont le sang est mélange Hutu-Tutsi.

La femme a commence a avoir des céphalées chronique résistants aux antalgiques, puis elle a développe des hallucinations auditives qui lui disaient que son mari allait I'abandonner etc. Vous voyez comment cette dame est entrée dans la psychose, après avoir développe des céphalées psychogenes, qui n'ont pas pu être décodes et qui n'ont pas ainsi été pris en charge. La encore nous avons fait une psychothérapie de couple après avoir éteint le délove et les hallucinations par les neuroleptiques, ayant pour but d'empêcher la rechute psychotique, en soignant la cause.

En conclusion, nous pouvons affirmer que notre corps parle pour exprimer un malaise individuel, familial, économique ou conjugal. Nous devons être a I'écoute de ce langage pour assurer la prévention en santé et la meilleure prise en charge de nos patients.

Abstract 10: Introducing Electronic counselling in Nigeria: Implication for counsellor Education.

By **Dr. Charles Ngozi Ugwuegbulam,** PhD, Department of Educational psychology, Alvan Ikoku College Of Education, P.M.B 1033, Owerri, lmo state, Nigeria.

The world is becoming a global village due to the influences of technology. This is affecting many spheres of life and it is causing changes. Counseling will not be left out. Electronic counseling is gaining grounds in the developed world and Africa including Nigeria should get to the starting line. In Nigeria as else where in the world people are experiencing a lot of challenges for which they need counselors to talk to. A good number of such people do not have physical access to counselors due to time constraint and distance.

In view of this background, this paper proposes that Electronic counseling should be introduced in Nigeria. In doing this, the need and benefits for E-counseling and it's constraints were highlighted. The paper makes a case for E-counseling to take off in Nigeria. It should start from the counselor procedure. The paper therefore highlights the implications of introducing E-counseling in Nigeria in respect of counselor Education.

Abstract 11: An Investigation of Teachers' Knowledge of ADHD: Implications for Counselling at CJSS.

By **Aaron Ronnie T. Majuta,** Counselling and Human Services Programme, Educational Foundations Department, Private Bag 00702, Gaborone, University of Botswana, Phone: 3552199, e-mail: majuta@mopipi.ub.bw,

Attention Deficit Hyperactivity Disorder (ADHD) is a mental disorder that affects children, adolescents and adults. However, little is known about teachers' knowledge of the condition in Africa in general, and Botswana in particular. Teachers are aware of the students who have learning disorders and often give up on them, describing them as "class clowns, rude, immature, unmotivated, lazy, inconsistent and irresponsible" (AEL, State Policy Program, 1994). Teachers are also aware of the students who do not fit these labels and are also necessarily low achievers but end up dropping out of school or failing at Junior Secondary School levels. The aim of this paper therefore is to investigate Botswana teachers' knowledge of ADHD and highlight the implications for counseling. In the investigation, the following questions were asked:

- What do teachers at CJSS know about ADHD?
- What do teachers do when they encounter students preset with ADHD symptoms?
- What are the implications for student counselling at CJSS in the face of possible termination of schooling after form three?

The research method used is the survey type in which interviews and questionnaires were applied for data collection. The study covered a few sampled schools from different regions as a representative sample. The results indicate that a significant number of teachers are not knowledgeable about ADHD and assistive services are also minimal.

Abstract 12: Challenges of Counselling Training in Zimbabwe

By **Gertrud Bischoff**, Child Psychiatrist and Psychotherapist

The concepts and theories of professional counselling training worldwide are based on the western belief that the individual is mostly responsible for whatever he becomes, meaning it lies solely in his responsibility to take action towards change in case of perceived problems which he wants to have solved. The first counselling training institute to offer, a degree in counselling in Zimbabwe choose the **systemic counselling approach**, based on the systems theory, which assumes that every living organism is part of interlinked systems and therefore every change coming from one or more parts in a system causes the whole system to change in order to keep its homeostasis. This approach is the one amongst all the different counselling theories and schools which is specifically suited for the African context, where traditionally problems are solved involving the help of the members of the system(s) where they occur, i.e. family, community etc., as the individuals in these settings have no power of decision making on their own. Every

counselling approach in a professional counselling setting is based on the assumption that the counsellor and the one seeking help (client) can build a trusting relationship, in which the counsellor succeeds to empower the client to take action towards change in the solution finding process. Though the systemic approach accommodates the involvement of the surrounding environment of the client, it quite often is faced with the problem that the client, being part of a hierarchical culture where decisions are made at the top and individuals are not used to making own decision, wants to be told what to do. Advice giving is part of the traditional problem solving process, and the counsellors, though trained in "modern" counselling techniques, are themselves part of this culture, and are tempted to succumb to the request of their clients by "taking over" and directing them. This tendency is supported by the fact that most trained counsellors come from professions where being in charge and giving information is the biggest part of their work (teachers, nurses). As the use of the "self" of the counsellor is the most important tool in every counselling approach in building a relationship with a client to facilitate change, this aspect needs more attention in the counselling trainings, which are operating.

As mentioned above, for both counsellor and client the concept of being in charge of your life and able to make decisions as an individual is foreign in most of the African settings. The person, who by power of a professional position is in charge, executes this power to make decisions, and the recipient does not question it. This is detrimental to a situation where change of behaviour of the individuals and as consequence of the society as a whole is perceived as the only solution to tackle the many problems, which haunt many African countries. An important step towards more insight into the processes of what happens in a counselling relationship is the emphasis on **self-awareness** in the counsellor. This is an area which, due to the pressuring prevailing problems and the resulting need of "producing" more counsellors, has been neglected in the training or has not been included in the training curriculum at all. The other important issue is the supervision of the counselling work, meaning supervision of counsellors to improve their skills and share experiences, which is not yet part of most of the counselling trainings up to now, where acquiring of theoretical knowledge is still the most important requirement of training. There is a considerable increase in counselling training in Zimbabwe in the recent years. As the profession of a counsellor is not standardised, the quality of training varies considerably, and it should be in the interest of all counsellors and therapists to work towards building professional associations in the individual countries, which watch over ethics, enhance standards and protect the interests of counsellors and clients alike.

Abstract 13: Secondary school students' knowledge, attitudes and risk behaviors in relation to HIV/AIDS as a basis for youth counseling in Rwanda.

By **KAMANZI Desire**, Department of Nursing Sciences, Kigali Health Institute,
B P 3286 Kigali Rwanda, Tel +250 (08868207), e-mail: kamanzides@yahoo.fr

Schools reach further into communities than any other institute hence they are critical for reducing the vulnerability and risk among young people (UNESCO, 2002). There is a number of contributing factors to the increase of HIV/AIDS infection in secondary schools in Rwanda. Among others, the following are mentioned:

(1) The fast growth in the number of schools over the last decade has compromised some aspects of quality, such as discipline;

(2) The number of students is increasing, due to the gratuity paid to school according to a government declaration.

(3) Young people including students have been reported to initiate sexual activities at earlier age.

(4) In Rwandan socio-culture, sex has been considered as taboo. There is no direct communication between parents or adults with children or young people regarding sex. As a result youth lack knowledge on sexual and reproductive health issues.

(5) In addition to poverty and misconceptions or myths around HIV infection, there is strong intergeneration mixing (young girls and adult men).

(6) As problematic as behavior change is in general population, it is even more so for adolescents and young adults.

This is especially with HIV infection, whereby the long interval between exposure and the onset of illness further complicates youths' adaptation of preventive behaviors. If the schools could be used as an entry point for prevention activities, it is important to have a clear idea of the current level of knowledge, attitudes and behavior with regard to HIV/AIDS. Thus a study was conducted with the aim of describing the HIV/AIDS knowledge, attitudes of secondary school students and their risk behaviors on HIV transmission. Qualitative and quantitative data were collected between June and September 2004. A total number of 613 secondary school students participated in this study. A random sample of 51 students was drawn per school except for the school A; which had one more respondent. Qualitative data was generated by asking each student to write any concerns or experiences with HIV/AIDS, which they wanted to share on a piece of paper. Without names, all respondents expressed their thoughts freely on these papers (n= 613).

Furthermore, interviews were conducted with some key informants amongst the students. Interviews were documented by the researcher making copious notes during interviews. It was realized, however, that generally, respondents were more concerned about their reproductive health issues rather than HIV/AIDS as specific topic. A very large proportion (91%) of participants confirmed that they knew at least one person living with HIV/AIDS from their communities. When asked why they engage in sexual intercourse instead of abstaining from sex, respondents expressed similar attitudes but in different ways. They are some who could not believe that a person can be a teenager without having sexual intercourse. However their responses could be summarized in six main reasons:

(1) experience,
(2) curiosity,
(3) peer pressure,
(4) partner empathy,
(5) monetary gain, and
(6) coercion sex.

Abstract 14: Positive Prevention Activities For PLWHA - Training in Basic Counselling and Communication skill

By **Despina Madonko**, Social Worker (MsC), Director CONTACT Family Counselling Centre, 9, Barbour Avenue, Park view, Bulawayo, Zimbabwe.
Tel. +263 9 72400, FAX +263 9 883607

According to the latest statistics received by the National Council an estimated of 1.8 million out of 12.5 million Zimbabweans are living with HIV, while the prevalence is 24.6% in the 15-49 years groups. The majority of them are women (870,000) and children at the age of 0-14 (165,000). Since 1999, PLW Zimbabwe, with the encouragement of various institutions work the field organize themselves in support groups with the aim to emotionally and practically help each other. The number of support groups and their membership is constantly increasing. There are an estimated number of 60 support groups operating in the region of Bulawayo. CONTACT Family Counselling Centre is a non-Governmental Organization founded in 1993 in Bulawayo, Zimbabwe with the aim to provide counselling services to the public free of charge and also to train counsellors in systemic counselling. Since June 2004 CONTACT is focusing on involving PLWAs in positive prevention and mitigation activities by offering Basic Counselling Skills courses to the PLWAs. The main objectives of the project are as follows:

- To reduce transmission of the virus through individuals who are conscious of their status and the negative consequences for themselves and the society.

- To disseminate information and systematise the knowledge on feelings and behaviour of PLWHA.

- To promote self-awareness and understanding of human behaviour through introduction to basic counselling and communication skills.

- To reduce stigma, fear, rejection and discrimination among PLWHA through empowerment that emanates from the fact that some knowledge and skills have been acquired.

- To boost self-esteem and confidence of PLWHA.

- To identify individuals who can be further trained and become counsellors.

The training is offered free of charge and takes place in the parts of the city where the support groups are operating. The local languages are used in order to make all the issues easily understood. During the course people learn how to live positively and healthy with HIV and learn skills that help them to understand and analyse their feelings better. They also learn how to listen to others and understand their behaviour.

The project is been currently evaluated through group discussions with the last year's participants and the findings are very encouraging. The participants do remember the basic concepts they were thought, several of them use their knowledge to help other members of the support group or their immediate environment. Some of them became peer counsellors in their workplace, two registered to attend professional training in counselling. However, the most important impact of the course refers to the issue of disclosure and how the participants felt confident enough to disclose their status to their relatives or the public. The project has attracted the interest of an international Donor that will finance the expansion of the training for more support groups in the near future.

Abstract 15: Counselling People Living With HIV/AIDS (PLWHA): Principles and Practice

By **Dr. Tina NWEZE**, EBONYI STATE UNIVERSITY, ABAKALIKI - NIGERIA

This paper acknowledges the fact that there are people living with Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (PLWHA) in Ebonyi State. It focuses on what Counselling is all about; and discusses the concept of HIV/AIDS counselling and those expected to benefit from such counselling service(s). It explains the three types of HIV/AIDS counselling (pre - HIV test, post - HIV test, and ongoing HIV counselling) before discussing the guiding principles underlying the practice of Guidance and Counselling. This paper equally shades light on how the HIV/AIDS counsellor could address the tragedy of HIV/AIDS infection. It concludes by emphasizing that confidentiality is the counselling watch-word and that it is wrong in Law Medicine and Ethics to discriminate against any person infected and/or affected by HIV/AIDS. This calls for all hands to be on deck to help in assisting PLWHA to adjust to school (if they are students); workplace (if they are workers) and home environments.

Abstract 16: HIV/AIDS intervention strategies in Africa: case of Maseru - Lesotho

By **Mr. Monaheng Maximus Sefotho**, Lecturer in Educational Psychology and Counselling, National University of Lesotho
e-mail: msefotho@hotmail.com, Sefotho@yahoo.com.mx

Counselling is relatively new on the African continent and many African countries find themselves having to resort to counselling in the fight against HIV/AIDS. However, most were caught unawares and find they are ill-prepared to blend the conventional intervention strategies well with indigenous practices. Therefore, there is a great need to examine the current intervention strategies against traditional African interventions. The study examines the utilisation of the HIV/AIDS intervention strategies in Maseru - Lesotho with special emphasis on counselling strategies against indigenous intervention practices. Research trends show a strong inclination towards the use of the Rogerian model as a theory mostly used in HIV/AIDS counselling. This is examined in-depth in relation to the Basoto traditional ways of dealing with sensitive and confidential issues such as those related to HIV/AIDS. The behaviour communication change model is also examined as a measure to see how far this strategy benefits the client.

Abstract 17: The Quality of Pre and Post HIV-Test Counselling at Sinikithemba HIV/AIDS Christian Care Centre in Durban

By **UWIZEYE Gloriose,** Psycharitric Nurse, Head of HIV/AIDS Programs "Association MWANA UKUNDWA", Rwanda; e-mail : gloryuw@yahoo.fr

In view of the implications of HIV/AIDS, counselling is considered to be crucial before and after the HIV-test. Studies revealed that most of the clients, receive a single pre- or post-test counselling session, with little or no follow-up opportunity. However the quality of pre and post-test counselling is crucial if it is to impact on emotional support and long-term care and prevention. The purpose of this study was to investigate the quality of pre and post-test counselling amongst people infected with HIV that attend Sinikithemba HIV/AIDS Christian Care Centre at McCord Hospital, situated in Durban, in the Province of KwaZulu Natal. The study described the experience of people how underwent the pre and post HIV-test in terms of emotional support, information, and referral provided by the counsellors. A qualitative approach using descriptive design was used in this study. A purposive sampling helped to select the six participants of the study amongst people who live with HIV/AIDS that attend Sinikithemba HIV/AIDS Christian Care Centre at McCord Hospital. Six participants were interviewed. This study showed that the counsellors used mostly information and advice and missed out to attend to emotional reactions of the clients. Hence failed to help the latter to deal with those emotions, which is essential to the quality of pre and post-test counseling. The information received by most participants seemed to be very superficial and lacked details whereas the quality of information should

be ensured if the pre and post-test counselling is to lead on long-term prevention and care. This study also revealed that the referral such as to HIV infected people support group increased the quality of pre and post-test counselling because the members of support group shared their emotions, experiences and information. It was also reported that the support group provide HIV infected people with a sense of belonging. The findings of this study suggest that counsellors should be provided with further counselling skills and techniques to manage clients' psychological needs such as helping the clients to express, explore and deal with their emotional reactions to the HIV test and also to AIDS in general. This implies the need of adequate basic counselling training, on-going in-service training and supervisions; enough time for pre and post HIV test counselling sessions; follow up sessions and if appropriate referrals to specialized counselling service. More detailed information be given to people who undertake pre and post HIV-test counselling. It should be noted that most clients do not get chance to attend other counselling sessions beside pre and post HIV-test counselling. In view of the crucial role that the support group plays in the life of the people living with HIV/AIDS, counsellors should encourage clients to attend such groups. The latter should also be reinforced and group counselling sessions could be organized though support group.

Abstract 18: Causes and Consequences of Examination among Secondary School Students.

By Olubode-Awosola A.A. (Mrs.) & J. C. F. Venter (Mrs.) Fasasi (Dr)

Department of Curriculum Studies, University of the Free State, Bloemfontein, South Africa, olubodeo.sci@mail.uovs.ac.za, venterjc.HUM@mail.uovs.ac.za

Examination plays the roles of evaluation, selection, placement and certification of students. However, the social vices associated with examination have defeated these roles. Subsequently examination stress and anxiety have become a topic of inter-disciplinary concern and research because most schools are recording increasing occurrence of mental or physical problems among students during examination periods.