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A Qualitative Analysis of Counsellors' Experiences Working with Individuals Diagnosed with FASD

by

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I would like to dedicate this work to all the people who have supported me as I worked towards my goals. Without your support I would never have made it this far. I would also like to dedicate this work to my sisters. I hope that any research I undertake will help to create a more positive future for you.

Abstract

This study used phenomenological methodology in effort explicit the experiences of three registered psychologists and one registered clinical social worker, who counsel individuals with FASDs. An interview was conducted with each participant and then each interview was analyzed for themes and subthemes. The analysis resulted in three primary themes: Thinking Outside the Box, Finding a Foothold and Finding the Fit Between Tools and The Client. The results of this study indicate that counselling an individual with an FASD is challenging and requires flexibility on the part of the therapist. Finally, the results of this present study will be situated within the literature discussing other non-counselling methods used in working with individuals with an FASD and the literature pertaining to counselling individuals with other disabilities.

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Chapter 1: Introduction

Fetal Alcohol Spectrum Disorder (FASD) is an umbrella term used to describe the variable range of defects caused by prenatal alcohol exposure. When a mother consumes alcohol while pregnant, the ethanol crosses the blood brain barrier of the neonate and causes various malformations in the fetal brain (Pollard, 2007). Depending upon the brain areas affected and the severity of the effect, children with an FASD suffer from cognitive and behavioral deficits which lead to poor life outcomes (Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004; Fast & Conry, 2009). Individuals with an FASD need high levels of support to lead as full a life as possible and to overcome their deficits. Thanh and Jonsson (2009) estimated that the treatment, support, and management of FASDs in the province of Alberta costs approximately 130 to 400 million dollars per year.

Although individuals with an FASD require high levels of support, due to the variability of the brain damage they may have suffered, they may score within the average or below average range on standardized intelligence quotient (IQ) tests (Campbell, Li, Conry, Conry & Loock, 2000). IQ scores, however, are not indicative of the number and level of cognitive deficits an individual with an FASD may experience (Connor, Sampson, Bookstein, & Streissguth, 2000). Unfortunately, IQ scores on standardized testing are the primary method by which the Government of Alberta vets candidates for disability support programs (Government of Alberta, 2012), thereby excluding many individuals with an FASD from funding and specialized supports. Streissguth et al. (2004) found that only 13% of their 415 participants qualified for specialized supports based on IQ.

Since they do not qualify for traditional disability supports, individuals with an FASD use mainstream sources, such as counselling, to manage their cognitive challenges and behaviours (see Jirikowic, Kartin, & Carmichael Olson, 2008 for review). An estimated 64.3% of children with an FASD will access the services of a mental health professional, with 35.7% visiting a psychologist, 50% visiting a mental health or behaviour therapist, and 57.1% visiting a psychiatrist (Mills, McLennan, & Caza, 2006). Taking into account the amount of money spent on supporting individuals with an FASD each year, and the number seeking mental health support, it is necessary for psychotherapeutic researchers to examine the practices in use to determine which methods may work most effectively. It is the purpose of this paper to make explicit the experience of providing psychotherapy to those with an FASD with the hopes that the information may be used as a springboard for future much needed research.

Research Interest

Over the past 14 years, I have watched and helped guide the development of two girls with an FASD who came into my family's care when they were three months old. I have experienced the challenges faced by those caring for individuals with an FASD and observed the challenges the children have faced as they have grown. As they grow older, I am concerned about the lack of supports that they can access. I have also observed unhealthy interactions with their birth parents; however, efforts to attain counselling for the girls have not been fruitful since few counsellors have had experience dealing with individuals with an FASD. From these concerns, I developed this research project to make explicit the experiences of counsellors who have a background in working with individuals with an FASD. Perhaps this project will help the development of recommendations for counsellors working with individuals with an FASD.

Though I am a student in Counselling Psychology at the University of Alberta and have had some practical experience, I have not had the opportunity to counsel someone with an FASD. I do, however have knowledge of the impacts of FASD which may be reflected in my interpretation of the results. I hope my background will make it possible for me to develop an accurate picture of the experiences of counselling someone with an FASD as described by the four individuals who participated in this study.

Chapter 2: Literature Review

This review will provide an overview of the literature regarding FASD, beginning with an introduction to the diagnosis of FASD, followed by a focus on behavioural and cognitive deficits which are most likely to be encountered by those providing counselling. Then, evidence-based interventions and supports will be briefly presented. Given the absence of information regarding counselling for individuals with an FASD, the review will extend to literature pertaining to counselling those with other intellectual disabilities.

FASD as a Category

The term FASD has not always been used to describe the deficits associated with maternal prenatal drinking. Counsellors may encounter different terms for individuals suffering these deficits, depending upon where and when a diagnosis was made.

Initially, the terms Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) were used to describe the extent of the terratogenic effects of alcohol (Chudley et al., 2005). The term FAS referred to individuals with a specific pattern of facial feature abnormality, central nervous system damage, and slowed growth rate both in *utero* and after birth, while FAE referred to those who were affected by in *utero* exposure but did not fit within the FAS diagnosis (Chudley et al., 2005). Eventually these terms were recognized to be too general and were replaced with partial FAS, FAS with and without a confirmed history of alcohol exposure, alcohol-related neurodevelopmental disorder (ARND), and alcohol-related birth defects (ARBD) (Stratton, Howe, & Battaglia, 1996). In

2000, Astley and Clarren introduced a four-digit diagnostic code, which became the primary method of diagnosis throughout the United States. Chudley et al. (2005) established the current standard of diagnosing individuals with an FASD throughout Canada, recommending the diagnoses of FAS, Partial FAS, and ARND. Throughout this paper no distinction is made between the diagnoses under the umbrella of FASD.

Deficits Common to FASDs

Individuals with an FASD may have a variety of neurocognitive deficits attributed to the teratogenic effects of prenatal alcohol exposure. Deficits in executive function (EF), intellectual ability, attention, memory and learning, language, sensory integration, and social skills (Kodituwakku, 2009) likely affect all aspects of the lives of those with an FASD, including their participation in counselling (Hurley, Tomasulo, & Pfadt,1998). Literature suggests the importance of taking deficits into account when adapting counselling strategies to people with disabilities and keeping their disabilities in mind during counselling so that success can be achieved (Hemadez-Halton, Hodges, Miller, & Simpson, 2001).

Executive function. Executive function (EF) refers to the cognitive processes required for an individual to act in goal-orientated, adaptive, and efficient ways, including the ability to think flexibly, suppress impulse, think ahead, retain information, and sustain attention (Huizinga & Smidts, 2010). EF deficits are typical of individuals with an FASD (Rasmussen, 2005). Mattson et al. (1999) found that children with an FASD performed more poorly on tests used to measure EF than the control group, particularly for response inhibition and planning. Green et al. (2009) confirmed the response inhibition and planning deficits and also identified spatial working memory deficits. Other common indicators of EF dysfunction found to be present in individuals with an FASD are problem solving, spatial concept formation, flexibility of thinking, verbal fluency, working memory, self regulation, manipulation, and goal management (Rasmussen & Bisanz, 2009; Kodituwakku, Handmaker, Cutler, Weathersby, & Handmaker, 1995). These impairments lead to a variety of difficulties in day to day functioning and can be linked to many of the cognitive impairments discussed throughout the rest of this literature review.

Intellectual ability. Prenatal alcohol exposure typically leads to Intelligence Quotient (IQ) deficits (Kodituwakku, 2009) with the typical IQ score falling within the low average range (Kodituwakku, 2009; Streissguth, Barr, & Sampson, 1990; Mattson et al., 1997). The IQ of those diagnosed with an FASD, however, does not fall within a specific range, nor do functioning deficits always coincide with IQ scores (Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004; Kerns, Mateer, & Streissguth, 1997).

IQ can be divided into verbal IQ which is the ability to reason and problem solve verbally and performance IQ which refers to the ability to reason and problem solve nonverbally. Research has produced conflicting results as to whether performance or verbal IQ is most affected by prenatal exposure or if the effects are global in nature (Mattson & Riley, 1998). Rasmussen, Horne, and Witol (2006) found that children with FASD scored lower on verbal IQ measures than performance IQ measures; however Aragon et al. (2008) found no significant difference between verbal and performance IQ scores. These results suggest that no specific IQ deficit pattern is typical of an individual with FASD, and therefore we cannot use it to define the disorder or establish expectations for expected functioning.

Learning and memory. Learning and memory deficits are frequently identified in individuals with an FASD, independently of IQ scores (Vaurio, Riley, & Matson, 2011). Apparent memory deficits may be related to poor encoding, or learning, of the information, rather than with the retention, or remembering, of that information (Willford, Richardson, Leech, & Day, 2004; Mattson & Roebuck, 2002). Congruent with this idea, Pei, Job, Kully-Martins, and Rasmussen (2011) indicated that learning and memory deficits are not due to inability to receive information but to poor integration of the information, indicative of EF deficits. The results of this poor integration are manifest through learning and memory deficits in several distinct areas, including verbal learning and spatial recall (Willoughby, Sheard, Nash, & Novet, 2008) as well as both verbal and nonverbal memory (Coles, Lynch, Kable, Johnson, & Goldstein, 2010).

Taking into account the role of poor encoding in the memory deficits typical of individuals with an FASD, Coles, Lynch, Kable, Johnson, and Goldstein (2010) examined whether the modality of information presentation affected an individual's ability to encode information. Their results indicated that individuals with an FASD struggle to encode information regardless of what method was used to present the information. Introducing strategies to help people with an FASD encode information more efficiently, however, may increase their ability to retain information (Roebuck-Spencer & Mattson, 2004).

Attention. Parent and teacher ratings of children with FASDs indicate attention difficulties (Rasmussen, Horne, & Whitol, 2007; Lee, Mattson, & Riley, 2003), and standard measures of attention support these reports (Lee, Mattson, & Riley, 2003). Researchers have further examined the correlation between FASDs and specific types of attention deficits, attempting to develop a profile of deficits unique to FASDs. Mattson, Calarco, and Lang (2006) suggest that children with an FASD struggle with both visual and auditory focus but not with disengaging and re-engaging auditory or visual attention. Their study also indicated that those with FASDs struggled more with auditory attention during long periods, while visual attention deficits occurred more globally. An earlier study by Coles, Platzman, Lynch, and Freides. (2002) also found deficits in visual attention, whereas auditory attention deficits were less pronounced. Therefore individuals with an FASD may struggle to pay attention to visual stimuli but attend to auditory stimuli more adeptly. In contrast, some studies have found that individuals with an FASD struggle more with auditory attention, yet visual attention ability remains intact (Connor et al. 1999). This suggests that individuals with an FASD may show some attention difficulties, but the specific areas of difficulty are variable.

Language deficits. Expressive and receptive language deficits are common in individuals with an FASD (Church, Eldis, Blakley, & Bawle, 1997;

Carney & Chermak, 1991) along with verbal and nonverbal fluency deficits (Schonfeld, Mattson, Lang, Delis, & Riley, 2001). Expressive language refers to the ability of individuals to verbally make themselves understood. Those with an FASD may struggle to express themselves without ambiguity and to elaborate on topics they are explaining (Thorne & Coggins, 2007). The ability to verbally express ideas clearly is further compounded by the tendency of individuals with an FASD to fail to take into account the perspectives of others during communication (Timler, Olswang and Coggins, 2005). Often individuals with an FASD will produce a great number of words, which at times makes them look very intelligent, but the words will have little meaning content (Malbin, 2004).

Receptive language, which can be defined as the ability to understand the communications of others, is another area in which those with an FASD can experience a deficit. A study by Kodituwakku et al. (2006) found that poor language comprehension was one of the characteristics which differentiated the participants in their FASD group from the participants in their control group. Often individuals with an FASD are able to repeat something verbatim, however their actions indicate that they did not comprehend what was said (Malbin, 2009) suggesting that they actually may not have understood what was said. Difficulties with expressive and receptive language do not follow a specific pattern in individuals with an FASD (Coggins, Olswang, Carmichael Olson, & Timler, 2003), however language deficit on some level is typical of FASD diagnoses**.**

Social skills deficits. Individuals with an FASD have been noted to have social skill deficits that occur due to developmental factors (Kodituwakku, 2009), and animal research into the effects of alcohol on subsequent development suggests that alcohol exposure effects social skill development even when environmental factors are controlled for (Kelly, Day, & Streissguth, 2000). Researchers have also indicated that these social skill deficits do not seem to be explained by intellectual deficit (Mattson & Riley, 2000; Thomas, Kelly, Mattson, & Riley, 1998) or any of the co-occurring diagnoses common to FASDs (Rasmussen, Becker, McLennan, Urichuck, & Andrew, 2010).

Efforts are being made to establish the specific deficits that lead to poor social skills in individuals with an FASD. McGee, Fryer, Bjorkquist, Mattson, and Riley (2008) found impairments in social problem solving, as well as low frustration and tolerance levels which are necessary to adeptly navigate social situations. Children with an FASD also may not be able to differentiate familiar people from those who are unfamiliar (Streissguth & Giunta, 1988), making social connection difficult. Furthermore, social skill deficits in individuals with an FASD may be related to low social cognition and specifically the ability to understand the intricacies of social communication (Saltzman-Benaiah & Lalonde, 2007) and facial expression reading abilities (Greenbaum, Stevens, Nash, Koren & Rovet, 2009). Consequently, the ability of individuals with an FASD to function within and sustain social relationships can be severely impaired.

Sensory processing deficits. Sensory processing is "the way in which the [central nervous system] and the peripheral nervous system manage incoming sensory information from the seven peripheral sensory systems" (Miller & Lane, 2000, p. 2). Individuals with an FASD have significantly more sensory processing issues when compared to control groups (Wengel, Hanlon-Dearman, & Fjeldsted, 2011). Individuals with FASD tend to manifest their sensory deficits by being primarily sensation seeking—that is, they seek out stimuli from their environment to satisfy their neurological needs (Wengel, Hanlon-Dearman, & Fjeldsted, 2011). These deficits have been linked to poor social skills (Baker et al., 2008) and problem behaviour (Franklin, Deitz, Jirikowski, & Astley, 2008).

Environmental Conditions

Along with the challenges experienced by individuals with an FASD due to their cognitive deficits, it is common for individuals with an FASD to encounter negative environmental conditions at some point in their lives. Many individuals with an FASD suffer from abuse and/or neglect at some point during their childhood (Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004) and are removed from the care of their biological parent/s (Victor, Wozinak and Chang, 2008). Individuals removed from the care of biological parents often enter foster care. About 70% of children with an FASD receive foster care at some point in their lives (Burd, Cohen, Shah, Norris, 2011) and 57% live in more than one foster home (Victor, Wozinak, & Chang, 2008). Adults with FASDs also face adverse environmental experiences. Adults with an FASD have been found to be very vulnerable to manipulation (Fast & Conry, 2009) and are often victims of verbal, sexual, and physical violence. In one study, 100% of the female participants had been victimized by some form of abuse at some point in their lives (Astley, Bailey, Talbot, & Clarren, 2000). Since abuse is often perpetrated by trusted individuals, and those with an FASD are susceptible to manipulation, the victims may not be aware of abuse or may be convinced by perpetrators that abuse is not occurring (Fraser, 2008).

Presenting Concerns

Although we understand there are significant underlying deficits in the FASD brain, these are not observable. Instead, individuals may present with behavioral concerns (Nash et al., 2006) and co-occurring diagnoses (Steinhaussen, 1996) that can be further complicated by environmental factors (Streissguth, Bookstein, Barr, Sampson, & Young, 200). Therefore an individual with an FASD may have behavioural, environmental and co-occurring diagnosis issues.

Behavioural concerns ascribed to FASD. Behaviour concerns are common to individuals with an FASD. In a study done by Nash, Rovet, Greenbaum, Fantus, Nulman, and Koren (2006), responders rated children with an FASD more likely to steal, lie, disobey, argue, act young for their age, be unable to pay attention, be hyperactive, be cruel, act on impulse, clown around, and not show guilt for disobeying. Streissguth, Bookstein, Barr, Press, and Sampson (1998) found that over 75% of caregivers indicated that the children in their care could be classed as impulsive, stubborn, being unaware of consequence, and demonstrating poor attention. Over 60% of the children were found to be unable to take a hint, to have tantrums, to be easily led, to be sensitive, to over react, to have mood swings, to interrupt, and to show poor judgment. Children with an FASD have also been found to be more hurtful to themselves and to others, destructive to property, and disruptive with tendencies to harm others

(Jirikowic, Kartin, & Carmichael Olson, 2008). They also have unusual habits and socially offensive behaviours (Jirikowic, Kartin, & Carmichael Olson, 2008) and tell lies (Rasmussen, Talwar, Loomes, & Andrew, 2008). It is also likely that children with FASD will be incarcerated at some point during their journey to adulthood (Fast & Conry, 2009).

Behavioural concerns are less well documented in adults with FASDs. The evidence of maladaptive behaviours in adults can be seen most clearly in their life outcomes. In a study by Stressguth et al. (2004), 60% of adults with FASD had trouble with the law of which 50% were confined, and 49% had repeated inappropriate sexual behaviours. Women were more likely to have unplanned planned pregnancies and less likely to use protection during sexual activity possibly because of the impulsivity common in FASD individuals. Adults with FASD are also at heightened risk for drug and alcohol problems (Famy, Stressguth, & Unis, 1998; Stressguth et al., 2004).

Behavioural concerns due to environmental events. An individual's mental health is often adversely affected by traumatic events, such as placement in foster care or abuse (Trickett, Negriff, Ji & Peckins, 2011). Though not all children who have been maltreated develop challenging behaviours, the presence of a developmental disability, a category in which FASDs can be included, increases the likelihood that externalizing behaviours will result (Tabone et al., 2011). For example, children and adolescents who are maltreated are more likely to exhibit risky sexual behaviour (Oshri, Tubman, & Burnette, 2012), struggle with socialization (Becker-Weidman, 2009), exhibit delinquent behaviours, and abuse substances (Trickett, Negriff, Ji & Peckins, 2011).

Children and youth in foster care have higher levels of risky behaviours, such as early and frequent sexual activity, smoking, and consuming alcohol (Gramkowski, Kools, Paul, Boyer, Monasterio, & Robbins, 2009). When foster care terminates at age 18, many individuals report homelessness, unemployment, and high levels of physical and psychological illnesses (Zlotnick, Tam, & Soman, 2012). For individuals with an FASD, growing up in foster care may exacerbate behaviours resulting from cognitive deficits and may even cause externalizing behaviours.

Co-occurring disorders. Co-occurring disorders found in children with FASD include eating disorders, sleep disorders, enuresis, encopresis, speech delay, hyperkinetic disorders, conduct disorders, anxiety disorders, and affective disorders (Steinhaussen, 1996). Burd, Klug, Martsolf, and Kerbeshian (2003) found a significant comorbidity between FAS and ADHD, learning disabilities, developmental disorders, anger problems, and social skill deficits. They concluded that, "FAS appears to be an important marker for an increased risk of multiple neuropsychiatric comorbidities" (p. 702). One clinical study found that up to 87% of the children in their sample population met the criteria for at least one psychiatric disorder (O'Connor, Shah, Whaley, Cronin, Gunderson, & Graham, 2002). Adults with FASD struggle primarily with depression, substance abuse, and psychotic disorders (Famy, Streissguth, & Unis, 1998). There are also high levels of co-occurring mental illness in adults with FASD (Famy, Streissguth, & Unis, 1998). Any of these co-occurring diagnoses could bring an individual with an FASD into contact with a mental health practitioner.

Counselling and Intellectual Disability

Little research exists on counselling individuals with FASD, but a small body of research examines the use of counselling and psychotherapy with individuals with developmental disabilities. As most scholars agree that FASD is a form of disability that persists through an individual's lifetime, disability literature as a whole provides a place to start when considering psychotherapy with FASD individuals.

Efficacy in counselling individuals with intellectual disabilities. Only recently has the efficacy of psychotherapy for individuals with developmental disabilities been examined. Bender (1993) blamed this historic lack of research on the assumption that people with disabilities are unsuitable candidates for psychotherapy, an assumption challenged in recently emerging research. Meta-analyses even on the small amount of research conducted suggest that psychotherapy is effective with individuals with intellectual disabilities (Bhaumik, Gangadharan, Hiremath, & Russel, 2011; Prout & Nowak-Drabik, 2003; Willner, 2005). Hurley and others (as cited in Whitehouse, Tudway, Look, & Kroese, 2005) stressed that, with flexibility and adaptation, people with intellectual disabilities and psychotherapists can create a positive working alliance that effectively makes changes in the client's life.

Adapting counselling for those with intellectual disabilities. Hurley, Tomasulo, and Pfadt (1998) identified several adaptations therapists of all types successfully use with those with intellectual disabilities. Common modifications are as follows: simplify techniques into smaller chunks, use shorter sessions, use lower-level vocabulary with simple sentences, words, and phrases, use activities to augment traditional techniques, adjust methods to the appropriate developmental level, use more direct therapy, uses visual aids, involve caregivers and support staff in the therapeutic process, keep stronger therapeutic boundaries, and address issue of disabilities within treatment (Hurley, Tomasulo, & Pfadt 1998). Whatever technique the therapist prefers, the literature suggests that to be effective, therapy must be refined and adjusted to the individual needs of those with intellectual disabilities (see Lynch, 2004 for review). This paper reviews psychodynamic psychotherapy and cognitive behavioural therapy, the counselling methods most often researched with people with intellectual disabilities (Brown, Duff, Karatizas, & Horsburgh, 2011).

Psychodynamic psychotherapy. Psychodynamic psychotherapy has its origins in the work of Freud and Jung and centres on the principles of instinctual drive and sexual energies (Mitchell & Black, 1995). Its variations unite around the theme that the more honest we are with ourselves, the more likely we are to live a happy, satisfying, and useful life (McWilliams, & Weinberger, 2003). Some mental health professionals use psychodynamic psychotherapy to bring change to individuals with intellectual disabilities. Gaedt (2008) offered the following psychodynamic conceptualization of difficulties faced by individuals with intellectual disabilities: if problem behaviours are an expression of a pathological form of identity, then attempting to eliminate them as is common among behavioural interventions, will be disastrous. Instead therapists should work to replace the problem behaviours so that the client's energies can be released in a safer and more acceptable way.

Psychodynamic psychotherapists working with individuals with intellectual disabilities propose certain modifications. Parks (2007) suggested that traditional psychodynamic techniques—verbalization of insight, classification and interpretation, resolution of conflict, making the unconscious conscious, and analysis of transference and defence mechanisms—become less important. Instead the focus should be on therapeutic play if appropriate, working with transference and counter transference, nonverbal communication, rational reworking, and integration of self and dissociative states. He encouraged therapists to work in the present instead of relying heavily on interpretation and to recognize that some deficits are biological in nature, so empowering the ego of the individual must occur and exist along with the disability. As long as therapists realize the limitations of their clients and of themselves, psychic development can occur (Hemadez-Halton, Hodges, Miller, & Simpson, 2001).

Some empirical evidence shows that psychodynamic psychotherapy is effective with individuals with intellectual disabilities. In 1996, Beail and Warden conducted a practiced-based study with 10 participants. They provided each participant with an average of 18 psychodynamic psychotherapy sessions and found a level of positive effect on their participants. This type of therapy also helps to end recidivism among individuals with intellectual disabilities (Beail, 2001). A naturalistic study of the effectiveness of psychodynamic psychotherapy concluded that psychodynamic psychotherapy effectively increased the self esteem and interpersonal skills and decreased the psychological distress of those with intellectual disabilities (Beail, Warden, Morsely, and Newman, 2004).

Cognitive Behavioural Therapy. Cognitive Behavioral Therapy (CBT) emerges from the works of Elis and Beck, based on the theory that a person beliefs influence actions and feelings (Hollon & DiGiuseppe, 2011). The present situation of the individual becomes the focus, as the past cannot be changed (Somers, 2007). CBT assists psychotherapy clients change their negative beliefs into positive ones (Somers, 2007) and is commonly used to treat depression, bipolar disorder, substance use disorders, generalized anxiety disorder, panic disorder, obsessive compulsive disorder, specific phobias, schizophrenia and psychosis, and eating disorders (Somers, 2007).

Researchers suggest that CBT is a potentially useful method of therapy for individuals with intellectual disabilities; however, the degree of effectiveness is closely related to the IQ level of the individual. Willner (2009) indentified a specific ability needed to undertake CBT: *psychological-mindedness*, the ability to consider one's own thoughts and feelings and to reflect upon their meaning. Individuals with intellectual disabilities must be able to draw connections between thoughts and feelings for CBT to work, although studies have shown that those with intellectual disabilities struggle in this area (Dagnan & Chadwick, 1997). The most commonly used CBT-based interventions for with people with intellectual disabilities are self-management techniques such as self monitoring and self instructional methods (Taylor, Lindsay, & Willner, 2008).

Most therapists approach CBT with individuals with intellectual disabilities in one of two ways (Dagnan & Jahoda, 2005). The first approach believes the cause of emotional and behavioural problems are an individual's cognitive skill and process deficits. This model focuses on the deficits of the individual and would likely lead to the behaviourally focused work criticized by Gaedt (2008). The second approach assumes that both clients with and without intellectual disabilities experience behavioural and emotional problems related to *cognitive distortions,* or problematic beliefs and ideas that lead to behavioural and emotional issues (Dagnan & Jahodam, 2005).

Starvrakaki and Klien (1986) suggested the following modifications for CBT with individuals with intellectual disabilities. First, the client's receptive and expressive language should be assessed to guide the therapist's use of verbal and nonverbal techniques. According to Kroese, 1997, this assessment should include the individual's comprehension level, ability to express him- or herself, ability to self regulate, and ability to self report. Second, therapists should use directive rather than nondirective techniques. Therapist should also keep session length flexible, recognizing when their clients become fatigued, and keep goals simple. Finally, as in other therapies, caregivers must be involved to reinforce gains made within the therapeutic process (Starvrakaki & Klien, 1986).

Willner offered additional advice for CBT with individuals with intellectual abilities. Therapists must explain the connection between behaviour and consequence, increase clients' motivation to change themselves, and ensure that clients feel they are making progress at an early stage of the treatment (2006).

Willner suggested two changes to the CBT to make it more effective for people with intellectual disabilities (2006). First, change the context of the therapy. As Parks (2007) noted, a client will only listen to a therapist if that therapist matters to the client; therefore, the fit between the client and the therapist is important. Therapist must also offer educational workshops for caregivers and involve caregivers in the counselling process (Willner, 2006). Second, Willner suggested changing the therapy to suit the individual with the intellectual disability by using supporting homework, psychoeducational information to change distorted beliefs, and narrative therapy to restructure unhealthy cognitions.

Most research on CBT therapy with individuals with intellectual disabilities has been presented with many components, not all of which are CBT (Bhaumic, Gangadharan, Hiremath, & Russel, 2011), making it difficult to determine what findings are related to the CBT and what findings related to other components. In spite of this, Taylor, Novaco, Gillmer, and Thorne (2002) found that CBT can be effectively used to lower anger levels in individuals with intellectual disabilities who live in institutions. Rose (2010) also examined the effect of CBT on anger management on 37 participants with intellectual disabilities, split into six groups. At the end of the allotted sessions, the carers of the participants found a significant decrease in the participants' ability to be provoked to anger. Given CBT's success with anger and aggressiveness, scholars suggest that CBT may also help individuals with intellectual disabilities who struggle with anxiety and depression (Dagnan & Jahoda, 2005; Jahoda, Dagnan, Jarvie, & Kerr, 2006). In addition, CBT may affect those who have sexually abusive behaviours (Murphy, Powell, Guzman, & Hays, 2007).

Summary

FASDs are lifelong disorders that result from prenatal exposure to alcohol. Due to the brain abnormalities found in individuals with FASD, those with this diagnosis struggle with cognitive (Kodituwakku, 2009) and behavioural (Nash Tomasulo, & Pfadt, 2006) challenges, trauma (Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004), and co-occurring diagnoses (Famy, Streissguth, & Unis, 1998). These deficits cause a myriad of poor life outcomes for those with FASD and lead to a high cost to society and the individual (Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004). Because those with FASD often have average to low average IQs (Kodituwakku, 2009; Streissguth, Barr, & Sampson, 1990; Mattson et al., 1997), they often do not qualify for supports offered to those with intellectual disabilities, leaving them to seek more traditional methods of support. One of these methods is counselling (Mills, McLennan, & Caza, 2006).

Given the lack of research on psychotherapy for individuals with an FASD, since FASD can be considered a form of intellectual disability, research into psychotherapy for those with intellectual disabilities may shed light on conducting psychotherapy with FASD individuals. This research suggests that therapy for those with intellectual disabilities is effective, though modification is necessary (Hurley et al., 1998). Psychoanalytic psychotherapy has effectively increased social skills and self concept (Beail, Warden, Morsely, & Newman, 2004), while CBT, most commonly used in groups, affects anger, aggression, sexual offending, and possibly depression and anxiety (Dagnan & Jahoda, 2005; Jahoda, Dagnan, Jarvie, & Kerr, 2006)—all challenges that occur within the FASD population (Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004).

Due to lack of research into the use of psychotherapy with individuals with an FASD, the purpose of this study is to make explicit the phenomenon of conducting psychotherapy with individuals with FASD by speaking to psychologists to practice in this area. The research questions asked by this study are as follows:

1. Are there any commonalities among the experiences of therapists counselling individuals with FASDs?
2. Will those shared experiences could provide insight into tools or methods which may be effective while working with individuals with an FASD?
3. In the experience of therapists providing counselling, is it effective to counsel someone with an FASD?
4. Are there similarities between the experience of counselling someone with disabilities and the experience of counselling someone with an FASD?

When therapists share their experiences in counselling someone with FASD, their comments may identify areas for further research.

Chapter 3: Methodology

This section explains the research methodology employed during this study: outlining an overview of the chosen qualitative research paradigm; discussing the data collection methods, sample size and composition, and method of data analysis; and discussing the methods used to assure trustworthiness of the data.

Research Paradigm

The research methodology chosen for this study was phenomenology. According to Collingridge and Gantt (2008) phenomenology is "particularly suited for identifying the foundational aspects of what is taking place in a health care setting from the perspective of those who provide ... care" (p.393). Because counselling can be considered a branch of health care, phenomenology is suited to understand what it is like for those providing counselling to individuals with FASD. Learning about therapists' experiences may lead to new insights into methods of practice and challenges of working with this population. In turn, these challenges and methods may act as a launching point for further research.

The purpose of phenomenology is to explore the depths of the human experience of a phenomenon with an understanding that knowledge comes from the experience itself and not from the outside interpretation of that experience (Dukes, 1984). Van Manen (1984) explains that phenomenology is the study of the essence of a lived experience, an examination of what it means to be human, and the application of thoughtfulness. The belief in which phenomenology is founded is that "the truth of the event, as an abstract entity, is subjective and knowable only through embodied perception"(Starks & Trinidad, 2007).

Phenomenology finds its origin in the works of Husserl, who began to reintroduce the subjective back into scientific inquiry (Schacht, 1972). Husserl embraced the Platonic idea that an ideal world exists independently from subjective experience, and he proposed that our only access to these ideals is through an individual's experience of them (Kockelmans, 1994). Therefore that Husserl believed in two realities, the reality of the physical world and the reality of the experience of the physical world (Grbich, 2007). Phenomenology is the methodology through which Husserl proposed to study his realities. Today "the major outcome sought in phenomenology is the description of the structures of consciousness of every day experiences as experienced firsthand" (Grbich, 2007, p. 86).

Within phenomenology, the interview is the means through which participants describe and elaborate on their experience of the phenomenon being investigated (Kvale, 1996). The basic belief that underlies the interview is that people have stories that are of worth and that we can learn information of worth from those stories (Seidman, 2006). In keeping with this belief, this study contends that information of worth can be learned from those practicing psychotherapy with FASD clients.

Data Collection

After ethical approval was gained from the Research Ethics Board (1) at the University of Alberta, a convenience sample of 4 counselling professionals was chosen for this study that number falls within the range of 3 to 10 recommended by Dukes, 1984. At the beginning of the study, an attempt was made to find counselling professionals by searching the Psychologists' Association of Alberta website which lists Alberta psychologists with their area of focus. Eight of the 14 psychologists listed as providing services to individuals with FASDs were contacted; however, few met the criteria for inclusion, and those that met the criteria declined to participate. A search of professionals listed on the FASD Support and Resources in Alberta website proved more fruitful, gaining the participation of two registered psychologists. The names of the other two participants were provided through networking with professors at the University of Alberta.

Participants were contacted by email and phone to determine their interest in the study and whether they met the criteria for the study. To qualify, participants needed to be registered in Alberta as a psychologist or clinical social worker and have intentionally provided psychotherapy to individuals with FASD for over six months. Clinical social workers were included in the potential research population as, within Alberta, registered clinical social workers may provide counselling to individuals and must meet educational and practicum requirements similar to those of a registered psychologist. When participants indicated that they met the criteria and that they were interested in participating, they were sent an email containing a full explanation of the study and a consent form. A date and time for the interview was also set.

The sample consisted of three female psychologists and one female clinical social worker, all of whom indicated they intentionally worked with individuals who have or were suspected of having an FASD diagnosis. To ensure confidentiality, each participant was assigned a pseudonym that will be used to identify them throughout this paper. Deana has been working as a registered psychologist since 1994. Her practice consists primarily of adults and adolescents. Though she does not specialize in working with individuals with FASDs, she does encounter them on a regular basis within her practice. Jane is a registered counselling psychologist who has been working with individuals with FASDs periodically throughout her 17 years of practice. She is also the adoptive mother of an individual with an FASD. Kim is a registered psychologist who works primarily with children, many of which have FASDs, using non-traditional therapies. Finally, Marion is a registered clinical social worker who has been working with children with FASDs periodically throughout her 30 years of practice using play and art therapy. Each of these individuals participated in a 30 to 45 minute interview conducted at their office. The researcher transcribed each interview verbatim and also kept descriptive and reflective field notes. Participants received a summary of their individual interview and given the opportunity to correct any of the information it contained.

Interviews

At the beginning of each interview the researcher reviewed the consent forms and gave participants the opportunity to ask questions about the study. The researcher explained that the interview would be recorded and transcribed and reminded participants that they could withdraw from the study at any time without providing a reason. After participants had given verbal indication that they understood the consent form and had signed it, the interview began. First, participants were asked what it is like for them to counsel people with an FASD. The intent of this question was to give participants the opportunity to express their experience in their own words with minimal prompting by the interviewer. After they described their experience, participants were asked to compare their experience counselling people with FASDs with their experience counselling people with other disabilities. The aim of this question was to discover if, within the participants' experience, there are enough similarities to suggest literature from the broader disability counselling field may be useful to those counselling individuals with FASDs. Next, participants were asked how they as therapists determined if counselling an individual with an FASD is working. This question was followed up with prompts encouraging participants to describe successful and unsuccessful counselling experiences with individuals with FASDs. It was hoped that this question would lead to information about how useful therapists feel counselling is with individuals with FASDs and what techniques they have found to be effective. Participants were then asked to reflect upon their experiences with different counselling methods and tools in effort to determine which techniques therapists felt worked best with individuals with FASDs and which techniques are not as effective. With the aim of to gleaning demographic information, participants were asked to describe their preferred therapeutic techniques. As the interviews drew to a close, participants were asked to state the one thing they would want others to know about counselling people with FASDs. This question was followed by participants being asked to speculate what they would do if they had unlimited resources and client compliance in their work with individuals with FASDs. It was hoped that this question would encourage participants to hypothesize and broaden their answers.

Data Analysis

Data was analyzed using the Stevick-Colaizzi-Keen method recommended and modified by Creswell (2007). First the interviewer outlined her own experiences with the phenomenon to bracket out any personal bias although no interviewer can entirely remove her or himself from the data. Memos kept throughout the process allowed continued reflection of the researcher's own thoughts and feelings. Next, a search of the transcripts identified significant statements. The researcher made notes attempting to capture the meaning of each individual statement and sorted the statements according to topic. In each statement group, the researcher chose the statements that seemed to most clearly represent the main idea the participant was conveying. All other statements in the group were considered repetitious and removed. Once repetitious statements were removed, all participant statements were placed together and the reviewer grouped remaining statements according to themes. A summary of the experience described during the interviews was then written. Finally, the researcher developed a description of the phenomenon of counselling individuals with FASD. The summary of the significant statements and a summary of the resulting themes were sent to participants for their review in order to give participants the opportunity to compare the themes to their lived experience and provide any adjustment needed to improve the authenticity of the themes.

Trustworthiness and Qualitative Research

There are several distinct views on the methods to be used to establish the credibility of qualitative research (Hammersley, 1992). Although some believe qualitative research should be judged on the same criteria as quantitative research (Cavanagh, 1997), this perspective presents a challenge. The theoretical basis for quantitative research is the positivistic and empirical traditions, with universal laws and objectivity (Cutcliffe &McKenna, 1999), where as qualitative research recognizes the subjectivity of human experience (Schacht, 1972). An alternate view claims that qualitative research should be judged upon specific criteria developed with an understanding of its unique paradigm (Burnard, 1991). To ensure accuracy of the data interpretation, this paper relies on the alternative criteria outlined by Lincoln and Guba (1985), who replaced the quantitative terminology of internal and external validity, reliability, and objectivity with the qualitative-based terms of credibility, transferability, dependability, and conformability (Lincoln and Guba, 1985).

Credibility. Similar to the concept of internal validity used in quantitative research, credibility is what "measures how vivid and faithful the description of the phenomenon is" (Beck, 1993, p. 264). Credible research presents the data accurately and clearly, so that others who share the same experience may identify with what is written (Thomas & Magilvy, 2011). Highly credible qualitative research contains such clear and detailed descriptions that readers feel their experiences are being described along with the experiences of those who participated in the study.

One method used in this study to achieve credibility is *thick description,* as suggested by Lincoln and Guba (1985). A thick description is detailed and includes small nuances of information important to allow other individuals to identify with the research data presented (Creswell, 2007).

Another method used in this study to ensure credibility is *member checking,* or the involvement of members during the analysis of the data by sending them transcripts and encouraging their feedback on findings (Creswell, 2007). The researcher provided each participant with summaries of their respective interviews, as well as the list of themes assembled from the research. Participants were given the opportunity to change or omit any information from their interviews, and to indicate which themes were not representative of their experiences. Not all participants responded with comments; however any comments received were noted and included in the data analysis.

Finally, this study included frequent meetings with researcher's supervisor that led to adjustments to the project. As Shenton (2004) noted, frequent debriefing sessions with a supervisor ensure credibility because they identify the study's flaws and the researcher's own bias.

Transferability. Recognizing that the information gathered during the qualitative research process is often situational and participant dependant, Lincoln and Guba (1985) replaced the quantitative term *external validity* with the qualitative term *transferability*. A qualitative study does not apply to any situation at any given time but allows others who experience the same phenomenon to identify with the experiences described within the research. One recommended method of assuring transferability is to describe the population participating in the research in detail (Thomas & Magilvy, 2011). Considering the small and specialized field of this study's participants, a detailed description of each participant's practice would breach confidentiality. Instead, the study provides a detailed description of the methods used to recruit participants, along with a brief description of the professionals who participated. With these descriptions, readers can to identify with the qualifications and locate themselves within the study.

Dependability. *Dependability* refers to the extent to which a researcher presents the data collection process so that the methods are repeatable (Morrow, 2005). For example, to enhance the findings, the researcher can develop a decision trail that other researchers can follow and evaluate (Thomas & Magilvy, 2011). As a qualitative study relies on the views and opinions of the participants involved as well as the views and opinions of the researcher, however, study results cannot be duplicated exactly. Changing either the participants or the researcher could affect the findings. For this study, the researcher kept descriptive field notes for each interview and recorded decisions made in the coding process.

Confirmability. Confirmability refers to the extent to which the results of the study reflect the actual phenomenon, not the biases of the researcher. Cutcliffe (2003) suggests that researchers using memoing to examine their thoughts and feelings throughout the research process and allow introspection. Such introspection should allow the researcher to recognize and remove bias from the results of the project. This researcher kept memos throughout the research process and informed readers of information that may affect her interpretation of the data.

Chapter 4: Results

Analyzing the interview transcripts three themes were identified — Thinking Outside the Box, Finding a Foothold, and Finding a Fit Between Tools and Clients. Each of these themes and their subthemes are outlined below and supported with participant quotes taken directly from interview transcripts.

Thinking outside the box

Thinking outside the box describes the participant's experiences forming working alliances with individuals with an FASD. In particular participants reported that what you see is not always what you get, and often the frustration experienced while attempting to think outside the box can be managed in a number of ways.

What you see is not always what you get. Participants expressed significant challenges setting expectations and goals with clients with an FASD. Specifically, they noted that there is tremendous variability between and within clients requiring high levels of flexibility. As Deana stated "that's another thing with FASD, you've got one person who can do it and another person who can't. It's the range of ability and disability is so broad cause it's a spectrum right" and "I never know what's going to click and so the more of the person I can engage in the intervention the better." Participants reported that one client will be very different from the next, and a given client could be very different from day to day. For instance, Deana shared that one of the biggest differences between counselling someone with an FASD and counselling someone with another type of disability is that "when you get a brain injury that is acquired over time or your born with, it there is a progression that's knowable. Someone who has Downs Syndrome, what they know today, they will know tomorrow and you can do some incremental building, you can have some reliability. With FAS folk often what they know today they might know tomorrow, they might not know the next day. There is a whole lot of randomness."

What you see is also not what you get in the case of verbal ability. Participants reported that although most individuals with an FASD produce a large amount of verbal communication, their communication was at times disorganized and difficult to follow, while at other times clear but incongruent with their ability to act. As Jane shared

> "they will often be extremely verbal and they will appear very intelligent. They'll tell you grand stories and they'll follow a kind of cognitive logic that makes perfect sense, but if you match that up with their behaviours you find even though they speak in that way, their behaviour does not seem to match that kind of knowledge in the way we'd expect it. So teaching them more about how to be doesn't make any sense because they can speak very clearly about how to be. They can lecture you about how to be."

Participants also suggested that the progress and understanding they saw within a session did not indicate that their clients would act differently. According Jane, if she were working with an individual to help her change her living arrangement, "I can get agreement [to make change] but it's very hard to get follow through with that agreement." They attributed some of this uncertainty to the impulsivity that is common to individuals with an FASD. As Marion stated, "Frontal lobe damage is frontal lobe damage. So we can do all the breathing in the world and sometimes they are able to not impulsively leap into things, but sooner or later they are going to do it. I think it's inevitable." Even an apparent mastery of a therapeutic technique does not guarantee that the technique will be put to use.

Managing Frustration. Participants stated that the degree of variation within the FASD population required high levels of flexibility on their part, and at times resulted in frustration and uncertainty as they questioned their own approaches, conclusions and goals for a client. For instance, Kim described experiencing frustration because, "you think they have a concept, or they have grasped something, or gained some insight, and then you are reviewing it two weeks later." When discussing how she manages her frustration Deana stated that she reminds herself, "it's about me having more patience and having more of an open mind and being more creative". In other words she must be more flexible in her conclusions and approaches. Marion echoed this opinion by stating "I don't care what techniques I steal from what theory. I just don't care. Whatever works."

There are four subthemes that emerged within the theme of *Managing Frustration.* Each subtheme refers to a specific way that participants reported managing the frustration they experience during the process of counselling someone with an FASD. Firstly, participants reported expecting to encounter uncertainty in therapy. Next, they reframed their expectations of success, adjusting their expectations based on the capability of the client. They also kept an understanding of FASD diagnoses in the front of their mind while counselling, so that they were able to account for and anticipate difficulty. Finally, they adjusted their beliefs about their own roles as therapists to fit the demands of counselling someone with an FASD.

Expecting uncertainty in therapy. Attempting to define a universal mold for therapy with individuals with an FASD is not possible due to the variability of the disorder. Often participants felt they started therapy without knowing which direction it would go. They also noted how difficult it was to draw generalizations from their experience due to the wide spectrum of functioning within the umbrella of FASD, both within and between individuals. When asked what it is like to counsel someone with an FASD, Kim responded " That's not an easy question to answer, cause as you know it's a spectrum disorder so the variety of cognitive deficits is so extreme". Deana reported solving some of this uncertainty by performing assessments of executive function with their clients with an FASD in order to determine the strengths and weaknesses that the client was bringing to therapy. Even these assessments, however, did not provide a clear indication of how the therapy process would unfold. Participants also used therapy techniques involving a variety of senses to engage as much of the person as possible until they discovered what worked best.

Reframing expectations of success. Participants acknowledged that achieving the same levels of therapeutic success as they might with individuals without an FASD is unlikely. When faced with the challenge of achieving successful counselling experiences with clients with an FASD participants stated that they adjust their expectations of therapy. For instance, Jane reported keeping herself orientated to efficacy by attending only to her successes and quickly moving on from failures, barely noticing them. Similarly, Deana explained that she keeps focused on small successes by reminding herself that she needs to keep her expectations realistic. She stated, "I don't see the client necessarily doing brilliant things. They do better, then they do worse, then they do better. See if you get focused on them being happy ever after that's not their life. They have brains that don't click." In order to ensure the experience of success participants adjust their therapeutic goals.

Understanding FASD. A strategy used by most participants to attend to their successes is to be aware of when difficulties during therapy are due to FASD related brain injury. In unsuccessful sessions, Kim often assumes she is missing or misinterpreting the client's cues, which, in her opinion, the diagnosis of FASD can cause to vary greatly from cues she expects to see. Jane was very careful to emphasize that people with FASDs "have emotional barriers, they have cognitive barriers and they have behavioural barriers that interact in a very complex way and so in counselling someone with FASD it's important for me to take all three of those things into account." Other aspects of FASD which participants attributed therapeutic challenges to are poor planning abilities, impulsivity, the inability to learn from mistakes, and the lack of third party support. Participants indicated that third party support is necessary for therapeutic success and that failure is often the result of poor follow through by others providing support for their client. Kim explained, "We can only do so much here. That's why we talk to the foster parents and the biological parents and the group homes, because the expectation is that they're going to continue the work there. When they don't, that's when the therapy a lot of times falls apart." This was echoed by Jane who stated "I get the third person involved in carrying out the strategies. If we send homework home in writing or pictures I get the third person to be involved in carrying out that homework and in praising that person for things," because often "it's been fine for the first interview, but left to their own devices they [clients with FASDs] don't always re-engage."

Expectations of therapists' roles. Participants also reframed their expectations of their roles as therapists. Often participants have found themselves not doing the type of therapy that is typical of therapists, but functioning as team coordinators and educators. Deana suggested, "…part of the problem of getting services for folks is there aren't that many people who are comfortable working in a case coordination kind of framework." Often participants, especially those working with adults, find themselves advocating for their clients and attending case conferences with other professionals. Participants also often find themselves providing education. They may teach foster parents what to expect of the child and how best to parent or educate other professionals such as child service workers and those mandating individuals into therapy what therapy can accomplish. Marion described her approach as follows: "I don't assume the foster parents know how to parent FASD kids. I know that there are trainings around but sometimes they don't get the training or they've forgotten the training."

Summary. Therapy with individuals with an FASD requires participants to adjust their traditional ideas and expectations and to think outside the box.

Participants indicated that what they observe in therapy may not always be congruent with what they expect to see in the clients ability and/or behaviour, which requires adjustment to their expectations. Working with individuals with an FASD requires participants to be prepared to encounter unpredictability and uncertainty and to be open minded and flexible about their expectations and celebrate the small successes.

Finding a Foothold

Interviews revealed that although therapy with individuals with an FASD is very individualized, the process itself is not totally foreign to the participants. Often participants encountered situations with a familiar component or situations which allow them some measure of assurance in the therapeutic process. This theme contains the subthemes of recognizable core issues, safety in the process, and the need for strong theoretical foundation.

Recognizable core issues. All participants stated that their clients with an FASD brought issues to therapy that they had encountered before and they felt they could work with. For example, clients with an FASD often have suffered a great deal of trauma as children and adults, and the participants felt they could address this trauma in therapy. Participants also noted that individuals with an FASD often experience attachment difficulty. Attachment issues varied from children with an FASD attaching to everyone very quickly to children struggling to attach to anyone. Participants felt that both these attachment issues were common to individuals who have suffered abuse. Marion stated, "FASD kids are just like other kids with issues around attachment. For the most part FASD kids seem to want to attach to everyone very quickly, but then children who have been in long foster care have often developed strategies of connecting quickly." Kim, however, has noticed the opposite to be true. She states, " For a lot of clients I've worked with connecting with another human appears to be difficult. Now whether that's the FASD or the trauma that they've gone through I'm not exactly sure." Participants also mentioned that people with an FASD often struggle with depression based in their histories of failure and subsequently do not have a positive outlook for their future. Jane stated, "often [people with FASD] have quite serious depression when they come for counselling. They have quite a depressed mood and a negative outlook so from a psychological counselling perspective we need to find ways to work with that depression." Though working with an individual with an FASD can be challenging and uncertain, participants seemed to find balance in the familiarity their knowledge of the core issues they are working with.

Client direction. Although the participants often felt uncertain, they all indicated that their clients with an FASD would make steps towards success during a session even if the clients reached that success by following a very nonlinear path. Each participant stressed the need to follow the client's lead, even if unclear. As Kim stated, "sometimes they ramble on and you think, 'what are we doing here today?' All of a sudden they are getting where they need to be." Clients seem to take their own unpredictable path towards recovery, so therapy can stall if they are rushed or overly directed. Sometimes the client's pace is set by their readiness to confront certain issues. Deana stressed the need to go at a client's pace, "because if you're trying to go at a normal pace, it doesn't work". Though the individual with an FASD presented challenges to the participants’ ability to conceptualize where a session is headed, they can find some surety in knowing that the client does not always need them to lead.

Foundational security. The responses of the participants indicate that they are vigilant in their reflection of practice decisions to justify/support approaches used. This vigilance is due to encountering so much variation on a day-to-day basis and wanting to ensure the use of efficacious approaches. Factors such as hit-and-miss therapeutic techniques, undiagnosed clients, and an inability to predict the deficits present in an individual with an FASD make therapy challenging and requiring of constant modification. To counter the uncertainty of this therapy, the participants strongly embraced their theoretical bases. Each felt secure in the psychological theory she works from, although each participant subscribed to a slightly different theoretical basis. As Kim stated, "Even in (alternative therapies) you don't neglect your theories." Though the tools may change or be altered, the reason behind using specific tools is grounded in theory.

Safety in the process. A necessary component of successful therapy is safety for the client and seems to centred around building report with the client. Participants stated that, as with other clients, individuals with an FASD need to feel safe and connected to their therapist. According to Jane, "people who have FASD need to feel safe if you're going to communicate with them." Participants indicated that clients with an FASD seemed to seek out safe places, so if therapy is considered a safe place, then clients will continue to attend. As Deana shared, "it's working when they show up again and again and again. They might not be able to tell you why they're here but they found a safe place, they found a comfortable place. I worked with one woman for over three years and then she stopped coming and then she [had some trouble] and she came back. Right, so that tells me whatever was happening, she felt safe here and it was helpful." In successful therapy, the client feels that the therapist looks out for the client's interest, is someone who can help, and understands the client's needs. These factors are especially critical for adult clients who have more of a choice about attending sessions.

Summary. Participants indicated that the process of working with someone with an FASD is a complicated one, however they were able to find footholds in their past therapeutic experiences with core problems such as depression, the need for safety and report with their clients, and their therapeutic basis. Though participants encounter a great deal of challenge, they have foundational knowledge and beliefs that they believe make working with individuals with FASDs effective.

Finding the Fit Between Tools and Clients

Participants described high level of intentionality as they select tools for use with clients, and consequently were able to identify both effective and ineffective therapy techniques. Most effective techniques have a visual or experiential component that focus on creating change, and many incorporate activities. Ineffective techniques focused on abstract concepts. Participants stressed that just as with any other person in therapy, not every technique will work with every person and not every technique will fail with every person. According to Marion " all techniques fail with some of the children some of the time, so you're always trying to figure out what works best with some children." These techniques can provide a starting place when working with someone with an FASD, however they cannot be considered a comprehensive list of effective and ineffective techniques. The techniques are presented in Table 1 and Table 2.

Table 1

Techniques that Therapist have Found Effective when Working with Clients with an FASD

Technique	Examples	Purpose
Calming Techniques	Breathing exercises with visual stimuli	To allow clients to experience being calm
	Computer Programs	To provide a visual aid while the client is learning deep breathing To work on attention management
	Relaxation techniques	To create emotional connection
	Arousal Management Techniques	To teach clients to remain calm
Creative Therapies	Sand play therapy Play therapy Art therapy	Methods of working that bypasses the verbal challenges of FASD
	Creating projects to take home - Writing - Drawing	Gives clients a visual reminder of therapy concepts
Activities to encourage conversation	Holding EMDR buzzers while speaking	Kinaesthetic stimulation can help keep people focused
	Therapist being present during play	Children talk as they play
	Using many senses in therapy	Engaging many senses increases the probability success
	Walking with the client	Conducting an activity while talking keeps people focused

Participants indicated that calming techniques such as breathing exercises with visual stimuli, relaxation techniques, and arousal management techniques are invaluable. For instance, Deana describes using a computer program to guide her clients through breathing exercises as follows, "instead of saying now what I want you to try and do is breath and this is how you breath, it's like pay attention to the tree. When the tree is getting big, breath in, when the tree is getting small, breath out, and just breath in time with the tree. So they can watch the tree, the tree makes movement and they match the movement." While the aim of most relaxation techniques, including breathing exercises, is typically to calm an individual down, Kim states that she uses them to create emotional connection. "Relaxation techniques are one of the biggest things that I use, and again it's because so many individuals that I work with aren't connected to their emotions. So that's one of the ways that I help connect them."

Participants also reported using creative techniques during therapy, specifically ones that produce works that can be taken home. When working with children Marion stated that she uses "paint and sand, so [children] go to that anyway and do the emotional work that children do through their play. And they can do some really interesting things, just incredible things they do in the sand and I think 'my gosh that's such a visualization of what has happened for this child'". While working with adults both Jane and Deana agreed that producing visual works that individuals can take home is important. Deana stated, "if I'm talking about a concept then I’m drawing the concept, using a lot of very practical metaphors... so I'm drawing pies and things and what I try and do is connect the client to the drawings cause their gonna take the drawings with them."

Finally, participants described using various activities to encourage talking during therapy. Deana describes using the physical stimulation from hand held Eye Movement Desensitization and Reprocessing buzzers as follows:

> "I've found that I use the buzzers so they alternate in each hand and that really works well, it helps ground people, so often we do talk, so some discussion while they're holding the EMDR buzzers and we don't do EMD we just talk. So its kinaesthetic and that seems to help." Marion mentioned that while using play therapy she is not using it in the traditional psychoanalytic way, but is "joining with the child and the children talk when they're playing. They tell me all kinds of things not just with how they are organizing their play, but just in the regular course of conversation."

Finally, Kim described walking with her clients to help them remain focused on the conversation stating that in the summer she can walk up to six miles a day.

Table 2

Techniques that Therapists have Found Ineffective when Working with Clients with an FASD

Technique	Example (if given)	Reason for Failure
Hypnosis		People with FASD struggle with abstract concepts
Thought Interruption	Interrupting a stream of thinking and trying to restate the thoughts in a more positive way	Clients struggle with the complexity of these ideas
Contracting	Developing an agreement between the therapist and the client that the client would carry out a course of action	People with an FASD usually do not follow through on the agreement
Insight	Working over several years to help the client develop insight into their issues and behaviours	Clients get frustrated
Visualization	Relaxation techniques that involve creation of mental imagery	Clients struggle with the abstract ideas involved in this technique
Talk Therapy	Conversational discourse between the client and the therapist	Children with FASD will shut down when asked many questions People with FASD become distracted

Participants stated that they had all tried therapeutic tools that did not produce results. Any therapeutic tool that required abstract rather than concrete thought was found to frustrate clients with FASDs and to be unsuccessful. Deana reported trying hypnosis with her clients with FASDs, but finding that it "doesn't work, by in large, in my experience because it's too abstract." During her work with adults with FASDs, Jane has not found thought stopping to be very useful, because "I don't think that the people I see in counselling are not giving much thought to what they are saying. They're just saying more and more and more but they're really not giving much thought to it in a deep sense". Jane has also not had success with contracting. She describes a hypothetical situation in which she may try to use contracting in this way: "I might at that time start saying, 'well, you know, maybe it's possible that we could say I will not accept gifts from this person?' Sometimes I can get agreement to that, but it's very hard to get follow through with that agreement. I do try then to send that away in writing ... it hasn't been as successful as it might be all the time." Deana has also experienced difficulty with encouraging clients to develop insight. "I try not to worry so much about insight because a lot of time insight doesn't help them because they get frustrated and they don't necessarily remember the insights they had from one session to the next." Participants also noticed that individuals with FASDs tended to struggle with visualization techniques. Kim stated that "trying to do an actual relaxation, you're trying to get them to visualize something and then try to find a happy place ... they struggle with that." Finally, Marion noted that talk therapy on its own without the use of visual aids or experiential techniques will not be successful.

Summary

According to the participants in this study, the experience of counselling individuals with an FASD is multifaceted. The participants themselves and third parties involved in the process bear most of the responsibility for the success of therapy. None of the participants interviewed indicated that a client with an FASD held responsibility for his or her therapy process. Participants suggest that their responsibility lays in making the actual therapy sessions productive and educating the third parties to ensure the client carries out the therapeutic strategies. The participants expect therapy to be a complicated process that will challenge both their personal characteristics and professional skills. Participants deal with these challenges by remaining committed to their theories and to the idea that they can effect change for their clients with an FASD.

Counselling people with an FASD requires participants to think outside the box. They benefit from being willing to question their assumptions and not rely solely on their experience and knowledge to guide their decisions. Participants indicated the need to be aware that what they see or expect in a therapeutic situation is not always congruent with reality. Expectations are adjusted to account for this incongruence and to ensure that the participants' experience self-efficacy, set manageable goals and are able to adjust to the demands placed upon them as therapists.

Often therapy encounters required participants to redefine much of what they believe about therapy; however participants were able to find footholds of familiarity. The issues presented during therapy were not entirely foreign to participants, though the presentation may be unique and the methods used to work with the concern in need of modification. Participants reported securing themselves to their chosen psychological theory. All participants were adamant that they remained faithful to their theory no matter what technique they used or modification they made. One of the basic needs of therapy that remained constant was the need to build rapport. Strong rapport is necessary to any therapeutic encounter, and gave participants a place to start when counselling a person with an FASD.

Finally, when choosing a technique participants indicated that hands on and experiential techniques were most effective. Techniques were chosen on an individual basis, with no guarantee that all techniques would work for all individuals. These techniques, however, provided participants with a place to start.

Chapter 5: Discussion

The purpose of this study was to make explicit what it is like to counsel someone with an FASD. Participants recounted their experiences of conducting therapy with people with an FASD, and their interviews yielded the themes of thinking outside the box, finding a foothold, and finding a fit between tools and clients. Research into conducting therapy with individuals with an FASD is nearly non-existent; however, these participant's stories can be positioned within literature examining the overall experience of counsellors, specifically counsellor self efficacy, and the characteristics of individuals with a life history similar to those with an FASD. The process and tools of therapy can be positioned within the disability counselling literature and the FASD intervention literature.

Theory and the Search for Efficacy

The themes identified throughout the participants interviews point to the need to achieve efficacy in within the counselling relationship and the need to experience self efficacy. The participants began thinking outside the box in order to experience success, they adjusted their expectations to account for uncertainty so that they could experience success, and they chose to adapt tools in order to effect the most change. Counsellor or therapist self efficacy can be defined as therapist's opinion about her or his ability to changes the lives of clients through counselling and is a necessary component of the counselling relationship (Larson & Daniels, 1998).

Therapist self efficacy. This present study's results suggest that the therapists interviewed demonstrated high levels of self efficacy: they expressed that they could make changes with individuals with an FASD and they attributed poor counselling outcomes to external factors—such as the deficits associated with FASDs or the failure of a third party to work with the therapist—rather than the therapist. Researchers hypothesize that self efficacy helps therapists continue in the face of failures (Larson & Daniels, 1998) and to have thoughts about themselves that are helpful (Bandura, 1991). Both of these characteristics were demonstrated by the therapists interviewed in this study. Individuals with high self efficacy are motivated to act (Bandura, 2000)—in this study, to counsel—whereas those with negative self efficacy would likely stop working with individuals with FASDs altogether.

This research shows that counselling individuals with an FASD can be a frustrating experience. Even experienced therapists are unsure where to begin or what techniques will be effective. Therapists with high self efficacy seem to meet this challenge by paying closer attention to their successes than to their failures. Success at an activity has been shown to increase the feeling of self efficacy while failure decreases it (Bandura, 2000), so in an area where failure, even temporary failure, is common, therapists who focus on their success may maintain their high self efficacy and their motivation to continue. Therefore high self efficacy may be a necessary characteristic of therapists who work with individuals with an FASD.

Client Characteristics

The client characteristics of impulsivity, retention difficulty, and verbal deficits noted by the therapists interviewed were also identified in the literature as common characteristics of FASDs (Kodituwakku, 2009). Surprisingly, none of the participants mentioned the cognitive delays also characteristic of some individuals with an FASD (Kodituwakku, 2009; Streissguth, Barr, & Sampson, 1990; Mattson et al., 1997). Perhaps those seeking services from practicing therapists represent those individuals with an FASD who fall within the average to low average functioning range. In Alberta, these individuals are often not eligible for governmental funding, so the therapists may be filling the role of support worker as well as mental health therapist.

Therapists observed two issues in their clients: attachment and traumatisation. Trauma in childhood has been found to be related to attachment difficulties (Muller, Thornback, & Bedi, 2012), and the FASD population commonly experiences abuse and neglect (Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004). The quality and stability of the caregiver–child relationship functions as a template for all other relationships the individual will enter, as child and adult (Fitton, 2012). An individual with a strong and secure attachment with the primary caregiver is likely to have higher self esteem, be less vulnerable to negative interpersonal influences, and have a more healthy development (see Sousa et al., 2011 for review). Individuals with unhealthy forms of attachment are more likely to have antisocial behaviour, impulsivity, hostility, helplessness, and lack of empathy (Styron & Janoff-Bulman, 1997). In fact, the results of problematic attachment are similar to the characteristics of children with an FASD. Perhaps these individuals' life experiences exasperate the occurrence of the behaviours typical of attachment disorders. These results were not unexpected and could help therapists developing their case conceptualizations.

Counselling Individuals with an FASD and the Existing Literature

Counselling professionals are not working in isolation when they provide counselling to individuals with an FASD. Though very little research has examined the use of counselling with FASD, more attention has been paid to counselling people with intellectual disabilities. This literature can be used to inform the practice of those counselling people with an FASD. Counsellors are also not the only individuals to provide services to individuals with an FASD. Other writers, such as those in the fields of social services and education, have accumulated a significant body of literature surrounding the work they do with individuals with FASDs. In absence of counselling specific information, information can be gleaned from these other collections of research to inform the practice of those counselling people with an FASD.

Counselling FASD and Intellectual Disabilities. The intellectual disability literature shows that individuals with an intellectual disability can benefit from the use of modified psychotherapy. Therapists studied here also believe therapy benefits individuals with an FASD and they modified their therapy tools for these individuals. The modifications reflect the suggestions made in the research on counselling individuals with other disabilities. Mirroring the recommendations of Parks (2007), therapists abandoned the idea of developing or expanding on insight. Instead they focused on concrete and tangible practices such as creating art and using diagrams to explain the practical aspects of the client's life. Their modifications also reflect the work of Hurley, Tomasulo, and Pfadt (1998), who recommended adjusting therapy based on client ability, including third parties in therapy whenever possible, and using visual and concrete ideas. Since individuals with an FASD often struggle to maintain attention (Rasmussen, Horne, & Whitol, 2007), it is interesting that therapists choose to leave sessions the same length, especially considering Hurley Tomasulo, and Pfadt's recommendations (1998) for shorter, more direct sessions for individuals with intellectual disabilities. The similarities between the intellectual disability counselling literature and the experiences of participants in this study suggest great overlap between the two, so those working with individuals with an FASD could turn to the intellectual disability literature for guidance.

Counselling and other professions. Though research into counselling is sparse, other professionals such as educators working with children with an FASD have developed several strategies. Some recommendations by teaching professionals are similar to the effective counselling techniques the therapists described, suggesting that certain techniques may work for people with an FASD in a variety of situations. For example, therapists in this study believe a third party must be involved in therapy, and Alberta Learning (2004) suggests the use of a multidisciplinary team to help children learn. Individuals with an FASD seem to others people's support in many circumstances. Carpenter's (2011) many recommendations for teachers of students with FASD include creating a calm learning environment; presenting instructions using visual aids, short sentences, visual clarity and graphic simplicity; breaking tasks into smaller steps; and presenting tasks in visual and tactile ways. The therapists in this study overwhelmingly recognized the importance of visual aids and simple explanations, since complex ideas confuse clients. Finally, therapists worked to involve multiple senses, and Alberta Learning (2004) recommends multisensory learning as a method to enhance the retention. Since interdisciplinary communication enhances the lives of people with an FASD, therapists may benefit from the knowledge gained by other professionals who work with this population.

Counselling and other programs targeted for FASD. Though counselling seeks to meet a unique mental health need for individuals with an FASD, such individuals may also access other interventions through programs provided by various agencies throughout Canada and the United States. Researchers investigating these programs suggest that, "effective interventions must consider the interplay between the behavioural symptoms and the neuropsychological effects of prenatal alcohol exposure" (Green, 2007, p. 106). This statement reflects the workable and static characteristics that counsellors identified in this study. Green's review of programs for individuals with an FASD concluded such programs must teach those with an FASD to learn to regulate their emotions and behaviours as well as modify their environment to maximize the opportunities for adaptive behaviour (2007). Therapists interviewed in this study encouraged self regulation through the use of breathing techniques and paid some attention to environmental modifications by involving third parties in carrying out changes. Overall the results of this study agree with Green's recommendations to adapt therapy and other types of intervention or prevention to the effects of FASD.

The results of this study are similar to the results of other programs offered to individuals with an FASD. For example, Children's Friendship Training (Frankel and Myatt, 2003), a method of addressing social skills in children, makes use of instruction, modeling, rehearsal, homework assignments, performance feedback, and parent education. Research into this program indicates that it helps maintain social skill levels but offers no recorded improvement (O'Connor et al., 2006). The information provided in this study suggests that some of the methods used in Children's Friendship Training may not be effective for children with an FASD. Therapists indicated that simply teaching knowledge is not effective because individuals with FASD are often already able to identify the actions they need to take—the clients instead struggle with implementing the skills. Therapists also avoided homework, even for children, because clients did not follow through with the assignments. On the other hand, this study and knowledge provided by teaching professionals supports the parent education provided in Children's Friendship Training. Those experienced with FASD consistently indicate that involving a third party is necessary to effect change.

In fact, involving third parties most closely correlates this study with other intervention-based research. The Families Moving Forward program works with parents to improve caregiver effectiveness, reduce problem behaviours in children, and meet the needs of the families of those with FASD. The program successfully changed in parental attitudes and achieved some headway with the problem behaviours (Betrand, 2009). Parent Child Interaction Therapy also focuses on educating parents of children with an FASD and reduces problem behaviours and caregiver stress (Betrand, 2009). Grant et al. conducted an FASD-adapted version of a Parent Child Assistance Home Visitation Program with young women with FASD (2004), with each participant receiving an advocate to work with them for the three years. The young women's ability to access supports increased while the advocate assisted them, but they did not improve at accessing supports on their own. Grant et al. (2004) noted that provider education about FASD produced more change than work directly with the FASD clients. These results mirror those of this study, as the therapists felt they were most effective when they helped others working with individuals with an FASD.

In contrast, the Canadian version of Parent Child Assistance Home Visitation, called Step By Step, increased clients' ability to access supports for themselves (Denys, Rasmussen and Henneveld, 2009). These results raise the question of whether individuals with an FASD are responsible for their own personal changes. Most research, including the opinions expressed in this study, suggest that working with third parties has the greatest effect; however the results of the Step by Step program indicated alternative possibilities that warrant further research. Considering that the cognitive deficits seen in individuals with FASDs are due to brain damage and considering the unanimous opinions of the participants in this study that third party involvement is necessary, it is unlikely that further research will yield results to the contrary.

This study also drew conclusions similar to other studies regarding the use of computerized aides in teaching self regulation and other new behaviours. Programs such as Cognitive Control Therapy (Peadon, Rhys-Jones, Bower & Elliot, 2008) and Attention Process Training (Vernescu, 2007; Kerns, Macsween, Vander Wekken & Gruppuso, 2010) focus on teaching self regulation with computer programs, while most of the therapists in this study report teaching self calming and centering using computerized programs. Other successful programs have used virtual reality to teach fire safety to children with an FASD (Coles, Strickland, Padgett, & Bellmoff, 2007; Padgett, Strickland, & Coles, 2006).

Study Limitations

The results of this current study were limited by geographical restrictions, yet provide a picture of counselling within an urban setting. This study provides a description of what it is like to counsel someone with an FASD in an area where individuals with FASDs have access to the same types of non-counselling supports from similar service providers. This may increase the transferability of the results to other individuals who also counsel individuals with an FASD within Alberta. In addition, a blind co-coding of the results would have strengthened their conformability and dependability, however use of thick description allows readers the opportunity to examine the findings and determine if they agree with the conclusions drawn from the data. Finally, conformability and transferability would have been increased with a larger sample, however the small pool of possible participants within Alberta limited the sample size. The smaller sample size allowed greater attention to be paid to each individual interview and thicker descriptions to be developed using the data.

Implications for Further Research

Further studies done in this area should use larger sample sizes and consider adult, adolescent, and child therapists respectively. They could also consider the differences between mandated and voluntary therapy. Specific research into effective types of therapeutic tools could identify additional and more specific therapeutic methods. Examining the roles that therapists play in the lives of their clients with FASDs could benefit those determining the types of supports available for individuals with an FASD and an average IQ. Finally, further research around the effect that counselling individuals with an FASD has upon the therapists themselves would provide information about therapist burnout and self care.

Implications for Clinical Work

This paper may provide therapists counselling individuals with an FASD some useful starting points. They may learn what to expect from the experience, which may prevent frustration and self-doubt if therapy is not working. The knowledge that they need to be flexible and think outside the box when encountering a client with an FASD may allow them to be more open minded as to which techniques they may choose to try. The results of this study suggest that using tools and techniques that engage more than one sense and that are hands on and/or visual will work well with this population, while abstract techniques will often be ineffective. This study may also encourage individuals providing counselling to adjust their definitions of success to what their client with an FASD is capable of achieving. The results suggest that success may look very different than it does with a non-FASD client and that often the key to success is allowing the client to guide the therapy session. Therapists may also benefit from the knowledge that their role with their client with an FASD will be very different than it is with clients without an FASD. They may be called upon to participate in case conferencing and education in ways that are not normally a part of the therapeutic process. Finally, therapists may benefit from knowing that having a third party involved in therapy will likely be essential to success. Counselling someone with an FASD does not seem to occur effectively when it is done in isolation from other supportive individuals in the life of the client.

Conclusion

To the knowledge of this researcher no one has examined the process of counselling individuals with an FASD to determine if it is effective. The results of this study indicate that counselling is perceived as an effective intervention for individuals with an FASD, however it requires great modification on the part of the therapist. Therefore, taking the individual`s diagnosis of FASD into account is the first step in successful therapy. Tools and mindsets need to be adjusted to account for the clients’ capability. For a therapist working with someone with an FASD, it is helpful to adjust expectations, to actively maintain self efficacy and to be prepared to function in different roles. Often participants indicated working as team coordinators for their clients with FASDs instead of doing work that is usually associated with therapy. It is possible that more would be accomplished by therapists if they were able to focus primarily on therapy. Tools need to be adjusted or chosen based on their fit with the strengths of an individual with an FASD and disregarded when they are not working. Overall, this study shows that participants providing counselling with FASD individuals were passionate about their work and felt that they could use counselling to make change.

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Appendix A

Greetings,

The following is an introduction of the research project "A Qualitative Analysis of Psychotherapeutic Techniques Used to Treat Individuals with FASD". Your name has been provided as a possible participant in this study due to your experience in working with FASD individuals. This project begins in September 2010 and ends in August 2012.

The purpose of this project is to make explicit some of the methods used by psychotherapy providers such as yourself when treating individuals with FASD. It is the hope of this research to find similarities between methods used by psychotherapists which will lead to more effective means of counselling individuals with FASD. By participating in this project you will have to opportunity to learn what other psychotherapists are doing to treat their FASD clients and perhaps learn new methods or techniques for implementation in your own practice.

Involvement in this study consists of participation in a single one on one interview with the researcher during which you will be asked to describe the techniques you use during therapy with FASD individuals. Interviews will take place at a mutually convenient time and location. Interviews will be recorded, and upon transcription of the interviews you will have the opportunity to read through them and make any additions or changes you feel are necessary. During the interview you will not be asked specific questions about your clients. The aim of this study is to take examine your techniques as a psychotherapist so any direct reference to clients during the interview is not encouraged.

Participation in this study is voluntary. You may withdraw from the project at any time, without penalty, simply by notifying the researcher. All information provided during the interviews will be confidential, and your name will not be included on any transcripts. All data collected will be accessed only by the researchers and will be kept in a secure location.

If you have any concerns about participation in this research project or if you know of other psychotherapists who may be interested in participating please contact Lisa Rowbottom at ldrowbottom@hotmail.com. Thank you for your interest in this project.

Sincerely,

Lisa Rowbottom

Ph: (780) 270-4813 Ldrowbottom@hotmail.com

Appendix B

Consent Form

For A Qualitative Analysis of Psychotherapeutic Techniques Used to Treat Individuals with FASD

* I have read and retained a copy of the letter of information concerning the study: A Qualitative Analysis of Psychotherapeutic Techniques Used to Treat Individuals with FASD, and I agree to participate in the study.

* All questions I have regarding this study have been adequately explained to me. I understand the purpose and procedures of this study.

* My participation in this study in voluntary. I understand that I can withdraw at any time.

* I understand that all measures have been taken to protect my confidentiality. Appropriate data storage methods, access of data and pseudonyms will be used.

* I understand that participating in this study will involve a one on one interview with the researcher which will be recorded on a digital voice recorder. I understand that I will have the opportunity to review the summery and make additions or deletions.

* I understand that I will not be required to discuss client specific details. If I choose to relay client specific information I will be responsible to maintain client confidentiality. Client specific stories will not be included in publication.

* I understand that, upon request, I may have a copy of the results of this study upon its completion.

* I understand that the researchers may choose to publish the results of this study or present the results at a conference.

I am aware that I can contact the researchers Lisa Rowbottom at ldrowbottom@hotmail.com or Jacqueline Pei at Jacqueline.pei@ualberta.ca at any time during the study if I have any questions about this study.

I understand that the plan for this study has been reviewed by the Faculties of Education, Extension and Augustana Research Ethics Board (EEA REB) at the University of Alberta. I am aware that if I have any questions about participant rights and ethical conduct of research I can contact the Chair of the EEA REB at (780) 492 - 3751.

I HAVE READ AND UNDERSTOOD THIS CONSENT FORM AND I AGREE TO PARTICIPATE IN THE STUDY.

Participant's Name_______________________________________

Signature ____

Date ____

Witness ____

Appendix C

Interview Protocol

The individual participants in this study will participate in one on one interviews with the researcher. The same protocol questions will be used with each participant, however different prompt questions will be used to guide the participants to keep answers within the perimeter of the study. The protocol includes:

a) Locating a mutually convenient interview location which ensures confidentiality.
b) Explaining the consent form and having participants sign it.
c) Adhering to the 45 minute time limit.

Interviewers Role

The role of the interviewer is ask the interview questions and to use supplementary questions to keep the interviewee on track.

Opening

The following ideas will be ad libbed in introduction of the interview.

a) Read through and explain the consent form. Have participant sign consent form.

b) The purpose of this research is to determine understand the experience of counselling persons with FASD.

c) I want to remind you before we begin that you are not required to share client specific stories with me. You may choose to provide some examples however in doing so please use a pseudonym and avoid any identification. The goal of this study is to understand the experience from your point of view.

d) Do you have any questions before we begin?

Individual Interview Questions

Any participant answers which are unclear or possibly ambiguous will be prompted by asking one of these questions: A) Can you tell me what that looks like for you? B) Could you provide me with examples? C) Could you explain that in more detail?

1) Can you tell me what it is like to counsel a person with FASD?
    Do you feel that it is different than counselling people without a disability?
        If so how?

Do you feel it is similar to counselling people without disabilities?
  If so how?

2)How do you determine if psychotherapy with a client with FASD is working?
 Have you ever conducted psychotherapy with a FASD client that did not work?
  Why do you think this happened?
 Have you had any exceptionally successful psychotherapeutic experiences with FASD clients?
  What do you think made things so successful?

3) What are some techniques that you find work very well with persons with FASD?
 Do you find you use more hands on therapeutic activities?
 Do you use primarily behaviourist interventions?
 Have you ever tried cognitive behavioural therapy?
  What are some challenges with that type of therapy?
 Do you feel long term or short term therapy is more effective with persons with FASD?

4) What is/are your preferred therapeutic method/methods?

5) Are there techniques you have tried that do not work?

6) From your experience, what is the most important thing to remember when counselling someone with FASD?

7) If you had all the resources in the world, all the time you needed and knew that your FASD client would always come to session and always follow through on all your recommendations and assigned homework what would you do?