Asian Journal of Advanced Research and Reports

Volume 18, Issue 6, Page 346-355, 2024; Article no.AJARR.117059
ISSN: 2582-3248

Clinical Motivation Experience Practicum at Rehabilitation Center, Boston: A Case Study.

Konaku Doo Kuusegmeh [a*] and Jacob Aaworb-nang Maabobr Kor [a]

[a] Catholic University of Ghana, Fiapre- Sunyani (CUG), Ghana.

Authors' contributions

This work was carried out in collaboration between both authors. Both authors read and approved the final manuscript.

Article Information

DOI: https://doi.org/10.9734/ajarr/2024/v18i6678

Open Peer Review History:
This journal follows the Advanced Open Peer Review policy. Identity of the Reviewers, Editor(s) and additional Reviewers, peer review comments, different versions of the manuscript, comments of the editors, etc are available here: https://www.sdiarticle5.com/review-history/117059

Short Communication

Received: 11/03/2024
Accepted: 15/05/2024
Published: 24/05/2024

ABSTRACT

Rehabilitation is defined as "a set of interventions designed to optimize functioning and reduce disability in individuals with health conditions in interaction with their environment". Anybody may need rehabilitation at some point in their lives, following an injury, surgery, disease or illness, or because their functioning has declined with age.

Some examples of rehabilitation include Speech and language training to improve a person's communication after a brain injury; physical exercise training to improve muscle strength, voluntary movements and balance in persons with stroke or Parkinson disease; modifying an older person's home environment to improve their safety and independence at home and to reduce their risk of falls; educating a person with heart disease on how to exercise safely; preparing a person with an amputation to be able to use a prosthetic and making, fitting and refitting the prosthesis; positioning and splinting techniques to assist with skin healing, reduce swelling, and to regain movement after

**Corresponding author: Email: kon2.doo3@yahoo.com;*

***Cite as**: Kuusegmeh , K. D., & Kor , J. A.- nang M. (2024). Clinical Motivation Experience Practicum at Rehabilitation Center, Boston: A Case Study. Asian Journal of Advanced Research and Reports, 18(6), 346–355. https://doi.org/10.9734/ajarr/2024/v18i6678*

burn surgery; prescribing medicine to reduce spasticity for a child with cerebral palsy; psychological therapies for a person with emotional distress following a spinal cord injury; Social skills training for persons with schizophrenia, autism spectrum disorders or disorders of intellectual disability. training a person with vision loss in the use of a white cane; and working with a patient in intensive care to improve their breathing, prevent complications and speed their recovery after critical illness.

Rehabilitation is an essential part of universal health coverage along with the promotion of good health, prevention of disease, treatment and palliative care. Rehabilitation helps a child, adult or older person to be as independent as possible in everyday activities and enables participation in education, work, recreation and meaningful life roles such as taking care of family. Globally, an estimated 2.4 billion people are currently living with a health condition that may benefit from rehabilitation. With changes taking place in the health and characteristics of the population worldwide, this estimated need for rehabilitation is only going to increase in the coming years. People are living longer, with the number of people over 60 years of age predicted to double by 2050, and more people are living with chronic diseases such as diabetes, stroke and cancer. At the same time, the ongoing incidence of injury and child developmental conditions (such as cerebral palsy) persist. These health conditions can impact an individual's functioning and are linked to increased levels of disability, for which rehabilitation can be beneficial.

In many parts of the world, this increasing need for rehabilitation is going largely unmet. More than half of people living in low- and middle-income countries who require rehabilitation services do not receive them.

The need for rehabilitation worldwide is predicted to increase due to changes in the health and characteristics of the population. For example, people are living longer, but with more chronic disease and disability. Currently, the need for rehabilitation is largely unmet. In some low- and middle-income countries, more than 50% of people do not receive the rehabilitation services they require. Emergencies including conflicts, disasters and outbreaks create enormous surges in rehabilitation needs while also disrupting rehabilitation services. Rehabilitation is an important part of universal health coverage and is a key strategy for achieving Sustainable Development Goal 3 – "Ensure healthy lives and promote well-being for all at all ages".

In this case study, an in-depth review of the situation of the rehabilitation centre practicum at Bostson, United States of America, is, highlighting important contributions that this research/practicum conducted by a student of the Department of Social Sciences Education, of the Catholic University of Ghana, Fiapre-Sunyani, could make to this important field of rehabilitation research in the next two decades.

Keywords: Clinical motivation; counselling trainees; narcissistic defence; psychosis.

1. INTRODUCTION

The objective of the study, *Clinical Motivation Experience Practicum*, is to empower Career Guidance and Counseling Students with motivation to be able to write clinical case reports in their training to become professional counsellors. The *problem of the study* being addressed is that, to my estimation, many counselling trainees whom I experienced are either unaware of clinical case studies or do not have the technical know-how to write one. Counselling trainees need to learn how to appreciate case studies which is inevitable in their career as future counsellors. A professional counsellor should be able to document a case of a patient (NCMHCE, 2023) in a clean, intelligent, and presentable fashion. To be able to do it correctly, the counselees during their practical training must equip themselves with the skill, knowledge and technique of client history-taking and problem presentation in a case study [1]. The counselling student in training should be an empathic listener, listening carefully and understandably to be able to get the meta-story of the patient during the session to write a good clinical case report [2]. The significance of a case study is that it is an effective way of helping students to apply their skills [3], in a practicable manner and to understand learned information in real-life events. Most importantly case study is particularly useful where a situation is complex and solutions are difficult to arrive at a given time and environment.

The study identified in the patient elements of depression, paranoia, anxiety, delusion, psychosis, fantasy, narcissistic defence, anger, emotions, destructive thoughts and revenge, frustration, resistance etc. [4]. The evaluation includes a discussion about the patient's feelings and behavior as was observed during the study.

Field in her 1968 study stated that there was an increase of schizophrenia in Ghana within the last 20 years. However, she could not substantiate her claim with any data. She made a longitudinal study of hundreds of cases in Ashanti and Brong Ahafo by visiting rural shrines in these areas and provided information on clinical and contextual detail but did not quantify many of her pieces of work. Another study was conducted in the 1980s about the prevalence of schizophrenia in La and its environs in Greater Accra by the use of clinical interviews and reviewing medical records which identified 28 cases of schizophrenia. Methods were restricted to track cases from some hospitals.

Any particular case which explains a patient's situation, the nurse's interview after the encounter, the in-depth description of the nurse-patient conversation, and the observational data obtained from it. Pearson in 1991 and Patton in 1990 indicated that a case study can be used for example, for investigating how different concepts emerge or change in any particular context, and what can be learned from the single case study. Tredennick, A. T., Hooker, G., Ellner, S. P., & Adler, P. B. [5]. hints that we select a case that seems to offer us the opportunity to learn and make a contribution to the understanding of specific phenomena. Whatever we do, our emphasis is put on health counselling where the patient's situation is respected, the initiated action is supported, and shared knowledge and clear understanding are nurtured [6]. This might not be true in some patients' situations where rights are not respected and no action is taken and no knowledge shared.

Ghana has seen the establishment of mental health centers, the drafting and passing of a new mental health bill on March 12, 2012, (Act 346), the training of psychiatric nurses, primary care specialists etc. There has been an increase in research projects and publications on mental health in various disciplines such as psychology, sociology, and anthropology. Kintampo Health Research has aided studies of risk factors for psychosis, mental disorders and depression. The Mental Health and Poverty Project conducted research on mental health policy in some African countries with Ghana as one of the beneficiaries. Mental health care in Ghana seems to be overlooked and much is left to be desired.

Motivation, therefore, is a process of developing skills and perceptions of patients [7]. It is not something which just happens but a process that is encouraged and facilitated. In every individual health counselling, the ultimate goal is not so much to change the patient's way of behaving and seek his/her compliance with the presented problem, but instead to raise awareness by learning and support, and to offer patients the necessary tools for making changes on their own. The aim is personal motivation; control and efficiency [8]. The summary of the literature review suggests there are still important areas for future research to be conducted especially in disciplines such as helping professions like Career Guidance and Counseling.

2. RELEVANT LITERATURE REVIEW AND DISCUSSION OF THE CASE STUDY OBSERVATION/ FINDINGS REPORT

This fieldwork placement was at Goddard House, Jamaica Plain, Boston. Counselor started the fieldwork placement preparations in February 2008 the beginning of the Spring Semester, 2008 but never got started till the beginning of April 2008. Counselor started with four patients and Mr. Jackson Brown has been my main patient for the three semesters. Mr. Jackson Brown is a Black American who was born in North Carolina on January 4, 1923. He moved from North Carolina to settle in Boston.

According to his medical chart, his relations (next of kin) are John Brown and Caroline Gerald. He was admitted at Goddard House on April 5, 2006. His diagnoses are nosocomial pneumonia, chronic renal insufficiency, diabetes, depression with paranoia, latent syphilis, hyperlipidemia infarct, senile, dementia, delusion, and DVT-deep vein thromb.

He has Medicare and Medicaid. His medications include glipizide 5mg, glucerna 120 ml, plavix 75 mg, Protonix 40mg, lisinopril 5mg, simvastatin 5mg, Xalatan, and acetaminophen.

Mr. Jackson Brown is my main patient. He is a Black American. Mr. Brown mentioned to me in our first session on April 7, 2008, that he was married with 14 children, all married. He said some of the children were living in Boston with their families and some in North Carolina where he first lived. According to him his sister still lives in North Carolina. But Brown's chart reported that he is single. He spoke little at the time and still speaks very little. He hardly looked up into my face. His head was mostly down on the table and he hardly raised his head to look up. In our first 3 or 4 sessions counselor made a great effort to hear and understand what he was saying to me.

He spoke slowly and his words were not audible enough. Counselor was getting frustrated but as we progressed he improved in auditory and could keep eye contact more frequently than before (Cf. Margolis B, 1983/2024).

Mr. Brown said he did not like speaking to people about himself because he did not trust people especially the staff of the house. That he would not like to tell people things about himself only to hear it outside and the police may come and arrest him. He repeated the lack of trust of the staff and people a significant number of times. He complained that the food was not good and even he was not allowed enough time to finish his food before it was removed from his table.

According to Mr. Brown, his brother used his name to borrow money and it became a big case and he could do nothing. His car was taken. That was one of the reasons why he found himself in a nursing home, a place of shelter (hideout) from the police. (I thought, did he commit a crime?). He said he has money in the bank but when he asks no one is saying anything to him. “I don’t have money with me and I can’t do anything about it. I’m not sure of what the bankers are doing. I’m always afraid of the people here. I don’t know what to do.” He rested his head on the table. I looked at him as helpless and that could be frustrating for him, I thought.

In one of our sessions, he started talking by saying, “they” wanted some time from him. So, I asked him which people wanted some time from him. He responded by saying he thought it was the office people. ”They wanted some time, I don’t have their time. My time, they don’t know I need time.” He said he could not think of anything. That his family could not think of him. “I don’t think of nobody.” Then he never spoke for the rest of the time.

Spotnitz (1969/2020) said “While the patient develops a transference, the analyst usually develops a countertransference which is based on unconscious reactions to the patient's transference attitude and behaviour. The success of the therapy depends in large measure upon the analyst's ability to feel the tendencies toward instinctual discharge. The capacity to sense the latent emotions and to help the patient feel them determines whether the relationship is grounded in genuine emotional understanding, or is primarily an intellectual exercise" (p. 83). Spotnitz said the essential capacity for an analyst is the capacity to feel induced emotions, to help the patient to verbal them is the process of resolving his resistances [9].

Normally, frustration brings hate to a patient’s life (Cf. Melanie Klein, 2018). Mr. Brown complained, “The money is mine, why don’t they want to release it to me? They are annoying me.” Hate tension when accumulated can take only one direction. The patient must release them in his sessions toward his treatment partner. The impulses must be tamed and worked on through feelings and language without improper action.

During one of the sessions, Mr. Brown told me that he felt the presence of some figure in his room and he felt like doing something, just hitting something against the table. “My brother is very old. He does not know where I am, but I know he is somewhere.” (inferring from the figure he felt in the room and that the brother was very old – could he be thinking of the death of the brother? I thought). But then he said the brother did not care about him. Then he started to talk about his money which was helped by the administration in the office. “Who do they think they are?” He seemed tense, and frustrated, as he complained that the way he was treated was unfair to him.

In one of our sessions on September 19, 2008, Mr. Brown came in, sat down and never said a word. He only would look at me from time to time as he usually did in sessions. There was silence throughout the whole period. Some of the sessions he kept silent for a long pause but spoke. But this silence experienced this day was a dead one. It made one frustrated and angry which the writer tried not to show. When the time was up the counselor stood up for some time and told him he was leaving but still not a word from him. What was the resistance to talk about? The counselor could not tell. This could as well be my resistance or transference to Mr. Brown’s silence because the counselor thought he had to speak. Mr. Brown had the habit of putting his head down on the table during sessions. But one day during our session, he was able to look directly into my face for most of the period without saying a word. That constant look into my face with absolute silence was very significant and symbolic.

Burgoom, J. K., Manussov, V., Guerrero, L..K, (2021) has this to say about non-verbal communication. “Nonverbal communication speaks to today’s students with modern examples that illustrate nonverbal communication in their lived experiences. It emphasizes nonverbal codes as well as the

functions they perform to help students see how nonverbal cues work with one another and with the verbal system through which we create and understand messages and shows how consequential nonverbal means of communicating are in people's lives." (Burgoom, Manussov, Guerrero, 2021).

Silence can be a resistance and therefore a defense against something. He only nodded his head and the counselor left. Freud (1914a) regarded defence as a conscious process, a means of forgetting painful realities. He referred to a process of rejection called defense which he later referred to as regression. Defence is also seen as a protection against anxiety. This kind of defence is basically to prevent the action of anxiety from taking place. By his silence, only Mr. Brown knew what it was that he was defending against.

During one of the sessions, on October 24, 2008, Mr. Brown complained that he was not feeling well and he would not take medication. When the counselor asked him why, he said the medication he received so far was too much and did him no good. "I think sometimes the nurses want to kill me with all that," he said. "What else can I say, my world is here. Look I feel pain. Nobody feels pain. Nobody understands, and they should keep quiet and go away from me," he said. The counselor looked at him and his face was sad looking. He put his head on the table and never said a word again [10]. Just as much as the counselor was with him in his pain and frustration, the counselor felt disrespected. In some way, the counselor also felt the loneliness of Mr. Brown.

Meadow, P.W. [11] noted that "One category of patient conveys the feeling that he is alone in the world. He is cut off from all experience. Energy is used to reduce stimulation and control tension. He may speak in a monotone, make no contact with the analyst, and, although he reports thoughts freely, his experience does not allow for the presence of the analyst in the room" (p. 202). It was my feeling that Mr. Brown was experiencing loneliness in his world.

During one of our sessions, Mr. Brown complained about the medications that he was taking and said he did not want to take them because he thought the nurses were trying to kill her. "I think sometimes the nurses want to kill me with all that. Who do they think they are? I'm tired of everything here. Nobody in the family thinks of me. I think of myself (Cf. Spotnits H, Meadow PW, 1995/2023). Why do they disturb me." In his fantasy, he feels the nurses want to destroy him. He may also in that same fantasy wish to destroy those whom he thinks are trying to get rid of him. For example, from *The Narcissistic Defense,* "When I feel like killing you, I kill my feeling instead." This is a statement I have frequently heard from schizophrenic patients. Some of them say they don't feel that I am in the room with them. Feelings of emptiness are another characteristic complaint" (Meadow, p. 107).

In one of our meetings, Mr. Brown told the author of this project work that he felt the presence of some figure in his room doing something. That he felt like doing something, just hitting something against the table. "My brother is very old. He does not care about me, he does not know where I am, but I know he is somewhere." Then he said, "Who do they think they are?"

From observation and experience with Mr. Brown, he tends to be psychotic, delusional, and paranoid most times. Spotnitz, H. [12] has this to say about the rage reaction in a psychotic patient. "Delusional, hallucinations and the like can take one on an interminable detour." A brief history of their onset and development is sufficient. Once I have this history, the symptoms are explored to the extent necessary to get to the roots of the narcissistic defence. In the process the patient's contact functioning is "utilized to resolve his resistance to the verbal release of hostility as quickly as possible" (p.113).

Little, M. [13] said that transference delusional hides states in the patient that he both needs and fears to reach. In its subject and object, all feelings, thoughts, and movements are experienced as the same thing. That is to say, there is only a state of being or of experiencing, and no sense of there being a person; there is only anger, fear, love, movement, etc., but no person feeling anger, fear, or moving. And since all these things are the same, there is no separateness or distinction between them. It is a state of undifferentiatedness, both as regards psyche and soma, experienced as chaos (p. 134).

Mr. Brown said, "Nobody feels pain. Nobody understands," I made an effort to concentrate my attention on understanding and resolving my resistance to meeting Mr. Brown's needs. "Having the right feelings for the patient provides him with the emotional closeness that the

preoedipal patient requires to move on to autonomy. The ability to feel the feelings induced by the patient is a function of the analyst's mental health" (Spotnitz, p. 168).

Transference feelings manifest themselves after the resolution of each resistance. Repeatedly, treatment destructive resistances and status-quo resistances interfere with the communication of transference feelings. When they dominate, the analyst doesn't work for progressive communication. As the resistances are resolved the patient is moving towards the repetition in the transference of early object relations.

In our session of November 14, 2008, Mr. Brown continued to share with me his problems. The writer greeted him that day and said we could not meet the previous week because of the visitors. "Yes, those people came to disturb me, my friend and his friends. I did not need anybody. I did not know why they came. I just stayed there," he said. But counselor could see you were happy that they came because he saw you smiled," counselor said. When the counselor said that he kept quiet for a while and wiped his face with the hand, then he looked at counselor "Are you alright Mr. Brown?" counselor asked. He said to counselor that he was not feeling well. The counselor asked him if he had taken any medication and he said no, and added, "I am sick and I'm tired of their medication. The doctor is supposed to come but has not come. I don't know what is going on. I asked them for a walker and instead, they brought me a wheelchair. That was not what I needed. How can I trust what they are doing to me? I gave my money to the lady in the office to keep for me. But any time I asked for my money they would tell me there was no money. The bank people are doing exactly that to me. They have my money but they have refused to release it to me," he said.

The counsellor wondered if sometimes Mr. Brown acted instinctively with impulses, the emotions that accompanied the mood. According to Fenichel (1945/2024) the 'impulse neuroses betray a characteristic irresistibility" which is caused by "the condensation of instinctual urge and defensive striving' (p. 367). He further noted: "They make their objects responsible for not providing the needed relaxation and they feel guilty for the aggressiveness with which they provoke their objects. This may cause them to evoke rebuffs which ally their guilt feelings by establishing the idea of unjust treatment, thereby rationalizing revengeful sadistic attitudes" (p. 368).

Mr. Brown put down his head on the table he was sitting at. He kept quiet for a while raised his head and said, "I don't need their money. I am asking them to give me my money. That is all I want from them. I am sick and I don't want any more of their attention on refusals." Desperation was what the counselor could say about him at this point. How could the counsellor be of help to him? Just listened and got frustrated with his complaints.

"What else can I say? My world is here. Look I feel pain. Nobody feels pain. Nobody understands, and they should keep quiet and go away from me." Mr Brown is in emotional conflict and follows a pattern of feeling and behavior to orally discharge or cope with tension.

According to Meadow P. W. [11], understanding the way orally regressed patients relate to the analyst requires a shift in our thinking about the transference relationship. We can notice the development of a narcissistic attachment in patients when patterns of self-expression emanate from pre-ego tension states. We may see that transference manifestations are different from those of patients whose emotional growth continued successfully through the use of speech and who can use language to elaborate more complex defence measures to control impulse discharge (p. 206).

Any time Mr. Brown spoke and expressed his feelings of emotions, the counselor was induced with the feeling of helplessness. His emotional transference instinctively developed in the counselor some kind of countertransference which was based on his unconscious reaction to Mr. Brown's transference attitude or behavior. He expressed feelings of frustration and disappointment about the way things were operating at the nursing home.

These were some of his words that made me feel emotionally induced by the emotional discharge. The counselor did not know what to do or say since he was trying to keep the contact. Spotnitz, H. [12] noted that "In analytic therapy, emotional induction is a reciprocal process. As the patient develops a transference, the therapist usually develops a countertransference, which is based on unconscious reactions to the patient's transference attitudes and behaviour. The effectiveness of the therapy depends in large measure on the therapist's ability to 'feel' the patient's tendencies toward instinctual discharge. The capacity to sense his latent emotions and

help him feel them determines whether their relationship is grounded in genuine emotional understanding or is primarily an intellectual exercise. In working with a severely disturbed patient, one must have the capacity to experience the emotions the patient induces and to help him verbalize them in the process of dealing with his resistances" [12].

That day, November 12, 2008, when I went Mr. Brown was down with pneumonia. Two weeks later he was sent to the hospital and was operated upon. The counselor asked Mr. Brown and the nurse manager what the diagnosis was but no one was able to say anything to counselor. Mr. Brown complained about the administration for not giving out his money to him in the same way he complained about them not caring about his health. He said it was hard for him to stay in the nursing home. He had the fantasy that patients were not taken proper care of, and if he had the chance he would have left that home.

Meeting Mr. Brown on this day, December 19, 2008, did not look happy. He was upset like the previous week. Responding to the counselor's greeting Mr. Brown said, "The day has not been good. I needed my money and I went to the administrative assistant and she asked me to go and come back tomorrow to see her."

Spotnitz (1969/2020) said when a patient is frustrated, an appropriate way to discharge his feelings is to put them into words. If he is prevented from doing so when frustrated and feeling deprived by the analyst, he usually bottles up the aggression. In other words, he turns these feelings inward and begins to attack the self. Often there is no chance for patients like Mr. Brown in the nursing home to express their feelings. That is why at times they seem to be angry with any worker who comes their way because they feel they are deprived of some basic rights.

Mr. Brown continued to talk about his money. "The money is mine, why don't they want to give it to me? They are annoying me. They are annoying me. They don't know that. I wish they knew that," he said. They will have to give me that money. It is not their money. It is mine and I have to get it. I don't want any policeman here," he said. "You don't want any police here,"

The counselor reflected, and wondered what the mention of police here could mean, but he never responded when counselor reflected. Thus, counselor failed in his attempt to explore more on the mention of police. What does he want me to say or do by telling me all this? He seemed to be making the same complaints over and over. Counselor felt he was finding an outlet for his frustrations. In so doing he was inducing in me also frustration of having to listen to the same story each week.

Sometimes counselor had the feeling that he was identifying him with the authority that be. "They are annoying. They don't know that. I wish they knew that." Here, counselor had the feeling that he could be sending him a signal to be careful not to annoy him too. That could be one of the counselor's fantasies next visit to Mr. Brown, counselor noticed something different in him. He hardly raised his head to look at him during our sessions. But this visit was unique for couselor because from the moment of counselor entry into the recreational hall, Mr. Brown's head was up and he looked directly into the counselor's eyes throughout the session. Normally, his head would be on his table most of the time. "How has been your surgery, Mr. Brown?" counselor asked. "It is alright and successful and I hope you can see that from me."

You look great. Patient response to the statement was, "I feel a bit better than before. But I still have a problem, not a problem with the illness or age but it may be related to the two. I'm a bit worried and that makes me uncomfortable. I was told so much money was spent on my surgery. That upsets me greatly." "That upsets you greatly," counselor mirrored back. "Yes, it upsets me because they have my money. The bank has my money too. The administration would not give me my money yet they sit back and say what they want. Give me what is mine and I will take it and do what I want." "What does that make you feel when you can't do what you want?" counselor asked. That makes me angry. I don't like the people here and I feel they have nothing good to offer me."

"Mr. Brown but they are taking care of you," counselor said. "Really?" "What do you mean by they are taking care of me," he asked. "I feel they are cruel, not good at all for the home. All that I need is my money. They should give me my money and stop making me angry." His voice was getting high and emotional. This could be the counselor's countertransference on Mr Brown – to tell him that he was being taken care of by the nursing home, the counselor's fantasy.

According to Evelyn Liegner, objective countertransference analysis is how the therapist can best understand and make therapeutic use of his response to the patient's transference reactions. These reactions must be distinguished from subjective countertransference which is based on the analyst's life history and requires the analyst's further analysis. These induce feelings and the resistance they produce is the greatest source of failure when working with preoedipal disorders [14].

Mr. Brown never spoke much but counselor kept the contact. At least that was a good sign even though it could be frustrating. Many a time Mr. Brown would not look at counselor even when he decided to talk. "Mr. Brown, how are you doing today?" asked the counselor. He looked at counselor and smiled. "I'm doing better today. I was expecting the nurse. She told me that we may be visiting the doctor. But that was around 1.00 pm she told me that. You see, it is going to be 3.00 pm now but no sign that we are going to be heading to the hospital. I even don't think I should go again.' "Why, Mr. Brown? You could go when she comes in."

Constantly, Mr Brown would say that the nursing home was not an ideal place to be, and the staff didn't respect him. He said, "Yes, they don't respect time because they think that I'm here and I don't reason. You tell me something when you know that you don't mean it. That is what it is like to be a resident here. I am tired even. May I go into my room? I don't feel like talking again. I'm sorry but I may not be able to keep on here."

Working with Mr. Brown for over a year now, counselor could say that he lives with anxiety, a depressive state, a yearning for freedom, a sense of loneliness, feelings of being oppressed, hate, anger etc. Feelings that are too extreme, that "overstep the right limits in either a positive or negative sense" [15].

Mr. Brown has much anger in him. According to Bernstein, nothing new can happen while the patient is in its grasp [16] Freud connected repetition with aggression. There is a lot of aggression in the refusal to move ahead. The patient will fight to remain in the repetition and to continue to have the experience with people. The repetition compulsion is supposed to be beyond pleasure; that is why it is called compulsion rather than an impulsive disorder. However, as Freud (1924) repeatedly pointed out, no drive ever appears in its pure form and "even the subject's destruction of himself cannot take place without libidinal satisfaction" (p.170).
The counselor has been trying carefully to understand and find the source of his emotional energy or frustration. In counselor's understanding, frustration leads to aggression, and as Nacht S. (1948/2021) said, "We need to look carefully for the operation of aggressive as they are not always manifested directly. On the contrary, the very determinants of the state of frustration nearly always prevent these reactions being freely expressed" (p. 202).

According to Shapiro [17] as cited in Nacht (1998), reactions are inevitable and a deliberate avoidance of them would doubtless lead to a disturbance of the transference situation and so damage the effectiveness of the cure. The only means the doctor has of overcoming these reactions are to be found in the actual manifestations of transference. By observing these, and interpreting them correctly, he can control to a certain extent the strength of the aggressive reactions and determine the time of their appearance (p. 220).

Mr Brown continued with his hospital checkups and recovered fully from the surgery, according to him. But he was to go again to the hospital on March 12, for the last check-up. Now plays cards with his fellow residents. In one of our sessions, he mentioned to counselor that he used to go down to Atlanta City to do gambling. Counselor was tempted to think, that, in delusion, he was thinking about money that he probably made through gambling. That was counselor's fantasy. It was really hard for him to say.

Mr. Brown recently told counselor that one of his sons came over to see him. He said he had ambivalence about that visit – happy that he came but sad that he was neglected for such a long time. But he said the son told him that he had family problems which was the reason why he could not come to see him but he doubted that.

Mr. Brown's verbal expressions were seen as frustration, at times angry and could be attacking. His thoughts were perhaps destructive and revengeful, counselor could not say exactly. His fantasies are paranoid and retaliatory, painting people as not caring, callous and persecutory. Mr. Brown talked about money a significant number of times which counselor was not able to figure out what it was all about; talked about the presence of a figure in his room which made him

feel like destroying things in the room; talked emotionally a lot about lack of trust of the authority that be; complained a lot about health not been taken care of, talked about having married with 14 children but his medical chart mentioned he never married; just to mention but a few. With these observations and others, counselor may say Mr. Brown was psychotic, delusional, and paranoid thus, confirming two of his medical diagnoses (paranoia and delusion).

Generally speaking, counselor must say his working relationship with Mr. Brown has been good. No one shouted at the other. Clark, T. K., [18] stated that "a mode of interpersonal participation which bears all the earmarks of an effort to drive the other person crazy may be powerfully motivated, in actuality, by a conscious or unconscious desire to encourage the other person into a healthier closeness, a better integration both interpersonally, with oneself, and intra-personally, with himself. The conscious or unconscious effort is to activate dissociated or repressed elements in the other's personality, not with the goal of his ego's becoming overwhelmed by their accession into awareness, but rather the goal of his ego's integrating them" (p. 269).

The clinical practicum was rich in different learning experiences. The fieldwork placement and supervision have been enriching and of tremendous help. There was a wait with eagerness to get started. It took about a month till it finally got started. Out of the four patient's counselor had for the exercise, one must say Jackson Brown cooperated to the best of his ability perhaps, and to counselor's knowledge by making himself available any time the counselor went for the clinical visitation to have sessions with him. As already said, each session had its unique learning experiences and writer has been grateful to come thus far [19]. Since gratitude to everybody experienced during the clinical work (patients and supervisors), and anyone who in any way was connected to the clinical practicum.

3. CONCLUSION

What the counselor discovered in the Case Study of Mr. Brown was that he was psychotic, delusional, and paranoid, thus confirming two of his medical diagnoses (paranoia and delusion). Generally, the counselor must say there was a cordial working relationship for Mr. Brown did cooperate well in most of the counseling sessions.

4. RECOMMENDATIONS

This write-up will help policy makers enforcing graduate counseling educational programs to guide and facilitate students doing practicum and on internship to manage with issues and challenges they experience during the period of their practicum (Tatton GO, 1990/2023)..

Practitioners are reminded that counseling is an interesting profession to practice, but it can also be a difficult profession to practice if care is not taken by the professional. The patient's transference can induce in the counselor countertransference which most times is difficult for the counselor to exhibit [20].. For instance, "Mr. Brown verbal expressions were seen as frustration, at times angry and could be attacking."

This practicum project is not exhaustive in any way [21], it is only setting a pace for future research in the field of counseling profession in this regard contextualized for Ghana.

The objective of the practicum is to help graduate counseling student to develop his/her own personal theory with his/her experiences from the practicum. The Council for Accreditation of Counselor Education acknowledges this when it states: "Students will be exposed to models. And students will begin to develop a personal model of counseling." (Draft III, Standard K, 5 cp.12). Consequently, this case would fit into models of counseling as an extension of knowledge in the field theory [22-25].

COMPETING INTERESTS

Authors have declared that no competing interests exist.

REFERENCES

1. Akimov A, Malin M. When old becomes new: A case study of oral examination as an online assessment tool. Assessment and Evaluation in Higher Education. 2020; 45(8):1205-1221.
2. Sampa RL, Sitali N, Mpolomoka DL, Lubbungu J, Kangwa KN, Nyirenda OG, Chitondo L. Grammar error analysis of narrative compositions of learners in senior secondary school grades: A case study of selected public secondary schools in Chingola district, Zambia. Journal of Education and Practice. 2022;13(21):143-153.

3. Mahdi OR, Nassar IA, Almuslamani HAI. The significance of a case Study is that it is an effective way of helping students to apply their skills; 2020.
4. Buie DH, Meissner WW, Rizzuto A, Sashin JI. Aggression in the Psychoanalysis int. R. Psycho-Ana; 1983/2020.
5. Tredennick AT, Hooker G, Ellner SP, Adler PB. A practical guide to selecting models for exploration, inference, and prediction in ecology. Ecology. 2021;102(6):e03336.
6. Werder O. Nurturing a shared vision: Self-identity, relationship building, and people-powered interventions. In Transformational Health Communication: A New Perspective on Healthcare and Prevention. Singapore: Springer Nature Singapore. 2024;149-169.
7. Hosseini F, Masoudi N, Mohammadi E, Sadar Z. Scoping review on the concept of patient motivation and practical tools to assess it. Published Online; 2021.
8. Lepper MR, Malone TW. Intrinsic motivation and instructional effectiveness in computer-based education. In Aptitude, learning, and instruction. Routledge. 2021; 255-286.
9. Spotnitz H, Meadow PW. When the analyst intervenes, treatment of the narcissistic neuroses, Northvale, NJ; Jason Aronson. 1995/2023;148.
10. Margolis B. Joining, morning, psychological reflection: Terminology, definitions, theoretical considerations. Modern Psychoanalysis; 1986/2024.
11. Meadow PW. Drive theory in diagnosis and treatment, modern psychoanalysis; 1996/2020.
12. Spotnitz H. Emotional induction, psychotherapy of preoedipal condition. 1976/2020;29(113):168.
13. Little M. On Delusional transference (Transference psychosis). Int. J. psycho-Anal. 1958/2020;39.
14. Liegner E. The first interview in modern psychoanalysis, modern psychoanalysis. 2003/2018;8.
15. Homburg C, Wielgos DM. The value relevance of digital marketing capabilities to firm performance. Journal of the Academy of Marketing Science. 2022; 50(4):666-688.
16. Mayer T, Warikoo N, Eliassaf A, Atzil-Slonim D, Gurevych I. Predicting Client Emotions and Therapist Interventions in Psychotherapy Dialogues. In proceedings of the 18th conference of the European chapter of the association for computational linguistics. 2024;1:1463-1477.
17. Shapiro EL. Aggression in psychodynamic psychotherapy and supervision: Becoming a more effective therapist. Psychodynamic Psychiatry. 2024;52(1):96-113
18. Clark TR. The four stages of psychological safety: Defining the path to inclusion and innovation. Berrett-Koehler Publishers; 2020.
19. Meadow PW. Drive theory in diagnosis and treatment. Mod play. 1981/2020;202:206.
20. Myers WA. Actions speak louder. Psychoanal. Q. 1987/2018;56.
21. Pearson FJ. Qualitative evaluation methods. Sage Publication; 1991/2023.
22. Margolis BD. The contact function of the ego: Its role in the therapy of narcissistic patient, Psychoanalytic Review. 1983/2017;70.
23. Pally R. Emotional processing: The blind-body connection. Int. J. Psych-Anal. 1998; 79.
24. Patton GQ. Qualitative evaluation and research methods, 2nd Edith. Sage Publications; 1990/2023.
25. Spotnitz H, Meadow PW. Toward an understanding of emotional contagion treatment of the narcissistic neurosis, revised ed. Northvale, NJ: Aronson. Illinois Press; 1995/2023.

Peer-review history:
The peer review history for this paper can be accessed here:
https://www.sdiarticle5.com/review-history/117059