MINDFULNESS-BASED STRESS REDUCTION AND DIVERSIONAL THERAPIES IN THE MANAGEMENT OF PSYCHOLOGICAL DISTRESS AMONG CERVICAL CANCER PATIENTS IN LAGOS AND IBADAN, NIGERIA

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CERTIFICATION

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DEDICATION

This study is dedicated to my beloved parents, Mr. Ganiyu Abidemi Azeez and Mrs. Simiat Arike Azeez, and my darling husband, Mr. Ismail Apata

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ABSTRACT

Psychological distress, an affective, cognitive and behavioural response to crisis precipitating events, is manifested by anxiety and depressive symptoms. Evidence has shown that cervical cancer patients in Lagos and Ibadan, Nigeria exhibit psychological distress after diagnosis. Previous research efforts focused on the predisposing factors to psychological distress, with little attention paid to psychological interventions in managing the psychological distress among cancer patients. This study, therefore, was carried out to determine effects of Mindfulness-based Stress Reduction (MbSR) and Diversional Therapy (DT) in the management of psychological distress among women diagnosed of cervical cancer in Lagos and Ibadan, Nigeria. It also examined the moderating effects of Health Self-efficacy (HSe) and Social Support (SS).

The study was anchored to Stress Process Model, while the mixed methods design (QUAN+qual) was adopted. The multi-stage sampling procedure was used. The purposive sampling technique was utilised to select three teaching hospitals (Lagos University Teaching Hospital, Idi Araba, Lagos, Lagos State Teaching Hospital, Ikeja, Lagos and University College Hospital, Ibadan) that provide comprehensive cancer treatment from Lagos and Ibadan, Nigeria. The cancer patients attending these teaching hospitals were screened with Distress Thermometer (α=0.75) and those who scored above the threshold of four were selected. The teaching hospitals were randomly assigned to MbSR (24), DT (21) and control (16) groups. The instruments used were Kessler Psychological Distress (K10) (α=0.81); Health Self-efficacy (α=0.84), Social Support (α=0.89) scales and training manual. Focus group discussions were held with 10 cervical cancer patients in Ibadan. The intervention lasted eight weeks. The quantitative data were analysed using descriptive statistics, Analysis of covariance and Scheffe post-hoc test at 0.05 level of significance, while the qualitative data were content analysed.

The participants' age was 48.00±3.60 years. There was a significant main effect of treatment on psychological distress among cervical cancer patients ($F_{(2;44)}$ =79.73, partial η^2 = 0.7l). The participants exposed to MbSR had the lowest psychological distress mean score (17.96), as against those in the DT (20.76) and control (43.19) groups. Health Self-efficacy had a significant main effect on psychological distress ($F_{(1;44)}$=6.68, partial η^2 =0.13). The participants with high HSe recorded lower psychological distress mean score (18.00) than those with low HSe (20.20). There was no significant main effect of social support on psychological distress of the cervical cancer patients. The two-way and three-way interaction effects were not significant. Financial help facilitated cervical cancer patients' adjustment to the diagnosis, while frequent awareness programmemes; free vaccine and cervical cancer screening were suggested ways in which cervical cancer could be prevented.

Mindfulness-based stress reduction and diversional therapy were effective in reducing psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria. Clinical and counselling psychologists should adopt these two therapies in the treatment of psychological distress among cervical cancer patients.

Keywords: Cervical cancer, Psychological intervention, Health self-efficacy, Depressive symptoms

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LIST OF ABRREVIATIONS

CCPs	-	Cervical Cancer Patients
MbSR	-	Mindfulness-based Stress Reduction
DT	-	Diversional Therapy
HSe	-	Health Self-efficacy
SS	-	Social Support
SSS	-	Social Support Scale
LUTH	-	Lagos University Teaching Hospital
LASUTH	-	Lagos State University Teaching Hospital
UCH	-	University College Hospital

CHAPTER ONE
INTRODUCTION
1.1 Background to the study

Cancer, a term referring to the abnormal growth of cells in the body, presents a complex set of challenges for individuals affected by various types of it. Cervical cancer is a type of cancer arising from the tissues of women's cervix. It has been regarded as one of the main illnesses affecting women who are fertile (Ogbonna, 2021). One specific manifestation cervical cancer brings forth is a unique array of obstacles that extend beyond the purely medical aspects. This diagnosis is usually accompanied with psychological distress that permeates various facets of patients' lives. Emotionally, a cervical cancer diagnosis triggers a profound psychological impact. Feelings of anxiety, fear, and depression are common responses. Coping with the uncertainties surrounding the disease, enduring treatments, and facing the prospect of long-term health consequences contribute to heightened psychological distress. Unmanaged psychological distress may affect work-related activities; the physical toll of treatments, coupled with the emotional strain of battling cancer, can disrupt a patient's ability to work. Frequent medical appointments, treatment side effects, and necessary recovery periods can lead to inconsistencies in employment, resulting in financial instability and job insecurity (Berg, Fossa, Sanne and Dahl, 2007).

Socially, the repercussions of cervical cancer can be isolating. Stigma surrounding the disease and its impact on personal relationships can lead to a sense of alienation. Conversations about cervical cancer might be laced with misunderstandings or discomfort, contributing to feelings of social detachment. The sexual intimacy may also be impaired. Cervical cancer and its treatments can lead to physical changes in the pelvic area, causing discomfort, pain, or altered sensations during sexual intercourse. Beyond the physical discomfort, these changes may erode emotional closeness and intimacy shared with a partner. The implications of cervical cancer extend beyond personal experiences and often impact matters tied to identity and future plans (Komatsu,

Yagasaki, Shoda, Chung, Iyata, Shugiyama and Fuji, 2014). Fertility and family planning become areas of concern, as the disease and its treatments may compromise a woman's ability to conceive and bear children. The delicate interplay between health and dreams of starting a family creates emotional turmoil (Shepherd, 2009). In addition, financial burden of treatments, medications, and supportive care places considerable stress on patients and their families. The costs associated with battling cervical cancer often necessitate difficult decisions regarding treatment options and access to quality healthcare. Moreover, the physical changes brought about by cervical cancer treatments can erode the self esteem of a cervical cancer patients leading to psychological distress

Globally, cancer stands as a prevalent disease impacting women negatively, with a significant toll of 8.2 million lives lost to the illness in 2018 (World Health Organisation, 2019). With over 567,000 incident cases and about 311,000 fatalities in 2018, cervical cancer was ranked as the fourth most frequent malignancy among women worldwide (GLOBOCAN, 2018). It is thought to be the second most common reason for women's death in developing countries (WHO, 2017). Estimates for 2018 in Sub-Saharan Africa indicated that there were 111,632 new cases of cervical cancer and 68% of cervical cancer deaths. Over the next fifteen years, it is projected that the occurrence of cancer in Sub-Saharan Africa will witness an 85% rise. (Fatiregun, Bakare, Ayeni, Oyerinde, Sowunmi, Popoola, Salako, Alabi and Joseph, 2020). Cervical cancer, however, is another very common disease among women in Nigeria and the second most common cancer in women between the ages of 15 and 44. (HPV Information Centre, 2018). Cervical cancer cases among Nigerian women were predicted to total 14,083 in 2017, with 14,943 new cases reported in 2018 and about 10,403 deaths (HPV Information Centre, 2018).

The primary cause of cervical cancer is consistent infection with thigh-risk human papilloma virus, which is usually spread through sexual contact. Other variabless that increase a woman's risk of developing cervical cancer include having many sexual partners, high parity, smoking, STIs, poverty, and early exposure to sexual activity. Cervical cancer risk may be increased by sexually transmitted diseases including the HIV/AIDS virus and acquired immunodeficiency syndrome (Abdolmaleki and Sohrabi, 2018). Cervical cancer is a kind of cancer that, if found early enough, can be totally

treated, yet many women are unaware of the need of cervical cancer screening (Asuzu, Unegbu and Akin-Odanye, 2012). Many cervical cancer patients are still at the hospital receiving modalities of treatment not because the threatments are not effective but because they are experiencing high level of psychological distress that is not managed and they are too weak to exhibit healing.

Emotions such as upset, tension, perplexity, anxiety, sadness, and intrusion are more prevalent in women with cervical cancer and are all indicators of psychological distress (Maree, Mosalo and Wright, 2013). According to the experimenter's pilot study at Grace Hospital, Cervical Cancer Patients (CCPs) reported a distress thermometer-measured prevalence level of psychological distress of 59.7%. Furthermore, CCPs who reported stress-related symptoms had a 33% higher risk of passing away from the condition than those who did not (Lu, 2019). In general, the word "psychological distress" refers to unpleasant emotions that interfere with a person’s level of functioning and daily activities.

Psychological distress was categorized as an all-encompassing psychological issue (Dohrenwend, Shrout, Egri, and Mendelsohn, 1980). Veit and Ware (1983) identified three components of psychological distress: lack of emotional and behavioural control, signs of depression, and signs of anxiety. Psychological distress is conceptualised by Ridner (2004) as distinct unsettling state of emotion that a person experiences in reaction to a particular stressor or demand that causes the person pain, either temporarily or permanently. Additionally, the phrase "psychological distress" is frequently used in literature to refer to emotional stress brought on by a variety of pressures and demands that are challenging to handle in the life of a woman with cervical cancer (Drapeau, Marchand and Bwaulieu, 2012; Mathias and Wheoton, 2007).

Patients with cervical cancer experience psychological distress for a variety of reasons: long hospital wait times, poor information delivery, and issues with referral 111systems are other sources of concern, according to health care experiences (Dhillon, Mathur, Nandakumar, Fitzmaurice, Kumar, Mehrotra, and Dandona, 2018). Another significant cause of psychological distress in CCPs is the fear of stigma and discrimination; when women feel stigmatized by medical professionals, this can lead to delayed diagnosis and treatment avoidance (Hobenu and Naab, 2022). Consequently, the

social consequences related to cervical cancer prevent patients from seeking medical attention and from telling their partners and family members about their condition (Hobenu, 2015).

However, managing psychological distress experienced by patients can be considered very challenging among experts, probably because only few studies have sufficient statistical power which can generate consensus among researcher on the way forward in the reduction of psychological distress outside provision of free treatment or financial support for victim's medication. Many CCPs are still at the hospital receiving modalities of treatment, not because the treatments are not effective but because the patients have been experiencing an elevated level of distress which is left untreated, and they are too psychologically distressed to exhibit healing. In other words, every chronic medical illness has its behavioural undertone, and for an illness to be thoroughly treated, it must be investigated medically and behaviourally. In light of this, Asuzu and Adenipekun (2015) stressed the significance of psychological assessments of every oncology patient and the deployment of psychological interventions as the situation demands. Therefore, the use of psychological interventions to address this menace becomes important, thus the rationale for the study; Mindfulness-based Stress Reduction and Diversional Therapies in the management of psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria.

Mindfulness is a quality of consciousness that emphasizes attention to and awareness of one's experiences, which many other well-established theories in psychology do not emphasize. This is in contrast to the majority of psychologists who are interested in the content of unconsciousness, thought, memory, emotion, and so on (Brown, Ryan and Creswell, 2007). An eight-week Mindfulness-based Stress Reduction Training (MbSR) teaches people how to use their innate resources and capacity to respond more skillfully to stress, sickness, and suffering (Kaba-Zinn, 1990). Kabat-Zinn established the MbSR clinic at the University of Massachusetts Medical Center in the 1970s to help people who were experiencing life's hardships as well as physical and/or mental disease (Kabat-Zinn, 2013). MbSR is a fluid and adaptable stress-reduction technique; rather than adhering to a step-by-step script, MbSR is applied in the way that is most effective for each individual (Centre for Mindfulness, 2017). Although each

person who uses MbSR may experience it differently, it is still founded on the same concepts. In the light of this, Kabat-Zinn believed that because mindfulness takes very little time and uses minimal resources, everyone has the ability to practice it.

MbSR has proven its effectiveness in the management of many psychological and psychosocial problems including pains. For example, it was effective in enhancing the quality of life of patients with chronic low back pain (Kabat Zinn, 1986). Prior to the creation of MbSR, there was a programme called the Stress Reduction and Relaxation Programme, which was an adaption of the Buddhist mindfulness teachings. In order to make the programme more secular and appealing to people from all systems of belief, Kabat-Zinn removed the Buddhist framework and renamed it "MbSR" (Shea, 2018). The programme continues to focus on the development of mindful awareness of mindfulness (Grossman, Tiefenthaler, Raysz, and Kesper, 2007) and the intentional non-judgmental awareness of present-moment experiences (Baer, 2003; Kabat-Zinn, 2003)

More importantly, the objective of MbSR is to train participants in developing emotional resilience to deal more effectively with present moment experiences as it emerges. This incorporates non-judgmental awareness of feelings, thoughts, and bodily sensations with the aim of negating experiential avoidance and developing better emotional resilience. MbSR incorporates formal techniques such as: the body scan, simple yoga exercises, walking meditation, mindfulness meditation and prolonged periods of sitting meditation, which the participants engage in and gradually learn to accept intense bodily sensation and emotional discomfort, and a less formal technique such as mindful brushing of teeth, mindful eating, and mindful washing of clothes among others.

Through the use of mindfulness, patients are embedded with attentional skills that enable them to identify automatic activation of dysfunctional thought processes, including depression-related rumination and to dissociate from these, by diverting attention to experience as it unfolds and changes moment by moment (Kabat-Zinn, 1990; Segal, Moore, Hayhurst, Pope, Williams, and Teasdale 2002). Logically, it could be assumed that some sources of psychological distress for cervical cancer patients may be related to concerns about the past, for instance, rumination about the causes of cancer or regrets about former lifestyle and future-related worries such as fear of increased pain,

psychological suffering, and neglect by carers or loss of life. So paying attention to present moment reality cultivated by the practice of mindfulness may be of particular importance to support their psychological well-being,s as this enables them to enjoy every moment as it unfolds

Diversional Therapy (DT) is another therapeutic intervention that could be used to manage psychological distress. It is also known as diversional and recreational therapy or therapeutic recreation. DT was introduced by the Australian Red Cross Association under the leadership of Miss Leila Bloor in 1945. It is a client centred practice which regards leisure and recreational experiences as the right of every individual. The fundamental goal of DT is to promote empowerment process and to ensure participants are able to make choices and decisions which maximize their participation in leisure exercises that are suitable for their individual needs and wants (Silva and Howe, 2012).

Diversional therapy goal is achieved through the facilitation, coordination and planning of leisure and recreational programmes that are designed to support, challenge and enhance the psychological, social, emotional, spiritual, cognitive and physical well-being of people thereby promoting their self-esteem and personal fulfillment. Taking into account, the advantage of understanding human behaviour and functioning, diversional programmes use motivational strategies, such as social needs motivation, enjoyment motivation, and body Image motivation, to arouse interest and engagement of clients so as to overcome physical or cognitive barriers to leisure activities (Muntiga, Moorman and Smith, 2011).

Basically, diversional therapists work in a wide variety of settings and divert their client's attention away from anxiety producing problems by incorporating leisure programme into their lifestyles (Meichenbaun and Cameron, 1989). They also assist in decision-making and participation of their clients when developing and managing recreational programme. These are often quite diverse and can range from: Games, outings, gardening, computers, gentle exercise, music, arts and crafts, sensory enrichment activities like massage, discussion groups, education sessions such as grooming, beauty care, cooking as well as social, cultural and spiritual activities (Yen, Cohen, Wei and Asaad, 2022).

Throughout history, the concept of diversion has been a strong theme in the treatment of physical and mental illness. In the history of psychiatry, Stone (1997) reported that Friedrich Scheidemantal, the founder of psychosomatic medicine in 1787, admitted that the cure for many physical ailments was patients' experience of happiness. The Egyptian, Hebrew and Roman cultures gave a pronounced attention to diversional therapy (Friedland, 1988). These interventions include exercise, music, art, relaxation, as well as spiritual support. The therapy may involve individual and/or group sessions; group activities include lifestyle management, stress management, topical discussion groups and games. Suitable application of leisure programmes with constant sensitivity to client variation in mood and orientation is an important component of DT as well as important factor for clients with psychological distress (Stumbo and Pegg, 2008).

Leisure experiences enable social connectedness, cognitive stimulation, emotional well-being and physical exercise. Physical exercise is widely known to improve muscle tone, bone strength, the cardiovascular system, cognitive functioning and mood (Arden, 2010). Ultimately, the effect is maximized when the activity is self driven, such as in a leisure pursuit. Physical exercise not only improves circulation but promotes relaxation by releasing tension in the muscle spindles, breaking the stress feedback loop to the brain. This can sharpen cognition by the release and interaction of neurotransmitters, hormones and synaptic chemicals (Arden 2010) Passive physical exercise has limited physical benefit, yet just watching and engaging physical activity or listening attentively has been proven, using brain imaging techniques, to stimulate and enlarge active brain areas almost to the degree where the activity was physically being performed (Greenfield, 2000).

Furthermore, DT increases tolerance and endurance for participation in life and social activities, improves social interaction and skills, enhance coping skills, maintain strength, balance and endurance, assist with community integration after an illness or disabling condition and promote active aging, wellness and healthy living. All these ensure social interaction, stimulated interest, focused attention, or the feeling of usefulness on stress tolerance and improvement to the immune system (Arden 2010).

In the course of examining the intervention strategies such as MbSR and DT on psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria,

logically, there are possibilities of having variables that are capable of intervening into the study without the knowledge of the researcher. Therefore, the researcher considered incorporating health self-efficacy and perceived social support as moderating variables for this study

Self-efficacy beliefs are feelings about one's ability to organize and execute courses of actions imperative to produce certain accomplishments that are essential to manage forthcoming situations. In other words, self-efficacy beliefs are beliefs about competence which include quality and range of the cognitive constructions; and behavioural enactments that an individual is capable to construct diverse behaviours under appropriate conditions" (Maibach and Murphy, 1995). According to Bandura (1997), self-efficacy has a central role in regulation of emotional states. Its belief makes people able to interpret potentially threatening expectations as manageable significant challenges and help them feel less stressful in such situations. Thus, by reducing the negative thoughts and concerns of potential threats, they can regulate their emotional states. Bandura and Pastorelli, (1999) revealed a correlation of high self-efficacy with lower mental stress, higher adaptation and higher interest to health and care programmemes whereas individuals with weak self-efficacy avoid obstacles to their lives rather than encountering them effectively and select unrealistic criteria that result in their frequent faults and failure

People develop self-efficacy beliefs by integrating information from five sources namely: verbal persuasion, performance experience, imaginal experience, vicarious experience, and affective and physiological states. Self-efficacy beliefs are most strongly influenced by our own performance experiences (Bandura, 1997). For example, when attempts at control are successful, self-efficacy for that behaviour or domain is usually strengthened and weakened when it fails. Self-efficacy beliefs also influence the goals people decide to pursue. The higher one's self efficacy in a specific achievement domain, the higher will be the goals that one sets for oneself in that domain and similar ones (Bandura, 1997).

Health self-efficacy is a belief that one has the skills and abilities to engage in healthy behaviours and continuously integrate these behaviours into one's lifestyle. Expectations of self-efficacy determine whether an individual will be able to exhibit

coping behaviour and how far effort will be sustained in the face of difficulties (Pousa and Mathieu, 2015). people with high health self-efficacy might exert sufficient effort toward seeking solution to their physical and mental health challenges, which is not limited to psychological distress, whereas those with low health self-efficacy might not be willing to exert efforts toward achieving their psychological and physical wellness goal.

Similarly, health self-efficacy may play an important role in enhancing or reducing the effect of stress target treatment in which the active role of the cancer patients can operate as a buffer of efficacy of the intervention. Therefore, the impact of health self-efficacy in the management of psychological distress of cervical cancer patients can be considered a specific construct that helps cervical cancer patients respond more positively to the enormities of treatment while struggling for survivorship

On the other hand, perceived social support is often conceptualized as the perceived and received physical and emotional comfort that is given to an individual through social ties by other persons, friends and the larger community. Many of the people who are a part of one's life can provide social support. These may include parents, spouse, children, siblings, other family members, friends, co-workers, neighbours, health professionals and sometimes even strangers. Social support can be enjoyed in form of substantial assistance received from others when needed, which includes: differential appraisal of situations, emotional support and effective coping strategies (Yasin and Dzulkifli, 2011).

Perceived social support is a factor that can help individual to reduce the amount of stress experienced as well as to help individual cope better in dealing with stressful situations. It has been suggested that social support has a mediating role in consequence of coping style. As social support can reduce the effects of difficulties of life stress and incidence of mood disorder, cancer patients absolutely need such supportive system (Schrier, Amital, Arnson, Rubinow, Altaman, Nissenabaum 2012,). In general, the best support comes from the people one is closest to.

More importantly, receiving support from someone an individual has close emotional ties to helps one's emotional and physical health than support provided by strangers (Meyerowitz, 2000). Whereas, the negative interactions of family members and

lack of social support have a significant impact on the patient's psychological distress (Ashing-Giwa, Padilla, Bohorquez, Tejero, Garcia, and Meyers 2004).

This study investigated the effects of mindfulness-based stress reduction and diversional therapy in the management of psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria

1.2 Statement of the Problem

The rate of increase in cases of cervical cancer among Nigerian women as well as the psychological distress that accompanies the disease can be very tasking. Consequently, cervical cancer patients experiencing psychological distress suffer from a continuum of challenges ranging from sleep disturbances, loss of appetite, muscular spasms, nausea, extreme fatigue, confusion, social and verbal withdrawal, among others. More so, the enormity of the challenges of surviving as well as the treatment rigour and side effects could make patients prone to anxiety, sadness, depression, hopelessness, suicidal ideation and death.

Usually, unmanaged psychological distress could affect the overall quality of life of the CCPs as it impedes their sexual intimacy, home management, family and social relationship, and ability to maintain work activities. As a result of these, they may end up losing their job and their homes or feel dumped by their spouses because of their sexual inactivity. Moreso, untreated psychological distress may further result to the CCP having a negative self-image particularly due to some possible physical changes and such as, weight loss, hair loss, change in skin colour and bad odour from smelling virginal discharge which can certainly lead to low self-esteem

Evidently, efforts are usually geared towards finding medical relief for the treatment of cervical cancer, and pharmacological means of managing their psychological distress not minding the healing of the mind and soul which is necessary for their holistic well-being. The expenses and side effects of pharmacological treatment such as: antidepressant and nerve pain medication is an additional burden to cervical cancer patients suffering from psychological distress. Therefore, there is a need for a non pharmacological method of managing psychological distress, which is safer, cheaper, long lasting and with little or no side effect.

In addition, a good number of studies have dwelt on knowledge, attitude and practice of cancer screening (Heena, Durrani, Alfayyad, Riaz, Tabasim, Parvez and Abu-Shaheen, 2019; Olubodun, Odukoya and Balogun, 2019; Asuzu Unegbu and Akin-Odanye, 2012), and stigma, blame attribution and women's lack of knowledge of cervical cancer (Sheperd and Gerend, 2013), without recourse to how best to manage the psychological distress trailing cervical cancer patients as well as the therapeutic approach to managing the distress which is the thrust of this study, "Mindfulness-based stress reduction and diversional therapy in the management of psychological distress of cervical cancer patients in Lagos and Ibadan Nigeria"

1.3 Purpose of the Study

The main purpose of this study is to investigate the effect of mindfulness-based stress reduction and diversional therapies in the management of psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria.

Specifically, the study intends to;

i. Find out the effects of treatment (MbSR and DT) on psychological distress among cervical cancer patients

ii. Investigate the effect of moderating variables (SS and HSe) on psychological distress among cervical cancer patients

iii. Examine the interaction effect of treatment (MbSR and DT) and moderating variables (SS and HSe) on psychological distress among cervical cancer patients.

iv. To identify the causes, feelings, and impacts of psychological distress and cervical cancer via Focus Group Discussion

1.4 Hypotheses

The following null hypotheses were formulated and tested at 0.05 level of significance.

H_{01}: There was no significant main effect of treatment on psychological distress among CCPs in Lagos and Ibadan, Nigeria

H_{02}: There was no significant main effect of health self-efficacy on psychological distress among CCPs in Lagos and Ibadan, Nigeria

H_{03}: There was no significant main effect of social support on psychological distress among CCPs in Lagos and Ibadan, Nigeria

H_{04}: There was no significant Interaction effect of treatment and health self-efficacy on psychological distress among CCPs in Lagos and Ibadan, Nigeria

H_{05}: There was no significant interaction effect of treatment and social support on psychological distress among CCPs in Lagos and Ibadan, Nigeria

H_{06}: There was no significant interaction effect of health self-efficacy and social support on psychological distress among CCPs in Lagos and Ibadan, Nigeria

H_{07}: There was no significant three-way interaction effect of treatment, health self-efficacy and social supports on psychological distress among CCPs in Lagos and Ibadan, Nigeria

1.5 Focus Group Discussion Guides

1. How would you describe your feelings upon the diagnoses of cervical cancer?
2. How did you feel afterwards?
3. What are your coping strategies to manage these feelings?
4. What impacts does cervical cancer have on your sexual intimacy?
5. What factors do you believe contribute to cervical cancer?
6. Do you know how cancer of the cervix can be prevented?
7. What can the government do with regard to the prevention?

1.6 Significance of the Study

The findings of this study will be of immense benefit to the participants/cervical cancer patients, especially the knowledge, skills and strategies acquired during their participation in the programmeme as it would help them to thrive in spite of their experiences of pains and the psychosocial problems that come on with the diagnoses and management of cervical cancer. Thus having the opportunity to live a normal and quality life again.

Care givers would also find the outcome of this study very useful, in that it would help them identify the symptoms of psychological distress in cervical cancer patients and

thus prepare them to understand their emotions and equip them with diversified ways of assisting cervical cancer patients to overcome this challenging phase. Moreover, care givers would be able to understand the effects of social support in reducing psychological distress among cervical cancer patients and so give them the support adequately.

Furthermore this study will contribute to the field of clinical psychology, counselling psychology and other related specializations. The outcome of the study will shed light on the efficacy of the psychotherapy as regards the subject matter (psychological distress). Professionals in this area of specialization and other behaviour experts will be equipped with adequate information and knowledge which would enhance their mastery and inform their consciousness towards the scientific applications of psychotherapy such as mindfulness-based stress reduction and diversional therapy in the management of psychological distress.

Moreover, through this study, medical practitioners, mental health professionals and social health workers will be able to realize the need to be aware of the distress level of every cervical cancer patients and the need to make it the sixth vital sign, they would also be informed on how this can be affected by self-efficacy and social support. In addition, this study will have implication on policy making of distress assessment of oncology patients in Nigeria. The implications of mindfulness-based stress reduction therapy and diversional therapy in addition with other existing strategies in reducing psychological distress among cervical cancer patients will add more to the existing interventions and reveal more related implications

In addition, this study would serve as an empirical basis for future research and citations. Future researchers in the field of clinical and counselling psychology would benefit from this study as it serves as a source of references in academic writings. It will also fill the gap in the previous studies

1.7 Scope of the Study

This study is geared towards undertaking the effects of mindfulness-based stress reduction and diversional therapy in the management of psychological distress. The geographical scope includes registered cancer centres in Oyo State and Lagos State. Participants included in this study were specifically women already diagnosed of cervical

cancer and experiencing high level of psychological distress as at the time this study was carried out.

1.8 Operational Definition of Terms

The following terms were operationally defined as used within the context of the study.

Psychological Distress: is an unpleasant feeling of emotion experienced by cervical cancer patients which affects their level of functioning as well as day to day activities.

Mindfulness-Based Stress Reduction: is a conscious training of cervical cancer patients' mind in paying attention to the present moment without being judgemental.

Diversional Therapy: a group of programmes designed to rouse the interest and engagement of cervical cancer patients in leisure activities.

Cervical Cancer: an uncontrolled growth and spread of abnormal cells around the neck of the womb.

Health Self-Efficacy: can be referred to as the belief cervical cancer patients have in their ability to execute behaviours essential to manage forthcoming situations

Perceived social Support: is the cervical cancer patients' subjective assessment of the assistance, care and understanding they received through social ties by friends, family and the community at large.

CHAPTER TWO

LITERATURE REVIEW

Several researches have been conducted on the constructs under study. However, this study has reviewed related literature on psychological distress, mindfulness-based stress reduction and diversional therapy from the plethora of researches available. This includes theoretical and empirical review of related literature

2.1 Theoretical Review

2.1.1 Concept of Psychological Distress

Psychological distress is frequently used as a community-wide marker of mental health in public health, population surveys, epidemiological investigations, and clinical trials and intervention studies, according to Drapeau, Marchard, and Beauieu-Prevost (2012). However, the concept of psychological distress is still nebulous for some people. In fact, a more in-depth review of the scientific literature reveals that the term "psychological distress" is frequently used to refer to the undifferentiated combinations of personality traits, functional disabilities, behavioural issues, depression and generalized anxiety symptoms (Drapeau et al., 2012). Felipe et al., 2014 explained psychological distress as a multifaceted, unfavorable emotional experience of a psychological (cognitive, behavioural, emotional), social, and/or spiritual nature that may limit one's ability to effectively manage the illness, its physical symptoms, and its treatment. Psychological distress, according to Durvusula (2014), can take a variety of forms and range in intensity. However, to put it simply, it is a psychological distress. It can show up as symptoms of depression, anxiety, distraction, and, in the worst cases, psychosis. It could be caused by a variety of things, including physical or mental illness, common stressors, and extreme pressures. It is an unconfortable feeling that slows down everyday action (for example work, school, providing care, and taking care of oneself). Rest, taking a break, and engaging in self-care practices like exercise can control psychological distress in less severe circumstances. Also, brief activity with a certified

mental health professional is fundamental in dealing with the events that the distress and are blocking (Durvusula, 2014)

Psychological distress is also viewed as an emotional condition that involves negative views of one's self, others and the environment and is characterised by unpleasant subjective states such as feeling tensed, worried, worthless and irritable (Barlow, Durand and Hoffman, 2005). These subjective states can reduce the emotional resilience of individuals and impact on their ability to enjoy life and to cope with pain, disappointment and sadness. Psychological distress can be viewed as a continuum in which people can move from experiencing well-being to distress and back at various times throughout their lives (Doherty, Moran and Kartalova 2008).

2.1.2 Clinical Features of Psychological Distress

Psychological distress is frequently used as a community-wide marker of mental health in public health, population surveys, epidemiological investigations, and clinical trials and intervention studies, according to Drapeau, Marchard, and Beauieu-Prevost (2012). However, the concept of psychological distress is still nebulous for some people. In point of fact, a more in-depth review of the scientific literature reveals that the term "psychological distress" is frequently used to refer to the undifferentiated combinations of personality traits, functional disabilities, behavioural issues, and depression and generalized anxiety symptoms (Drapeau et al., 2012). Felipe and others described it as a multifaceted, unfavorable emotional experience of a psychological, social, and/or spiritual nature that may limit one's ability to effectively manage the illness, its physical symptoms, and its treatment was further elaborated on by (2014).

Psychological distress, according to Durvusula (2014), can take a variety of forms and range in intensity. However, to put it simply, it is a psychological discomfort. It can show up as symptoms of depression, anxiety, distraction, and, in the worst cases, psychosis. It could be caused by a variety of things, including physical or mental illness, common stressors, and extreme pressures.

Psychological distress is at times considered a condition described by terrible emotional sensations including strain, stress, uselessness, and peevishness. Negative attitudes toward oneself, others, and the environment are also part of it (Barlow et al.,

2016). People's emotional fortitude can be affected by these irrational feelings, which can make it harder for them to enjoy life and deal with pain, sadness, and despair (Tedstone, Moran, and Kartalova, 2008).

2.1.3 Concepts of Psychological Distress among Cervical Cancer Patients

Improvements in the early detection and treatment of cervical cancer have led to higher survival rates of cancer patients. However, the long-term consequences of cancer and its treatment can have prolonged effects that can significantly impede a patient's overall well-being and result to psychological distress. The National Comprehensive Cancer Network introduced the term "distress" to encompass the personal experience of hardship and the emotional challenges that are frequently associated with cancer (Mitchell, Basch and Dusetzina, 2016). The goal of this expression is to promote the acceptance and understanding of feelings rather than labeling individuals who are responding to the extensive impacts of cancer. In 1999, an interdisciplinary panel specifically selected the term "distress" to minimize the possible obstacle between patients who may require psychosocial services but hesitate to seek assistance, and the healthcare professionals who provide those services. Distress was defined globally as a multi-factorial unpleasant emotional experience of a psychological (cognitive, behavioural, emotional), social, and spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment.

Distress exists on a spectrum, spanning from everyday emotions like sadness, vulnerability, and fear, to more severe conditions such as depression, anxiety, panic attacks, social isolation, and even existential and spiritual crises that can be debilitating to yhe cervical cancer patients. In a study conducted by Zabora, Brintzenhofeszoc, Curbow, Hooker, and Piantadosi (2001), it was found that one-third of patients who received a new or recurrent cancer diagnosis experienced significant distress as they came to terms with their diagnosis. In the evaluation of psychological distress among 4,496 cancer patients, Zabora and colleagues reported a prevalence rate of 35.1% (Morrison, Novotny, Sloan, Yang, Pattern, Rudy and Clark, 2017). Despite various factors, individuals diagnosed with cervical cancer typically face varying degrees of discomfort stemming from the impact of the disease and its treatments. As they navigate through the

psychological distress associated with cervical cancer and strive to adapt to their new circumstances, mild symptoms of psychological distress can be seen as a natural and healthy response to the aggressiveness of the disease and the challenges of treatment.

Cancer significantly disrupts various aspects of a person's daily life, including relationships, employment, and income, even with the best available resources (Zabora et al., 2001). Common side effects of cervical cancer encompass physical exhaustion, aches, nervousness and sadness as individuals cope with their condition and make decisions related to their cancer journey. Expected signs of distress are uncertain feelings, fear, a sense of powerlessness, as well as anger, irritability, and grief due to changes in fitness and performance. Reflections on the fragility and impermanence of life, sleep disturbances, appetite changes, difficulty concentrating, worries associated to cancer as well as concerns about identity and social roles are also common (Mitchell et al., 2016). During critical stages such as potential cancer diagnosis, challenging treatment phases, and post-treatment, a majority of patients may exhibit symptoms of anxiety and depression.

Asuzu, Campbell, and Asuzu (2008) reported prevalence rates of moderate to high anxiety (20-45%) and depression among mixed-site cancer patients in Nigeria. Patients with pre-existing psychiatric disorders are particularly vulnerable and may struggle more with coping, although psychological and social distress is expected even in psychologically healthy individuals (National Comprehensive Cancer Network, 2016). Individual traits and psychosocial factors play a role in patients' resilience, and it is not surprising that these elements can either enhance or impair their adaptive capability to the cancer experience. Approximately one in three patients experienced significant psychological distress and required psychological intervention, while around two-thirds successfully adjusted without clinical intervention (Morrison et al., 2017). Previous research indicated pre-existing social-personal features such as social support and previous well-being strongly influenced initial adjustment to cancer (Brissette, Scheier and Carver). By considering psychological factors, clinicians can identify patients who may struggle more and face difficulties in adaptation. Identifying and treating patients who have the potential to experience emotional distress is crucial for their successful navigation through the healthcare system. Patients with severe distress may exhibit

frequent concerns, profound sadness, hopelessness, cognitive difficulties, and significant family, religiosity and social challenges, in contrast to those with milder distress (Mitchell et al., 2016).

Individuals with a prior mental health condition, substance dependency, and challenges in cognitive functioning are more prone to severe psychological distress. Additionally, individuals with complex co-morbid disorders, social issues such as lack of support or resources, conflicts with significant others and multicultural concerns are at risk for acute distress. Various stages of treatment, from initial workup to treatment resistance, side effects, finishing treatment, illness progression, and end-of-life, can also make patients more vulnerable to distress (Mitchell et al., 2016).

Refusing to acknowledge and appropriately respond to noteworthy distress can result in harmful consequences for both individuals and healthcare systems. Mental health issues among patients can diminish quality of life and hinder social and functional tasks. Neglected psychosocial challenges and distress can hinder adherence to treatment, jeopardize treatment results, and escalate healthcare expenses, as indicated by (IOM, 2008). Meta-analyses conducted by the National Comprehensive Cancer Network in 2016 and the Institute of Medicine (2008) have emphasized the risks of unaddressed social-personal needs and their impact on patients. Depression, lack of support, and limited resources are three key psychosocial factors that influence patient care and treatment outcomes. Emotional distress, such as depression and anxiety, along with co-morbid medical conditions, can lead to greater impairment in social and functional domains. Somatic symptoms of distress, including insomnia, discomfort, and pain, can heighten physiological symptoms of cancer and treatment, further impairing functioning and hindering the adoption of healthier behaviours (Ercolano, Hoffman, Tan, Lazenby, Mc corkle (2018).

Psychological distress can interfere with effective coping strategies and following treatment recommendations diligently resulting in non-compliance with treatment guidelines. Patients may develop pessimistic attitudes and self-defeating behaviours, hindering decision-making and impeding their ability to engage in adaptive coping mechanisms. Avoidant-based coping strategies, such as smoking, excessive drinking, or medication misuse, can negatively impact treatment compliance and ability to decide

(IOM, 2008). Mental infirmity can affect cognitive functioning, such as memory, executive functioning, and perception. Consequently, cancer patients experiencing stress, anxiety, and despair may struggle to comprehend complex medical information and effectively communicate, with healthcare professionals, potentially impacting treatment outcomes (IOM, 2008).

2.1.4 Concept of cancer

The body is made up of trillions of live cells that develop, divide, and pass away in a regular pattern. Normal cells reproduce more quickly during a person's early years, starting from conception, to promote growth and development in contrast to adulthood, when most cell division occurs primarily to replace worn-out, damaged, or dying cells (Anderson, 1995). When cells in a particular area of the body begin to multiply uncontrollably, cancer develops. Every type of cancer begins with this uncontrolled multiplication of abnormal cells. Cancer cells can spread to other regions of the body through the circulation or lymphatic vessels, where they start to grow and create new tumors that replace healthy tissue (Buckley, 1995). We refer to this process as metastasis. Cancer is usually given its name after the body part it affects first, regardless of how widely or wherein the cancer cells have spread. Because they can infect other organs in contrast to normal cells, these cancer cells are known as cancer cells. Cancerous cells typically develop a tumor. However, other diseases, like leukemia, hardly ever develop tumors. Instead, they are found in the bone marrow and blood. Not all tumours are cancerous. Malignant tumors are the ones that are cancerous, while benign tumors are those that are not. Although entirely benign tumors can become very large and press against healthy organs and tissues. However, because they cannot invade further tissue or disperse to different bodily areas, these tumors rarely pose a threat to life (Bukley, 1995).

2.1.5 Meaning of Cervical Cancer

Cervical cancer is the cancer of the cervix, the cervix is the lower part of the uterus that connects the body of the uterus to the vagina, or birth canal. The normal cervix is covered on its outer surface by a non-keratinizing, stratified squamous epithelium, which is continuous below with the squamous epithelium lining the vagina,

and above abuts onto the mucus secreting columnar epithelium lining the endocervical canal and its associated crypts. The junction between the two epithelia normally coincides with the external os, but this is not a constant relation. At puberty, in pregnancy and in some steroid contraceptive users, changes in the size and shape of the cervix result in the squamo-columnar junction (SCJ) being carried out on to the anatomical ectocervix (Sellors and Sankaranarayanan, 2003). Cervical cancer begins in the cells lining the cervix. These cells do not suddenly change into cancer. Instead, the normal cells of the cervix first slowly change into pre-cancer cells that can then turn into cancer. These changes may be called dysplasia. The change can take many years, but sometimes it happens faster. They can be found by the Pap test and treated to prevent cancer.

There are two main types of cervical cancer namely, squamous cell carcinoma (SCC) and adenocarcinoma. The majority of cervical cancer cases (>70%) are SCC, which is thought to arise from the transformation zone of the cervix (Saraiya Ahmed and Krishnan et al, 2011) SCC develops from the transformation zone, which locates at the junction between the squamous and columnar cells of the cervix (squamo-columnar junction), which migrates from the exocervix to the distal endocervical canal with advancing age. (Abeloff, Armitage, Niederhuber, Kastan, McKenna, 2004). Under the microscope, squamous cell carcinoma type of cancer is made up of cells that are like squamous cells that cover the surface of the cervix and about 90% of cervical cancer cases fall under this category while most of the rest are adenocarcinomas. Adenocarcinoma or mixed carcinoma, the second type of cervical cancer develops from the mucus-producing cells of the endocervix, it accounts for approximately 18 percent of cervical carcinomas. (Abeloff, Armitage, Niederhuber, Kastan, McKenna 2004). Other types of cancer that can also develop in the cervix are melanoma, sarcoma, and lymphoma. Cervical cancer tends to occur in midlife. Most cases are found in women younger than 50. It rarely occurs in women younger than 20. But even women over 50 are still at risk of getting cervical cancer. This is why it is important for older women to keep being screened for cervical cancer.

2.1.6 Aetiology of Cervical Cancer and Risk Factors

The prominent risk factor of cervical cancer is human papilloma virus (HPV). The majority of cervical cancer is caused by persistent infection with high risk of this virus (HPV) especially genotypes 16 and 18 (Kolawole, Ogah, Alabi, Suleiman, and Amuda, 2015). However, HPV is a group of over 150 related viruses; some of them cause a type of growth called papilloma, which are more popularly known as warts. HPV can infect cells on the surface of the skin, and those lining the genitals, anus, mouth and throat, but not the blood or internal organs such as the heart or lungs. It can spread from one person to another during skin-to-skin contact. One way HPV spreads is through sexual activity, including vaginal, anal, and even oral sex (Denny, 2009). Different types of HPV cause warts on different parts of the body. Some cause common warts on the hands and feet; others tend to cause warts on the lips or tongue. Certain types of HPV may cause warts on or around the female and male genital organs and in the anal area: these are called low-risk types of HPV because they are rarely linked to cancer. Other types of HPV are called high-risk types because they are strongly linked to cancers, including cancer of the cervix, vulva, and vagina in women, penile cancer in men, and cancers of the anus, mouth, and throat in both men and women. Infection with HPV is common, and in most people the body can clear the infection by itself. Sometimes, however, the infection does not go away and becomes chronic. Chronic infection, especially when it is caused by certain high-risk HPV types, can eventually cause certain cancers such as cervical cancer. Although there is currently no cure for HPV infection, there are ways to treat the warts and abnormal cell growth that HPV causes (Schiffman and Kjaer, 2006)

Thus, non-penetrative genital contact and other causes including Tobacco smoking, high parity, long-term hormonal contraceptive use, and co-infection with HIV are well established (NHS, 2014). Moreover, the causal relationship between HPV infection and occurrence of cervical cancer may be necessary but not sufficient (NHS, 2014); timing holds an important condition for HPV to cause cervical cancer infection (Moscicki, 2006). Various factors are involved in its progression; examples of such include sexual behaviour, number of sexual partners, age and smoking habit (Venuti, Badaracco, Sedati, Carbini and Marcante, 2004). When someone smokes, they and those around them are exposed to many carcinogenic chemicals that affect organs other than

the lungs. These harmful substances are absorbed through the lungs and carried in the bloodstream throughout the body.

Women who smoke are about twice as likely as non-smokers to get cervical cancer (Chan, Ho, Wong and Chang 2009). Moreover, tobacco by-products have been found in the cervical mucus of women who smoke. Researchers believe that these substances damage the DNA of cervix cells and may contribute to the development of cervical cancer (Moscicki, 2006; Chor and Yu, 2009)). Smoking also makes the immune system less effective in fighting HPV infections. Having a weakened immune system, human immunodeficiency virus (HIV), the virus that causes AIDS, damages a woman's immune system and puts them at higher risk for HPV infections. The immune system is important in destroying cancer cells and slowing their growth and spread. In women with HIV, a cervical pre-cancer might develop into an invasive cancer faster than it normally would (Maza, Schocken, Bergman, Randall and Cremer, 2017).

Another group of women at risk for cervical cancer are those taking drugs to suppress their immune response, such as those being treated for an autoimmune disease (in which the immune system sees the body's own tissues as foreign and attacks them as it would a germ) or those who have had an organ transplant (Zhu, Sharma, Stolina, Gardner, Roth, Tashkin, and Dubinett**,** 2000). Chlamydia infection is another possible cause of cancer. Chlamydia is a relatively common kind of bacteria that can infect the reproductive system. It is spread by sexual contact. Chlamydia infection can cause pelvic inflammation, leading to infertility. Some studies have seen a higher risk of cervical cancer in women whose blood tests and cervical mucus showed evidence of past or current chlamydia infection. Women who are infected with chlamydia often have no symptoms. In fact, they may not know that they are infected at all unless they are tested for chlamydia during a pelvic exam (Karunakaran, Yu, Jiang, Cha, Moon, Foster, Brunham, 2015).

In addition, women whose diets do not include enough fruits and vegetables may be at increased risk for cervical cancer, and overweight women are more likely to develop adenocarcinoma of the cervix. There is evidence that taking oral contraceptives (OCs) for a long time increases the risk of cancer of the cervix. Research suggests that the risk of cervical cancer goes up the longer a woman takes OCs, but the risk goes back

down again after the OCs are stopped, and returns to normal about 10 years after stopping. The American Cancer Society believes that a woman and her doctor should discuss whether the benefits of using OCs outweigh the potential risks before it is administered. Intrauterine device (IUD) use puts one at risk of cervical cancer as well. Some researches suggest that women who had never used an intrauterine device (IUD) had a lower risk of cervical cancer. The effect on risk was seen even in women who had an IUD for less than a year, and the protective effect remained after the IUDs were removed. Using an IUD might also lower the risk of endometrial (uterine) cancer. However, IUDs do have some other risks. Also, a woman with multiple sexual partners should use condoms to lower her risk of sexually transmitted illnesses no matter what other form of contraception she uses (American Cancer Society, 2017).

Having multiple full-term pregnancies is another risk factor, women who have had 3 or more full-term pregnancies have an increased risk of developing cervical cancer. No one really knows why this is true. Also, studies have pointed to hormonal changes during pregnancy as possibly making women more susceptible to HPV infection or cancer growth. Another thought is that pregnant women might have weaker immune systems, allowing for HPV infection and cancer growth. Being younger than 17 at one first full-term pregnancy is a risk factor, women who were younger than 17 years when they had their first full-term pregnancy are almost 2 times more likely to get cervical cancer later in life than women who waited to get pregnant until they were 25 years or older. Many low-income women do not have easy access to adequate health care services, including Pap tests (American Cancer Society, 2017). This means they may not get screened or treated for cervical precancerous cells which increases their risk of cervical cancer.

Diethylstilbestrol (DES), a hormonal drug that was given to some women between 1940 and 1971 to prevent miscarriage is a risk factor too. Women whose mothers took DES (when pregnant with them) develop clear-cell adenocarcinoma of the vagina or cervix more often than would normally be expected. These types of cancer are extremely rare in women who have not been exposed to DES. There is about one case of vaginal or cervical clear-cell adenocarcinoma in every 1,000 women whose mothers took DES during pregnancy. This means that about 99.9% of "DES daughters" do not develop

these cancers. DES - related clear cell adenocarcinoma is more common in the vagina than the cervix. The risk appears to be greatest in women whose mothers took the drug during their first 16 weeks of pregnancy. The average age of women diagnosed with DES -related clear cell adenocarcinoma is 19 years. Since the use of DES during pregnancy was stopped by the FDA in 1971, even the youngest DES daughters are older than forty years, past the age of highest risk. Still, there is no age cut-off when these women are felt to be safe from DES - related cancer (America Cancer Society, 2017).

Doctors do not know exactly how long these women will remain at risk. DES daughters may also be at increased risk of developing squamous cell cancers and precancerous cells of the cervix linked to HPV. Furthermore, heredity plays an important role; if one's mother or sister had cervical cancer, the daughter's chances of developing the disease are higher than if no one in the family had it. Some researchers suspect that some instances of this familial tendency are caused by an inherited condition that makes some women less able to fight off HPV infection than others. In other instances, women in the same family as a patient already diagnosed could be more likely to have one or more of the other non-genetic risk factors previously described in this section.

2.1.7 The Prevalence of Cervical Cancer

Cervical cancer has continued to be a huge public health issue in many developing countries of the world, where it ranks as either the leading cause or the 2nd leading cause of cancer-related deaths in the females (Bray, Ferlay, Soerjomataram, Siegel, Torre, Jamal, 2018) Globally, in 2018, it ranked as the 4th most common cancer and cause of cancer-related deaths in women with estimated 570,000 new cases and 311,000 deaths (Bray et al., 2018) Africa has the highest incidence and mortality rates of cervical cancer in the world, which are approximately ten times higher than that seen in western countries (Globocan, 2018). In Nigeria, cervical cancer is the 2nd most common cancer in the country and in women, where it accounts for 21% of all female malignancies in 2018, with estimated new cases of 14,943 (Globocan, 2018). As at 2005, the incidence rate of cervical cancer was 25 of 100,000 and over 10,000 women die of cervical cancer annually usually in painful, miserable and undignified manners (Mitra and Easley.2000). In Ibadan, the annual age standardized incidence has varied from 20.9

(1960–1969) to 19.9 per 100,000 (1998–1999) (Thomas, 2003), with no significant reduction in the 50 years since the establishment of the Ibadan Cancer Registry.

In the United States as at 2009, estimated new cases of cervical cancer was 11,270 and 4,070 were reported dead (National cancer Institute, 2010). Cervical cancer is the leading malignancy in North-east Brazil with annual incidence of 83 cases out of 100,000 women (Tristen and Bergstrom 2003). Cervical cancer is the most common cancer among women in sub-Saharan Africa and is a leading cause of death in women in Southern Africa. Mortality from cervical cancer in developed countries is substantially lower than in developing nations because of the availability of prevention, early detection, and treatment (Arbyn, Weiderpass, Bruni, de Sanjosé, Saraiya, Ferlay, and Bray). Despite being considered a preventable disease, cervical cancer remains the second most common malignancy in women worldwide with a high incidence in underdeveloped countries such as Nigeria (Shanta, Krishnamurthi, Gajalakshmi, et al 2001).

Cervical cancer is the third most common cancer in women, and the seventh overall, with an estimated 530 000 new cases in 2008. More than 85% of the global burden of cervical cancer occurs in developing countries, where it accounts for 13% of all female cancers. High-risk regions are Eastern and Western Asia, while rates are lowest in Northern America and Australia/New Zealand. Cervical cancer remains the most common cancer in women only in Eastern Africa, South-Central Asia and Melanesia (Globocan, 2008). Overall, a proportional prevalence rate of cervical cancer was 52%, and cervical cancer was responsible for 275,000 deaths in 2008, about 88% of which occur in developing countries: 53,000 in Africa, 31,700 in Latin America and the Caribbean, and 159,800 in Asia (Globocan, 2008).

According to the recent data, approximately 85% of new cases of cervical cancer occur in developing countries. Approximately 80%-90% cervical cancer cases in developing countries occur among women aged 35 and older. Cervical cancer progresses slowly from precancerous lesion to advanced cancer. Globally, the incidence of the cancer is very low in women under the age of 25 years. However, the incidence increases at age of 35 to 40 years and reaches the maximum in women in their 50s and 60s.

This high burden of disease is largely a result of lack of access to screening services and inadequate screening uptake due to female patients' limited knowledge or fears about cervical cancer screening (McFarland, 2003; Louie, Sanjose, Mayaud, 2009). Research has also suggested that a lack of male involvement may be an overlooked obstacle to cervical cancer screening (Lyimo and, Beran, 2012). In resource-poor settings, it is estimated that less than 5% of women are screened for cervical cancer compared to 40.0 to 50.0% in high-income countries (WHO, 2014). The 2014 World Cancer Report notes that vaccination against human papilloma virus (HPV) with early detection and treatment services are key interventions to decrease cervical cancer incidence (Ferlay, Soerjomataram, Dikshit, Eser, Mathers, Rebelo, et al 2012.; Paavonen, Naud, Salmerón, Wheeler, Chow, Apter, et all 2009).

2.1.8 Mindfulness-Based Stress Reduction

Jon Kabat-Zinn created the Mindfulness-based Stress Reduction programme group in the 1970s to help patients deal with the challenges of life and mental illness (Kabat Zinn, 2013). At the time of its creation, Kabat Zinn's main goal was to help hospital patients, but it is today widely employed by people from all walks of life. Since everyone experiences stress on a regular basis—regardless of age, skin color, or weight. MbSR is a versatile and adaptable method of stress reduction. This unavoidable aspect of life is accompanied with a variety of unpleasant and annoying symptoms that, if not treated properly and promptly, can affect every aspect of one's life. Mindfulness-based stress reduction is an approach for reducing physical or mental pressure. As a group intervention, MbSR emphasizes learning how to meditate so as to reduce stress and improve mental health as well as physical health. Usually, about 30 participants get this intervention over the course of eight weeks for 2.5 hours in a week. The objective is to acquire specific meditation techniques during group sessions and practice them most days of the week at home, putting what is learned into practice for up to 45 minutes a day (Brantley, 2005). When practicing mindfulness, it's vital to have these seven mindsets and attitudes.

2.1.9 The Seven Important Attitudes for Practicing Mindfulness

The following "attitudes" are necessary for practicing and maintaining mindfulness. We may strengthen our capacity to deal with fear, worry, panic, and sadness; lessen our suffering; and cultivate our sense of calm and well-being by learning to recognize, practice, and use these attitudes momentarily. Although they are discussed one after the other, they are interrelated, that mastering of one promotes knowledge and comprehension of others.

1. Non-judgement: Compassionate, unrestricted, and open-hearted awareness is mindfulness. It can be developed by impartially observing one's own experience as it develops in the present. Grouping and evaluating experiences is just a habit which holds one in reactive, automatic thought, emotion, and behaviour patterns that exacerbate issues rather than solve them. Many times, we are not even conscious of these habits. Judging prevent us from directly experiencing how our lives are playing out moment by moment each moment. Recognizing the judging nature of mind and recognizing judgemental thinking as it appears are important factors of mindfulness practice. It's neccessary to avoid passing judgment on the judging. Simply take note of its presence. The objective is to merely notice, not to banish judgmental ideas. One can develop new relationships with judgment by becoming aware of its presence and by choosing a response as opposed to reacting automatically.

2. Patience: The capacity for enduring negative occurrences with calmness and self-discipline. It necessitates bravery, faith, and a relationship with one's inner self. It also calls for self-kindness and compassion while one deals with the stress of a circumstance. Impatience frequently results from the ego, the self-centered aspect of self, railing against reality and yearning for a different world. The intelligent self, on the other hand, is aware of the reality that objects have a life cycle of their own, independent of one's desires. One's patience increases as one learns and accepts this truth. In order to develop patience, one must become aware of impatience and the temptation to rush from one thing to another.

3. Beginner’s mind: Beginning to observe the present moment, the thinking mind tends to believe it knows all about what is happening or tries to “control” by desperately seeking more information. The activity of thinking forms a filter or barrier between an

individual and direct experience of life – it is in the unfolding of life moment by moment that holds the full richness of life. To practice beginner's mind means to open to the experience of each moment as if meeting it for the first time. Remember and imaging one's experience as a child – the first smell of a flower, the first drop of rain, the first taste of an orange. Truly, each moment in life is unique. One may have experienced the sunset a thousand times, but this particular sunset is different from the rest and will never be again. Cultivating quality of direct experience, receiving whatever arises as a unique and precious experience is ultimate in practicing mindfulness; Practicing beginner's mind cultivates our ability to experience life in this way.

4. Trust: Learning to trust oneself and one's feelings is an important part of learning to meditate. This clearly allows one to see what is actually happening at the present moment. Practicing mindfulness deepens one's awareness of, sensitivity to and accuracy in discerning what is here now, what is happening within one's body, and around the self. This enables one to learn to trust his/her own knowing and authority, and not allowing a second party to tell one what they think he/she needs This process allows an individual to discover what it really means to be his own

5. Non - striving: A lot of human activity is spent "doing" and trying to change things. This "habit "frequently shows up in meditation. The ego mind wants more of what it likes and wants to get rid of what it does not like. This effort is felt as striving, or straining to be different, or do something else. Since mindfulness involves simply paying attention, without judgment, to whatever is happening, it is different from this more typical activity of doing – it is about "non -doing," about learning to "be" instead of do. As one is practicing or living mindfulness and feel a sense of striving or trying to change things, he/she should notice this simply without judging the self. Mindfulness is about truly relaxing into one's experience and allowing whatever is happening to happen, bringing clear, compassionate awareness to it as it happens. The paradox of meditation is that the best way to achieve one's goal is to let go of striving and, instead, focus carefully on seeing and accepting things as they are, moment by moment.

6. Acceptance: The process of acceptance begins with the willingness to see things exactly as they really are than the way one thinks they should be. It is important to see things as they are and oneself as he is. Ultimately, in this moment if you wish to change,

heal, or transform yourself or your life. Often to be able to accept what comes into awareness, one must pass through periods of intense feelings such as anger, fear, or grief. These feelings themselves require acceptance. Acceptance does not mean liking everything or being passive. It does not also mean satisfaction with things as they are, or that one has to stop trying to change things for the better. Rather acceptance simply means willingness to see things as they are, deeply, truthfully, and completely. This attitude sets the stage for acting in the moment in the most potent and healthy way, no matter what is happening. There is every likelihood to know what to do when there is a clear picture of what is actually happening than when one's vision is clouded by his mind's self-serving judgments and desires or its fears and prejudices.

7. Letting go: Letting go, or non attachment is another key attitude of mindfulness. People practice a contrary attitude most of the time by clinging to the way they want things to be without even having the idea of what it is all about. Often, what is embraced most strongly are ideas and views about oneself, others and situations, these ideas often shape one's moment-to-moment experience in profound ways. Paying attention to one's experience through meditation, enables individual to discover the thoughts, feelings and sensations he is trying to hold onto. And will also notice other things he will desperately want to get rid of. Clinging is driven by our likes and dislikes and our judgments. It is important to just let experience be what it is, moment by moment. By not interfering, there is a better chance to let go. (Kabat-zinn 1990)

2.1.10 Components of Minfulness-based Stress Reduction

Mindfulness Meditation

One route to fix the pieces of one's live and honourably hold up to responsibilities from family, friends, work, health, financial well-being, as well as to lead full and satisfying live is in practicing Mindfulness-Based Stress Reduction. Intensive training in mindfulness meditation can cultivate states of relaxation, improve physical symptoms of pain and chronic illness, open minds to greater insight, and enhance physical health and sense of well-being for fuller and more satisfying lives. This form of meditation practice stems primarily from the Buddhist tradition and was intended as a means of cultivating greater awareness and wisdom, helping people to live each moment of their lives as fully

as possible. While some forms of meditation involve focusing on a sound or phrase in order to reduce distracting thoughts, mindfulness training does the opposite. In mindfulness meditation, distracting thoughts, sensations or physical discomforts are equally important as the desirable ones and attention is given to them all

The practice of mindfulness meditation is rooted in the Theravada tradition of Buddhist spiritual practices (Trammer, 2017). Also known as Vipassana, this 2500-year-old tradition has been explicitly and systematically articulated in many Buddhist texts, although, the importance of mindful living is emphasized in many spiritual traditions (Walsh and Shapiro, 2006). In the context of Buddhist practice, mindfulness meditation was taught as a means to cultivate greater awareness and insight (Hanh, 1976). Mindfulness-based skills, as taught by Western researchers and clinicians, are typically taught independently of the religious and cultural traditions of their origins (Kabat-Zinn, 1982; Linehan, 1993). Kabat-Zinn argues that there is nothing intrinsically Buddhist about paying attention and the Buddha's teachings are a sort of "universal generative grammar" (Kabat-Zinn, 2003). He notes that interventions that teach mindfulness skills needed to be "free of the cultural, religious, and ideological factors associated with the Buddhist origins of mindfulness," as the programmes' objectives are not to espouse Buddhism or even to teach people to become "great meditators" (Kabat-Zinn,2003).

A group of eminent mindfulness researchers held a series of discussions to generate an operational definition of mindfulness (Desbordes, Gard, Hoge, Hölzel, Kerr, Lazar, and Vago, 2015). They proposed a two-component model of mindfulness. The first component involves self-regulating attention so that it is maintained in the present and on the immediate experience. The second component involves the adoption of a particular orientation to experience, specifically, an attitude of non-judgment, curiosity and acceptance. The first component, self-regulation of attention, involves bringing awareness to one's experience in the present moment, that is, observing and attending to the changing stream of thoughts, feelings, and sensations from moment to moment. The breath is a point of focus to anchor the awareness in the present. The client is directed to notice each object in the stream of consciousness (e.g., a thought), to discriminate between different elements of experience (a thought versus a feeling), and observe how one experience leads to another (e.g., a feeling leads to a critical thought and then the

critical thought amplifies the unpleasantness of the feeling). However, rather than getting caught up in and elaborating upon the thoughts, worries, plans, feelings so forth that are entering one's mind, mindfulness meditation practice involves a direct experience of the mind and body (Williams, Simmons, and Tanabe,).

The second component of mindfulness elucidated by Bishop et al., (2004) involves adopting and cultivating a particular orientation in mindfulness meditation practices. This involves bringing an attitude of curiosity about where the mind wanders when it drifts away from the breath. It also involves an open and inquisitive attitude about the different facets of one's experience at any moment, including thoughts, feelings, and sensations. A non-judgmental and accepting stance towards one's experience is encouraged. This involves being open to the reality of the present moment as it is, and not trying to change how one is feeling or force a particular state such as relaxation. Bishop et al., (2004) predict that adopting a stance of curiosity and acceptance may lead to reductions in the use of cognitive and behavioural strategies to avoid aspects of experience and over time would lead to improved affect tolerance. Mindfulness teachings instruct clients to relate to their thoughts and feelings in a wider, decentred perspective, treating them as passing mental events rather than as accurate reflections of self or reality. Thus, if self-deprecating thoughts, such as 'I am worthless' or negative thoughts about the future such as 'I will always feel like this' (both frequently found in individuals experiencing depression) are recognized simply as thoughts, the client will be better able to disengage from them. It has also been suggested that mindfulness practice over time may lead to greater cognitive complexity and increased emotional awareness due to an increased ability to differentiate between discrete cognitive and affective experiences (Bishop et al., 2004).

In summary, when an individual adopts a mindful state, feelings, thoughts and sensations are observed with awareness as events in the mind, without attaching the meaning and interpretations that usually come from our mind and without reacting to these events in automatic ways. The process of observing and attending to thoughts as events without judgment is thought to allow a "space" between one's perception and one's response. This mindful space allows individuals to act with intention rather than react automatically (Bishop et al., 2004). Mindfulness has been conceptualized as a state

that exists along a continuum from heightened levels of clarity to lower levels of automatic, mindless functioning (Brown and Ryan, 2003). Thus, everyone contains the inherent capability to be mindful, however, individuals differ in the regularity with which they maintain a mindful state of being. Moreover, an integral part of mindfulness practice is to look at, accept and actually welcome the tensions, stress and pain, as well as disturbing emotions that surface such as fear, anger, disappointment and feelings of insecurity and unworthiness. This is done with the purpose of acknowledging present moment reality as it is found - whether it is pleasant or unpleasant - as the first step towards transforming that reality and one's relationship to it. Mindfulness can be practiced while eating, walking, driving, or sitting; anytime throughout the day. This conscious act of remembering and bringing attention to the present moment and simple activities throughout the day enhances formal meditation practice. Both formal and informal practice are just that, practice at being fully present to each moment as life unfolds just as it is.

Hatha Yoga also includes the practice of yoga. Exercise is a good tonic for the body and mind, the benefits is not only to improve physical health, but also enhance emotional well-being. Regular physical activity remains an essential for endorsing health, postponing health or preventing predominant musculoskeletal disorders such as mechanical low back pain, neck and shoulder pain and decreasing the risk of increasing coronary heart disease, hypertension, osteoporosis, obesity and colon cancers (Jones, Ainsworth and Croft 1998). With all these merits of exercise, many people find it difficult to exercise because it involves discomfort or strain, or requires special equipment or others to work out with, or going to a special place to do it. If this has been the case for an individual, then mindful hatha yoga may just be the perfect practice to engage in because it requires no special equipment and can be done almost anywhere unilaterally.

The word “Yoga” means “yoke” in Sanskrit, and implies a harnessing together and unifying of body and mind. Yoga is a form of meditation, and when done regularly, is an excellent mind/body discipline for people who wish to move towards greater levels of health. Hatha yoga consists of postures done mindfully and with awareness of breathing. They are easily learned and have dramatic effects if practiced regularly.

Regular yoga practice promotes relaxation and awareness. It also encourages musculoskeletal strength, flexibility and balance, as well as inner stillness. It can both relax and energize. Applied in conjunction with mindfulness techniques, yoga is a gentle but powerful form of body-oriented meditation. With continued practice, one can begin to fully inhabit the body, pay closer attention to its fluctuating states and learn to cultivate an early warning system for the presence of stress, tension or pain. With an attitude of mindfulness to both body and mind states, one has more information to work with in potentially handling the day-to-day stressful events in life. Can thoughts in the mind and tension in the body actually have the capacity to produce bodily symptoms? There is growing evidence that by implementing mind/body techniques, the mind and body are capable of relaxing, new perspectives can be gained, and new ways of coping with one's life can be achieved. While practicing yoga, it is advised to practice in the same way with when meditating, that is maintaining moment to moment awareness, and not striving to get somewhere, just allowing one to be who he is, and not being judgmental. Movements in hatha yoga should be slowly and consciously, mindful yoga involves exploring one’s limits but not pushing beyond them. Instead, one plays with dwelling at the boundary and breathes. This requires honouring the body and the messages it gives about when to stop and when to avoid doing a posture because of a particular health condition (Kabat Zinn 2013).

Body Scan

The body scan has proven to be an extremely powerful and healing form of meditation. It forms the core of the lying down practices that people train in Mindfulness-Based Stress Reduction. It involves systematically sweeping through the body with the mind, bringing an affectionate, openhearted, interested attention to its various regions, customarily starting from the toes of the left foot and then moving through the entirety of the foot – to sole, the heel, the top of the foot – then up the left leg, including in turn the ankle, the shin and the calf, the knee and the kneecap, the thigh in its entirety, on the surface and deep, the groin and the left hip, then over to the toes of the right foot, the other regions of the foot, then up the right leg in the same manner as the left. From there, the focus moves into, successively, and slowly, the entirety of the pelvic region, including the hips again, the buttocks and the genitals, the lower back, the abdomen, and

then the upper torso – the upper back, the chest and the ribs, the breasts, the heart and lungs and great vessels housed within the rib cage, the shoulder blades floating on the rib cage in back, all the way up to the collarbones and shoulders. From the shoulders, we move to the arms, often doing them together, starting from the tips of the fingers and thumbs and moving successively through the fingers, the palms, and backs of the hands, the wrists, forearms, elbows, upper arms, armpits, and shoulders again. Then one moves in to the neck and throat, and finally, the face and head (Kabat-Zinn, 2013). When practicing body scan, one is systematically and intentionally moving his attention, thought, the body, and attending to the various sensations in the different regions. Being able to attend to these body sensations at will is quite remarkable. We can put our mind anywhere in the body we choose and feel and be aware of whatever sensations are present in that moment.

Experientially, we might describe what we are doing during a body scan as tuning in or opening to those sensations, allowing oneself to become aware of what is already unfolding, much of which is usually tune out because it is so obvious, so mundane, and so familiar that it is hard to know it is there, body scan is like experiencing the body, in the body, of the body. In the domain of relative reality, there is the body and its sensations (object), and there is the perceiver of the sensations (subject). They appear separate and different. Then there are moments of pure perceiving that arise sometimes in meditation practice, and sometimes at other very special moments in life. Yet such moments are potentially available to one at all times, since they are attributes of awareness itself. Perceiving unifies the apparent subject and apparent object in the experiencing itself. Subject and object dissolve into awareness. Awareness is larger than sensation. It has a life of its own separate from the life of the body, yet intimately dependent on it.

Awareness is deeply bereft, however, when it does not have a full body to work with due to disease or injury to the nervous system itself. The intact nervous system provides all of the extraordinary gateways into the feeling, sensing world. Yet, like most of everything else, these capacities are so much taken for granted that it is hard to notice that every exquisite moment of one's life in relationship, both inwardly and outwardly, depends on them. Not only might one come more to his senses, we might realize that we

only know through our senses, if one includes the mind, or awareness itself as a sense – it could be said, the ultimate sense. It is not uncommon while practicing the body scan for the sensations in the body to be felt more acutely, even for there to be more pain, a greater intensity of sensation in certain regions. At the same time, in the context of mindfulness practice, the sensations, whatever they are and however intense, are also being met more accurately too, with less overlay of interpretation, judgment and reaction, including aversion and the impulse to run, to escape. In the body scan, we are developing a greater intimacy with bare sensation, opening to the give-and-take embedded in the reciprocity between the sensations themselves and our awareness of them.

As a result, it is not uncommon to be less disturbed by them, or disturbed by them in a different, wiser way, even when they are acute. It seems as if awareness itself, holding the sensations without judging them or reacting to them, is healing one's view of the body and allowing it to come to terms, at least to some degree, with conditions as they are in the present moment in ways that no longer overwhelmingly erode our quality of life, even in the face of pain or disease. The awareness of pain really is a different realm from being caught up in pain and struggling with it, and setting foot in that realm, we discover some succour and respite. This in itself is an experience of liberation, a profound freedom in that moment, at least from a narrower way of holding the experience of pain when it is not seen as bare sensation. It is not a cure by any means, but it is learning and an opening, and an accepting, and a navigating the ups and downs of what previously was impenetrable and unworkable. Paraphrasing James Joyce in one of his short stories in Dubliners, "Mr. Duffy lived a short distance from his body." That may be an address too many of us share. Taking the miracle of embodiment for granted is a horrific loss. It would be a profound healing of our lives to get back in touch with it. All it takes is practice in coming to our senses, all of them. And a spirit of adventure. The body scan is not for everybody, and it is not always the meditation of choice even for those who love it. But it is extremely useful and good to know about and practice from time to time, whatever the circumstances or condition

Physical sensations one might notice with the body scan includes :tingly, burning, pounding, throbbing, trembling, light, heavy, tight, loose, shooting, stinging, airy cutting etc. Emotional reactions one might notice are impatience, wanting to stop neutral

enjoyment, wanting to continue, release, joy, sadness, fear, grief, pride, disgust, surprise, anger, frustration, anticipation, and shame. Thoughts that may occur include: reviewing the past, imagining the future, thinking about others, planning, evaluating, circular thinking, wishing, comparing, labeling and judging one's experience

2.1.11 Diversional Therapy

Diversional Therapy (DT) originated from Australia and it is a relatively new discipline that articulates recreation and leisure programmes to help people of all ages and abilities enjoy life in good health by improving their physical and psychological wellness through a variety of programmes and support activities, DT also known as recreational therapy or therapeutic recreation emphasizes the importance of social interaction, with the engagement of person-centred and purposeful living as the right of every individual. It works to enhance the spiritual, emotional and psychosocial needs of persons who are at risk of social and emotional disengagement. Human well-being is central to DT by working effectively to alleviate human suffering. DT capitalises on the client's ability to survive by mobilizing the client's strengths to achieve resilience (Wartel, 2003), and motivating them through various activities towards positive change. Recognizing that positive thought patterns challenges other negative beliefs and thereby create feelings of well-being (Wartel, 2003)

DT as a person centred and restorative practice respects and appreciates the importance of human dignity, imagination and creativeness and assist vulnerable people across the life-span in many sectors such as mental health, palliative care, disability, youth and aged care. DT facilitates recreational and leisure experiences that seek to enhance an individual's physical, cultural, psychological, social and emotional well-being. DT work to uphold the rights and dignity of vulnerable people underpinned by a social justice framework. A social justice framework reflects the principles of the egalitarian distribution of societal goods, prescribed rights and freedoms. Including opportunities and income which aim to reduce the incidences of inequalities, pertaining to health, social mobility, social exclusion or income inequality caused by globalization (Crow,2007 ; Noonan,2011).

DT is drawn from a Strengths-based framework that focuses on the well-being and hope of recovery for disadvantaged persons; it reveals the "Strengths approach" by actively engaging the process of capacity building, along with compassion and empathy for clients (Francis, et.al, 2014). The focus is what the client can do; correspondingly, the client is not defined by deficit or disease. To define clients by their strengths as opposed to their weaknesses is restorative, and instills hope for the future (Francis, Pulla, Clark, Mariscal, and Ponnuswami, 2014). DT incorporates person-centred restorative practices that seek to broaden human potential and enhance well-being (Helmer, Pulla, and Carter, 2013). DT values and recognizes the client as the expert as they seek to empower them via therapeutic facilitation to build hope for recovery..

In addition, DT from a “Strengths-based approach", highlights the importance of acknowledging strengths and capacities as well as integrating the principles of social justice, inclusion, self-determination and respect with a mutual regard for human rights (Francis, et.al, 2014). It is in this way DT seeks to understand and meet the needs of clients by facilitating well-being that is respectful and socially just. The framework for Strength-based practice focuses on the respect and dignity of people with the right to govern their lives by employing their strengths, capabilities and resources to overcome adversity (Pulla, 2012). Strength-based practice communicates hope for the future by encouraging social change thus opposing the dominant social structures that seek to oppress vulnerable people (Pulla, 2012). It gives credence to the belief that individuals can promote their recovery by drawing from personal strengths to aid resilience (Riggs and Pulla, 2014).

Moreover, strength-based practice is not only about re-framing clients thinking to find good in the situation, re-labeling weaknesses as strengths, ignoring that serious symptoms and problems exist and continue to exist, or compiling a list of strengths, it is about finding strengths alone that is held even during critical moments and crises (Pulla,2012). Strength-based methodologies focus on what is working well, highlighting successful strategies, while issues are not ignored but defined and prioritized. This approach “focuses on identifying, mobilizing, and honouring the resources, assets, wisdom and knowledge that every person, family, group, or community has and lead to a rediscovery of these resources” (Pulla, 2012). Clients have experiences, abilities,

knowledge and external support systems that assist them to move on in life. Using a strength-based approach allows the client, supported by the DT, to identify and build on strengths so that the client can reach goals and retain or regain independence in daily life, and also improve self-care abilities, build confidence and self-esteem, and become independent in its activities (Pulla, 2012).

The body representing DT in Australia, describes DT as a tool that assists in shaping the environment for the comfort of others. Its role is to observe and facilitate positive leisure opportunities which contribute to health and well-being as well as the enhancement of life quality. DT accepts, encourages and provides an opportunity for fun and friendship via meaningful social engagement; to meet the social and emotional needs of clients by means of recreational and leisure activities (Ahn, Black and Roger,2019) DT is targeted at managing the multiplicity of client's circumstances (Chenoweth and McAuliffe, 2012). DT embraces a reflexive methodology to improve the quality of practice by engaging in critical reflection that plans, acts, observes and reflects on individual uniqueness (Chenoweth and McAuliffe, 2012).

DT seeks to enhance the social functioning of clients and reduce the incidence of depression, stress and anxiety by building on an individual's capacity for self-confidence and self-determination. Enhancing social functioning consequently can lead to improvements in an individual's quality of life. DT activities are purposefully designed to promote health and wellness by limiting restrictions to social participation caused by illness, disability or cognitive impairment (Buettner and Legg, 2011). The intention is to overcome barriers and helps to maintain the physical, mental and emotional well-being of clients by seeking to reduce depression, stress and anxiety; recover basic motor functioning and reasoning abilities; build confidence, and socialize effectively. Various activities of diversional therapy improve the bio, psycho-social functioning of the clients (Buettner and Legg, 2011).

Viewed in the context of social isolation, it is contended that many clients have a sense of "otherness" that comes from social withdrawal and it is recognized that this may relate to the psychological self, the emotional self, the physical self or the environment. The power of a strength perspective is optimism as it magically works to improve the quality of the client's lives by focusing on strengths as opposed to deficits (Healy, 2005).

Many clients of DT live with depleted cultural social capital due to factors that may be out of their control such as financial constraints, limited education or physical or psychological illness (Chenoweth and McAuliffe, 2012). These clients have a reduced capacity to master their environment as limited autonomy prevails in their otherwise "governed" lives. With limited choices, their decision making is also undetermined or virtually non-existent. DT has the ability to assist those to help themselves by providing an opportunity for coping and resilience; within a respectful, culturally sensitive and supportive partnership that enables the client to seek positive change.

In opposition to negative assumptions, a strengths-based approach focus is the inner strength of individuals to become resilient by way of positive adaptations coupled with enhanced coping mechanisms (Pulla, 2012,). Strength-based practice is collaboration between the client and the diversional therapist; it helps clients to tell their stories or lived experiences in an interactive environment that is adaptive. The Strengths approach assists vulnerable clients to recognize and change negative narratives by exploring and acknowledging alternative narratives (Walther and Fox, 2012) DT seeks to liberate the visions and hopes of vulnerable clients in a process of reconstruction (Riggs and Pulla, 2014). Social interaction is the key to maintaining optimal health and is correlated to greater optimism including more positive self-evaluations with well-developed coping mechanisms proffering increased resilience (Ford, 2005).

2.1.12 Components of Diversional therapy

Perceived freedom: This implies that the activity or setting is more likely to be seen as a typical leisure when individual's reasons for participation is attributed to themselves rather than determined externally by someone else or by circumstances (Mannell and Kleiber, 1997). "Freedom is not the absence of limit or constraint, but involves some element of self-determination" (Kelly, 1996).Freedom implies that individuals have a choice or perceive they have a choice in the pursuit of leisure experiences. Freedom also suggests that an individual is free of the obligations or compulsions that might arise from family, work, or home activities or of the constraints that may inhibit participation or involvement. Lee and Mobily (1988) stated that therapeutic recreation services should build skills and provide participants with options

for participation. The Leisure Ability Model emphasizes content areas that help clients build skills in a variety of areas that will enable them to experience several options for future independent leisure functioning. The individual feels that he or she would have more fun "if only" he or she had more money, more time, fewer constraints, etc. These individuals express the need for more "freedom from" obligations and responsibilities. Individuals with disabilities, however, often have the opposite, but equally important, experience needing "freedom to" participate. That is, having the requisite skills to participate, knowing where and with whom to participate, being able to get to a recreation facility at one's own convenience, etc. Leisure choices are only valid when the individual has the knowledge, skills, abilities, and resources to consider, make, and implement decisions freely.

Intrinsic motivation: This is a second cornerstone to leisure behaviour (Iso-Ahola, 1997; Iwasaki and Mannell, 2000; Mannell and Kleiber, 1997). Deci and Ryan (2008) first presented the notion of intrinsic motivation. Mannell and Kleiber (1997) applied the theory of intrinsic motivation to leisure behaviour and noted its relationship to freedom of choice and self-determination. Activities, settings, and experiences construed as leisure are likely to be perceived as providing opportunities for the development of competence, self-expression, self-development, or self-realization. When people engage in activities and settings that provide these opportunities, they are said to be intrinsically motivated. This attribute is clearly not completely independent of the freedom of choice attribute; self-determination is theorized to be an essential ingredient of intrinsic motivation. (Mannell and Kleiber, 1997). Individuals often are intrinsically motivated toward behaviour in which they can experience competence and self-determination. Thus, individuals seek experiences of incongruity (that is, slightly above their perceived skill level) or challenges in which they can master the situation, reduce the incongruity, and show competence. This process is continual, and through skill acquisition and mastery, produces feelings of satisfaction, competence, and control. Involvement in leisure pursuits often occurs because participants are moved from within and not because they are influenced by external factors. This results in personal feelings of satisfaction, enjoyment, and gratification" (Edgington et al., 1998). The power and influence of

intrinsic motivation has been demonstrated in many areas of human behaviour, and it is an important feature of meaningful and beneficial leisure.

Creating leisure or helping others experience meaningful leisure through programme and service delivery or counselling and education is in large part dependent on fostering intrinsic motivation. If intrinsic motivation has to be facilitated in leisure pursuits, it must be sensitive to the social situation in which participation occurs and individual differences in how people react to those social circumstances as well as attention to what participants are perceiving and feeling (Iwasaki and Mannell, 2000).

Iso-Ahola (1997) reported that intrinsic motivation correlates positively with both psychological and physical health. In addition, those individuals who "seek" intrinsic rewards through their leisure are healthier than those who choose to "escape" through passive and unrewarding leisure. Escapism through passive leisure is psychologically troublesome because it leads to boredom, which in turn feeds into apathy and depression. It has been found that lack of awareness of leisure and its potential in one's life is the single most important factor contributing to boredom in leisure (Iso-Ahola 1997). In other words, failure to cognitively realize or personally discover leisure is a significant antecedent to leisure boredom. Other factors significantly contributing to it are poor leisure attitude or ethic, high work ethic, lack of leisure skills, barriers to leisure participation, and poor self-motivation in general (as a personality trait).

Self-efficacy or self-determination or competence is the central or pervasive personal belief that an individual can exercise some control over his or her own functioning and over environmental events to reach some desired end (Bandura, 1997, 2001; Warr, 1993). Efficacy beliefs are foundational to the individual's sense of competence and control. Individuals with higher self-efficacy believe their choices and actions will affect the outcome of a situation; those with lower self-efficacy believe their choices and actions have little relationship to the outcome. Efficacy beliefs affect adaptation and change not only in their own right, but through their impact on other determinants. Such beliefs influence whether people think pessimistically or optimistically and in ways that are self-enhancing or self-hindering. Efficacy beliefs play a central role in the self-regulation of motivation through goal challenges and outcome challenges to undertake, how much effort to expend in the endeavour, how long to

persevere in the face of obstacles and failures, and whether failures are motivating or demoralizing. A strong sense of coping efficacy reduces vulnerability to stress and depression in taxing situations and strengthens resiliency to adversity. Efficacy beliefs also play a key role in shaping the courses lives take by influencing the types of activities and environments people choose to get into. Any factor that influences choice behaviour can profoundly affect the direction of personal development. This is because the social influences operating in selected environments continue to promote certain competencies, values, and interests long after the decisional determinant has rendered its inaugurating effect. Thus, by choosing and shaping their environments, people can have a hand in what they become. (Bandura, 2001)

An internal locus of control implies that the individual has the orientation that he or she is responsible for the behaviour and outcomes he or she produces, and an **external locus of control** means the person believes that luck or chance or others are responsible for the outcomes (Iso-Ahola, 1980; Mannell and Kleiber, 1997). Typically, individuals with an internal locus of control take responsibility for their decisions and the consequences of their decisions. A typical statement might be "I am responsible for my leisure choices." An individual with an external locus of control may make the statement "It's your fault I didn't do this right" and place responsibility, credit, or blame on other individuals. Obviously, an internal locus of control is important for the individual to feel self-directed or responsible, be motivated to continue to seek challenges, and develop a sense of self-efficacy or self-competence. Mannell and Kleiber (1997) noted that opportunities for choice and the person's desire for choice need to coincide.

Personal causality or **attribution** implies that an individual believes he or she can affect a particular outcome (Iso-Ahola, 1980; Mannell and Kleiber, 1997). For instance, when an individual experiences success, he or she can attribute that success either to personal effort (personal causality), or to luck or chance (situational causality). An important aspect of the sense of accomplishment, competence, and control is the individual's interpretation of his or her personal contribution to the outcome. Without a sense of personal causation, the likelihood of the individual developing an internal locus of control is reduced. Haworth and Lewis (2005) characterized leisure as an important

contributor to internal locus of control, and believed that it may lead to enhanced mental health and well-being.

Optimal experiences: A fourth, closely related, concept is that of optimal experiences or "flow" researched and popularized by Csikszentmihalyi (1990). For a person to get into "flow" or to achieve "optimal experiences," a number of elements must be present (Godbey, 1999). Optimal experiences include feelings of intense involvement, clarity of goals and feedback, deep concentration, transcendence of self, lack of self-consciousness, loss of a sense of time, and intrinsically rewarding experience. A balance between challenge and skill is also important (Mannell and Kleiber, 1997). Among the strongest of these are the match between the challenge presented by the activity and the skill level of the participant. When skill level is high and activity challenge is low, the individual is quite likely to be bored. When the skill level is low and the activity challenge is high, the individual is most likely to be anxious.

2.1.13 Concepts of Self-Efficacy

Self-efficacy is another important variable in the study. It is conceptualized as individual's perception of his /her capability that is instrumental to the intents and the control which can be exercised over one's environment. Bandura (1977) portrayed self-efficacy as a person's belief about his adequacy which presumes one's extent of accomplishment and determines what is achieved with the possessed knowledge and skills. According to Bandura social cognitive theory, an individual possess a self-system which enable them to externalize a degree of control over their thoughts, emotions, motivations and actions. This self-system encompasses one's cognitive and affective measure that provides a reference mechanism of perceiving, regulating and evaluating behaviours that result from between the system and the environmental sources of influence. Every individual is aware of his estimated capability in attaining success, it may be a fundamental element of a person's self-concept, which is a constellation of beliefs and experiences about his or her ability to deal effectively with the tasks and accomplish what needs to be done. Bandura (1977) implied that self-efficacy is an important component of self-concept and suggested that low self-efficacy will lead to negative mood, pessimism, stress, tensions and psychological distress

Self-efficacy could be innate and it can be acquired as one develops. If a person is unable to gain self-efficacy or lose his sense of self-efficacy at a very important point of their development when they are supposed to focus on gaining autonomy and independence, the result may be irreparable. Right from childhood, parents and caregivers provide experiences that differently influence children's self-efficacy. Home influences that help children interact effectively with the environment positively affect self-efficacy (Bandura, 1997). Initial source of self-efficacy are centred in the family as the first agent of socialization, but the influence is bidirectional. Parents who provide an environment and stimulates youngster's curiosity ad allow for mastery experience help to build children's self-efficacy. When environments are rich in interesting activities that arouse children's curiosity and offer challenges that can be met, children are motivated to work on the activities and thereby learn new information and skills (Miller and Meece, 1997). There is much variability in home environments. Some contain materials such as computers, books, and puzzles that stimulate children's thinking. Young children must gain self-knowledge of their capabilities in broadening areas of functioning. They have to develop, appraise and test their physical capabilities, their social competencies, their linguistic skill, and their cognitive skills for comprehending and managing the many situations they encounter daily.

Deaux (1976) stated that people with high self-efficacy attribute success to ability or high effort and failure to lack of effort, in some instances individuals believe they are successful in what they do because others expect them to be. Self-efficacy originated as a situation-specific construct, but researchers investigated and refined the concept of general self-efficacy in recent years. Luszczynska, Scholz, and Schwarzer, (2005) opined that self-efficacy is an individual's belief in his/her own competence, while general self-efficacy can be described as a global sense of confidence in one's ability to cope with a wide range of challenging and stressful situations. It also refers to a broad and regular sense of personal competence (Luszcynska, Scholz et al 2005). Similarly, Scherier et al., (2012) described general self-efficacy as a global construct in the midst of all life challenges and achievements.

Tipton and Worthington (1984) observed that the performance of an individual is determined by both specific self-efficacy and general self-efficacy. It was pointed out

that in a familiar and more defined situation-specific self-efficacy accounts for more of the variance whereas in confusing and irregular situation, general self-efficacy accounts for more of the variance. Self-efficacy can affect an individual at any time; it can come into play at the initiation or persistence of coping or problem solving behaviour (kumara Singh and Kumara, 1989). People may be reluctant to initiate any actions if they assume they have a low self-efficacy in the task. The low efficacy people easily give up on a task and hardly notice the effects of their effort. The belief of an individual's efficacy will determine how much effort and time to expend on a given task. People with high self-efficacy would expend greater effort and persistence on an assigned task than those with low self-efficacy. Winnicott (1965) emphasized that every individual develops the public self that is an image of himself which he presents to others. He stated that a person is healthy if there is a high level of coherence between the public self and the true self. The idea of public self is theoretically similar to Buss' (1980) construct of public self-consciousness, which is defined as the individual's awareness of self as a social object. Bandura (1977) stated that the concept of the construct self-efficacy was introduced for the psychological changes that occur as a result of the various modes of treatment.

The self-efficacy theory states that the expectations of self-efficacy determine what activities people engage in and how much effort they will expend and how long they will reserve in the face of adversity. Bandura (1977) distinguished between self-efficacy expectancy and outcome expectancy. According to him, self-efficacy expectancy refer to convictions by which one can successfully perform the behaviour required to produce a given outcome. Whereas, the outcome expectancy are of the belief that a given behaviour will lead to that outcome, he emphasized that the self-efficacy expectancyvary on three dimensions viz. magnitude, strength and generality that may have implications on performance. Magnitude refers to the relative difficulty of a task as compared to others in hierarchy.

Furthermore, Bandura (1990) revealed a number of ways a person's perceived self-efficacy impacts motivation, behaviour, mood and mental functioning. Strong self-efficacy leads to improved goal setting and attainment mastery, perseverance and positive self-regard. Negative thought, on the other hand, can predict depression and distress, impair functioning, a heightened perception of threat in stressful situations, lack of

motivation, and surrender in the face of difficult tasks. In addition, perceived self-efficacy and depression act on each other bidirectionally, indicating a perpetual cycle of negative thought and affect. Efficacy expectations develop and are potentially modified through four sources of experiential information (Bandura 1977). These are performance experiences, vicarious learning, or modelling, verbal persuasion or encouragement from other people to engage in a specific behaviour and degree of emotional arousal with reference to a domain of behaviour. So people's beliefs about their efficacy can be developed by four main sources of influence which are mastery experience, modelling, social persuasions and psychological factors.

Mastery Experience: The most effective way of creating a strong sense of efficacy is through mastery experiences. Success builds a robust belief in one's personal efficacy. Failures undermine it, especially if failures occur before a sense of efficacy is firmly established. If people experience only easy success, they come to expect quick results and are easily discouraged by failure. A resilient sense of efficacy requires experience in overcoming obstacles through perseverant effort. Some setbacks and difficulties in human pursuits serve a useful purpose in teaching that success usually requires sustained effort. After people become convinced they have what it takes to succeed, they persevere in the face of adversity and quickly rebound from setbacks. By sticking it out through tough times, they emerge stronger from adversity.

Modelling: The second way of creating and strengthening self-belief of efficacy is through the vicarious experiences provided by social models. Seeing people who have similar aspirations as oneself and who have succeed by sustained effort raises observers' belief that they too are capable of mastering comparable activities prerequisite to success. By the same token, observing others fail despite high efforts could be demeaning to one's ambition. The impact of modelling on perceived self-efficacy is strongly influenced by perceived similarity to models. The greater the assumed similarities the more persuasive are the models' successes and failures. If people see the models as very different from themselves their perceived self-efficacy is not much influenced by the models' behaviour and the results it produces

Social Persuasion: Social persuasion is a third way of strengthening peoples' beliefs that they have what it takes to succeed. People who are persuaded verbally that

they possess the capabilities to master given activities are likely to mobilize greater effort and sustain it than if they harbour self-doubts and dwell on personal deficiencies when problems arise. To the extent that persuasive boots in perceived self-efficacy lead people to try hard enough to succeed, they promote development of skills and a sense of personal efficacy.

Psychological Factors: The fourth way of modifying self-beliefs of efficacy is to reduce people's stress reactions and alter their negative emotional proclivities and misinterpretations of their physical states. In unusual, stressful situations, people commonly exhibit signs of distress, shakes, aches, pains, fatigue, fear, and nausea etc. A person's perceptions of these responses can markedly alter a person's self-efficacy.

Virtually everyone can identify goals they want to accomplish, things they would like to change, and things they would like to achieve. However, most people also realize that putting these plans into action is not quite so simple. Bandura (1977) and others have found that an individual's self-efficacy play a major role in how goals, tasks and challenges are approached. People with a strong or high self-efficacy find an inner confidence which allows them to perform task that might otherwise seem beyond their reach. A belief in one's personal capabilities controls human functioning. Bandura (1997) explained four processes through which self-efficacy achieves its effect i.e. cognition, motivation, affect and selection

A. Cognitive Processes: The effects of self-efficacy beliefs on cognitive processes take a variety of forms. Much human behaviour, being purposive, is regulated by forethought embodying valued goals. Personal goal setting is influenced by self-appraisal of capabilities. The stronger the perceived self-efficacy, the higher the goal challenges people set for themselves and the firmer is their commitment to them.

B. Motivational Processes: Self-beliefs of efficacy play a key role in the self-regulation of motivation. Most human motivation is cognitively generated. People motivate themselves and guide their actions anticipatorily by the exercise of forethought. They form beliefs about what they can do. They anticipate likely outcomes of prospective actions. They set goals for themselves and plan courses of action designed to realize valued futures.

C. Affective Processes: People's beliefs in their coping capabilities affect how much stress and depression they experience in threatening or difficult situations, as well as their level of motivation. Perceived self-efficacy to exercise control over stressors plays a central role in anxiety arousal. People who believe they can exercise control over threats do not conjure up disturbing thought patterns. But those who believe they cannot manage threats experience high anxiety arousal. They dwell on their coping deficiencies. They view many aspects of their environment as fraught with danger. They magnify the severity of possible threats and worry about things that rarely happen. Through such bad thinking they distress themselves and impair their level of functioning. Perceived coping self-efficacy regulates avoidance behaviour as well as anxiety arousal. The stronger the senses of self-efficacy the bolder people are in taking on taxing and threatening activities.

D Selection Process: One centred on efficacy-activated process that enables people to create beneficial environments and to exercise some control over those they encounter day in and day out. People are partly the product of their environment. Therefore, beliefs of personal efficacy can shape the course lives take by influencing the types of activities and environments people choose. People avoid activities and situations they believe exceed their coping capabilities. But they readily undertake challenging activities and select situations they judge themselves capable of handling.

2.1.14 Health Self Efficacy

The self efficacy is a direct indicator of purpose and attitude. As indicated by social cognitive theory (Bandura 1997), an individual who has a perceived mode of control is capable of engaging healthy behaviours. In other words, strong individual's efficiency was associated with better health, better fulfilment and dynamic social support. Most prominent health behaviour theories include self-efficacy Self-efficacy is a proximal and direct predictor of intention and of behaviour. According to Social Cognitive Theory (SCT; Bandura, 1997), a personal sense of control facilitates a change of health behaviour. Self-efficacy pertains to a sense of control over one's environment and behaviour. Self-efficacy beliefs are cognition that determine whether health behaviour change will be initiated, how much effort will be expended, and how long it will be sustained in the face of difficulties and failures. Self-efficacy influences the effort

one puts forth to change risk behaviour and the persistence to continue striving despite barriers and setbacks that may undermine motivation.

Self-efficacy is directly related to health behaviour, but it also affects health behaviours indirectly through its impact on goals. Self-efficacy influences the challenges that people take on as well as how high they set their goals (e.g., “I intend to reduce my smoking,” or “I intend to quit smoking altogether”). Individuals with strong self-efficacy select more challenging goals (Blalock, Currey, DeVellis, DeVellis, Giorgino, Anderson, and Gold, 2000). They focus on opportunities, not on obstacles (e.g., “At my university there is a smoking ban, anyway,” instead of “There are still a lot of ashtrays at my university.”). According to the Theory of Planned Behaviour (Ajzen, 1991), intention is the most proximal predictor of behaviour. Cognition that affects a specific intention are attitudes, Self-Efficacy, subjective norms, and perceived behavioural control (perception about being able to perform a specific behaviour).

A typical item to assess perceived behavioural control is, “It is easy for me to do xy.” Self-efficacy and behavioural control are seen as almost synonymous constructs. However, self-efficacy is more precisely related to one’s competence and to future behaviour. According to the Trans theoretical Model (TTM; Prochaska, Norcross, Fowler, Follick, and Abrams, 1992), self-efficacy and perceived positive (“pros”) and negative (“cons”) outcomes are seen as the main social-cognitive variables that change across the stages. Self-efficacy is typically low in early stages and increases when individuals move on to the later stages. In the motivation phase, one needs to believe in one’s capability to perform a desired action (“I am capable of initiating a healthier diet in spite of temptations”), otherwise one will fail to initiate that action. In the subsequent volition phase, after a person has developed an inclination toward adopting a particular health behaviour, the “good intention” has to be transformed into detailed instructions on how to perform the desired action. Self-efficacy influences the processes of planning, taking initiative, maintaining behaviour change, and managing relapses (Marlatt, Baer, and Quigley, 1995).

This concept has been utilized in in different areas of academic success, physical and mental health, career decision making and also related to sociopolitical change. The perceived self-efficacy of health tends to believe that risky health practices can be

modified by valuable development, for example by using one's abilities to limit attractiveness. For example, a direct change is perceived as a threat to the apparent ability to conform to ones weight and exhaustion, as well as to identify points of interest and games plans to meet the needs of the situation. Effectiveness related emotions influence the the purpose of direct chance change. The amount of effort that is used to achieve that goal and the consistency of continuing to strive despite obstacles and challenges that can undermine inspiration. Perceived self-efficacy have evolved into an applied theoretical structure applied to models of dependence and breach of trust (Marlatt, Baer and Quigley, 1994). This view recommends that to acclimatize to high risk conditions is almost entirely dependent on how individuals feel they are working as one of their own experts and are directing their own abilities to regain control in the event of a risk

. As the theory planned behaviour shows (Ajzen, 1991), need is the most proximal marker of lead. Learning points that affected particular point are views, enthusiastic norms and social control (recognition of the choice to play a particular live). Self-efficacy and social control are considered in relation to all synonymous plans and objectives. Nevertheless, self-efficacy is identified much more decisively with inclination and future direction. As suggested by the hypothetical Trans mode (prochaska, norcross, fowler, follick and Abrams, 1992), self-efficacy and positive and negative outcomes are considered as the fundamental sociocognitive factors that change overtime. Self-efficacy is ordinarily low in beginning events and augmentation s when people proceed ahead to the latter stages.

The modifying effectiveness identifies the change of confidence according to the abandonment of the confidence urgency. Once an innovative effort has been made to stop, there is reference to a complete maintenance of the negotiation. At this stage the weak are confronted under very favourable conditions, for example, if they encounter negative effect or seductions under positive social conditions. The oversights are likely to occur unless the waste of time allows for optional modification strategies. Believing in its changing stock helps to choose even moderate decisions and to start adaptable change reactions. Stay away from the trust-destroying action that prepares the targets using a modified circumstance procedure that enhances modification efficiency (Gruder et al., 1993). It also soldier as cognitive modes of change.

The self -efficacy of the recovery is clearly identified and it's efficiency evolves, but the two points of view are alternated within the support engineer (as the obstruction capacity and the attribution malice are weakened by the self-efficacy in the adjustment action). If a pass occurs, people can fall prey to the influence of the violation of the restriction, attributing their stealthy past to the inside, to suffering and general causes, taking advantage of the opportunity and unraveling as a total loss of trust (Marlatt and Gordon, 1985). Be that as it may, the very self-accommodating people maintain a strategic distance from that impact by making possible a high threat situation and discovering approaches to manage the control of sickness and restore confidence. The self-efficacy for recovery of the limitation after a frustration essential has made it possible to advance the complete maintenance of the markets. Clinical intercessions revolve around recovery approaches after misfortune, for example, by monitoring and redistributing the condition, modifying elective modification strategies, causing a concise action plan for recovery (re-establishing commitment at an appropriate time) to stop to start social support, to re-frame the departure as a normal opportunity in a value learning process) (Curry and Marlatt, 1987). This restores self-efficacy and returns quickly to the maintenance technique. Be that as it may, Haaga and Stewart (1992) found that the self-efficacy of recovery, not high but moderate, gives the best rates of consistency. A number of studies on the adoption of health practices have measured self-efficacy to assess its potential influences in initiating behaviour change. Whereas general self- efficacy measures refer to the ability to deal with a variety of stressful situations, measures of self-efficacy for health behaviours refer to beliefs about the ability to perform certain health behaviours. These behaviours may be defined broadly (health food consumption) or in a narrow way (consumption of high-fiber food) (Luszczynska et al., 2005).Poor compliance with recommended treatment may result partly from patients experience of adverse side effects, but it may also be due to a lack of self regulatory skills.

2.1.15 Perceived Social Support

Social support has been shown to be a consistent protective factor for psychological problems in many researches and so it is an aspect to be reflected on in as much as it is described as a defence against life stressors as well as an agent promoting

health and wellness (Dollete, Phillips, and Matthews, 2004). Social support is a complex construct with numerous definitions. For example Cohen (2004) defines "social support as a social network's provision of emotional and material resources intended to benefit an individual's ability to deal with stress". Social support can take many forms, including structural support, that is the size and extent of individual's social network, frequency of social interactions; functional support, that is the experience that social interaction has been beneficial in terms of emotional or instrumentally needs; emotional support, that is behaviour that fosters feelings of comfort leading the person to believe that he/she is loved, recognized and cared for. Material support can be in form of goods and services or finances that help in solving practical challenges, it could also be informational, that is provision of relevant information that is helpful in understanding current difficulties and adjust to the changes that have occurred, which typically takes the form of counsel, advice or guidance in coping with one's problems. Social support has been identified as a specific aid to recovery (Onken, Craig and Ridgway, 2007).

Similarly, Social support can be characterized in various ways. In some cases, support can be defined by the function or purpose of the interaction, such as doing enjoyable things, sharing affection or exchanging advice or information (Sherbourne and Stewart, 1991). Support can also be positive interaction (someone to have a good time with, to get together with for relaxation), affectionate support (having someone to hug one and make one feel wanted) and emotional support (having someone to give you advice or suggestions, to share your private worries with) or tangible support (having others for help with daily living)

The presence of distinct components or functions of social support has been confirmed that the commonly used scales to measure social support have been shown to be good measures of the perceived availability of social support (Robitaille, Orpana and McIntosh, 2011). Social support can also be measured by the structure of specific relationships or the source from which support is obtained (Fuhrer, 1999; Orpana, 2009). Social support can be obtained through members of the family, colleagues at work, friends, neighbours and professional support. A different type of relationship provides different forms of social support at every point, and the adequacy of social supports

provided by one’s support network are more important than the number of people a person has in his social network (Brissete, Cohen, and Seeman, 2000)

Social support plays a pivotal role in helping persons with cervical cancer manage their illness and shield them from the array of stressors involved. Social support can improve healthcare outcomes by helping patients cope with the emotional stress of illness and the rigors of treatment procedures, providing informational support during instrumental treatment phases, and/or logistical support as a person’s functional abilities and roles change throughout the course of illness and treatment. With the knowledge that social support can help mitigate the stressors related to the challenges of illness, it is not surprising that inadequate or dysfunctional support systems can negatively affect the course of illness, including worse treatment outcomes and higher mortality rates (IOM, 2008). Inadequate social relationships lead to a decreased ability to cope with illness and often increase stress rather than insolate a person from it.

Perceived social support is viewed as having an indirect relationship with various symptoms that are related to psychological problems; however, Smith (2002) reported that social support has positive relationship with physical and mental health. It enables individuals to come to terms with their lives, and people who do not have the opportunity of this type of support are likely to be faced with psychological problems and may seek refuge in the company of other people. Family, friends and acquaintances play significant roles in the life of a person suffering from such mental and psychological problems (Uchino, 2004). There are varying models that differentiate the various types of social support but the most popular among them share common factors: emotional support, tangible aid, informational support and esteem support (Folkman and Moskowitz, 2004; Uchino, 2004).

1. Emotional support is the offering of empathy, encouragement, concern, affection, love, acceptance, trust, caring and intimacy. It is the warmth and nurturance provided by sources of social support to let the individual know that he is valued. Taylor (2011) also referred to it as esteem support.
2. Tangible support is the provision of financial assistance, material goods or services also called instrumental support. This type of social support encompasses the concrete and direct ways people assist others (House 1981).

3. Informational support is the provision of advice, guidance or suggestion of useful information to someone. This type of information has the potential to help resolve other's problems.
4. Companionship support is the type of support that gives someone a sense of social belonging. This can be seen as the presence of companions to engage in shared social activities.

Persons with fewer financial resources are also at greater risk of developing severe distress. Limited access to resources or financial means can interfere with a person's ability to fully participate in healthcare, thereby inadequately managing his/her illness. Indeed, a survey conducted in 2006 on households that were affected by cancer found that 8% of families had delayed or declined treatment because of the cost of care (IOM, 2008). Given the necessity of wealth and access to resources in this country, especially in the management of disease and health maintenance, socioeconomic status has become a strong predictor of illness, disability, and mortality rates (IOM, 2008).

In general, psychosocial stressors such as those described above depression and mental health problems, inadequate social support, and insufficient financial resources are correlated with higher morbidity and mortality rates as well as lower functional status (IOM, 2008). In and of it, psychological distress can cause emotional suffering and significantly decrease a person's effectiveness in his/her social and economic roles. Furthermore, psychosocial problems can affect health by obstructing a person's ability to effectively manage his/her illness, thereby creating sub optimal conditions for treatment. Studies have shown that psychosocial problems can impede access to necessary healthcare and treatment resources, interfere with treatment compliance, and restrict engagement in adaptive behaviours that promote good health (IOM, 2008).

In summary, persons with a chronic physical illness such as cancer must approach their cancer treatment from two angles: First, they must face their illness and the risks to their physical health that are at stake. Secondly, they must confront the many psychosocial challenges related to the sequel of cancer that threaten optimal functioning and high quality healthcare. As Zabora and colleagues indicated in their 2001 review of the prevalence of psychological distress among cancer patients, "Failure to detect and treat elevated levels of distress jeopardizes the outcomes of cancer therapies, decreases

patients' quality of life and increases healthcare costs". Thus, the detection and treatment of clinically significant levels of distress is critical in providing comprehensive cancer treatment. Early psychological intervention in particular, can benefit both patients and the medical institution. While psychological interventions may not affect cancer cure rates, evidence supports its efficacy in helping patients adopt positive coping mechanisms that can minimize symptoms of physical and psychological distress and improve overall health (IOM, 2008). In general, patients who receive psychosocial services have better quality of living and a lower likelihood of developing severe emotional disorders (National Comprehensive Cancer Network, 2016).

Additionally, these patients report greater satisfaction in their cancer care. Systemically, psychological interventions during appropriate treatment intervals help patients optimize their healthcare experience; psychosocial interventions such as social support are expected to improve treatment compliance provide recommendations, reduce unnecessary office visits with physicians and emergency room resources, and increase communication and collaboration with providers (National Comprehensive Cancer Network, s2016). Further, psychosocial services within oncology aim to benefit the community by promoting better health and wellness and working to improve the delivery of services and care for all persons affected by cancer(Association of Oncology Social Work (AOSW), 2012).

2.2 Theoretical Framework

2.2.1 Stress Process Model

The basis in which this study will be anchored is stress process model. Pearlin , Leonard, Elizabeth, Menaghan, Morton, and Lieberman (1981) developed the stress process model as a way to explain the relationship among stressors, social support, and mental health outcomes. According to Pearlin (1989), a stressor is an experience that takes the form of life events or chronic strains. Both life events and chronic strains have been studied separately in order to assess the effectiveness of social support and coping resources (Thoits, 2010). However, scholars recognize that these stressors seldom occur separately (Carr and Umberson 2003). In most situations, life events may create chronic

strains, or chronic strains may lead to a life event, often referred to as stress proliferation (Pearlin and Bierman, 2013).

. There are three key components to the stress process model: sources of stress, intervening factors and the manifestations of stress. Life experiences do not occur in a vacuum, but are instead influenced by the social structure and the status and roles individuals occupy. A central assumption of this paradigm **is** that stress is a process encapsulating a variety of factors. These may culminate in a range of outcomes including mental and physical health problems (Pearlin, Monton, Lieberman, Menaghan and Mullan, 1981). In general, the stress process model describes the interplay between potentially stressful occurrences, as well as personal and environmental resources that may influence the effects of stress on health outcomes.

Sources of stress

In the 1950s, Selye (1*956)* drew attention to the relations between noxious stressors and the patterned physiological reactions of laboratory animals. Selye's theory described a four stage process that included: stressors, conditioning factors, state of stress in the organism called the general adaptation syndrome (GAS) and the response. A basic principle guiding this model is that stressors and strains have the potential to produce elevated levels of distress. Thus, stressors produce a state of internal arousal resulting from external circumstances that challenge the individual. Stress, however, is not necessarily inherent in these external conditions, but rather results from discrepancies between these experiences, characteristics of the individual leisure needs, values, resources (Aneshensel, 1992) and the amount of change or re-adjustment that is brought about by these events (Holmes and Rahe, 1967).

Stressors are believed to have their origins in the course of social life. Although the stress literature now incorporates a wide variety of stressors including such things as daily hassles, non-events, macro-stressors and sudden trauma, the basic distinction between life events and chronic stress strain remains a central feature of the stress process model (Brown and Harris 1978). In addition to stressors, another component of the stress process model is factors that affect how stressors are experienced and the expression of dysfunction

Moderators*:* The second element of the stress process model is the moderators. These factors may be either internal (psychological predispositions) or external (social relationships), innate or acquired (Ensel and Lin, 1991). Moderators or buffers are those factors that affect the initial relationship between the stressor and the outcome under investigation, thereby producing an interaction effect. This interaction effect occurs when the joint presence of two exogenous factors affect the outcome. The presence of these factors serves to reinforce self-identity and or increase the capacity to either avoid or manage life experiences that may produce stress (Ensel and Lin, 1991). That is, these resources may protect individuals from the negative effects of stressors.

Manifestation of stress: Psychological distress is the outcome of stress and stress manifests itself distinctively to every individual, and can vary according to circumstances. Stress manifests itself physically through chronic fatigue, sneezing, indigestion, stomach aches, headache, constipation, frequent urination, insomnia etc; behaviourally through anger, hostility, mood swings, teeth grinding, denial, apprehension, nail biting, indecisiveness, depression, complaining, anxiety and withdrawal etc; and intellectually through forgetfulness, past orientation, lack of concentration, lack of awareness, lack of attention to details and reduced creativity. These identified manifestations are just some of the most commonly acknowledged or diagnosed indicators of stress. Some people experience the above symptoms without making a connection to stress, but in an attempt to identify and manage stress, it is helpful to have greater awareness about the way one's body and mind works

2.2.1b Application of Stress Process Model

Cervical cancer is regarded as a chronic stressor because it is a disease that, once developed, is persistent and takes the lives of many individuals (Dunkle-Schetter 1984; Wortman, 1984). It can also create related strains, such as financial, physical health, and mental health problems. In this regard, cancer is considered a life event that creates new chronic strains throughout the life course (Dunkle-Schetter 1984). Prior literatures have found that the impact of a cancer not only changes individuals' lives from the moment of diagnosis to possible remission, but it also affects them for the rest of their lives (Dunkel-Shetter 1984; Bloom 2002; Deimling et al.2006). In their study on long-term cancer

survivors, Deimling, Gary, Karen, Bowman, Sterns, Louis, Wagner and Kahana (2006) found that no matter the number of years after becoming cancer-free, cancer survivors never let go of the worry surrounding their cancer.

According to this theory, every individual is susceptible to change as a result of certain stressors that come their way and propel them for this change. In some instances, these changes can be planned, while in some other instances it may be unplanned. Pearlin (1981) postulated that there are four major elements that accounts for psychological distress in individuals namely; (i) individual characteristics, i.e. features of an individual which include gender, age, race, personality, etc. (ii) skills for coping with stress (iii) availability of social support network and (iv) nature and timing of stress.

2.2.2 The Lazarus Theory

Two concepts are central to any psychological stress theory: appraisal, i.e., individuals' evaluation of the significance of what is happening for their well-being, and coping, i.e., individuals' efforts in thought and action to manage specific demands. (Lazarus, 1993). Since its first presentation as a comprehensive theory (Lazarus, 1966), the Lazarus stress theory has undergone several essential revisions (Lazarus, 1991, Lazarus and Folkman 1984, Lazarus and Launier 1978). In the latest version (Lazarus 1991), stress is regarded as a relational concept, i.e., stress is not defined as a specific kind of external stimulation nor a specific pattern of physiological, behavioural, or subjective reactions. Instead, stress is viewed as a relationship (transaction) between individuals and their environment. `Psychological stress refers to a relationship with the environment that the person appraises as significant for his or her well being and in which the demands tax or exceed available coping resources' (Lazarus and Folkman 1986). This definition points to two processes as central mediators within the person–environment transaction: cognitive appraisal and coping.

The concept of appraisal, introduced into emotion research by Arnold (1960) and elaborated with respect to stress processes by Lazarus (Lazarus and Launier, 1978), is a key factor for understanding stress-relevant transactions. This concept is based on the idea that emotional processes (including stress) are dependent on actual expectancy that persons manifest with regard to the significance and outcome of a specific encounter.

This concept is necessary to explain individual differences in quality, intensity, and duration of an elicited emotion in environments that are objectively equal for different individuals. It is generally assumed that the resulting state is generated, maintained, and eventually altered by a specific pattern of appraisals. These appraisals, in turn, are determined by a number of personal and situational factors. The most important factors on the personal side are motivational dispositions, goals, values, and generalized expectancy. Relevant situational parameters are predictability, controllability, and imminence of a potentially stressful event.

In his monograph on emotion and adaptation, Lazarus (1991) developed a comprehensive emotion theory that also includes a stress theory (Lazarus, 1993). This theory distinguishes two basic forms of appraisal, primary and secondary appraisal. These forms rely on different sources of information. Primary appraisal concerns whether something of relevance to the individual's well being occurs, whereas secondary appraisal concerns coping options.

Within primary appraisal, three components are distinguished: goal relevance, describes the extent to which an encounter refers to issues about which the person cares. Goal congruence, defines the extent to which an episode proceeds in accordance with personal goals. Type of ego- involvement designates aspects of personal commitment such as self- esteem, moral values, ego-ideal, or ego-identity. Likewise, three secondary appraisal components are distinguished: blame or credit results from an individual's appraisal of who is responsible for a certain event. By coping potential Lazarus means a person's evaluation of the prospects for generating certain behavioural or cognitive operations that will positively influence a personally relevant encounter. Future expectations refer to the appraisal of the further course of an encounter with respect to goal congruence or incongruence.

Specific patterns of primary and secondary appraisal lead to different kinds of stress. Three types are distinguished: harm, threat, and challenge (Lazarus and Folkman, 1984). Harm refers to the (psychological) damage or loss that has already happened. Threat is the anticipation of harm that may be imminent. Challenge results from demands that a person feels confident about mastering. These different kinds of psychological

stress are embedded in specific types of emotional reactions, thus illustrating the close conjunction of the fields of stress and emotions.

Lazarus, (1991) distinguishes 15 basic emotions. Nine of these are negative (anger, fright, anxiety, guilt, shame, sadness, envy, jealousy, and disgust), whereas four are positive (happiness, pride, relief, and love). Two more emotions, hope and compassion, have a mixed valence. At a molecular level of analysis, the anxiety reaction, for example, is based on the following pattern of primary and secondary appraisals: there must be some goal relevance to the encounter. Furthermore, goal incongruence is high, i.e., personal goals are thwarted. Finally, ego- involvement concentrates on the protection of personal meaning or ego- identity against existential threats. At a more molar level, specific appraisal patterns related to stress or distinct emotional reactions are described as core relational themes. The theme of anxiety, for example, is the confrontation with uncertainty and existential threat. The core relational theme of relief, however, is a distressing goal-incongruent condition that has changed for the better or gone away. (Lazarus, 1991).

Coping is intimately related to the concept of cognitive appraisal and, hence, to the stress-relevant person-environment transactions. Most approaches in coping research follow Folkman and Lazarus (1980), who define coping as `the cognitive and behavioural efforts made to master, tolerate, or reduce external and internal demands and conflicts among them.'

This definition contains the following implications. (a) Coping actions are not classified according to their effects (e.g., as reality-distorting), but according to certain characteristics of the coping process. (b) This process encompasses behavioural as well as cognitive reactions in the individual. (c) In most cases, coping consists of different single acts and is organized sequentially, forming a coping episode. In this sense, coping is often characterized by the simultaneous occurrence of different action sequences and, hence, an interconnection of coping episodes. (d) Coping actions can be distinguished by their focus on different elements of a stressful encounter (Lazarus and Folkman, 1984). They can attempt to change the person–environment realities behind negative emotions or stress (problem-focused coping). They can also relate to internal elements and try to

reduce a negative emotional state, or change the appraisal of the demanding situation (emotion-focused coping).

Lazarus theory is a framework for evaluating the processes of coping with stressful events such as psychological distress as a result of cervical cancer. Stressful experiences are construed as person-environment transactions. These transactions depend on the impact of the external stressor. This is mediated by firstly the person's appraisal of the stressor, which is cervical cancer infection and secondly on the social and cultural resources at his or her disposal, such as social support from family and friends.

When faced with a stressor like cervical cancer infection, a person evaluates the potential threat (primary appraisal). Primary appraisal is a person's judgment about the significance of an event as stressful, positive, controllable, challenging or irrelevant. Facing a stressor, the second appraisal follows, which is an assessment of people's coping resources and options, which may be denial, acceptance, self blame, etc. Secondary appraisals address what one can do about the situation. Actual coping efforts aimed at regulation of the psychological distress as a result of cervical cancer give rise to outcomes of the coping process.

2.2.3 Cognitive Theory

The cognitive theory was developed by Beck in 1964. The theory states that the basis of psychological distress is negatively biased cognition. In its simplest form, the cognitive model 'hypothesizes that people's emotions and behaviours are influenced by their perceptions of events. In other words, it is not a situation parse that determines what people feel but rather the way in which they construe a situation' (Beck, 1995). This process is expressed when distressed patients naturally have a detrimental view of themselves, their environment and the future. They view themselves as worthless, inadequate, unlovable and deficient; the environment as hostile and the future as collapsing. According to the cognitive theorists, people's excessive affect and dysfunctional behaviour is due to contrary or inappropriate ways of interpreting their experiences.

The core of the theory is that emotional crisis begins when the way events are construed gets exaggerated beyond the available evidences. This manner of perceiving

things tend to have a negative influence on feelings and behaviour in a vicious cycle. Ultimately, people's perception about events can be affected by their background, culture and disposition. However, modern views of occurrences are a little more sophisticated and tractable than the ancient ones.

Fundamental to the cognitive model is the way in which cognition (the way we think about things and the content of these thoughts) is conceptualized. Beck (1976) outlined three levels of cognition: Core beliefs, dysfunctional assumptions and negative automatic thought. Core beliefs, or schemas, are deeply held beliefs about self, others and the world. Core beliefs are generally learned early in life and are influenced by childhood experiences and seen as absolute. Dysfunctional assumptions are rigid, conditional 'rules for living' that people adopt. These may be unrealistic and therefore maladaptive. For example, one may live by the rule that 'It's better not to try than to risk failing'. Negative automatic thoughts (NATs) are thoughts that are involuntarily activated in certain situations. In psychological distress, NATs typically centre on themes of negativity, low self-esteem and uselessness. For example, when facing a serious illness, a NAT may be 'I'm not going to survive it'. This kind of statements is debilitating and will cause more havocs to the patient's health.

Cognitive Theory is used as a framework to understand a person's mental distress or presenting complaint. This process of placing an individual's idiosyncratic experiences within a cognitive behavioural framework is known as 'formulation'. A formulation is a hypothesis about the causes, precipitants and maintaining influences of a person's problems. The formulation is intended to make sense of the individual's experience and aid the mutual understanding of the individual's difficulties. Formulations can be developed using different formats, exemplified by different ways of formulating depression. Beck, Rush, Shaw, and Emery. (1979) created a longitudinal formulation of depression. Within this formulation, early experiences (e.g. rejection by parents) contribute to the development of core beliefs, which lead to the development of dysfunctional assumptions (e.g. 'Unless I am loved I am worthless'), which are later activated following a critical incident (e.g. loss, chronic illness), leading to NATs and the symptoms of depression.

2.2.4 Learned Helplessness Theory (LHT)

The theory of learned helplessness was first introduced by Richter (1957). In 1967, Overmier and Seligman found that dogs exposed to inescapable and unavoidable electric shocks in one situation later failed to learn to escape shock in a different situation where escape was possible. Shortly thereafter Seligman and Maier (1967) demonstrated that this effect was caused by the uncontrollability of the original shocks after experimenting with animals. LHT is a learning theory that focused on the behaviour of animals and men faced with rewards and punishments that could be controlled by the subject or not. So, in an actual instrumental learning experiment, the subject can either make some response or refrain from making it and thereby influence the events around him. However, nature is not usually generous in its emergence of the contingencies. Animals generally do not only face events that can be uncontrollable by their conscious and unconscious actions, but are also faced with many circumstances to which they can do nothing at all. Such uncontrollable occurrences can significantly debilitate organisms: they produce passivity in the face of trauma, inability to learn that responding is effective, and emotional stress in animals, and possibly depression in man.

When carrying out this experiment, Overmier and Seligman (1967) exposed an experimentally naive dog to electric shock in a shuttle box, at the onset of the first electric shock, the runs frantically about, until it accidentally scrambled over the barrier and escaped the shock. On the subsequent trials, the dog running frantically, crosses the barrier more quickly than on the preceding trial and within a few trials, the animal becomes very efficient at escaping and learned to avoid shock altogether. After about 50 trials the dog becomes nonchalant and stands in front of the barrier. At the onset of the signal for shock, the dog leaps gracefully across and rarely gets shocked again. But the case is strikingly different for a dog that was first given inescapable shock in a Pavlovian hammock. The dog's first reactions to shock in the shuttle box are much the same as that of a naive dog. He ran around frantically for about 30 sec without any effect, but then stopped moving, lied down, and whines quietly. After 1 min. of this, the shock terminates automatically. The dog has failed to cross the barrier and escape from shock. On the next trial, the dog again fails to escape. At first he struggles a bit and then, after a few seconds,

seems to give up and passively accept the shock. On all succeeding trials, the dog continues to fail to escape.

However, in dramatic contrast to a naive dog, a typical dog which has experienced uncontrollable shocks before avoidance training soon stops running and howling and sits or lies, quietly whining, until shock terminates. The dog does not cross the barrier and escape from shock. Rather, it seems to give up and passively accepts the shock. On succeeding trials, the dog continues to fail to make escape movements and takes as much shock as the experimenter chooses to give. Another peculiar characteristic of the behaviour of dogs which have first experienced inescapable shock is that such dog occasionally jump the barrier early in training and escape, but then revert to taking the shock (Overmier and Seligman, 1967), they fail to learn that barrier-jumping produces shock-termination. In naive dogs, however, a successful escape response is a reliable predictor of future, short-latency escape responses.

The term "learned helplessness" was used to describe the interference with adaptive responses produced by inescapable shock and also as a short hand to describe the process which is believed underlies the behaviour. The phenomenon seems widespread, and such interference has been reported in dogs by a number of investigators (Carlson and Black, 1957; Seligman, Maier, and Geer, 1968). Nor is it restricted to dogs: deficits in instrumental responding after experience with uncontrollable shock has been shown in rats (Cohen and Looney, 1971), cats, fish (Padilla, Padilla, Ketterer, Giacalone, 1970), mice (Braud, Wepmann, Russo, 1969), and men (Thornton, Jacobs, 1971). Inability to control the emergence of cervical cancer does not only disrupt the life of the patients, but also interferes with a range of adaptive behaviours such as isolation. Uncontrollable shock produces more stress than controllable shock as measured by behavioural suppression (Hearst, 1965), by defecation and conditioned fear (Weiss, 1968), and by subjective report (Lepanto, Moroney, Zenhausern, 1965). Finally, more weight loss, anorexia, and whole brain norepinephrine depletion is found in rats experiencing uncontrollable as opposed to controllable shock (Weiss, Stone and Harrell, 1970). Experience with uncontrollable trauma typically has three basic effects: response initiation, retardation of learning and emotional distress.

Firstly, the probability that the subject will initiate responses to escape is lowered because part of the incentive for making such responses is the expectation that they will bring relief. In other words, the motivation to respond in the face of later averse events seems to wane, if the subject has previously learned that its responses have no effect on trauma. Secondly, learning that responding and shock are independent makes it more difficult to learn that responding does produce relief, when the subject makes a response which actually terminates shock. In general, if one has acquired a "cognitive set" in which A's are irrelevant to B's, it will be harder for one to learn that A's produce B's when they do. By the helplessness hypothesis, this mechanism is responsible for the difficulty that helpless dogs have in learning that responding produces relief, even after they respond and successfully turn off shock. Thirdly, learning that trauma is uncontrollable may produce more stress than learning that it is controllable. Thus, it is not shock per se but only uncontrollable shock that produces failure to escape (Seligman, Maier and Solomon, 1971)

Similarly, animals and human beings after exposure to prolonged life threatening events begin to feel powerless and thus the outcome is learned helplessness. Learned helplessness means to be helpless after experiencing a negative situation and this helplessness is a product of learning i.e. conditioning process. The learned helplessness theory has been widely used to explain how life threatening or traumatic events predispose individuals to helplessness and distress. In relation to the present study, the learned helplessness theory reflects that cervical cancer patients can also feel helpless, especially when side effects of chemotherapy, radiotherapy and sometimes surgery become unbearable or at the recurrence of the ailment. In addition, learned helplessness among cervical cancer patients can also breed physical and psychological distress, thus increase the likelihood of further comorbidity in them.

2.3 Empirical Review

2.3.1 Mindfulness-Based Stress Reduction and Psychological Distress

Over seventy studies published on MbSR in scientific journals have proven to be effective in alleviating psychological distress related to depression (Teasdale, Segal, Williams, Ridgeway, Soulsby and Lau, 2000), anxiety (Shapiro, Schwartz and Bonner,

1998), and chronic pain (Kabat-Zinn, 1986), and it has been shown to improve mood in people suffering from different kinds of cancer (Carlson, Ursuliak, Goodey, Angen, and Speca, 2001) and to be associated with increased general wellbeing (Carmody and Baer, 2008; Reibel, Greeson, Brainard and Rosenzweig, 2001; Shapiro, Oman, Thoresen, Plante, and Flinders, 2008).

Callion, 2013 compared the effectiveness of mindfulness-based stress reduction therapy with cognitive-behavioural stress management (CBSM) among Latino and non-Latino primary health patients. Thirty five subjects were recruited from a primary healthcare centre and took part in MBSR (n=21) and CBSM (n=14) The results showed that for subject in MBSR group, there was a significant decrease in anxiety from 71.4% to 33.3% and from 78.6% to 13.3% in depression. For Subjects in the CSBM group, anxiety decreases from 78.6% to 54.5% and from 71.4% to 27.3% in depression. While both MBSR and CBSM groups displayed significant reductions in anxiety and depression of a Latino and non-Latino primary care patients, MBSR was more effective in increasing mindfulness.

Asuero and Banda, 2010 undertook a study to deepen the understanding of the mechanisms behind MBSR training by examining the role of rumination and positive and negative affective states. The study employed 29 participants with an average age of 41.10 years of whom 83% were women. The 29 participants comprised 76% health care professionals (doctors, nurses, and psychologist), and the other 24% were educational professionals seeking stress reduction. The result showed that a mean of 8.66 out of 10.79% of participants indicated that the intervention has helped them change their lifestyle in some way and adherence to the different components of the MBSR was very high given that 93% continued to practice meditation at the end of the intervention and 72% practiced yoga or stretched regularly. Between intervention and follow-up, there was also a slight decrease in the meditation practice which fell to 82% and a slight increase in yoga which rose to 75%

Furthermore, as the novel objective of the study is to find out the mechanisms by which MBSR reduces psychological distress, it was confirmed that the negative effect and rumination were influenced by MBSR while positive effect was not. In other words, it was found out that the practice of Mindfulness reduces rumination, even after

controlling the effect of affective symptoms and dysfunctional thoughts and that negative effect was significantly decreased after treatment. This was probably due to the fact that MBSR training allows one to observe their sensations and negative emotions without producing automatic reactions of rejection.

Rosenzweig, Reibel, Greeson, Brainard and Hojat, 2003 studied the effect of Mindfulness-based stress reduction on psychological distress of medical students and the result reflected that The MBSR group experienced an 18% decrease in overall psychological distress, whereas the control group experienced a 38% increase during the intervention and observation period ($p<.01$). At the end of each MBSR seminar, 133 students completed a course evaluation survey. One hundred and seventeen students (88%) rated mindfulness practice as very helpful. Ninety-four students (71%) reported being more “mindful” in day-to-day life. Eighty students (60%) rated themselves as more effective in handling stressful situations as a result of the intervention. One hundred and thirty students (98%) stated that they would recommend the MBSR course to other medical students and that they would refer patients to a similar programme.

Shapiro, Schwartz, and Bonner (1998) conducted a randomized, wait-list control trial of MBSR in a mixed group of premedical and medical students. No significant differences were found between groups’ pre-test scores. However, post intervention the MBSR group reported significantly less depression, less anxiety, greater empathy, and greater sense of spirituality compared with control. Also, MBSR has been found to be effective on pain reduction, and affect improvement among chronic patients (Kabat-Zinn, 1982), and also effective on hostility, self-esteem, and mood disturbance among inmates (Samuelson, Carmody, Kabat Zinn, and Bratt, 2007). Benefits also have been found among cancer patients in terms of increasing quality of life and decreasing stress symptoms (Carlson, Speca, Patel, and Goodey, 2003), and improving sleep quality, decreasing stress, mood disturbance and fatigue (Carlson and Garland, 2005).

Furthermore, Grossman, Niemann, Schmidt, and Walach (2004) conducted a meta-analysis about mindfulness-based stress reduction and health benefits. They revealed that mindfulness-based stress reduction improves the ability to cope with distress in everyday life. Neuroscience research on mindfulness conducted by Davidson et al. (2003) also indicated the efficacy of MBSR on stress. Many other studies also

indicated the efficacy of MBSR among university students. For instance, Rosenzweigh, Reibel, Greeson, Brainard, and Hojat (2003) conducted an experimental study with second year medical student sample (140 students for MBSR group, and 162 students for control group), and results indicated that MBSR is effective intervention to alleviate psychological distress among medical students. Similarly, Shapiro, Schwardz, and Bonner (1998) found that MBSR is effective to reduce psychological distress among medical students. 17 Oman, Shapiro, Thoresen, Plante, and Flinders (2008) conducted another study among undergraduate students, and they revealed that participants reported less stress and higher forgiveness after MBSR intervention

In another study, Masuda and Tully (2012) recruited 684 university students (76 % female) and investigated the role of mindfulness on psychological distress. Findings indicate that mindfulness significantly and negatively predict psychological distress. They also stated that females had higher level of distress than males, but in terms of participants' mindfulness scores, there were not significant differences. Age was not related to any variables.

Similar to Masuda and Tully (2012), Parto and Besharat (2011) investigated the relationship between mindfulness and psychological distress. They used The Mental Health Inventory (Veit and Ware, 1983) which consists of 14 items for psychological well-being, and 14 items for psychological distress. They found direct relationships between mindfulness and psychological distress, and mindfulness and psychological well-being among 717 men high school students. With 414 university students in Turkey, Ülev (2014) examined the relationship between mindfulness and coping styles with symptoms of depression, anxiety and stress. Findings indicated that mindfulness negatively and significantly associated with symptoms of depression, anxiety and stress, and mindfulness significantly predict symptoms of depression, anxiety and stress.

In another study in Turkey, Kaynakci (2017) investigated the relationship between mindfulness and psychological distress and attachment with 452 university students by using Mindfulness Awareness Scale and Brief Symptom Inventory. Results of the study also illustrated that mindfulness negatively associated with psychological distress. In terms of facets of mindfulness, Bowlin and Baer (2012) examined the relationships between mindfulness, self-control, and psychological functioning. 39 They

found that except observing, five facets of mindfulness significantly and negatively associated with psychological distress. Findings also indicated that age and gender were not significantly related to any variables. Bränström, Duncan, and Moskowitz (2011) investigated the relationship between mindfulness, psychological well-being, and perceived health among Swedish individuals (N = 1000). Of the participants 59% were female. Results showed that higher levels of mindfulness associated with lower levels of distress and there exists non-significant relationship between observing, perceived stress, and health. They also stated that there was not significant difference between males and females in their total scores of mindfulness, but females had significantly lower scores on acting with awareness, non-judgment, and non-reactivity to inner experience than males, and males had significantly lower scores on observing and describing than females.

Another study investigated the relationship between five facets of mindfulness and emotional problems, Pearson, Lawless, Brown and Bravo (2015) conducted a study with 941 university students (64.3% female), and they distinguished subgroups of college students based on their all facets of mindfulness scores. Results showed that individuals with low mindfulness score have more emotional problems than individuals with high mindfulness score, and except for observing, five facets of mindfulness negatively associated with symptoms of depression and anxiety.

Kaynakci (2017) further examined the relationship among self-care, mindfulness, and psychological distress in medical students by recruiting 207 students (139 female). According to canonical correlation results, they found strong relationship between psychological distress and total level of mindfulness. In terms of facets of mindfulness, observing was not significantly associated with psychological distress, describing, awareness, non-judging of inner experience, and non- 40 reactivity to inner experience were significantly and negatively associated with psychological distress. Moreover, the non-judgmental face of mindfulness was most strongly associated with lower levels of distress. There were not significant differences between males and females in their level of distress, but there was a significant gender differences in the level of awareness and non-reactivity to inner experience sub-scales of mindfulness. Males had higher score on those scales.

In a more recent study, Jacobs, Wollny, Sim, and Horsch (2016) tested the relationship between mindfulness facets, psychological distress, and multiple health behaviours and mediator role of emotional intelligence. The model tested with 427 German-speaking occupational therapists by using DASS. They found that acting with awareness, and acceptance are significantly and directly related to psychological distress, but observing and describing are not significantly and directly related to psychological distress. They also found partial mediation between acting with awareness, acceptance and psychological distress via emotional intelligence.

In another study, Duan (2016) found negative relationship between mindfulness and psychological distress among 790 participants from communities and universities, but observing sub-scale was not included while calculating total score of mindfulness in the study because of collecting data from community sample. Findings also indicate significant negative relationships between psychological distress and three facets of mindfulness (describing, acting with awareness, and non-judging of inner experience), and non-significant relationship between non-reacting and psychological distress.

Harnett, Reid, Loxton, and Lee (2016) examined the relationship between motivational systems, mindfulness and psychological distress by using hierarchical regression analysis with 452 university students (72% female). Bivariate correlation showed that observing had a positive relationship with 41 psychological distress thus, excluding observing subscale, they conducted hierarchical analysis. Findings indicated that four facets of mindfulness significantly and negatively predicted psychological distress. They also examined gender differences on five facets of mindfulness. Findings indicated that males had significantly higher level of non-reactivity to inner experience than females, and there were not any significant differences for other components of mindfulness. Study conducted about five facets of mindfulness in Turkey by Kinay (2013) examined the psychometric properties of Five Facets of Mindfulness Questionnaire among 465 university students (% 55.3 female), and in that study, the relationships between mindfulness, gender and age were also investigated. Findings revealed that there were not any significant differences of males and females scores in describing, observing, and non-reactivity to inner experience scales, but scores of females on acting with awareness were higher than males, and scores of males' on non-judging of

inner experience were significantly higher than females. Findings also revealed that there was not any significant relationship between age and five facets of mindfulness. As seen, mindfulness has been linked to psychological distress, but the reason of this association might be due to reduced emotion regulation difficulties. In that, mindfulness is evaluated as a form of emotion regulation (Corcoran et al., 2010), and one of the purpose of mindfulness is enhancing adaptive emotion regulation (Chambers et al., 2009). Moreover, from a mindfulness perspective, the important point is changing one's relationship with feelings, rather than changing feelings, so mindfulness emphasizes developing awareness and acceptance of emotions rather than changing emotional experience (Hayes and Feldman, 2004; Corcoran et al., 2010).

Furthermore, Nyklicek (2011) offered that mindfulness is not regulation of emotion explicitly such as emotion suppression and cognitive reappraisal, but it provides emotion regulation by decreasing emotion suppression and increasing cognitive reappraisal in a 42 natural way. In ERT, mindfulness is as an emotion regulation skill, and they use the terminology of "attending" and "allowance" (Mennin and Fresco, 2015). The role of mindfulness in emotion regulation is supported in studies. Hayes and Feldman (2004) stated that mindfulness practice may enhance emotion regulation abilities because of providing less over engagement (e.g., rumination) and avoidance (e.g., suppression).

Feldman, Hayes, Kumar, Greeson, and Laurenceau (2007) found that higher mindfulness scores were associated with lower levels of maladaptive emotion regulation, including experiential avoidance, thought suppression, worry, rumination, and overgeneralization among university students. Roemer et al. (2009) offered that mindfulness and emotion regulation difficulties associated with depression, anxiety, stress, and generalized anxiety disorder among urban university students. With 613 undergraduate students (70% female), and by using five facets of mindfulness questionnaire and brief symptom inventory, Baer et al. (2006) examined the relationship between mindfulness, emotion regulation difficulties and psychological distress. The results of the study illustrated that describing, act with awareness, no judging, non-reactivity significantly and negatively associated with psychological distress; however, observing was not related to psychological distress. Similarly, except for observing, five

facets of mindfulness were significantly and negatively associated with emotion regulation difficulties. Further, the link between mindfulness and emotion regulation has been supported with neurocognitive studies (e.g., Creswell, Baldwin, Eisenberger, and Libertman, 2007; Davidson et al., 2003).

2.3.2 Diversional Therapy and Psychological Distress

Lam, Chow, Cheung, Lee, Li, Ho, Flint, Yang and Yung (2017) reviewed the effectiveness of Recreational Therapy (RT) to treat depression based on five electronic databases which were employed to identify interventional studies on RT in depressed older adults. The five electronic databases include: Pubmed, PsycINFO, ProQuest, Academic Search Premier and ERIC. The five articles were screened against inclusion criteria and assessed with respect to methodological quality. Based on eighteen (18) articles reviewed, fourteen (14) studies reported improvement in depression but six (6) studies lack adequate significance in the positive effect of RT. The study concluded that RT is effective in improving geriatric depression but however encouraged future investigation to explore the mechanism between physical activity RT and depression improvement.

In an experimentally designed study, Mazza (2015) investigated the effectiveness of recreation therapy protocols in improving the quality of life of active Cancer treatment patients and individuals considered to be in remission and/or Cancer survivors. The study intended identifying the effect of dimensions of recreational therapy intervention participation (e.g. therapeutic arts, leisure education, and relaxation and stress management) on quality of life. While employing thirty (30) participants in group intervention sessions designed to promote socialization/communication, self-esteem, creativity, and fine motor coordination, the study obtained evidence that recreation therapy can provide positive therapeutic benefits when included in the cancer treatment process. Moreover, the study suggested that further studies should identify the extent to which recreation therapy can be used in the oncology process.

In a descriptive study, Toyoshima, Kaneko and Motohashi (2016) explored a wide range of leisure-time activities and associated with lower psychological distress in previous studies. The study employed a population-based questionnaire survey among

residents in a suburban area of northern Japan. After a complete enumeration, the simultaneous analyses revealed that engaging in regular outdoor leisure activity was associated with less psychological distress in both men and women if leisure-time activity was related to psychological distress separately. Furthermore, engaging in regular physical activity was associated with less psychological distress in women. However, the study found no association between volunteer work and art activities and psychological distress in either men or women. The study therefore concluded that greater engagement in outdoor leisure activity and physical activity was significantly associated with a lower likelihood of psychological distress.

Orr (2010) examined the association of recreational therapy services with changes in psychosocial functioning of people with serious mental illness (SMI). The study employed 2,051 samples comprising mainly adult (participants) with SMI who received treatment in an inpatient behavioural health centre in the south-eastern United States between 2007 and 2010. Based on the outcome of the study, no evidence was found for improvement in serious mental illness (SMI) based on effects of specific RT interventions. The study challenged health care service providers to justify the roles of recreational activities in the treatment of people with illnesses and disabilities.

Kim, Kang and Park (2020) researched on the effect of therapeutic recreation programmes for the elderly in Korea. The study gathered finding of idividuals studies related to diversional therapy or therapeutic recreation programmes for the elderly fromm 2000 to 2018, and a total number of 15 papers were selected for meta-analysis. The result of this study prove thay therapeutic recreation programmes for the elderly can be an effective way to bring along a positive change , and show that the programme period and hours per session are crucial factors in the design of therapeutic recreation for the elderly.

Lam, Chow, Cheung, Lee, Cheung, Ho, Flint and Yung (2017) systematically reviewed 18 articles. In which fourteen studies reported improvement in depression but 6 studies lack adequate significance in the positive effect of DT. Methodological quality assessment of 13 randomized controlled trials and 5 non-controlled studies indicated an overall mean of 5.67 ± 1.94 points out of 9. The result showed that there was positive findings that RT is effective in improving geriatric depression.

Do (20160, who used diversional therapy of music in managing dementia in the elderly, as well as the findings of park who use divertional and therapeutic to improve women elderelder's physical. Also, Lai, Woo, Hue and Chan 2004 who found out the effectiveness of divertional therapy in enhancing the psychological, physical and social well-being of people in community-based stroke rehabilitation center. Additionally, this study is similar to the findings of

Austin, Johnston and Morgan (2006) undertook a pilot project, to examine what effect, if any, a community gardening based DT at a senior center might have on the level of functional health, depression, and physical fitness for independent-living elders, by employing a quantitative one-group, pre-test/post-test design to evaluate each of these areas of functional health, depression and physical fitness. The sample consisted of six participants drawn from attendees at a senior center in upstate New York; all participants were ambulatory and lived in private homes or apsartments. There was a general trend toward lower, improved, scores for most Dartmouth COOP Functional Health Assessment Charts at the post-test and most notably for Social Activities ($p = .046$). In addition, mean scores for Total Emotional Score ($p = .042$) and the Geriatric Depression Scale decreased from the pre-test to the post-test indicating an improved level of function, and the Six-Minute Walk Test increased indicating a greater distance walked and improved function. It was found out that community gardens located in senior centers represent ideal opportunities for health professionals including recreational therapists to collaborate with local agencies to encourage healthy lifestyles for older adults. Recreation/Diversional therapists are particularly qualified to provide the leadership necessary to assist older adults in the development of community garden programmes.

Diversional therapy has been used successfully as an intervention to decrease children's pain and behavioural responses during painful procedures (International Association for the Study of Pain (IASP), 2011). In another study, distraction among respondents was shown to relieve pain during various procedures ranging from singing, video games, and various forms of play, television visual and auditory stimulation (Jeffrey et al., 2006; Elizabeth, 2012; Jill and Lindsey, 2007). In children, cartoon-based diversional therapy is effective in managing pain (Nora and Thomas, 2016; Nabarum et al., 2018). In another study, diversional therapy of music therapy, which is a form of

diversional therapy was used in managing pain and anxiety levels of cancer patients. The study concluded that music therapy can reduce cancer pain and anxiety when used along with standard palliative care in cancer patients with moderate to severe pain (Priyadharshini and Shoba, 2016). According to Huang et al., (2010), music therapy showed a significant reduction in pain experienced by patients when the choice of music determined by the patient (Huang et al., 2010). Comparing this study with Huang et al., 2010, patient choice of diversion for chronic pain sufferers may improve the outcome. Meditation, another form of diversional therapy showed to be effective in decreasing the severity of pain perception and disability in chronic pain patients (Farzaneh et al., 2011; Hassed, 2013).

Generally, from various studies, it can be inferred that diversion/recreation can alleviate distress by helping patients gain relief from their symptoms, but additionally can help patients to develop and to use their strengths and potentials to deal with barriers to health and to facilitate optimal functioning.

2.3.3 Health self-efficacy and Psychological Distress

Liu, Xu and Wang (2017) carried out a research on the role of self-efficacy on the association of social support with depressive and anxiety symptoms in Chinese patients with rheumatoid arthritis and found that self-efficacy was negatively associated with anxiety symptoms while it was positively associated with depressive symptoms. The authors concluded that the result may be indicated that if more self-efficacy is present, RA patients can better manage their psychological distress at a lower social support level possibly because the RA patients feel more other positive psychological resources such as optimism and resilience.

Marks, Allegrante, Lorig (2005) hypothesised that higher self-efficacy is associated with better outcomes, and that better outcomes reduce health services burden. A meta-analysis concluded that self-management support for a range of single conditions was associated with small but significant improvements in health outcomes, but only a minority of interventions reported reductions in the use of health services. Multi-morbid patients usually find self-management harder, for example, because treatments prescribed by different health care providers can lead to conflicts in care across condition. Self-

efficacy can be improved through self-management support, and improvements of the chronic disease outcomes are related to improvements in self-efficacy Furthermore, it has been shown that higher self-efficacy leads to reduced health care utilization.

Endler, Speer, Johnson, and Fleet (2001) and Lenz, Shortrige, Bagget and Lillie (2002) found negative relationship of general self-efficacy with depression and anxiety. They found that positive self-efficacy beliefs have an effective role in the treatment of mental diseases. Sing, Shukla and Sing (2010) found that perceived self-efficacy emerged as an important predictor of mental health among elderly males and females i.e. elderly who perceive themselves self-efficacious to have control over their environment reported better mental health and vice versa. Jonathan (2010) found that general self-efficacy moderates the negative effect of manifestation of stress as shown by indices of psychological distress on psychological, emotional and social well-being. Researchers have found out that cancer patients with high self-efficacy expectations are better able to manage their personal functioning, harness the resources and influence the effect of a supporting treatment

According to Catz, Kelly, Bogart, Benotsch andse McAuliffe (2000), Psychosocial factors, and adherence to medication is related to lack of social support and lack of self-efficacy beliefs about one's ability to adhere to medication. Also, Molassiotis et al., (2002) have found that adherence to anti retro-viral medication in patients with HIV was strongly related to self-efficacy (that is, optimistic self -beliefs about the ability to follow the medication regimen). These self-beliefs, together with anxiety and nausea, were related to adherence to the recommended treatment. The relationship between social support and medication adherence was weaker than the relationship between self-efficacy and medication adherence. Low self-efficacy, together with low outcome expectancy regarding the benefit following the treatment regimen, have also been found to be related to low medication adherence in HIV symptomatic women or women with AIDS (Murphy, Green well, and Hoffman, 2002).

Cheung and Sun 2000 investigated the effects of self efficacy and social support on the mental health conditions of 65 participants of a mutual aid organization. The findings provide clear support that self efficacy is the critical mediator of mental health. By adopting a longitudinal design, robust evidence is gathered that changes in self

efficacy at an earlier time contribute to the variation of mental health months later.those participants whose self efficacy has been enhanced reported an improved mental health while those who self efficacy expectation has declined experienced deteriorated mental health condition. This study further expatiated that social support contributes to positive mental health, but its effect are mostly mediated by self-efficacy

2.3.4 Perceived social support and Psychological distress

Liu, Xu and Wang (2017) carried out a research on role of self-efficacy on the association of social support with depressive and anxiety symptoms in Chinese patients with rheumatoid arthritis (RA) and found that social support was negatively associated with anxiety and depressive symptoms. The authors concluded that compared with RA patients who possessed adequate social support, those who could not seek help from their social networks suffered from more severe symptoms of psychological distress.

The Canadian Institute of Health Information (2012) undertook several studies investigating the role of social support in reducing psychological distress. One of these studies is a longitudinal study based on the adult population of age 18 or older who reported high distress at the start of every circle and had a distress score at follow-up two years later. For the sake of the study a score of 9 out of 24 was considered high for the analysis and respondent who initially had a score of 9 or greater and who reported a score below this level later were considered to have transitioned out of psychological distress. Three types of support were analyzed and they are: positive interaction, affectionate support and emotional support. The results showed that emotional support or positive social interaction opportunities was associated with experiencing improvements in distress levels after adjusting for age, income, employment and health behaviours, while affection-related social support was not a significant factor in transitions out of psychological distress.

Furthermore, there was no significant difference in reporting improvements in distress for married populations compared with single and formerly married people. While married women and men had no significant difference in the chances of experiencing improvements in distress, the factors associated with improvements did differ by sex; however, when analyzed by sex, marital status became significant. It was

reported that men who were married or in a common-law relationship had nearly two times the odds of reporting improvements in distress compared with formerly married male after controlling other factors. However, among women, improvements in distress were less likely for those who were married, compared with women who were widowed, separated or divorced, after adjusting for types of functional social support and other factors. In other words, being married or in a common-law relationship was a buffer for experiencing improvements in distress for men, but not for women. Data suggest an association between social support and psychological well-being. For instance, individuals with greater social support are less likely to suffer from various psychological distress or exhibit neurotic symptoms (Procidano and Heller 2013), depressive (Hays, Turner, and Coates, 1992), or anxious (Sherbourne and Hays, 1990) symptoms.

Sumdaengrit, Jengprasert and Sriintravanit, 2018 carried out a descriptive correlational research on Fifty-three women diagnosed with cervical cancer and were followed up throughout the treatments and after treatment. The purposes of the study was to describe quality of life and social support and look at the correlation of certain factors and quality of life in women with cervical cancer after treatment, the results reported reflect that there was no correlation between age and social support with the quality of life. However, there was negative correlation between symptom distress and quality of life with r=--40 at p=0.003. This study disclosed that social support for this women's group could not help to improve their quality of life. Their symptom distress seems to have a direct effect on their QOL. Thus, the healthcare team needs to alleviate patients' distress in order to improve the quality of life in cervical cancer survivors.

Furthermore, data suggest an association between social support and psychological wellbeing in the educational psychology literature. For instance, the study completed by Dzulkifli (2011) showed how psychological problems i.e. depression, anxiety and stress can be influenced by social support. 120 undergraduate university students were involved in the study. And the findings of the study indicated that there exist significant negative correlations between social support and depression, social support and anxiety, and social support and stress.

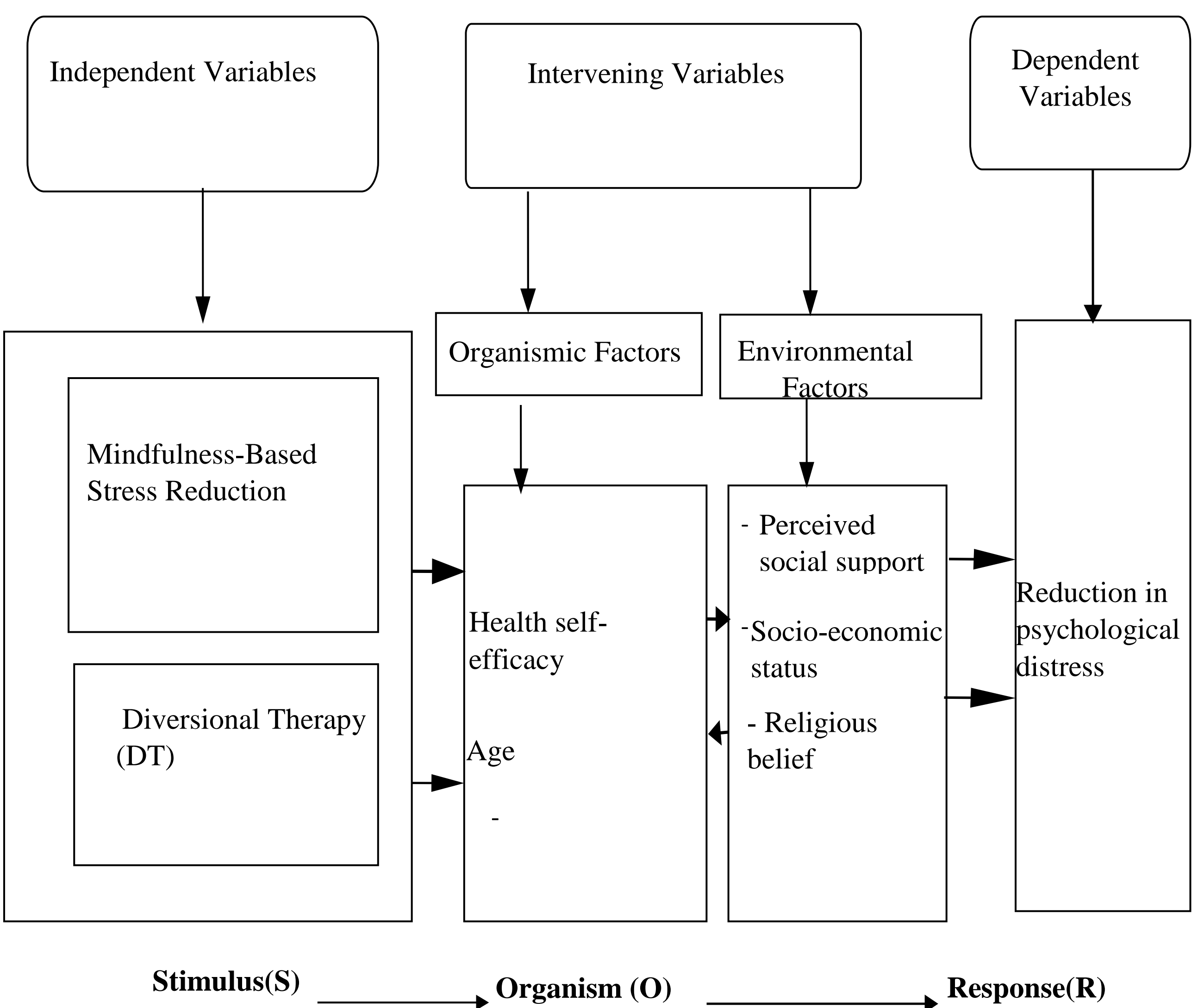

Fig 2.1 Conceptual Model for the Study.
Source: The Researcher, 2021

2.3.6 Explanation of the Conceptual Model

The conceptual model of this study is composed of the independent variables or the treatment packages namely; Mindfulness-Bases Stress Reduction (MBSR) and diversional therapies (DT). These variables will be manipulated by the researcher to observe their effect on the dependent variable (Psychological Distress). The intervening, mediating or moderating variables consist of organismic and environmental factors. These variables intervene between independent and dependent variable and when manipulated will be expected to produce measurable effects on the dependent variable which is reducing psychological distress. Though several intervening variables are capable of influencing the effectiveness of the interventions in reducing psychological distress, in this study, the moderating variables of interest are social support and self-efficacy. This is because literature has shown that these variables have significant influence on psychological distress of cervical cancer patients

CHAPTER THREE

METHODOLOGY

This chapter focuses on the explanation of how the study will be carried out. This includes the description of the research design, the study population, the sample and sampling techniques, instrumentation, procedure for data collection, summary of activities in the experimental groups and the method of data analysis.

3.1 Research Design

The study adopted a mixed methods design, using a pre-test-post-test, control group, quasi-experimental design with a 3x2x3 factorial matrix and a focused group discussion to enhance the quality of the information gathered. In essence, the rows consist of the two interventions; Mindfulness-Based Stress Reduction and Diversional Therapy and the control group. The row was crossed with the moderating variables; self-efficacy varied at two levels (High and Low) and social support varied at three levels (high, moderate and low). This is represented in table 3.1 below

Table 3.1: A 3x2x3 Factorial matrixes on psychological distress among cervical cancer patients

Treatment	Self-efficacy						
	High (B1)			Low(B2)			
	Social support						
	High S.S (C_1)	Moderate S.S (C_2)	Low SS (C_3)	High S.S (C_1)	Moderate S.S (C_2)	Low S.S (C_3)	Total
MBSR (A_1)	1	6	0	7	8	2	24
DT(A_2)	1	4	2	7	6	1	21
CG(A_3)	1	1	2	2	7	3	16
Total	**3**	**11**	**4**	**16**	**21**	**6**	

Key: MBSR = Mindfulness-based Stress Reduction, DT = Diversional Therapy, SS = Social Support, CG= Control Group

A_1= MBSR

A_2=DT

A_3=CG

B_1=High Health Self Efficacy

B_2=Low Health Self -Efficacy

C_1= High Social Support

C_2=Moderate Social Support

C_3=low social support

This design is schematically represented as

O_1 XA_1 O_2

0_3 XA_2 O_4

0_5 . O_6

Where O_1, O_3 and O_5 are pre-tests for the three groups

O_2, O_4 and O_6 are post-tests for the three groups

XA_1 = Experimental treatment of Mindfulness-Based Stress Reduction

XA_2 = Experimental treatment of Diversional Therapy

= No treatment was given to the Control Group

3.2 Population

The population for the study comprised all women diagnosed with cervical cancer and receiving treatment in Lagos and Ibadan cancer centres. There are three teaching hospitals with standard equipments and certified personnel to undertake the task in Lagos and Ibadan; Lagos University Teaching Hospital (LUTH), Lagos State University Teaching Hospital (LASUTH) and University College Hospital (UCH), Ibadan. Focus group discussion was also carried out at Grace Hospital, Ashi-bodija, Ibadan.

3.3 Sample and Sampling Technique

The sample comprised diagnosed cervical cancer patients who have already commenced treatments in Lagos and Ibadan cancer centres. Two-stage sampling technique was used in selecting 61 participants for this study. The first stage involved a purposive sampling technique in selecting three teaching hospitals from the two cities (Lagos and Ibadan); University College Hospital (UCH) Ibadan, Lagos University Teaching Hospital (LUTH) and Lagos State University Teaching hospital (LASUTH). The justification for selecting these hospitals is based on the quality and quantity of personnel and facility needed for cervical cancer treatment. On the other hand, these hospitals are considered as cancers registries in Lagos and Ibadan Nigeria (Nigerian National System of Cancer Registries (NSCR), 2018).

After confirming the psychological distress status of the participants through the screening procedure, a simple random sampling technique was used in selecting sixty-one (61) participants from three teaching hospitals: that is 24, 21 and 16 participants were selected from Lagos University Teaching Hospital (LUTH), Unversity of Ibadan Teaching Hospital (UCH), and Lagos State University Teaching Hospital (LASUTH) respectively. The sample size was calculated using the formula designed for comparing two proportions: $n=2\ (Za + Z\ [1-\beta\ ])^{2}\ _{X\ P\ xq/d}{}^{2})$, n=24 participants each at the selected teaching hospitals. To reduce the 29 participants got at LUTH to 24, Fish-bowl method was used (with 26 balls indicating “yes” and 3 balls indicating “no”). The Cancer centres were randomly assigned to MbSR (24; 2 of the participants fell out of the training), DT (21) and CG (16). Nine participants were also interviewed during focus group discussion

The sample size was determined using the formula for comparing two proportions:

$n=2\,(Za+Z\,[1-□])^{2} \times P \times q/d^{2}$ □ (Brasher and Brant, 2007)

P1 = 60% (The prevalence of Psychological distress among cervical cancer patients. Figure was gotten from pilot study)

P2 =20% (the reduction in the incidence of psychological distress up to 20% will be considered significant for the effectiveness of the therapy

P=It is the average of P1 and P2 i.e 60% + 20%/2= 40

Effect Size (d) i.e. P1 – P2 =40%

Za =1.96, Z (1-β) =0.842 i.e. conventional values for □ and □

$n=2(Za+Z\,[1-□])^{2} \times P \times q/d^{2}$

$n= 2(1.96 + 0.842)^{2}\text{-}\times 40 \times 60/40^{2}$

$=2(2.802)^{2} \times 40 \times 60/40^{2}$

$= 2(7.851204) \times 40 \times 60/40^{2}$

$=15.7024 \times 40 \times 60/40^{2}$

=15.7024 x40 x60/1600

=37,685/1600

=23.55

n=24

3.4 Instrumentation

The following standardized instruments were used for data collection in this study:

i. Distress Thermometer
ii. Kessler Psychological Distress Scale
iii. Health Self-efficacy Scale
iv. Social Support Scale.

These instruments were also translated in to Yoruba by a Yoruba language expert for easy understanding of the participants who have little or no knowledge of English Language.

3.4.1 Distress Thermometer (DT)

Distress Thermometer is a pencil and paper-based measure with two parts, the first part is a single item tool using a 0 (no distress) to 10 (extreme distress) point likert scale resembling a thermometer and was developed by Roth 1998 to screen prostate cancer patients with psychological distress. Patients will indicate their level of distress with a mark on the scale, the established cut off mark is 4. The second part of distress thermometer includes a problem checklist added by NCCN. This contains 39 items from five different problem dimensions namely; practical, family, emotional, spiritual and physical problems. Patients who mark 4 and above will identify those problems contributing to their score on the problem checklist. The scale is considered reliable for use in the present study as test-retest reliability value of .72 was recorded. Meanwhile, it was evaluated by the original author through interviews with patients and professionals. To justify the suitability of the test, a pilot study was conducted using thirty (30) cervical cancer patients in Grace Hospital, Bodija-Ashi, Ibadan. The internal consistency of the scale was tested through Cronbach Alpha (α =0.75), while the temporal stability of the test was established through test-retest (r= 0.731). This scale was adapted to screen the participants.

3.4.2 Kessler Psychological Distress Scale (K10)

Kessler Psychological Distress Scale developed by Kessler (1992) for mental health screening in population survey. The scale consists of 10 items about the level of

anxiety and depressive symptoms a person may have experienced in the past few weeks, and it will be adapted to measure the level of psychological distress of cervical cancer patients at the pre-test and post-test stages. The items are built on a 5-point Likert scale which are: 5 = All of the time; 4 = Most of the time; 3 = Some of the time; 2= A little of the time and 1= None of the time. The possible range of score is 10-50 with higher score indicating more psychological distress. The scale uses the question stem "During the last 30 days, about how often did…." With sentence completers such as "…you feel depressed" and "…you feel tired for no good reason" The possible range of score is 10-50 with higher scores indicating more distress. According to the author, an analysis of reliability indicates that the scale has a high internal consistency (a = .88). To justify the suitability of the test, a pilot study was conducted using thirty (30) cervical cancer patients in Ibadan. The internal consistency of the scale was tested through Cronbach Alpha (α =0.81), while the temporal stability of the test was established through test-retest (r= 0.76). The scale was administered at the pre-test and post-test stages

3.4.3 Health Self-Efficacy Scale (HSS)

This scale was developed by Lee, Hwang, Hawkins and Pingree in 2008. The scale consists of (5) items and it will be adapted to measure health self-efficacy of cervical cancer patients. The items are built on a 5-point likert scale which are 1=strongly Disagree; 2=Disagree; 3=Undecided; 4=Agree; and 5= Strongly Agree, so the participants are to indicate their level of agreement to each statement in the scale. Sample items on the scale are "*I am actively working to improve my health, I have set some definite goals to improve my health"* The items in the scale represent a wide range of contexts in which perceived self-efficacy has been measured reliably. And they can be adapted to health contexts under study. In a pilot testing conducted to determine the suitability of the scale for the present study, the scale was found to have high internal consistence (a =.97) which makes it suitable for use in the study. However, the cronbach alpha coefficient recorded by the original authors was (α = .84). To justify the suitability of the test, a pilot study was conducted using thirty (30) cervical cancer patients in Ibadan. The internal consistency of the scale was tested through Cronbach Alpha (α

=0.89), while the temporal stability of the test was established through test-retest (r= 0.791). The Health Self Efficacy Scale was administered at the pre-test stage

3.4.4 Social Support Scale (SSS)

The social support scale was developed by Zimet, Dahlem, and Farley (1998). The scale consists of twelve (12) items and will be adapted to measure the perceived social support from three sources: family, friends and a significant other of the cervical cancer patients at the pre-test stage. The items are built on a 5-point Likert scale which are: 1 = Strongly Disagree; 2= Disagree; 3 = Neutral; 4 Agree; and 5= Strongly Agree. Items 1, 2, 5,10, 11and 13 are on significant other; items 3, 4 and 8 are on family, while 6, 7, 9, and 12 are on friends. According to the authors, an analysis of reliability indicates that the scale has a high internal consistency (a = .85). Sample items on the scale include: *"there is a special person who is around when am in need", "I get the emotional help and support I need from my family" and "my friends really try to help me believe I am worthwhile"* The items will be coded and scored so that higher scores will show high social support and vice-versa. To justify the suitability of the test, a pilot study was conducted using thirty (30) cervical cancer patients in Ibadan. The internal consistency of the scale was tested through Cronbach Alpha (α =0.89), while the temporal stability of the test was established through test-retest (r= 0.82). The Social Support Scale was administered at the pretest stage

3.6 Inclusion Criteria

The following criteria were used in selecting participants for the study:

i. Patients must have been diagnosed of cervical cancer and receiving treatment from selected teaching hospital in this study.
ii. Patients with high level of psychological distress, that is the patients that mark 4 and above on the Distress Thermometer.
iii. Patients must be committed to participate in the treatment programme voluntarily by signing the consent form and committing to being part of the training

3.7 Procedure for Data Collection

The researcher obtained an introduction letter from the Head of the Department of Counselling and Human Development Studies, University of Ibadan, Ibadan. Ethical approval was sought to carry out the study from the ethical committees of the selected teaching hospitals; Lagos University Teaching Hospital, University College Hospital, Ibadan and Lagos State University with ethics committee approval numbers: ADM/DCST/HREC/APP/4454, UI/EC/21/0113 and LREC/06/10/1673 respectively. The researcher then visited selected teaching hospitals prior to the commencement of the training to enable the researcher gets acquainted with the participants and the hospital environment. The participants were informed adequately of the research purpose as well as the benefits of the research

The study was carried out in four phases: pre-sessional activities, pre-test, treatment, and post-test. At the pre-session, activities involved were screening, recruitment and assignment of participants randomly into the two experimental and control groups. Advertisement was made to request for participants in selected hospitals. A preliminary meeting was organized to familiarize with the interested participants and to solicit their willingness to participate in the study. The researcher recruited and trained two master's degree students with a background in Counselling and Human Development Studies as research assistants for the study. At the pre-test stage, Psychological distress questionnaire, health self-efficacy questionnaire and social support questionnaires were administered to the participants. Only the participants in the two experimental groups were exposed to the sessions of treatment (Mindfulness-Based Stress Reduction and Diversional Therapy). Each session lasted an average of 60 minutes equivalent to one hour (1 hour) for eight weeks. Though the control group was not treated, participants were exposed to a lecture titled "Drugs Abuse and Addiction". The post-test instrument was administered following the conclusion of the intervention. The treatment modules were translated into the local Yoruba language for effective communication and to cater for participants who did not understand English language. Focus group discussion was also carried out to elicit responses from the cervical cancer patients for further understanding of the causes, feelings, consequences and impacts of psychological distress and cervical cancer disease.

For ethical consideration, no names were used in this study, codes and serial numbers were giving ti the participants during data collection to ensure confidentiality of information. All information collected in this study, publications or reports from this study cannot be linked to them in anyway.

The therapy did not pose any risk or danger to participants; it only took their time for participating in the study while they were able to learn new skills in coping with their psychological distress. The participants were also free to withdraw their participation in the study at any time they wished to withdraw

3.8 EXPERIMENTAL GROUP 1: MINDFULNESS-BASED STRESS REDUCTION

Process of Therapy

- Interacting and engaging the Individuals
- Assessment of problem, person and factors causing psychological distress
- Preparing Individuals for therapy
- Implementing treatment package
- Monitoring/ Evaluation of progress made so far during each sessions
- Preparing the Individuals for termination of sessions

Screening

The CCPs along with other CCPs were screened using Distress Thermometer. While the CCPs who demonstrated high level of psychological distress were retained for the therapeutic process, other CCPs were discarded.

Treatment Goal

The overall goal of the intervention is to utilise MbSR techniques in the reduction of psychological distress level of the CCPs

- **First session: Overview and Implementation of Tool for Obtaining Initial Assessment Scores**

Objectives: CCPs the experimenter was able to

i. build a sound therapeutic relationship with the CCPs
ii. give the CCPs orientation about the structure and process of the study

iii. administer Kessler Psychological distress questionnaire, SSS and HSe scales for the purpose of having baseline information.

Activities

Step 1: The experimenter welcomed the CCPs and familiarised herself with them.

Step 2: The experimenter established rapport between herself and the CCPs by creating an alocation for experimenter/CCPs introduction. The experimenter also ensured that every participant fill an informed consent form to document their consent to participate in the study.

Step 3: The experimenter provided an overview of the programmeme; she explained the purpose of the programmeme/research and the benefits derivable by the end of the programmeme. The CCPs were assured of confidentiality during and after the programmeme

Step 4: The experimenter conducted preliminary assessment with the CCPs

Step 5: Assignment: Give four factors that are instrumental to your psychological distress

Conclusion

- The experimenter persuaded the CCPs to attend the next session and reminded them of the day, time and location.

- **The concept of Psychological distress and cervical cancer were introduced in the second session**

Objectives: the CCPs were able to:

i. define cervical cancer

ii. relate and explain the meaning of psychological distress

Activities:

Step 1: The CCPs were warmly welcomed to the session.

Step 2: The experimenter re-examined the assignments with the CCPs

Step 3: The experimenter provided an explanation regarding cervical cancer.

Cervical disease is the malignant growth of the cervix; the cervix is the part beneath the uterus that joined the body of the uterus to the vagina, or birth canal. Cervical cancer is usually brought about by constant infection with high-risk Human Papilloma Infection (HPV); Human papilloma infections (HPV) are little non enveloped infection

containing twofold DNA as their genetic material and are around 55 nm in size. HPV is for the most part communicated through sexual contact. Other reasons for cervical cancer are tobacco smoking, high equality, prolonged hormonal prophylactic use, various sex partners co-infection with Human Immunodeficiency Virus.

Step 4: The experimenter explained the meaning of psychological distress

Psychological distress is a general term used for unpleasant sensations of emotion that influence one's degree of functioning and impedes his/her everyday exercises. More extensive descriptors for psychological distress incorporate emotional distress, strain, perplexity, burdensome state, concern, and interruption. Similarly, psychological distress is marked by affective, cognitive, and behavioural responses to potentially dangerous, crisis-precipitating situations that are also accompanied by symptoms of despair and anxiety. Most heavily emphasized is the notion that distress can range from common emotions like vulnerability, grief, and fear to debilitating illnesses like depressive symptoms, feelings of anxiety, occurrences of panic attacks, experiences of social isolation, and encounters with existential and spiritual challenges. . Depression and anxiety were found to be the most noticeable symptoms of psychological distress and were present in varying degrees in the majority of women who underwent cervical cancer tests due to the following reasons:

i. Shock of the sudden news
ii. Financial constraint
iii. Rigorous treatment
iv. Side effects of treatment
v. Comorbidities
vi. Lack of Social Support
vii. Stigma

Evaluation: The CCPs were asked the following questions:

i. explain cervical cancer
ii. list the symptoms of psychological distress

Assignment

What measures do you put in place to manage your psychological distress?

Connclusion

- The CCPs were persuaded to carry out the task assigned to them.

❖ **The third session introduced MbSR**

Objectives: The CCPs were able to:

- Explain Mindfulness
- Discuss three of the seven attitudes of mindfulness:
- Non judging, patience and beginner's mind
- Practice eating exercise or meditation independently or through an audio guide
- Practice body scan independently or through an audio guide

Step 1: The experimenter gave the CCPs a warm welcome joyfully.

Step 2: The experimenter went over the lesson of the previous session with the CCPs and reviewed their homework

Step 3: The experimenter explained what mindfulness is

Mindfulness is a practice that emphasizes being in the moment without passing judgment on it. When someone adopts a mindful state, they are able to watch sensations, feelings, and thoughts as events of the mind without giving them the meaning and interpretations that arise from our minds and without automatically responding to them. It is believed that the art of viewing and paying attention to thoughts as happenings without passing judgment allows for "space" between perception and reaction. We are able to behave with intention rather than just reacting out of habit in this conscious space.

The idea of mindfulness has been developed as a continuity ranging from higher levels of clarity to lower levels of automatic, mindless functioning. Therefore, everyone possesses the innate ability to be mindful; nevertheless, people vary in how frequently they sustain a conscious state of being. The perplexing feelings that arise, such as fear, wrath, disappointment, insecurity and unworthiness, should be seen, accepted, and even welcomed as part of a mindfulness practice. This is carried out in order to acknowledge current reality as it is, regardless of how pleasant or painful it may be, and as the first step toward changing it and one's relationship to it. Any time of the day, when eating, walking, driving, or sitting, one can practice mindfulness. This deliberate process of recalling and focusing on the present moment and basic daily tasks improves formal meditation practice.

Step 4: The experimenter discussed attitudinal mindfulness: Non-judgment, tolerance, and a fledgling's point of view

Non-judging: Compassionate, unrestricted, and open-hearted awareness is mindfulness. It can be developed by impartially observing one's own experience as it develops in the present. Ordering and assessing encounters is just a propensity, however it keeps you trapped in programmemed, receptive idea, feeling, and ways of behaving that compound issues instead of solving them. Many times we are not even conscious of these habits. Passing judgment keeps us from straightforwardly encountering how our lives are working out in every second. Perceiving the making a decision about nature of psyche and perceiving judgemental thinking as it seems are essential parts of mindfulness practice. Also vital is not passing judgment on the judgment! Essentially observe its presence. The objective is to merely notice, not to banish judgmental ideas. One can develop new relationships with judgment by becoming aware of its presence and by choosing a response as opposed to reacting automatically.

Patience is the ability to deal with misfortune with composure and restraint. It calls for boldness, confidence, and an association with one's internal identity. It likewise calls for self-benevolence and empathy while one deals with the stress of a situation. Impatience much of the time results from the ego, the conceited self, railing against reality and desiring things to be otherwise. The intelligent self, on the other hand, understands the reality that things have their own life cycles, independent of what one wishes. One's patience increases as one learns and accepts this truth. In order to develop patience, one must become aware of impatience and the temptation to rush from one thing to another.

Beginner's mind: As one learns to watch the present experiences, the wandering mind has a tendency to imagine it already understands all that is taking place or to attempt to "manage" the situation by frantically looking for more knowledge. The process of thinking creates an obstruction between a person and their subjective experience of reality; the whole richness of life is found in how life unfolds moment by moment. To cultivate a beginner's mindset, one must be receptive to each moment's experience as if they were meeting it for the first time. Recall and visualize your childhood experiences, such as your first taste of an orange, first raindrop, or first flower scent. Each moment of

life is truly unique. Even if sunsets have been seen a thousand times, this one is unique and will never be repeated. The ultimate goal of practicing mindfulness is to develop the quality of direct experience, which involves viewing everything emerges as a singular and priceless encounter. A beginner's mind practice helps us develop this capacity for experiencing life in this way.

Step 5: the experimenter introduced guided fruits eating exercise/meditation

You can get ready for this exercise by selecting a special food to go along with it; many people opt for a piece of chocolate or a raisin. Any delicious dish is yours to choose from. If it's a date, focus on it by taking the food and holding it between your thumb and pointer finger. like it's a brand-new thing. Watch it intently and completely. Allow your eyes to explore every inch of it, taking note of the surfaces, colors, and shapes. Look closely at its grooves, where the light reflects and casts shadows like you've never seen one before. Hold the raisin under your nose and breathe in and out normally. Take note of any new smells or aromas. Bring the raisin to your lips carefully, hold it there for about 10 seconds, and then begin chewing quietly. Be conscious of any effects in your mouth or stomach at this point. Spend some time chewing without swallowing while observing how your mouth's flavor and texture may alter over time. Bring consciousness to the sensation as you are about to swallow the raisin so that you can do it consciously. After finishing this exercise, take note of how your body feels and what is left of the raisin as it passes through your stomach and is swallowed.

Spend some time talking about your thoughts on the following inquiries:

i. Did this experience like how you usually eat, or was it different?
ii. If anything, what about the experience shocked you?
iii. In terms of taste, smell, touch, sound, and sight, what did the raisin or whatever food you selected make you notice?
iv. What ideas or memories came to mind while performing this exercise?
v. What is one piece of advice you will give yourself to use in the future to improve your eating habits in light of this experience?

There is no need to go overboard when eating slowly. Still, it is a good idea to keep in mind that eating is not a competition for you and your family. One of the healthiest things you can do is to take the time to appreciate and enjoy your cuisine. You

will likely chew your meal more thoroughly and, as a result, digest it more quickly. You will also be more likely to recognize flavors you would have otherwise missed. Many people decide to eat one meal slowly and deliberately while using a special plate or dish.

Step 6: The experimenter specifically requested comments and promoted debate about the date-eating exercise.

Step 7: The experimenter explained and gave instructions to the CCPs on how to carry out helpful body scan

A body scan involves mentally moving through the body in a methodical manner, paying affectionate, open-hearted, and interested attention to each of its various regions. It usually begins with the left foot's toes and moves up the left leg, stopping at each of the following: ankle, shin, calf, knee, and kneecap, as well as the entire thigh, both above and below the surface, groin, and left hip. The whole pelvic region, including the hips again, the bottom and genitalia, the lower back, the mid-region, and afterward the upper middle, including the upper back, the chest and the ribs, the bosoms, the heart and lungs, and extraordinary vessels housed inside the rib confine, as well as the shoulder bones drifting on the rib confine toward the back, up to the collarbones and shoulders, come into focus from that point. From the shoulders, we go to the arms, regularly doing them mutually, starting with the tips of the fingers and thumbs and working our direction down through the wrists, lower arms, elbows, upper arms, and armpits prior to getting back to the shoulders.

The neck and throat are straightaway, trailed by the face and head. At the point when we play out the body check, we purposely and purposefully get our concentration across the body as we focus on the differed sensations in the different parts. It's very astonishing that we could focus on these actual sensations. More significant still is the way that we can do it at whatever point we pick, whether rashly or in a more organized, deliberate way. One can put hisr psyches wherever in the body he wishes and believe and know about anything that sensations are available around then without jerking a muscle. Experientially, we could express that during a body scan; we are tuning in or opening to those sensations and permitting ourselves to become mindful of what is now occurring. Quite a bit of what is as of now occurring, I mean here, is something that we commonly

block out in light of the fact that it is so self-evident, so regular, thus recognizable that we scarcely even realize it is working out.

All the while, we could likewise guarantee that all through the majority of our life, we barely even acknowledge we are here, feeling the body, in the body, and of the body. As a matter of fact, the words neglect to encapsulate the occasion. As we have proactively shown, language constrains us to talk about a particular "I" who "has" a body when we examine it. We put on a show of being irredeemably dualistic eventually. We have recently depicted this just like the degree of regular reality, the family member, the degree of appearances, yet there is as yet areas of strength for a that there is a different I who "has" a body. The body and its senses (the object) exist in the realm of relative reality, as does the person who perceives the sensations (subject). They seem distinct and separate.

Even for those who adore it, not everyone finds the body scan to be their preferred form of meditation. But regardless of your situation or health, it is quite beneficial to know about and practice occasionally. The body scan can be considered tuning your body, in the event that you consider it an instrument. The body scan is a way to get to know it, to consider it a universe.

Step 8: The experimenter received responses and encourages guided body scan discussion

Step 9: The experimenter commended participants and allows them to ask questions about the day's work

Evaluation: The CCPs answerd the questions below

i Discuss the concept of mindfulness

ii Discuss non-judging, patience and beginner's mind as essential attitudes to mindfulness

Closing Remarks: When the session was finished for the day, the experimenter thanked the participants, gave them homework, set the time for the next meeting, and adjourned.

Homework:

I. Practice mindful breathing for 6 days for 10 to 15 minutes.

ii. Engage in daily body practice for 15 minutes.

iii. Pick a new daily habit to pay close attention to (e.g. washing, brushing etc.).

Session 4

Topic: This session continues with MbSR: Mindful attitudes: Trust and non-striving; Mindful yoga and sitting meditation, mindful sharing, guided walking meditation and 15 minutes breathing space.

Expectation: The CCPs were able to do the following at the end of the session:

- Discuss trust and not striving as an essential attitude to mindfulness
- Practice mindful yoga
- Practice 15 minutes sitting meditation at a stretch
- Engage in mindful sharing
- Engage in guided walking meditation
- Practice 15 minutes breathing space

Step 1: The experimenter gave the participants a warm welcome joyfully

Step 2: The experimenter went over the works of the last session with the participants and receives feedback from their homework

Step 3: Discuss trust and not striving as an essential attitude to mindfulness

Trust: Trusting oneself and feelings make it easy to understand what is actually going on right now. One's awareness of sensitivity to and ability to distinguish circumstances as they unfold inside their bodies and all around them improves when they practice mindfulness. As a result, one can learn to trust his or her own wisdom and authority rather than relying on a third party to provide what they believe the other person needs. An individual can learn what it truly means to be his own through this process.

Non-striving: Humans waste time "doing" and striving to make changes to the world. In meditation, this "habit" regularly manifests. The real self move away from pains wants less of what it dislikes and more of what it enjoys. This endeavor is perceived as a struggle or strain to be unique or do something different. Since practicing mindfulness merely means paying attention to whatever is going on without passing judgment. It differs from this more common activity of doing since it focuses on "non-doing," or learning to "be" rather than to do. One should merely observe this without passing judgment on themselves as they feel trying to turn things around while engaging in or living mindfulness. True relaxation into one's experience entails letting whatever is occurring unfold while maintaining a clear, compassionate awareness of it. The paradox

of meditation is that it's preferable to let go of striving and pay close attention to accepting things as they are, moment by minute, rather than trying to change them.

Step 4: The experimenter introduced mindful yoga

Yoga doesn't require any specialized equipment and can be practiced practically anyplace. Many of us find exercise to be uncomfortable or taxing, or it demands us to work out with others or in a certain location. The poses in hatha yoga are performed attentively and while paying attention to your breathing. If routinely used, they offer remarkable results and are simple to master. The ones we are performing are really delicate. Your musculoskeletal system's flexibility, strength, and balance will improve with regular practice, and it will also make it easier for you to achieve profound levels of relaxation and awareness. Many people report slimmer body, and fewer illnesses as well as a higher sense of peace about life in general due to frequent practice of yoga.

Yoga practitioners suggest keeping moment-to-moment awareness, not pushing themselves to achieve anything, just accepting themselves as they are, and letting go of any self-judgment. This is similar to how one should meditate. Experimenting with breathing while you stay at your stretching limit. This necessitates respecting body signs and the signals postures that are beyond one’s capability.

The experimenter included a 15-minute seated meditation in step 5.

Everyone has experience sitting; yet, the only distinction between ordinary sitting and mindful sitting, just as there is no distinction between ordinary and mindful breathing, is awareness. We set aside a specific time and location to practice sitting. We typically practice sitting meditation on a chair or the floor while being consciously aware. In the practice of meditation, posture is crucial. It can serve as an external aid in developing an interior attitude of respect, tolerance, and self-acceptance. The three essential things to remember when it comes to posture are to relax your shoulders, maintain your back, neck, and head vertical, and use your hands to support yourself comfortably. Typically, we lay them on our knees or on our. We focus on our breathing after we have taken up the posture we have chosen. We can sense it coming in and leaving. We live in the present, each instant and each breath. It is as easy as it sounds; full awareness of both the inhalation and exhalation.

Body scan involves observing the breath as it occurs and taking in all the subtle and gross feelings that go along with it. If you are genuinely interested in being more calm and at ease, you may be curious as to why your mind is so easily bored when left alone. You could question what motivates filling every moment with something, and to be delighted anytime you have a "empty" moment. Why do the body and mind resist remaining motionless? We don't attempt to provide answers when we meditate. Instead, we simply notice the want to stand up or the thoughts that enter our minds. We softly keep focusing on the breath, rather than leaping up and doing whatever the mind determines is next on the agenda. We may wonder why the mind is like this for a brief period of time. You are teaching your mind to be more stable and less impulsive by doing this. You are maximizing every second. You are living in the now and not prioritizing one moment above another. You are developing your innate capacity for mental focus in this way.

Similar to how muscles get stronger by continuously lifting weights, concentration grows and deepens by focusing on the breath each time it wanders. The resistance of your own mind can be overcome by consistently working with it (rather than fighting it). You are practicing being non-judgmental and building patience at the same time. Because your attention wandered from the breath, you are not being severe on yourself. You forcefully yet gently restore it to the breath in an unassuming manner. To calm your mind during meditation, do not push thoughts away or isolate yourself from them. We're not attempting to stop our ideas from racing around in our heads. The breath is our basis for observation and serves as a constant reminder to remain calm and focused. We are just making space for them, seeing them as ideas, and letting them be.

Step 6: The experimenter introduced mindful sharing

A different type of interactive social talking or sharing that one undertakes in a group is mindful sharing. You could initially feel uneasy. As you speak, be mindful of your body and thoughts. During this period of practice, you have the chance to be mindful of your own body, thoughts, and emotions at any given time. You speak concisely, honestly, and from personal experience. Stay on topic instead of recounting stories; mindful sharing is not group therapy. We share in order to deepen our understanding of the dharma. Everyone's practice is different, therefore your comments

on your experiences are personal and particular to you. All perspectives are welcome in mindful sharing. Speaking with awareness makes it possible for everyone to share in a secure environment. Between speakers, there should be a little period of silence to allow for attentive listening. Mindful listening is just as vital as mindful speaking, and it entails observing what arises in your own body and mind. Cross-talk, advice, explaining the dharma to another person, or speaking too frequently are not permitted, and all conversations should remain private.

Step 7: The experimenter introduced a guided meditation for walking.

Meditating while strolling is a straightforward accessible technique for enhancing calmness, closeness, and mindfulness, similar to breathing meditation. Regular practice can be done either before or after sitting meditation, or it can be done on its own at any time, such as at the end of a long day in office or weekends morning. Meditating while walking is to develop awareness and awakened presence via the use of the natural movement of walking.

Step 8: The participants were instructed to practice breathing for 15 minutes.

Evaluation: The CCPs answerd the questions below.

I. Describe the importance of trust and non-aggression in mindfulness.

Finishing Thoughts: The experimenter thanked the participants, assigned them homework, set the time for the following meeting, and then called the session to a close for the day.

Homework

i. Engage in daily body practice for 15 minutes.

ii. Every day, spend 10 minutes focusing on your breathing.

iii. Three times a day, perform a 2-Minute Breathing Space

Session 5:

Topic: This session introduced “mindful attitudes”: Acceptance and Letting go

Objectives: The CCPs were able to demonstrate the following after the session:

i. describe acceptance and letting go as essential attitudes to mindfulness
ii. understand and practice mindful sharing
iii. practice loving-kindness meditation
iv. observe sacred pause

Step 1: The experimenter gave the participants a warm welcome joyfully

Step 2: The experimenter revised the works of the previous session with the participants

Step 3: According to the study, mindfulness requires two crucial mental states: acceptance and letting go.

Acceptance: The first step in the acceptance process is to be open to seeing things for what they truly are rather than for what one believes they should be. It's critical to accept oneself and the world as it is. In the end, if you want to alter, heal, or improve yourself or your life right now, you frequently have to go through tough emotions and accepting these emotions is necessary in and of itself. Acceptance does not imply passivity or enjoying everything. It does not imply acceptance of things as they are or that one must give up on making improvements. Acceptance simply refers to the ability to perceive things as they are, entirely, honestly, and thoroughly. This mindset creates the conditions for responding in the present in the most effective and healthy way, regardless of what is occurring. When one has a clear understanding of what is truly happening, as opposed to when their view is obscured by self-serving desires, anxieties, and preconceptions, they are much more likely to know what to do.

Letting go: Nonattachment, or letting go, is another crucial mindfulness attitude. Most of the time, people have a contradictory attitude because they hold on to the way they think things should be without even understanding why. Ideas and perspectives on oneself, other people, and circumstances are frequently what are adopted most fervently. These concepts frequently have a dramatic impact on how one experiences the present. Through meditation, paying attention to one's experience helps people identify the ideas, emotions, and sensations they are clinging to. Additionally, he will see additional items that he will be desperate to get rid of. Clinging is motivated by our preferences and evaluations. It's crucial to simply let experiences be what they are, moment by moment. A better likelihood of letting go exists when you don't interfere. (1990, Kabat-Zinn)

Step 4: The experimenter introduced guided loving kindness meditation and practice it with the CCPs "Shut your eyes, and sit confortably. Your entire body should relax. Close your eyes and keep your attention on yourself the entire visualization. Simply relax and calmly follow the instructions while taking deep breaths in and out."

Receiving Kindness and Doing Kind Things

Imagine a loved one who is very close to you while closing your eyes. It could be a spiritual mentor or instructor, someone from the past or the present, someone who is still alive or someone who has passed away. As if they were there to your right, sending you their love, picture that person in your head. That person is sending you positive energy and well wishes for your safety, joy, and wellbeing. Feel the affection and goodwill that person is sending your way.

Now consider the person or people that have a particular place in your heart. Think of that person standing to your left, sending you good vibes and wishing you happiness and health. Feel the kindness and compassion that person is directing at you. Imagine being surrounded by all of the people who have ever loved you. Consider being surrounded by all of your friends and family. They are standing there wishing you happiness, good health, and wealth. Enjoy the love and congratulations that are coming your way from all angles. You are overflowing with affection and kindness.

Wishing family members love and kindness

Refocus your attention on the person standing to your right. As you begin to experience that person's affection, begin to return it. This individual resembles you. Like you, this person yearns for happiness. Send your love and best wishes to that person.

Say these three blessings aloud while remaining silent: "May you live easily, joyfully, and pain-free."

May your life be free of suffering, tranquil, and joy.

May your life be free of suffering, tranquil, and joy.

Pay close attention to the person standing to your left right now. Start showing that person your affection. Please send that person all of your love and kindness. That person and you are similar. That person, like you, wants a happy life.

"Just as I wish to, may you be secure, may you be well, may you live easily and with pleasure," say it out loud.

I wish for you to live as comfortably, happily, and healthily as I do.

I wish for you to live as comfortably, happily, and healthily as I do.

Now picture another someone you adore, perhaps a friend or a member of your family. Like you, this person desires to live a happy life. Send your warmest regards to that person.

While doing this, say the following out loud: "May you live a happy, healthy, and prosperous life."

Sending Goodwill to Those Different From Me

Right now, think about a distant acquaintance-someone you don't particularly like or know well. Like you, this person desires to live a happy life.

You can transmit all your best wishes to that person by saying the following aloud: "Just as I hope, may you also live with ease and happiness."

Like me, I wish for you to lead a joyful and carefree life.

Like me, I wish for you to live a joyful and carefree life.

Now consider a different friend who you feel neutral toward. It can be a stranger you pass on the street, a coworker, or a neighbor. Like you, this person desires joy and happiness in his or her life.

Say the following quietly to that person to convey your best wishes:

Wishing you a happy, healthy, and pain-free life 3x.

All Living Things Receive My Love and Kindness

Now, broaden your awareness and picture the entire universe as a small ball in front of you.

All living things ,who like you want to be happy, are sent my warmest wishes.

I wish for you to live as comfortably, joyfully, and healthily as I do.

I wish for you to live as comfortably, joyfully, and healthily as I do.

I wish for you to live as comfortably, joyfully, and healthily as I do.

Take a deep breath in. Then let out a breath. After that, exhale after taking another big breath. After this meditation, pay close attention to how you're feeling and thinking.

When you're ready to begin, close your eyes.

Step 5: The scholar described the sacred pause.

The sacred pause allows us to re-establish our connection to the present. Particularly when we are preoccupied with striving, worrying, and leaning into the future,

pausing enables us to re-enter the mystery and vitality that can only be found in the moment.

Consider pausing for a little period of time when performing a task that has a clear objective, such as reading, using a computer, cleaning, or eating. To begin, halt what you're doing, find a comfortable seat, and close your eyes. Breathe deeply a few times, and as you exhale, let go of any tightness in your body and any worry you may be feeling about what to do next.

As you continue to pause, pay attention to your feelings. What sensations in your body are you aware of? Do you feel any anxiousness or restlessness as you try to leave your mental narrative? Do you have a strong want to continue where you left off ? Please allow whatever is happening inside of you to continue for the time being.

You can incorporate the sacred pause into your regular life by taking a little break once an hour or at the start and finish of each work. Whether you're sitting, standing, or lying down, you can take a rest. Walking or driving, with your eyes open and your senses awake, you can stop internally while in motion. Every time you feel distant or stuck in life, take a moment to halt, relax, and pay attention to your current experience.

Step 6: The experimenter commended CCPs and allows them to ask questions about the day’s work.

Evaluation: The CCPs answered the following questions

i. explain acceptance and letting go as essential attitudes to mindfulness
ii. demonstrate loving kindness meditation
iii. demonstrate sacred pause

Connclusion: The therapist appreciates the CCPs, gives them homework, fixes the time for the next meeting.

Session 6:

Topic: This session followed similar structure outlined in session three and introduced how to overcome obstacles in meditation.

Objectives: The CCPs were able to explain overcoming obstacles in meditation.

Step 1: The experimenter gave the CCPs a warm welcom joyfully.

Step 2: The experimenter went over the activities of the previous session with the CCPs.

Step 3: The experimenter listed obstacles in meditation – Doubt, restlessness, irritation, sleepiness and wanting.

Step 4: The experimenter explained how this obstacle can be overcome

1. Doubt: This is the unpredictability of whether or not an action will give the desirable results. People usually have this thought at the commencement of this act. The idea is that "others may benefit from a practice, but not for me." Doubt can occasionally be helpful since it teaches us to examine objects attentively before purchasing them. However, unhelpful skepticism just blocks us from learning through personal experience. We must keep in mind that ideas are only ideas and not actual truths (even the ones that say they are). Simply note the uncertainty as it creeps in, maybe even the dread that is frequently lurking beneath it, and immediately resume back to it.

2. Restlessness – An active mind makes it difficult to remain motionless for an extended amount of time. Initially we learnt to do, do, and do some more. When learning how "to be," the mind could struggle a little. All of this is entirely natural.The best defense is to realize that boredom and restlessness are only feelings, just like any other. If you look closely, worry or fear is frequently hidden beneath restlessness or boredom. But labeling it as you recognize it can actually lessen its influence; you don't even need to look into it. You might also attempt developing a beginner's mindset and being interested in the restless feeling. This is how you regain control of the situation.

3. Irritation - There are numerous causes of irritation. Perhaps we are not having a pleasant meditation session because of unwanted noise or the supplementary emotion that follows being restless. So we find it annoying that we are agitated during the practice.Although we are tempted to fight the discomfort, we must keep in mind that "what we resist persists." Here, the task is to incorporate it into the experience of mindfulness. The Now Effect begins with the phrase "It is what it is, while it is," Our task is to acknowledge the annoyance, accept it as it is, and then choose whether to look into it further or simply observe how it naturally comes and passes.

4. Sleepiness: Because we are such a sleep-deprived nation, it is easy to feel a little tired after leaving our busy thoughts. Our body rests, as it would normally desire to do. It's wise to ask yourself whether your fatigue is a sign of need to catch some rest because we sometimes feel drowsy when we are experiencing something overwhelming. If you

occasionally nod off when meditating, think of it as a necessary snooze. If this keeps occurring, you might want to try sitting up straight.

5. Wanting: During practice, you may find that your thought occasionally slips into the want to go somewhere other than where you are. Perhaps the cause is even more innocent—just a simple urge to eat, which causes the mind to wander to other food-related subjects. Or your mind may have other ideas about the circumstances before you even start practicing, preventing you from starting. This mentality either prevents us from practicing or sparks agitation, annoyance, and other negative emotions.

Before practicing, if you become aware of this mental state, you might think about what you can practice rather than what you cannot do. For instance, "the sky of awareness" technique from "the now effect" would work well in a noisy environment. During the practice, if the mind is preoccupied with wanting to go somewhere else, try not to be hard on yourself. Just keep noticing when your thoughts wander and gently bring them back. If the attraction is still strong, you might purposefully change your practice style to include the awareness of your thoughts, similar to the "movie in your head practice."

In the end, practicing regular mindfulness meditation may appear straightforward, but it is not always simple. Our brains present all of these challenges that we must overcome. That would be a really helpful habit to get into even if you just made it a point to be aware of these barriers and use the countermeasures as best you can. As you move forward, be kind to yourself and keep in mind that you can always start over.

Step 5: The experimenter finished by putting the MbSR elements into practice.

Homework

i. Use the guided meditations on a daily basis to practice sitting meditation.
experience negative emotions.

iv. Practice 15 minutes of body scan every day.

Session 7:

Topic: This session introduced unhealthy thinking styles and summarized all that have been taught in the previous session.

Objectives: After the completion of the session, the CCPs could recognize unhealthy thoughts and shut it down immediately.

Step 1: The experimenter gave the CCPs a warm welcome. joyfully

Step 2: The experimenter introduced negative thought patterns

A person normally has a lot of harmful self-statements and thoughts going through before they experience an unpleasant emotion, such as despair or anxiety. Such beliefs frequently follow a pattern, which is why we refer to them as unhelpful thinking styles. One of the things we observe is that people automatically fall into unhelpful thought patterns. We frequently aren't aware of it. When someone uses some of these thinking patterns repeatedly and unceasingly, they frequently put themselves through a significant lot of emotional distress. Various unproductive thought patterns are described in this information. As you read through them, you might identify certain recurring thought processes and behavioural tendencies. These harmful thinking patterns may resemble one another in some cases. Although they are not intended to represent unique categories, they could enable you to identify any patterns in your thinking.

Mental filter

By focusing on one aspect of a topic while ignoring the others, this type of thinking includes filtering information in and out. This typically entails focusing on a situation's negative aspects while ignoring its positive aspects, which can cause a single negative detail to cast a shadow over the entire scenario. For instance, focusing on our mistakes but failing to recognize our successes

Jumping to conclusions

When we presume that we can read someone's thoughts (mind reading) or when we forecast what will happen in the future, we tend to jump to conclusions (predictive thinking).

Personalisation

This entails holding oneself accountable for everything that goes wrong or could go wrong, even when one may be just partially or not at all at fault. One may be assuming complete accountability for the occurrence of extraneous events.

Catastrophising

When we overestimate problems and see them as terrible, awful, dreadful, and horrible, even though they are actually fairly minor, this is known as catastrophizing.

Black and white thinking

When thinking in this way, you only consider one extreme or the other. You can be good or bad, wrong or correct, etc. There are no gray areas or shades of in-between. Think in terms of all or nothing.

Musting and shoulding

It's possible to impose unfair demands or pressure on oneself and other people by using the phrases "I should..." or "I must..." Even though these words, such "I shouldn't get drunk and drive home," are not always damaging, they can occasionally set unrealistic expectations. When one attaches expectations to other people's behaviour, the outcome is frequently frustrating.

Overgeneralisation

When someone overgeneralizes, they extrapolate a circumstance from the past or present to all potential future scenarios. If someone says, "You always...", "Everyone...", or "I never...", for instance, he is definitely overgeneralizing.

Labelling

When we create generalizations based on actions taken in certain circumstances, we label both ourselves and other people.

Even though there are numerous additional cases that contradict this label, we may still use it. An example of this would be labeling oneself or someone as a loser, fool, or useless

Emotional reasoning

This mode of thinking entails interpreting events or oneself in light of how you are feeling. For instance, the fact that you feel as though something horrible is going to happen is the sole indication that it will.

Magnification and minimisation

In this way of thinking, one downplays his own positive traits while exaggerating the favorable traits of others. It seems like you're minimizing your own positive traits.

Step 3: The experimenter observed all the practical experiences once again with the CCPs:

Mindful yoga, sitting meditation, mindful sharing, body scan, breathing space, and sacred pause

Evaluation: The following query was posed to the CCPs:

I. Describe problematic thinking patterns with examples.

Finishing Thoughts: The experimenter thanked the CCPs, assigned them homework, set the time for the following meeting, and then called the session to a close for the day.

Session 8: Administration of Post-Test and Termination of Session/Refreshment

Goals: CCPs were able to discuss their experiences and describe any noticeable improvements they saw at the conclusion of the sessions.

ii. talk about how they'll keep incorporating the practice into their daily lives and turning it into a way of being.

Step 1: The experimenter gave a kind welcome to the CCPs and thanked them for their cooperation, focus, consistency, timeliness, and useful contributions to the session's progress.

Step 2: To assess the treatment's efficacy, the experimenter now administered the Kessler Psychological Stress scale.

Step 3: The experimenter urged the individuals to use their newly learned abilities in their everyday lives.

Step 4: The experimenter adjourned the meeting and thanked all the attendees. After obtaining their permission, she asked that everyone take a group photograph before asking that they all take a seat for refreshments.

EXPERIMENTAL GROUP 2: DIVERSIONAL THERAPY FOR THE MANAGEMENT OF PSYCHOLOGICAL DISTRESS AMONG CCPs

During Session the first session, the focus will be on delivering a comprehensive introduction and facilitating the administration of various instruments to collect pre-test scores

Objectives: CCPs the experimenter was able to

iv. build a sound therapeutic relationship with the CCPs

v. give the CCPs orientation about the structure and process of the study

vi. administer Kessler Psychological distress questionnaire as well as social support scale and self-efficacy scale for the purpose of having baseline information.

Activities

Step 1: The experimenter welcomed the CCPs and familiarised herself with them.

Step 2: The experimenter established rapport between herself and the CCPs by creating an alocation for experimenter/CCPs introduction. The experimenter also ensured that every participant fill an informed consent form to document their consent to participate in the study.

Step 3: The experimenter provided an overview of the programmeme; she explained the purpose of the programmeme/research and the benefits derivable by the end of the programmeme. The CCPs were assured of confidentiality during and after the programmeme

Step 4: The experimenter administered the pre-test instruments.

Step 5: The CCPs were given a task to write out the factors that contribute to their psychological distress

Connclusion

- The experimenter persuaded the CCPs to attend the next session and reminded them of the day, time and location.

❖ **Psychological distress and cervical cancer was explaid at the second session**

Objectives: the CCPs were able to:

iii. define cervical cancer

iv. relate and explain the meaning of psychological distress

Activities:

Step 1: The CCPs were warmly welcomed to the session.

Step 2: The experimenter reviewed the assignments with the CCPs

Step 3: The experimenter explained the cervical cancer.

Cervical disease is the malignant growth of the cervix; the cervix is the part beneath the uterus that joined the body of the uterus to the vagina, or birth canal. Cervical cancer is usually brought about by constant infection with high-risk Human Papilloma Infection (HPV); Human papilloma infections (HPV) are little non enveloped infection containing twofolds DNA as their genetic material and are around 55 nm in size. HPV is for the most part communicated through sexual contact. Other reasons for cervical cancer

are tobacco smoking, high equality, prolonged hormonal prophylactic use, various sex partners co-infection with Human Immunodeficiency Virus.

Step 4: The experimenter explained the meaning of psychological distress

Psychological distress is a general term used for unpleasant sensations of emotion that influence one's degree of functioning and impedes his/her everyday exercises. More extensive descriptors for psychological distress incorporate emotional distress, strain, perplexity, burdensome state, concern, and interruption. Similarly, psychological distress is marked by affective, cognitive, and behavioural responses to potentially dangerous, crisis-precipitating situations that are also accompanied by symptoms of despair and anxiety. Most heavily emphasized is the notion that distress can range from common emotions like vulnerability, grief, and fear to debilitating illnesses like depression, anxiety, panic attacks, social isolation, and existential and spiritual crises. Depression and anxiety were found to be the most noticeable symptoms of psychological distress and were present in varying degrees in the majority of women who underwent cervical cancer tests due to the following reasons:

viii. Shock of the sudden news
ix. Financial constraint
x. Rigorous treatment
xi. Side effects of treatment
xii. Comorbidities
xiii. Lack of Social Support
xiv. Stigma

Evaluation: The CCPs were asked the following questions:

iii. explain cervical cancer
iv. list the symptoms of psychological distress

Assignment

What measures do you put in place to manage your psychological distress?

Connclusion

- The CCPs were persuaded to attempt their homework.

Session 3

Topic: This session introduced DT.

Objectives: CCPs were able to explain what DT encompasses.

Activities

Step 1: The CCPs were welcomed to the third session of the programmememe and appreciated them for devoting their time.

Step 2: The assignments were gone through with the CCPs. The CCPs listed various activities they stopped engaging in since the diagnoses of cervical cancer. This list comprises but not limited to the following: Making-up, playing games, window shopping, going to cinemas, attending parties, visiting friends and families, exercises, making new friends, listening to music, gisting, arts and craft, painting, exploring the social media and so on

Stage 3: The experimenter then discussed DT.

Diversional Therapy (DT), which is also known as Diversional and Recreational Therapy or Therapeutic Recreation, is a client centred practice which regards leisure and recreational experiences as the right of every individual. The main objective of DT is to encourage empowerment and to make sure that CCPs make decisions that will optimize their involvement in leisure activities that are appropriate for their particular requirements and desires. This is accomplished by facilitating, organizing, and planning leisure and recreational programmes that are intended to support, stimulate, and improve people's psychological, social, emotional, spiritual, cognitive, and physical well-being, thus elevating their sense of self-worth and personal fulfillment. Diversional programmes use motivational tactics, such as social needs motivation, enjoyment motivation, and body image motivation to stimulate Individuals' interest and involvement and get them involved in leisure activities by taking advantage of the benefit of knowing human behaviour and functioning.

Step 4: The experimenter discussed the benefits of DT

Social interaction, mental stimulation, emotional well-being, and physical activity are all made possible by leisure activities. Exercise is well established to enhance mood, cardiovascular health, bone density, and cognitive and muscular function (Arden, 2010). Ultimately, when the action is self-driven, such as in a leisure activity, the effect is maximized. Exercise breaks the stress feedback loop to the brain by reducing tension in the muscle spindles, which also increases circulation and encourages relaxation. By

releasing and interacting with neurotransmitters, hormones, and synaptic chemicals, this can improve cognition (Arden 2010) Although watching or listening intently to an engaging physical activity has been shown to excite and grow active brain areas to a degree that is practically equivalent to where the activity was being physically done, passive physical exercise provides little physical benefit (Greenfield, 2000). Studies have shown how social engagement, piqued interest, concentrated attention, or a sense of usefulness can increase immune function and stress tolerance (Arden 2010).

Evaluation:

List three benefits of DT

Assignment

The CCPs were asked to list the activities they usually enjoyed during their leisure time before they were diagnosed of cervical cancer. Subsequent sessions/activities greatly depended on the list submitted by the members. The following session's schedule and location were emphasized to the members.

Session 4

Topic: Picking up our old habits/hobbies.

Objectives: The CCPs were able to

i. realize their rights to leisure experiences and how this can benefit their state of health.

ii. accept that their old habbits would have an everlasting effect on their general health

Activity:

Stage 1: The CCPs were welcomed to the day session.

The experimenter working with the list of recreational activities provided in the second session started the fourth session with different types of music. This was played for ten minutes till about 90% of the CCPs already got to the location

Step 2: The experimenter brought out the material she got the CCPs, this includes indoor games, such as ludo game, what, cards and drought. The experimenter dropped 2 of each game and asked them to pick whichever they are interested in. So, the experimenter implored them to use these games at their leisure time as there would be games

competition the following week and there are prizes for the best player. They insisted on playing the games that day and this was what we did for the rest of the session. The experimenter also dropped few make-up tools for the woman who filled that she had not been making up since the diagnoses of cervical cancer

Step 3: The experimenter persuaded them to use the games at their free time as this will give them a break from their worries.

Conclusion

i. The experimenter rounded up the session with appreciation and the CCPs thanked the experimenter for the beautiful moments and the materials she got them. They also prayed for the experimenter

ii. The experimenter persuaded them to use the games at their free time and gave them a heads-up about the following session's start time, date, and location.

Session 5

Topic: Indoor Games.

Objectives: The CCPs were able to feel the impacts of recreational activities on their state of health

Activities

Step 1: The experimenter played in music while she awaited the remaining CCPs

Step 2: The experimenter facilitated the games competitions with her assistants and played with the winners of the four games. The four winners were given a five-hundred-naira recharge card each.

Step 3: The session ended with music and dance

Step 4: The CCPs were happy and appreciated the experimenter and her assistants with kind words and prayer. They also requested that a party be thrown the next session

Connclusion: The CCPs were commended for their effort and time and also reminded them of their rights to recreational activities regardless of all odds. She dropped the Bluetooth speaker to the house so they can enjoy the same experience even when the experimenter is not there

i. The experimenter will review the assignments with the CCPs.

ii. The experimenter will explain the meaning of DT.

Session 6

Topic: Party Time.

Objectives: The CCPs were able to feel the impacts of recreational activities on their state of health

Activities

Step 1: The experimenter played in music while she awaited the remaining CCPs

Step 2: The party began and all CCPs were beautifully dressed. The experimenter got them enough drinks and foods to go round. They were so elated that they started taking pictures. The party lasted 40 minutes, then foods and drinks were shared

Step 3: The session ended with music and dance

Step 4: The CCPs were very happy and appreciated the experimenter and her assistants with kind words and prayer.

Connclusion: The experimenter commended the CCPs for their effort and time and also reminded them of their rights to recreational activities regardless of all odds.

Assignment: The CCPs were told to discuss how recreational activities have impacted their state of health and state of mind

Session 7: Discussion, games dance, music, stories, jokes, and testimonies

Objectives: The CCPs were able to:

i. highlight the impacts of DT on their psychological wellbeing
ii. share their cancer diagnostic experience with much gratitude to God
iii. accept that the experience of happiness is the beginning of healing

Step 2: The experimenter asked them of the activities they would like for the session

Step 3: The experimenter put the CCPs into groups according of their interest. While the majority of them prefer to watch movie, some chose painting and few just wanted to watch others play games

Step 4: The experimenter ended the session and commended their keen interest in recreations.

Session 8: Administration of Post-Test and Termination of Session/Refreshment

Objectives: CCPs were able to:

i. share their experience and state the observable changes they have witnessed.

ii. discuss how they will continue to exercise and enjoy their right to leisure experiences even after survival of cervical cancer

Step 1: The CCPs were welcomed and thanked them for their cooperation, attentiveness, regularity, punctuality and useful contribution to the course of the session.

Step 2: The experimenter now administered the Kessler Psychological Stress scale to check the effectiveness of the treatment.

Step 3: The CCPs were persuaded to put the newly acquired skills to practice in their daily living.

Step 4: The session was terminatedand then appreciated all the CCPs. She requested for group photographs to be taken after seeking their consent, and thereafter requests that all the CCPs should be seated for refreshments.

CONTROL GROUP

During Session the first session, the focus will be on delivering a comprehensive introduction and facilitating the administration of various instruments to collect pre-test scores

Objectives: The experimenter was able to

i. Build a sound therapeutic relationship with the CCPs
ii. Give the CCPs orientation about the structure and process of the study
iii. Administer Kessler Psychological distress questionnaire as well as SSS and HSEfor the purpose of having baseline information.

Activities

- The CCPs were welcomed into the programmeme
- The experimenter established rapport between herself and the CCPs by creating an alocation for experimenter/CCPs introduction. The experimenter also ensured that every participant fill an informed consent form to document their agreement to partake in the study.
- The experimenter provided an overview of the programmeme, she explained the purpose of the programmeme/research and the benefits derivable by the end of the programmeme. The CCPs were assured of confidentiality during and after the session

- The experimenter administered the pre-test instruments (Kessler Psychological Distress Scale, HSe and SSS) to the CCPs with maximum guidance.

Connclusion

- The CCPs' cooperation and patience were acknowledged.
- The experimenter reminded them of next session and urged them to come.

Session 2:

Topic: Drug Abuse and Addiction

Objectives: The CCPs could

i. Explain Drug Abuse and addiction
ii. Identify the commonly abused drugs
iii. Explain the dangers in drug abuse and addiction

Activities:

- The experimenter asked the CCPs what they understand by drug abuse and addiction
- The experimenter built on the CCPs' response and explained further that drug abuse is the use of certain chemicals without a doctor's prescription for the purpose of creating pleasurable effects on the brain. One becomes addictive to these chemicals when he can't resist using them no matter how much harm the drugs may cause. Drug abuse and addiction isn't only about illegal substances such as cocaine or heroin, one can get addicted to ordinary paracetamol, sleep medications, anti-anxiety medications and other legal substances too. Side effects of drug abuse and addiction ranges from nausea and mild abdominal pain which can also lead to changes in appetite and weight loss, to increased strain on the liver which puts the person at the risk of significant liver damage. Other side effects include seizures, stroke, mental disorder, brain damage and lung disease
- The experimenter explained eight ways to overcome addiction. These include admitting there is a problem, accountability to someone, exercise, breaking the habit, discovery of a new hobby, self-love, and writing down the harmful effects one's drug addiction

- The experimenter implored the CCPs to stay away from drug abuse and addiction for a healthy lifestyle
- The experimenter gave the CCPs the opportunity to seek clarifications where necessary.

Conclusion:

The CCPs were persuaded to attend the next session while reminding them of the day, time and location

Session 3:

Topic: Conclusion and Post-test Administration

Objectives: The CCPs were able to

i. Describe the activities of the previous session

ii. Complete the post-test instrument.

Activities:

Step1: All the CCPs were welcomed to the last part of the programmeme. She appreciated them for their cooperation, regularity and punctuality throughout the programmeme

Step2: The CCPs were asked to discuss what they gained from the previous session

Step3: The post-test instrument was administered and completed.

Conclusion:

i. The experimenter brought the programmeme to closure by thanking the CCPs for being a meaningful part of the research. She also commended them for their time and dedication

ii. The experimenter terminated the therapeutic process

3.9 Focus Group Discussion Guide

Introduction:

- Welcome participants and thank them for their participation.
- Introduce yourself as the moderator/facilitator.
- Explain the purpose of the focus group discussion: to explore the impact of cervical cancer diagnoses.
- Emphasize that their participation and honest opinions are highly valued.

Icebreaker:

- Begin with an icebreaker question to create a comfortable and open atmosphere.
- For example: "Can each of you briefly introduce yourself and share one word that comes to mind when you think about the emotional aspects of a cervical cancer diagnosis?"

Main Discussion Questions:

1. How would you describe your feelings upon receiving the diagnoses of cervical cancer?
    - Encourage participants to share their personal experiences and emotions.
    - Probe deeper with follow-up questions to explore the intensity and specific aspects of their emotional responses.
2. How did you feel afterwards? How have your emotions evolved or changed over time?
    - Explore how participants have coped with their initial emotional reactions.
    - Investigate if there have been any shifts or changes in their emotional state as they progress through their cervical cancer journey.
3. What are some of the coping strategies you have used to manage these feelings?
    - Encourage participants to discuss the strategies they have employed to cope with the emotional impact of their diagnosis.
    - Probe further to understand the effectiveness of these strategies and any challenges they have encountered.
4. How has cervical cancer affected your sexual intimacy and relationships?
    - Explore participants' experiences and challenges related to sexual intimacy after their diagnoses.
    - Discuss changes in their relationships and communication with their partners or spouses.
5. What do you think are the causes of cervical cancer?
    - Encourage participants to share their beliefs and perceptions about the causes of cervical cancer.
    - Probe deeper to understand if they have any specific cultural or personal beliefs regarding the disease's origins.

6. Are you aware of any prevention methods for cervical cancer? If yes, what are they?
    - Explore participants' knowledge and awareness of prevention methods for cervical cancer.
    - Discuss any preventive measures they have personally taken or are sfamiliar with.
7. What do you think could make your condition better, and how can the government or healthcare system support you?
    - Encourage participants to share their thoughts on what could improve their situation and emotional well-being.
    - Discuss potential support services, policies, or initiatives that they believe would be beneficial.

Closing:

- Thank the participants for their valuable insights and contributions.
- Offer any additional resources or support available to them.
- Reiterate the importance of their participation in furthering the understanding of cervical cancer's emotional impact

3.10 Control of Extraneous Variables

The researcher implemented various methods to minimize the effects of extraneous variables, which are elements that could potentially influence the results of the trial alongside the proposed interventions. These strategies included appropriately randomizing individuals into the experimental and control groups, strictly adhering to the established inclusion criteria, employing a well-designed 3x2x3 factorial matrix design, and utilizing analysis of covariance (ANCOVA) for data analysis

3.11 Data Analysis

Simple percentages and Analysis of Covariance (ANCOVA) were the major statistical tools employed in this study. Simple percentage was used to analyze the demographic characteristics of the respondents while ANCOVA was used to test the hypotheses on the main effects and the interaction of treatment and moderating variables

at 0.05 level of significance. Also, Duncan post-hoc analysis was used to determine the extent of the significance of the main effects of the independent and moderating variables.

The qualitative data were analysed thematically, the researcher began by familiarizing herself with the responses of the participants in the focus group discussions. Meaningful units of data within each FGD response were identified and assigned appropriate codes. Similar codes were grouped together to form preliminary themes. These themes were named and defined to capture the essence of the participants' experiences and perspectives. The named themes were then analyzed in relation to the research objectives and existing knowledge about the emotional and psychological impact of cervical cancer diagnoses. This involved examining patterns, commonalities, and differences across the responses to extract meaningful insights. Based on the thematic analysis, conclusions were drawn regarding the emotional and psychological impact of cervical cancer diagnoses on the participants. The identified themes provided valuable insights into their feelings, coping strategies, challenges in sexual intimacy, beliefs about the causes of cervical cancer, awareness of prevention methods, and recommendations for improvement.

CHAPTER FOUR

RESULTS AND DISCUSSION

This chapter presents the results and discussionbof findings. The study investigated the effect of mindfulness based stress reduction and diversional therapy on psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria.

4.1 Presentation of Tables

Table 4.1 Demographic characteristics of respondents

Age	**Frequency**	**Percent (%)**
below 30 years	3	4.9%
30-49 years	17	27.9%
50-60 yesars	18	29.5%
above 60 years	23	37.7 %
Religion	**Frequency**	**Percent (%)**
christianity	32	52.5
islam	26	42.6
Other	3	4.9
SES	**Frequency**	**Percent (%)**
High	15	24.6
Moderate	28	45.9
low	18	29.5
Interview	**Frequency**	**Percent (%)**
group 1	5	50%
Group 2	5	50%

Source: Field survey, 2021

Table 4.2: Summary of 3x2x3 analysis of covariance showing the significant main and interactive effect of treatment groups, health self-efficacy and social support among psychological distress cervical cancer patients

Source	**Type III sum of squares**	**Df**	**Mean square**	**F**	Sig.	**Partial eta squared**
Corrected model	7540.699[a]	16	471.294	21.022	.000	.884
Intercept	383.698	1	383.698	17.115	.000	.280
Pretest	107.893	1	107.893	4.812	.034	.099
Trtgroup	3574.861	2	1787.430	79.727	.000	.784
HSE	149.752	1	149.752	6.680	.013	.132
PSS	57.701	2	28.851	1.287	.286	.055
trtgroup*HSE	63.130	2	31.565	1.408	.255	.060
trtgroup*PSS	104.560	4	26.140	1.166	.339	.096
HSE * PSS	.674	2	.337	.015	.985	.001
trtgroup* HSE * PSS	7.963	2	3.981	.178	.838	.008
Error	986.449	44	22.419			
Total	48320.000	61				
Corrected total	8527.148	60				

Source: field survey, 2021

Table 4.3: Scheffe post-hoc analysis showing the significant differences of psychological distress ofcervical cancer patients among various treatment groups and the control Group

Treatment group	N	Subset		
		1	2	3
MbSR	24	17.9583		
Diversional Therapy	21		20.7619	
Control group	16			43.1875
		0.271	0.271	1.000

Source: field survey, 2021

4.2 Section A: Demographic Characteristics of Respondents

Table 4.1 reveals that out of 61 respondents, 4.9% of them are beelow 30 years of age, 27.9% of the respondents are between 30 years and 49 years, 29.5% are between the age of 50 years and 60 years and 37.7% are above 60 years of age. While 52.5% of them are Christians, 42.6% of the respondents are Muslims and 4.9% fell into the category of others. 24.6% of thsem are of high socio-economic status, 45.9% are of moderate socio-conomic status while 29.5% are of low socio-economic status. 50% of them were exposed to Mindfulness-based stress reduction (group 1), while the remaining 50% were exposed to Diversional Therapy (group 2). This implies that most of the respondents with psychological distress are between the age of 60 years and above. Also, majority of them with psychological distress are Christians with moderate socio-economic status. Furthermore, the focus group discussion comprises nine participants

4.3 Hypotheses Testing

Hypothesis One: There is no significant main effect of the treatment on psychological distress among cervical cancer patients.

To test this hypothesis, Analysis of Covariance (ANCOVA) was adopted to analyse the post-test scores of the participants on their psychological distress level using the pretest scores as covariate to ascertain if the post experimental differences are statistically significant. Table 4.2 showed that there is a significant main effect of treatment on psychological distress among cervical cancer patients in Lagos and Ibadan. ($F_{(2, 44)}$ = 79.727, $p < .05$, η^2= .784). This implies that there was a significant difference in the psychological distress of the treatment groups. Hence, the null hypothesis is rejected. The table further reveals that treatment groups explained 78.4% variance in psychological distress experienced by the participants. For further clarification on the margin of differences among the three groups a Duncan post-hoc analysis was computed and the result is as shown on table 4.3 respectively.

Table 4.3 further reveals that experimental group I (Mindfulness-based Stress Reduction (MBSsR)) had the lowest mean ($\bar{x}$=17.9583); the experimental group II (Diversional Therapy (DT)) ($\bar{x}$ =20.7619) and control group ($\bar{x}$ =43.1875). By implication, Mindfulness-based Stress Reduction (MBSR) was more effective in

managing psychological distress of cervical cancer patients than Diversional Therapy (DT). The co-efficient of determination (Adjust.ed R^2 = 842) over all indicates that the differences that exist in the group account for 84% in the variation of psychological distress of cervical cancer patients.

Hypothesis Two: There is no significant main effect of health self-efficacy on psychological distress level of cervical cancer patients in Lagos and Ibadan.

The results on table 4.2 indicated that there was significant main effect of health self-efficacy on psychological distress among cervical cancer patients ($F_{(1, 44)} = 6.680$, $p < .05$, $\eta^2 = .132$). Therefore, the null hypothesis was rejected. Those with high health self-efficacy has (mean = 20.20) and low health self-efficacy has (mean = 18.00). In other words, those with high health self-efficacy benefited from the treatment more than those with the low health self-efficacy. The table further reveals that level of health self-efficacy accounts for 13.2% variance in the psychological distress of cervical cancer patients

Hypothesis Three: There is no significant interaction effect of social support on psychological distress among cervical cancer patients.

Table 4.2 showed that there was no significant main effect of social support on psychological distress among cervical cancer patients ($F_{(2, 44)} = 1.287$, $p > .05$, $\eta^2 = .055$). Hence, the null hypothesis is accepted. This implies that there is no significant difference in the psychological distress of cervical patients with high, moderate and low level of social support

Hypothesis Four: There is no significant interaction effect of the treatment and health self-efficacy on psychological distress among cervical cancer patients.

Table 4.2 indicated that there was no significant interaction effect of treatment and health self-efficacy on psychological distress among cervical cancer patients ($F_{(2, 44)} = 1.408$, $p > .05$, $\eta^2 = .060$). Hence, the null hypothesis was accepted. This implies that health self-efficacy did not significantly moderate the effect of treatment on psychological distress among cervical cancer patients.

Hypothesis Five: There is no significant interaction effect of treatment and social support on psychological distress among cervical cancer patients.

Table 4.1 indicated that there was no significant interaction effect of treatment and social support on psychological distress among cervical cancer patients ($F_{(4, 44)} = 1.166$, $p > .05$, $\eta^2 = .096$). Therefore, the null hypothesis was accepted. This denotes that social support did not significantly moderate the effect of treatment on psychological distress among cervical patients.

Hypothesis Six: There is no significant interaction effect of the health self-efficacy and social support on psychological distress among cervical cancer patients.

Table 4.2 indicated that there was no significant interaction effect of health self-efficacy and social support on psychological distress among cervical cancer patients ($F_{(4, 44)} = 0.015$, $p > .05$, $\eta^2 = .001$). Hence, the null hypothesis was accepted. This implies that health self-efficacy did not significantly moderate the effect of social support on psychological distress among cervical patients was not significant

Hypothesis Seven: There is no significant three-way interaction effect of the treatment, health self-efficacy and social support on psychological distress among cervical cancer patients.

Table 4.1 indicated that there was no significant interaction effect of treatment, social support and health self-efficacy on psychological distress among cervical cancer patients ($F_{(2, 44)} = 0.178$, $p > .05$, $\eta^2 = .008$). Therefore, the null hypothesis was accepted. By implication, health self-efficacy and social support are not significant moderators of the effect of treatment on psychological distress of cervical cancer patients.

4.2b Qualitative Report of Data from FGD

Seven focus group discussion guides were developed to be talked over. Focus group discussion was employed to elicit responses for further understanding of the causes, feelings, and consequences of psychological distress and cervical cancer. The following are the transcriptions of the oral interview had among the cervical cancer

patients at Grace Hospital, Ashi-Bodija, Ibadan. The sub themes examined in the interview include: the participants knowledge of cervical cancer, the feelings of the participants upon diagnoses of cervical cancer, and afterwards, impacts of the disease on their sexual intimacy and more importantly, the coping strategies adopted in managing their feelings and what the government can do with regards to prevention

Qualitative Data from FGD

Seven FGD questions were raised to elicit responses from the participants on the following major themes "Emotional Impact of Diagnosis," "Coping Strategies," "Impact on Sexual Intimacy," "Beliefs about the Causes of Cervical Cancer," "Awareness of Prevention," and "Recommendations for Improvement

FGDQ-1: How would you describe your feelings upon the diagnoses of cervical cancer?

Respondent G

I felt hopeless and helpless. I never knew I would make it this far.

Respondent F

I couldn't hold my tears before the doctor; I was trying to understand why I could be diagnosed of cervical cancer. I have never been as low as that in my life before.

Respondent H

I was dumbfounded; I didn't know what to say or ask. Although I have been seriously sick lately with little discomfort around my abdomen, the worst I could expect was typhoid until the doctor asked me to go for cervical cancer screening. Only God knows how I got home that day

Respondent C

HMbSRm, I thought it was because of my lifestyle, I was so embarrassed and ashamed of myself

Respondent I

Fortunately for me, I went with my husband, he was just asking the doctors series of questions when I was there looking like it was a dream. That day was the worst day of

my life. I was supposed to eat before I left home but I couldn't because I was running late already. Throughout that day, I could not take ordinary water, neither did I sleep. I lost my aappetite immediately.

Respondent A

I just felt I never went for the screening, infact I thought of death immediatelly. The sadness was unbearable

Respondent B

I didn't understand the type of illness it was until my daughter came days after and I showed her the result. That was when I realized I was finished

FGDQ-2: How did you feel afterwards?

Respondent B

Honestly, I am yet to get over the shock, coupled with the serious side effects of chemotherapy.

Respondent D

I was initially adjusting to the disease until I heard that majority of cervical cancer cases are usually accompanied by human immunodeficiency virus/aids. Even after I was confirmed HIV negative, I was still very worried and panic

Respondent C

The only time I am sad is whenever I have appointment and I must undress before male doctors, most expecially the young doctors and the ones that called themselves student doctors too. They were always in the room looking at me. And I will have to open myself, it was a shameful thing. Besides that, I am doing my best

Respondent H

I am still sad. I am a retired teacher without children to help me with the finance and my husband has other wives. Cervical cancer burden is just too much to bear

Respondent E

The feelings become worst, most of the times I isolate myself because I believe people around me may not be able tolerate the smell coming out from the area and to avoid further embarrassment, I must stay alone.

Resspondent I

I started treatment immediately, so the sadness and fear were minimal. Treaments have not been taking it lightly on me, but my husband has been supportive

Respondent A

The sadness and anxiety is intensed, sometimes I pray I don't survive because if I do, I don't know how I am going pay the debt I have incurred in the name of cervical cancer treatment

Respondent F

I was a bit releaved when my children asure me that they would try their best to ensure I survive it. It is just the pains and treatment side effecst that depress me sometimes I am trying to adjust too

FGDQ-3: What are your coping strategies to manage these feelings?

Respondent E

I have not been able to cope because I withdraw myself from family and friends and only my husband is aware of my diagnoses

Respondent B

Thank God for good neighbours and few family members, I would have died of raised BP and not even cervical cancer. I was really depressed and scared.

Respondent H

I was told to see a psychiatrist at the clinic, and I was given some drugs

Respondent D

I took my treatment seriously and look up too God for miracle

Respondent G

Gratitude! Praise and worship

FGDQ-4: What impact does cervical cancer have on your sexual intimacy?

Respondent B

We rarely had fun before I was diagnosed of cervical cancer but now he has moved out of our matrimonial room. He sleeps in the children's room

Respondent G

I am a widow, that never comes to my mind

Respondent I

My husband is not making move; he has been saying he wants me to recover fully while I keep telling him I am good to have sex since it's only chemotherapy I am still receiving. I don't want to believe he doesn't find me attractive anymore

Respondent E

Sex is painful to me lately; I never enjoyed any part of it. My hubby is the type that has high libido; I don't think I can satisfy him again. I already advised him to get a second wife. My life is more important than sex

Respondent H

My husband has a second wife before I was diagnosed, so he told me it's not save for him to have sex with me because of the second wife. I told him we can be using protection but it's like he has made up his mind already

Respondent C

Since about 2 years that I have been diagnosed of cervical cancer, my husband never touched me. It didn't bother me at first, but I am beginning to suspect he has a girlfriend now. This has been given me sleepless nite. Anytime I raised the topic he was not always ready to discuss it. I am in my mid 40's; does that mean he will never touch me again? Honestly, i am really bothered

FGDQ -5 What do you think are the causes of cervical cancer?

Respondent H: *Hereditary*

Respondent B*: Every cancer type is a spiritual attack*

Respondent G: *it is the hand work of the devil*

Respondent E: *Poor personal hygiene*

Respondent C: *One may end up with cervical cancer, having had series of abortion and multiple sex partners*

Respondent F: *multiple births and poor diet*

FGDQ-6: Do you know the prevention of cervical cancer?

Respondent A: *I am not aware that it can be prevented*

Respondent G: *I don't know it can be prevented*

Respondent C: *It can be prevented by sticking to one man*

Respondent D: *Yes, through a vaccine*

Respondent F: *I thought it can never be prevented*

FGDQ-7: What can make your condition better and how can the government come in?

Respondent E:

Eventhough my husband has said to me severally that I don't smell, I find it difficult to believe it. I may feel better if I can continue with my usual way of life before the diagnoses. For the government, HPV Vaccine should be free and awareness programme should be frequent

Respondent B

If government should subsidize the treatment cost, I will be much relieved. For pains and nsomia, I use pain reliefs and sedatives.

Respondent D

Awareness programmeme, cervical cancer is more curable than other cancer types but because people have little or no information about it, they think it's a life sentence. Personally, awareness programmeme can be used to lessen the effects on our mental health.

Respondent G

Moving closer to God, believing he will not forsake me and being grateful for the gift of life. Also, I don't hesitate to seek help if necessary because personally, lack of finance is another root cause of my sadness and emptiness. Many times, I have to call on my son inlaw and pastors in church and they tried their best

Respondent I

Support from family and friends will also go a long way in managing psychological distress. Also, support from the Government by subsidizing cancer treatment will also be helpful.

Respondent C

Visiting mental health professionals will also be helpful. Also, having more of female hospital staffs could make one more confortable. My experience with the male doctors was terrible.

Respondent A

Finance is important in managing psychological distress; if money is available the distress will be minimal. All my savings have gone for it and my husband is a pensioner. Most times I skip doctor's appointment because of a common transportation fare. Government can sponsor regular awareness programmeme, give free vaccine and free pap smear test

4.4 Discussion of Findings

Main Effect of the Treatment on Psychological Distress

The first hypothesis examined the significant main effect of the treatment on psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria. The result reveals that there was a significant main effect of treatments in the management of psychological distress among cervical cancer patients. That is there is a significant difference in the mean score among the psychological distressed cervical cancer patients that participated in the MBSR, DT and the Control group. Based on this, the null hypothesis was rejected. It is inferred that MBSR and DT are effective in the management of psychological distress of cervical cancer patients who participated in the training.

Using post-hoc analysis the results showed further that MBSR was more effective in the management of psychological distress among participants than DT and the control group. This means that those in MBSR group benefited more from the training than those in DT and control group. The differences can be explained in terms of the higher sample size and the efficacy of the different interventions and its respective delivery method. This result could be attributed to the goal of the MbSR, which is the training of the participants from simple few minutes' meditation to a way of being. Once the participants were able to master the attitudinal skills of MbSR, they inculcated them to their daily activities formally or informally and also apply them to conflicts encountered in their daily life. Therefore, with MbSR, the participants were able to imbibe seven attitudinal skills capable of building their resilience and enhancing their adversity quotient.

Another possible explanation for this result is that MbSR training, which involves observing sensations, thoughts and emotions instant by instant may prevent obsessively ruminating on negative aspects of the past, reduce emotional reactivity, increases feelings of responsibility, personal control, psychological flexibility and enhances one's capacity for emotional regulation. It is important to note that to the best of the researcher's knowledge, no study has been conducted to investigate the effects of MbSR and DT on psychological distress of cervical cancer patients in Lagos and Ibadan, Nigeria. But there

are similar studies related to the variables that can be used to substantiate the findings of the study.

The outcome of this findings corroborates the work of Sedaghatb, Mohammadia, Alizadeha , Imania (2011), who confirmed that MbSR has a significant impact in the enhancement of mindfulness, psychological and emotional well-being and reduction of stress among Iranian population, the study is also in consonance with the outcome of Shapiro, Schwartz and Bonner (1998), who also affirmed that MbSR is highly effective in reducing state and trait of anxiety, psychological distress and increases overall empathy level and spirituality among medical and pre-medical students experiencing psychological distress. In the same vein, MbSR has been found to be capable of reducing anxiety and depression of a Latino and non-Latino primary care patients (Callion, 2013)

The work of Kabat-Zinn, (1986) further proof the relevance and efficiency of MBSR in enhancing the quality of life of patients with chonic low back pain. Similarly, MBSR has been shown to improve mood in people suffering from different kinds of cancer (Carlson, Ursuliak, Goodey, Angen, and Speca, 2001) and to be associated with increased general wellbeing (Carmody and Baer, 2008; Reibel, Greeson, Brainard and Rosenzweig, 2001; Shapiro, Oman, Thoresen, Plante, and Flinders, 2008).

In addition, Asueru and Banda (2010) confirms the effectiveness of MbSR techniques at reducing health care professionals' levels of psychological distress in Spain, and with a maintained psychological distress level at the time of follow up. While trying to deepen the understanding of the mechanisms behind MbSR, Asuero and Banda (2010) found out that MBSR is highly effective in changing the lifestyle of participants in some way and their adherence to practice. During follow up, Asuero and Banda further discovered that meditation practise after training is higher than yoga practice. Aligning with this, is the study of Rosenzweig, Reibel, Greeson, Brainard and Hojat (2003), who reported the capability of MBSR in reducing psychological distress of medical students

On the other hand, diversional therapy was also found to be effective in reducuing psychological distress, although not as effective as MbSR. Nevertheless, the effectiveness of Diversional therapy is in congruence with the findings of Lam, Chow, Cheung, Lee, Li, Ho, Flint, Yang and Yung (2017) who affirmed that DT is effective in improving geriatric depression among older adults. Consistent with this finding is the

report of Mazza (2015), who indicated improved quality of life of active cancer patients and individuals considered to be in remission and/or cancer survivors after been exposed to an eight week DT. In line with this finding is the study of Motohashi, Toyoshima, Kaneko and (2016), who reported a significant impact of a wide range of leisure-time activities on psychological distress among both male and female residents in sub urban area of northern japan.

More so,this finding is in consonance with the findings of Kim, Kam and Park (2020), who reported the effectiveness of therapeutic recreation programmeme in bringing positive changes to the elderly in social, emotional, physical and cognitive domain. Similarly, this result is consistent with the results of the prior studies of Do 2016, who used DT of music in managing dementia in the elderly, as well as another finding of Park who use diversional therapy to improve older women physical fitness. Also, Lai, Woo, Hue and Chan 2004 found out the effectiveness of DT in enhancing the psychological, physical and social well-being of people in community-based stroke rehabilitation center

Additionally, this study is in the same line with the findings of Austin, Johnston and Morgan (2006), who reported a significant effect of therapeutic recreation in improving the health of older adults; and Singh, Shukla and Sign (2010) who confirmed the efficacy of diversional therapy of exercise as a long term anti-depressant in elderly people. Also the work of Allsop, 2012 affimed that DT is useful in enhancing the social self-efficacy of adolescents with chronic illness

In the same vein, DT has been used successfully as an intervention to decrease children's pain and behavioural responses during painful procedures (International Association for the Study of Pain, 2011). In another study, distraction among respondents was shown to relieve pain during various procedures ranging from singing, video games, and various forms of play, television visual and auditory stimulation (Jeffrey et al., 2006; Elizabeth, 2012; Jill and Lindsey, 2007). In children, cartoon-based diversional therapy is effective in managing pain (Nora and Thomas, 2016; Nabarum et al., 2018)

Further more, music which is a form of DT was used in managing pain and anxiety levels of cancer patients. The same study concluded that music therapy can reduce cancer pain and anxiety when used along with standard palliative care in cancer

patients with moderate to severe pain (Priyadharshini and Shoba, 2016). According to Huang et al., 2010, music based DT showed a significant reduction in pain experienced by patients when the choice of music was determined by the patients (Huang et al., 2010). Comparing this study with Huang et al., 2010, patient choice of diversion for chronic pain sufferers may improve the outcome. Meditation, another form of DT showed to be effective in decreasing the severity of pain perception and disability on chronic pain patients (Farzaneh et al., 2011; Hassed, 2013). This discovery further affirmed the finding of Orr (2010), who recorded a significant association of DT services with changes in psycho-social functioning of people with serious mental illness.

Generally, from various studies, it can be inferred that diversional therapy can alleviate distress by helping patients gain relief from their symptoms, and also help them develop and use their strengths and potentials to deal with barriers to recreations and to facilitate optimal functioning. This imply that DT and MBSR have been effective all along and it further lays credence to the fact that psychological distress can be managed among cervical cancer patients with the proper use of the therapeutic interventions.

Main Effect of Health Self-Efficacy on Psychological Distress

The second hypothesis stated that there was no significant main effect of health self-efficacy on psychological distress among cervical cancer patients in Lagos and Ibadan. The result showed that health self-efficacy had significant effect on psychological distress among cervical cancer patients. This confirms the findings of Endler, Speer, Johnson, and Fleet (2001), who found negative relationship of general self-efficacy with depression and anxiety and also agrees with the findings of Adeyemo and Adeleye (2008), who reported the effectiveness of self-efficacy in predicting psychological well-being of adolescents.

Similarly, Sing, Shukla and Sing, (2010) found that perceived self-efficacy emerged as an important predictor of mental health among elderly males and females. In the same vein, Jonathan (2010) found that general self-efficacy moderates the negative effect of manifestation of stress as shown by indices of psychological distress on psychological, emotional and social well-being. This is also in consonance with the finding of Marks, Allegrante, Lorig (2005), who indicated that higher self-efficacy, is

associated with better outcomes, and that better outcomes reduce health services burden in a meta-analytic study among co-morbid patients it was further reported that higher self-efficacy leads to reduced health care utilization.

Furthermore, this result agrees with the findings of Marks, Allegrante and Lorig (2005) who discovered that higher sellf-efficacy is associated with better treatment result and that better results reduce health services burden. More so, Molassiotis et al., 2002 also reported that adherence to antiretroviral medications in patients with HIV was a function of self-efficacy

Main Effect of Social Support on Psychological Distress

The third hypothesis which stated that there was no significant main effect of social support on psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria was accepted. The result from analysis showed that there was no significant main effect of social support on the management of psychological distress. This support the findings of Sumdaengrit, Jengprasert and Sriintravanit, (2018), whose study disclosed that social support for cervical cancer patients could not help to improve their quality of life, and whose symptoms of distress seem to have a direct effect on their quality of life. This result is also similar with the findings of Cheung and Sun (2000), who reported that there was no significant association between social support and depressive symptoms of Chinese patients with rheumatoid arthritis

In addition, this result also support the findings of Meyerowitz (2000), who reported that receiving support from someone an individual has close emotional ties to helps one's emotional and physical health than support provided by strangers, and the study of Ashing-Giwa, Padilla, Bohorquez, Tejero, Garcia, and Meyers(2004) who discovered that negative interactions of family members and lack of social support have a significant impact on the patient's psychological distress

This is also in contrast with the work of Canadian Institute of Health Information (2012), who reported that emotional support or positive social interaction opportunities was associated with experiencing improvements in distress levels after adjusting for age, income, employment and health behaviours, but in line with the affection-related social support part that was not also a significant factor in transitions out of psychological

distress. Also, the study completed by Dzulkifli (2011) showed how psychological problems i.e. depression, anxiety and stress can be influenced by social support by indicating that there exist significant negative correlations between social support and depression, social support and anxiety, and social support and stress among 120 university students .

More importantly, this result does not align with the findings of Cumming, Cadihac, Rubin, Crafti and Pearce, 2012 who confirmed that increased social support was correlated with lower level of depression, anxiety and inward irritability in care givers. Inaddition, the findings partially agree with the work of Sharpley, Hussain, Wark, Mcevoy and Attia (2015) who reported a significant mediating effect of social support on depression while there was no significant relationship between anxiety and social support

Interaction Effect of Treatment and Health Self-efficacy on Psychological Distress

There was no significant interaction effect of the treatment and health self-efficacy on psychological distress among cervical cancer patients. This finding is in contrast with the study of Chang et al., 2004, who affirmed a significant interaction effects between MBSR intervention on pain and mindfulness self-efficacy on positive states of mind. It is also in contrast to the findings of Vallis and Bucher (1986) who reported a significant interactive effect of self-efficacy, behaviour change and pain tolerance among eighty university women

In the same vein, Jonathan (2010) found that general self-efficacy moderates the negative effect of manifestation of stress as shown by indices of psychological distress on psychological, emotional and social well-being. This is also in consonance with the finding of Marks, Allegrante, Lorig (2005), who indicated that higher self-efficacy, is associated with better outcomes, and that better outcomes reduce health services burden in a meta-analytic study among co-morbid patients it was further reported that higher self-efficacy leads to reduced health care utilization.

The result of these findings is not also in consonance with the findings of Lenz, Shortrige, Bagget and Lillie (2002) who reported that positive self-efficacy beliefs have an effective role in the treatment of mental diseases.

Interaction Effect of the Treatment and Social Support on Psychological Distress

There was no significant interaction effect of the treatment and social support on psychological distress among cervical cancer patients. This is in contrast with the findings of Peterson and Seligman (2003); Blair (2004); Jane, (2015) and Jamil (2011) who agree that of the three kinds of support, the most investigated is the emotional support coupled to his connections with psycho-social outcomes with women suffering from cancer. For example, cervical cancer patients that discuss her personal experiences with friends and family achieve notable level of psychosocial adjustment.

More importantly, this study is in contrast with the work of Peters-golden (2002) concluded that problem of adjustment to situations is associated to insufficient support from a partner, in other words, cervical cancer women experiencing higher level of distress are those whose husbands do not give adequate support during the cervical cancer care trajectory. In addition, a problematic partner relationship can never be replaced by receiving a massive support from other people. (Pistrang and Barker, 2002)

Interaction Effect of Health Self-efficacy and Social Support on Psychological Distress

There was no significant interaction effect of the health self-efficacy and social support on psychological distress among cervical cancer patients. This is supported by the findings of Chan 2002 who affirmed that neither self-efficacy nor social support mediated the impact of teacher stress on psychological distress among 83 prospective teachers experiencing somatic problems in Hong Kong. But in contrast with the findings of Kristina, saltzman and Holahan (2002), who confirmed in an integrative model that Time 1 social support and Time 2 depressive symptoms was fully mediated by self-efficacy and adaptive coping strategies among 300 depressed college students. This finding was also somewhat in contrast with the work of Khalid and Dawood (2020), he revealed that self-efficacy mediated the effect of social support on depression, anxiety and stress, but no mediation was found between friends support and anxiety among psychologically distressed infertile women.

In addition, this finding is in line with the study of Catz, Kelly, Bogart, Benotsch and McAuliffe (2000), who affirmed that psychosocial problems, and adherence to

medication is related to lack of social support and lack of self-efficacy beliefs about one's ability to adhere to medication. But in contrast with the work of Molassiotis et al., (2002) who found out that adherence to anti retro-viral medication in patients with HIV was strongly related to self-efficacy (that is, optimistic self -beliefs about the ability to follow the medication regimen). These self-beliefs, together with anxiety and nausea, were related to adherence to the recommended treatment; the relationship between social support and medication adherence was weaker than the relationship between self-efficacy and medication adherence. This is also in contrast with the findings of Murphy, Green well, and Hoffman, (2002), who reported Low self-efficacy, together with low outcome expectancies regarding the benefit following the treatment regimen adherence in HIV symptomatic women or women with AIDS .

Three-Way Interaction Effect of Treatment, Health Self-Efficacy and Social Support on Psychological Distress

There was no significant three-way interaction effect of the treatment, health self-efficacy and social support on psychological distress among cervical cancer patients. This is in contrast with Miller, Mesagno, McLaren, Grace, Yates, and Gomez (2019), who reported that exercise-induced mood, was significantly related to depressive symptoms which were moderated by social support sin a two-way interaction terms between exercise-induced mood, exercise self-efficacy, and social support of older adults with depressive symptoms.

This findings is not also in consonance with the result of Josefa, Paz and Maria 2013 have provided evidence that mindfulness-based intervention is effective in improving maternal self-efficacy, mindfulness, self-compassion, satisfaction with life, and subjective happiness, and at reducing psychological distress of breast-feeding mothers.

4.4b Discussion of Data from FGD

Thematic Analysis of Qualitative Data

Theme 1: Emotional Impact of Diagnosis

- Sub-themes: Hopelessness, Helplessness, Shock, Embarrassment, Sadness, Fear, Anxiety
- Findings: Participants expressed feelings of hopelessness and helplessness upon receiving their cervical cancer diagnoses. They described being shocked and unable to comprehend the news. Some felt embarrassed and ashamed, attributing their condition to their lifestyle choices. The participants also experienced intense sadness, fear, and anxiety, with a significant impact on their emotional well-being.

Theme 2: Coping Strategies

- Sub-themes: Withdrawal, Social Support, Professional Help, Faith and Gratitude
- Findings: Participants coped with their feelings by withdrawing from family and friends, isolating themselves. Some relied on social support from neighbors and family members to alleviate their distress. A few sought professional help, such as seeing psychiatrists or taking prescribed medication. Faith and gratitude were also mentioned as coping mechanisms by some participants.

Theme 3: Impact on Sexual Intimacy

- Sub-themes: Relationship strain, Physical discomfort, Self-esteem issues
- Findings: The diagnosis of cervical cancer had a significant impact on participants' sexual intimacy. Some reported strain in their relationships, with partners distancing themselves physically or emotionally. Physical discomfort and pain during sexual activity were mentioned, leading to a decrease in sexual satisfaction. Participants also expressed self-esteem issues and concerns about their attractiveness and ability to satisfy their partners.

Theme 4: Beliefs about the Causes of Cervical Cancer

- Sub-themes: Hereditary factors, Spiritual beliefs, Poor personal hygiene, Lifestyle choices
- Findings: Participants attributed the causes of cervical cancer to various factors. Some believed it was hereditary, while others viewed it as a spiritual attack. Poor

personal hygiene practices and lifestyle choices, such as multiple sex partners and a history of abortions, were also mentioned as potential causes.

Theme 5: Awareness of Prevention

- Sub-themes: Lack of knowledge, Monogamy, Vaccination
- Findings: Participants demonstrated limited awareness of cervical cancer prevention. Some were unaware that it could be prevented, while others mentioned sticking to one sexual partner as a preventive measure. A few participants were aware of the HPV vaccine as a preventive measure against cervical cancer.

Theme 6: Recommendations for Improvement

- Sub-themes: Financial support, Awareness programmes, Access to healthcare, Emotional support
- Findings: Participants recommended that the government provide financial support, such as subsidizing treatment costs, to alleviate the burden of cervical cancer. They also emphasized the need for frequent awareness programmes and free access to HPV vaccines and pap smear tests. Emotional support through counseling and the presence of female healthcare professionals were suggested to enhance patient's comfort.

Summarily, cervical cancer patients interviewed during Focus group discussion described their emotional response upon diagnoses as hopelessness, helplessness, confusion, low mood, speechlessness, lost of appetite, regret and embarrassment

Furthermore, out of the eight responses gotten from their feelings afterwards to the time of the interview, six of them reported heightened negative feelings such as sadness and anxiety while the other two people were trying to adjust with the diagnoses and enormities of treatment. One of these two interviewees reported constant support from her husband while the second woman reported outstanding support from her children

In addition, five interviewees responded to the third question of how they manage their feelings or emotions. Three out of them relate their coping style and technique to believing in God. While one of the other two got help from a mental health professional, the other interviewee was still struggling to adjust as at the time of this interview

Cervical cancer has enormous impacts on the patients' sexual intimacy, many of the patients felt neglected by their spouses and the few that were not neglected never enjoyed sex. More so, none of them was aware of the risk factors of cervical cancer, they were just assuming cause. In addition, only one of the participants demonstrated knowledge of preventing cervical cancer, many others were just assuming based on their experiences.

Conclusively, to be able to adjust better to diagnoses of cervical cancer, about 85% of the respondents suggested financial help probably through government subsidy on cancer treatment cost, other suggestions include: having more of female hospital staff, visiting a mental health professional, getting support from a significant other, awareness programmeme, trusting God and getting oneself back to her usual way of life. Also, the participants implore the government to frequently sponsor awareness programme, provide free vaccine and free cervical cancer screening as many of the ways in which cervical cancer can be prevented.

CHAPTER FIVE

SUMMARY, RECOMMENDATIONS AND CONCLUSION

This chapter provides an overview, recommendations, contributions to knowledge as well as limitations to the study and suggestions for further research.

5.1 Summary

The study examined the effectiveness of MBSR and DT in the management of psychological distress among cervical cancer patients in Lagos and Ibadan, Nigeria.

The psychological distress experienced by cervical cancer patients is alarming and debilitating to their physical and psychosocial well-being. Undetected or untreated elevated level of distress jeopardizes the success of treatment, increases care cost, decreases quality of life, delay recovery or causes untimely death, thus the need to manage the psychological distress of cervical cancer patients.

The research study was presented in five chapters focusing on general introduction, the background to the study, Statement of the problem, purpose of the study, Research hypothesis Research questions, significance of the study, Scope of the study and finally the operational definition of concepts used in the study. Seven hypotheses were formulated for the study while seven questions were also raised to serve as focus group discussion guides

The present study is anchored on the stress process model. The theory explains the relationship among stressors, social support, and mental health outcomes. According to Pearlin (1989), a stressor is an experience that takes the form of life events or chronic strains and in most situations, life events may create chronic strains, or chronic strains may lead to a life event, often referred to as stress proliferation (Pearlin and Bierman 2013). Cervical cancer is regarded as a chronic stressor because it is a disease that once developed, it is persistent and takes the lives of many individuals (Dunkle-Schetter 1984; Wortman 1984). It can also create related strains, such as financial, physical health, and

mental health problems. In this regard, cancer is considered a life event that creates new chronic strains throughout the life course (Dunkle-Schetter 1984).

Empirical evidence of stress process model on psychological distress **is** central on the assumption that stress is a process encapsulating a variety of factors. These may culminate in a range of outcomes including mental and physical health problems (Pearlin, Monton, Lieberman, Menaghan and Mullan, 1981). In general, the stress process model describes the interplay between potentially stressful occurrences, as well as personal and environmental resources that may influence the effects of stress on health outcomes.

5.2 Implications of Findings

The insights garnered from this research possess wide-ranging implications that extend across various spheres of healthcare, psychology, policy, and patient advocacy. These implications underscore the potential for positive change and the transformative impact of addressing psychological distress among cervical cancer patients in Lagos and Ibadan.

The discovery of the efficacy of MbSR and Diversional therapies offers a tangible pathway to enhancing the quality of life for cervical cancer patients. Clinical practitioners and psychologists can integrate these evidence-based interventions into treatment plans, moving beyond the sole focus on physical health to encompass the emotional well-being of patients. By providing tailored psychological support, these interventions can serve as a cornerstone in comprehensive patient care.

The identification of health self-efficacy as a moderating variable provides a critical insight into the power of patients' beliefs in managing their health. This revelation underscores the significance of fostering patients' knowledge, skills, and sense of control over their well-being. By integrating education and empowerment into healthcare programs, practitioners can amplify the positive impact of interventions and empower patients to actively participate in their healing journey.

The collaborative nexus between medical practitioners, mental health professionals, caregivers, and social workers gains enhanced prominence in light of these findings. The interplay between physical health, emotional well-being, and the effectiveness of interventions necessitates a multidisciplinary approach to patient care.

This collaborative effort can result in comprehensive, patient-centered treatment plans that acknowledge the multifaceted nature of cervical cancer patients' experiences.

The implications of this research extend to the realm of policy making. Policy makers can leverage the findings to advocate for the integration of psychological support services within healthcare frameworks. Recognizing the value of psychological well-being alongside medical interventions, policies can be tailored to prioritize holistic care that encompasses emotional and psychological dimensions.

The qualitative insights derived from focus group discussions add depth to the understanding of patients' emotional journey. The reported emotions of hopelessness, helplessness, and anxiety, coupled with varied coping strategies, provide valuable guidance for crafting patient-centered awareness and support initiatives. Awareness campaigns can be tailored to address patients' unique emotional challenges and to promote the acceptance of diverse coping mechanisms.

The revelation of strain in sexual intimacy and relationships highlights the importance of holistic patient support. Addressing the emotional and physical distancing experienced by patients and their partners necessitates tailored interventions that encompass psychological and relationship counseling. By integrating these components, healthcare providers can foster healthier relationships and emotional well-being among patients and their partners.

Patients' recommendations for increased access to HPV vaccines, Pap smear tests, and financial support underpin the significance of preventive measures and equitable healthcare access. Policymakers can utilize these insights to advocate for policies that ensure the availability of essential preventive services and financial support for cervical cancer patients, thereby fostering a proactive approach to health management.

These findings prompt the call for continued research and adaptation. As the healthcare landscape evolves, ongoing research can delve deeper into the long-term effects of interventions, evaluate the scalability of strategies, and examine the evolving dynamics of patient experiences. The lessons learned from this study form a foundation for continual improvement in patient care and psychological support.

Summarily, the implications of this research reverberate across the domains of patient care, field of counseling and clinical psychology, policy, and advocacy. The

findings serve as a clarion call for a comprehensive and multidisciplinary approach to addressing the psychological distress of cervical cancer patients. By heeding these implications, stakeholders have the opportunity to collaboratively shape a healthcare landscape that prioritizes holistic well-being, empowers patients, and fosters a profound positive impact on the lives of those navigating the challenges of cervical cancer

5.3 Conclusion

Cervical cancer presents a significant challenge to the well-being of affected individuals, both physically and emotionally. Through an exploration of the effectiveness of MbSR and DT, this research has shed light on avenues to alleviate the psychological distress experienced by cervical cancer patients in Lagos and Ibadan. The findings have unveiled crucial insights into the role of health self-efficacy as a moderating variable, while also highlighting the nuanced impacts of social support if it's from an unexpected or insignificant others. Furthermore, the focus group discussions have added depth to our understanding of the emotional journey of patients, their coping strategies, and their recommendations for enhancing their experience.

The initial exploration of the research findings underscores the efficacy of MbSR and Diversional therapies in managing psychological distress among cervical cancer patients. This discovery holds significant promise for patients grappling with feelings of hopelessness, helplessness, embarrassment, shock, sadness, and anxiety. The inclusion of these therapies in treatment plans has the potential to alleviate the emotional turmoil that often accompanies cervical cancer diagnosis. By empowering patients with effective coping strategies and a renewed sense of control, MbSR and DT have the capacity to enhance the overall quality of life throughout their cancer journey.

An equally crucial revelation lies in the role of health self-efficacy as a moderating variable. This variable acts as a pivotal point of interaction between the effectiveness of psychological interventions and the individual's belief in their capacity to manage their health. This connection underscores the significance of empowering patients with the knowledge and skills to actively participate in their healing process. Recognizing and harnessing this moderating factor can lead to more personalized and

targeted interventions, fostering a sense of agency that positively impacts patients' emotional well-being.

The focus group discussions provide a poignant narrative of patients' emotional trajectories from diagnosis through treatment and recovery. The gamut of emotions expressed—hopelessness, helplessness, embarrassment, shock, sadness, and anxiety—paint a vivid picture of the emotional rollercoaster these patients endure. The coping strategies they employ—ranging from withdrawal and seeking social support to engaging professional help, faith, and gratitude—underscore the diversity of approaches individuals utilize to manage their distress. It is evident that a multidimensional approach to psychological support is essential, acknowledging the individuality of each patient's experience.

The participants' candid insights into the impact of cervical cancer on sexual intimacy reveal the intricate interplay between physical health, emotional well-being, and relationship dynamics. Strain, emotional distancing, and physical separation emerge as themes, underscoring the need for comprehensive support that extends beyond the medical realm. The participants' recommendations for financial assistance, frequent awareness programs, free access to HPV vaccines and Pap smear tests, as well as emotional support, further illuminate the pathways toward enhancing patients' experiences.

In light of these comprehensive findings, the implications ripple across various domains. Cervical cancer patients stand to gain from improved psychological support, more effective coping strategies, and the integration of MbSR and DT. Caregivers can play a pivotal role armed with an understanding of these interventions. Clinical and counseling psychologist can adapt their practices, while medical practitioners and mental health professionals can collaborate to provide holistic care. Social workers can design tailored support programs, and policy makers can craft informed policies that prioritize psychological well-being.

5.4 Limitations of the study

While the present study offers valuable insights into the effectiveness of MbSR and DT in managing psychological distress among cervical cancer patients in Lagos and Ibadan, several limitations warrant consideration.

First, the study's sample size may restrict the extent to which the findings can be generalized. A more expansive and diverse participant pool could enhance the representation of various experiences and perspectives, thereby strengthening the applicability of the conclusions.

Moreover, the geographical focus on Lagos and Ibadan might limit the extent to which the findings can be extrapolated to other regions. Variations in cultural norms, socioeconomic conditions, and healthcare infrastructures across different locations could influence the transferability of the results.

A potential limitation arises from the reliance on self-report data, including the information gathered through focus group discussions. Such data may be susceptible to self-report bias, where participants' accounts are influenced by their personal perceptions or memory recollections, possibly leading to inaccuracies in their reported coping strategies and emotional experiences.

Additionally, participants might have been influenced by social desirability bias, providing responses that align with societal expectations rather than reflecting their genuine feelings or experiences. This could introduce a distortion in the portrayal of their psychological responses and coping mechanisms.

While the study has examined health self-efficacy and perceived social support as moderating variables, other unexplored factors could play a role in shaping the effectiveness of interventions and the psychological well-being of patients. The intricate interplay of various moderating elements could contribute to a more comprehensive understanding of the observed outcomes.

Furthermore, the short-term nature of the study might not capture the potential long-term effects of the interventions on patients' psychological well-being and coping strategies. A longitudinal approach could provide deeper insights into the sustainability of the observed positive outcomes.

Selection bias could also be a potential concern, as participants who volunteered for the study might possess unique characteristics or experiences that differ from those who chose not to participate. This could influence the representativeness of the sample and consequently the generalizability of the findings.

Interpretation of qualitative data, such as the insights gained from focus group discussions, is inherently subjective. Different researchers may interpret the same data in diverse ways, highlighting the importance of multiple perspectives and employing triangulation methods for more robust qualitative analysis.

Lastly, external influences, such as changes in medical treatments, social support systems, or policies, could impact the applicability and relevance of the interventions and findings over time. The dynamic nature of healthcare and societal contexts necessitates ongoing vigilance in interpreting and applying the study's outcomes. However, these limitations do not eliminate the research's quality and validity.

5.5 Recommendations

Considering the findings, the following suggestions are recommended:

- The adoption of MbSR and DT by hospitals in dealing with cervical cancer patients
- The need for increased sensitization and enlightenment is required. Awareness and informed knowledge about cervical cancer will reduce the patients' psychological distress level upon diagnoses
- The need to make psychological distress the sixth vital sign of women with cervical cancer, after temperature, pulse, respiratory rate, blood pressure and pain is recommended
- Medical practitioners, social health workers and others could utilize MbSR and DT as evidenced based treatments in the reduction of psychological distress level of CCPs.
- Many CCPs have attributed their cervical cancer diagnoses to their risky sexual behaviour which further aggravate their psychological distress level. Participants and every CCP should realize that risky sexual behaviour is one of many predisposing factors to cervical cancer. therefore, they should use their non-

judgemental attitudes and exercise their right to good life and recreation activities learnt from MbSR and DT respectively during the intervention programmeme

- CCPs and their care givers should consult an expert in managing the psychological distress and other emotional problems of the CCPs as this will go a long in hastening their recovery process
- Enhanced health self –efficacy is instrumental to reduced psychological distress, so CCPs are implored to work on their health self-efficacy and also be empowered psychologically across all phases of the cancer care trajectory
- The psychotherapy is recommended for a larger population by including them in daily care for CCPs who have significant psychological distress level in Lagos and Ibadan, Nigeria.
- More work is required to create additional psychological therapies for CCP so they can select from a variety of therapeutic options.
- Finance is another trigger of psychological distress among CCP, the government should make treatment accessible by subsidizing the cost

5.6 Contributions to Knowledge

The study contributed to knowledge in the following ways:

- The foundation of the viability of MbSR and DT in treating psychological distress of women with cervical cancer.
- The study established that MbSR was more effective than DT in reducing psychological distress among cervical cancer patients
- The study has shown that an exceptionally elevated degree of HSe is important to experience reduced psychological distress among cervical cancer patients.
- The study contributed to the existing literature on management of psychological distress among women with cervical cancer
- This study has likewise laid the foundation for future examinations on MbSR and DT in sub-Saharan Africa.

5.7 Suggestions for Further Studies

In this study, CCPs from Lagos and Ibadan, Nigeria, were examined to see how well MbSR and DT managed their psychological distress. Given this, the study might be repeated in various regions of the nation. The experimenter recommends expansion of the scope to include all the geopolitical zones of Nigeria in order to extend the generality of the study

In addition, a longer-term study of this kind could be carried out to provide cancer patients more chances to internalize the lessons learned through the psychotherapy techniques. More so, the inclusion of additional moderating factors including religiosity, socioeconomic status, and cultural orientation could be done through a longitudinal study.

Finally, the management of other emotional and behavioural issues connected to cervical cancer diagnoses could also be handled with MbSR and DT.

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APPENDIX I

DEPARTMENT OF COUNSELLING AND HUMAN DEVELOPMENT STUDIES
FACULTY OF EDUCATION
UNIVERSITY OF IBADAN

Dear Respondents,

The primary goal of this questionnaire is research. It wants to know your response to these statements. All given information will be kept private.

Section A

Demographic Information

Please mark the correct box and complete the fields as required.

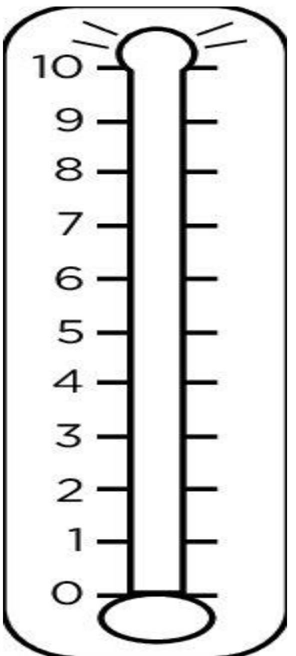
5. Age: Below 30 years ( ), 30-50 ( ), 50-60 ( ), Above 60
6. Religion: Christianity ( ), Islam ( ), Others ( )
7. Social Economic Status: High ( ), Modeate(), Low ( )

Section B

Distress Thermometer

Instruction

Indicate your level of distress on the distress thermometer from a 0 (no distress) to 10 (extreme distress) identify those problems contributing to your score on the problem checklist.



Section C

Kessler psychological Distress Scale (K10 Test)

Instruction: These questions concern how you have been feeling over the past 30 days. Tick the appropriate option that best describes how you have been.

Key: 1 = None of the time, 2 = A little of the time, 3 = Some of the time, 4 = Most of the time and 5 =All of the time

S/N	**ITEMS**	**1**	**2**	**3**	**4**
1	Over the last 30 days, about how many times have you felt inexplicably drained				
2	During the last 30 days, about how often you felt anxious				
3	During the last 30 days, about how many times have you felt so anxious that nothing can calm you				
4	During the last 30 days, about how many times have you felt irredeemable				
5	During the last 30 days, about how often you felt anxious/stressed				
6	During the last 30 days, about the number of times you felt so anxious that you were unable to stand aside				
7	Over the last 30 days, about how many times have you been feeling down				
8	During the last 30 days, about how many times have you felt like everything was working out				
9	Over the last 30 days, about how many times have you felt so miserable that nothing can cheer you up				
10	During the last 30 days, about how many times have you felt useless				

Section D

Health Self-Efficacy Scale

Instruction: Please tick ( ) the appropriate column as it is applicable to you

Key: **SA- S**trongly Agree, A- Agree, **U-** Undecided, **D-** Disagree, **SD-** Strongly Disagree

S/N	Items	SA	A	U	D	SD
1.	I am sure that I can definitively influence my voice					
2.	I set some unambiguous goals to work on my well-being					
3.	I had the choice to achieve the goals I set for myself to work on my own well-being					
4.	I am actively trying to work on my health					
5.	I feel responsible for how and what I find out about my well-being					

Section E

Social Support Scale

Instruction: Please tick () in the appropriate column as it is applicable to you.

Key: 1 = Strongly Disagree, 2 = Disagree, 3 = Neutral, 4 = Agree, and 5 = Strongly Agree

S/N	**ITEMS**	**1**	**2**	**3**	**4**	**5**
1	There is a special person nearby whenever you need help.					
2	There is someone special in my life who makes me feel wanted.					
3	Regardless of my physical well-being, my family provides me with the necessary emotional support that helps me feel a greater sense of worth					
4	I have a unique person who offers me a great deal of solace					
5	My buddies are doing their best to convince me that I am a VIP.					
6	When things take a turn for the worse, I can rely on my friends for support and assistance					
7	I feel comfortable discussing my problems with my family, knowing that they are willing to listen and offer support.					
8	I can share my happiness and sadness with others.					
9	I have friends with whom I can socialize and find distraction from my worries, especially when I'm in bedridden					
10	I have someone to hang out with for relaxation					
11	There is a special person nearby whenever you need help.					
12	There is someone special in my life who makes me feel wanted.					
13	No matter my health, my family provides the emotional support I need. They make me feel more valued.					

APPENDIX II

RESPONDENTS' INFORMED CONSENT FORM

Title of Research

MbSR and DT in the management of psychological Distress among Cervical Cancer Patients in Lagos and Ibadan, Nigeria

Name of the Principal Investigator: This research is being conducted by Azeez Afusat Adebisi of the Department Counseling and Human Development Studies, Faculty of Education, University of Ibadan

Sponsor of Research: The research is self-sponsored

Purpose of Research: is to investigate the impacts MbSR and DTon psychological distress of CCPs in Lagos and Ibadan, Nigeria.

Research Procedures: A total of 61 members will be recruited for the review. After completing the initial test, you will receive either a variety therapy or a MbSR intervention for eight weeks, as determined by the survey. Data will be analyzed using a post-intervention testing tool.

Research Timeframe: You will be expected to participate in this study for a period of eight weeks. Each session should not last more than one hour.

Risks: Participants are not expected to be at risk from the research.

Costs Associated with Study Participation: Only the time you spend participating in this study will cost you anything else.

Benefits: The aim of this examination is to speed up the recovery cycle for patients with cervical diseases and work on their personal satisfaction by reducing the degree of their psychological pain.

Confidentiality: This study will not use any names, and codes and serial numbers will be used to collect data to maintain the privacy of information. All data collected in this review, distributions, or reports from this study cannot be linked to you.

Volunteering: Your participation in this study is entirely at your discretion.

Options other than participation: You are allowed to withdraw your support in the review if you wish and this will not affect your admission to hospital in any capacity.

Due Motivational Force: Withdrawal from the research by a participant has specific consequences, and there is a procedure in place to ensure a smooth and organized

termination of their participation: You will be reimbursed for the cost of transportation (#500) to and from the research site; however, you will not be paid to participate in the research. You can decide to end your participation. Please be aware that some of the information collected about you prior to your opt-out may have been changed or used in publications and reports. It can no longer be removed. In any case, the experimenter undertakes to present pure intentions attempt to agree to your desires with as much interest as can really be expected

The most effective way to guide treatment and actions to take if injury or unfavorable events arise: What happens to the communities and people who participated in the research after it ends? You will receive a newsletter from the experimenter detailing the results of the study. A statement about benefit-sharing among investigators and whether it includes or excludes research participants: Any information that may affect your continued participation or health will be communicated to you while this study is being conducted. Because the research is self-financed and not sponsored by a commercial organization, there is no intention to communicate to any participants about the benefits: participants will benefit from this study. There is nothing in my knowledge that would compel an experimenter to abandon his work out of fear or favour.

Statement of the person obtaining informed consent:
I have fully explained this research to
And have given sufficient information, including about risks and benefits, to make an informed decision
DATE:
SIGNATURE
NAME

Statement of person giving Consent: I have either read a summary of the research or obtained a translated version in a language that I can comprehend. Furthermore, I have engaged in a fulfilling discussion about it with the doctor. I am aware that my involvement is entirely optional. I am knowledgeable enough about the research study's goals, procedures, risks, and advantages to decide whether or not I want to participate. I

am aware that I retain the right to withdraw from this study at any given time. I have been provided with a copy of the consent form as well as an informational leaflet, which I can keep for my personal records.

DATE:_____________________ SIGNATURE:__________________

SERIAL NO________________

This research has been approved by the Health Research Ethics Committee of the following centers:

1. UI/UCH ETHICS COMMITTEE

Biode Building, Room 210, 2nd floor, Institute of Advanced Medical Research and Training, College of Medicine, University of Ibadan.

E-mail:uiuchirc@yahoo.com and uiuch@gmail.com

2. LUTH HEALTH RESEARCH ETHICS COMMITTEE'S CONTACT

Room 107, Administrative block

Lagos University Teaching Hospital,

Idi-Araba, Lagos.

3. LASUTH HEALTH RESEARCH ETHICS COMMITTEE

1-5, Oba Akinjobi Road, Ikeja, Lagos.

E-mail:dcst@lasuth.org

You can get in touch with the lead experimenter if you have any queries about your involvement in this study: Azeez, Afusat Adebisi. From the Department Counselling and Human Development Studies, Faculty of Education, University of Nigeria. Phone: 07032642718 E-mail: tolani89@yahoo.com

APPENDIX III

YORUBA VERSION OF INSTRUMENTS AND TREATMENT MANUALS

ÈDÌDÌ/ERÙ FÚN ÌTỌ́JÚ

ÌDÁNWÒ ÌSÒWỌ́ KÌNÍNNÍ:

ÌFIYÈSÍ-ÌPÌLẸ̀ ÌLÒ AGBÁRA NÍNÚ ÈTÒ ÌSÀKÓSO FÚN ÈKỌ NÍPA ÈRÒ ỌKÀN/ÌFÈRÒ ỌKÀN/ÌPÒRUURU ỌKÀN/ỌGBẸ́ ỌKÀN LÁÀRIN ALÁRÙN JẸJẸRẸ ̣INU ILÉ ỌMỌ OBÌNRIN/OJÚ ARA ABẸ́ OBÌNRIN

Ọ̀NÀ ÌDÓÒLÀ Ẹ̀MÍ ALÁÌSÀN/ṢÍṢE ÌTỌ́JÚ ÀÌSÀN NÁÀ

- Fi arakínra kí o sì dá aláìsàn náà dúró nípa sísọ̀rọ̀ pọ̀
- Ṣíṣe ìgbéléwọ̀n/àyẹ̀wò ìsòro, ẹni àti okùnfà ìsòro ọgbẹ́.
- Pèsè ọkàn oníbàárà (aláìsàn sílẹ̀ fún ìtọ́jú).
- Ṣe àmúlò èdidi/ẹrù fún títọ́jú ẹni náà.
- Ṣe ìtọpinpin/ìgbéléwọ̀n àṣeyọrí ìdàgbàsókè tí ó ti ní lásìkò ìkókòó kọ̀ọ̀kan.
- Pèsè ọkàn oníbàárà/akópa/aláìsàn sílẹ̀ fún ìfòpin sí ìjókòó ìfọ̀rọ̀wánilẹ́nuwò náà.

Àyèwò Fínnífínní

Àwọn akópa pẹ̀lú àwọn mìíràn tó ní àárùn/àìsàn jẹjẹrẹ ẹnu ilé ọmọ obìnrin/aláìsàn náà ni a ṣe àyẹ̀wò wọn nípa ṣíṣe àmúlò ẹ̀rọ tó ń ṣe àyẹ̀wò ìfòró ọkàn tàbí ìọ́njú ọkàn (Distress Thermometer). Nígbà tí ìpòruuru ọkàn/ìpọ́njú èrò ọkàn tó ga, irú ẹni náà gbọ́dọ̀ jẹ́ dídádúró fún ìgbésẹ̀ títọ́jú. Àwọn aláìsàn jẹjẹrẹ ojú ara ilé ọmọ obìnrin yóò di àkọ̀ti/àpati.

Àyọrísí/Òpin Ìtọ́jú

Ìkésẹjárí òpin dídásí láti ṣe àmúlò ọgbọ́n "MbSR" nínú ètò ìṣàkóso gbèndéke ìpòruru ọkàn/ìfòró ọkàn/ọgbẹ́ ọkàn àwọn aáìsàn tó ní àìsàn/àárùn jẹjẹrẹ ilé ọmọ obìnrin lára.

Ìjókòó Kìn-ín-ní

Orí Ọ̀rọ̀: Ìfihàn gbogbo-gbò àti gbọ́n ìpínfúnni ohun èlò ìwádìí tí ó lè gbé àmì máàkì ìdánwò àṣesáájú (Preọ́test sẹores).

Èròngbà

Ní ìparí ìjókòó yìí, olùwádìíyóò le:

i. Kọ ilé ìlera pípé àjùmọ̀ṣepọ̀ pẹ̀lú àwọn akópa
ii. Fún àwọn akópa ní ẹ̀kọ́/ìmọ̀ ìfinimọlé nípa ọ̀nà àti ìlànà kíkọ ẹ̀kọ́ náà
iii. Ṣe àmúlò ohun èlò ìwé ìléwọ́ ìbéèrè tí a mọ̀ sí Kessler Psyẹhologiẹal Distress Áuestionnaire àti pẹ̀lú ìwọn àtìlẹyìn ọ̀làjú àwùjọ (Soẹial Support Sẹale) àti ìwọ̀n tí a mọ̀ sí (selfọ́effiẹaẹy sẹale) fún èròǹgbà láti ni àbò ìwádìí/ìròyìn tó fẹṣẹmúlẹ̀/tó kira.

Àmúṣe Iṣẹ́:

Ìgbésẹ̀ Kìn-ín-ní: Olùwádìí fi tayọ̀tayọ̀ ki àwọn akópa káàbọ̀ síbi ètò náà àti fífaramọ́ra rẹ̀ pẹ̀lú àwọn akópa.

Ìgbésẹ̀ kejì: Olùwádìí ṣe ìdamsílẹ̀ ìhà ìfarakínra láàrin òun fúnrarẹ̀ àti àwọn akópa nípa wíwá àyè kan fún fífara hàn olùwádìí/àwọn akópa olùwádìí gbọ́dọ̀ tún ri akópakọ̀ọ̀kan mọ̀ nípa fífiwọ́sí fọ́ọ̀mù mo mọ̀sí láti le ṣe àkọsílẹ̀ èrò ọkàn wọn láti kó ipa nínú ẹ̀kọ́ náà.

Ìgbésẹ̀ Kẹta: Olùwádìí ṣe àgbékalẹ̀ bí ètò náà ṣe máa rí, ó ṣe àlàyé ìdí pàtàkì ètò/ìṣẹ́ ìwádìí náà àti ohun akompa kọ̀ọ̀kan la fi lọ́kàn balẹ̀ pẹ̀lú ìdánilójú pé àṣírí ìwádìí náà yóò jẹ́ pípamọ́ lásìkò ìwádìí àti lẹ́yìn ìwádìí náà ètò náà.

Ìgbésẹ̀ Kẹrin: Olùwádìí ṣe àlàyé àwọn òfin tó de ṣíṣe àkóso ètò náà àti ohun tí olùwádìí n retí/fẹ́ kí akópa kọ̀ọ̀kan mọ̀ jẹ́ nnkan tí a sọ̀rọ̀ lé lórí tí a sì fi ìdí òkodoro ò.rọ̀ náà múlẹ̀.

Ìgbésẹ̀ Karùn-ún: Olùwádìí ṣw àkójọpọ̀ àwọn ohun èlò tó ṣe àmúlò fún iṣẹ́ ìwádìí yìí (ohun èlò ìdánwó àṣesáájú) (the preọ́test instrument Kssler Psyẹhologiẹal Distress Sẹale, Health Self Effiẹaẹy Sẹale àti Soẹial Support Sẹale).

Ìgbésẹ̀ Kẹfà: Àwọn akópa ni a fún ni iṣẹ́ àyànṣe láti ṣe bọ láti ilé wa. Láti ṣe ìdámọ̀ ìyàtọ̀ tó wà lamàrin àwọn nnkan tí o máa ń jẹ́ kí ìfòrò/ọgbẹ́ ọkàn wà fún akópa.

Ọ̀rọ̀ Ìparí/Ìkádìí

- Àwọn akópa ni a gbé òṣùbà káre fún lórí ìfọwọ́sọwọ́pọ̀ àti àkókò tí wọ́n fi sílẹ̀.
- Olùwádìí fún wọn ní ìwúrí láti le gbáradì fún pípèsẹ̀ níbi ìjókòó iṣẹ́ ìwádìí mìíràn tó ń bọ̀ àti rírán wọn létí ọjọ́ kejì àti ibi àkókò ìpàdé.

Ìjókòó Kejì:

Orí ọ̀rọ̀: Èrò nípa nnkan tí ó mú ìfòró ọkàn/ìbànújẹ́/ọgbẹ́ ọkàn wa àti àárùn/àìsàn jẹjẹrẹ ilé ọmọ obìnrin.

Èròǹgbà: Ní ìparí ètò ìjókòó yìí, àwọn akópa yó le:

i. Sọ ohun tí àárùn jẹjẹrẹ ilé ọmọ obìnrin jẹ́.

ii. Ṣe àlàyé àti mọ̀ nípa ohun tí ìfòró/ìpòruurù ọkàn/ọgbẹ́ ọkàn jẹ́.

Àmúṣe iṣẹ́:

Ìgbésẹ̀ Kìn-ín-ní: Tìdùnnnútìdùnnú ni olùwádìí fi kí àwọn akópa káàbọ̀ síbi ètò ìjókòó ẹ̀kọ́ yìí.

Ìgbésẹ̀ Kejì: Olùwádìí ṣe àgbéyẹ̀wò iṣẹ́ àṣetiléwá/iṣẹ́ àyànṣe pẹ̀lú àwọn akópa.

Ìgbésẹ̀ Kẹta: Olùwádìí ṣe àlàyé ohun tí àìsàn jẹjẹrẹ ilé ọmọ obìnrin jẹ́. àìsàn jẹjẹrẹ ilé ọmọ obìnrin jẹ́ àìsàn jẹjẹrẹ tó máa n ba ilé ọmọ obìnrin jẹ́ nínú ojú ara obìnrin.

Ilé ọmọ obìnrin yìí ló wà ní apá ìsàlẹ̀ abẹ́ ilé ọmọ obìnrin tó so mọ́ ara ojú abẹ́ títí kan ilé ọmọ (òbò) níbi tí ọmọ n gbà wá sí ilé ayé.

Àìsàn jẹjẹrẹ obìnrin sábáà máa n wáyé nípasẹ̀ ìṣẹ̀lẹ̀ àárùn ara pẹ̀lú ewu tó ga jù nínú àgọ́ ara ènìyàn tí a mò sí Human Papilloma GBirus (HPGB): Àárùn ara yìí (HPGB) Human Papilloma GBirus jẹ́ nnkan tí ó kéré tí kìí ṣe kòkòrò àìfojúrí tó kóa jọ ó ní ìpele méjì tan (Double Stranded GBirus (DNA) gẹ́gẹ́ bí ohun èlò àtọ̀ ara àti pé ó tó bí ìwọ̀n máàrúnléláàdọ́ta ní títóbi rẹ̀. HPGB jẹ́ àárùn tó máa n ràn lásìkò ìbálòpọ̀ láàrin akọ àti abo. Àwọn nnkan mìíràn tó tún máa n fa àìsàn jẹjẹrẹ ilé ọmọ obìnrin nìwọ̀nyí – Tábà mímu, ìṣe dédé tó ga/Ìjọra tó ga, ìlò ògùn ọjọ́ pípẹ́/tọ́jọ́ ti lọ órí rẹ̀, ìbálòpọ̀ àdàlù aláìní gbèndéke ọkùnrin pẹ̀lú obìnrin àti kíkó àárùn ìbálòpọ̀ HGB.

Ìgbésẹ̀ Kẹrin: Olùwádìí ṣe àlàyé lórí ohun tí ìpòrurù/ìfòró ọkàn jẹ́ fún àwọn akópa (Psyẹhologiẹal distress) nnkan tó dá ọkàn láàmú tó fa ìfòró ọkàn jẹ́ kókó kan tó kárí ayé tí à ń lò láti ṣe àpèjúwe ipò àìdùnnú ẹ̀dá tí ó sì máa ń ṣe àkóbá fún ìgbésẹ̀ ẹ̀dá mìíràn fún ìṣe dédé àti ddíásí ọ̀rọ̀ ọkùnrin tàbí obìnrin nínú iṣẹ́ àmúṣe ojoojúmọ́.

(Psyẹhologiẹla distress) túmọ̀ sí ọ̀nà kan gbòógì bí àpẹẹrẹ - Ìrúnnú, Jìnnìjìnnì, ìpáyà òjijì, ìpòruru ọkàn, ìyọjú sí láìpẹ́, àìbalẹ̀ àyà/ọkàn. Bákan náà a lè ṣe àlàyé pé ìfòró ọkàn tàbí àìbalẹ̀ àyà jẹ́ nnkan tó máa n da ọpọlọ wa láàmú àti ìhùwàsí wa lásìkò tí ìjà tàbí ìsẹ̀lẹ̀ òjijì bá ṣẹlẹ̀ tí ó sì fẹ́ mú ìdẹ̀rùbáni dání èyí tí ìpayà tàbí ìfòró ọkàn mú dání àti àmì ìdoríkodò/ìrẹ̀wẹ̀sì.

Ó jẹ́ nnkan tí a ṣe àlàyé pé ìfòró ọkàn máa tàn kalẹ̀ fún ìgbà pípẹ́ bẹ̀rẹ̀ láti ibi nnkan tí ó n dunni tí a sá lọ́gbẹ́, ìbànújẹ́ àti ẹ̀rù (ìbẹ̀rù) sí àpẹẹrẹ: ìrẹ̀wè.sì/ìdoríkodò, àìbalẹ̀àyà/ìpayà, ìgbọ̀nrìrì, dídáwà láìgbé ṣe àti ìwà láyè àti ìkọ́lú tẹ̀mí.

Ìfòró ọkàn àti àìbalẹ̀ àyá jẹ́ nnkan tí a lè sọ¸pé ó jẹ́ okùnfà tí ó máa ń fa ìròró ọkàn ó sì má n wà ní agbọn gbogbo ní pàtàkì tí a bá ń ṣe àyẹ̀wò àwọn obìnrin fún àárùn jẹjẹrẹ ilé ọmọ obìnrin fumn àwọn ìdí wọ̀nyí:

i. Ìpayà idròyìn òjijì tàbí àìròtẹ́lẹ̀
ii. Ìsòro àìrówóná
iii. Ìtọ́jú Agbára
igb. Àléébù/àyọrísí gbígba ìtọ́jú

gb. Ẹomorbidities??______________

gbi. Àìsí ìrànló.wọ́ láti ọ̀dọ̀ àwọn ẹlẹ́gbẹ́ ẹni

gbii. Àmì ẹ̀gàn, ṣíṣe àléébù sí ẹni

Ìgbéléwọ̀n: Àwọn ìbéèrè wọ̀nyí ni olùwádìí béèrè lọ́wọ́ àwọn akópa:

i. Ṣe àlàyé àárùn jẹjẹrẹ ilé ọmọ obìnrin
ii. Dárúkọ àwọn àmì tó ń ṣe àfihàn ìfòró/ìpòrurù ọkàn hàn

Iṣẹ́ Àyànṣe/Àṣetiléwá: Kín ni òdiwọ̀n/òṣùwọ̀n tí o lè lò láti ṣe àdínkù ìfòró/àìbalẹ̀ ọkàn rẹ̀ tó n bá ọ finra.

Ìkádìí:

- Àwọn akópa gba oríyìn fún ìfowọ́sowọ́pọ̀ wọn àti ṣíṣe gbìyànjú láti ṣe iṣẹ́ àṣetiléwá wọn.
- Àwọn akópa ti gbọ́ nípa àsìkò àti ibi ìpàdé fún ìjókòó mìíràn tó n bọ̀.

Ìjókòó Kẹta

Ori Ọ̀rọ̀: Ìjókòó yìí n ṣe àfihàn ìdínkù ọkàn tí ó kún fún ìpòrurù.

Èròngbà: Ní òpin iṣẹ́ ìjókòó yìí, àwọn akópa yóò le:

- Ṣe àlàyé ìfiyèsí ara tàbí mọ̀ sínú nípa nǹkan
- Ṣe àkómọ́ra àwọn nǹkan mẹ́ta nínú ìwà méje tó jẹ́ ti ìfiyèsí ara: Àìṣe ìdájọ́, sùúrù iyè àsẹ̀ṣẹ̀dé.
- Máa kọ iṣe bí ó a ti ṣe ń jẹun tàbí ṣíṣe àsàrò òmìnira tàbí nípasẹ̀ ìtọ́ni ohun tí a gbà sílẹ̀.
- Máa ya àwòrán ara olómìnira ọ̀tọ̀ tàbí ìtọ́ni ohun tí a gbà sílẹ̀.

Ìgbésẹ̀ Kin-inọ́ni: Olùwádìí fi tayọ̀tayọ̀ kí àwọn akópa káàbọ̀

Ìgbésẹ̀ Kejì: Olùwádìí ṣe àgbéyẹ̀wò ẹ̀kọ́ tí a kọ́ ní ìjókòó tí a ṣe àlàyé pẹ̀lú àwọn akópa kí ó ṣe àtúnyẹ̀wò iṣẹ́ àṣetiléwá/iṣẹ́ àyànṣe pẹ̀lú wọn.

Ìgbésẹ̀ Kẹta: Olùtọ́jú aláìsàn tàbí onímọ̀ nípa àisàn náà ṣe àlàyé ohun tí a mọ̀ sí ìfiyèsí tàbí ìsọ̀ra nípa nǹkan.

Ìsọ́ra nípa nnkan/ìfiyèsí ara jẹ́ ọ̀nà tí a fi máa tẹ́tísílẹ̀ sí àwọn nǹkan tó bá ṣẹlẹ̀ lójijì láìsí pé à ń ṣe ìdájọ́. Nígbà tí ẹnìkọ̀ọ̀kan bá ti gbà ìpò ọkàn/irọ́gidi níròrí nnkan tí ó ṣẹlẹ̀ jẹ́ nǹkan tí a ṣe àkíyèsí pẹ̀lú àwọn ìṣẹ̀lẹ̀ tí ó rò nínú ọkàn láìsí àsomọ́ ìtumọ̀ àti ìtumọ̀ tí ó wà láti inú ọkàn wa àti láìsí ìfàbínúyọ èyí tí ìṣẹ̀lẹ̀ rẹ̀ n ṣíṣẹ́ ní ọ̀nà yàjóyàjó. Ìgbésẹ̀ fún ṣíṣe wà láti inú ọkàn wa àti láìsi ìfàbínúyọ èyí tí ìṣẹ̀lẹ̀ rẹ̀ ń ṣiṣẹ́ ni ọ̀nà yàjóyàjó. Ìgbésẹ̀ fún ṣíṣe àkíyèsí àti bíbẹ èrò inú gẹ́gẹ́ bí ìṣẹ̀lẹ̀ kan láìsí ìdájọ́ tí ó ní èrò to le fàyè gba "àyè láàrin èrò inú ẹnìkan àti ìdáhùn sí irú ẹni bẹ́ẹ̀.

Àyà ìkólékàn máa n gbà wá láàyè láti ṣe nǹkan pẹ̀lú èrò tẹni dípò kí a fa ìbínú yọ lọ́nà tí a fẹ́/tí ó wù wá.

Ìsọ́ra nípa nǹkan/àkólékàn nípa nǹkan jẹ́ nǹkan tí a máa mú ìmọ̀ nía bí a ti rò pé ó yẹ kí nǹkan rí tàbí ṣíṣe gẹ́gẹ́ bí ipò tí ó ti wà láti ọjọ́ pípẹ́ ní ìbámu pẹ̀lú nǹkan tí ó n tẹ̀síwájú láti ibi gíga óhàn kedere sí ibi tó kéré lọ́nà òjijì tó n ṣíṣẹ́ fún ara rẹ̀, pẹ̀lú ọkàn yẹpẹrẹ tó n ṣiṣẹ́ déédéé bí irú èyí, oníkálukú ló ní agbára tàbí àyè láti ní àkólékàn tara rẹ̀, bí ó tilẹ̀ jẹ́ pé ẹnìkọ̀ọ̀kan ló yàtọ̀ nípa síṣe déédéé pẹ̀lú bí wọ́n ṣe ń ṣe ìtọ́jú àkólékàn ipò ìṣẹ̀dá wọn.

Ṣíwájú síi, nǹkan lára èyà kan nínú ohun tó mú kí èrò ọkàn ó kún tàbí di odidi nípa ṣíṣe láti wò, gba àti nítòótọ́ láti fàyè gbà agídí, lílé àyà, ìpòrurù ọkàn àti ara ríro/ìnira gẹ́gẹ́ bí ìdààmú ọkàn tí o máa n fojù hàn bíi ìbẹ̀rù (ẹ̀rù, ìbínú, ìjákulẹ̀ àti ìbẹ̀rùbojo àìsí ààbò àti ẹni àìkàsí láwùjọ/ẹni tí kò jẹ nǹkan láwùjọ. Èyí jẹ ṣíṣe pẹ̀lú èròǹgbà gbígba káámú ipò tí ènìyàn ba ara rẹ̀ lẹ́sẹ̀kẹsẹ̀ tí a bá ṣe àwárí rẹ̀, bóyá ó dùn mọ́ ni/wuni tàbí kò dùn mọ́ni/wuni tàbí kò dùn mọ́ni àti pé ó jẹ́ ìgbésẹ̀ àkọ́kọ́ sí mímú àyípadà tim óhànde tàbí jẹ òtítọ́ àti tí ó ní ìbáṣepọ̀ pẹ̀lú rẹ̀. Ìsọ́ra nípa nǹkan/àkólékàn ni a lè ṣe àmúlò lásìkò tí a bá ń jẹun, tí a bá ń wa ọkọ̀ lọ tàbí tí a bá jókòó, nígbàkígbà ní gbogbo ọjọ́. Ìtara níní ẹ̀bùn ìrántí àti mímú ìtẹ́tísílẹ̀ sí nǹkan tó n ṣẹlẹ̀ lọ́wọ́ àti àwọn iṣẹ́ ṣíṣe tó rọrùn ní gbogbo ọjọ́ tó mú ṣíṣe dárú.

Ìgbésẹ̀ kẹrin: Olùwádìí ṣe àlàyé ìṣesí ìsọ́ra nǹkan tàbí àkólékàn bíi: àìṣe ìdájọ́, sùúrù àti èrò/iyè ọkàn ẹni tó ṣẹ̀sẹ̀ bẹ̀rẹ̀.

Àìlè ṣe ìdájọ́: Ìsọ́ra nípa nǹkan jẹ́ nínú àànú tàbí ìyọ́nú ọkàn tó sípayá, ìmọ̀ nípa ààyò/àṣàyàn nǹkan tí a ò fẹ́/ti a kò náání. Ó jẹ́ nǹkan tí a rò tàbí tọ́ nípa ṣíṣe ẹlẹ́rìí ìrírí tí ẹnikan ní, láìṣe ìdájọ́ tàbí ṣègbè ẹjọ́ gẹ́gẹ́ bí ohun tó n ṣẹlẹ̀ tí kò ṣe sípayá/fihàn, kíkópọ̀ àti ṣíṣe ìdájọ́ ìrírí kò tó nǹkan bí ìṣesí/àdámọ́, ṣùgbọ́n ó n wo ènìyàn ni ipò àṣèyíòwùú bi ẹni tí ó n ṣiṣẹ́ fún ara rẹ̀, ẹni tí èrò inú rẹ̀ máa yípadà/yapa sí ẹlòmíràn, ìmọ̀/ìfọwọ́bá àti ìhùwàsí èyí tí ó lè mu wàhálà /ìṣòro dání dípò kí ó ṣe ìrànló.wọ́. Nígbà púpọ̀ a kò tilẹ̀ mo ìmọ̀ pé irú bátánì/àpẹẹrẹ wìwà báyìí wá. Ṣíṣe ìdájọ́ yà wá nípa kúrò nínú ìrírí ọlọ̀ gbọnrangandan èyí tí ó tú/sípayá igbé ayé ẹrú lójú ẹsẹ̀/lẹ́sẹ̀kẹsẹ̀. Ní ṣíṣe àmúlò ìsọ́ra nípa èrò inú, ó ṣe pàtàkì láti ṣe ìdámọ̀ ìwà/agbára/ìrí ọkàn, dídá èrò ṣíṣe ìdájọ́ mọ̀ gẹ́gẹ́ bí ó ti súyọ. Ó tún ṣe pàtàkì láti máa ṣe ìdájọ́ àwọn ẹjọ́ tí wọ́n ti dá. Kìkì kí ènìyàn kíyèsí ìgbà tó dé/bẹ̀rẹ̀. Èròǹgbà rẹ̀ ni kí ó ṣe àkíyèsí, kí á máa ṣe àmúkúrò ìdájọ́ èrò ọkàn/inú. Nípa ṣíṣe

àkíyèsí pé ètò ìdájọ́ tó wà nílẹ̀, nígbà náà ẹnìkan tó ní ànfààní láti kọ nípa ọ̀nà titun tí a lè gbà sọ mọ́-ọn, mímú èsì kan dípò kí am sìwàhù lọ́nà tí a ò mọ̀, lérò àìmọ̀.

Sùúrù: Sùúrù ni òye láti farada ìṣòro pẹ̀lú iṣe jẹ́jẹ́ àti ìṣéra ẹni/ìkóna-ẹni-níìjánu. Ó fẹ́ ìbáṣepọ̀ pẹ̀lú èrò inú ẹnìkan, ìgbàgbọ́ àti ìgboyà.

Ó tún n fẹ mú rere àti ìláàánú/ìyọ́nú fún ẹnìkan gẹ́gẹ́ bí ẹnìkan ti lè ní ìfaradà ìrúnú ìṣẹ̀lẹ̀ kan/ayé kan. Àìnísùúrù máa n wáyé nígbà tí èrò ẹni bá dánilójú.jọra ẹni lójú, èrò tèmi-nì-kan jẹ́ ara tẹni èyí tí ó kọlu ìṣẹ̀lẹ̀ ododo, wíwá nǹkan tó ṣe é yàtọ̀ kúrò nínú bí ó ṣe yẹ. Ní ìpínhùn tàbí ní sókí, ọgbọ́n ẹnìkan ṣe ìdámọ̀ ohun tí ó jẹ́ òtítọ́ pé àwọn nǹkan ní ìpìl̀ ìgbé ayé tí wọn, ní ìpínyà tàbí-nípa kúrò nínú nǹkankan tí ẹni n fẹ́.

Gẹ́gẹ́ bí òtítọ́ ti jẹ́ kíkọ́ àti títẹ́wọ́gbà, sùúrù ẹnìkan n dàgbà sí. Láti kọ́ sùúrù, ènìyàn gbọ́dọ̀ kọ bí a ti ṣe n dá àìnísùúrù mọ̀ àti títiraka láti súré simwájú sí ìṣẹ́jú kan dé ìpele tó kàn.

Èrò inú Àsẹ̀ṣẹ̀bẹ̀rẹ̀ ẹ̀kọ́: Bíbẹ̀rẹ̀ láti ṣe àkíyèsí ìṣẹ́jú kan nísìsìyí, èrò ọkàn/inú máa n ní ìgbàgbọ́ pé o mọ̀ nípa àwọn nǹkan tó n ṣẹlẹ̀ tàbí kí wọ́n gbìyànjú láti wá bí a ṣe lè ṣàkóso nípa fífi ààké kọ́rí láti ṣe àwárí àwọn idròyìn tàbí ọ̀rọ̀ tí a sọ síi. Àwọn aápọn ìrònú ṣíṣe lo máa n di àṣẹ omi/lo máa n ro tàbí ìdíwọ́ ìdìgbòlù láàrin ẹnikọ̀ọ̀kan àti ìrírí ayé tààrà ó jẹ́ nǹkan tí ó wà nínú ayé ojú ẹsẹ tí kò ṣe é ká nípasẹ̀ ìṣẹ̀lẹ̀ ojú ẹsẹ̀ tí ó di ẹ̀kúnrẹ́rẹ́ ọ̀rọ̀ inú ayé mú. Láti ṣe eré pẹ̀lú èrò ọkàn asẹ̀sẹ̀bẹ̀rẹ̀ wò jẹ nǹkan tàbí túmọ̀ sí kí a síjú sí ìrírí ìṣẹ́jú kan gẹ́gẹ́ bí ọmọdé, òórùn àkọ́kọ́ òdòdó, àkọ́kọ́ kan omi òjò, ìtòwò àkọ́kọ́ ọsàn. Tòótọ́, ìṣẹ́jú kan inú ayé jẹṃ ọkàn tàbí aláìlẹ́gbẹ́. Ènìyàn le ni ìrírí, òòrùn tó n ràn nígbà ẹgbẹẹgbèrún ṣùgbọ́n òòrùn tó rí ran yìí yàtọ̀ sí ti àwọn yòókù, wọ́n ò ní le wà bẹ̀ẹ̀ mọ́ kíkọ́ nípa ìwà tó ní láárí/wuyì, tó ní ìrírí tààrà, gbígba ohunkóhun tó bá dìde gẹ́gẹ́ bí aílẹ́gbẹ́/ọ̀kan àti ìrírí tó ṣe iyebíye jẹ òpin nínú kíkọ́ ìsọ́ra nípa nǹkan, kí ènìyàn kọ nípa ọkàn àṣẹ̀sẹ̀dá/àṣẹ̀sẹ̀bẹ̀rẹ̀ ló máa n jẹ́ kí á ní ìtọ́ni nípa agbára wa láti ní ìrírí ayé ní ọ̀nà yìí.

Ìgbésẹ̀ Karùn-ún: Olùwádìí ṣe àfihàn àwọn èso tó tọ̀nà láti máa jẹ tàbí ṣe àsàrò lórí rẹ̀.

O lègbáradì fún iṣẹ́ ṣíṣe yìí nípa tọ́tọ́kasì oúnjẹ pàtàkì tó ní ìrírí pẹ̀lú rẹ̀. Ọ̀pọ̀lọpọ̀ ènìyàn ló máa n mú nǹkan tí a gbé sókè tàbí àdídùn tí a fi kọ́kọ́ ṣe (ẹhoẹolate) kòkó ti a pèsè fún ìpamọ́. O lè mú oríṣI oúnjẹ tí ó ládùn fún ìpamọ́. O lè mú oríṣI oúnjẹ tí ó ládùn fún ọ. ní

àkọ́kọ́, mú oúnjẹ náà, kí ò gbé e dání láàrin ọwọ́ ìtọ́ka àti àtànpàkò rẹ̀, jẹ́ kí ìfojúsí/farabalẹ̀ rẹ̀ wa níbẹ̀, tí ó bá jẹ́ ọjọ́ kan ni. Bí ó ti jẹ èròjà ìtàn àròsọ kan. Gbé e yẹ̀wò dáadáa pẹ̀lú ìfokànsí. Jẹ́ kí ojú rẹ̀ ṣe àwárí gbogbo ẹ̀yà tó jẹ mọ́ ọn. kíyèsí ìrísí, àwọ̀ àti ojú inú tàbí ode rẹ̀. Ṣe àyẹ̀wò ihò ìtẹ̀bọ́ rẹ, níbi ti ìmọ̀ lẹ ti n mọ́lẹ̀, tí òjijì rẹ̀ gẹ́gẹ́ bí pe oòti ẹ ríirí tẹ́lẹ̀ nínú ayé.

Gbá èso àjàrà lábé igi mú, múu kí o sí inú bi o ti n mí sínú àti sóde, kíyèsí èyíkéyìí òórùn dídùn tàbí èyí tí òórùn rẹ, rùn síta/òórùn tó rùn síta. Mú ìmọ̀/ìfura sí èyíkéyìí èso iṣẹ́ nínú ẹnu wa ti kan àti kí á mú èso àjàrà díẹ̀díẹ̀/jẹ́jẹ́ lọ sí ẹnu wa, kí á sì dìí sẹ́nu fún ìsẹ́jú akàn mẹ́wàá (ẹ́ò seẹonds) kí ó tó di pè a ó máa rún un lẹ́nu jẹ́jẹ́ láìsí ariwo. Fi àyè/àkókò sílẹ̀ láti rún un lẹ́nu láì gbéemì, kíyèsí adùn àti ìwọn lẹ́nu rẹ àti bí ó ṣe le è yípadà lẹ́yìn àkókò pípẹ́. nígbà tí o bá ṣe tán láti gbé èso àjàrà náà mi mu ìmọ̀ wá síbi iyè dé bi pé ó fi ní ìrírí ìmọ̀sínú/mímọ̀ sínú. Níkẹyìn kíyèsí ohun tó ṣẹ́kù nínú èso àjàrà náà gẹ́gẹ́ bí ó ti n gbé e mi, tí ó sì ri lọ sínú tàbí sísàlẹ̀ ikùn rẹ, kí ó sì kíyèsí bí ara rẹ̀ ti rí lẹ́yìn tí ó parí eré ìdárayá náà.

Wá àyè láti jíròrò lórí ìfiyèsí/òye lórí àwịn ìbéèrè wọ̀nyí:

i. Ǹjẹ́ ìrírí rẹ̀ rí bákan náà tàbí ó yàtọ̀ kúrò níbi ó ti ṣe máa n jẹun tẹ́lẹ̀
ii. Kín ni nǹkan náà, bí ohunkóhun bá ya ọ lẹ́nu nípa ìrírí náà?
iii. Kín ni nǹkan tí ó kíyèsí pẹ̀lú èso àjàrà náà tàbí èyíkéyìí oúnjẹ tó o yàn láàyò, ní ìbámu pẹ̀lú díùn (adùn) òórùn, ìfọwọ́kàn, ìró àti ìrísí ojú rẹ̀
iv. Kín ni èrò tàbí ìrántí tó wá sí ọkàn rẹ tó sún giri nígbà tí ó n ṣe àwọn nǹkan wọ̀nyí?
iv. Kín ni ohun ẹ̀bùn kan fún ra rẹ̀ ti o fẹ́ gbà/tí ó n lọ gbà nínú ìrírí ti ó fẹ́ ṣe àmúlò sí ìṣesí bí ó ṣe ń jẹun lọ́jọ́ iwájú.

Jíjẹun jẹ́jẹ́ kò ní ìtumọ̀ sí jíjẹun lájẹjù, síbẹ̀, ó jẹ́ èrò tí ó dára láti ran ara ẹni léti àti àwọn ìdílé ẹni pé jíjẹun kì í ṣe sísáré jẹun/eré ìjẹ/ìfikánjú ṣe

Kíyèsí àkókò ìtọ́wò/òórùn/ààdùn àti gbígbádùn oúnjẹ rẹ̀ jẹ ọ̀nà ìlera kan gbòógì tí o lè ṣe.

Ó lè ṣe é ṣe kí ó ṣe káíyésì nígbà tí o bá yó/ti ikùn rẹ̀ bá kún, ó máa n rún oúnjẹ rẹ̀ lẹ́nu jù fún ìgbà pípẹ́ títí tí yóò fi dá dáadáa, o sì le ṣe àfàyọ fún ra rẹ̀, kíyèsí òórùn/àádùn í o ro tẹ́lẹ̀ pé ti sọnù.

Ọ̀gọ̀rọ̀ ènìyàn lómáa yàn láti ṣe àmúlò awo oúnjẹ tó ṣe pàtàkì tàbí abọ́ oúnjẹ kí wọn sì rí oúnjẹ kan tíwọ́n le è farabalẹ̀ jẹ ní ìmọ̀ sínú tara wọn.

Ìgbésẹ̀ Kẹfà: Olùwádìí gba àbọ̀, ó sì gba ìgbìyànjú láti jíròrò lórí àwọn ọjọ́ ìjẹun

Ìgbésẹ̀ Keje: Olùwádìí ṣe àfihàn àwòrán atọ́nà ara (Guided Body Sẹan).

Ìwò ara wẹ́mọ́ gbígbàlè lẹ́sẹlẹ́sẹ yíká ara pẹ̀lú ọkàn, mímú ìfẹ́ ọkàn sísípayá, níní ìfẹ́ sí ìfetísílẹ̀ sí onírúurú agbègbè, àṣà tàbí ìṣe tó bẹ̀rẹ̀ láti ọmọ ìka òsì tí ó sì wọ́ká gbogbo ẹsẹ̀ lọ sí ọmọ ìka ẹsẹ̀, gìgíṣẹ̀ dé òkè àtẹ́lẹsẹ̀ títí dé ẹsẹ̀ òsì, kíká kún ni ipò kókósẹ̀, egungun ẹsẹ̀ àti ọpọlọsẹ̀, eékún/orúnkún, itan náà lápapọ̀, ní ojú àti jíjìn, kòtò ìtan àti ikún/ìgbáròkó òsì, nígbà náà sí ọmọ ẹsẹ̀ tí ẹsẹ̀ ọ̀tún, agbègbè ẹsẹ̀ mìíràn bákan náà lókè ẹsẹ̀ ọ̀tún ní ìbámu pẹ̀lú ẹsẹ̀ òsì.

Láti ibẹ̀, ìfojúsùn tó ń lọ sí àṣeyọrí àti ní pẹ̀lẹ́pẹ̀lẹ́, àpapọ̀ gbogbo agbègbè ìgégérù mọ itan ìgbaròkó náà kun un, ìbàdí àti ẹpọ̀, gẹ̀rẹ́gẹ̀rẹ́ ìgbá ẹ̀yìn, ikùn àti ẹ̀dọ̀ fóró/fùkùfùkù àti agbẹ̀du ilé ńlá tó wà láàrin eegun ìhà/fọ́nránhà, abẹ̀bẹ̀ ẹ̀jìká tó san lọ sí bi egungun ìhà ni ẹ̀yìn, títí lọ sí ọ̀nà egungun ọrùn àti èjìká.

Láti àwọn ẹ̀jìká, a lọ sí apá kí á ṣe gbogbo rẹ̀ pàápàá láti sónsó ìka ọwọ́ àti àtànpàkò tí ó lọ sí ìka ọwọ́, àtẹ́lẹwọ́ àti ẹ̀yìn ọwọ́, ọrùn ọwọ́, iwájú apá, ìgbọ̀nwọ́, òkè apá, abíyá àti èjìká lẹ́ẹ̀kansíi.

Nísìsiyi a ó lọ si ibi ọrùn àti ọ̀fun/ọ̀nà ọ̀fun, parípari gbogbo rẹ̀ ni ojú àti orí. Nígbà tí a bá ń ṣe ìwò ara/àyẹ̀wò ara, à rí rọra n dọ́gbọ́n létòlétò àti mímọ̀-ọ́n mọ̀ rin síwájum láti jẹ́ kí ìfetísílẹ̀/ìkọkànsí wa lọ sí gbogbo ara náà, kí á sì bẹ gbogbo àìbalẹ̀ ọkàn/ìrọ́gìdì ni orí nǹkan tó ṣẹlẹ̀ wò ní agbègbè tí ó yàtọ̀. Èyí tí a lè yá sí/kà sí àwọn ara àìbalẹ̀ ọkàn níbi gbogbo tí ó bá ti jeṃ ìyanú tàbí tí ó yẹ.

Èyi jẹ́ ká mọ̀ pé a lè ṣe nǹkan pẹ̀lú ìfẹ́ ọkàn yálà nípa agbára ìrọ́lù tàbí ọfà ọkàn tàbí ni ọ̀nà ìṣẹ́ra ẹni ni ọ̀nà pẹ̀lẹ́pẹ̀lẹ́, óle tún jù bẹ́ẹ̀ lọ. láìgbé isan ara wa nílẹ̀, a lè gbe ọkàn wa

sí ibikíbi nínú ara tí a bá yán àti ti atọ́ka sí, kí á sì ṣe àkíyèsí ọkàn tó bá wá lójú ẹsẹ̀/ní ìṣẹ́jú kan ní ìbámu pẹ̀lú ìrírí tó kún, a lè ṣe àpèjúwe ohun tí à ń ṣe nínú àwòrán ara gẹ́gẹ́ bía ti kọ ibi ara sí tàbí bí a ṣe sí àwọn ibi àìbalẹ̀ ọkàn náà sílẹ̀. Kí a jẹ́ kí àwa fúnrawa mọ̀ nípa àwọn nǹkan tí ó ti sípayá tàbí hàn síta. Ọ̀pọ̀ àwọn nǹkan tí a máa ń tú síta nimtorípé ó hàn gbangban tàbí kò sòro láti rí, ó jẹ́ ti ayé, ohùn tí ó hàn sí ni tí ó nira/sòro látimọ̀ pé ó wà níbẹ̀, èyí tí mo mọ̀ sí hìhà-hìn in. àti n pa ọ̀nà pẹ̀lú ìlàkàkalẹ̀ kan náà kékeré a lè sọ pé lọ́pọ̀ ìgbà nínú ayé wa, ó máa ń nira/ṣòrò láti mọ̀ pé a wà níbẹ̀, a níhà hìn-ín; nípa ìrírí ara náà, nínú ara àti ni ti ara namà. Ọ̀pọ̀ ọ̀rọ̀ náà máa mú fa ìjákulẹ̀, bá àpọ̀jù ìrírí. Nígbà tí a bá n sọ̀rọ̀ nípa rẹ̀, gẹ́gẹ́ bí ìwòye watàbí àkíyèsí wa bí a ṣe rí èdè fún ra rẹ̀ fi agbára mú ni láti máa sọ nǹkan tí ó yàtọ̀ tàbí yà nípa bí "Èmi" gẹ́gẹ́ bí ẹni "tó ni" ara náà. a ti kádìí tàbí kásẹ̀ ìró àìnírètí oníbejì/ìpele méjì nílẹ̀. Àti síbẹ̀, ní ọ̀nà kan, ó dájú pé ìyàtọ̀/ìyapa wa láàrin "Emi" – ẹni tí ó ni ara kan tàbí òkéré tan àwọn ìfarahàn tí ó lágbára tí ó sì rí bẹ̀ẹ̀/bí àpótí. A ti sọ̀rọ̀ nípa èyí gẹ́gẹ́ bí títẹ̀ bẹrẹ àpèjọ/tí àṣà tó fojú hàn tàbí ẹ̀yà tó jẹ́ odidi òtítọ́/òdodo àwọn ìbátan, títọ́jú ibi ìfarahàn/yọ jáde. Ní agbègbè tàbí ìjọba, ìbátan òtító/òdodo àwọn ara máa n wà àti òun pẹ̀lú àìbalẹ̀ ọkàn (ohun tí a rí/gbé ka iwájú wa) èyí tí àwọn tó máa n mọ òye nípa àìbalẹ̀ ọkàn (ohun tí à n sọ̀rọ̀ lé lórí).

Wọ́n fojú hàn ni ìyapa síra bákan náà ni wọ́n yàtọ̀. Àwòrán arak ò sí fún gbogbo ẹ̀dá/ènìyàn àti pé kì í ṣe ìlàjá èyí tó wù wá tàbí tí a yàn láàyò nígba gbogbo fún àwọn tó fẹ́ ẹ tàbí tí ó ni ìfẹ́ rẹ̀. Ṣùgbọ́n ójẹ́ òpin ohun tó wúlò tí ó sì dára láti mọ̀ nípa nǹkan àti kí ènìyàn le e ṣẹ̀ wọ́n láti ìgbà dé ìgbà/àkókò kan dé àkókò kan, èyí yówù kó jẹ́ìṣòro/ọ̀ràn àti ipò/.ayé ènìyàn. Tí o bá ro ara rẹ̀ gẹ́gẹ́ bí ohun èlò orin, àwòrán ara jẹ́nǹkan tí a lè yi i po. Bí a bá sì lérò pé o jẹ ayé/gbogbo èá, àwòrán ara jẹ́ ọ̀nà tó n bọ̀ wá kí o ye ènìyàn tàbí kí a mọ̀-ọ́n. tí ó bá sì rò wí pé àgọ́ ara rẹ̀ dàbí ilé, àwòrán ara rẹ̀ jẹ́ ọ̀nà láti sí gbogbo fèrèṣé àti ìlẹ̀kùn sílẹ̀ kí ìwòye atẹ́gùn àlàáfià sì le è gba lágbà-mọ.

Ìgbésẹ̀ Kẹjọ: Olùwádìí gba àbọ̀ ìdádìí, ó sì ni ìfọ̀rọ̀wérọ̀ nípa ìtọ́ni àwòrán ìwádìí ara.

Ìgbésẹ̀ Kẹsàn-án: Olùwádìí gbóríyìn fún àwọn akópa, ó sì fàyè gbà wọ́n láti bèèrè ìbéèrè nípa ẹ̀kọ́ òòjọ́ ti wọ́n kọ́.

Ìgbéléwọ̀n: Àwọn akópa ni olùwádìí bí ni àwọn ìbéèrè wọ̀nyí:

i. Ṣe àlàyé nípa ìfiyèsí ara/àkóÍkàn nǹkan?

ii. Jíròrò lórí àìṣègbè/àìṣedájọ́, sùúrù àti èrò ọkàn pẹ̀lú àìsẹ̀dé/asẹ̀sẹ̀bẹ̀rẹ̀ gẹ́gẹ́ bi ìwà tó ṣe pàtàkì/kókó nínú ìfiyèsí ara tàbí àkọlékàn ẹ̀dá.

Ọ̀rọ̀ ìkádìí: Olùwádìí dúpẹ́ lọ́wọ́ àwọn akópa, ó sì fún wọ́n ní iṣẹ́ àṣetiléwá, ó sì sọ ìgbà tí wọn yóò tún pàdé fún iṣẹ́ ìjókòó mìíràn. Ó sì mú ètò ìjókòó ọjọ́ náà wá sí òpin/ìparí.

Iṣẹ́ Àṣetiléwá:

i. Ṣe ìdárayá ìsẹ́jú mẹ́wàá sí mẹ́ẹ̀dógún nípa ara/ìmọ̀ sínú èémí fún ọjọ́ mẹ́fà.
ii. Ṣe ìdárayá mẹ́ẹ̀dógún fún ṣíṣe ara lójòòjúmọ́
iii. Mú ọ̀nà titun iṣẹ́ ojoojúmọ́ èyí tí o kòlékàn bíi fífọ eyín rẹ, bibomi sára/ìwẹ̀ wíwẹ̀, wíwakọ̀, oúnjẹ jíjẹ àti bẹ́ẹ̀ bẹ́ẹ̀ lọ

Iṣẹ́ Ìjókòó Kẹrin

Orí Ọ̀rọ̀: Iṣẹ́ ìjókòó yìí ń tẹ̀síwájú lórí àdínkù ìpòrurù ọkàn: Ìsesí ọkàn, ìgbékẹ̀lé àti àìtiraka tàbí àìlàkàkà tàbí àìkọjú ìjà sí/àìfagbára ṣiṣẹ́.

Ìfiyèsí nǹkan àti ìjókòó sàsàrò, ìfọkàn pín nǹkan, ìrìn ìtọ́ni ìsàsàro lórí ìrìn àti ìsẹ́jú mẹ́ẹ̀dógún fún ìfàyè gba èémí mímí.

Èròngbà: Ní òpin iṣẹ́ ìjókòó yìí àwọn akópa yóò le

- Sọ kíníkínní/ṣàlàyé ìgbékalẹ̀ àti àìlàkàk̀ gẹ́gẹ́ bí ìwà/ìṣesí pàtàkì sí ìfiyèsí.
- Ṣe eré ìfiyèsí ara nípa ìtọ́jú ara àti ọkàn láti jẹ ọkàn.
- Ṣe eré ìṣẹ́jú mẹ́ẹ̀dógún ní ìjókòó ẹ̀ẹ̀kan nípa ṣíṣe àsrò.
- Kópa nínú àsàrò ìtóni nípa ìrìn rinrìn.
- Ṣe eré ìsẹ́jú mẹ́ẹ̀dógún fún ìfàyè gba èémí mímí (ìmísínúàti ìmísóde)

Ìgbésẹ̀ Kìn-ín-ní: Olùwádìí kí àwọn olùkópa káàbọ̀ tìdùnnú tìdùnnú.

Ìgbésẹ̀ Kejì: Olùwádìí ṣe àtúnyẹ̀wò iṣẹ́ ìjókòó àtẹ̀yìnwá pẹ̀lú wọn akópaàti ààbò ìwádìí/ìmọ̀ràn nípa iṣẹ́ àṣetiĺwá.

Ìgbésẹ̀ Kẹta: ṣe àlàyé nípa ìgbékẹ̀lé àti àìlàkalà tàbí àìfagbáa iṣẹ́ gẹ́gẹ́ bí ìsesí tàbí ìwà pàtàkì fún ìfiyèsí ara/ọkàn

Ìgbékẹ̀lé: Kíkọ nípa bí a ṣe ń gbékẹ̀lé ara ẹni àti ní ìmọ̀ tàbí ìfọwọ́bà tàra ẹni gẹ́gẹ́ bí ẹ̀yà tí ó ṣe pàtàkì nípa kíkó bí a ti n ṣe àsàrò. Èyí fi àyè fún àrídájú láti jẹ́ kí ènìyàn le è ríohun kan pàtó tó n ṣẹlẹ̀ ni ìṣẹ́jú kan tàbí lójú ẹsẹ̀.

Ṣe eré ìdárayá nípa ìfiyèsí ara dé kùnúnkùndun òye tẹnikan mọ́, ìyára ni ìmọ̀ tàbí ni ìfura àti ìse déédé nípa fífi ìyàtọ̀ hàn sí nǹkan tó wà níhà-ìhín nísisiyi; ohun tó ṣẹlẹ̀ nínú ara ẹnìkan àti ní àyíká ẹni gan-an náà. èyí yóò mú kí ènìyàn le è kọ nípa bí a ṣe e gbẹ́kẹ̀lé ọkùnrin àti obìnrin tó ní mímọ̀ àti àṣẹ tàbí agbára tíkò sí fàyè gba ẹgbẹ́ kejì tàbí ẹnìkejì láti máa sọ fún un nípa ohun tí wọ́n lérò pé akọ/abo n fẹ́. Ìgbésẹ̀ yìí tó fàyè gba ẹnìkọ̀ọ̀kan láti ṣe àwárí ohun pàtó tí dídádúró/dídáwà lọ́wọ́ ara tumọ̀ sí.

Láìlákàkà: Ọ̀pọ̀lọpọ̀ àwọ eré tọ́mọnìyàn máa ń ṣe ni a ṣe lórí "ṣíṣe"àti gbígbìyànjú láti ṣe àyípadà nǹkan. Ìwà yìí ni a ti n ihàn lọ́pọ̀ ìgbà nínú àsàrò ṣíṣe.

Ìfagbára iyè ọkàn/inú hàn ọ. Èmi ni mo tó báyìí kò sí ẹlòmíràn tó tó mi –máa n fẹ́ àwọn nǹkan tó bá n fẹ síi, ó sì máa n làkàkà tàbí wá ọ̀nà tí yóò fi mú nǹkan tí kò bá fẹ́ kúrò.

Ìgbìyànjú yìí ni a rí nípa ìlàkàkà, tàbí yíyọ láti jẹ ìyàtọ̀, tàbí ṣe nǹkan mìíràn. Níwọ̀n ìgbà ti ìfiyèsí nǹkan wémọ́ káfetísílẹ̀ tàbí té.tísílẹ̀, láìṣe ìdájọ́, sí ohun yòówù tí ó bá n ṣẹlẹ̀. Èyí yàtọ̀ sí eré kan pàtó tí a máa n ṣe. ó jẹ mọ́ àìṣe nípa kíkọ bi "wà/nbẹ̀" dípò kí á ṣe é. Bí ènìyàn ti ń ṣe tàbí gbígbé ìgbé ayé ìfiyèsí àti ìfọwọ́bà ìmọ̀nípa ìlàkàkà tàbí kí á ṣe àyípadà nǹkan, ọkùnrin tàbí obìnrin gbọ́dọ̀ ṣe àkíyèsí nǹkan tó rọrùn láìṣe ìdájọ́ ara ẹni.

Ìfiyèsí nǹkan/Ìkíyèsí nǹkan jẹ mọ́ kí ènìyàn dá ara rẹ̀ lójú nípa ìrírí tí ènìyàn ní àti fífi àyè gba èyíkéyìí ohun tó bá sí ṣẹlẹ̀, mímú kí ò mọ́ gara/tótó, mọ̀ nípa nínú ìyọ́nú síi bí ó ti n ṣẹlẹ̀. Ọ̀rọ̀ àsàrò méjì tí wọn ṣe bí ẹni yàtọ̀ sí ara wọn nip é ọ̀nà tí ó rọrùn tàbí dára jù láti mú èrò àbí òpin eré-ìje ni ṣẹ láti le jẹ́ kí á lọ fún lílàkàkà àti dípò kí à rọ́nà tàbí láfojúsùn nípa rírí àti títẹ́wọ́gbà nǹkan gẹ́gẹ́ bí wọn ti ri ni ìṣẹ́jú kan sí ìṣẹ́jú kan.

Ìgbésẹ̀ Kẹrin Olùwádìí ṣe àfihàn ìkíyèsí tàbí ìfiyèsí nǹkan láti mọ bí a ṣe lè darí ara àti ọkàn wa ní ìgbàgbọ́ pé a lè jẹ ọ̀kan pẹ̀lú àwọn ẹ̀mí inú ayé tàbí ṣíṣe eré ìdárayá fún ara wa àti dídarí èémí wa láti mú kí ara ẹni kalẹ̀ (Mindful yoga).

Ọ̀pọ̀ wa la n ṣe oríkunkun láti ṣe ìdárayá nítorí pé ó lọ́wọ́ ìbànújẹ́ tàbí ìrora tàbí yọ́, tàbí pè fún ohun èlò pàtàkì tàbí òmíràn láti siṣẹ́ jáde pẹ̀lú rẹ̀, tàbí lílọ síbi pàtàkì láti lọ ṣe é.

Nǹkan tí à ń pè ni “Yoga” kò ni lò ohun èlò oàtàkì àti pé o le ṣe níbikíbi àti níbi gbogbo. Yoga jẹ́ ìwò àsàrò, àti ìgbà tí à ń ṣe nígbà gbogbo, ó jẹ́ títayọ ọkàn tàbí iṣẹ́ ara fún àwọn tí wọ́n fẹ́ láti sún síwájú dé dídọ́gba gíga ìlera.

“Hatha yoga” kún fún ṣíṣe ìfiyèsí ìdúró tàbí ipò àti nínú ìmọ̀ nípa èémí mímí.

Wọ́n rọrùn láti kọ́, wọ́n sì ní ìyọrísí eré orí ìtàgé tí wọ́n bá ń ṣe e nígbà gbogbo. Èyí tí a máa ń ṣe jẹ́ òpin ìwà ìrẹ̀lẹ̀ tàbí ìṣe jẹ́jẹ́. eré ṣíṣe ìgbà gbogbo máa n mú kí títè tàbí lílo egungun ẹran ara rẹ̀ gbilẹ̀, tàbí pọ̀ si.

Okun àti ọgbọọgba, bé.ẹ̀ gẹ́gẹ́ ló n ṣe ìrànlọ́wọ́ fún ọ láti wo ipò tàbí ìpìlẹ̀ ìjìnlẹ̀ ìfọ̀kànbalẹ̀ àti ìní ìmọ̀/ìkíyèsí. Ọ̀pọ̀ ènìyàn ló máa ní ìrírí ìdákẹ́rọ́rọ́ tó ga nípa ìgbé ayé lápapọ̀, fi kún ìpínyíká tàbí sísàn ẹ̀jẹ́ láti inú ọkàn yíká ara, alágbára adwòrán tàbí àpẹẹrẹ alátúnṣe àti ẹni tí àìsàn rẹ̀ kò pọ̀ nítorí ìdí kan. Ní ṣíṣe àgbéyẹ̀wò Yoga ṣíṣe, a gbà ọ nímọ̀ràn láti ṣe eré yìí ní ìbámu tàbí ọ̀nà tí o lè ṣe é nígbà ń ṣàṣàrò, èyí ni pé ṣíṣe ìtọ́jú ìṣẹ́jú kan síìmọ̀ ìṣẹ́jú kan, kìí ṣe láìtiraka láti dé ibòmíràn pátápátá kí o fúnra rẹ̀ lááyè láti wa bí o ṣe wà. Kí o sì lọ ní ìdájọ́kídájọ́ ti ara rẹ̀.

Máa lọ jẹ́jẹ́ tàbí ní pẹ̀lẹ́pẹ̀lẹ́ ìmọ̀ sínú rẹ̀. Ìfiyèsí eré ìdárayá mímí sínú ti sóde tó n ṣe àwárí bí agbára rẹ̀ ṣe tó ṣùgbọ́n kìí ṣe láti tìí ṣubú jù wọn lọ.

Dípò rẹ̀, kí o máa ṣeré pẹ̀lú àwọn olùgbé tó wà ni ẹnu àlà àti mí. Èyí ń fẹ́ kí dídálọ́láàgọ́ ara wa àti ìròyìn tí olè fún ọ nípa ìgbà tó yẹ láti dúró àti ìgbà tó yẹ láti yàgò fún ṣíṣe ìdúró tàbí ipò nítorí ipò pàtàkì rẹ̀

Ìgbésẹ̀ Karùn-ún: Olùwádìí ṣe àfihàn ìṣẹ́jú mẹ́ẹ̀dógún àsàrò jíjókòó.

Jíjókòó kìò ṣe ohun àjòjì sí ẹni kọ̀ọ̀kan, yàtọ̀ kan ṣoṣo tó wà láàrin jíjókòó lásá àti jíjókòó ìfiyèsí ni níní ìmọ̀ gẹ́gẹ́ bí ìmọ̀ níní jẹ́ nǹkan tó mú ìyàtọ̀ wa láàrin àkíyèsí èémí mímí àti mímí èémí mìíràn.

Láti dán iṣẹ́ jíjókòó wò, a ó wá àkókò àti ibi tí a kò ì tí ṣè é tàbí ti ṣíṣe rẹ̀ kìí wáyé.

A lè ní ìmọ̀ sínú dídá ọgbọ́n ìtalólobó àti ṣíṣe eré jíjókòó àsàrò náà yálà lórí àga ìjokòó tàbí ní orí ilẹ̀ẹ́lẹ̀. Tí o bá yan jíjókòó lórí aga, ohun tó yẹ ni pé kí o ṣe àmúlò aga tó ni ẹ̀yìn tó tọ́ èyí tí yóò le gba ẹsẹ̀ rẹ̀ lááyè láti nà gbọrọ lórí ilẹ̀ẹ́lẹ̀. Nígbàkúùgbà ni a máa ń

yìn/sọ̀eọ̀ ẹnìkan ní rere pé tí ó bá ṣe é ṣe, kí o jókòó jìnnà kúrò láti ẹ̀yìn ga kí egungun ẹ̀yìn le ní ìtìlẹ́yìn tàbí ìfaratì tara-ẹni. ṣùgbọ́n tí o bá fẹ́ ṣe èyí, fífi ẹ̀gbẹ́ ti ẹ̀yìn aga náà jẹ́ nǹkan tó dára. Tí o bá sì yàn láti jókòó lórí ilẹ̀ẹ́lẹ̀, ṣe èyí lórí àga tó dúró ṣinṣin, tó ní tìmùtìmù tòki nílẹ̀, tí o le gbé ìdí rẹ̀ sókè orí ilẹ̀ ilé ni nǹkan bí ìdá mẹ́ta sí mẹ́fà ìwọn ẹsẹ̀ bàtà kan (Tìmùtìmù tàbí ìrọ̀rí tí a sẹ́po lẹ́ẹ̀kan tàbí ìgbà nejì máa ń ṣe dáadáa, tàbí kíènìyàn ra tìmùtìmù tó ṣe àsàrò tàbí Àafu, tí a kàn ṣe fún jíjókòó.

Yálà ó yan ilẹ̀ẹ́lẹ̀ tàbí àga, ipò tàbí àyè ṣe pàtàkì nínú ṣíṣe àṣàrò tàbí ìsàrò. Ó lè jẹ́ àtìlẹyìn ìhà ìta tàbí òde nípa ríro ìwà inú ibu ọlà fún, sùúrù àti gbígba tara-ẹni. Ohun pàtàkì tó yẹ kí á pamọ́ lọ́kàn nípa ipò tàbí àyè wa ni láti gbìyànjú láti pa ẹ̀yìn mọ̀, ọrùn àti orí tó wé eegún mọ́rùn láti mú kí èjìká ní ìsinmi àti láti ṣe nǹkan mìíràn tó dùn pẹ̀lú ọwọ́ rẹ̀.

Tẹ́lẹ̀tẹ́lẹ̀ a gbé wọn ka orí ìtan pẹ̀lú ìka o.wọ́ wa ní ọwọ́ òsì. Lékè àwọn ọmọ ìka ọwọ́ ọ̀tún àti ìgórí àtànpàǹkò tí wọn nkan ara wọn. nígbà ó bá dáwọle tàbí gbà ṣebí ipò tí a yàn, a máa mú ìfarabalẹ̀ wá sí ibi èémí/mímí wa. A máa nmọ̀ ọ́n pé ó wá ilé, a sì máa n mọ-ọn nígbà tí ó bá jáde. A gbé ni ìgbà ìsisìyí, ìṣẹ́jú kan nípa ìṣẹ́jú kan, mímí èémí nípa ìmí èémí.

Ó dùn níwọ̀nba àti bí ó ti jẹ́. Ìfarabalẹ̀ mímọ́ nípa èémí àmísínú àti ìmọ̀ nípa èémí àmísóde. Jíjẹ́ kí èémí náà wáyé tàbí ṣẹlẹ̀, fojù ríi, fọwọ́ba gbogbo àìbalẹ̀ ọkàn, sàkìsàkì àti lárèékérekè èyí tí ó kẹ́gbẹ́ pẹ̀lú rẹ̀. Tí o bá jẹ́ tòótọ́ ni ó kẹ́mììlé sí jíjẹ́ ẹni tó ni àlàáfíà tí ó sì dẹwọ́ yóò yà ọ́ lẹ́nu pé báwo ni ọkàn rẹ̀ ti ṣe kíákíá láti rẹ̀ ẹ́ pẹ̀lú wíwá lóun nìkan àti pé báwo ni ara ti wà láìsinmi ti nǹkan kò rọrùn fún un.

O lè máa sọ pé kín ni n bẹ lẹ́yìn ọgbẹ́/ọfà ọkàn tàbí lágbá ìrọ́lù tó kún ni ìṣẹ́jú kan pẹ̀lú ohun kan. kín Ni nǹkan tó wà lẹ́gbẹ̀ẹ́ nǹkan tó nílò láti fi ṣe àlejò ni? Nígbà yòówù tí ó bá ní”ofo” ìṣẹ́jú kan, ò sókè, kí o sì máa lọ, láti padà sẹ́yìn láti ṣe nǹkan náà àti kí ọwọ́ rẹ̀ dí.

Kín ni n tukọ̀ ara àti ọkàn tó fi kọ́ láti dúró lójú kan? Nígbà tí a bá ń ṣe àsàrò a ó ni le dáhùn àwọn ìbéèrè wọ̀nyẹn.

Ká kúkú jàre ṣíṣe àkíyèsí níní agbára ìrọ́lù tàbí ọgbẹ́/ọfà ọkàn láti gòkè tàbí gbè ra nílẹ̀ tàbí èrò tó wá sọ́kàn. Dípò kí á máa fò sókè kí a sì máa ṣe nǹkan tí ọkàn pinnu jẹ, kókó tó kàn nínú ètò àtẹ. A rọra tàbí fi pẹ̀lẹ́pẹ̀lẹ́, ṣùgbọ́n ní ìdúróṣinṣin mú ìfarabalẹ̀ tàbí ìfetísílẹ̀

wá padà wá sí ikùn náà àti síbi mímí tàbí èémí kí á sì tẹ̀síwájú láti máa wo èémí náà ní ìṣẹ́jú kọ̀ọ̀kan. A lè máa rò wí pé kín ni iddí tí ọkàn fi ri báyìí fún bí ìṣẹ́jú kan tàbí méjì ṣùgbọ́n ni pàtàkì jùlọ àwa ń ṣe nǹkan tí a fi tẹ́wọ́gba ìgbésẹ̀ kọ̀ọ̀kan gẹ́gẹ́ bí ó ti rí láìsí pé afaraya tàbí kọ bí ó ti ri. Nípa ṣíṣe èyí à n tọ́ tàbí kọ́ ọkàn wa lẹ́kọ̀ọ́ láti jẹ ẹni tí kò kanra, tí ó sì dúró déédéé. Ó ti n mú kí ìgbésẹ̀ kọ̀ọ̀kan di kíkà, ó sì ti mú kí ìṣemjú kan/ìgbésẹ̀ kan gẹ́gẹ́ bí ó ti n wa láìka ẹnikẹ́ni tó ju ẹlòmíràn lọ kún. Ní ipasẹ̀ ọ̀nà yìí, ò ti n gbin ẹ̀bùn àtọ̀runwá láti fọkànsí tàbí kẹ́mìílé iyè/inú rẹ̀. Nípa ṣíṣe àwítúnwí mímú ìfarabalẹ̀/ìtẹ́tísí padà wá sí ibi èémí lẹ́ẹ̀kọ̀ọ̀kan tí ó bá ti n sáko tàbí rìn lọ, fọkànsí àròjinlẹ̀ kíkọ́ àti jínjinlẹ̀, níwọ̀n bí ẹran ara w abá ti n ṣiṣẹ́ tàbí dàgbà sí ní ṣíṣe àwítúnwí gẹ́gẹ́ bí irin tàbí òkúta tówúwo. Ṣíṣẹ́ nígbà gbogbo pẹ̀lú (láìjìjàgbara ìtakò) ìkọjú ìjà sí tàbí ọkàn rẹ̀ tí o kò le agbára tàbí okun inú. Nígbà kan náà ó ṣe ìmúdàgbà sùúrù àti kọ́ nípa àìṣe ìdájọ́. Ìwọ kòwulẹ̀ fùnra rẹ̀ ní àkókò tó le nítorí ẹ̀mí/ọkàn rẹ̀ ti fi èémí sílẹ̀. Ó nìkan ṣoṣo àti èrò òtítọ́ lòpadà sí ọ̀dọ̀ èémí, ṣe pẹ̀lẹ́pẹ̀lẹ́ tàbí jẹ́jẹ́ ṣùgbọ́n lágbára ní ìdúró ṣinṣin.

Ìsàrò kì í ṣe pé ó lọ́wọ́ sí títu èrò síta tàbí sísún ara ẹnin kan ògiri kúrò lọ́dọ̀ wọn láti pa èrò ọkàn iyè rẹ̀ lẹ́nu mọ́. A kò gbìyànjú láti pa èrò inú wa lẹ́nu mọ́ gẹ́gẹ́ bí àwọn ọ̀ṣọ́rọ̀ tàbí omi sísàn nípasẹ̀ èrò ọkàn tàbí iyè inú. À n wulẹ̀ ṣe ìyára fún wọn, fífeyìsí wọn gẹ́gẹ́ bí èrò tàbí iyè inú, kí á sì jẹ́ kí wọ́n rí bẹ́ẹ̀, lílo èémí gẹ́gẹ́ bí ìdákọ̀ró wa tàbí ìpilẹ̀ ilé fún ṣíṣe àkíyèsí, fún ríran wa léti láti dúró lórí àfojúsùn àti ìwà ìgbà àlàáfíà láàyè.

Ìgbésẹ̀ Kẹ́fà: Olùwádií ṣe àfihàn pínpín ìfiyèsí/ìtọ́jú tàbí ìrántí nǹkan

Pinpin ìfiyèsí wá ni ìyànà ọ̀tọ̀ nínú ìfarakínra ìbákẹ́gbẹ́ sí sọ̀rọ̀ tàbí pínpín sí ènìyàn máa n ṣe nínú àkójọpọ̀ ẹgbẹ́. Ó lè máa rọrùn fún ọ ní ìbẹ̀rẹ̀ pẹ̀pẹ̀. Kíyèsi iyè inú ara rẹ̀ bí o ti n sọ̀rọ̀. Gbogbo ìṣẹ́jú àsìkò yìí tí à n ṣeré jẹ́ àǹfààní láti ní ìmọ̀ nípa ara tẹni, ọkàn àti ìfọwọ́ bà. Ó sọ̀rọ̀ ìfaratì àti láti inú ọkàn rẹ̀ àti ìrírí tàrà. Pínpín ìfiyèsí kì í ṣe àkójọpọ̀ ìtọ́jú àìsàn; dúró lórí orí ọ̀rọ̀ kan dípò kí ẹ máa dera yín nínú ìtàn sísọ. Pínpín jẹ́ àfẹ́sọ́nà/ìgbìrò tàbí ìpinnu fún wa lái dàgbà nínú ìmọ̀ ìpìlẹ̀ òfin àdánidá tàbí ìwà ẹ̀dá tí gbogbo ẹ̀dá. Gbogbo ọ̀nà tí à ń rò nípa nǹkan ló jẹ́ ìtẹ́wọ́gbà nínú pínpín ìfiyèsí tàbí ìṣọ̀rọ̀ sí nípa ìrírí jẹ́ ohun tó jẹ́ tara ẹni tí ó sì jẹ́ aláìlẹ́gbẹ́ sí ọ.

Nípa sí sọ̀rọ̀ ìfiyèsí/ìkíyèsí, ò n ṣe ìrànlọ́wọ́ láti da àyè sílẹ̀ tàbí wá àyè tó pamọ́ fún ẹnìkọ̀ọ̀kan láti pín.

Ìlú kìkì tí ọkàn tó dákẹ́ láàrin olùsọ̀rọ̀ máa n fàyè ìfiyèsí/ìfetísílẹ̀ tàbí gbígbọ́.

Ìfiyèsí ìfetísílẹ̀ jẹ́ nǹkan pàtàkì gẹ́gẹ́ bí ìfiyèsí ìsọ̀rọ̀ àti ìfetísílẹ̀ túmọ̀ sí kíkíyèsí ohun tó farahàn nínú rẹ̀, àgọ́ ara àti iyè inú/ọkàn, àjálù ọ̀rọ̀ sísọ, ìgbani nímọ̀ràn, àlàyé ṣíṣe nípa ìpìlẹ̀ òfin àdánidá/ìwà ẹ̀dá (Dharma) fún ẹlòmíràn tàbí sísọ̀rọ̀ lọ́pọ̀ ìgbà jẹ́ ohun tí kò sí àyè fún un/tí a kò fàyè gbà àti pé ohunkóhun tí ó bá jẹ́ sísọ níbẹ̀ gbọ́dọ̀ jẹ́ ohun tí ó pamọ́ tàbí fọkàn tán.

Ìgbésẹ̀ Keje: Olùwádìí ṣe àfihàn ìtọ́ni/àmọ̀nà àsàrò/ìsàrò ìrìn rínrìn.

Gẹ́gẹ́ bí àsàrò èémí/mímí, àsàrò ìrìn rínrìn jẹ́ ohun tí ó rọrùn àti eré ṣíṣe ni àgbáyé fún ìdàgbàsókè ìfarabalẹ̀, ìbániwapọ̀ t̀bí ìbánitan/ìfarakọ́ra àti ìkíyèsí. Èyí lè máa jẹ́ ṣíṣe nígbà gbogbo, ṣáájú tàbí lẹ́yìn jíjókòó àṣàrò tàbí nígbàkúùgbà ni òun nìkan, èyí ànà ni lẹ́yìn iṣẹ́ òòjọ́ tó láàpọn tàbí tọ́wọ́ bá di tàbí ààrọ̀ ọjọ́ ìsinmi (Sunday) ó jẹ́ ọ̀lẹ. Ọ̀nà ìsàrò ọkàn rínrìn mú kí a kọ nípa bí a ṣe ní ìmọ̀ gẹ́gẹ́ bí a ṣe ń rìn, láti lo àdánidá ìgbésẹ̀ ìrìn rínrìn láti le tọ́ ìfiyèsí akólékàn tàbí mímọ̀ sínú nípa nǹkan àti àìráyè sùn níbi kan tàbí wíwà níbi tí kò sáàyè oorun tàbí àìróorun sùn.

Ìgbésẹ̀ Kẹjọ: Olùwádìí sọ fún àwọn akópa láti dánrawò ìsẹ́jú mẹ́ẹ̀dógún nípa àyè tàbí afo mímí èémí.

Ìgbéléwọ̀: Olùwaẃdìí béèrè àwọn ìbéèrè wọ̀nyí lọ́wọ́ awọn olùkópa:

i. Ṣe àlàyé ìgbẹ́kẹ̀lé àto àìfagbára ṣiṣẹ́/àìlàkàkà/àìjòwerè gẹ́gẹ́ bí ìwà/iṣẹ́ pàtàkì sí ìfiyèsí/ìmọ̀ sínú.

Ọ̀rọ̀ Ìkádìí/Ìparí: Olùwádìí mọ rírì/ìgbóríyìn fún àwọn akópa fún wọn. Iṣẹ́ àṣetiléwá, fi àkókò sí ìgbà ìpàdé ìjókòó mìíràn kí o sì fòpin sí iṣẹ́ ìjókòó ọjọ́ náà.

Iṣẹ́ Àmúrelé/Iṣẹ́ Àyànṣe:

i. Ṣe eré ìṣẹ́jú mé.ẹ̀dógún ara ṣíṣe lójoojúmọ́
ii. Ṣe eré ìṣẹ́jú mẹ́wàá "Ìfiyèsí ara/mímọ̀ sínú míí èémí lójoojúmọ́
iii. Ṣe eré ìṣẹ́jú mẹ́ta àyè mímí èémí nígbà ẹ́ẹ̀mẹ́ta lọ́jọ́ kan

Ìjókòó Karùn-ún

Orí Ọ̀rọ̀: Ìjókòó yìí ṣe àfihàn ìfiyèsí ìṣesí/ìwà, ìtẹ́wọ́gbà àti jíjẹ́ kí o lọ/fífún láyè láti lọ.

Èròngbà: Ní ìparí/òpin iṣẹ́ ìjókòó yìí àwọn olùkópa yóò le:

i. Ṣe àlàyé ìtẹ́wọ́gbà àti jíjẹ́ kí ó lọ gẹ́gẹ́ bí ìṣesí/ìwà pàtàkì sí ìfiyèsí tàbí ìsọ́ra nípa nǹkan.

ii. Àgbóyé àti pínpín ìfiyèsí

iii. Ṣíṣe àsàrò ìsẹun-ìfẹ́

iv. Kíyèsí ìsinmi/ìdákẹ́ mímọ́

Ìgbésẹ̀ Kìn-ín-ní: Olùwádìí kí àwọn akópa káàbọ̀ tayọ̀tayọ̀.

Ìgbésẹ̀ Kẹta: Olùwádìí ṣe àyẹ̀wò iṣẹ́ tí a ṣe ní ìjókòó tí a ṣe gbẹ̀yìn pẹ̀lú àwọn akópa.

Ìgbésẹ̀ Kẹta: Olùwádìí ṣe àlàyé ìtẹ́wọ́gbà àti jíjẹ́ kí ó lọ bí ìṣesí pàtàkì sí ìfiyèsí/ìsọ́ra nípa nǹkan.

Ìtẹ́wọ́gbà: Ìgbésẹ̀ fún ìtẹ́wọ́gbà bẹ̀rẹ̀ pẹ̀lú ìfẹ́ inú láti rí àwọn nǹkan bí ó ti yẹ/bí wọ́n ṣe rí ju ọ̀nà tí ènìyàn rò pé óyẹ kí ó rí. Ó ṣe pàtàkì láti rí nǹkan gẹ́gẹ́ bí wọ́n ṣe rí àti òun tìkalára rẹ̀ gẹ́gẹ́ bí ènìyà ṣe wà. Nígbẹ̀yìn, í ìṣẹ́jú kan yìí tí o bá fẹ́ yípadà, wòsàn/múuláradátàbí <u>yí ara rẹ̀ po</u> tàbí pawọ́ ìgbé ayé rẹ dà nígbákúùgbà láti lè tẹ́wọ́gbà ohunkóhun tó ba n bọ́ si ìfara, ènìyàn gbọ́dọ̀ kọjá láàrin ìgbà tàbí àkókò ìfọwọ́bà jọjọ gẹ́gẹ́ bi ìrúnú, ẹ̀rù/ìbẹ̀rù tàbí ìbànújẹ́. Ìfọwọ́bà wọ̀nyí fúnra wọn ńfẹ́/bèèrè fún ìtẹ́wọ́gbà.

Ìtẹ́wọ́gbà kò túmọ̀ sí fífẹ́ gbogbo nǹkan tàbí jẹ́ ẹni tí ó nírẹ̀lẹ̀/ní sùúrù. Kìí ṣe pé ó túmọ̀ sí níní ìtẹ́lọ́rùn nípa nǹkan gẹ́gẹ́ bí wọ́n ti rí, tàbí pé ènìyàn yóò dáwọ́ dúró nípa ìgbìyànjú láti yí nǹkan padà sí dáradára. Kuku tẹ́wọ́gbà túmọ̀ sí ìfẹ́ inú rere láti rí nǹkan bí wọ́n ti rí, jíjinlẹ̀ sí, kún fún sísọ òtítọ́, àti yíyan/pátápátá. Ìṣesí yìí fẹsẹ̀múlẹ̀ ibi ìdúró fún ṣíṣe eré ni ìṣẹ́jú kan ni agbára ju àti ni ọ̀nà ìlera. Ohun yòówù kí ó ṣẹlẹ̀. Ó ṣe é ṣe kí àyè wà láti dsọ nǹkan tí a lè ṣe nígbà tí àwòrán tó mọ́jú tàbí mọ́lẹ̀ nípa nǹkan tí ó yẹ kí ó ṣẹlẹ̀ ju ìgbà tí kùrukùru bá bo ìríran nípaọkàn ẹnikan tí ó sìn ìdájọ́ àti fẹ́ tàbí béèrè tàbí ipa ìbẹ̀rù àti èrò búburú láìnídìí sí ẹ̀ta inú tàbí ènìyàn.

Jíjẹ́ kí á lọ: Jíjẹ́ kí á lọ tàbí láìnídàpọ̀ mọ̀ tàbí láìsífaramọ́/ẹni tí kò ní ìdàpọ̀ mọ́ tàbí àsomọ́ òun ìfaramọ́ jẹ́ kọ́kọ́rọ́ ìṣesí tàbí ìwà mìíràn fún ìsọ́ra tàbí àkíyèsí ara. Ènìyàn máa ń ṣe nǹkan tí ó lòdì sí ìṣesí ní ọ̀pọ̀lọpọ̀ ìgbà nípa rírọ̀mọ́ tàbí sísomọ́ ọ̀nà tí wọ́n bá n fẹ́ kí nǹkan jeṃ láìsí pé ó ní iyè inú tàbí ìrò nípa bí gbogbo rẹ̀ ṣe jẹ́.

Nígbà gbogbo, nǹkan tó wàmọ́yà tàbí gbàmọ́ra tó lágbára jù ní èrò/ìrò àti ìbojúwo ara ẹni, ẹlòmíràn àti ìtẹ̀dó tàbí ipò/àyè.

Ìrò/èrò yìí máa n mú àwòrán ìrírí ẹnìkan ní ìṣẹ́jú kan sí ìṣẹ́jú kan nígbà gbogbo ní ọ̀nà jíjinlẹ̀ ní ìmọ̀.

Fífetí sílẹ̀ tàbí fífi arabalẹ̀ sí ìrírí ẹnìkan nípasẹ̀ ìsàsàrò/àsàrò máa ń jẹ́ kí ẹnìkọ̀ọ̀kan ṣeàwárí àwọn èrò inú tàbí àníyàn láti dìmú tàbí fúnka mọ́ ọn tàbí tẹ̀bà tì.

Ó sì le sàkíyèsí àwọn nǹkan mìíràn, ó le ni ọkàn ìgbékú tà láti jẹ́ kí ó le e lọ tàbí gbà á kúrò.

Rírọ̀mọ́/Fífàmọ́ jẹ́ ìdarí nípa àwọn nǹkan tí a fẹ́ àti èyí tí a kò fẹ́ àti àwọn iddájọ́ wa. Ó ṣe pàtàkì ká jẹ́ kí ìrírí ju nǹkan tí ó jẹ́, ní ìṣẹ́jú kan sí ìṣẹ́jú kan. Nípa àìlèdásí tàbí fífẹ́nu sí, ó jẹ́ àǹfààní tó wuyì tàbí dára jù láti jẹ́ kí à lọ (KabatọÀinn, ẹ́óóò).

Ìgbésẹ̀ Kẹrin: Olùwádìí ṣe àfihàn ìsàrò ìṣeun-ìfẹ́.

Ìsísẹ̀/Ìwà híhù tàbí Ìtàtẹ̀síwájú:

Di ojú rẹ̀ méjèèjì. Jíkòó dáadáa pẹ̀lú ẹsẹ̀ rẹ̀ nínà sílẹ̀ gbalaja sórí ilẹ̀ẹ́lẹ̀ àti egungun ẹ̀yìn rẹ̀ lóòró gangan. Dẹwọ́ fún tàbí mu gbogbo ara rẹ̀ fúyẹ́ díẹ̀. Pa ojú rẹ̀ mọ́ tàbí di ojú rẹ̀ títí gbogbo àwòrán ọkàn àti kí o mú ìkíyèsí tàbí ìfura nínú.

Láìsí yítọ̀ tàbí fíkọkàn sí, kàn sí kí o sì máa tẹ̀lé ẹ̀kọ́ tàbí àẹ bí o ti gba jíjinlẹ̀ èémí àmísínú àti àmimsóde.

Gbígba ìṣeun-ìfẹ́: Pípa ojú rẹ̀ dé, ìrònú ẹnìkan tó súnmọ́ ọ, ẹni tí o nífẹ̀ẹ́ rẹ̀ jù, o lè jẹ́ ẹni àtijọ́ rẹ tàbí ẹni tí o mọ̀ nísisiyi; ẹnìkan tí ó sì wwà láàyè tàbí ẹni tí o kọjá lọ; o le è jẹ olùkọ́ nínú ẹ̀mí tàbí amọ̀nà/ afinimọ̀nà. Wòye pé ẹni náà dúró ní apá ọ̀tún rẹ̀, tí ó ránṣẹ́ ìfẹ́

wọn sí ọ. Ẹni náà n fi iṣẹ́ ìfẹ́ ràn ọ́ nítorí ààbò ẹ̀mí rẹ̀ fún ìgbé ayé ìrọ̀rùn àti àlàáfià̀ tàbí inú dídùn. Fọwọ́ba ìkíní ìló.wọ́wọ́ ti ìfẹ́ tó n bọ̀ láti ọ̀dọ̀ ẹni tó wà níhà tàbí sọ́dọ̀ rẹ̀.

Nísisiyi mú ọkàn ẹnì kan náà yìí tàbí ẹlòmíràn tí o fẹ ọ tàbí gba tìrẹ dénu tàbí sìkẹ́ rẹ̀. Wòye pé ẹni tí ó dúró lápá òsì rẹ, fi iṣẹ́ ìkíni fún ìwà lálàáfíà ránṣẹ́ sí ọ, fún ìlera rẹ̀, àti ìdùnnú tàbí inú dídùn rẹ̀.

Fọwọ́ba ìṣeun/Oore àti ìtara ìfẹ́ tó n bọ̀ fún ọ láti ọ̀dọ̀ ẹni náà.

Nísisìyí wòye pé a ti yí ọ p ní gbogbo ẹgbẹ́/àyíká nípa àwọn ènìyàn tí o ní ìfẹ́ rẹ̀ tí wọ́n sì ní ìfẹ́ rẹ̀. Wo àwòrán gbogbo àwọn ọ̀rẹ́ rẹ̀ àti àwọn olólùfẹ́ tí ó yí ọ po/ká,. Wọ́n dúró láti fi ṣé ìkíni/ìdùnnú fún ayọ̀ ìdùnnú rẹ̀, ìgbé-ayé ìrọ̀rùn àti ìlera pípé.

Yáná/ya òòrùn ìfẹ́ gbígbónà náà àtii ìfẹ́ tó n bọ̀ wá láti ibi gbogbo. Ó ti ní ẹ̀kúnrẹ́rẹ́/ìtẹ́lọ́rùn àti àkúnwọ́sílẹ̀ pẹ̀lú ìfẹ́/ìgbóná ti ìfẹ́.

Fífi Ìṣeun-ìfẹ́ ránṣẹ́ sí àwọn olólùfẹ́ rẹ̀/tí o fẹ́ràn jù. nísisìyí mú ìró inú/ìkíyèsí rẹ̀ padà sọ́dọ̀ ẹnìkan tí ó dúró ní apá ọ̀tún rẹ̀. Bẹ̀rẹ̀ sí máa ránṣẹ́ ìfẹ́ tó o mọ̀ nípa rẹ̀ si ẹni náà. Ìwọ àti ẹni náà rí bákan ńà/jíjọra. Gẹ́gẹ́ bí ìwọ ẹni yìí máa n fẹ ní ayọ̀/ìdùnnú. Ránṣẹ́ gbogbo ìfẹ́ àti ayọ̀ ìfẹ́ gbígbóná sí ẹni náà.

Máa tún àwọn àpólà gbólóhùn yìí wí jẹ́jẹ́. kí o máa gbé ní ìrọ̀rùn, kí o ni ayọ̀/ìdùnnú kí o sì di òmìnira kúrò nínú ìrora/ara ríro/ìnira.

Kí o máa gbé ní ìrọ̀rùn, àti kí o di òmìnira kúrò nínú ìrora/ìnira.

Kí o máa gbé ní ìrọ̀rùn, kí o máa ní ayọ̀/ìdùnnú kí o sì di òmìnira kúrò nínú ìrora/ìnira/ara ríro. Nísisìyí fọkàn sí ìkíyèsí rẹ̀ nípa ènìyàn tí ó dúró lápá òsì rẹ̀.

Bẹ̀rẹ̀ sí ní máa darí/ṣe amọ̀nà ìfẹ́ tó wà nínú rẹ̀ sí ẹni náà. Fi gbogbo ìfẹ́ inú rẹ̀ àti ìgbóná ọkàn ránṣẹ́ sí ẹni náà. Ẹni yẹn gangan àti ìwọ rí bákan náà, gẹ́gẹ́ bí ìwọ, ẹni yẹn náà n fẹ́ láti ní ìgbé ayé rere.

Ṣe àwítúnwí/àtúnwí àwọn àpólà gbólóhùn yìí jẹ́jẹ́. gẹ́gẹ́ bí mo ti fẹ́ kí o lè wà ní àìléwu/àlàfíà, kí o lè ní ìlera pípé, kí o lè gbé ìgbé ayé ìrọ̀rùn àti ayọ̀/ìdùnnú. Gẹ́gẹ́ bí mo ti fẹ́, kí o lè wà láìléwu/àlàáfíà, kí o ní ìlera pípé, kí ó gbé ìgbe ayé ìrọ̀rùn àti ayọ̀/ìdùnnú.

Gẹ́gẹ́ bí mo ti fẹ́ kí o lè wá láìléwu/àlàáfíà, kí ó ní ìlera pípé, kí o máa gbé ìgbé ayé ìrọ̀rùn àti ayọ̀/ìdùnnú. Nísisìyí tún ya àwòrán ẹlòmíràn tí o tún fẹ́ràn, ó lè jẹ́ ìbátan kan tàbí ọ̀rẹ́ kan. Ẹni yìí rí bíìrẹ ó n fẹ́ láti ní ìgbé ayé ìdùnnú/ayọ̀. Fi ìkíni/ìfẹ́ gbígbóná hàn sí ẹni náà. ṣe àwítúnwí/àtúnwí àwọn àpólà gbólóhùn yìí jẹ́jẹ́: kí ayé rẹ̀ kún fún ayọ̀, ìlera àti ìgbé ayé ìrọ̀rùn kí ayé rẹ kún fún ayọ̀, ìlera àti ìgbé ayé ìrọ̀rùn. Ríránṣẹ́ ìṣẹun ìfẹ́ sí ènìyàn tí a kò mọ̀: Nimsisìyí rò nípa ojúlùmọ̀ kan, ẹnìkan tí o kò mọ̀ dáadáa àti sí ẹni tí ó tilẹ̀ ní ìfowọ́ bà kan pàtó pẹ̀lú rẹ̀. Ìwọ àti ẹni yìí jọ rí bákan náà nínú ìfẹ́ láti ní ìgbé ayé. Fi gbogbo ìkíni tàbí ìfẹ́ fún ìgbé ayé ìrọ̀rùn ránṣẹ́ sí ẹni náà, máa ṣe àwítúnwí àwọn àpólà gbólóhùn èdè yìí jẹ́jẹ́.

Gẹ́gẹ́ bí mo ti n kí ọ, kí o máa gbé ìgbé ayé ìrọ̀rùn àti ìùnnú tàbí ayọ̀. Gẹ́gẹ́ bí mo ti n ki ọ, kí o máa gbé ìgbé ayé ìrọ̀rùn àti ìdùnnnú tàbí ayọ̀.

Nísisìyí mú oojúlùmọ̀ mìíràn wá sí ọkàn rẹ tí o rò pé ó wà ní ìyànà ọ̀tọ̀ tàbí tó dáwà. Ó le jẹ́ alájọgbé, ẹgbẹ́ rẹ̀ tàbí ọ̀rẹ́ alájọrìn tàbí ẹlòmíràn tí o rí nítòsí ṣùgbọ́n tí o kò mọ̀ ọ́n dunjúdunjú, bí ìrẹ, ẹni yìí fẹ́ fi ìrírí ayọ̀ tàbí ìdùnnú àti ìgbé ayé ìrọ̀rùn tó wà nínú ayé rẹ̀ hàn (ó lè jẹ́ akọ tàbí abo). Fi gbogbo ìkíni rere ránṣẹ́ sí ẹni náà nípa àtúnwí àwọn\ àpólà gbólóhùn wọ̀nyí jẹ́jẹ́;

“kí o lè ní ayọ̀/ìdùnnú kí o lè ní ìlera pípé, kí o lè dòmìnira kúrò ni ìrora/ìnira tàbí ara ríro”.

“kí o lè ni ayọ̀/ìdùnnú, kí o lè ni ìlera pípé, kí o lè dòmìnira kúrò nínú ìrora/ìnira tàbí ara ríro. Mí èémí tó jinlẹ̀ sínú, àti èémí sóde. Àti èémí tó jinlẹ̀ mìíràn sínú kí o sì jẹ́ kí ó lọ. kíyèsí ipò tí ẹ̀mí tàbí ọkàn rẹ̀ wà àti bí ó ṣe rí lára rẹ̀ lẹ́yìn àsàrò tàbí ìsàrò yìí nígbà tí o bá ṣe tán, o lè ya ojú rẹ̀ méjèèjì.

Ìgbésẹ̀ Karùn-ún: Olùwádìí ṣe àlàyé ìdúró tàbí ìsinmi mímọ̀ pẹ̀lú àwọn olùkópa.

Ìsinmi/ìdúró tàbí ìdákẹ́ máa ran wa lọ́wọ́ láti rántí àwọn nǹkan ti à ń ṣe ìṣẹ́jú kan lọ́wọ́lọ́wọ́. Pàápàá jùlọ nígbà tí a bá mú wa gòkè nínú ìlàkàkà tàbí ìfagbára ṣíṣẹ́, fífa ọkàn sí ọ̀dọ̀ nb ènìyàn tàbí ìkólékàn nípa ènìyàn àti fífaratì nǹkan tó máa ṣẹlẹ̀ lọ́jọ́ iwájú, ìsinmi tàbí ìdúró díẹ̀ máa mú wa bọ sínú ohun àràmọ̀ndà tàbí ìjìnlẹ̀ àti agbára ìwàláàyè tí a rí níbi àti nísisìyí.

Wá àyè tàbí àkókò kan nígbà tí o bá n kópa nínú eré òpin ìsúré ìje níhà ìlà oòrùn kan, níbi àti nísisìyí.

Wá àyè tàbí àkókò kan nígbà tí o bá ń kópa nínú eré òpin ìsúre ìje níhà ìla oòdùn kan, ìwé kíkà, iṣẹ́ ṣíṣe lórí ẹ̀rọ kọ̀npútà, wíwẹ̀mọ́, oúnjẹ jíjẹ àti wá kiri dídúró tàbí dídákẹ́ fún ìṣẹ́jú kan tàbí méjì. Bẹ̀rẹ̀ nípa dídáwọ́ nǹkan tí ò ń ṣe dúró, jíjókòó dáadáa àti gbígba àwọn ojú rẹ̀ láàyè láti pàdé. Gba èémí tó jinlẹ̀ díẹ̀ àti pẹ̀lú ìmí atẹ́gùn síta yálà láti ẹnu tàbí imú. Jẹ́ kí ó lọ tàbí gba èyíkéyìí wàhálà tàbí èrò tàbí àníyàn nípa ohun tó kàn láti padà ṣe, jẹ́ kí a lọ múle tàbí falé nínú ara. Nimsisìyí, kíyèsí àwọn nǹkan tó n ṣe.eẹ̀ tàbí tó ní ìrírí bí o ti gbé inú simi tàbí dákẹ́. Irú àìbalẹ̀ ọkàn wo ni ó kíyèsí nínú ara rẹ̀ ǹjẹ́ ó n saájò tàbí sàníyàn ìfọwọ́bà tàbí láìsinmi/láìsùn tàbí hílàhílo gẹ́gẹ́ bí o ti n gbìyànjú láti gbésẹ̀ kúrò nínú àwọn ìtàn ti iyè rẹ̀? Ǹjẹ́ o mọ̀ láti fà kí o sì bẹ̀rẹ̀ aápọn? ṣé o lè nìkanṣọṣo, gbá, fún ìṣẹ́jú kan yìí, ohunkóhun tí ó bá ṣẹlẹ̀ nínú rẹ̀?

O lè hun/wun ìsinmi mímọ́/ìdúró mímọ́ sínú ìgbé ayé ojoojúmọ́ rẹ nípa sísinmi/dídúró fún ìṣẹ́jú kan díẹ̀ ní wákàtí kan tàbí gẹ́gẹ́ bí ó ṣe bẹ̀rẹ̀ àti ìparí àwọn ìyàrá/aápọn ṣíṣe náà. o lè sinmi/dúró nígbà jíjókòó, dídúró tàbí sùn sílẹ̀. Bó bá jẹ́ lórí eré, ó n rìn ìrìn lọ tàbí ó n wakọ̀/wíwakọ̀; o lè sinmi sínú, ojú á yá sílẹ̀ àti àwọn òye/ìmọ̀/ọgbọ́n wa yóò tají. Ohunkóhun tó bá ṣe àwamrí dìímú tàbí pín níyà/túuká, o lè bẹ̀rẹ̀ ìgbé ayé lákọ̀tun ni ìṣẹ́jú kan náà nípa sínsimi, mímúfúyẹ́ àti ìfetísílẹ̀, ìkọkàn sí àwọn ìrírí tó ń ṣẹlẹ̀ lẹ́sẹ̀kẹsẹ̀.

Ìgbésẹ̀ Kẹfà: Olùwádìí gbé òṣùbà káre fún àwọn akópa àti pé ó gbà wọ́n láàyè láti béèrè ìbéèrè lórí iṣẹ́ tí a ṣe lọ́jọ́ náà.

Ìgbéléwọ̀n: Àwọn akópa béèrè àwọn ìbéèrè wọ̀nyí:

i. Ṣe àlàyé ìtẹ́wọ́gbà àti jíjẹ́ ká lọ gẹ́gẹ́ ìṣesí/ìwà pàtàkì sí ìkíyèsí ara/ìsọ́ra nípa nǹkan
ii. Ṣe àfihàn ìsàrò ìṣeun-ìfẹ́
iii. Ṣe àfihàn ìsinmi mímọ́

Ọ̀rọ̀ ìkádìí ìparí: Olùtọ́jú àìsàn yìí/olùwádìí dúpẹ́ lọ́wọ́ àwọn akópa, fún wọn ni iṣẹ́ àṣetiléwá, wá àkókò fún ìjókòó ìpàdé tó ń bọ̀, kí o sì mú ètò ìjókòó ọjọ́ náà wá sí ìpamọ́.

Iṣẹ́ Àṣetiléwá:

i. Ṣe ìsàrò jíjókòó ojoojúmọ́, ṣe àmúlò àko.sílẹ̀ ìsàrò tí gba sílẹ̀.

ii. Ṣe eré ìṣẹ́jú mẹ́ta àyè èémí/mími

iii. Ṣe eré ìsàrò ìṣeun-ìfẹ́ nígbà mẹ́ta ní gbogbo àárín ọ̀sẹ̀

iv. Ṣe eré ìsẹ́jú mẹ́ẹ̀dógún gbígbé ara nílẹ̀ lójoojúmọ́

Iṣẹ́ Ìjókòó kẹfà

Orí ọ̀rọ̀: Ìjókòó yìí tẹ̀lé àwọn ìlànà kan náà ti a ti lapa rẹ sílẹ̀ ni iṣẹ́ ìjókòó kẹta àti fi hàn bi a ṣe lè borí òkúta ìdìgbòlù/ìṣòro tó wà nínú ìsàrò.

Èròǹgbà: Ní ìparí ìjókòó, àwọn akópa yóò le ṣe àlàyé ọ̀nà tí a fi lè borí ìṣòro tó wà nínú ìsàrò/àsàrò.

Ìgbésẹ̀ kìn-ín-ní: Olùwádìí fi tayọ̀tayọ̀ kí àwọn akópa káàbọ̀

Ìgbésẹ̀ kejì: Olùwádìí ṣe àtúnyẹ̀wò iṣẹ́ ìjókòó àtẹ̀yìn wà pẹ̀lú àwọn akópa

Ìgbésẹ̀ kẹta: Olùwádìí dárúkọ àwọn ìṣòro/òkùta ìdìgbòlù/ìdíwọ́ tó wá nínú ìsàrò/àsàrò-iyèméjì, àìsífọ̀kànbalẹ̀, súnási tàbí mú bímú, àìróorunsùn àti àìní tàbí àìtó.

Ìgbésẹ̀ kẹrin: Olùwádìí ṣe àlàyé bí ìṣòro/ìdíwọ́ yìí ṣe le dohun ìgbàgbé tàbí bí a ṣe lè borí ìṣòro náà.

Iyè Méjì: Èyí ni àìnídánilójú nípa bóyá nǹkan kan le è ṣe tàbí kò lè ṣe é ṣe. Ó jẹ́ àjàkálẹ̀ àárùn tó máa ń yọ ènìyàn lẹ́nu nígbà gbogbo ní ìbẹ̀rẹ̀ pẹ̀pẹ̀ tí wọ́n bá n ṣe é. Ìrò tàbí èrò náà nip é "èyí lè ṣiṣẹ́ fún òmíràn, ṣùgbọ́n èyí le è máa ṣíṣẹ́ fún mi". Ní ọ̀pọ̀ ìgbà iyèméjì jẹ́ ìlera pípé, kíkọ́ni láti máa wo nǹkan láwòfín kí á tó rà wọ́n, ṣùgbọ́n iyèméjì nípa àìgbádùn tàbí àìlera máa n mú wa lọ jìnnà kúrò nínú ìrírí kan kí o tó di pé ó n kọ́ni ni ohunóhun.

Apágùn/Aporó: À ní láti ṣe ìrántí pé èrò inú tàbí àníyàn tòótọ́, wọn kì í ṣe òtítọ́ gan-an pàápàá àwọn kan tó sọ pé àwọn wà. Nígbà tí a kíyèsí iyèméjì yíyọ́ sínú yìí, ẹ jẹ́ kíá kíyèsí nǹkan náà, bóyá bí a bá sàkíyèsí ìbẹ̀rù tí o mú dání tàbí wà lábẹ́ rẹ̀ àti nígbà náà a rọra yípadà sẹ́yìn ṣíṣe nǹkan náà.

ẹ Àìnísinmi/Àìesùn: Ẹ jẹ́ ká kojú rẹ̀. Ó jẹ́ nǹkan tó le láti jókòó tàbi ítẹ̀bà tì ni ìdákẹ́ fún ìgbà kan nígbà tí ọkàn bá kún fún iṣẹ́/ṣíṣe lọ́wọ́. A ti n kọ́ wa láti ìgbà ọmọdé tàbí èwe láti ṣe, ṣe àti ṣe síi.

Ọkàn lè fẹ̀ sọ̀tẹ̀ níwọ̀nba nígbà tí a bá n kọ́ nípa báwo "ló yẹ kó rí". O lè gbá a mú lásìkò tó bá n sáré láàrin ẹgbẹẹgbẹ̀rún mílíọ̀ọ̀nù kan tí a ka orúkọ wọn sílẹ̀ àti tí à n gbìyànjú láti ka ìṣẹ́jú tìtí dé ìparí eré ṣíṣe náà.

Èyí jẹ́ gbgbo nǹkan tó kún pátápátá ní ti ìwà ẹ̀dá tàbí ìwà àdánidá.

Apààgùn/Aporó: Ó ṣe pàtàkì àti ṣe ìdámọ̀ pé àìlesùn tàbí àìsinmi àti ẹ̀mí sísú jẹ àwọn àìbalẹ̀ ọkàn bí nǹkan mìíràn bí o bá ṣeàwòfín tàbí àwòdélẹ̀ àìlesùn tàbí àìsinmi tàbí ẹ̀mí sísúni lábẹ́ rẹ̀ ójẹ́ ara àwọn iṣẹ́ tàbí àwòrán àìbalẹ̀ àyà tàbí ìbẹ̀rù.

Ṣùgbọ́n o ò nílò láti ṣe ìwádìí rẹ̀ láti ṣe dínkù agbára/ipa tó o nìkàn rí pe ó dárúkọ rẹ̀ bí ó ti ṣe ìdámọ̀ rẹ̀, èyí le ṣe àdínkù ipa tó ní lórí rẹ̀.

O lè tún gbìyànjú láti dá ọgbọ́n ọkàn àsẹ̀sẹ̀ bẹ̀rẹ̀ àti kí ó si fẹ́ mọ̀ nípa àìbalẹ̀ ọkàn tí àìlesùn tàbí àìsinmi. Báyìí ni ó ṣe bá ara rẹ̀ lẹ́yìn ìjókòó awakọ̀.

é. **Ìmúnibínú**: Láti múni-bínú máa n ṣẹlẹ̀ fún onírúurú ìdí. O lè jẹ́ pé a kò rí bí a tin i ìrírí ìsàrò rere tàbí ìgbé ariwo tó bi ni nínú láti inú iyàrá tàbí ó jẹ́ ìmí ẹ̀dùn kejì tí ó wá lẹ́yìn ìfọwọ́bà àìsinmi/àìlesùn.

Ní ìdàkejì ọ̀rọ̀, a ti mú wa bínú pé a ní àìsinmi ní ṣíṣe nǹkan náà.

Aporó/Apààgùn: Níwọ̀n bí ìtiraka wa jẹ nǹkan tí a lè kọjú ìjà sí ìmú-bínú tàbí ìsúnásí. A ní láti rántí òwe àtijọ́ kan tó sọ pé "ohun tí a kọjú ìjà sí ni a dìmú tàbí kí a tẹramọ́ṣẹ́. Iṣẹ́ tó wà ni ibi ni láti ṣe àfikún rẹ̀ gẹ́gẹ́ bí ara ìrìn ìfiyèsí náà. bí orim ìwé náà tí n lọ sí ìyọrísí tàbí èso ìṣẹ́ibà ìsisìyí, "ó jẹ́ ohun tí yóò jẹ́ nígbà tí o sì ti jẹ́". Iṣẹ́ wa ni láti dá ìmúnibínú mọ̀, kí a gbàá láàyè láti wà níbẹ̀, a sì le ṣe ìwádìí bí o ti jinlẹ̀ tàbí kí á wòó bí to tí wá, tí yóò sì lọ tinútinú.

ẹ̀. Àìróorunsùn/Láìsùn: Nítorí oorun máa fọwọ́ aago orílẹ̀ èdè sẹ́yìn tí o wà níbẹ̀, ó jẹ́ nǹkan tó rọrùn láti fọwọ́bà ìwọ̀nba oorùn nígbà tí a bá ń padà bọ̀ wá sílẹ̀ láti ọkàn wa tó ń ṣiṣẹ́ lọ́wọ́. Ara wa n ṣe nǹkan tí ó n fẹ́ láti ṣe tinútinú lọ ki o sinmi. A máa mọ̀ ìtòògbé lára

nígbà kan ti ìrírí bá rub o ni lẹ̀, ó dára kí a yanilẹ̀nu bóyá ti ààrẹ̀ ara/agara to n sọ fún ọ pé o nílò kí o sinmi díẹ̀ síi tàbí pé ìfọwọ́bà kan wá tí o nílò láti sọ̀rọ̀.

Apáàgùn/Aporó: Tí o bá jẹ́ láti àkókò sí àkókò tí o bá ti sun nígbà tí ó n ṣe àsadrò, ri i gẹ́gẹ́ bí òòbbé tó dára tío nílò. Bí ó ti wù kórí, tí èyí bá ṣẹlẹ̀ nígbà pípọ̀ o lè gbìyànjú jíjókòó ní ipò òdodo/òtítọ̀, díde dúró, jẹ́ kí ojú rẹ̀ rọra sísílẹ̀ tàbí ó le tá omi sí ojú rẹ̀ kí ó tó bẹ̀rẹ̀.

ù. Ṣíṣe àìní/fífẹ́: O lè kíyèsí nígbà tó bá n ṣeré pé ọkàn rẹ ti subú sínú ipò fífẹ́-kù/ṣíṣe àìní láti wà níbi kan bíbẹ́kọ̀ọ́ ju ibi tí ó wà tàbí o le jẹ nǹkan tọ́jú láìjẹ̀bi/láìṣe nítorí à n fẹ́ wa nǹkan díẹ̀ láti bùjẹ́ àti ọkàn síbẹ̀rẹ̀ sí ni tari lọ sí onírúurú orí ọ̀rọ̀ oúnjẹ tàbí kí o tó lọ ṣe ọkàn rẹ̀ n fẹ́ ipò/ìrí tó mú kí àyètọ̀ kúrò nínú òun tí wọ́n kò rò pé bí ó ti ri kò wá sí ṣíṣe. ipò tí ọkàn wà kò le dá wà dúró kúrò nínú ṣíṣe tàbí àìlèsùn/àìnísinmi/àìnísinmi ìsúnásí àti nǹkan mìíràn.

Aporó/Apààgùn: Tí o bá kíyèsí ipò tí ọkàn wà ṣáájú ṣíṣe, o lè ro ìrí ohun tóle ṣe dípò nǹkan tí o lò le ṣe. Fún àpẹẹre. níbi ti ariwo wà, ìkíyèsí ojú ọ̀run ṣe láti èso iṣẹ́/ìyọrísíìsinsìyí, le ṣe dáradára.

Bí ọkàn bá ń ṣiṣẹ́ lọ́wọ́ tó sì ń fẹ́láti wà níbi kan náà láàkò/ṣíṣe, wò bóyá ó rọrùn fún, kíkí títẹ̀síwájú láti kíyèsí ìrò/èrò inú jinnà àti pẹ̀lẹ́pẹ̀lẹ́ nímú ìifetisílẹ̀/ìfarabalẹ̀ padà bọ̀. Tó bá tẹ̀síwájú láti jẹ́ nǹkan agbára láti fà, o lè nǹkan ti a mọ̀ ọ́n mọ-ọn gbè iṣẹ́ rẹ̀ kúrò sí ìmọ̀ nípa èrò inú gẹ́gẹ́ bí o ti wà nínú fíìmù tó wà ní ọkàn iṣẹ́ wa.

Ní ìparí, tí a bá ní ikíyèsí ara ìsàrò tó ṣe déédéé tó dbí pé ó rọrùn, ṣùgbọ́n ṣíṣe rẹ̀ kò fi gbogbo ìgbà rọrùn. A ní ọpọlọ wa ti a bá díje/bá sọ pẹ̀lú pé o sọ gbogbo àwọn ohun ìdènà wọ̀nyí sókè. Bí o bá jẹ́ pé ó tilẹ̀ gba lérò láti wà ní ìfojúsóde fún àwọn ìdíwọ́/ìdèná wọ̀nyí tí ó sì ṣe àmúlò àwọn apààgùn/aporó wọ̀nyí gẹ́gẹ́ bí ó bá ṣe dára jù tàbí bí ó bá ṣe mọ̀ọ́n lò, èyí yóò le jẹ́ òpin àǹfààní ṣíṣe rẹ̀. Kí o darí ẹ̀sẹ̀ jinra rẹ gẹ́gẹ́ bí óti lọ àti pé ó lè rántí láti tún bẹ̀rẹ̀ lẹ́ẹ̀kan síi.

Ìgbésẹ̀ Karùn-ún. Olùwádìí gbé òṣùbà kre fún àwọn olùkópa, ó sì gbà wọ́n láàyè láti béèrè ìbéèrè nípa iṣẹ́ ọjọ́ náà.

Ìgbésẹ̀ Kẹfà: Olùwádìí kásẹ̀ iṣẹ́ ìdánilẹ́kọ̀ọ́ nílẹ̀ pẹ̀lú iṣẹ́ ẹ̀yà MbSR.

i. Eré ìmí sínú àti sóde èémí látimú kí ara kalẹ̀/tàbí wà ní ìsinmi (Mind yoga)

ii. Jíjókòó ìsàrò: Kíkíyèsí èémí, àgọ́ ara, ìró àti èrò inú ṣe àfihàn ìṣòro ìrò/àníyàn/ìrántí.

iii. Pínpín ìfiyèsí/ìrántí: Ìlàjì àwọn ìsọ̀rí ni wọ́n sọ̀rọ̀ lórí báwo ni nǹkan náà ṣe ń lọ, ṣe ìyípadà kan wà tí àwọn ènìyàn n fẹ́ láti le ni ìdátó pọ̀jù pọ́ju àwọn ìsọ̀rí ọ̀sẹ̀ tó sẹ́ kù.

igb. Ìfi-ọ̀rọ̀-wé-ọ̀rọ̀ yíká "èrò inú tàbí àníyàn kì í ṣe òtítọ́ ìṣe tàbí nǹkan tó dájú gan-an.

gb. Ìsẹ́jú èémí tàí mímí bíbá du àlàfo tàbí àyè.

Ìgbéléwọ̀n: Àwọn akópa ni a béèrè àwọn ìbéèrè wọ̀nyí lọ́wọ́ wọn:

i. Tòó lẹ́ṣẹẹ́ṣe àwọn ìdènà tàbí ìdíwọ́ tó wà nínú ìsàrò.

ii. Ṣe àlàyé bí àwọn ìdènà tàbí iddíwọ́ tó wà nínú ìsàrò ṣe lè jẹ́ ṣíṣẹ́gun tàbí bíborí.

Ìkádìí/Ọ̀rọ̀ ìparí: Olùwádìí bóríyìn fún àwọn àkóbá fún wọn ní iṣẹ́ àṣetiléwá, wá ààyè tàbí àkókò fún ìpàdé iṣẹ́ mìíràn tó ń bọ̀ àti iṣẹ́ ìjókòó ọjọ́ náà wá sí ìpamọ́.

Iṣẹ́ Àṣetiléwá:

i. Ṣe ìsàrò jíjókòó lójoojúmọ́ nípa ṣíṣe àmúlò àwọn ìsàrò tí a kọ sílẹ̀ nínú ìwé ìrántí.

ii. Ṣe eré ìsẹ́jú mẹ́ta àyè àlàfo mímí tàbí èémí ṣe é bí ìgbà mẹ́ta lóòjọ́.

iii. Ṣe eré ìṣẹ́jú mẹ́ta bíbádu àlàfo mímí tàbí èémí. Máa ṣe èyí nígbà tí o bá ṣe àkíyèsí ìfọwọ́bà àìládùn.

iv. Ṣe eré ìṣẹ́jú mẹ́ẹ̀dógún àyẹ̀wò ara tàbí wádìí ara lójoojúmọ́.

Iṣẹ́ ìjókòó keje:

Orí Ọ̀rọ̀: Ìjókòó yìí n ṣe àfihàn àṣà ríronú láìní ìlera tí ìsọnisókí gbogbo nǹkan tí a kọ̀ ni ìjókòó mẹ́ta sẹ́yìn.

Èròngbà: Ní òpin ìdánilẹ́kọ̀ọ́ náà, àwọn akópa yóò le dá àwọn èrò inú aláìnílera mọ̀, wọn yóò sì pa á dé lẹ́sẹ̀kan náà tàbí ní lọ́gán.

Ìgbésẹ̀ Kìn-ín-ní: Olùwamdiì fi títayọtayọ̀ kí àwọn akópa káàbọ̀.

Ìgbésẹ̀ Kejì: Olùwádìí ṣe ìfihàn àsàtò/èrò inú aláìnílera "nígbà tí ẹnìkan bá ní ìrírí ìmí ẹ̀dùn láìsí ìrànlọ́wọ́, bí irú ìrẹ̀wẹ̀sì tàbí ìdoríkodò àti àìbalẹ̀ àyà. Ó sábá máa n ṣáájú nípasẹ̀ iye ìpèdè tara ẹni láìsí ìrànlọ́wọ́ àti èrò inú.

Nígbà gbogbo àwòrán tàbí àwòkọ́ṣe kan wá sí ìrò tàbí èrò inú wọ̀nyí àti pé àwọn àṣà ìrònú aláìsíràǹlọ́wọ́. Ọ̀kan nínú àwọn nǹkan tí a kíyèsí ni pé àwọn ènìyàn máa ń ṣe àmúlò àṣà ìrònú láìsí ìrànlọ́wọ́ bí ìwà tó n ṣiṣẹ́ fún ara rẹ̀. Ó jẹ́ nǹkan tí a ò mọ̀ nígbà gbogbo. Nígbà tí ẹnìkan bá dúró láìyẹsẹ̀ àti ìfẹsẹ̀múlẹ̀ tàbí ìsòótọ́ nípa lílo àwọn àṣà ríronú, wọ́n lè títorí nǹkan yìí hùwà tó le fa ìfòró ìmí ẹ̀dùn. Ìwífún yìí ló ṣe àpèjúwe àìníye àṣà ìrònú láìníràǹlọ́wọ́. Bí o bá kàwé nipa wọn, o lè kíyèsí àwọn àwòṣe ìrònú àti àṣà tí ó máa dúró lò láìyẹsẹ̀.

Ọ̀pọ̀ àwọn àṣà ìrònú láìsí ìrànlọ́wọ́ yìí le lágbára tàbí dún bi irú kan náà si ara wọn. wọ́n kò túmọ̀ sí pé wọ́n ní ìsọ̀rí ènìyàn tóyàtọ̀ ṣùgbọ́n wọn le è ràn ọ́ lọ́wọ́ láti rí bóyá àwòṣe kan wà sí èrò inú tàbí àníyàn.

Ríro Orí:

Àṣà ríronú yìí ni nǹkan ṣe nípa ọ̀nà rírò sínú àti rírò síta. Ó jẹ́ ihò/ojú ọ̀nà tí a là fún ìríran tàbí ìsípayá, fífojúsí ọ̀nà apá kan ipò tàbí àyè kan àti gbígbójú kúrò níbi ìyókù, èyí túmọ̀ sí wíwo ìdàkejì tàbí òdìkejì apá kan ipò yàbí ayé kan àti gbígbàgbé apá kan tó jẹ́ ìtítọ́ tàbí tí a kò lè yíhùn padà, àti gbogbo àwòrán ni a kùn nípa nǹkan tí o lè jẹ́ ẹ̀kúnrẹ́rẹ́ ọ̀rọ̀ iyàn. Fún àpẹẹrẹ kíkọbi ara sí ìfarabalẹ̀ tàbí ìfojúsí àwọn àṣìṣe tàí ìjákulẹ̀ wa ṣùgbọ́n kì í ṣe ìrírí àṣeyọrí wa.

Fífò sí orí Ìpinnu/Ìparí:

A fò sí orí ìpinnu tàbí ìparí nígbà tí a bá rò pé a mọ nǹkan tí ẹnìkan mìíràm n rò lọ́kan (mọ èrò ọkàn) àti nígbà tí a bá ń sọ àsọtẹ́lẹ̀ nípa ohun tàbí nǹkan tó n bọ̀ wá ṣẹlẹ̀ ní ọjọ́ iwájú (ìwòye/ríronú ìsọtẹ́lẹ̀).

Ìgbàmọ́ra/Ìfohùnpeni:

Èyí ni nǹkan ṣe nígbà tí ẹnìkan bá di ẹ̀bi ru ara rẹ̀ fún gbogbo nǹkan tó bá jẹ́ ìsìnà tàbí ìpanilára tàbí o lè ṣe àìdára tàbí ìpanilára tàbí ìsìnà, kódà bó jeṃ ìgbà tí ẹnìkan bá le nìkan dúró láti dáhùn fún ìpín kan tàbí kí ó dúró láti dáhùn fún gbogbo rẹ̀. Ènìyàn le mú bí idà ọgọ́rùn-ún erù tàbí ìgbékẹ̀lé fún àwọn nǹkan tàbí ohun tí ó ṣẹlẹ̀ tàbí ti ìṣẹ̀lẹ̀ ẹ̀yìn òde.

Òpin Ọ̀ràn tàbí Ìparí tí kò dára:

Àjálù /òpin ọ̀ràn máa n ṣẹlẹ̀ nígbà tí a bá fọn rere nǹkan jáde lára òsùwọ̀n àti pé à n wo ipò tàbí àyè náà gẹ́gẹ́ bí ìbẹ̀rù tàbí bíbanilẹ́rù/burú/lọ́wọ̀/ni fòyà tàbí ní ìbẹ̀rù/bani lẹ́rù tàbí burújù, bí ó tilẹ̀ jẹ́ pé ohun tó jẹ́ òtítọ́ tàbí òdodo ibẹ̀ ni ìṣòro náà jẹ́ kékeré pátápátá.

Rironú dúdú àti funfun:

Àṣà ríronú yìí máa n wémọ́ rírí ohun ẹyọ kan lí òpin tàbí òmíràn. Ó lè jẹ́ pé ó kùnà tàbí ó ṣiṣẹ́ tàbí ó jánà/ó tọ̀nà, dára tàbí sàìdára àti bẹ́ẹ̀ bé.ẹ̀ lọ. kò sí ẹni tó wà nínú láàrin tàbí ìbòjì ewù irun funfun tàbí dúdú. À n pè ní gbogbo rẹ tàbí ríronú òfo/òfìfo.

Bíbá àti Gbígbọ́dọ̀ tàbí kò gbọ́dọ̀ ṣe aláìṣe.

Nígbà kan nípa sísọ "mob á…" tàbí "mo gbọ́dọ̀…" ènìyàn le gbé ìbéèrè àìkàkún tàbí àìnítumọ̀ tàbí fagbára mú ẹnìkan tàbí ẹlòmíràn (kíkìmọ́lẹ̀). Bí ó tilẹ̀ jẹ́ pé àwọn ìpèdè tàbí́ gbólóhùn wọ̀nyí kò fi gbogbo ìgbà ṣe ìrànlọ́wọ́, fún àpẹẹrẹ:

Èmi kò gbọdọ̀ ní lọ mu ọtí yó ki n sì tún wakọ̀ lọ sílé… Wọ́n fi ìgbà kan dá rúgúdù tàbíìpayà àìlénígbẹkẹ̀lé ìfojúsọ́nà sílẹ̀ tàbí ìrètí.

Bí ènìyàn bá le ṣe àfikún "bá" sí iṣẹ́ tàbí ìwà ènìyàn mìíràn. Ó yọrísí fífòró ìgbà gbogbo.

Kíkó àkólù nǹkan jù:

Nígbà tí ènìyàn bá ti n kó àkólù nǹkan jù, ó máa n mú àpẹẹrẹ láti ara nǹkan tó kọjá tàbí nǹkan tó n ṣẹlẹ̀ lọ́wọ́ àti kí a fagbára gbé lé e gbogbo nǹkan tó bá ṣẹ̀ṣẹ̀ ń ṣẹlẹ̀ lọ́wọ́ tàbí ìṣẹ̀lẹ̀ ipò tàbí àyè ọjọ́ iwájú. Fún àpẹẹrẹ: tí ènìyàn bá sọ pé "o máa… tàbí ẹnikọ̀ọ̀kan…" tàbí "èmi kò le ṣe…" ó n ṣiyèméjì tàbí ṣe bóyá lórí akólù nǹkan ju.

Sísàmì sí ẹrù tàbí ẹni:

A máa n sàmì sí ara wa àti ẹlòmíràn nígbà tí a bá ń sọ ọ̀rọ̀/…tàbí gbé ìpèdè tó kárí ayé jáde tí ó dá lé orí ìṣesí/ìhùwàsí ní ipò/àyè tó bá nǹkan mu.

Alè lo àmì yìí dọ́gba bí ó tilẹ̀ jẹ́ pé àwọn àpẹẹrẹ pọ̀ jantirẹrẹ tí wọn kò ṣe kẹ́míí le/dúró láìyẹsẹ̀ pẹ̀lú àmì yẹn. Fún àpẹẹrẹ, pípe ara ẹni tàbí ẹlòmíràn tí ó pàdánù, àti asiwèrè/òmùgọ̀ tàbí ẹni tí kò wúlò/láìwúlò.

Sísọ Àsọyé Ìmí-ẹ̀dùn

Àṣà ìrònú/èrò inú yìí ni ipa nínú gbígbé èrò ẹni lórí ipò/àyè tàbí ẹnìkan fúnra rẹ̀ lórí ọ̀na tí ó bá n dùn ni/fowọ́ba ni. Fún àpẹẹrẹ, ohun ṣoṣo tó jẹm ẹ̀rí pé nǹkankan kò dára/bàjẹ́ ó n lọ ṣẹlẹ̀ nip é ó fọwọ́ba nǹkan tí kò dára/bàjẹ́ to n lọ ṣẹlẹ̀.

Sísọdi títóbi/Sísọ dolókìkí àti Dídínkù nǹkan

Níbi àṣà ìrònú/ìtànmọ́lẹ̀ yìí, ènìyàn le saláì yíhùn padà nípa ìkàsí àwọn ẹlòmíràn àti ìdínkù aláìyíhùn padà ìkàsí tirẹ̀. Ó fẹ́ dàbí pé ó n ṣàlàyé aláìyíhùn padà iṣẹ́ rẹ̀/sọ bí ó ti rí/àbùdá rẹ̀.

Ìgbésẹ̀ Kẹta: Olùwaẃdìí kíyèsí gbogbo àwọn ìwúlò ìrírí èèkari sí pẹ̀lú àwọn akópa:

Ìfiyèsí ìmí sínú àti sóde èémí bí ọkàn le wà ní ìsinmi (Mindful yoga), jíjókòó ìsàrò, pínpín ìfiyèsí/ìrántí, àwòrán ara, àlàfo/àyè èémí àti, dídákẹ́/ìdúró mímọ́.

Ìgbéléwọ̀n: Àwọn akópa ni a bèèrè àwọn ìbéèrè wọ̀nyí lọ́wọ́ wọn:

i. Ṣe àlàyé pẹ̀lú àwọn àpẹẹrẹ àṣà ríronú láìní-ìlera.

Ọ̀rọ̀ Ìparí/Ìkádìí: Olùwádìí mọ rírì ìkópa àwọn olùkópa ó fún wọn ní iṣẹ́ àṣetiléwá, wá àyè àti àkókò fún iṣẹ́ ìpàdé tó n bọ̀, kí o sì mú iṣẹ́ ìjókòó ọjọ́ náà wá sí ìpamọ́/ìdúró.

Ìjókòó kẹjọ: Ìpinfúnni àwọn ìdánwò tó kẹ́yìn àti ìfòpin sí iṣẹ́ ìjókòó sáà/ohun ìpanu/ìtura.

Èròngbà: Ní òpin/ìparí ìjókòó yìí, àwọn olùkópa yóò le

i. Ṣe àjọpín ìrírí wọn, àti kí wọn sọ àkíyèsí àyípadà tí wọ́n ti fojú rí/ṣe ẹlẹ́rìí rẹ̀.

ii. Ṣe àlàyé bí wọn yóò ṣe ṣàmúlò ẹ̀kọ́ tí wọn kọ́ sínú ìgbé ayé ojoojúmọ́ wọn, kí wọn sì sọ ọ́ di ònà ìwà/ẹ̀dá.

Ìgbésẹ̀ Kìn-ín-ní

Olùwádìí kí àwọn akópa káàbọ̀ ó tẹ̀síwájú láti gbóríyìn fún wọn fún ìfowósọwọ́pọ̀ ìfarabalẹ̀, ìṣe déédé lásìkò ìdánilẹ́kọ̀ọ́, ìtètède lákókòó àti ìdí ìwúlò wọn nínú àwọn ẹ̀kọ́ iṣẹ́ ìjókòó sáà náà.

Ìgbésẹ̀ Kejì: Nísisìyí, olùwádìí wá ṣe ìpín fún ni "The Kessler Psyẹhologiẹal Stress Sẹale" Oóohun èlò ffún mímọ́ òdiwọ̀n ìfòró/ìpòrurù ọkàn/ọgbẹ́ ọkàn) láti kí wọ́ àrùn náà bọlẹ̀ bí ó ti lágbára sí ní títọ́jú.

Ìgbésẹ̀ Kẹta: Olùwádìí gba àwọn akópa níyànjú/mú wọn lọ́kàn le láti ṣe àmúlò ẹ̀kọ́ titun tí wọ́n kọ́ láti máa ṣe wọn ní ìgbé ayé ojoojúmọ́ wọn.

Ìgbésẹ̀ Kẹrin: Olùwádìí fòpin sí iṣẹ́ ìjókòó sáà náà ó sì dúpẹ́ lọ́wọ́ gbogbo àwọn akópa. Ó sì bẹ̀bẹ̀ fún fọ̀tò ajọyà lẹ́yìn tí ó bi í léèrè fún ìlóhùnsí wọn lẹ́yìn ìbéèrè tàbí ẹ̀bẹ̀ yìí pé kí gbogbo olùkópa lọ jókòó fún ohun ìpanu tàbí ìtúra.

Ìdánwò Ìkójọpọ̀ Kejì:

ÌYÁSÁPÁKAN ÌTỌ́JÚ ÀÌSÀN NÁÀ FÚN ÌSÀKÓSO/ÀBOJÚTÓ NÍPA BÍ ÌFÒRÒ/ÀÁRẸ̀ ỌKÀN ṢE N ṢÍṢE LÁÀRIN ALÁÌSÀN TÓ NÍ ÀÀRÙN JẸJẸJẸRẸ OJÚ ARA ILÉ ỌMỌ OBÌNRIN

ÌJÓKÒÓ IṢẸ́ KÌN-ÍN-NÍ:

Orí Ọ̀rọ̀: Ìfihàn/Ìdí mímọ̀ tó wọ́pọ̀/gbogbo àti ìpínfúnni ohun èlò iṣẹ́ ìwádìí láti lè ṣe àkójọ àwọn àmì máàkì ìdánwò tó ṣáájú tí akópa gbà (Pre-test sẹores).

Èròngbà; Ní ìparí iṣẹ́ ìjókòó náà, olùwádìí yóò le:

igb. Mọ ilé ìrànlọ́wọ́ ìtọ́jú àìsàn/ìkàfàró àìsàn tó yege nípa ìbátan pẹ̀lú àwọn akópa

gb. Fún àwọn akópa ní ẹ̀kọ́ ìfinimọ̀lé nípa ọ̀nà àti ìlànà tàbí ìgbékalẹ̀ ìkẹ́kọ̀ọ́.

gbi. Pín ìwé ìléwọ́ ìbéèrè tíi ṣe ohun èlò fún iṣẹ́ ìwádìí (Kessler Psyẹhologiẹal distress, “Soẹial support sẹale”, àti selfọ́effiẹaẹy sẹale. Fún ìdí láti rí òkodoro tàbí ìpilẹ̀ ìmọ̀lẹ̀ ẹ̀kọ́ tàbí ọ̀rọ̀ tí a sọ fún ni.

Àmúṣe iṣẹ́:

Ìgbésẹ̀ kìn-ín-ní: Olùwádìí fi tìtaratara kí àwọn akópa káàbọ̀ síbi àpèjọ ètò náà àti fífarakínra pẹ̀lú àwọn akópa.

Ìgbésẹ̀ kejì: Olùwádìí náà ṣe ìdásílẹ̀ ìbáṣepọ̀ tàbí ìbátan tí àwọn ènìyàn fẹ́, tí àgbóyé sì wà àti ìfọ̀wọ̀¸fúnní láàrin olùwádìí àti àwọn akópa nípa wíwá àyè fún iṣẹ́ àfihàn olùwádìí tàbí akópa. Olùwádìí tún gbọ́dọ̀ ríi pé gbogbo akópa gbọ́dọ̀ ffffọ́ọ̀mù ìlóhùnsí láti lè ṣe àkọsílẹ̀ ìlóhùnsí wọn láti kópa nínú ẹ̀kọ́ náà.

Ìgbésẹ̀ Kẹta: Olùwádìí pèsè ìlapa èrò nípa ìwé ètò ohun tí wọ́n fẹ́ ṣe níbi iṣẹ́ ìjókòó yìí, ó ṣe àlàyé ìdí pàtàkì ìwé ètò yìí/iṣẹ́ ìwádìi àti àǹfààní tí ó súyọ níbẹ̀ ní òpin ètò yìí. Àwọn akópa ni wọ́n fọkàn wọn balẹ̀ tàbí ní ìgbékẹ̀lé/ìfọkàn tàn láàrin àti ní ìparí ètò náà.

Ìgbésẹ̀ kẹrin: Olùwádìí ṣe àlàkalẹ̀ òfin tó de àkóso ètò náà àti nǹkan tó yẹ kí á kópọ̀ ṣe ni wọ́n jíròrò lé lórí tí wọ́n sì ṣe àlàkalẹ̀ rẹ̀/sọ ọ́ di mímọ̀.

Ìgbésẹ̀ Karùn-ún: Olùwádìí pín ìwé ìléwọ́ ohun èlò ìwádìí fún ìdánwò tó ṣaájú (Pre-test instrument) tí a mọ̀ sí (Kessler Psyẹhologiẹal Distress Sẹale, Health Self Effiẹaẹy. Sẹales àti Soẹial Support Sẹale) fún àwọn akópa pẹ̀lú ìtọ́sọ́nà tó kira láti ọ̀dọ̀ olùwádìí àti àwọn aṣèrànlọ́wọ́ iṣẹ́ ìwádìí.

Ìgbésẹ̀ Kẹfà: Àwọn akópa gbó iṣẹm àṣetiléwáláti lè dá àwọn nǹkan tó ṣe ìyàtọ̀ mọ́ ti o sì ṣ okùnfà ọgbẹ́ ọkàn/mú ìpọ́njú ba/àárẹ̀ ọkàn.

Ọ̀rọ̀ Ìkádìí/Ìparí:

- Àwọn akópa gbóríyìn fún ìfowọ́sowọ́pọ̀ àti àkókò wọn
- Olùwádìí gbà wọ́n níyànjú/rọ̀ wọn láti wà nínú iṣẹm ìjókòó tó n mú kí ó sì rán wọn létí ọjọ́, àkókò àti ibùjókòó ẹ̀kọ́ náà.

Orí ọ̀rọ̀: Ohun tí à ń ni Àárẹ̀ ọkàn/ọgbẹ́ ọkàn/ìfòró ọkàn àti àrùn jẹjẹrẹ ojú ara ilé ọmọ obìnrin.

Èròǹgbà: Ní ìparí iṣẹ́ ìjókòó yìí, àwọn akópa yóò le:

iii. Sọ ìtumọ̀ ààrùn jẹjẹrẹ ojú ara ilé ọmọ obìnrin

iv. Ròyìn/sọ àti ṣe àlàyé ìtumọ̀ Àárẹ̀/ọgbẹ́ ọkàn.

Àmúṣẹ Iṣẹ́:

Ìgbésẹ̀ Kìn-ín-ní: Àwọn akópa ni a kí káàbọ̀ síbi ìjókòó yìí.

Ìgbésẹ̀ Kejì: Olùwádìí ṣe àtúnyẹ̀wò iṣẹ́ àyànṣe pẹ̀lú àwọn akópa.

Olùwádìí ṣe àlàyé ohun tí ààrùn jẹjẹrẹ ojú ara ilé ọmọ obìnrin túmọ̀ sí.

Ààrùn jẹjẹrẹ ojú ara ilé ọmọ obìnrin ní ààrùn jẹjẹrẹ ti ojú ara ilé ọmọ obìnrin. Ojú ara ilé ọmọ obìnrin jẹ́ ẹ̀yà arak an tó wà ní ìsàlẹ̀ ilé ọmọ tí máa ń gbèrú nínú aláboyún, tí o so ara inú aláboyún pọ̀ mọ́ abẹ́ tàbí òbò obìnrin tàbí ojú abẹm tọ́.mọ n gbà jáde/wáyé. Ààrùn

jẹjẹrẹ ojú ara obìnrin sábà máa n wáyé/ṣẹlẹ̀ nípa ìtẹramọ́ ààrùn kíkó pẹ̀lú ewu tó ga tí à ń pè ni “Human Papilloma GBirus” OHPGBÒ; Human Papilloma GBiruses ÓHPGBÒ jẹ́ kòkòrò tó kéré tí kò pádé nínú àpò tó ní ìlópò méjì títàn (Double Strande DNA) gẹ́gẹ́ bí ohun èlò tó so mọ́ àtọ̀/ẹ̀yìn inú abẹ́ obìnrin. Wọ́n tó márùn-ún léláàdọ́ta (úúmn) ní títóbi/wọ́n.

HPGB jẹ́ àrùn/kòkòrò tó máa n ràn nípasẹ̀ ìbálòpọ̀ takọtabo. Àwọn nǹkan tó máa n fa ààrùn jẹjẹrẹ ojú abẹ́ ilé ọmọ obìnrin ni tábà mímu, ìjọra/ìṣedéédé tó ga, ìlo òògùn tọ́jọ́ ti lọ lórí wọn/ọlọ́jọ́ pípẹ́ tó ṣe àtọ̀nà “dídàgbà, àti dídàgbà ìbálòpọ̀ akọ àti abo, àpọ̀jù ìbálòpọ̀ láàrin àwọn olùfẹ́ méjì àti tó ní ààrùn ìbálòpọ̀ kò gbóògùn (HIGB).

Ìgbésẹ̀ Kẹrin: Olùwádìí ṣe àlàyé ìtumọ̀ ọgbẹ́ ọkàn/ìbànújẹ́ ọkàn/Àárẹ̀ ọkàn/ìfòró ọkàn/àìbalẹ̀ ọkàn.

Ọgbẹ́ ọkàn/àìbalẹ̀ ọkàn jẹ́ ọ̀rọ̀ tó wópọ̀ tí à ń lò láti ṣe àpèjúwe ipò àìdùnnú ìmí-ẹ̀dùn tí o máa n kóba ìgbésẹ̀ kan ni wíwúlò àti díásí àwọn iṣẹ́ àmúṣe ọjọ́ sí ọjọ́ akọ tàbí abo. Ọgbẹ́ ọkàn/àárẹ̀ ọkàn ni a tún lè kì lóríkì mìíràn tí ó wọ́pọ̀ pé ìrúsókè, ìmí-ẹ̀dùn, ìfòró/ìpayà, ìfale/ìfàgùn, ìpòrurù ọkàn, ìdoríkodò/ìrẹ̀wẹ̀sì, àìbalẹ̀ àyà/hílàhílo, ìyọjúsí nǹkan láìpeni. Bákan náà, a lè ṣe àlàyé pé ọgbẹ́ ọkàn/ìmí-ẹ̀dùn/àárẹ̀ ọkàn gẹ́gẹ́ bí ipò tí ẹ̀dá bá ara rẹ̀ (ìmí ẹ̀dùn), dídámọ̀ àti gbígbọ́ àgbéọ́yè nǹkan, ìhùwàsí ìfèsì àwọn awuyewuye/ìṣẹ̀lẹ̀ tí ó si mú àìbalẹ̀ ọkàn àti àmì àrùn ìrẹ̀wẹ̀sì ọkàn wá. Ó jẹ́ ohun tí a lè ṣe àlàyé jùlọ pé ọgbẹ́ ọkàn ń ràn pẹ̀lú ìṣẹ̀lẹ̀ kan bẹ̀rẹ̀ láti ìfọwọ́bà tó jeṃ gbajúgbajà tí a lè sa lọ́gbẹ́/pa lára, ìbìnújẹ́/ìfajúro, ìbẹ̀rẹ̀ sí àwọn ìṣòro tí o le padà di aláìlágbára, irú bí ìrẹ̀wẹ̀sì /ìdoríkodò, àìbalẹ̀ àyà/hílàhílo/ìpayà, ìdádì láàrin ẹgbẹ́/àdágo ló láàrin ẹgbẹ́ àti ìwà/ìrírí àti ìjà ẹ̀mí. Ìrẹ̀wẹ̀sì àti àìbalẹ̀ àyà la rí gẹ́gẹ́ bí ohun tó ní ìsípayá/ìfihàn kan pàtó, èyí tí a fi orúkọ fún ọgbẹ́ ọkàn/ìpòrurù ọkàn tí ó sì mú ìyàtọ̀ wá ní ìwọ̀n ni ààrin obìnrin tí a ṣe àyẹ̀wò fún jùlọ fún ààrùn jẹjẹrẹ ilé ọmọ obìnrin fún àwọn iddí wọ̀nyí:

gbiii. Ìgbọ̀ntìtì/ìjayà ìròyìn àìròtẹ́lẹ̀.

iṣ. Ìṣòro àìrówóná/àìsówó

ṣ. Ewu tó wà níbi ṣíṣe ìtọ́jú àìsàn náà.

ṣii. Ẹomorbidities (ọkàn lára ìdí tí ààrùn jẹjẹrẹ mú dáni)

ṣiii. Àìsí ìrànlọ́wọ́ẹgbẹ́ àwùjọ.

ṣgbi. Àmì ẹ̀gàn/ìpẹ̀gàn ènìyàn/àìlèébù ara.

Ìgbéléwọ̀n: Àwọn olùkópa ni a bi ní àwọn ìbéèrè wọ̀nyí:

iii. Ṣe àlàyé ààrùn jẹjẹrẹ ilé ọmọ abẹ́ obìnrin

igb. Dárúkọ àwọn àmì tó máa n yọjú fún ẹni tí ó ni ọgbẹ́ ọkàn/ìfòró ọkàn/ààrẹ̀ ọkàn/àìbalẹ̀ ọkàn.

Iṣẹ́ Àyànṣe:

i. Kín ni òṣùwọ̀n tí o lè gbà láti ṣe ìtọ́jú ààrùn ọgbeṃ ọkàn/ìpòrurù ọkàn tí o ní?

Òrọ̀ Ìparí:

- Àwọn akópa ni a gbé òṣùbà káre fún ìfowósowọ́pọ̀ wọn a si gbà wọ́n níyànjú láti ṣiṣẹ́ lórí iṣẹ́ àṣetiléwá wọn.
- Àwọn akópa ni a sọ fún nípa àkókò àti ibùjókòó iṣẹ́ tó n bọ̀.

Ìgbéléwọ̀n: Àwọn akópa ni a bi ni àwọn ìbéèrè wọ̀nyí:

i. Ṣe àlàyé ààrùn jẹjẹrẹ ilé ọmọ obìnrin

ii. Dárúkọ àwọn àmì ọgbẹ́ ọkàn/ìpodrurù ọkàn tàbí àìbalẹ̀ ọkàn.

Iṣẹ́ Àyànṣe:

Dárúkọ àwọn eré inàjú mẹ́wàá tí o ti fòpin sí lẹ́nu àsìkò tí o mọ̀ nípa nǹkan tó mú àìsàn/ààrùn jẹjẹrẹ ilé ọmọ obìnrin wá.

Òrọ̀ Ìparí: Àwọn akópa ni a gbóríyìn fún ìfọwósowọ́pọ̀ wọn, olùwádìí sì gbà wọn níyànjú láti dáwólé tàbí ṣe iṣẹ́ àṣetiléwá wọn.

- Àwọn akópa ni a sọ fún nípa àkókò àti ibùjókòó iṣẹ́, ìjókòó tó n bọ̀.

Iṣẹ́ Ìjókòó kẹta:

Orí ọ̀rọ̀: Ìjókòó yìí ṣe àfihàn ìyàsápákan ìtọ́jú àìsàn náà.

Èròǹgbà: Lẹ́yìn òpin iṣẹ́ ìjókòó náà àwọn akópa yóò le ṣe àlàyé ohiun tí ìyàsápákan ìtọ́jú àìsàn náà tó rọ̀gbàká tàbí mú dání.

Àmúṣe Iṣẹ́:

Ìgbésẹ̀ Kìn-ín-ní: Àwọn akópa ni a fi tayọ̀tayọ̀ kí káàbọ̀ sí iṣẹ́ ìjókòó kẹta àwọn ìwé ètò ohun tí a ó ṣe ní ìpàdé ni pin. Ó sì mọ rírì gbogbo wọn fún fífi àkókò wọn sílẹ̀.

Ìgbésẹ̀ kejì: Olùwádìí ṣe àgbéyẹ̀wò iṣẹ́ àṣetiléwá àwọn akópa. Àwọn akópa ti damrúkọ onírúurú eré tí wọ́n ti fòpin sí ní ṣíṣe lẹ́nu ìgbà tí ìtọ́jú ààrùn jẹjẹrẹ ojú ara ilé ọmọ obìnrin ti bẹ̀rẹ̀. Àwọn orúkọ eré tí a dárúkọ ni a ka kún ṣùgbọ́n kò ni òpin tàbí gbẹ̀déke sí àwọn nǹkan wọ̀nyí: ìtúnraṣe, ṣíṣe eré ayò/lumdò tàbí káàdì títa, nínágà lójú fèrèsé, lílọ wo àwòrán fíìmù/sinimá, lílọ sí òde àríyá, ṣíṣe àbẹ̀wò sí àwọn ọ̀rẹ́ àti ẹbí, eré ìdárayá, yíyan ọ̀rẹ́ titun, fífetísílẹ̀ sí gbígbọ orin, sísọ kókó ọ̀rọ̀, iṣẹ́ ọnà àti ọwọ́ ṣíṣe, ilé kíkùn, wíwá kiri àwọn ọ̀nà tí à n gbọ́ ìròyìn lẹ́gbẹ́lẹ́gbẹ́ àti bẹ́ẹ̀ bẹ́ẹ̀ lọ.

Ìgbésẹ̀ kẹta: Olùwádìí tún ṣe àlàyé ìtumọ̀ ìyàsápákan ìtọ́jú àìsàn.

Ìyàsápákan ìtọ́jú àìsàn (DT), èyí tía mọ̀ sí ìyàsápákan àti eré ìdárayá tó ń ṣe ìtọ́jú àìsàn tàbí eré ìdárayá fún ṣimṣe ìtọ́jú àìsàn. Ó jẹ́ ibùdó ìṣeré abẹ̀wẹ̀ alágbàwí èyí tí ó mú ìyìn, fàájì tàbí bọ́wọ́ bá dilẹ̀ àti dídárayá tó ni ìrírí dání gẹ́gẹ́ bí ẹ̀tọ́ ti oníkálùkù ni. pàtàkì àṣeyọrí tàbí òpin ìsúre ije ìyàsápákan ìtọ́jú aláìsàn (DT) ni láti ṣe ìgbéga ọ̀nà ìrónilágbára tàbí ìfi àṣẹ fún láti rii pé àwọn akópa lè dá yàn àti ṣe ìpinnu tí ó lè ú kí kíkópa wọn pọ̀ sí nínú eré fàájì tàbí tọ́wọ́bá dilẹ̀ èyí tí ó yẹ fún ìlò oníkálukú àti nǹkan tí wọ́n ń fẹ́.

Èyí rí bẹ́ẹ̀ nípasẹ̀ ìmú rọrùn, àmójútó tàbí ìdarí àti ṣíṣètò eré fàájì àti eré ìdárayá èyí tí a gbé kalẹ̀ láti kín lọ́wọ́ tàbí tìí lẹ́yìn, pípè níjà àti ṣíṣe àkópọ̀ tàbí gbígbà mọ́ra.

Bí ọkàn ṣe ń ṣiṣẹ́ nínú ìró inú wa, ìbákẹ́gbẹ́, ìmí ẹ̀dùn, tí ẹ̀mí ọgbọ́n ìrònú láàgbọ́yé àti ìwà lálàáfíà ara àwọn ènìyàn nípasẹ̀ láti ṣe gbígbéga ibu ìyìn fúnra ẹni àti ìmú àǹfààní kí á gbọ́ àgbọ́yé tàbí ní ìmọ̀ nípa ìhùwàsí ẹ̀dá tàbí ènìyàn àti bí ó ti ń ṣiṣẹ́ tàbí bí ó ṣe lágbára, ètò ìyàsápákan nípa ìlò ọgbọ́n mímú ìyípadà bá ṣíṣe nǹkan bí àwọn nnkan bí àwọn nǹkan tí o le gbé ẹgbẹ́ ró, àwọn nǹkan tí a lè fi mú inú ẹni dùn àti ìmú àgọ́ ara yágágá, láti ta ìfẹ́ jí

àti wíwáṣẹ́ fún akópa ẹlẹ́jọ́ tàbí abẹ̀wẹ̀ alágbàwí bẹ́ẹ̀ ni kí á lè borí àwọn ewu tàbí ìjàm̀bá tí eré ìdárayá àti ọpọlọ tàbí ọgbọ́n le fà bá eré ìgbà tọ́wọ̀ bá dilẹ̀ tàbí eré fàájì.

Ìgbésẹ̀ Kẹrin: Olùwádìí jíròrò lórí àǹfààní tí ìyàsápá kan ìtọ́jú aláìsàn (DT) mú dání. Àwọn ìrírí fàájì máa mú kí àjọṣepọ̀ wà láàrin ẹgbẹ́, ìrusókè ọgbọ́n ìrònú tàbí àgbóyé, wíwá àlàáfíà ara láìsí ìmí ẹ̀dùn àti eré ìdárayá. Eré ìdárayá jẹ́ eré tí gbogbo ènìyàn mọ̀ pé o máa ṣe àtúnṣe isan ara, ookun fún egungun, ọ̀nà tí ọ̀pá agbẹ́jẹ́/omi káàkiri inú ọkàn rí gbá ṣíṣẹ́ (Ẹardiogbaṣeular system ìṣiṣẹ́ ọgbọ́n ìrònú àti idwà tàbí inú

Nígbẹ̀yìn àyọrísí rẹ̀ ní o ṣe àmúlò púpọ̀ jùlọ nígbà tí àmúṣe iṣẹ́ bá jẹ́ tẹnitẹni/ohun tí a n wà tàbí darí, èyí ni ìlépa fàájì tàbí ìgbà tọ́wọ̀ bá dilẹ̀. Eré ìdárayá kì í ṣe pé o ṣe ìmú gbòòrò ìpín káàkiri ṣùgbọ́n ó ṣe ìgbéláruge ìsinmi nípa yíyọ̀nda ìfàale/líle tó wà nínú kẹ̀kẹ́ òwú isan ara, fífọ àbájáde agbára rírẹ̀ ihò kòròbojo tó lọ sínú ọpọlọ. èyí le pọ́n tàbí ta ọgbọ́n ìrònúj jí nípa yíyọ̀nda àti ìbá ṣíṣẹ́ẹ̀rọ̀ tó n gbé èrò inú ọpọlọ jáde, hormones àti oògùn synaptiẹ

Eré ìdárayá ṣíṣe pẹ̀lú sùúrù ní àlà agbára àǹfààní tó ni, síbẹ̀ kàn máa wòran àwọn eré ìdárayá amúnisílẹ̀ tàbí kí o máa tẹ́tísílẹ̀ pẹ̀lú ìfarabalẹ̀, ó ti jeṃ rírí ìdí, ṣíṣe àmúlò wíwòye ọgbọ́n ìfọpọlọ ṣe, láti ru sókè àti ṣe àmúgbòòrò agbègbè ọpọlọ tó jí pépé fẹ́rẹ̀ kù díẹ̀ sí ìwọ̀n níbi tí àmúṣe eré yóò ti jẹ́ ṣíṣe lójúkojú tàbí ní gbangba

Àwọn olùwádìí/onímọ̀ ló ti ṣe àkọsílẹ̀ ipò tí ìfarakínra àjọlẹ́gbẹ́, ìfẹ́ ìrusókè, tẹjúmọ́ ìfarabalẹ̀ tàbí ìtẹ́tísílẹ̀, tàbí fífọwọ́bà ìwúlò lórí agbára ìfaradà àti ìmúdára sí àjẹsára tó wà ní àgọ́ ara.

Ìgbéléwọ̀n: Dárúkọ mẹ́ta nínú àǹfààní ìtọ́jú ìyàsápákan aláìsàn.

Iṣẹ́ Àyànṣe: Àwọn akópa ni a fún ni onísùúrù eré ìdárayá láti tọ́ka sí tàbí fa àmì sí oríṣìí eré tí wọ́n máa ń ṣe lásìkò ìnajú tàbí fàájì wọn. Àwọn ìjókòó tó tẹ̀lé eré ìdárayá wà ni ìbámu pẹ̀lú ohun tí àwọn akópa bá kọ sílẹ̀ nínú iṣẹ́ àyànṣe tó kọjá. Àwọn akópa ni a rán létí àkókò àti ibùdó fún iṣẹ́ ìjókòó tó n bọ̀.

Ìjókòó Kẹrin:

Orí ọ̀rọ̀: Mímú sókè lára àwọn ìwà/ìṣe tọ́wọ́ bá dilẹ̀/iṣẹ́ tó wu ni jù/tàbí a fẹ́ràn láti máa ṣe.

Èròngbà: Ní ìparí iṣẹ́ ìjókòó yìí, àwọn akópa yóò le:

i. Mọ ẹ̀tọ́ wọn nípa ìrírí fàájì tàbí ìgbà tọ́wọ́ bá dilẹ̀ àti bí ó ṣe le ṣe àǹfààní fún àlàáfíà àgọ́ ara.

ii. Gbà pé ipò iṣẹṃ àtijọ́ tàbí ìwà àatijọ́ wọn máa n ní ipa mánigbàgbé nínú ìlera wọn.

Àmúṣe iṣẹ́:

Ìgbésẹ̀ Kìn-ín-ní: Àwọn akópa jẹ́ kíkí káàbọ̀ tìdùnnú-tìdùnnú síbi ìjókòó ètò iṣẹ́ kẹrin. Olùwádìí ṣiṣẹ́ pẹ̀lú àkópọ̀ orúkọ àwọn eré ìdárayá tí a lànà/pèsè rẹ̀ sílẹ̀ ni iṣẹ́ ìjókòó kejì bẹ̀rẹ̀ láti iṣeṃ ìjókòó kẹrin pẹ̀lú onírúurú orin. Èyí jeṃ títẹ̀/ṣíṣe fún ìseṃjú mé.wàá títí nǹkan bi ìdá àádọ́rùn-ún àwọn akópa tó ti de ibùdó ìpàdé.

Ìgbésẹ̀ kejì: Olùwádìí mú àwọn ohun èlò jáde tí o mú wá fún àwọn akópa, èyí jẹ mọ́ àwọn eré àtìlẹ̀kun mọ́rí ṣe tàbí eré abẹ́lé, gẹ́gẹ́ bí eré ayò lúdò, káàdì what títa, káàdi eléwé títa, àri ayò díráfítì lójú ọpọ́n àti ọ̀gbẹlẹ̀ olùwádìí fi méjì nínú àwọn eré náà sílẹ̀, kí o sì béèrè ló.wọ́ wọn láti mú ọ̀kan tí wọn bá nim ìfẹ́ nínú rẹ̀. Nítorí náà olùwádìí bẹ̀ wọ́n láti ṣe àmúlò eré wọ̀nyí ní àsìkò fàájì/ìgbà tọ́wọ́ bá dilẹ̀ wọ́n gẹ́gẹ́ bí ìdíje eré wọ̀nyí máa wáyé lọ́sẹ̀ tó ń bọ̀ àti pé ẹ̀bùn yóò wa fún òṣèré tó bá jáwé olúborí tí ó fakọyọ. Gbogbo wọn pátá ni wọ́n n fẹ̀ kí eré náà jẹ́ ṣíṣe lọ́jọ́ náà, èyí ló ṣe okùnfà nǹkan tí a ṣe ní gbogbo àsìkò ìjókòó iṣẹ́ náà. olùwádìí fi àwọn ohun èlò ìsagbeji ara díẹ̀ sílẹ̀ fún àwọn obìnrin tí wọ́n rò pé àwọn kò ti múra dáradára tó lásìkò ìdádìí ohun ti n mú àìsàn/ààrùn jẹjẹrẹ ilé ọmọ abẹ́ obìnrin wá.

Ìgbésẹ̀ kẹta: Olùwádìí gbà wọ́n níyànjú láti ṣe àmúlò àwọn eré náà lásìkò ìgbà tọ́wọ́ wọn bá dilẹ̀ gẹ́gẹ́ bí nǹkan wọ̀nyí yóò ṣe fún wọn ni ìsinmi kúrò nínú iddààmú ọkàn/ìnira/wàhálà tí wọ́n ní.

Ọ̀rọ̀ Ìparí:

i. Olùwádìí káàdí iṣẹ́ ìjókòó yìí nílẹ̀ nípa dídúpẹ́/gbígbé orí yìn fún àwọn akópa bákan náà ni àwọn akópa náà dúpẹ́ lọ́wọ́ olùwádìí fún dídára ẹwà lẹ́sẹ̀kẹ́sẹ̀/ìṣẹ́jú kan àti àwọn ohun èlò tí ó gba fún wọn tún gbàdúrà/wúre fún olùwádìí.

ii. Olùwádìí gbà wọ́n níyànjú láti ṣe àmúlò àwọn ìdárayá náà lásìkò tí ọwọ́ wọn bá dilẹ̀/lásìkò tí wọn kò ṣe nǹkan kan tí wọ́n di olómìnira ara wọn àti kí o rán wọn létí ìdíje tí ó wáyé, ọjọ́, àkókò àti ibùdó iṣẹ́ ìjókòó tó ń bọ̀.

Iṣẹ́ Ìjókòó karùn-ún

Orí ọ̀rọ̀: Àwọn eré abẹ́lé

Èròngbà: Ní ìparí/òpin iṣẹ́ ìjókòó yìí, àwọn akópa yóò le mọ̀ ìdunra ipa ti eré-ìdárayá ní lórí ipò ìlera wọn.

Àmúṣe iṣẹ́:

Ìgbésẹ̀ kìn-ín-ní: Olùwádìí n gbé awo orin síi lásìkò tó n retí àwọn akópa tó kù.

Ìgbésẹ̀ kejì: Olùwádìí mú rọrùn wá fún ìdíje àwọn eré náà pẹ̀lú àwọn olùrànló.wọ́ àti pé ó tún ta ayò/ṣe eré náà pẹ̀lú olúborí ìdíje eré mẹ́rẹ̀ẹ̀rin.

Àwọn mẹ́rin tó jáwé olúborí eré mẹ́rẹ́ẹ̀rin ni olùwádìí fún ní ẹ̀bùn owó ẹ̀ẹ́dẹ̀gbẹ̀ta náírà àti káaddì ìpè ẹnìkọ̀ọ̀kan.

Ìgbésẹ̀ kẹta: Ìṣẹ́ ìjókòó náà parí pẹ̀lú orin àti ijó ní rẹbutu.

Ìgbésẹ̀ kẹrin: Ìdùnnú gba ọkàn àwọn akópa wọ́n sì fẹ̀mí ìmoore hàn sí olùwádìí àti àwọn àsọmagbè tàbí olùrànlọ́wọ́ wọn pẹ̀lú ọ̀rọ̀ inú rere àti àdúrà/ìwúre, wọ́n tún bẹ̀bẹ̀ fún kí ètò àwẹ̀jẹ̀wẹ̀mu wáyé ní ìjókòó tó ń bọ̀.

Ọ̀rọ̀ Ìparí: Olùwádìí gbóríyìn fún àwọn akópa fún ipa takuntakun tí wọ́n kó àti àkókò tí wọ́n fi sílẹ̀, ó sì tún rán wọ́n létí ẹ̀tọ́ tí wọ́n ni sí eré ìdárayá láì fi ti onírúurú ìjà/àìṣedéédéé ṣe.

Ó fi gbohùngbohùn sílẹ̀ fú ilé kí wọ́n le è ba gbádùn ìrírí kan náà pàápàá nígbà tí kò bá sí olùwádìí níbẹ̀.

i. Olùwádìí yóò ṣe àgbéyẹ̀wò iṣẹ́ àyànṣe pẹ̀lú àwọn akópa.

ii. Olùwádìí yóò ṣàlàyé ìtumọ̀ ìyàsápákan ìtójú àìsàn náà.

Iṣẹ́ Ìjókòó Kẹ́fà:

Orí Ọ̀rọ̀: Àsìkò Àríyá

Èròngbà: Ní ìparí iṣẹ́ ìjókòó náà, àwọn akópa yóò le mọ̀ àyọrísí eré ìdárayá lórí ipò ìlera wọn.

Àmúṣe iṣẹ́:

Ìgbésẹ̀ Kìn-ín-ní: Olùwádìí gbé awo orin síi nígbà tí olùwádìí dúró dé àwọn akópa tó kù kí wọ́n wọlé.

Ìgbésẹ̀ kejì: Ètò àríyá náà bẹ̀rẹ̀ gbogbo àwọn akópa wọ́n wọ aṣọ dáradára. Olùwádìí ṣe àwárí ọtí ẹlẹ́rìndòdò tó le tó wọn mu àti oúnjẹ tó le kárí wọn. wọ́n gbéraga lójú ara wọn pé wọn ti kẹ̀rẹ̀ sí ní ya àwòrán (fọ́tò).

Ètò àwẹ̀jẹwẹ̀mú àríyá gbà tó ogójì ìṣẹ́jú, nígbà náà oúnjẹ àti ọtí jẹ́ pínpín.

Ìgbésẹ̀ kẹta: Iṣẹ́ ìjókòó náà wásí ìpari pẹ̀lú orin àti ijó ni rẹbutu.

Ìgbésẹ̀ kẹrin: Àwọn akópa ni inú wọn dùn gan an, tíi wọn sì dúpẹ́ lọ́wọ́ olùwádìí àti àwọn olùrànló.wọ́ rẹ̀ pẹ̀lú ọ̀rọ̀ ìṣeun/ọ̀rọ̀ inú rere àti àdúrà.

Ọ̀rọ̀ Ìparí: Olùwádìí yan àwọn akópa fún ipa tí wọ́n kó àti àkókò tí wọ́n fi sílẹ̀ bẹ́ẹ̀ náà ló tún rán wọn létí àwọn ẹ̀tọ́ wọn sí ètò eré ìdárayá ṣíṣe láì fi I ewu tàbí ìdíwọ́ ṣe.

Iṣé. Àyànṣe: Àwọn akópa ni a sọ fún láti ṣe àlàyé/sọ kínníkínní bí eré ìdárayá ṣe ní ipa lórí ipò ìlera wọn àti ipò ọkàn wọn.

Iṣẹ́ Ìjókòó keje: Ẹ̀rí/Ìjẹ́rìí

Èròngbà: Ní òpin iṣẹ́ ìjókòó náà, àwọn akópa yóò le:

i. Tan ìmọ́lẹ̀ sí ìyọrísí ìyàsápákan ìtójú àìsàn ìgbé ayé àlàáfíà bí ọkàn ṣe ń ṣiṣẹ́
ii. Sọ ìrírí wọn nípa ìmọ̀ àìsàn ààrùn jẹjẹrẹ pẹ̀lú fífi ọpẹ́ fún Ọlọ́run.
iii. Gbà pé ìrírí inú dídùn àlàáfíà ló máa n jẹ bíbẹ̀rẹ̀ ìwòsàn.

Ìgbésẹ̀ kìn-ín-ní: Olùwádìí kí àwọn akópa káàbọ̀ síbi iṣẹ́ ìjókòó yìí.

Ìgbésẹ̀ kejì: Olùwádìí béèrè lọ́wọ́ wọn nípa oríṣìíríṣìí eré ìdárayá tí wọ́n le é fẹ́ fún sáà ìjókòó náà.

Ìgbésẹ̀ kẹta: Olùwádìí fi àwọn akópa sí ìsọ̀wọ́/ìsọ̀rí kọ̀ọ̀kan ní ìbámu pẹ̀lú ìdùnnú/ìfẹ́ ọkàn wọn. nígbà tí àwọn tó pọ̀jù nínú yan wíwo fíìmù/sinimá, àwọn kan yan iṣeṃ kíkum àwòrán àti díẹ̀ lára wọn máa ń fẹ́ wòran àwọn oríṣìí eré ṣíṣe.

Ìgbésẹ̀ kẹrin: Olùwádìí mú iṣẹ́ ìjókòó wá sí ìparí bẹ́ẹ̀ ni ó sì gbé òṣùbà káre fún àwọn akópa lórí ìfẹ́ àtọkàn wá tí wọ́n ní sí eré ìdárayá náà.

Iṣẹ́ Ìjókòó: Ìpín fúnni ìdánwò àṣekẹ́yìn àti ìfòpinsí iṣẹ́ ìjókòó sáà náà/ohun ìpanu.

Èròngbà: Ní òpin iṣẹ́ ìjókòó náà, àwọn akópa yóò le:

i. Pín ìrírí wọn àti ṣe àlàyé àwọn nǹkan tó yípadà tí wọ́n ṣe àkíyèsí tí wọ́n sì jẹ́ ẹlẹ́rìí rẹ̀.
ii. Jíròrò lórí bí wọ́n s lè tẹ̀síwájú nínú eré ṣíṣe àti gbádùn ẹ̀tọ́ wọn sí ìrírí ìgbà tọ́wọ́ bá dilẹ̀, pàápàá lẹ́yìn tí wọ́n bá wà láàyè/bá borí ààrùn jẹjẹrẹ.

Ìgbésẹ̀ Kìn-ín-ní: Olùwádìí kí àwọn akóp káàbọ̀, ó sì tún yẹ̀ wọn sí fún ìfọwọ́sowọ́pọ̀, ìfarabalẹ̀, ìsedéédéé, wíwá àti títètè dé síbi ìjókòó àti àwọn dídásí tó wúlò fún ètò ẹ̀kọ́ iṣẹ́ ìjókòó náà.

Ìgbésẹ̀ kejì: Olùwádìí ṣe agbátẹ̀rù ṣíṣe ìpínfúnni ohun èlò ìwádìí tí a mọ̀ sí Kessler Psyẹhologiẹal Stress Dẹale láti lè ṣe àyẹ̀wò yíyọrísí ìtọ́jú tí wọ́n fún ààrùn ọkàn náà.

Ìgbésẹ̀ Kẹta: Olùwádìí rọ àwọn akópa láti ṣe àmúlò ẹ̀kọ́ titun tí wọ́n gbà, kí wọ́n sì máa ṣe wọn ní ìgbé ayé ojoojúmọ́ wọn.

Ìgbésẹ̀ kẹrin: Olùwádìí mú iṣẹ́ ìjókòó náà wá sí òpin àti pẹ̀lú pé ó dúpẹ́ lọ́wọ́ gbogbo àwọn olùkópa. Ó béèrè fún yíya fọ́tò àjùmọ̀yà lẹ́yìn tí o béèrè fún ìlóhùnsí wọn nípa fọ́tò yíyà náà, àti lẹ́yìn èyí ó tún sọ fún gbogbo àwọn akópa láti jókòó fún ètò àwẹ̀jẹwẹ̀mu/ìpanu.

Àkójọpò/Àwọn Ìsọ̀wọ́ tí a kó Nìjánú/Sàkóso Rẹ̀

Iṣẹ́ Ìjókòó kìn-ín-ní: Ìṣàfihàn gbogbogbòò àti ìpínfúnni, ohun èlò máàkì, ìdánwò àṣesáájú (Pre-test sẹores).

Èròngbà: Ní òpin iṣẹ́ ìjókòó náà, olùwádìí yóò le:

gbii. Mọ ilé ìtọ́jú tó yẹ/lágbára ni ìbáṣepọ̀ pẹ̀lú àwọn akópa

gbiii. Fún àwọn akópa ní ètò ìfinimọlé nípa ọ̀nà àti ìlọsíwájú ọ̀nà ìkẹ́kọ̀ọ́ náà.

iṣ.   Ṣe ìpínfúnni ìwé ìléwọ́ ìbéèrè fún "Kessler Psyẹhologiẹal Distress, Kessler bi ìfòró ọkàn ṣe ń ṣiṣẹ́ àti pẹ̀lú ohun èlò mìíràn tí a mọ̀ sí "Soẹial Support Sẹale" àti "Selfọ́ effiẹiẹaẹy sẹale láti le mọ ìdí pàtàkì tó fi yẹ kí á ní ẹ̀kọ́/ìròyìn tó ní kìmí/tó fẹsẹ̀ rinlẹ̀ dáadáa.

Àmúṣe iṣẹ́:

- Olùwádìí fi tayọ̀tayọ̀ kí àwọn akópa káàbọ̀ sí ètò náà àti fífara ẹni mọ́ ara ẹni àti olùwádìí àti akópa.
- Olùwádìí ṣe ìdásílẹ̀ ìfarakínra láà olùwádìí àti akópa náà nípa pípèsè ibùdó/àyè fún olùwádìí/akópa lásìkò ìfara ẹni hàn. Olùwádìí náà gbọ́dọ̀ rìí pé ẹnìkọ̀ọ̀kan àwọn akópa fọwọ́ sí ìwé fọ́ọ̀mù ìmọ sí/ìlọ́hùsí kí a lè ṣe àkọsílẹ̀ ìlóhùnsí wọn láti kópa nínú ètò ẹ̀kọ́ náà.
- Olùwádìí pèsè àwọn ohun tí ìwé ètò náà dá lé lórí, ó ṣe àlàyé ìdí pàtàkì ètò/iṣẹ́ ìdádìí náà àti àǹfààní tí ó le ara rẹ̀ jáde ní òpin ètò náà. àwọn akópa ni olùwádìí fún ní ìdánilójú ìfọkàn tán láàrin àti ní òpin ètò náà.
- Olùwádìí ṣe àlàyé àwọn òfin tó dé ṣíṣe àwọn ètò prógráàmù náà àti ohun tí olùwádìí ń retí láti ọ̀dọ̀ àwọn akópa ní àgbéyẹ̀wò/jíròrò wáyé lórí rẹ̀ tí ó sì di mímọ̀.
- Olùwádìí ṣe ìpínfúnni ohun èlò ìwádìí fún iṣẹ́ ìwádìí yìí bíi (Kessler psyẹhologiẹal Diress Sẹale, Health Self Effiẹaẹy Sẹale àti Soẹial Support SẹaleÒ sí àwọn akópa náà pẹ̀lú àtìlẹ́yìn tó ga jù láti ọ̀dọ̀ olùwádìí àti àwọn olùrànlọ́wọ́ olùwádìí.

Ọ̀rọ̀ Ìparí/Ìkádìí:

- Àwọn akópa ni a gbóríyìn káre fún nípa ìfowósowọ́pọ̀ àti ìfisílẹ̀ àkókò wọn
- Olùwádìí gbà wọn níyànjú láti pésẹ̀ níbi iṣẹ́ ìjókòó tó ń bọ̀ àti ṣe ìránnilétí ọjọ́, àkókò/àsìkò àti ibùdó ìpàdé tó ń bọ̀.
- **Iṣẹ́ Ìjókòó Kejì:**

Orí Ọ̀rọ̀: Àsìlò oògùn àti kíkúndùn oògùn tó di bárakú.

Èròngbà: Ní ìparí/òpin iṣẹ́ ìjókòó yìí, àwọn akópa yóò le:

i. Ṣe àlàyé àsìkò oògùn àti mímú oògùn oloro.

ii. Dá àwọn àsìlò oògùn tó jẹ gbajúgbajà mọ̀.

iii. Ṣe àlàyé àwọn ewu tó wà nínú lílò oògùn àti oògùn olóró.

Iṣẹ́ Àmúṣe:

- Olùwádìí béèrè ìbéèrè lọ́wọ́ akópa nípa kín ni wọn ń pè ní àsìlò oògùn àti kíkúndùn oògùn tó di bárakú.
- Olùwádìí mọ́ ọn le èsì tí àwọn akópa mú wá, o sì ṣe àlàyé síwájú pé àsìlò oògùn ni lílò àwọn oríṣì kẹ́míkà/oògùn kan láìjẹ́ pé onímọ̀ ìṣègùn kọ ọ tàbí dáa fún aláìsàn láti lò fún ìdí àti mú ìgbádùn tó lágbára wá sínú ọpọlọ. Ènìyàn le jẹ́ ẹni tó kúndùn lílo oògùn/kẹ́míkà yìí nígbà tí kò bá leèkọ̀ láìṣe aláìló wọn kò sí bó ti wù kó oògùn náà ṣe ìpalára tó. Àsìlò oògùn àti kúkúndùn rẹ̀ kì í ṣe pé ó lòdì sí òfin ẹ̀dá ara nìkan bí àpẹẹrẹ kokeénì, tàbí Hẹroinni, ènìyàn le kúndùn lílo oògùn parasitámọ̀ lásán, oògùn oorun, oògùn tó n gbógun tí àìbalẹ̀ àyà/hílàhílo àti àwọn oògùn tó jẹmọ́ ẹ̀dá ara to òfin fọwọ́sí pẹ̀lú. Àkóbá tí àsìlò oògùn àti kíkúndùn rẹ̀ mú dáni bẹ̀rẹ̀ láti ibi èébì/ìgbẹ́ yíyà àti inú rírun jẹ́jẹ́ èyí tí ó lè yọrísí àìlejẹun àti kí ara ènìyàn fúyẹ́ tàbí rù, láti àfikún yíyọ̀ lórí ẹ̀dọ̀ èyí tí ó fi ènìyàn sínú ewu tí ó lài bíba ẹ̀dọ̀ jẹ́. Ewu míìràn tó mú dání fi kún ìfagbára mú, ìfọwọ́pa/irọ lápá àti ẹsẹ̀, ọpọlọ dídàrú/orí dídàrú/àrùn ọpọlọ, ìjàm̀bá ọpọlọ/orí àti àarùn ẹ̀dọ̀ fóró/fùkùfúkù.
- Olùwádìí ṣe àlàyé ọ̀nà méjọ láti borí kíkúndùn àsìlò òògùn. Èyí wà ní ìbámu pẹ̀lú gbígbà pé ìṣòro wà, ríròpin sọ́rùn ènìyàn, eré ṣíṣe, dídá ìwà/ìwọsọ, àwárí iṣẹ́ tó

wúni jù, ìfẹ́ tara-ẹni, àti ṣíṣe àkọsílẹ̀ àwọn ewu tó mú ìpalára dání fún ẹni tó kúndùn àsìlò oògùn.

- Olùwádìí bẹ àwọn akópa láti jìnnà tàbí sá fún àsìlò oògùn àti kíkúndùn lílò rẹ̀ fún ìgbé ayé ìlera tó ní ìtumọ̀.
- Olùwádìí fún àwọn akópa ní àǹfààní láti máa béèrè fún àwọn nǹkan tí kò bá yé ni níbi tí ó bá yẹ.

Ọ̀rọ̀ ìparí

Olùwádìí dúpẹ́ lọ́wọ́ gbogbo àwọn akópa fún ìfọwó.sowọ́pọ̀ wọn àti àkókò tí wọn fi sílẹ̀.

Olùwádìí gbà wọ́n níyànjú láti yọjú sí/pésẹ̀ sí iṣẹ́ ìjókòó.

Iṣẹ́ Ìjókòó kẹta:

Orí Ọ̀rọ̀: Ìkádìí àti Ìpínfúnni Ìdánwò tó kẹ́yìn

Èròngbà: Ní ìparí/òpin iṣẹ́ ìjókòó náà, àwọn akópa yóò le:

i. Sọ kínníkínní àwọn iṣẹ́ àmúṣe/eré ìdárayá tí a ti kọ nínú iṣẹ́ ìjókòó tí a ṣe gbẹ̀yìn.
ii. Parí ohun èlò ìdánwò tó kẹ́yìn.

Iṣẹ́ Àmúṣe:

Ìgbésẹ̀ kìn-ín-ní: Olùwádìí kí gbogbo àwọn akópa káàbọ̀ síbi iṣẹ́ ìjókòó tó gbẹ̀yìn àwọn ètò náà. ó dúpẹ́ lọ́wọ́ wọn fún ìfọwọ́sowọ́pọ̀ wọn àti wíwá déédéé àti ní gbogbo ìgbà.

Ìgbésẹ̀ Kejì: Àwọn akópa náà sọ fún pé kí ìjíròrò àwọn nǹkan tí wọ́n jèrè/rí gbà nínú àwọn iṣẹ́ ìjókòó tí a ti ṣe kẹ́yìn.

Ìgbésẹ̀ Kẹta: Ohun èlò ìdánwò àṣekẹ́yìn/àṣekágbá jẹ́ pínpín káàkiri, wọ́n sì ṣiṣẹ́ lórí rẹ̀ nípa dídáhùn rẹ̀ pẹ̀lú olùwádìí àti olùrànlọ́wọ́ iṣẹ́ ìwádìí.

Ọ̀rọ̀ Ìparí:

i. Olùwádìí mú ètò náà wá sí ìparí/òpin nípa dí dúpẹ́ lọ́wọ́ àwọn olùkópa fún jíjẹ́ alábàápín tó ní ìtumọ̀ nínú ètò iṣé ìwádìí náà. Ó sì gbé òṣùbà káre fún wọn fún àkókò àti ìfarajìn lásìkò iṣẹ́ ìwádìí náà.
ii. Olùwádìí fòpin sí/mu ètò ṣíṣe ìtọ́jú àìsàn náà wá sí ìdádúró.

APPENDIX IV

ETHICAL APPROVAL

INSTITUTE FOR ADVANCED MEDICAL RESEARCH AND TRAINING (IAMRAT)

College of Medicine, University of Ibadan, Ibadan, Nigeria.

Director: **Prof. Catherine O. Falade,** MBBS (Ib), M.Sc., FMCP, FWACP
Tel: 0803 326 4593, 0802 360 9151
e-mail: cfalade@comui.edu.ng lillyfunke@yahoo.com

UI/UCH EC Registration Number: **NHREC/05/01/2008a**

NOTICE OF FULL APPROVAL AFTER FULL COMMITTEE REVIEW

Re: Mindfulness-Based Stress Reduction and Diversional Therapies in the Management of Psychological Distress among Cervical Cancer Patients in Lagos and Ibadan Cancer Centers

UI/UCH Ethics Committee assigned number: UI/EC/21/0113

Name of Principal Investigator: **Afusat A. Azeez**

Address of Principal Investigator: Department of Counselling and Human Development Studies
Faculty of Education
University of Ibadan, Ibadan

Date of receipt of valid application: 30/03/2021

Date of meeting when final determination on ethical approval was made: **N /A**

This is to inform you that the research described in the submitted protocol, the consent forms, and other participant information materials have been reviewed and *given full approval by the UI/UCH Ethics Committee.*

This approval dates from **08/06/2021 to 07/06/2022.** If there is delay in starting the research, please inform the UI/UCH Ethics Committee so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. *All informed consent forms used in this study must carry the* UI/UCH EC *assigned number and duration of* UI/UCH EC *approval of the study.* It is expected that you submit your annual report as well as an annual request for the project renewal to the UI/UCH EC at least four weeks before the expiration of this approval in order to avoid disruption of your research.

The National Code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the Code including ensuring that all adverse events are reported promptly to the UI/UCH EC. *No changes are permitted in the research without prior approval by the* UI/UCH EC *except in circumstances outlined in the Code. The* UI/UCH EC *reserves the right to conduct compliance visit to your research site without previous notification.*

UI/UCH EC
APPROVED
COLLEGE OF MEDICINE, U.I.

Professor Catherine O. Falade
Director, IAMRAT
Chairperson, UI/UCH Research Ethics Committee
E-mail: uiuchec@gmail.com

LAGOS UNIVERSITY TEACHING HOSPITAL

HEALTH RESEARCH ETHICS COMMITTEE

PRIVATE MAIL BAG 12003, LAGOS, NIGERIA
e-mail address: luthethics@yahoo.com

Chairman
PROF. N. U. OKUBADEJO
MB. ChB, FMCP

Secretary
E. U. LAWRENCE
Diploma (Computer Science)

Chief Medical Director:
PROF. CHRIS BODE
FMCS (NIG) FWACS

Chairman, Medical Advisory Committee
PROF. W. L. ADEYEMO
FWACS, FMCDS (Nig.), PHD (Cologric), MPA (Lagos)

LUTH HREC REGISTRATION NUMBER: NHREC: 19/12/2008a
Office Address: Room 107, 1st Floor, LUTH Administrative Block
Telephone: 234-1-5850737, 5852187, 5852209, 5852158, 5852111

1st September, 2021

NOTICE OF EXPEDITED REVIEW AND APPROVAL

PROJECT TITLE: "MINDFULNESS-BASED STRESS REDUCTION AND DIVERSIONAL THERAPY IN THE MANAGEMENT OF PSYCHOLOGICAL DISTRESS AMONG CERVICAL CANCER PATIENTS IN LAGOS AND IBADAN, NIGERIA".
HEALTH RESEARCH COMMITTEE ASSIGNED NO.: ADM/DCST/HREC/APP/4454
NAME OF PRINCIPAL INVESTIGATOR: AZEEZ AFUSAT ADEBISI
ADDRESS OF PRINCIPAL INVESTIGATOR: DEPT. OF COUNSELING AND HUMAN DEVELOPMENT STUDIES, UNIVERSITY OF IBADAN, IBADAN, NIGERIA.
NAME OF INSTITUTIONAL SUPERVISOR: DR. M. Y. M. HABEEBU
ADDRESS OF INSTITUTIONAL SUPERVISOR: DEPT. OF RADIOTHERAPY, LUTH.
DATE OF RECEIPT OF VALID APPLICATON: 18-06-2021

This is to inform you that the research described in the submitted protocol, the consent forms, and all other related materials where relevant have been reviewed and given full approval by the Lagos University Teaching Hospital Health Research Ethics Committee (LUTHHREC).

This approval dates from 01-09-2021 to 01-09-2022. If there is delay in starting the research, please inform the HREC so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of this dates. All informed consent forms used in this study must carry the HREC assigned number and duration of HREC approval of the study. In multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

The National code for Health Research Ethics requires you to comply with all institutional guidelines, rules and regulations and with the tenets of the code including ensuring that all adverse events are reported promptly to the HREC. No changes are permitted in the research without prior approval by the HREC except in circumstances outlined in the code. The HREC reserves the right to conduct compliance visits to your research site without previous notification.

CHAIRMAN
HEALTH RESEARCH & ETHICS COMMITTEE

PROF. N. U. OKUBADEJO
CHAIRMAN, LUTH HEALTH RESEARCH ETHICS COMMITTEE

LAGOS STATE GOVERNMENT

LAGOS STATE
UNIVERSITY TEACHING HOSPITAL,
IKEJA

HEALTH RESEARCH AND ETHICS COMMITTEE
REG.NO. NHREC04/04/2008
(www.nhrec.net)

PROJECT TITLE: MINDFULNESS-BASED STRESS REDUCTION AND DIVERSIONAL THERAPY IN THE MANAGEMENT OF PSYCHOLOGICAL DISTRESS AMONG CERVICAL CANCER PATIENTS IN LAGOS AND IBADAN NIGERIA.
REF. NO.: LREC/ 06/10/1673
PRINCIPAL INVESTIGATOR: AZEEZ AFUSAT ADEBISI
ADDRESS: DEPT. OF COUNSELLING & HUMAN DEVELOPMENT STUDIES, UNIVERSITY OF IBADAN.
DATE OF RECIEPT OF VALID APPLICATION: 14/09/2021
DATE OF APPROVAL: 07/10/2021

PROF. A. O. FABAMWO
Chief Medical Director

DR. ADEBOWALE O. ADEKOYA
CMAC / Director Of Clinical Services and Training

DR. Y.A. KUYINU
Ass. Prof. Public Health & Community Medicine
Chairman, LASUTH HREC

NOTICE OF APPROVAL

This is to inform you that the research described here in the submitted protocol, the consent forms, advertisements and other participant information materials have been reviewed and given full approval by the Health Research and Ethics Committee of LASUTH (LREC)

This approval dates from 07/10/2021 to 06/01/2022. If there is any delay in starting the Research, Please inform the HREC LASUTH so that the dates of approval can be adjusted accordingly. Note that no participant accrual or activity related to this research may be conducted outside of these dates. All informed consent forms used in this study must carry the HREC LASUTH assigned number and duration of HREC approval. In a multiyear research, endeavor to submit your annual report to the HREC early in order to obtain renewal of your approval and avoid disruption of your research.

THE NATIONAL CODE FOR HEALTH RESEARCH AND ETHICS(www.nhrec.net) REQUIRES YOU TO COMPLY WITH ALL INSTITUTIONAL GUIDELINES, RULES AND REGULATIONS AND WITH THE TENETS OF THE CODE INCLUDING ENSURING THAT ALL ADVERSE EVENTS ARE REPORTED PROMPTLY TO THE HREC. NO CHANGES ARE PERMITTED IN THE RESEARCH WITHOUT PRIOR APPROVAL BY HREC LASUTH EXCEPT IN CIRCUMSTANCES OUTLINED IN THE CODE.THE LREC RESERVES THE RIGHT TO CONDUCT COMPLIANCE VISIT TO YOUR RESEARCH SITE WITHOUT PREVIOUS NOTIFICATION.

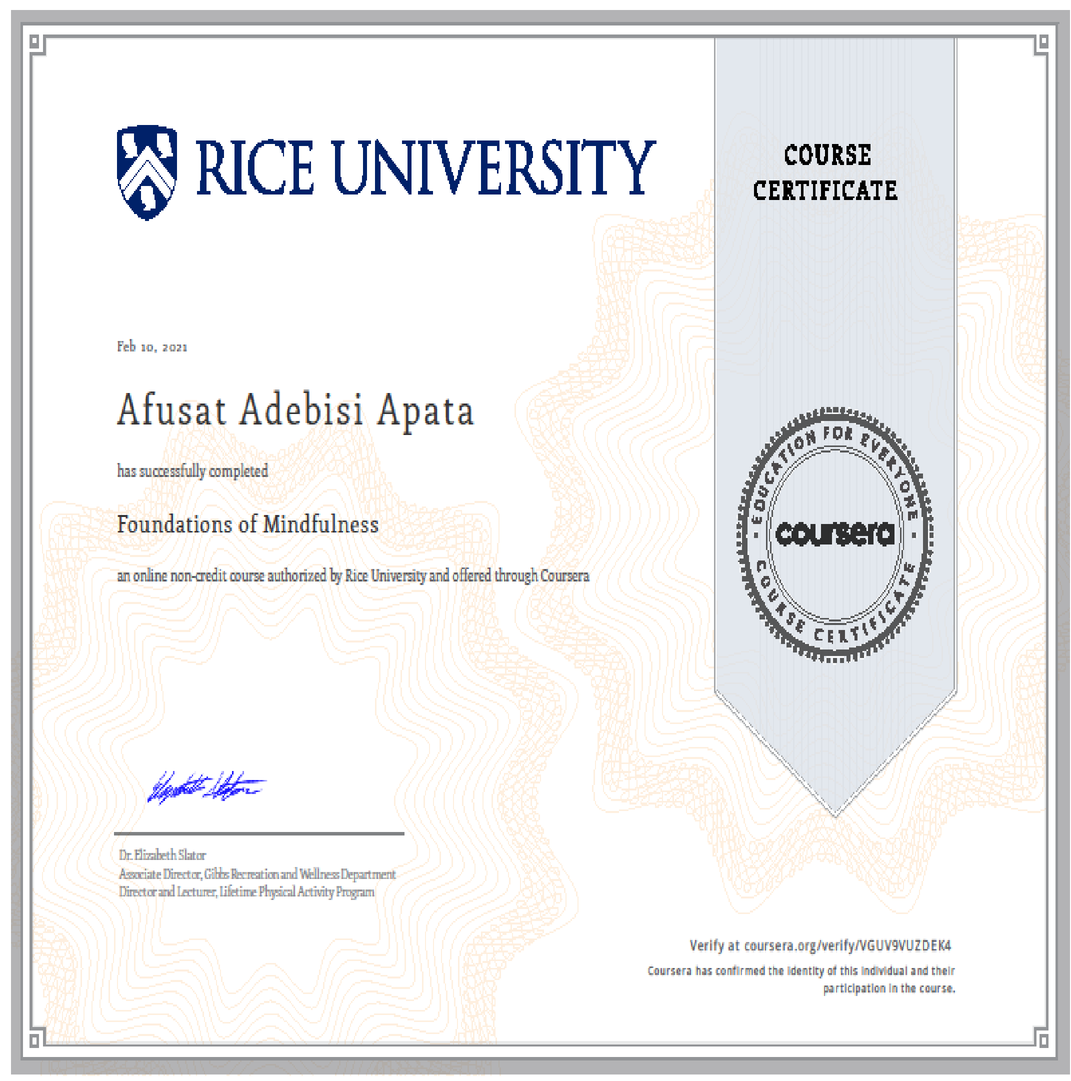
DR. Y.A. KUYINU

LASUTH HEALTH RESEARCH ETHICS COMMITTEE
1-5, OBA AKINJOBI ROAD, IKEJA, LAGOS. P.M.B. 21005, TEL:01-4710670
www.lasuth.org E-mail:dcst@lasuth.org

APPENDIX V
RESEARCH FIELD IMAGES

APPENDIX VI

CERTIFICATION IN MINDFULNESS TRAINING



Certificate of Completion
This is to certify that Afusat Apata successfully completed 1 total hour of Mindfulness for Children Diploma - Focus & Freedom for Kids! online course on March 5, 2021
Dr Karen E Wells
Dr Karen E Wells, Instructor
&
Udemy
Certificate no: UC-6e8addc7-02f4-4a6e-87d9-bd17085cbdd5
Certificate url: ude.my/UC-6e8addc7-02f4-4a6e-87d9-bd17085cbdd5
Version 3
#BeAble