THE EXPERIENCE OF COUNSELLING FOR INDIVIDUALS
WITH PARTICULAR LEARNING DISABILITIES

by

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ABSTRACT

Clients with specific deficits in communication, memory, processing of information, or attention, may have difficulties with the counselling process. This study was designed to explore the experiences of individuals with these specific deficits in counselling, and thereby increase awareness of the existence and effect of possible barriers or supports in the counselling process. The methodology used was Interpretive Description, developed by Sally Thorne (Sally Thorne, Kirkham, & O'Flynn-Magee, 2004). Ten individuals with particular learning disabilities (one or more of the above deficits) who have experienced counselling were interviewed. Up to four interviews were conducted with each participant; one screening interview, an initial interview, an optional interview including a significant other, and a member check at the end of the study. The researcher recorded a field and research journal during data collection. For the initial and optional interviews the researcher gathered transcripts, and then immersed himself in the data, in order to find themes about the participants’ experiences of counselling. The participants confirmed themes for accuracy and completeness. Finally, four participants contributed a short paragraph at the end of the thesis, nine participants contributed drawings that represented their counselling experience, and five participants created poses representing their relationship with their therapist. These alternate forms of data were used as further evidence in the study. The data gathered demonstrated that participants believed that they needed a more flexible approach to therapy which depended on having a safe relationship with a therapist that was sensitive to their needs. Although certain kinds of counselling processes were preferred by certain participants, the participants’ particular cognitive deficits were not the determining factors of what
kinds of help the participants wanted in therapy. Rather, the participants were more interested in the creation of a counselling process based on a collaborative approach between them and their therapist, dependant on the participant’s knowledge about his or her needs and the therapist’s experience in counselling and with learning disabilities.
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CHAPTER 1

Introduction

As a person with dyslexia (reading, writing, word finding and memory difficulties) who has experienced a number of years in my own counselling process, I have become aware of some of the difficulties inherent in developing my own self awareness as a function of my language difficulties. In the past few years I have spoken to a number of other individuals with other kinds of learning disabilities that have experienced similar problems in the counselling process. So, through my own experiences I have come to believe that individuals with particular kinds of learning disabilities (communication, memory, processing, and attention difficulties) might experience difficulties in the counselling process. For example, learning in the counselling process may also be affected by the same communication, memory, processing and attention difficulties that affect learning in the academic setting. Moreover, I have experienced interventions chosen for me by professionals and seen interventions prescribed for other persons with similar disabilities. Therefore, I want to provide a voice for individuals who have particular kinds of learning disabilities, and add my own, so that we might have some input into the kind of experiences available to us in our counselling process. It is not an easy road for me or the participants of my study to travel, as I must find adaptations that will enable me and the participants to find a clear and true voice despite our learning disabilities. Nevertheless, I am determined to find a way.
Statement of the Problem

The focus of this study is to understand the nature of experiences individuals with particular learning disabilities (individuals with difficulties in at least one of communication, memory, processing and attention) have in the counselling process. This population has unique perceptual, expressive, and cognitive impediments that may not only affect their academic abilities but also could have an effect on psychotherapy (Ceci, Ringstrom, & Lea, 1981; Ford & Milosky, 2003; Most & Greenbank, 2000; Nigg et al., 2002; Rourke, Young, & Leenaars, 1989; Linda S Siegel & Ryan, 1989). In addition, individuals with the particular learning disabilities in question may experience specific presenting non-academic concerns, as a function of their deficits (Grolnick & Ryan, 1990; Sisterhen & Gerber, 1989; Stone & May, 2002; Svetaz, Ireland, & Blum, 2000). This population has received attention from researchers developing approaches to remediate academic limitations (Groff, 1981; Guyer & Sabatino, 1989; Oakland, Black, Stanford, Nussbaum, & Balise, 1998; Orton, 1937). However, individuals in this population may have needs for both academic and counselling interventions. Researchers have paid far more attention to the creation of therapeutic approaches that address the possible academic struggles of individuals with learning disabilities, than to those that address the challenges they may face in working through the counselling process. Moreover, few have asked individuals with particular learning disabilities about how they experience the counselling process. As a researcher, it is my intention to record the experience of individuals with particular disabilities in the counselling process, and thereby increase awareness of the existence and effect of possible barriers and of effective supports in their counselling process.
Definitions

Learning Disability

While keeping in mind that this research focuses on particular kinds of learning disabilities, it does require the initial description of a general definition, and a particular philosophy about the label of learning disabilities. As Canada has not formally defined learning disability in its laws, I shall use the United States’ Individuals with Disabilities Education Act, which states that:

The term specific learning disability means those children who have a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in imperfect ability to listen, think, speak, read, write, or do mathematical calculations. The term includes such conditions as perceptual handicaps, brain injury, minimal brain dysfunction, dyslexia and developmental aphasia. The term does not include a learning problem which is primarily the result of visual, hearing, or motor handicaps, of mental retardation, of emotional disturbance, or of the environmental, cultural, or economic disadvantage. ("Individuals with Disabilities Education Act Amendments of 2004," 2004)

The US Federal Definition of specific learning disabilities does not include Attention Deficit Hyperactivity Disorder (ADHD), which they put under the category of disabilities-other. For the purposes of this thesis my term, particular learning disabilities, will include this disorder because there is evidence that it does affect learning (Cutting, Koth, Mahone, & Denckla, 2003) and therefore may affect counselling. ADHD is defined through behavioral observation, behavioral rating scales, interviews with parents,
and the client in question as inattention, hyperactivity, and impulsivity (Cutting et al., 2003).

The commonly used psychometric definition of a learning disability, one that is most often used for determining eligibility for funds and which is most commonly described as the discrepancy definition, has been questioned (Linda S. Siegel, 1988, 1989; Keith E. Stanovich, 1989; Stanovich, 1991). The discrepancy definition requires there to be a discrepancy between achievement and intelligence (as defined by an IQ score) for a learning disability (LD) to be diagnosed. The difficulty with this definition is that individuals with lower IQ scores and poor achievement, according to this definition, are less likely to be described as learning disabled and individuals with high IQs and poor achievement are more likely to be described as learning disabled. However, individuals who suffer from learning disabilities generally have learning problems unrelated to intelligence, such as phonological difficulties (Catts, 1996). Consequently, Stanovich (1989) claims that it may be more appropriate to define learning disabilities according to the discrepancy between performance of an individual in a specific area of capacity, compared to a capacity in another area (for example reading comprehension versus listening comprehension). Moreover, this type of definition would be more helpful when targeting interventions towards specific needs.

Kavale (2000) expresses a number of difficulties in the current approaches to defining learning disabilities; they may be seen as real rather than stipulative, and they may not have any link to scientific understanding of their etiology. Moreover, stipulative definitions do not have any practical use. Therefore, Kivale promotes the use of an operational interpretation which includes multiple elements rather than simply an
aptitude-achievement discrepancy. He describes that discrepancy is necessary but not sufficient and that other elements, such as learning efficiency, memory, perception, cognitive processing, social cognition, linguistic processing, problem solving, concept formation and metacognition may also be components of a learning disability. Therefore, discrepancy may not be sufficient to define the nature of an individual’s learning disability.

This study will employ a definition of learning disability more like that of Linda Siegel (1988; 1989). Rather than being concerned solely with the difference of capacity in one area of competency compared to competency in another, in this thesis the useful part of the operational interpretation from Kavale, that describes difficulties in specific areas that may cause challenges in learning during the counselling process, will be used. For, it is these particular difficulties that, in specific areas, may hinder the client in resolving issues during the counselling process. Furthermore, it may be that specific patterns of deficits lead to different experiences in counselling. Therefore, for the purpose of specifying criteria for individuals’ inclusion in this study, a particular learning disability will be defined as difficulties with communication expression/reception, memory, processing or attention, compared to the rest of the population. Individuals’ experiences will be described, along with a description of relevant information about their specific difficulty, such as communication expression/reception, memory, processing and attention.

*Counselling*

Counselling psychological services are defined as:

services provided by counselling psychologists that apply principles, methods
and procedures for facilitating effective functioning during the life-span developmental process… these services are intended to help persons acquire or alter personal-social skills, improve adaptability to changing life demands, enhance environmental coping skills, and develop a variety of problem-solving and decision-making capabilities. Counselling psychological services are used by individuals, couples, and families of all age groups to cope with problems connected with education, career choice, work, sex, marriage, family, other social relations, health, aging, and handicaps of the social or physical nature (Kirk, 1982).

Research Questions

1. For individuals with particular learning disabilities (who have particular difficulties in at least one of: communication, processing, memory and/or attention), what is their experience in the counselling process?

2. Given their particular difficulties (particular learning disability and presenting problems), what elements in the process do they believe helped/hindered them in their change process?

3. Given their level of experience in receiving academic adaptations and their experiences in counselling, what kinds of adaptations would they like to have added to their counselling process?

4. Given their past experiences in counselling, what kind of relationship do they need with their therapist in order to progress in their therapy?

5. What elements or activities, outside the therapy process, make the therapeutic process more or less productive?
These research questions require the selection of participants with specific difficulties that could affect the counselling process. Elements may be defined by the participants in this study as any aspect of the counselling experience that supports the client’s change process. The change process may also be defined by participants as any area of personal growth and development. Methods of data collection will be adapted, depending on the participants’ deficits, to allow for their difficulties in expressing themselves, so that their voice is most clearly heard.

**Introduction to Methodology**

Dr. Sally Thorne’s Interpretive Description methodology will be used to gather and analyze data from participants who have experienced counselling and have particular learning disabilities (Sally Thorne, Kirkham, & MacDonald-Emes, 1997; Sally Thorne et al., 2004). Her method originated from the constructivist paradigm, where participants and investigators are co-constructors of the data. Thorne comes from a nursing background, where the participants, who are medical patients, are in a power imbalance with the researchers. Doctors prescribe interventions that are only moderately understood or controlled by those who receive them. In the same way, individuals with the particular learning disabilities in question have historically been prescribed interventions by professionals that are only vaguely explained as to the way they work and recipients have limited choice about what they are given. Interpretive Description is designed to give the participants of this study a voice about their own care and thus make the interventions more sensitive to the needs of the recipients. Individuals with the particular learning disabilities of interest have difficulties in self-expression, and a variety of other specific problems, that could make it difficult to collect data about their experience. Sally
Thorne's method allows for flexible methods of data gathering which allow for adjustments to be made in the interview approach to support expression in individuals with communication deficits. These adjustments are designed to help the participants express their perspective as accurately as possible. The method can allow for different forms of data gathering (such as interviews of different kinds, surveys, written submissions, surveys of popular media), and modifications to techniques for different kinds of populations (such as combining drawing and physical movement to support expression in interviews). Interviewing of participants, along with providing them alternate activities of drawing and a sculpture, was chosen as a way to answer the research questions because of the unique viewpoints that individuals with particular learning disabilities have on their own struggles.

In this study, up to four different interviews will be conducted with each participant, one for screening, one initial interview, an optional interview with a significant other, and a confirmatory interview. The addition of a drawing and a physical activity will be used to enhance data gathering during the initial and optional interviews. This will allow for the different modalities of expression that may compensate, in part, for each participant’s particular learning disability.

Interviews have been shown elsewhere (Zambo, 2004; Zambo & Brem, 2004) to be an effective way to uncover the thoughts and experiences of individuals with learning disabilities. As interviews can be modified during the process to explore unique aspects of the participant’s experience, and since each participant will most likely have a distinctive pattern of deficits and presenting concerns, this method may provide the most precise, detailed and in-depth account of the types of challenges faced by these
individuals. As counselling works with description of experiences, and internal perceptions in the same way as an interview, the same challenges experienced by individuals with particular learning disabilities in counselling may be observed in an interview. In addition to the interviews, the participants will be encouraged to contribute a 100 word paragraph that summarizes their understanding of their learning difficulties and a retrospective view, after participation in the interviews, about their experience in counselling.

Thorne’s method uses the Constant Comparative approach to data collection and participant sampling (Corbin & Strauss, 1990; Eaves, 2001). As the area under study in this thesis has received limited investigation that can aid in directing the research process, constant comparisons can aid in determining the research, as any data gathered during the research process can help determine what choices will be made in subsequent procedures.

The research approach used in this study was designed to provide some insight into what helped, hindered and might improve the counselling process for the participants with particular learning disabilities. To these ends it was necessary for the researcher to take into account the complexity of the participants’ experiences in gathering data, to the extent that many qualities of participants (including life experience, disability, personal issues, family background, and previous counselling experience) may all contribute to participants’ preferences in counselling. Moreover, rather than looking at the outcome of various approaches to therapy or examining the effect of a particular approach, the researcher decided to ask individuals with the widest available range of particular learning disabilities about all issues that concerned them about their counselling process. In this way, the researcher wanted to gather the widest and deepest range of data possible
about an area in counselling that had received little attention, such that the research would uncover as many kinds of issues affecting these individuals in their counselling process as possible. So, through interviewing individuals with particular learning disabilities, about their experience in their counselling process, this research was aimed at uncovering some of the kinds of barriers that hindered the counselling process and supports that helped improve the counselling process that may be faced by individuals with particular kinds of learning disabilities. In this way, it was hoped that this research would pave the way to further research in to looking at the particular needs of individuals with learning disabilities in their counselling process and give some direction to help counselors provide effective services for individuals with particular learning disabilities.

**Summary of Rationale**

Overall, this study has been designed to describe the experience of some individuals with particular kinds of learning disabilities with the counselling process. As counselling often involves verbal discourse, memory and problem solving, difficulties with communication, memory, processing and attention may have distinctive kinds of influences on individuals’ experiences in the counselling process. The literature, discussed below, has little to say about the effects of particular learning disabilities on the counselling process. Moreover, as stated below, some individuals with learning disabilities experience issues to do with their learning disabilities that require counselling. Consequently, this exploratory qualitative study will be used to uncover the unique issues that some individuals with particular learning disabilities experience in the counselling process. Moreover, Sally Thorne's Interpretive Description model, using multiple methods of data gathering and analysis, will be used as a way of adapting methods to
address the particular needs that participants experience, due to their deficits. Although each particular pattern of deficits may lead to different kinds of needs in the counselling process, this thesis has not been designed to explore this relationship. More general issues, relevant to individuals with particular kinds of learning disabilities, will be found in this exploratory work. By carrying out this initial study, the subject may be introduced as an area worthy of more comprehensive investigation.
CHAPTER 2

Literature Review

The Nature of Learning Disabilities

Although statistics about the prevalence of particular disabilities that may affect
counselling are not available, the estimated prevalence of learning disabilities as a whole,
not including Attention Deficit Hyperactivity Disorder, in the United States is 4.6% of
the general population (U. S. Department of Education, 2000). The prevalence of
Dyslexia in the Netherlands was recently shown to be 3.6% (Blomert & De Vries, 2004).
The prevalence of Attention Deficit Hyperactivity Disorder (ADHD) has been estimated
at anywhere between 2% to 18% of the general population in North America and
(Holowenko & Pashute, 2000; Rowland, Lesesne, & Abramowitz, 2002). However,
prevalence of these disorders depends on the definition used (e.g. whether it is the
discrepancy definitions or another, such as the one suggested above). For example,
Shaywitz found the prevalence of dyslexia to be between 3.2% and 9.0% in one study (S
E Shaywitz, Shaywitz, Fletcher, & Escobar, 1990) and in another, between 5% and 17%
of the US population (Sally E Shaywitz & Shaywitz, 2003). Irrespective of the
definitions, particular learning disabilities are seen to affect a significant amount of the
general population.

Deficits That May Affect Counselling

Deficits in auditory processing, verbal expression, memory or cognitive
processing have the potential to cause problems with counselling, as counselling requires
the use of these capacities.
Central auditory processing deficits (CAPD) are seen both in individuals with Attention Deficit Hyperactivity Disorder and learning disabilities (Gomez & Condon, 1999; Kruger, Kruger, Hugo, & Campbell, 2001), although a recent study has shown that it may be when individuals with ADHD may have a co-morbid learning disability that they experience auditory processing problems. CAPD can be defined as “limitations in the ongoing transition, and analysis, organization, transformation, elaboration, storage, retrieval, and use of information contained in audible signals that cannot be attributed to peripheral hearing loss or intellectual impairment” (Gomez & Condon, 1999). Understanding of implied meaning can also be affected (Rinaldi, 2000). Since counselling often involves the therapist sharing auditory information with the client, a CAPD may affect the counselling process when the client misses what the therapist is trying to convey, such as empathy (Horvath, 2001).

Verbal expression can also be affected in some individuals with learning disabilities. Word finding capacities in some individuals with reading disabilities have been found lacking (Faust, Dimitrovsky, & Davidi, 1997; D. German, 1984; D. J. German, 1984; German, 1979; Miller & Felton, 2001; Rubin & Johnson, 2002; Rudel, Denckla, & Broman, 1981; Stiegler & Hoffman, 2001). The word finding capacity is an individual's ability to retrieve the correct word that expresses the meaning an individual wishes to convey. As counselling often involves the client expressing understandings to the therapist, if an individual cannot retrieve specific words and communicate his or her internal understanding, it will be harder for the therapist to understand the client’s inner world (Horvath & Luborsky, 1993).
Memory can also be affected in individuals with learning disabilities. Semantic memory (coding for items that have a specific meaning) has been shown to be affected in individuals with learning disabilities (Ceci et al., 1981). In addition individuals with dyslexia tend to have verbal memory deficits. That is, they may have difficulty remembering information that they have heard (Howes, Bigler, Burlingame, & Lawson, 2003). In addition, individuals with learning disabilities may have working memory deficits (Linda S Siegel & Ryan, 1989; Smith-Spark & Fisk, 2007). Working memory is used for comparison of previously stored information with information coming from the sensory systems in order to make semantic sense of the information being currently perceived. It is a place where information is cognitively processed. Taken as a whole, these deficits in semantic, working, and verbal memory may cause difficulties in not only remembering what was learned, and processing new information in a counselling session, but also recalling past events, and reprocessing them in the present in Gestalt therapy (O'Leary & Nieuwstraten, 2001), Adlerian Therapy (Hester, 2004) or family therapy (Eckstein, Welch, & Gamber, 2001).

Some individuals with learning disabilities, such as individuals who have been described as having nonverbal learning disabilities, have specific processing problems that may make counselling especially difficult (Palombo, 1996). The characteristics of non-verbal learning disabilities include:

- marked deficits in the area of nonverbal problem solving, concept formation, hypothesis testing, and the capacity to benefit from positive and negative informational feedback in novel or otherwise complex situations… difficulties
in dealing with cause-effect relationships

(Harnadek & Rourke, 1994)

These nonverbal disabilities could have distinct effects on the outcome of problem solving aspects of the counselling process.

Attention may also have an effect on the client’s counselling process (Nigg et al., 2002; Tripp, Ryan, Peace, & Willcock, 1999). Individuals with Attention Deficit and Hyperactivity Disorder (ADHD) have deficits that may result in distraction, not listening when spoken to directly, and difficulty in sustaining attention (Nigg et al., 2002). Having ADHD may increase the need for sensory stimulation (Antrop & Roeyers, 2000) and also increase the effect of auditory distractions (Geffner, Lucker, & Koch, 1996) and visual distractions (Landau & Others, 1992). Moreover, having ADHD may cause an effect on executive function (Fuggetta, 2006), so that individuals with ADHD may have difficulty disengaging from one activity and re-engaging in another. Struggling with executive functioning may also mean that clients have difficulty engaging in therapy when they have been thinking about things before therapy or difficulty disengaging from a resolved issue in therapy, in order to re-engage in another. However, increased motivation may decrease these symptoms (Tripp et al., 1999), and fidgeting may help to maintain concentration (Hild, 1997). Medication may also help (Howard Abikoff et al., 2004; Anastopoulos, DuPaul, & Barkley, 1991) with concentration during sessions. In addition, giving additional auditory (H Abikoff, Courtney, Szeibel, & Koplewicz, 1996), and visual stimulation (Imhof, 2004) may aid focus during the counselling session. In addition, tiredness and depression of those with ADHD may affect therapy as the stronger the symptoms of ADHD the stronger the problems with sleep and depression (Stein et al.,
Moreover, sensitivity to touch (to clothing and other objects), may cause problems with clients in therapy being uncomfortable (Broring, Rommelse, Sergeant, & Scherder, 2008). Given that some individuals tend to be more night owls while others tend have more of a day time preference for cognitively taxing work (Deyoung, Hasher, Djikic, Criger, & Peterson, 2007), and individuals that have ADHD may be more tired (Stein et al., 2002) they may have a preference for therapy at a specific time of day. Moreover, some individuals with these conditions are better at working in the evening than in the morning and vice versa (Deyoung et al., 2007). Consequently, the therapist may need to guide the clients into re-engagement with the counselling process and determine optimal conditions for therapy.

To the extent that the process of counselling involves the receptive, expressive, memory, cognitive processing and attention capacities of the client, clients with deficits in these areas may experience difficulties in counselling.

**Presenting Concerns May Affect the Counselling Process**

Not only may individuals with learning disabilities have trouble with the counselling process, they may also experience challenges that amplify the need for counselling services. Some individuals with learning disabilities may have problems in social functioning, emotional functioning, self-efficacy, family adjustment and substance abuse. These areas in life may need to be addressed during the counselling process.

Individuals with learning disabilities may have difficulties with social perception, skills, and functioning. In particular, some individuals with learning disabilities may have information processing difficulties which affect social perception (Haagar & Vaughn, 1995; Kavale & Forness, 1996), according to the reports of parents, teachers and
peers. Individuals with low social status, compared to individuals with higher social status, may differ in “sensitivity to social cues in the environment, interpretation of social situations in relation to their own experiences, and levels of self-control” (Meadan & Halle, 2004). Some individuals with ADHD show problems with nonverbal social perception (Hall, Peterson, Webster, Bolen, & Brown, 1999). Not attending to nonverbal cues in a counseling session may cause the client to miss important communication by the therapist. Moreover, a study of the social skills research showed that current attempts at social skills training have been shown by some to be ineffective with this population (Elbaum & Vaughn, 2001; Kavale & Mostert, 2004). Problems with these interventions have been ascribed to problems in assessment of programs, the measurement of social skills and immaturity of the interventions available for social skills training (Kavale & Mostert, 2004).

In addition, many individuals with learning disabilities seem to possess difficulties with their emotions. They may have difficulties perceiving certain emotions (Ford & Milosky, 2003; Manassis & Young, 2000; Most & Greenbank, 2000). Moreover, some individuals with learning disabilities may be at risk for mood and anxiety disorders (Svetaz et al., 2000; Wright Strawderman & Watson, 1992). In addition, in a study of 128 college students (54 LD and 74 not LD) (Reiff, 2001), individuals with learning disabilities were significantly more likely to have depressive systems and be under severe emotional distress than were individuals without learning disabilities. Girls with learning disabilities appeared to have more suicide attempts, and experienced more emotional distress than did boys with learning disabilities. Moreover,
a number of individuals with learning disabilities were less capable of tolerating and managing stress.

Problems with mood could be the result of self-efficacy problems. A number of individuals with learning disabilities have expressed an external locus of control and low self-efficacy, which lead to a belief that success is due to elements outside their control and in the environment (Grolnick & Ryan, 1990; Klassen & Lynch, 2007). Individuals may see themselves as less competent than matched-IQ peers (Grolnick & Ryan, 1990). They may also have lower self-esteem when compared to individuals without learning disabilities (Stone & May, 2002).

Some families containing individuals with learning disabilities tended to have a number of different problems, although many provided protective factors. Family members may have higher levels of anxiety (Margalit & Heiman, 1986) in families that contain a learning disabled individual, compared to families that don’t have members with learning disabilities. These families are more likely to be controlled, ordered and less enabling of free expression (Margalit & Heiman, 1986). Some families with learning disabled children tend to be more disengaged and rigid (Michaels & Lewandowski, 1990). Two studies have found increased stress in some of these types of families: Brown and Pacini’s study (1989) that included families that contained a child with ADHD, and Dyson’s study (1996) included children with general learning disabilities.

Family stress may not be the result of just one child in the family having a learning disability. Some learning disabilities may be an inheritable condition. Genetics has been shown to play a role in the cause of reading difficulties (DeFries & Alarcón, 1996). Another study showed a distinct familial pattern of heritability for learning
disabilities, with gender being a significant predictor of heritability (Oliver, Cole, & Hollingsworth, 1991). Nevertheless, in a longitudinal study of a group of people with dyslexia, participants expressed their need for support from their parents (McNulty, 2003), while another study stressed the importance of active support systems for individuals with learning disabilities (Goldberg, Higgins, Raskind, & Herman, 2003).

Chemical dependency tends to be more likely for some individuals with learning disabilities, compared to their age matched peers (Beitchman, 2001; Karacostas & Fisher, 1993). A longitudinal study of participants matched for age and gender, measured at 5 to 15 years after initial contact, showed a markedly higher risk for substance abuse for individuals with learning disabilities than the controls (Beitchman, 2001). Part of the risk could be accounted for by the marital status of the parents and the behavioral problems of the children. In another study of 123 learning disabled students (mean age 14.3 years) compared with 138 non-disabled students (mean age 13.71 years), tobacco and marijuana use was higher for adolescents with learning disabilities, but not alcohol abuse (Karacostas & Fisher, 1993).

Although some individuals with learning disabilities may be at risk, as stated above, there are a number of factors that may increase their resilience. Murray (2003) describes protective factors such as personality characteristics (high self-esteem, internal locus of control, strong academic skills, strong social problem-solving skills, optimistic), community and society (access to mentors, opportunities for employment, pro-social organizations), family context (secure attachment, authoritative parenting, high expectations for child, parent level of education and employment), and finally school and peers (supportive teacher-student relationships, focus on building academic social and
emotional competencies, encouraging internal locus of control). These types of protective factors have been also described elsewhere (Polloway, Schewel, & Patton, 1992; Raskind, Goldberg, Higgins, & Herman, 1999; Vogel & Adelman, 1992). It may be important for a therapist and client to explore these kinds of factors in searching for supports to aid in the resolution of a client’s issues and to protect the client against some of the other presenting concerns.

Between the specific deficits of many individuals with learning disabilities and the different difficulties that they may experience in life, counselling could be important to securing their success. For some, expressive and receptive problems, memory deficits, cognitive processing deficits, and attention difficulties, all may make the counselling process more challenging. Even so, the difficulties of some individuals with learning disabilities, such as social perception, emotional problems, struggles with self-efficacy, hardships with family relations, substance abuse, and resiliency factors, can be addressed within the counselling process.

Counselling Individuals with Learning Disabilities

Although the literature on counselling with learning disabilities is not of the same quality, or quantity, as the literature about deficits and life challenges, it does provide a sense of the different issues that are faced when counselling an individual with a learning disability. There are three types of literature found in this area: empirical quantitative studies, case studies, and reports from clinical experience.

Empirical Quantitative Studies

These studies can be divided into four different kinds of therapy types: group therapy, brief therapy, parent psycho-educational training and Eye Movement
Desensitization and Reprocessing (EMDR). These studies focused on the problems that some individuals with learning disabilities experience. However, none of them addressed the specific deficits that may make counselling more difficult.

Although many of these studies used tests that are said to be reliable, these tests were not assessed for reliability using the particular sample in a study. Best practice is to “estimate score reliability for one's own data” (Vacha-Haase & Thompson, 2000). Moreover, for many of the tests, there were no numbers for either reliability or validity, even though they were said to be acceptable. The second problem is that many of the studies show significant differences between control and treatment groups, however often there is no mention of the effect size. Therefore, although there may be a significant difference, this does not mean that there was a large enough difference in the effect of the treatment between control and treatment groups to say that the treatment is truly effective (Jacobson & Truax, 1991; Rosnow & Rosenthal, 1988). A third drawback of these studies arises from the limited description of the methods used for assessment of the participants’ learning disabilities and a limited description of the type of deficits that affected the participants. It is with these three cautions in mind that I review the following studies.

The first set studies, about group therapy, can be divided into three categories: biofeedback and relaxation, emotional/cognitive (rational emotive, reality therapy) and Bibliotherapy.

Biofeedback and relaxation therapies, the first of three categories of group therapies, are focused on decreasing impulsive behavior and shifting to a perception of internal locus of control. One study focused on social skills, relaxation and behavior
control, either through social skills or relaxation training (Amerikaner & Summerlin, 1982). The study’s forty-six participants, first and second grade students with an unknown gender ratio, were defined as learning disabled by their assessed academic functioning was one standard deviation below the mean of the district and one standard deviation below the student’s intellectual functioning. They were given the Walker Problem Behavior checklist and Primary Self-confidence Inventory, which were said to have “acceptable levels of reliability and validity”. Using a one way ANOVA the researchers found that the relaxation group had more significant changes in acting out behavior and the social skills group had significantly higher social self-esteem scores than the controls or relaxation group. This study seems to show that relaxation training can help some learning disabled individuals self-mediate and keep calm in the face of emotionally tense situations; while social skills training helped many of these children feel more in control of their social interactions.

The next category of group therapy involved Reality therapy (Omizo & Cubberly, 1983) and Rational Emotive Education (Omizo, Cubberly, & Omizo, 1985). Omizo, with others, conducted two studies based on the classroom meetings; classes of individuals with learning disabilities were involved in discussions about obstacles to success. These meetings were led by classroom teachers who were trained in a particular approach to therapy. The participants included in this study were defined as LD (learning disabled) under the Texas Education Agency guidelines (unspecified in this paper). In the first study, which included 30 control and 30 treated children, 48 boys and 12 girls were selected for the study, ages 12 to 14. The effectiveness of Reality therapy was assessed using the dimensions of self-concept form (reliability coefficients .70 to .84) and the
Nowicki-Strickland scale. Individuals were encouraged to develop positive self-identity by “becoming involved in life in a manner that allows them to fulfill to basic needs: the need to feel that they are worthwhile both to themselves and to others (individual responsibility), and the need to love and be loved” (Omizo & Cubberly, 1983). The study also focused on developing greater self-efficacy. Compared to controls (using a one way ANOVA), some individuals who experienced the treatment showed higher levels of aspiration and less anxiety, and were more interested in and satisfied with their academic achievement. The second study, about Rational Emotive education, used the same measures (60 children participated, ages 8 to 11 years, 48 boys and 12 girls). The ABC format of Rational Emotive therapy was used to address basic problem solving skills, to demonstrate feelings of influence on thoughts and to show how feelings are not expressed in identical ways. The therapy also provides transfer of learning by encouraging students to test, in various life situations, the principles learned and to develop rational coping strategies. In addition, Rational Emotive therapy stresses the use of concretely and accurately expressed feelings, instead of speaking in generalities, in order to give support, empathy and encouragement to others and to learn how to dispute irrational thoughts (Omizo et al., 1985). The group that participated in the treatment showed higher levels of aspiration, lower anxiety and improved locus of control (as measured by an ANOVA); therefore, this approach appeared to increase self-efficacy in some individuals.

Finally in the last category of group therapy, Lenkowsky et al (1987), using the Piers-Harris Children's Self Concept Scale, showed that Bibliotherapy can also be used in conjunction with group therapy to support improvements in self concept, compared to a control group. Their study included emotionally handicapped boys (n 78) and girls (n
16) aged 12 to 14 years with WISC-R scores between 92 and 114 and with reading levels between fourth and sixth grades. While these students were described as learning disabled and emotionally handicapped, none of the particular measures or criteria used to define the participants as learning disabled was described by the authors.

As a whole, the group studies seem to indicate that understanding how to assess thoughts and emotions and learn to fill basic needs can improve self-efficacy and decrease anxiety in some individuals with learning disabilities. However, the effect size of the treatment was not evaluated in these studies (Rosnow & Rosenthal, 1988) and the authors did not describe in detail the criteria used to define the participants as learning disabled.

The second set of studies, about brief solution-focused counselling, has shown promise with some individuals who have learning disabilities. In general, the approach is to support individuals in picking a specific problem and through learning how to address that problem, become more effective in addressing others. An exploratory study used a seven-point Likert based questionnaire (reliability and validity unknown) and the Counselor Rating form (with reliability ratings between .85 and .91) to examine the effect of brief counselling. The participants were between 16 to 18 years old, with the Anglo-American ethnicity, which had been defined, according to Iowa guidelines, as learning disabled. For the 14 participants (according to pre/post test analysis), the questionnaire showed that the severity of their concerns and the intensity of their feelings tended to decrease. Unlike other studies, the participants were interviewed and they felt that due to their treatment, they were thinking and doing things differently (Thompson & Littrell, 1998).
In another study using brief therapy for participants with ADHD, the researchers used the Wiggins adult ADHD checklist (reliability and validity not mentioned) (Wiggins, Singh, Getz, & Hutchins, 1999). The treatment group consisted of 9 Caucasian students, 1 male, 8 female, aged 31 to 52 years. Participants were pre-diagnosed before the study as ADHD by a neurologist, psychologist or psychiatrist. Pre/post test measures indicated that after therapy, disorganization decreased, and that inattention and then emotional labiality decreased. However, self-confidence and self-esteem decreased (all significantly, according to the t-tests used and all with large effect sizes, between 1.31 and 1.90). No significant changes were found for the eight subjects in the control group (4 males and 4 females). Wiggins believed that self-esteem and self-confidence decreased because most of the participants realized the challenges involved in finding solutions to their problems.

The third set of studies outlines the effects of parent training for parents that have children with learning disabilities. In the first study, children with diagnosed learning disabilities (as determined by psycho-educational assessment, written by a registered psychologist, and defined under the Ontario’s guidelines of a learning disability) were between seven and 12 years of age and had full-scale IQs greater than 85. Although not formally a style of counselling therapy, parent training is used by therapists to support some parents who have children with learning disabilities. It may be included with family therapy to support the restructuring of the family. In one study of parent training, the parents were taught about learning disabilities, structuring the learning disabled child's environment, communication skills, supporting a child's problem solving skills and development of appropriate consequences (all taught in a group setting) (Kuzell &
Brassington, 1990). The Psychosocial Competence Incomplete Stories Test (psychometric properties unknown) was used to assess the children's self-esteem (for the 48 participants, 24 treatment and 24 controls). The measure showed significant improvement in the children's self-esteem both immediately and after the intervention, for up to one year later.

In the second study, parent training was conducted for parents who had preschool children with ADHD. Parents in the treatment group were educated about ADHD and given behavioral strategies to help children increase their attention, behavioral organization, and compliance (compared to those in the control group, who were given “non-directive support and counselling”) (Sonuga-Barke, Daley, Thompson, Laver-Bradbury, & Weeks, 2001). The children started the study at 3 years of age and were diagnosed using the Parental Account of Childhood Symptoms (PACS, no mention of psychometric properties). The researchers used the General Health Questionnaire to assess disturbed mood (said to be reliable and valid), the Personal Sense of Competence Scale (factor Analysis, for construct validity, showed robust factors, and test-retest validity high) to assess parent’s feelings of being able to have control over their child’s behavior and clinical interviews and observation, with 50 children and their parents. Individuals in the treatment group had clinically significant change (53% for Parent Training) according to Jacobson and Truax’s criteria (1991), with a treatment effect on conduct problems and significant effect on ADHD symptoms, but not maternal adjustment (Sonuga-Barke et al., 2001). Similar results have been shown from other studies (Diament & Colletti, 1978; Hammett, Omizo, & Loffredo, 1981; Pisterman et al., 1989).
As described above, family functioning may be affected by having children with learning disabilities in the family. Parent training was shown to significantly change the behavior and self-esteem of individuals with ADHD or learning disabilities. However, neither the type of learning disability nor the veracity of the assessment of the learning disability was addressed in these studies. Therefore, it is unknown how styles of training are addressing the particular deficits or levels of deficits of the individuals in these studies.

One final kind of therapy evaluated empirically, Eye Movement Desensitization and Reprocessing (EMDR) (F. Shapiro, 1997; R. Shapiro, 2005) has not been used with learning disabled individuals, but two studies have described how it has been used to support individuals with developmental disabilities (Giamp, 2004; Seubert, 2005). EMDR is commonly used with good effect to help individuals overcome traumatic events. It uses eye movements and reprocessing of the traumatic event in order to decrease the emotional distress associated with a particular memory. EMDR includes visualization of the particular event, association exercises, stress reduction exercises and particular eye movement exercises. The two studies described significant decrease in the intrusiveness of the traumatic memory. The individuals in the two studies were defined as developmentally delayed, according to their state legislation. Individuals with developmental delays commonly have difficulty describing their traumatic experience, as do individuals with particular learning disabilities, who have specific communication deficits. Therefore, EMDR may be useful for individuals with learning disabilities as it does not depend on verbal expression in order to reprocess the traumatic event.
Overall, the quantitative studies show some promise in being able to support some children and adults with learning disabilities in understanding their own cognitions and feelings, and developing effective ways of coping with their learning disability. Group therapy may be effective in compensating for some deficits and may provide different ways for individuals to understand their difficulties; they hear others express their struggles, typically multiple modalities are used for communication and opportunities are made for them to try out learned skills. Brief therapy may also be effective, because it involves not only learning skills, by supporting cognitive processing, but also aiding clients in applying their skills to everyday situations. Adjusting family interactions may provide children with learning disabilities another practical way of addressing their difficulties with social interactions. Finally, EMDR, which involves visualization of a traumatic event, may help individuals with learning disabilities in processing traumatic events as it does not rely on verbal communication in order to process the event. Nevertheless, as the psychometric properties of assessment tests were not described, and particular deficits were not taken into account, these results may not be completely reliable or valid.

Case Studies

Case studies of counselling individuals with various kinds of learning disabilities have been used to either explain the researcher’s theoretical point of view or describe the nature of counselling outcomes. A total of eighteen papers were found; one was discarded because of questionable qualifications of the researchers (no PhD’s and limited experience in the area) (Geib, Guzzardi, & Genova, 1981), others were discarded for incomplete disclosure of the subject background. Papers described below provided
more creative approaches to counselling and also were consistent with some of the observations made in the quantitative studies. The interventions used in certain approaches, described in the case studies reviewed here, may help individuals with learning disabilities compensate for their deficits. For example, they provided alternate ways, other than talk therapy, to address the problems in communication that some individuals have who experience learning disabilities. However, other than in one paper (Trimble, 2001), the alternate methods were not expressly chosen to compensate for individuals’ deficits. Unfortunately, again these papers did not provide detailed descriptions of the assessments and participants were only described as having a non-specified learning disability.

The case studies could be divided into group therapy, integrated therapy, Bibliotherapy, therapy using alternate modalities, and family therapy. Common themes were found between the different case study papers and between the case study and quantitative papers.

The first set of studies, about group therapy, contained two papers that described therapy with a group of learning disabled 12-year-olds (DuPlessis & Lochner, 1981) and adults (Rosenblum, 1987), respectively. Both papers used techniques discussed in the quantitative papers.

The twelve year old participants in the first paper (DuPlessis & Lochner, 1981) were reported as underachieving scholastically compared to their ability. During therapy, they made puppets, created plays with their puppets, sculpted different emotions that they were feeling and used a Two Chair Gestalt exercise to resolve specific issues. Anecdotal evidence was given about the results for four of the group members. On the whole these
children were more optimistic, self moderated, self-sufficient, responsible and realistic about their difficulties. These observations, made by the clinician, were confirmed in observations made by their school teachers (DuPlessis & Lochner, 1981).

The second paper also used a Gestalt approach; the Empty-Chair exercise was used in to address family dynamics. Participants in this study were 8 or 9 adults, but some did not come routinely. Individuals were described as learning disabled because they had fulfilled the requirements necessary to receive the support of the local learning disabilities centre. But their specific assessments were not described. The group included a junior college student, a waitress, a supermarket clerk, a receptionist, a craftsman, a landscape gardener, a nurse's aide, a graduate student, and a custodian. They were of diverse ages, occupations, and ethnic groups. In the Empty-Chair exercise, clients talk to an empty chair that represents a family member with whom they have an issue. Therapists directed their clients in what to do during the activity, and gave structuring questions to help their clients address particular issues. In addition, observations by the counselor, sharing of coping approaches, and role play were used to aid the individuals in finding new ways to interact with their families (Rosenblum, 1987). Findings showed that the individuals tended to behave in similar ways to how they behaved in their family system. It was observed that each individual had experienced difficulties with their parents at one time or another. Each of the group members was reported to have gained considerable strength, comfort, and a sense of belonging from participation in the group. In both papers the group process seemed to be curative; as members shared their experiences they felt understood and accepted. As they found shared experiences these helped them reduce their feelings of isolation and peculiarity in their world view. The
therapists provided alternate modes for the participants to express themselves, instead of using talk therapy (sitting down to talk about events).

The second set of papers, about family therapy, contained two case study papers, one study for individuals who were diagnosed as having Attention Deficit Hyperactivity Disorder (Widener, 1998) and another that included an ADHD population group with others (Greenfield & Senecal, 1995).

Both included a psycho-educational component, information about ADHD, and parenting skills. But neither paper described how the participants were diagnosed with ADHD. Each paper discussed the importance of the therapist observing child-parent interactions and then provided new ways of understanding a child's actions (Greenfield & Senecal, 1995; Widener, 1998).

Greenfield et al.'s (1995) paper involved multifamily recreational therapy with 17 children with ADHD, 11 with anxiety disorders, and 4 with Pervasive Developmental Delay. These families were predominantly poor; many of the parents were on welfare. They underemphasized academic achievement and play. In this study, therapists watched the parents play with their children, they coached the parents in specific interaction skills, and then parents were paired up to discuss what they had experienced. Parents reported that they increased in their confidence in parenting and the interventions repaired relations between them and their child.

In the second paper, Widener (1998) described a seven-year-old boy with a clinically diagnosed case of ADHD. Family therapy was used to uncover some of the family patterns that were being replayed. The learning disabled child was being cast as the family’s problem. It was concluded that the parents themselves sometimes also have
learning disabilities (see genetic component above and self-efficacy), or family interaction patterns (feelings of inadequacy or behavior of a family member), which might be associated with unhelpful parenting practices; insecurities of the parent may somehow contribute to the problems of the child (Widener, 1998).

The third set of case study papers described how Bibliotherapy, just as in the quantitative studies, was used with a learning disabled population. Lenkowsky (Lenkowsky, 1978, 1987) discusses Bibliotherapy as a three-step process; building from identification to catharsis to insight. The individual identifies with the characters in a particular text as like them (each text was chosen by the therapist to describe some part of the client’s situation), then vicariously the individual relives the particular element of their lives through the character (which gratifies his or her own impulses or desires), which leads to insight about his or her own situation. Awareness of difficulties with reading must be taken into account when using this approach, and texts must be at the child’s reading level, or the text must be read to the student. This approach also requires knowledge of the resources that would target the client’s particular difficulties and ways to support the development of insight (book conferences and group meetings). In this study, Lenkowsky describes the implementation of the process with a 15 year old, Bonnie, who had a reading level just above grade 6. She was directed to read the short book Red, which was of high interest to her but had low grade level vocabulary. The plot was about a girl who on the one hand excelled in basketball, but on the other, was unable to make friends. In the end, she made friends when she showed others her ability to play basketball. Bonnie had a group book conference where she discussed the meaning in the plot and how it related to her life. The author reported that this approach improved
Bonnie's self-confidence, concept of self, and outlook on life (Lenkowsky, 1978). A second paper discussed the implementation of a Bibliotherapy process for development of problem-solving skills (Forgan, 2002). Bibliotherapy may circumvent some of the deficits associated with auditory perception expression and memory. Individuals can read passages that contain the words or concepts they find hard to recall, or verbalize, and process the information within their own time frame. However, it may be of limited use for individuals with reading disabilities. Perhaps taped books or movies might have the same effect for some.

Finally, the fourth set of studies described approaches to counselling for individuals with learning disabilities that used modalities other than talk therapy. Play therapy (Ray, Schottelkorb, & Tsai, 2007; Rosenberger, 1991) and drama therapy (Goodrich & Goodrich, 1986) have been used effectively to support growth in some individuals with learning disabilities. In both cases the clients had blocked verbal self expression. While art therapy (Odell-Miller, Hughes, & Westacott, 2006) has been shown to be fruitful for others with problems with verbal expression, drama, sustained simile, and imagery, may free some clients from trying to find the correct words to express their problems directly, and instead encourage clients to focus on the resolution of their issues. In the first study, a combination of the principles described above was used with a seven-year-old with acute dyslexia (Callow, 2003). He had difficulties with verbal expression and word finding. In the creation of a sustained simile, the therapist created a story with the child that included symbolic representations, which could be reworked by the child, in order to come to a resolution. Dagnall (2003) used image therapy with some clients with learning disabilities. The author claimed these clients had
linguistic disabilities (discrepancies between linguistic ability and intelligence) or ADHD, but their deficits were not described in reference to any formal testing procedure. That said, many of the clients had difficulties verbally expressing their presenting concerns. The clients were asked to interact with images of a picture in their minds and play with parts of the images to resolve conflicts. Assessments of key memories, through images of home or a specific significant object, were used as a way of accessing specific themes in the client’s life. These case studies described many different kinds of results, including resolution of conflicts between father and son, resolution of unfinished business with parents, clear understanding of the parents’ roles in their lives, acceptance of their own abilities and disabilities, and moving beyond looking for approval to acceptance of their own capacities. As a whole, these approaches show promise for some individuals with difficulties in verbal expression, as a way for them to express their internal states and process their ideas.

Finally, the fifth set of case studies, about family therapy, contained two papers on family systems therapy, which showed how their dynamic approach can aid in family functioning and provide exercises and techniques that facilitate understanding for some individuals with learning disabilities. Neither specifically mentioned the nature of the clients’ deficits, or particular assessment procedures used with the clients, and each described family therapy with children of a wide range of ages. In the first study, Trimble (2001) explained that learning disabilities may cause inflammation of the boundaries between different systems (for example conflict between parents and the school system, social workers and school system, teachers and the family system, child and parental system) in reaction to a child’s failed efforts to do their best. As the children
become more defiant and avoidant, the different systems’ patterns become more inflexible in reaction to the child, resulting in misunderstandings, blaming and confusion. Trimble stresses that the therapist needs to listen carefully, empathically, respectfully and compassionately, and stay connected with the clients (even during high levels of emotion). In one case, the therapist “talked in multiple-choice”; he offered alternative hypotheses and descriptions, and then asked the child to choose which one best fit her understanding of the situation. A similar process was used with her mother who had a similar disability (from the description it may have been a problem with word finding). Increasing the connections between teacher, mother and child by interpreting communication, and ensuring messages were understood, helped to decrease inflammation (conflict) between elements of the system. In the family therapy approach (Labauve, 2003), role play, play therapy, structured games, planned family events, and behavioral techniques were used in aiding family systems to be restructured and attachment issues to be resolved.

Case studies, as a whole, contribute to the understanding of how creative approaches may be able to work around the deficits of individuals with learning disabilities. Counselors may be able to address the needs created by the cognitive deficits of their learning disabled clients through the use of positive approaches that involve physically active and non-verbal components. In particular, as the counselling interventions present in these case studies use multiple senses, and multiple modes of expression, they may prove successful as they use the same principles found in multi-sensory educational interventions (Groff, 1981; Guyer & Sabatino, 1989; Oakland et al., 1998).
Clinical Studies

Eleven papers were found that described clinical experiences in counselling for individuals with various types of learning disabilities. However, only seven qualified for review. The excluded four papers did not include the credentials of the author, or the credentials did not indicate any long-term experience in counselling clients with a range of learning disabilities. These papers also had not received peer review. Moreover, they repeated information about therapy with the ADHD population, and the effect of the therapeutic alliance on empathy that was covered in the quantitative and case study sections of this thesis. The remaining papers reviewed here were included because they provided additional subject matter, not covered elsewhere, that could be useful in identification of themes from the interviews gathered in my research.

Three papers for counselling individuals with ADHD also investigated the treatments discussed in the quantitative group studies, which focused on cognitively-based treatments that were found to be useful for individuals with ADHD. One encouraged counselling clients in problem solving, identification of self-defeating patterns and building well structured environments (Schwiebert, Sealander, & Dennison, 2002), while another focused on Cognitive Behavioral therapy that emphasized self-esteem, management of attention problems, problem solving, interpersonal skills, and anger management (Young, 1999). Finally, one other discussed expressive–supportive group therapy as a means to increase social competence and friendship (Shechtman & Katz, 2007).

Anastopoulos and Barkley (1989) describe a comprehensive behavioral approach to training parents with elementary age children who have ADHD. The steps used were:
orientation to the nature of ADHD, understanding parent-child relations, enhancing
parent attending skills, paying positive attention to appropriate play and compliance,
using a token system at home, using response/cost systems, using time out strategies,
extending time out to public places, problem solving strategies for future behavior
problems and a booster session (to check in on progress). This process involved
education, practice by parents and counselling sessions to discuss any concerns/
difficulties implementing the approach. This approach was applied both with groups of
parents and with individual families. These kinds of structuring approaches were said to
help some parents become more confident and the child to see his or her environment as
more predictable.

A single paper expressed the efficacy of using play therapy with children with
ADHD and different learning disabilities (Guerney, 1979). However, the differences in
diagnostic tools and conceptualization of learning disabilities may make this paper
outdated. Therefore, more research about play therapy and learning disabilities may be
useful.

One important aspect of counselling, not mentioned in detail in other studies, is
development of the therapeutic alliance through the use of empathy. The therapeutic
alliance has been well investigated, defined, and measured in a general sense (Horvath,
Lyddon, 1998; Sharpley, Fairnie, Tabary-Collins, Bates, & Lee, 2000). Indeed the
therapeutic bond may have a significant effect on social development (Shechtman &
Katz, 2007). Respect, openness, trust, freedom and familiarity were found to be adult
qualities that were preferred by teenagers (Martin, Romas, Medford, Leffert, & Hatcher,
However, for some individuals with learning disabilities, the development of therapeutic contact between therapist and client may require special attention to the effects of deficits of communication (Bergin & Bergin, 2001), memory, cognitive processing, and attention. Byrne and Crawford (1990) discuss how validation through empathy can help some clients with learning disabilities heal from the type of insult to self that they call type II (insult to self as a lovable being). This insult, the authors explain, comes about due to difficulty of self expression, poor impulse control, and seeing themselves as a source of problems, which results in anger, anxiety and sadness. Searching for the source of these emotions may help the clients with self acceptance, and acceptance of a learning disability. However, Byrne and Crawford do not describe how the therapist should address the client’s deficits in order that the client can experience the empathy.

There are a number of questions about the utility of the clinical papers. They do not provide any specific definition for learning disabilities or describe how their approaches affect particular kinds of deficits. They are of debatable clinical utility because they do not provide evidence based-outcomes for particular kinds of deficits. Nevertheless, they point to areas for this paper’s investigations and may help other researchers with further studies.

In summary, the empirical, case and clinical studies point to the utility of having counselling for individuals with learning disabilities. They all express that individuals with learning disabilities do have needs, related to their learning disabilities that could be helped by counselling. However, none of these studies only generally specify the participants’ learning disabilities, rather than being descriptive about the participants’
deficits. Moreover, there are no studies asking the participants about their perspectives on their counselling process. This study has been designed to provide a detailed description of the deficits of the individuals with learning disabilities and look at their own personal experiences of the counselling process, so that a clearer picture might be developed about the experience of individuals with particular learning disabilities in their counselling process.
CHAPTER 3

Methodology

This study has been constructed to understand the character of experiences of individuals with particular kinds of learning disabilities (individuals with difficulties in at least one of communication, memory, processing and attention). These individuals have specific deficits in perception, expression, reception, and cognition that often have been addressed in educational settings but only addressed in a limited way in psychotherapeutic settings. While researchers have investigated the issues that may be faced by individuals with learning disabilities, there has been little investigation into how deficits affect the counselling process, and what individuals need in therapy, in order to be successful in the counselling process.

The research reported in the current study investigated the nature of the experience of individuals with particular learning disabilities in the counselling process. To review, five specific questions were addressed:

1. For individuals with particular learning disabilities, what is their experience in the counselling process?

2. Given their particular difficulties (particular learning disability and presenting problems), what elements in the process do they believe helped/hindered them in their change process?

3. Given their level of experience in receiving academic adaptations and their experiences in counselling, what kinds of adaptations would they like to have added to their counselling process?
4. Given their past experiences in counselling, what kind of relationship do they need with their therapist, in order to progress in their therapy?

5. What elements or activities, outside the therapy process, make the therapeutic process more or less productive?

Research Design and Overview

Thorne’s Interpretive Description approach (Sally Thorne et al., 2004) was used to answer these research questions. This approach was chosen because it allowed for the varying needs of participants with particular learning disabilities to be accommodated. The researcher’s goal was to provide optimal conditions for the participants to as completely as possible, express their experience of counselling. Therefore, different kinds of opportunities were provided, for communication in multiple modalities, in order to aid in the participants’ expression of their ideas. Multiple interviews were conducted, including one with an individual who knows the participant well, to help with communication. Three optional exercises were offered: one using drawing, one creating a physical pose, and one writing exercise. In addition, the constant comparative approach (Eaves, 2001) was used to deepen the opportunities for data collection by allowing for the gathered data to inform the next choices in the research process. The gathered data were used to guide the selection of participants (so as to select participants with different disabilities, genders, ages, therapeutic issues and experiences in therapy), and the selection of additional interview questions (so as to expand the depth and range of data, based on what had been already gathered).

Figure 1 presents an overview of the study design. As depicted, four different kinds of interviews could be conducted for each participant: a screening interview, two
interviews to gather information about the research questions and a member check. But, some participants did not participate in the second optional interview to gather information about the research questions or the member check. Opportunities were also provided for participants to express themselves through drawing (in interview type one), in a pose (in interview type two), and in writing (between interviews and the final member check).

*Figure 1: Study Design*

Sampling

Purposive Sampling, with maximum variation, was done until the themes recovered from the data provided minimal new information (Sandelowski, 1995). A range of participants with different learning disabilities, ages, genders, deficits (i.e. evidence of auditory processing, verbal expression, memory, cognitive processing or attention deficits) and problems (i.e., social perception, emotional, self-efficacy, family) were sought (participant variables). These participants experienced either (what they
believed to be) positive or negative outcomes with counselling, and had some insight into
the challenges they faced in the counselling process. The participants with learning
disabilities provided psycho-educational assessments, reports from their schools/colleges,
Statements of Permanent Disability from a doctor, or a letter from the assessor
confirming their learning disability. These were used as evidence of their learning
disability (specifically, a particular learning disability). Determination of each
participant’s status as learning disabled and having particular deficit(s) was confirmed
with the help of a trained educational psychologist, Dr. Deborah Butler. To be included,
participants had to have access to a significant other who was willing to participate in an
interview with the participant. The significant others were individuals who had spent a
significant amount of time with a participant and had developed an understanding of his
or her history, internal life and modes of communication (these could be a family
member, long-term friend, spouse, or colleague). The participant needed to be willing to
share their experience of their counselling process and have some kind of insight into
how the counselling process worked for them.

Recruitment

The process of finding places to advertise for participants and finding participants
for the study took approximately a year. The process started in November 2006. During
that time, a large number of places that offer disability services where canvassed,
including: five universities, three colleges, three schools designed to support individuals
with learning disabilities, and a disabilities association, all in south western British
Columba, Canada. Early on in the recruitment process, the primary researcher canvassed
five places to get letters confirming that they would help this researcher find participants,
which was required by the Behavioral Ethics Research Board at the University of British Columbia in order to pass ethical review. Ultimately, three universities, two colleges and two schools for individuals with learning disabilities agreed to help in participant recruitment. These centers agreed to various approaches to find participants for the study: three put posters up in their centers (see appendix 1), four made pamphlets available in their centers (see appendix 2), and two put a copy of the poster on their website and two in their newsletter. One of the colleges required application to their ethics boards before they would allow advertisement for this study. The researcher was given a certificate of exemption (see appendix 3). The Behavioral Ethics Board at the University of British Columbia approved this project on the 28th of November 2006 (see appendix 4).

It took so long to recruit for a number of reasons. First, given the percentage of individuals in the general population that have particular learning disabilities (between 3% and 17%), and the percentage of those individuals that had both assessments and counselling, there were very few individuals to draw from. Second, it took a long to find places that were willing help canvas for participants. In addition, at the start of the study the Behavioral Ethics board wanted letters from five institutions stating their willingness to participate in recruitment. The researcher canvassed 4 universities and 8 colleges, 3 schools for learning disabled students and 3 associations for learning disabilities, before finding enough places to advertise for participants. In a number of cases the researcher had to receive permission from the ethics boards of that institution. Third, it was hard to find time to meet with these individuals; many had very busy schedules. For one participant it took over 6 months to find time for them to meet. For others it took any
where from 3 weeks to 4 months, to make time. Finally, although the researcher spent a considerable amount of time in, putting up posters and delivering leaflets, it was pointed out by one of the participants that, because of their reading disability they often didn’t read posters. Therefore, recruitment was a slow and steady process.

It took until October 2007 to recruit all of the eleven volunteers. Six volunteers were recruited through universities; three were recruited through a learning disabilities association, one through a school for individuals with learning disabilities and one through a college. Ultimately ten individuals with particular learning disabilities participated in the study.

Screening the Participants

An initial screening was done by phone call, after each volunteer was emailed a copy of the pamphlet that had been left at various colleges. The potential participants were then given a brief comprehension check to ascertain if they understood the nature of the study. If they wished to continue, they were asked a number of screening questions over the phone. These questions were designed to obtain information about the volunteers for future selection of the appropriate participant, according to the constant comparative approach. First, the volunteers were asked background information about their age, gender, how long ago they were assessed and what kind of professional assessed them. Then the researcher inquired about their type of learning disability: verbal expression, written expression, reading, auditory processing, memory deficit, information processing and other. Next, they were asked to describe, in generalities, the kind of issues they addressed in counselling: relationships, mood, life transitions, academic issues, career, family relations, self-esteem, addictions, and trauma, gender issues, and
others. Finally, they were asked to describe their counselling experience: the length of their previous counselling experience (including the number of sessions) and the nature of their counselling experience (group, individual, family, other – specify). Potential participants were told that if they consented to participate in the study, they would be contacted again, within a certain range of time. If they were not selected for inclusion, they were told, they would be contacted at the end of the study to inform them of the results, if they wished. At the end of the phone call, if the interviewee met the criteria for participation, they were asked if they wished to join the study.

The participants were selected using the constant comparison technique (Sally Thorne et al., 1997), during the process of the study. The initial participant was admitted into the study based on the types of particular deficits, outlined in the literature, which may lead to difficulties in the counselling process. As subsequent individuals contacted the researcher to participate, the researcher reviewed the age, presenting issues, and cause of disability to see if the individual was sufficiently different from those who had come before. In general, participants were selected based on gathering the greatest breadth and depth of data possible. In the end, all volunteers that applied, except one, were selected. The depth and breadth of disabilities, issues, and ages of the participants were sufficient for the purposes of the study. One volunteer was excluded because she could not provide evidence of her learning disability; although it was informally diagnosed. She could not afford to pay for assessment, nor could she find a way to be assessed for free.

If volunteers wished to join the study, and were selected, they were emailed copies of the interview protocol and consent form(s). Participants younger than eighteen years of age were sent an assent form for the participant (see appendix 5) and a consent
form for the parent or guardian (see appendix 6). Participants older than eighteen years of age also received a consent form for individuals older than eighteen (see appendix 7). The consent forms contained information about: the purpose of the study, the risks and benefits of participation, the time commitment, and the questions that would be asked during the interview, a description of the activities that they would undertake and possible dates of participation. Significant others were asked to fill out an agreement of consent which also included a confidentiality agreement (to ensure information disclosed by the participant in the interview sessions would not be discussed by the significant other outside the interview room, without the participant's consent). The interview protocol listed the questions for interview one and interview two and the additional data gathering techniques (see appendix 8). Each gave signed consent forms to the researcher before the interview started. The participant phoned the researcher to set up an appointment for the interview when they were ready to be interviewed.

Background of the Participants

A total of 10 participants were included in the study. The participants ranged in age from fourteen to forty-six years of age. Eight were Caucasian, one was Native American, and one was Asian. Participants had a variety of learning disabilities (see Table 1). Three participants had ADHD alone. The rest had various other kinds of disabilities (four of the rest also had ADHD). Five had working memory problems. Two had information processing problems and two had problems with verbal expression. Six of the participants had reading disabilities and three had writing disabilities. One had a math disability. All but two had lifelong learning disabilities; Nicole received her disability as a consequence of a brain injury from car accident, and Mark had
Neurofibromatosis, associated with subsequent learning disabilities. Participants had received many different kinds of counselling and each had different kinds of issues that they brought to their sessions. Issues included, family relationship issues, self-esteem, learning disability related issues, a phobia, and traumatic experiences (see Table 2) Two had a diagnosed mental illness, one with bipolar disorder and one with depression.

Participants had experienced anywhere between ten and thirty sessions of counselling.

Table 1.

Participations’ List of Learning Disabilities

<table>
<thead>
<tr>
<th>Participant</th>
<th>Verbal Express.</th>
<th>Working Memory</th>
<th>Visual Memory</th>
<th>Auditory Memory</th>
<th>Processing Speed</th>
<th>Reading</th>
<th>Writing</th>
<th>Math</th>
<th>ADHD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owen</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Tyra</td>
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<td>x</td>
<td>x</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Sarah</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>Fiona</td>
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<tr>
<td>Mary</td>
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<td>x</td>
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<tr>
<td>Rachel</td>
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<td></td>
</tr>
<tr>
<td>Mark</td>
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<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Nicole</td>
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<td></td>
<td></td>
<td></td>
<td>x</td>
<td></td>
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<tr>
<td>Ted</td>
<td>x</td>
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<td>x</td>
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<tr>
<td>John</td>
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</tr>
</tbody>
</table>

While 10 participants were included in the study, some participants contributed more data than others. In the next section, I provide profiles of each participant, including a description of the data provided by each.

Profiles of Participants

Owen

Owen, a twenty-two year old male university student, had play therapy at a young age (to address relationship and family issues) and then Eye Movement Desensitization and Reprocessing (EMDR) about a year before we met (to address a traumatic event). He was both gifted and learning disabled. The participant received his full psycho-
educational assessment in 1995. He had been given the Stanford-Binet, Wechsler Intelligence Scale for Children, Peabody Picture Vocabulary test, Beery Developmental Test of Visual-Motor Integration among others at that time and then retested with the Stanford-Binet Intelligence Scale and Wechsler Individual Achievement Test (WIAT) in 2002.

Table 2.
Kinds of issues faced by participants

<table>
<thead>
<tr>
<th></th>
<th>Couple Relationships</th>
<th>Mood Disorders or Symptoms</th>
<th>Life Transitions</th>
<th>Academic Issues</th>
<th>Career</th>
<th>Family Relations</th>
<th>Self-esteem</th>
<th>Addictions</th>
<th>Trauma</th>
<th>Gender issues</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owen</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
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<tr>
<td>Tyra</td>
<td></td>
<td>Anxiety sympt.</td>
<td>x</td>
<td>x</td>
<td></td>
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<td></td>
<td>LD Issues</td>
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<tr>
<td>Sarah</td>
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<td>x</td>
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<tr>
<td>Fiona</td>
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<tr>
<td>Mary</td>
<td></td>
<td>Anxiety sympt. Bipolar Disorder</td>
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<tr>
<td>Rachel</td>
<td></td>
<td>Depressive Disorder</td>
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<td></td>
<td>LD Issues</td>
</tr>
<tr>
<td>Mark</td>
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<td>x</td>
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<tr>
<td>Nicole</td>
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<td>x</td>
<td>x</td>
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<tr>
<td>Ted</td>
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<td></td>
<td></td>
<td></td>
<td>LD issues</td>
</tr>
<tr>
<td>John</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
<td>ADHD Issues</td>
</tr>
</tbody>
</table>

The Stanford Binet showed that he had superior scores in verbal reasoning (99th percentile) and quantitative reasoning (99th percentile) and high average scores in abstract/visual reasoning (95th percentile). But the results in his short-term memory tests were inconsistent from the first to the second assessment. While he was significantly weaker (average at the 25th percentile) in 1995, in more recent testing his short-term memory was shown to be stronger (89th percentile). The testing in the second testing showed variable results between the different subtests of his short-term memory.
Moreover, Owen, when interviewed for intake, said that he still occasionally experienced problems with his short-term memory, but these problems were inconsistent and therefore were not represented in his assessment. The WIAT showed that his reading was in the 57th percentile, his word reading was at the 53rd percentile, his spelling score was at the 55th percentile, and his written expression was at the 61st percentile, all the middle of the average range, but low given his intelligence scores. Overall, he was classified as having a learning disability in reading and writing. Although gifted, his skills were assessed to be sufficient to achieve at an average academic level. He felt that he was able to express all his ideas in the first interview and therefore did not want to participate in a second. He wrote a paragraph to include in the thesis.

*Tyra*

Tyra, a twenty-four year old female university student, received Cognitive Behavioral therapy, solution-focused therapy and an unspecified style of client-centered therapy to address both family and academic issues. It was also noted in her academic assessment that she had both anxiety and low self-esteem. These issues were addressed in counselling. This participant provided a letter that gave the psychometric data. She was assessed as having a verbal IQ at the 95th percentile, placing her in the gifted range, in comparison with her peers. She was given the WAIS II, and this was not considered an accurate estimation of her intelligence due to auditory working memory and visual memory problems. She showed specific achievement weaknesses with reading speed and math speed. She scored at the 9th percentile on the reading fluency subtest and at the 12th percentile on the math fluency subtest. The DSM-IV-TR Learning Disability Profile was of a reading and math disorder. She was given the diagnosis of gifted learner with a
learning disability. Tyra declined to participate in the second interview or to contribute a paragraph as she was experiencing unresolved issues that needed further counselling. As of this writing this researcher is continuing to suggest places to access additional supports.

Sarah

Sarah, a seventeen year old female high school student, found this study through a disabilities association website. She had experienced counselling for anxiety, social difficulties, oppositional behavior at home, and academic struggles in school. Neither she nor her mother was able to give a clear answer about the approach used, except to say that it was process-orientated and client-centered. This participant gave the researcher her full assessment. For cognitive and academic skills, the participant had been given the Wechsler Intelligence Scale for Children, The Wechsler Individual Achievement Test and the Woodcock-Johnson Tests of Achievement (Word Attack and Reading Vocabulary subtests). For behavior rating scales she had been assessed using the Achenbach Child Behavior Checklist, the Achenbach Teacher Report Form, The Academic Performance Rating Scale, School Situations Questionnaire, the Children’s Depression Inventory and Children’s Manifest Anxiety scale. In the Stanford-Binet she showed a Verbal-Performance IQ score discrepancy (Performance IQ at 113 and Verbal IQ score at 88), with auditory and visual memory weaknesses. In the Wechsler Individual Achievement test personal weaknesses were indicated in her Reading composite; her reading composite score was in the borderline range and her writing composite was at the high end of the borderline range. She received diagnoses of both a reading and a writing disability, with auditory and visual memory weaknesses. There
was a mention of attention difficulties given from the behavioral tests; however, these test results were not made available to the researcher. The participant gave verbal confirmation only that she had ADHD. However, the researcher noted on interview that she believed she had Attention Deficit Hyperactivity Disorder. This diagnosis had been made by her doctor and had been treated on occasion, with mixed results, with stimulant medication. Sarah also exhibited difficulties in her interview with staying on task (by talking off topic and being distracted by the environment), fidgeting and regularly needing breaks, revealing symptoms consistent with Attention Deficit Hyperactivity Disorder. Sarah participated in two interviews, one with her alone, and one with her mother. The first interview lasted 40 minutes, while the second, with her mother, lasted approximately an hour and 20 minutes. Sarah said the variability of the interview times was due to her difficulties with attention that she sometimes experiences as unpredictable.

Fiona

Fiona was a sixteen year old high school student who was recruited through a disabilities association website. She had received counselling for social (with peers) and academic difficulties. She and her mother couldn’t describe the orientation a counselor took other than it was process-oriented and client-centered. She experienced some level of distress and struggled with her performance in a French immersion program. Consequently, at the time of the study, she was enrolled in an English-speaking program. The researcher received her psycho-educational assessment that had been conducted in 2006. She was administered the Wechsler Intelligence Scale for Children, the Woodcock-Johnson Tests of Achievement, and the Developmental Test of visual-motor
integration. The assessor used the General Abilities Score of the Wechsler, as the verbal and perpetual reasoning were not significantly different. Her score was at the 81st percentile, within the high average range. She scored at the high average range, at the 79th percentile, in verbal reasoning. Her perceptual reasoning was at the 79th percentile, within the high average range. However, her working memory was at the 18th percentile, in the low average range. According to the assessor, this index measures the ability to sustain attention, concentration and exert mental control. Her processing speed was at the 13th percentile, at the low average range. According to the assessor, this measures the ability to process visually perceived non-verbal information quickly, with rapid eye-hand coordination being components. Her Woodcock-Johnson scores indicated that her spelling achievement was in the low average range and her writing fluency fell in the average range. As there was a 29 point difference between her verbal comprehension and her processing speed, she was assessed to have a learning disability, with problems specifically in processing speed and working memory. A previous assessment conducted in 1991 had left the assessor with the conclusion that the participant had both reading and writing problems. Fiona participated in one interview alone and one with her mother. She wrote a paragraph to include in the study.

Mary

Mary was a forty-six year old art school student who was recruited through a local college. In the last six years she had received art therapy, play therapy, and process-oriented client-centered therapy. She had great academic struggles in high school and issues with family dynamics that she chose to address later in life. She chose to return to college as a mature student. She was diagnosed with and was on medication for both
bipolar disorder and ADHD. The only documentation that the researcher could get was her Verification of Permanent Disability Form. It stated that she had poor concentration, limited ability to tolerate noise and crowds, was prone to stress and anxiety, and took longer than usual to understand and process information. It also concluded that her disability was moderately severe and that she would respond to accommodation of disabilities. At college she took the Assessment of Learning Styles and Personal Circumstances which described her as an auditory and kinesthetic learner with average stress management skills and poor time management skills. She believed her learning style affected her counselling process. She also reported difficulty with reading and writing; she was an art student, but it took her longer to write essays and read. She participated in one interview but was unable to find anybody suitable to help her in the second interview or to contribute a paragraph as she was feeling overly burdened by the demands of college.

Rachel

Rachel was a 32-year-old student at University. The participant gave a copy of her Verification of Disability Form from her university. It said that she had Attention Deficit/Hyperactivity Disorder: inattentive type (Moderate). Her symptoms that she experienced were chronic difficulty with mental activation, organizational capacity, task maintenance, ability to concentrate on reading and distractibility. She was also taking medication for depression. She received counselling from the university about her struggles with mood and received Cognitive Behavioral therapy. She believed many of her problems were attached to her learning disability, yet her counselor, as far as Rachel was concerned, did not address these issues. Rachel believed the counselor was
inexperienced in working with clients with ADHD. She was not interested in the second interview because she believed that she would not be able to find anybody who knew her well enough to support her in the second interview. But she did contribute a paragraph to this thesis.

*Mark*

Mark was a fourteen year old male student who went to a special school for learning disabilities. He had Neurofibromatosis, a rare genetic disorder that causes tumors around neurological tissue. The researcher was given the score sheets for Gray Oral Reading test, the Gates-MacGintie Reading tests and the Wide Range Achievement Test 4, which the school had used for his assessment. According to the educational profile from his school he had weakness in visual motor integration, visual tracking, ADHD, perseveration and a speech disorder (he was in speech therapy at the time of the research interview). The skill testing at the school indicated that he had average spelling skills, below average oral reading skills and high average reading comprehension. A report from his school stated he had a reading and writing disability. He had been diagnosed as having ADHD by his family doctor and had been prescribed the medication Concerta for his ADHD symptoms. He received Systematic Desensitization counselling for phobia of bees over the period of a number of months, along with a process-oriented client-centered counselling. His mother and father attended some of the counselling sessions. His mother and father were divorced. His mother had remarried. For the second interview the researcher was able to meet with the participant and both his mother and father, who supported the participant in retrieving important information for the study. He contributed a paragraph to the thesis.
Nicole

Nicole was a twenty-two year old female student who was recruited from a local college. She was in a motor vehicle accident five years ago that resulted in a head injury associated with her learning disabilities. The researcher received a letter from her college outlining her disability. She had diagnosed disabilities in information processing, memory, word retrieval and attention. In addition she had difficulties with verbal output and takes time to organize and produce her words orally and on paper. She also has received support for organizational skills. For the five years preceding this study, she had received counselling, paid for by ICBC, as a consequence of the car accident. She had counselling for issues with mood, anxiety, relationships, school and career. She had process-oriented counselling that included art therapy, play therapy and Two-Chair Gestalt exercises. She participated in two interviews for this study; the second session was with a close friend who had known her since she had the head injury. When describing why she wanted him to help with the interview, she stated that he had been excellent at helping her retrieve words and ideas that she had difficulty expressing.

Ted

Ted was a thirty-three year old male university student recruited through the disabilities centre at his university. He had been a forestry worker and then a paramedic for the last 8 years. He was taking courses at the university as prerequisites to get into medical school. The researcher received his full psycho-educational assessment. This participant was given the Wechsler Adult Intelligence scale (WAIS-III), the Woodcock-Johnson, Revised Cognitive Battery (WJ-R), the Peabody Picture Vocabulary test, the Wechsler Memory Scale, the SCAN-A: A Test of Auditory Processing Disorders, the
Lindmood Auditory Conceptualization test (LAC), the Wisconsin Card Sorting Test (WCST), the Beery-Buktenica Developmental Test of Visual-Motor Integration, the Woodcock Johnson-revised Achievement Battery of Selected Subtests and the Wide Range Achievement Test (Arithmetic and Spelling subcomponents). The WAIS-III indicated that he had an IQ score of 125, in the superior range. His Verbal IQ was 114 (high average) and performance IQ was 136 (very superior). There was therefore a 22 point difference between verbal IQ and performance IQ scores. On the sub-sections, he had a noticeable difference between the perceptual organization factor at the 99th percentile, but the processing speed index was at the 66th percentile and working memory score at the 61st percentile. This indicated his perceptual organization was very superior, reflecting an ability for spatial reasoning, visualization and simultaneous processing. His processing speed factor indicated he had difficulty with psychomotor processing and mental speed. This was influenced by his poor fine-motor coordination, as indicated by the Visual-Motor test. His verbal profile was also significant, with his Verbal comprehension, at 86th percentile, while his working memory factor index was at the 61st percentile, an indication that his auditory memory might be compromised. He had a Verbal vocabulary score in the 63rd percentile, indicating a relative problem with verbal comprehension, which the assessor noticed as a tendency to produce more concrete, rather than abstract answers to questions. However, the Peabody Picture Vocabulary indicted that he had a 74th percentile (high average) ability in receptive vocabulary. Overall, though, in a more absolute sense, the assessor reported that he had difficulty with comprehension of vocabulary throughout the testing. He was administered the Wechsler Memory scale to further evaluate his working memory. This indicated that his
visual memory was in the superior range, but his auditory memory was in the average range. This may have been because of attention difficulties in one task. The SCAN-A and the LAC, that were administered to assess for auditory processing problems, showed that he may have had problems with auditory discrimination and auditory closure difficulties. He was given the WCST test as a measure of executive functioning. This test showed perseverative behavior, which indicated mild perseveration. The (WJ-R) was used to assess achievement, with the participant’s scores in the average to superior range. He had difficulty with word attack and spelling, relative to other scores, indicting there were problems encoding and decoding words. Overall, while he could comprehend small passages and write single sentences, he had difficulty when the tasks became more complex. These were all indicative of a problem with his working memory, poor metacognitive strategies, and insufficient focused attention. In summary, the clinical test scores indicated evidence of Attention Deficit Disorder, mild language processing and auditory memory problems, but with exceptional abilities in spatial reasoning, visualization and processing. He had counselling during his high school years due to his frustrations at school and with family relationships. However, the first counselor he had was not, he believed, particularly helpful as she was not aware of how his learning problems were at the root of his problems with mood and oppositional behavior. After receiving an assessment at a university college, this participant was given counselling by an Adaptive Learning Specialist, a consultant psychologist for the university college. He reported that this counselling helped his mood, self confidence and learning capacity. Ted participated in two interviews. The second one included his mother as a helper. In addition, he contributed a written paragraph to the thesis.
John

John was a seventeen year old high school student who was recruited from a disabilities association. He was assessed using the Connors Rating scales for ADHD and diagnosed with Attention Deficit Hyperactivity Disorder (inattentive type), but reported that he did not have many problems concentrating during counselling sessions, unlike Sarah and Fiona. His counselling was sometimes alone and sometimes with his mother, and related to academic issues and his relationship with his parents. He had counselling with a child psychologist who had experience working with students with ADHD. He participated in two short interviews for this study, but did not do the second extra exercise (the sculpture/pose) as he was “in a rush”. John was willing to participate in the first interview, but not able to come up with detailed answers to the researcher’s questions. There was a lack of depth of insight and concentration that made it difficult for the interview to be more than 30 minutes. In the second interview, there was noted antagonism between mother and son during the second interview that resulted in the second interview only being 20 minutes long. John and his mother had ongoing issues that warranted further exploration and made progress during the second interview difficult. The researcher offered a referral to a family therapist for their further work. The participant was not interested in giving a paragraph for contribution to the thesis.

Participants in Summary

As a whole the goal of gathering a wide range of participants was a success. The sample had a wide range of ages, disabilities and personal concerns (that had been addressed in the therapeutic process). The etiology of the disabilities was a surprise. The researcher was able to find two participants who had learning disabilities that came about
due to some kind of neurological change; Mark had Neurofibromatosis and Nicole had
brain injury due to a car accident.

Data Collection

Data collection took approximately one and a half years, starting in November
2006. Data collection was concurrent with data analysis, according to the method of
constant comparison (Boeije, 2002; Corbin & Strauss, 1990; Lincoln & Guba, 1985).

As discussed earlier, there were four interviews in total (see figure 1); one
interview for screening participants, two interviews for data collection to gather
information for the research questions (each included an optional exercise), and one for a
member check. The two interviews to gather information about the research questions
consisted of interviews with individuals, and follow-up interviews with dyads, if
necessary. In addition the participants were offered an opportunity to write a paragraph,
to be included verbatim in the thesis.

Interviews about the Research Questions

Two types of semi-structured interviews were conducted for data collection (see
interview protocols in appendices 8 & 9). A type one interview was with the participant
only. An optional drawing exercise depicting the relationship between client and therapist
was used during this phase. This was implemented when researcher and interviewee
thought that additional information might be gathered using this strategy.

A type two interview consisted of an interview with a dyad. This interview was
conducted with the participant only if there was a mutual agreement, between participant
and researcher, that the participant needed support to express ideas that were unclear or
missing. The significant other acted as a translator (C. D. Murray & Wynne, 2001;
Twinn, 1997). However, unlike a translation, the participant was able to rely on another person to help scaffold his or her expression and thoughts. These support persons were selected because they knew the individual in sufficient depth that they could offer words and ideas that the participant couldn’t retrieve. Moreover, participants were asked to pick a significant other who would be satisfied with facilitating the participant’s expression rather than being focused on adding his or her own opinion. During the type two interview the researcher checked in with the participant about all ideas that the significant other brought up, to see if these were ideas that were in agreement with the participant’s experience about their counselling process. The type two interviews were also used to add depth to the data, both by using additional questions derived from the first transcript and by including an optional exercise where the dyads created a sculpture / pose to portray the relationship between therapist and client. These optional exercises were offered to all participants but only some participants wanted to participate in the type two interview (see table 3).

Table 3

List of participants’ contributions

<table>
<thead>
<tr>
<th>Participant</th>
<th>Interview 1</th>
<th>Picture</th>
<th>Interview 2</th>
<th>Pose</th>
<th>Paragraph</th>
<th>Member Check</th>
</tr>
</thead>
<tbody>
<tr>
<td>Owen</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Tyra</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Sarah</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Fiona</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Mary</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Rachel</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td></td>
</tr>
<tr>
<td>Mark</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Nicole</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td></td>
</tr>
<tr>
<td>Ted</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>John</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
</tbody>
</table>
Interview Protocol

A pilot interview was conducted. This was checked for quality by the researcher's adviser, Dr. Deborah Butler (a professor in education, who has conducted qualitative interview studies), to check for leading questions, clarity and understanding of the questions, adequate exploration of the participant’s understanding around each question.

Ultimately, four specific questions were asked that were focused on providing data around the research question (Foddy, 1993) (see appendix 8). These were:

What helped you the most to be understood by your counselor?
What, for you, made the process of counselling harder or easier?
What helped you compensate for your disability and allowed you work through your problems during counselling?
How would you like the counselling process to have been different?

Different lengths of time were spent on each of the questions, depending on the information gathered from previous participants. The questions sometimes were reworded to help the client understand the meaning of the questions.

Each participant was asked at the end of each interview if there was anything missing that they still wanted to say.

Additional exercise.

Two additional exercises were used to enhance the participants’ expression of their relationship with a counselor. These were employed if the researcher and participant thought that these processes might be useful in extracting additional information.
During the type one interview the participant was asked to draw symbolically how they saw themselves in relation to a counselor. This method was a reversal of an exercise used for counselor supervision; it is the client not the counselor that does the drawing (Amundson, 1988). The drawings were sometimes more symbolic and sometimes more of a realistic description of the client-counselor relationship. A copy of the drawing was kept for reference. Questions were asked to probe the meaning ascribed to the drawing by the participant:

Describe what this drawing is about.

What made you decide to draw the relationship that way?

What could you change about the drawing to show the relationship as you would prefer to be?

Describe how that would change things for you.

Additional questions about the relationships between parts in the picture, such as location, size shape and color, were added where appropriate to prompt the participants in talking about their meaning. The analysis of the exercise was based on answers to the questions that were asked about the drawing.

During the type two interview, the participant was asked to form a sculpture, with the help of the significant other, to symbolize his or her relationship with the counselor. This approach has been used effectively by others in expressing different aspects of family relations (Marchetti-Mercer & Cleaver, 2000). They were asked to create a sculpture to represent the client-counselor relationship by putting themselves, as the client, and the significant other as the counselor, in specific poses and positions. A photo
was taken of the pose. Again, questions were asked to check the meaning ascribed to the pose by the participant:

   Describe what this pose means to you.

   What made you decide to pose yourself and your significant other in this way?

   In what way could you change the sculpture to show the relationship as you would like it to be?

   Describe how that would change things for you.

After completion of the interviews the participants were asked if the interviews brought up any particular issues that they wish to explore with another counselor. If so, they were given a list of possible referrals.

   Additional questions for interviews.

   There were two kinds of additional questions. One kind of question was used to enhance the communication between the researcher and the participant. The other kind of question was used to add to the data using the constant comparison technique.

   Some additional questions were used to improve the communication in the interviews (Kvale, 1996): questions to structure the interview, questions to clarify what was said, interpretive questions (to clarify the researcher's concept of the clients’ meaning), iterative questions (to return to matters previously raised in order to ascertain the consistency of previous answers) and follow up questions (to encourage the participants to connect thoughts together and uncover missing elements when the researcher was unclear about how things fit together).

   Other additional questions were added in accordance with the constant comparison technique to add to the data (see appendix 9). These were created using the
data gathered as each interview was reviewed. The additional questions originated with ideas that had been previously brought up by other participants or a significant other. Therefore, these questions were used to test emerging understandings, systematically across cases. These questions were used to deepen and widen the range of data that was recovered from the participants and were meant as follow-up questions to the original four questions. Certain topics were discussed more than others, depending on the level of interest that a participant showed in each question. The additional questions were asked when the participant being interviewed brought subject matter related to these questions. Participants were told that previous participants had asked for or talked about a particular issues and the researcher asked if they had anything to add on that particular subject. No extra questions were added during the additional exercises.

Participant’s Final Paragraph

A major goal in this thesis was that participants were offered a voice. Thus, they were also offered the opportunity to produce a piece of prose. The prose was included in this thesis uncensored; the quality of spelling, grammar, and handwriting did not affect how their contribution was valued. The instructions, which were emailed to them, were: “write a paragraph of prose approximately 100 words long that describes, given understanding of your learning difficulties, and what was discussed in the interview, your experience in counselling. You have the option of having this prose be dictated to another for transcription or writing the paragraph yourself.” The inclusion of the prose gave the participants another opportunity to express how their learning difficulties could affect their counselling experiences. These paragraphs are included at the end of the results section in the thesis.
Member Check

Member checks were done by phone or email questionnaire (Lincoln & Guba, 1985). Special caution was made with respect to questions raised by Sandelowski (1993) about the member validation being a threat to trustworthiness. Problems that may threaten the member check’s trustworthiness are: input leading to a new story, instead of correction of the memories of what they said in the initial interview; participants not understanding the complex synthesis of information retrieved from transcripts; and participants being concerned about approval from the researcher. Individual member checks were undertaken, rather than a group member check, due to the expected diversity in participants’ experiences, and the possible expression of sensitive issues in the check, due to the personal nature of the counselling relationship. After all the interviews were complete, the participants were emailed a table containing a description of the codes, related to each question from which they originated and instructions about how to review the table. The table was written in layman’s language and in a way that didn’t identify who said what. The email asked them to add information they thought was missed and point out information they did not agree with. They were offered an opportunity to fill in another blank copy of the table, write their reply in the same table in a different color font, write a short paragraph in an email or discuss the results over the phone. Owen, Fiona and Mary simply emailed a short one or two sentence answer to their review of the table. Their replies can be seen at the end of the results section. A reply email was sent asking if they would like a telephone call to describe the table or discuss their ideas in greater depth, given the short length of their reply. Each of these three participants said that they felt that this wasn’t necessary and they had said all they wanted to say. The
remaining participants were contacted again, both by phone and email asking them again how they would like to respond to the table. Tyra, Sarah, Ted and John responded in more detail. Tyra, using the reviewing tools in Microsoft Word, wrote in the table, using a different color. The other three participants chose to give their feedback in a phone call. In each of these three member checks, participants had already read the table before the phone call took place. The researcher then read over the parts of each table that the participant said they did not understand and then participants responded verbally to what they had read or heard from the researcher. The researcher then took brief notes, underlining the parts of the table that applied to the participant. The comments of all four participants that gave detailed feedback were added to the themes in the results section of this thesis. Three participants did not complete a member check: one cited busyness in their lives as the reason for not being able to contribute, one said they would get back to the researcher and didn’t and one did not reply to any emails. As the table for the member check included information from all the participants some participants added new information in the member checks, in addition to confirming what they had already added. New information, gathered during the member checks, was highlighted as such in the results section. On completion of the member check, all individuals that participated were asked if participation brought up any issues that needed to exploration. If desired, a list of referrals was provided to where they could find additional support.

*Recording of the Research Process*

During the study the researcher kept two kinds of records of the procedure of the study; a Research Journal and Analysis Notes. The Research Journal documented the conceptualization of the problem, thoughts about ethics, aspirations for the study,
highlights and disappointments in the process of developing the study, information that I
gathered about the participants and the process of finding the participants. Analysis
Notes contained a record of the analysis of the data and compilation of tables presented in
the results section of this thesis.

Recording of the Data

All of the interviews were recorded using a digital audio recorder, downloaded to
the computer to be stored on encrypted CD-Rom’s. The digital files that were gathered
from the interviews were transcribed. Four transcribers worked on the interviews. The
first transcriber (Ch) acted as an administrator that supervised all transcriptions except
those from Ted. This transcriber had two years of experience transcribing for a professor,
under supervised conditions before working on this project. The second (Hu) and third
(Ha) transcribers were colleagues of the first and had had at least one year of experience
transcribing for other professors before participation in this project. Each transcribed two
interviews. The first three transcribers were Masters Students at the University of British
Columbia in Counselling Psychology. The administrative transcriber transcribed nine of
the transcripts and proofread another five. The recording from Ted was done in a noisy
room; consequently the first transcribers felt that they didn’t have sufficient experience to
create an accurate transcript. Consequently, I found a Ph.D. student (Co) who had
approximately 4 years of experience in transcribing to complete the final two transcripts.
Co. used a special program, Express Scribe, to slow down the recording so that it could
be accurately transcribed. The recording from Ted consequently had some missing
words. But, it was missing little, if any, of the meaning expressed by Ted during the
interview.
Each transcriber signed a confidentiality agreement (see appendix 10). The confidentiality agreement stated that the transcriber would not disclose any information learned from the tapes and would destroy any copies of the transcription after an electronic and paper copy of the transcription had been hand-delivered to me. I ensured that, when I delivered the tapes to the transcriber, there were no identifying marks on the tapes. Names that were recorded on the tapes were replaced with a letter in the transcripts. Transcriptions were kept in encrypted files on my personal computer, on an external hard drive (that was stored in a locked filing cabinet) and then transferred to CD-ROM (encrypted) for long-term storage. It was always stored without any identifying information. An encrypted Excel table was kept on a separate computer that linked participant number to identifying information. After the data analysis the file was stored in the filing cabinet, on a separate CD-ROM.

Data Coding

Process of Data-Gathering: Constant Comparative Method

The Constant Comparative method (Boeije, 2002; Corbin & Strauss, 1990; Eaves, 2001; Lincoln & Guba, 1985) was used to increase the depth and breadth of the data collection. In Constant Comparison, all of the data that has already been gathered and coded is compared to that which is currently being coded (see Figure 2).

The first participant, Owen, was selected using the sampling criteria described above. Then his type one interview was conducted and the sound recording was reviewed. Then, after the audio review, the type two interview was conducted. In this interview, the researcher asked the four standard questions and added questions to clarify information obtained from the first interview. The audio version of the interview was
reviewed to help the researcher choose the next participant for the study. In general, where a second interview was to be conducted, the review of the audio version was used to formulate the additional questions for subsequent interviews. The full analysis was not done immediately due to the lack of availability of the transcript. This strategy proved more effective than simply reading transcripts, as the researcher has dyslexia and found it easier to process the auditory version rather than written transcript. Each sound recording was reviewed at least two times, in order to come up with new questions for the next interview. Both the type one and type two interviews (if needed) were conducted for a given participant before the next participant was selected.

*Figure 2: Constant comparison with participants and data in interview type I and II*
The next participant was chosen based on information from the literature and information gathered from previous participants’ interviews. Each successive participant was selected to maximize the range of participant variables. Then the same kind of interview and analysis process occurred as was conducted for Owen: type one interview, review, type two interview, analysis. In the same fashion as the type two interview for the first participant, each time an interview was conducted, the researcher was able to use the additional information gathered to create and ask additional questions, where appropriate for the next interview. This greatly increased the scope and depth of the information that could be gathered.

Analyzing the Interview Data

Before coding each transcript, the researcher listened to the audio recording while reading. This helped the researcher to form an impression of each transcript as a whole, look for general themes, and identify potential problems with leading questions or the kind of input that was given by the significant others. This first review was used to write the research journal and gather questions to ask in subsequent interviews.

After all the transcripts were collected, the transcripts were analyzed in ATLAS.ti (Alexa & Zuell, 2000; La Pelle, 2004). Each transcript was assigned as a primary document in ATLAS.ti (given a ‘P’ or primary document number) and then coded. Each type one interview of a particular participant was coded before their type two interview. As coding proceeded on the first interview, internal comparisons were made within the interview to look at how quotes assigned similar coding differed or were the same. Likewise, codes from the type one and type two interviews were compared with each other. In addition, as more transcripts were coded, new interviews between participants
were compared. When interviews were compared, a greater depth of information was acquired, more patterns emerged, and the meaning of the data could be checked to make sure a significant other only added to what a participant had shared.

Three levels of analysis were produced. First, the researcher undertook coding of the transcripts so that each idea present in the interviews was given a code. As more examples of this idea were found in the transcripts, more quotes were assigned to each code. Second, these codes were organized into topic areas, to make the expanding list of codes more manageable and conceptually group them. Finally, the codes were organized into central themes, as the participants saw them, in the interviews. These levels of organization were recorded in the Atlas-ti analysis program.

For the first level of analysis, quotes were linked to codes (see table 4). Each code was a label for a group of quotes that all contained the same meaning. These codes arose from reading the transcripts, and looking for quotes that reflected a complete thought about the original research questions, or any additional questions that the researcher devised from listening to recordings of the interviews. New codes were added when units of meaning, inside the interview, did not fit any code that had already been created. The meaning of each code was encapsulated in a definition for the code. Some quotes were linked to more than one code, if they represented more than one idea. Ultimately, every interview was coded against the full set of codes; if a new code was created the researcher returned to apply the new code to previously coded interviews. This method was a computerized adaptation of methods that have gone before (Huberman & Miles, 1994; Knafl & Webster, 1988).
When new quotes were added, or codes were merged, the codes were adjusted as needed. Codes were merged with others either when two codes had accidently been created for the same idea or when codes had been created for very similar ideas that only had a few quotes each. For example, the codes “Include an individual in therapy that knows them well” and “Include a family member to help communicate” only had a few quotes each and were both about including an individual in therapy to help expression of ideas. Two codes were deleted because, on review, they did not have any relevance to the study of learning disabilities and counselling (these were Client directed education and Cross-cultural knowledge). Some of the codes were renamed, either because they did not accurately reflect the quotes that they contained, or because they did not accurately describe the idea they were trying to portray. Adjustments were made so that the coding more accurately reflected the content of the interviews.

As each successive participant was added, a comparison was made of the kinds of coding variations between different participants, as well as kinds of coding variations between the different types of interviews. This comparison enabled the researcher to see which codes were unique to particular participants or interviews and which codes were commonly found across a number of the participants. Comparison of different interviews of a given participant and interviews of different participants led to the discovery of new concepts and relations between the various codes. Consequently, new codes were added on review of previously coded interviews and new quotes were linked to codes. In contrast, on re-reading the researcher found the assignment codes did not accurately match the meaning intended, the assignment of quotes to codes were unlinked.
Table 4.

List of Codes

| Approach ineffective - Cognitive Behavioral therapy | Intervention that helps - drawing / diagrams to describe thoughts |
| Approach ineffective - solution-focused | Intervention that helps - drawing to relieve stress / free mind |
| Approach that helps - Bibliotherapy | Intervention that helps - feedback / paraphrasing |
| Approach that helps - EMDR | Intervention that helps - finding a solution that works |
| Approach that helps - experiential therapy | Intervention that helps - focus development |
| Approach that helps - family therapy | Intervention that helps - food available |
| Approach that helps - gestalt therapy | Intervention that helps - general questions |
| Approach that helps - non-verbal therapy | Intervention that helps - homework |
| Approach that helps - play therapy | Intervention that helps - mediation |
| Approach that helps - solution-focused therapy | Intervention that helps - medication |
| Approach the subject- can't start-stuck | Intervention that helps - metaphor |
| Client / Therapist Co-created Structure | Intervention that helps - Modality/ process to promote thinking |
| Client directed therapy - difficulty expressing needs | Intervention that helps - Movement in Session |
| Client directed therapy - express counselling needs | Intervention that helps - normalization |
| Client directed therapy - express learning style | Intervention that helps - Positive sessions |
| Client directed therapy - Helpful | Intervention that helps - provide options for solutions |
| Counselling more difficult because - having to face the issue | Intervention that helps - Question asking for clarification |
| Counselling more difficult because - felt that needed help to fix issue | Intervention that helps - questions or ideas reworded by therapist |
| Focusing - easy on the important stuff | Intervention that helps - questions that ask for meaning making |
| Focusing - optimal level of stimulation - from multiple modalities | Intervention that helps - reminder by counselor outside counselling session |
| Focusing in session - get back on task | Intervention that helps - role play |
| ADD/ADHD | Intervention that helps - stick in Memory a cognitive construct |
| Focusing in session - helps | Intervention that helps - strategies about learning disabilities discussed |
| Focusing in session - helps with - fidgeting/ sensory stimulation | Intervention that helps - summarize ideas to comment on a theme or gestalt |
| Focusing in session - hinders | Intervention that helps - systematic desensitization |
| Focusing in session - problems with | Intervention that helps - validation |
| Intervention that helps - changing beliefs by practice | Intervention that helps - visualization |
| Intervention that helps - diary | Intervention that helps - write notes with client |
| Intervention that helps - discuss clients interest as a vehicle to clients issues | Intervention that is ineffective - Metaphors |
| Intervention that helps - discussion about the purpose of an intervention | Intervention that is ineffective - questions multiple |
| Intervention that helps - discussion/assessment about learning style/ communication style/ thinking style | |
Intervention that is ineffective - worst case scenario
Intervention that is ineffective - written homework
Participant - comment about interview process
Participant - description of their LD
Participant - issues
Participant - lack of insight into LD affecting counselling
Participant - learning Style
Participant - learning style - detail oriented thinker
Participant - learning style - global thinker
Participant - learning style -circular thinker
Participant - learning style -Non Linear Thinker
Participant - learning style -Visual learner/thinker
Participant - personality
Participant - thinking style -thought Patterns
Participant - variable needs of the client
Participant - communication /expression style
Process of counselling - catharsis through expression
Process of counselling - change in thought patterns/ change in beliefs
Process of counselling - emotional processing forms beliefs
Safety - not open
Safety - power dynamics between therapist and client
Safety - privacy
Safety - safe Place
Safety - therapist sensitivity to client's willingness to talk about an issue
Safety - trust Building effective
Safety - wanting to be treated as normal
Sharing ideas - incomplete sharing of ideas
Sharing ideas - incomplete sharing of ideas- but sufficient for needs of client
Sharing ideas - incomplete sharing of ideas - insufficient for client
Sharing ideas - put it all on the Table
Sharing ideas - tip of the tongue
Sharing ideas - tip of the tongue resolving this
Situational Variables - continuity with same therapist/ environment
Situational Variables - environment - helps with counselling
Situational variables - environment - warm
Situational variables - environment that hinders
Situational variables - pre-session collecting ideas to share
Situational variables - pre-session helps therapy
Situational variables - pre-session hinders therapy
Situational variables - pre-session too much time to think before
Situational Variables - services for counselling LD needed - additional
Situational Variables - time of day
Structure - guides assessment for what has been done and goals for the future
Structure - in counselling wanted by client
Structure - options given to clients
Structure - options not too specific
Structure - process description - general to specific
Therapist - additional appointments available
Therapist - client relationship
Therapist - empathy - advanced
Therapist - empathy with Client
Therapist - empathy with client -lack of
Therapist - empowering
Therapist - equal partner with client
Therapist - experience / knowledge in counselling those with LD
Therapist - give space time -need additional sessions to process issue
Therapist - keeps client-centered on problem
Therapist - rigidity with approach
Therapist - role: agent of positive change
Therapist - safe confidante
Therapist - with a learning disability
Therapist Character - caring nature
Therapist Character - cold /distant
Therapist Character - disclosure of self
Therapist Character - genuineness
Therapist Character - genuineness- not
Therapist Character - openness - adapt
Therapist Character - optimistic
Therapist Character - openess - sharing of
therapeutic interventions to suit learning style
Therapist Character - openness - sharing of own learning style/thinking style
Therapist Character - patient
Therapist Character - Pigeon Holing - therapist
Therapist Character - respect for client
Therapist Character - unconditional positive regard of client
Therapist Character - warmth
Each interview was also reviewed numerous times, not only to ensure that each interview was coded against all codes, but also to allow for the researcher’s impression of each interview to change after interviewing additional participants. To keep track of these comparisons, ATLAS.ti was used to create tables of codes. These helped me cross-reference the codes and quotes against the interviews and participants, for the purpose of analysis. This meant that I could compare data in different ways: across codes, across names, across interviews and so on. Overall, the idea was to be immersed in the text over a number of readings (Tesch, 1990) and then to gather the information for analysis.

In the second level, after coding the first 11 interviews, the researcher started to organize the codes into topics (see Table 4). These topics were labeled according to different elements in the theory and practice of therapy. This was determined to be the best grouping at the time; it helped the researcher organize the codes along commonly discussed topics in research on counselling and help the researcher find the codes when coding. These topics were retained as a level of coding by keeping them as the first part of the name of each code, before a hyphen (see Table 5).

Finally, for the third level of analysis, the codes were grouped into themes (see Table 6). These were more detailed and representative descriptions of the subject areas that were discussed by the participants. The results were organized according to the themes because this reflected the pattern in which the participants expressed their ideas in the interviews.
Table 5.

List of topics and their definitions

**List of Topics**

**Approach effective/ ineffective** is a comprehensive theory that contains a view of human nature, a structure of personality a therapeutic process (therapeutic goals, therapist's role, client's experience and relationship between client/therapist) and application of the theory (possible techniques and procedures).

**Client directed therapy** is the ability of the client to express their needs for and choose their own direction in therapy, based on their needs and the available options provided by the therapist.

**Counselling more difficult** are miscellaneous elements that made therapy more difficult that did not fit in any other topic area.

**Focusing in session** are those areas to do with the participant being able to focus in the session, including problems with focusing, help for focusing.

**Intervention that helps** is a particular activity that the counselor carries out or gives the client to do which helps the client in counselling.

**Process of counselling** is the participant’s idea of what happens through the course of counselling.

**Safety** is the elements in therapy that helped the participants feel comfortable enough to share themselves with the therapist.

**Sharing ideas** is the codes related to how the participant shared ideas, the struggles with sharing their ideas, and the desired process for sharing ideas.

**Situational variables** are the elements that happened before therapy or in therapy or in therapy that created the circumstances for therapy (included environment, pre-session variables, availability of service).

**Structure** is the creation of a particular organization of the therapeutic process, hopefully negotiated between therapist and client, as per client-directed therapy.

**Therapist** is the actions or elements that the therapist is responsible for in therapy, other than interventions or approach.

**Therapist’s character** is a subset of the therapist topic that is related to the personality or character of the therapist.
Table 6.

List of themes and their definitions

**List of Themes**

**Preparation for therapy** is the events, activities or processes that happen before the session, which prepares the client for therapy.

**Body/mind needs for work** are the conditions that ensure that the mind and body are at their optimum functioning and ready for the therapeutic process. These elements include environmental, time of day, food, medication.

**Therapist express understanding** is the activities, carried out by the therapist, that the participant thinks helped the therapist to understand the client's point of view and the client understand the therapist's point of view.

**Client feels known** is the client’s perception that the therapist intuitively understands what they are meaning to say, even if they can’t completely say it, and know how the client wishes to precede, even if the client can’t completely express it in words.

**Safety / comfort** are additional elements, other than the therapist expressing their understanding of the client and client feeling known, which enable the client to feel safe enough and comfortable enough to share their inner most thoughts.

**Client /therapist co-created structure** is the negotiated choice of interventions, supports to the clients thinking, timing for therapist input, communication style, assessment process of the progression of counselling, such that the client feels that they have a process of therapy which works for them.

**Change process** includes the participant's understanding of what changes may or may not happen during therapy.

**Approach to therapy** is the comprehensive theory that contains a view of human nature, a structure of personality a therapeutic process (therapeutic goals, therapist's role, client's experience and relationship between client/therapist) and the application of the theory (possible techniques and procedures). This is also a topic in therapy.

**Modality/process to promote thinking** is a modality/process that the therapist introduces in order to help the client think through their issue, which caters to the particular learning needs of the client.

**Focusing/on task** is the ability for the client to stay with the therapeutic process, so that they can progress and the support that helps this occur. This is also a topic in therapy.

**Therapist supported thinking** is the therapist’s support, which helps the client bring clarity to their client’s thought processes, needed when their clients are challenged by problems with their learning style.

**Finding opportunities for therapy** are the additional opportunities for the client to work on their issue with those that know how to work with a particular with particular learning challenges.
As described earlier, the researcher kept an analysis journal that recorded addition of codes, modification of code names, merging of codes (when code names were duplicated or code meanings could be expanded), creation / re-creation of groupings of codes and the definition of the codes. In addition, information was recorded in the journal that emerged from using the active interview technique (Holstein & Gubrium, 2004). Information was recorded about how participants expressed their ideas (particular difficulties during the session with communication or particular needs to express information in session - examples: learning needs in session, relations with counselor of significant other, drawing expression added to expression, pose added to client’s expression). Additional data was gathered about the circumstances that surrounded the interview, as these could be compared to the participants’ experiences in counselling. How comments were said portrayed something of the difficulties that the person has in communicating in an interview session, which is a process similar to that of counselling. The circumstances of the interview demonstrated some of the preferred conditions for therapy that were expressed by the participant in the interviews. These additional data were used to support the participant’s view of their experience in therapy. How the participant talked and the circumstances surrounding the interview were compared to their view of their capacities to communicate and their needs in the counselling session.

Two sets of displays (Huberman & Miles, 1994) were created to further organize the data: a set of tables and a set of networks. The tables were created in Excel (then imported into Microsoft word tables). These showed which participants talked about each code and how many times each participant talked about a code (labeled as Participant by Code) and are interpreted in the results section to consider how ideas were stressed or
expressed by different participants. The networks, one for each theme, displayed the relationships between their codes and sub codes (labeled as the Network for a Theme). These tables are designed to show patterns and relationships among the participants and the ideas they expressed. Finally, when selecting quotes to include in the results, these were labeled so that they could be tracked back to the original documents. For example, the reference “Fiona int 1, line 644:646” signifies that the participant, Fiona, in her first interview (her type 1 interview), said this quote between line 644 and 646 in the transcript.

The complexity, breadth and depth of the information gathered in the interviews made it challenging to design a process to represent the participants’ ideas clearly and concisely. Three levels of analysis were used along with two different kinds of displays. Each element in the analysis and presentation of results was carefully chosen to balance the need to represent the data in a way that could be clearly understood, with the requirement of faithfully representing the participants’ experiences in counselling.

Trustworthiness and Assumptions

Assumptions

As a person with dyslexia, that worked with individuals with learning disabilities and who experienced the counselling process, I had a vested interest in the success of this study. I have lived with the day-to-day difficulties of having dyslexia and have had two years of counselling related to that disability. I worked as an educational assistant with those that have learning disabilities and I experienced the day-to-day social and emotional difficulties of my students. I was aware of their needs for appropriate counselling practices. It is not only important to me that the participants expressed their
desires for the counselling process, but that individuals with learning disabilities, as a whole, have their needs met in the counselling process.

So, there were certain assumptions that I brought to this research project that may have affected its outcome. First, I assumed that through the use of the constant comparison method, which helped me choose participants and follow up questions, this research project, represented many of the significant issues that face learning disabled population in counselling. So, the participants needed to have clear insight as to what helps them in counselling and how they might like things to be different. Also, it was assumed this interview process would enable the participants to portray a true representation of their experience in counselling. Therefore, I must assume that my clients, many of whom have expressive, receptive, social perception, and memory problems, were supported through the interview process sufficiently that they had their experience adequately understood and recorded. Second, I assumed that those whose learning disabilities indeed experience specific difficulties with counselling that are different to those of the general population. Specific research into counselling individuals with learning disabilities was only relevant to the extent that their needs and experiences may be different in the counselling process than the general population and that the counselling process can be tailored to provide for those needs and experiences.

**Trustworthiness**

To ensure that my expectations to not interfere with the accurate recording of my participant’s experiences I ensured that the trustworthiness of the study was addressed (Lincoln & Guba, 1986; Sandelowski, 1986, 1993; Shenton, 2004). The credibility of my study was supported by: using well-established research methods (citations given above),
participants with diagnosed learning disabilities and deficits (as assessed by a psychologist or doctor), my familiarity with the subject matter (a learning disability, experience working with the learning disabled population and my experiences in counselling), triangulation (field and research notes, multiple types of interviews, a member check, and constant comparison) and peer scrutiny (two supervisors and a thesis committee). As my study used constant comparative techniques to create a depth of data retrieval, and included participants with a wide variety of cognitive deficits, ages, life experiences, and personal issues, I believe my study was able to represent, in significant depth, many of the issues faced by those that have learning disabilities in counselling.

There was limited transferability planned, due to the number of participants in the study and the methods used. However, detailed description of my personal background, background of my participants, methods used, circumstances surrounding data collection and data analysis procedures might provide others with an understanding of how the results might be transferable. The dependability of my study was addressed by describing the methodology, the process of data-gathering, and my own appraisal of the effectiveness in answering the research questions. Finally, confirmability was addressed to the extent that transcripts, original tapes, descriptions and records of coding procedures, a research journal and a computer database (containing the analysis of the data) were all collected, stored and made available for anyone to check.

In summary, considering the wide range of backgrounds of the participants, the methodology used to gather the data and the care taken to demonstrate the trustworthiness of the data, the results may be considered a useful representation of the experience of a group of individuals with particular learning disabilities. Great care was
taken to accurately represent the experience of the participants in this study. The results
demonstrate the complexity of the participants’ experiences and the flexibility of the
processes required to gather the information present in this study.
CHAPTER 4

Results

Introduction

As stated earlier, this study was designed to record the experience of individuals with particular disabilities in the counselling process, in order to increase awareness of the existence and effect of possible barriers and of effective supports in their counselling process. It is hoped that by exploring the kinds of preferences and needs these participants have in their counselling process, the researcher will uncover some issues that might warrant further exploration in research.

The results were divided into three sections, results from the thematic analysis, participant paragraphs and member checks. The systematic analysis derived from data gathered from the sixteen interviews covering the four research questions, additional questions and alternate exercises. The participant paragraphs were included as a way for participants to add their ideas, unedited, about their counselling process. Finally, the member checks were taken to assess how accurately the thematic analysis represented the ideas of the participants. For the most part, data from the member checks were incorporated inside the results from the thematic analysis, but general comments about the participants’ agreement or disagreement with the data were entered in a separate section. The researcher took care to try to represent the ideas of the participants as clearly as possible.

Thematic Analysis

As described earlier, there was a comprehensive organization of the data from the transcripts during the analysis process, with three levels of analysis. First, codes were
created from quotes in the text, then these codes were subdivided into topic areas and then they were divided according to the twelve themes. These data were then organized in to displays, for inclusion in the results (Huberman & Miles, 1994). These displays included tables and networks described what was gathered from interviews. The Participant by Code tables showed which participants discussed which codes. Some codes had quotes from all participants while other codes only had quotes from one participant. The relevance of the patterns of codes was discussed in the results. The networks gave a graphical representation of how the different codes related to each other.

In the results reported here, I present findings related to the twelve themes ultimately identified from the data (level three analyses). For each theme, the patterns of codes and which participants talked about which issue will be discussed. If meaningful, the number of quotes for each issue and the number of codes for each issue will also be included. Note that, in constructing these summaries, notes recorded in the research journal, were used to help describe the pattern of codes. Specific quotes will also be included to exemplify the observations made about the participants’ counselling process.

_Preparation for Therapy_

During the interviews, a number of participants talked about the different things that happened before the therapy session that either helped or hindered them in preparing for therapy. Therefore, “Preparation for therapy” was identified as a theme in the participants’ comments (see table 7 and Figure 3). As seen in the data displays (Table 7 and Figure 3), participants talked about the different precursors to therapy that made it easier or harder to have a good session. Some of these were expressed by more than one participant; others discussed by only one participant a number of times (see Table 7).
Overall, in the theme *Preparation for therapy* there were a number of elements that happened between sessions that made a difference in sessions and some of these elements overlapped with other themes.

*Table 7.*

**Participants’ preparation for therapy - code by participant**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Owen</th>
<th>Lyra</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preparation for Therapy</td>
<td>Codes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational variables - pre-session helps therapy</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational variables - pre-session hinders therapy</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational variables - pre-session too much time to think before</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention that helps - reminded by counselor outside counselling session</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>2</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>2</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Figure 3: *Participants’ preparation for therapy - network*

Comparatively this theme, *Preparation for Therapy*, occupied only a small amount of the client’s conversations with the researcher (only five participants had something to say and there were only 18 quotes for this theme). The two codes with
feedback from the most participants, *Situational Variables - Pre-session – helps therapy* and *Pre-session- hinders therapy* contained a variety of different ideas about what helped and hindered therapy. These codes were discussed together because the elements that the participants’ reported that hindered therapy pointed to what they would have liked instead or what they believed would help. These codes appeared to be the consequence of having to manage a life affected by cognitive deficits.

Mark (Pa), a fourteen year old at a special school for individuals with learning disabilities and his mother (M) talked about the difficulties of fitting therapy into a busy schedule. He had at least 3 appointments a week related to support for his learning disability, which made it difficult to prepare for therapy.

**Int** Did you guys talk about things before you went into the session? Or prepare?

**M** Not really. It was more, it was, I mean at that time, and now, I’m always running around from place to place. It’s like geez, it’s like, I have to just try to slow it down a little, but it was hard, because you know, I’d have to take off time from work, and get him, get him to the counselling session, go through that, and then get him to the next place, or what-it was always difficult and parking was difficult and it was very stressful for me to get him to the sessions.

**Int** Mm. so there was a bunch of busyness of life that kind of--

**M** Yes.

**Int** --that made it a bit of a rush.
M And I think it can, I don’t know if it so much affected him, but um, like even now with this speech therapy I have to pick him up and bring him like way over on the other side of town to get him to that--

Int Ok.

M --and fighting traffic and stuff. It’s just really, very, very hard when you have somebody who has some problems to go to all the specialists--

Int Yeah.

M --and just to deal with traffic, parking, just all the stuff. It adds up. They’re called, in stress research, it’s called daily hassles.

Int Ok.

M And those things can actually add up.

(Mark, int 2, 229:240)

Mark’s mother reported it would have helped to know how much commitment it took, in order to schedule the time necessary to make the most of the opportunity for therapy.

M I think exactly that. You know, knowing that it would take a certain amount of time. Knowing that it wasn’t just the time in the session… Knowing that there should be time for reflection, and anticipation of the next one, or if I had to do it over again, actually I think I would do something with my work hours to make them different, and not everybody has that option.

Int Yeah, yeah.

M You know?

Int Mm hmm.
M But it was just the stress of being gone in the late afternoons from a job I knew that I shouldn’t be gone from, it was just pretty bad, um…

Int So other things were getting in the way? Did you feel that you’re mom was a little stressed?

Pa Mm hmm.

Int And busy?

Pa Yup.

(Fiona, int 2, 513)

Fiona, two years older than Mark, also talked about the challenge of getting to sessions. She led a busy life as she was studying hard, with tutoring to keep her marks up and many other responsibilities outside school. She spent much of her time working towards deadlines, with schoolwork taking longer than it did for her friends. She often felt pressured for time.

Pa Yeah. Like, just knowing that I won’t be late. (laugh). I hate being late (laugh), so...

(Fiona, int 2, 513)

Having help from her mother, at least to get to the session on time, helped her to be more focused on the session itself.

Pa Uhh, I don’t think so (laugh), I don’t know. Um, just drive me there, I guess (laugh).

(Fiona, int 2, 503)

Mary and John both talked about the difficulty of being tired. Mary, an adult, was busy taking courses, working and attending counselling.
Pa And not picking a day when you’re tired.

Int Yeah.

Pa Well, that’s ideal world, right?

(Mary, int 1, 615:618)

John had a very busy social life, and many struggles between him and his mother. He spent a lot of time outside the house. Much of the friction was to do with the lack of motivation John had at school, which he attributed to his ADHD. Therefore, he also felt tired. But, his quote was coded under *Focusing in session – hinders*, as his tiredness affected his ability to focus in therapy.

The busyness of the clients was very apparent. The nature of their lives lead to the participants feeling rushed and tired. Their difficulties with life challenges were sometimes because of the struggles with their disabilities and sometimes due to life issues.

Some participants talked about how they liked having some way of gathering information from outside their lives to bring to the therapy session (coded under the theme *Modality/process to promote thinking*). However, this might not always be the best approach. Mark, who had difficulties with verbal expression and ADHD, discussed how too much discussion outside the therapy session might be a problem (*Situational variables – pre-session too much time to think before*). Giving himself too much time to think about his session might get him anxious about the phobia that he was addressing in his sessions. While his comment was confusing at the start, after both the researcher and mother interpreted the comment, Mark confirmed that this is what he meant.
While Mark didn’t want to think about his phobia between sessions, he did do homework, in the form of desensitization experiences.

Nicole, who had verbal expression problems, memory problems and processing speed difficulties, felt that she needed reminders during the week. She talked during the session about doing homework and trying to keep a diary, but she often had difficulty
completing these tasks (see *Intervention that helps-diary* and *Intervention that helps – homework* codes). She wanted some help to remember to do these as she felt her poor memory was getting in the way of completing these tasks.

Pa Yeah, I was thinking maybe they could call to see how, um, I don’t know, remember how you had to write down something in your journal or something, but I don’t know if that would be--

Int Maybe just once?

Pa Yeah.

Int Yeah? “How are you doing with that journal writing? How’s it going?”

Pa Yeah.

(Nicole, int 1, 319:323)

This was prompted as Nicole had described earlier that her counselor’s secretary does phone to remind her of sessions.

Pa Um, my counselor also um, her office, like the secretary, they call me the day before the appointment just to confirm. I just find that very helpful because it reminds me of it, because I write it down, but sometimes I-so I think that’s a very good thing that they do. They just call me to remind me, kind of.

Int So a call to remind you of your counselling session.

Pa Yes.

(Nicole, int 1, 313:315)

Reminders for Nicole were helpful, as she had difficulty remembering things if she didn’t write them down. During the session with her counselor, Nicole used her Palm Pilot to
write down her appointment and said that she needed reminders in order to be able to keep appointments.

Two participants talked about this theme in their member checks. Tyra, in adding to what she had said in her research interviews said that what goes on during her day has a huge impact on being ready for therapy. She described how she would also like reminders during the week, from her therapist, to use the tools she had learned in her therapy sessions. She also had other appointments during the week that helped her prepare, such as music therapy and working out. John confirmed what he had said in his research interviews that he found it more difficult to work well in therapy if his mind was occupied with something else before the therapy session. As a whole, the participants’ comments in their member checks were consistent with what they had said in previous interviews.

Although Preparation for therapy is not a very detailed theme, it does show that some participants may need some support between sessions, in order to make sessions productive. Nicole, a participant with memory problems, wanted support to keep working on her issues between sessions. While some participants felt that it would be advantageous to develop strategies to remember the ideas for their next appointment, Mark didn’t want to think about his therapy session before he went. For Mark, and for others, the busyness of life was something that they felt needed to be taken into account. For Mark and Fiona busyness was as a consequence of the extra demands their learning disabilities placed on their lives. For John and Mary, it was more life issues, along with the stress that came with living with a learning disability, which made it more difficult to have enough energy for therapy. Mark’s mother commented that it would help if
therapists informed their clients that they need to make room in their schedules for therapy.

**Body/ Mind Needs for Work**

During the research interviews, a number of participants talked about the resources that helped them to prepare themselves physically and psychologically for their session (see Table 8 and Figure 4). Thus, “Body/ Mind needs for work” was identified as another central theme in discussions with the participants. As seen in Table 8 and Figure 4, the participants’ expressed needs could be separated into two components: circumstances of therapy (environmental conditions and time of day) and physiological needs (food and medication variables).

Table 8.

*What helps or hinders participants’ body/mind be ready for therapy - code by participant*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Owen</th>
<th>Tyra</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Body/ Mind Needs for work</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codes</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational variables - environment - helps with counselling</td>
<td>8</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td>1</td>
<td>7</td>
<td>26</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational variables - environment - warm</td>
<td>1</td>
<td></td>
<td></td>
<td>8</td>
<td>2</td>
<td></td>
<td>11</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational variables - time of day</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td></td>
<td>1</td>
<td></td>
<td>6</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention that helps - food available</td>
<td>1</td>
<td>1</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention that helps - medication</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
<td></td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
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<td>4</td>
<td>3</td>
<td>20</td>
<td>4</td>
<td>7</td>
<td>51</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

All but three participants talked about these needs. Moreover, there were more quotes about this theme (51 quotes) than for the theme Preparation for therapy. Far more participants talked about the effect of the environment on counselling than any other code in this theme. But, like the Preparation for therapy theme, the first two participants,
Owen and Tyra, who didn’t have ADHD, as well John, had nothing to say about this theme. Although for many participants this theme did not take much of their attention, it did for one participant. Mark, who had deficits in verbal expression and ADHD, had far more to say about this theme than did others, with most of his comments being about the environmental conditions. Tyra added to what she had already said in her member check. She said that she liked informal settings but that the environment didn't really affect her counselling. Ted confirmed what he had already said in his member check, that he didn't like to have a sterile environment. John said that his environment did not affect his counselling process in his member check.

*Figure 4: What helps or hinders participants’ body mind be available in therapy - network*

The first component seen in the theme *Body/Mind needs for work* were the circumstances for therapy, which included the environment and time of day for therapy. Six of the participants discussed different parts of the environment that they said helped with their counselling process (see Table 8, row 1). Participants believed that various environmental conditions made a difference for counselling, but most weren’t specific
about the way that environment made a difference. Comfortable seating, cushions on the floor, sufficient light, specific kinds of lighting (not fluorescent and overhead), windows to the outside world, the size of room and perhaps an environment other than an interview room were preferred.

Mark, who had struggles with verbal expression difficulties and ADHD, talked far more about concrete actions and surroundings in therapy, rather than how he felt about the therapist or how he needed to communicate. His mother confirmed that Mark felt far more comfortable when his sensory needs were met. This sensitivity was apparent in the issues he addressed in therapy, such as environmental phobias. His environmental preferences for soft and tactile surroundings were also apparent during his interviews. During the time Mark and the researcher were together in the first interview, at his mother’s apartment, he sprawled out on a leather couch that he covered with a blanket. This interview was conducted in a room with a hard wood floor. In the second interview, at his father’s place, he preferred to sit or lie on the floor, which was covered with a shag carpet. When the researcher started asking him questions about what made counselling easier, Mark talked about the environmental conditions of his therapy room. He started with talking about seating.

Int --made it easier. Is there anything else that can make your counselling easier?

Pa Um...what else could help? Um, the chairs…

Int Yeah? What about the chairs?

Pa They have to be um, they can’t just be plain old wooden.

Int What-how do they-what kind of chairs do you like?
Pa  Uh, soft…

Int  Ok.

Pa  Soft, and hard, but not wooden.

(Mark, int 1, 554:561)

He was also quite detailed in how he discussed the lighting conditions of the room.

Pa  Um, a good amount of lighting.

Int  A good amount?

Pa  Yeah.

Int  Really bright, or really dim, or just in between?

Pa  Um, it depends. If you-dim like this for doing mathematics, but I like brightness for counselling.

Int  Oh so brightness for in counselling sessions?

Pa  Yeah.

Int  How bright would it be?

Pa  As bright as this room, probably.

Int  Yeah? So just like regular lights.

Pa  Mm hmm.

Int  Not too dim. So do you like overhead lighting, or--?

Pa  Um, I like corner lighting.

Int  Corner lighting.

Pa  So basically the lights come from the walls.

Int  Oh ok. So can you tell me about why that might be? What helps about that?
Pa  Um, I like that because there’s no light overhead and it makes the room seem bigger.

Int  Oh ok. So light helps, comfortable chairs, um, is there anything on the floor, or wall?

Pa  Carpet.

(Mark, int 1, 577:595)

Mark also talked about clothing. He expressed a preference for loose, non-restrictive clothing, which was also was apparent in the research interviews. When he talked with the researcher, in his first session, Mark was wearing his school clothing, brown twill pants and a white shirt. As the interview went on, Mark’s shirt became untucked, his sleeves were loosened and his socks came off. For the second interview, on the weekend, Mark wore old stretched out grey sweatpants and a worn t-shirt, un-tucked. He talked about what he liked to wear for therapy.

Pa  Also what you’re wearing also helps.

Int  Oh ok.

Pa  What the person’s wearing, not the counsellor, but the uh--

Int  But you. What do you like wearing?

Pa  I like wearing comfortable clothing.

Int  Ok, so comfortable clothing.

Pa  Yeah.

Int  What does that look like to you?

Pa  More thin.

Int  Ok.
Pa  Thin clothing.

Int  What about the stuff you’re wearing now?

Pa  I don’t really like wearing this.

Int  No?

Pa  No.

Int  So what about that—what kind of clothing—like, sweatpants, or shorts, or--?

Pa  Um, these pants are good.

Int  Ok.

Pa  I just don’t like wearing a sweater.

Int  Ok so twill pants and you like a sweater?

Pa  No, I don’t like wearing sweaters that much.

Int  No, ok.

Pa  Unless it’s cold outside and cold in the room, then I like to wear a sweater.

Int  Ok, but given the ideal temperature--

Pa  Yeah.

Int  --with a comfortable temperature--

Pa  Or loose clothing, just so it’s--

Int  Ok.

Pa  --so you can move around better.

(Mark, int 1, 625:653)

Sarah, who also had ADHD, was sensitive to certain kinds of fabric on seating or clothing. In the first interview she sat on a cushioned chair and rubbed her feet against the
carpeted floor. In the second interview she talked about environmental sensitivity with her mother and the researcher.

Pa Well if like the couch, the thing I was sitting on felt un-comfy, or felt weird, the fabric, or something like that, then that would be something.

Int Yeah.

M She is very sensitive to touch, and certain fabrics, and clothes and things like that.

Int Yeah.

M It can really irritate her and set her off.

(Sarah, int 2, 84:88)

Rachel, who had ADHD, was also concerned about her environmental conditions for therapy. She chose to meet at her home. Rachel and the researcher sat at her kitchen table and drank tea, while talking, in her apartment. She talked about being more comfortable with a warmer counselling room and also with a less formal setting for therapy.

Pa Um, well, I think that uh, like, I mean, I don’t know, I think comfier seating would be good.

Int Yeah.

Pa Pillows; something to hold on to.

Int Yeah.

Pa Uh, uh, lower lighting.

Int Yeah.
Um, I don’t know, but I mean, I think that, I think it would be nice to have counselling in other settings--

--for sure, I just don’t know that that’s a possibility for anyone working in the educational field.

Yeah, but given, if you could wave a magic wand--

Wave a magic wand—probably in a park, or in, you know, um, something like that where it’s just like, where you don’t feel, where you don’t feel less than the counsellor. Anything that’s going to take away those power dynamics where you feel, you know.

Sarah, who had ADHD, was also sensitive about the lighting.

But I just don’t like the light.

Yeah. So if somebody turned the light off and turned it and put a different-

Maybe the light being off would be better, yeah.

These comments were reinforced by the participants’ preference of the location for their interviews. For example, Ted, who had ADHD, working memory and auditory memory problems, felt most comfortable being interviewed in a coffee shop with a moderate amount of noise, which made it more difficult to record the interview, even though he was offered a quieter place at a library. Mary, who also had ADHD, wanted to do her interview in a quiet space, at a specific library, as it was familiar to her. Even
though Sarah, John, Rachel and Mark, who also had ADHD, were given multiple options for sites for their interviews, they preferred to do their interviews at their homes. However, these four participants didn’t say why they made that specific choice of location.

Three of the participants talked more specifically about preferences for warm environments (see Table 8, row 2). Nicole, who had difficulties with verbal expression and ADHD, chose to meet at the back of a coffee shop, sit next to a fire in a soft cushioned armchair, at the back of the restaurant, and away from the other patrons. She gave a description of what it meant to her to have a warm environment for therapy.

Pa  Yes. And I think the room helps too. Like there are some rooms that, like they look too um, I don’t know, institution-like, I don’t know, and like, um, the one, we just went to a new office with the counselor I’m seeing right now, and it’s very artsy and very warm and incense and candles, and um, it just seems more warm.

(Nicole, int 1, 375)

Pa  Oh, I don’t, I like the um, we had one office and it was um, very um, office looking, um, but now we moved into a different one that she has and I find it’s much easier, it’s more comfortable. It’s more, um, relaxing, like she’s, she has like plants in there and it’s, we have comfortable couches, so it’s much easier to just, I think if you’re relaxed and you actually feel comfortable in the setting, you’re more-it’s easier to talk.

(Nicole, int 2, 552)
Mark, whose list of specific environmental needs was discussed above, also talked about how his preference was for a relaxing atmosphere.

Pa  Not like a totally formal—it’s basically a nice casual...

Int  Ok, like casual.

Pa  Yeah, like casual.

Int  So if it was kind of a more relaxing situation--

Pa  You’re more likely to answer better.

(Mark, int 1, 357:361)

All the participants who talked about their environment for counselling sessions had ADHD. They commented on how they preferred an environment that had softer lighting, chairs and flooring. For some participants this meant that they felt more relaxed. For others, they didn’t describe why it was preferable.

Another aspect of the circumstances of therapy, time of day, was discussed by four participants in the interviews. This was coded under the *Situational variables - time of day* code. Four participants had a preference for counselling sessions in the afternoon, all of these participants met with the researcher for their interviews in the afternoon or evening. Nicole who lived independently, and didn’t think of herself as a morning person to begin with, talked about a preference for afternoon sessions.

Pa  Um, well, I know that I sometimes used to make my appointments in the morning, but I’m not a morning person, so I ended up missing them a lot, so I guess if you’re not a morning person don’t have them in the morning.

(Nicole, int 1, 345)
Fiona, a teenager with a busy schedule and lots of homework, preferred appointments later in the day. Fiona’s mother reported that if she wanted to have a talk with her daughter it would be better done in the afternoon or evening, when work had been done and there was time to talk.

M Um, just…

Pa (indistinguishable)

M Before bed.

Pa Yeah.

M I say. Yeah, you don’t get into a lot of discussions first thing in the morning.

Pa No. (laugh)

M (laugh)

Int No counselling sessions at 8am.

Pa (laugh) Yeah.

M I think from my experience with my kids is that they…in the evening they seem to be processing their day, and that’s a good time to…good time to talk.

Int So, if I was a counselor, and I wanted you…an optimal time. What would be an optimal time? What do you think would be optimal?

M Yeah, you don’t want to…

In Not too…

Pa Like, right after dinner (laugh).

(Fiona, int 2, 414:427)
Similarly, Mary, an art student with ADHD, who liked working later in the evenings on her school work, talked about preferring therapy sessions in the afternoons.

Pa  Definitely I’m better in the afternoons.

Int  --what state you’re in.

Pa  I’m not a morning person.

Int  Ok. Ok.

Pa  I can barely be in my body in the mornings. Like today was a morning class, I had to get up at 7:30.

(Mary, int 1, 570:575)

Out of the four people who talked about time of day for therapy, all of them preferred having sessions in the afternoon or evening.

The second broad component that was discussed in the Body/Mind needs for therapy them was the client’s physiological needs (see Table 8, rows 4 and 5). Two aspects of this that were discussed were food needs and medication. Three participants discussed the possibility of having food either before or during therapy. Although they didn't discuss how it helped therapy they did believe it helped. For example, Mark enjoyed getting some food or drink before therapy. Given his busy schedule this was more of a time for him to slow down and relax for a few minutes before therapy.

Int  Is there anything else that you guys did together outside the sessions that helped?

Pa  Uh, the drinks before the sessions, mom.

M  The drinks before the sessions? Excellent! (Laughs)

Pa  Didn’t we get a drink?
M What?

Pa Didn’t we always get a Pepsi right before the session? Or a Coke?

M I didn’t notice that was a habit, but it’s possible. Do you think that was a good thing we did together?

Int Yeah.

Pa Yeah, get a drink.

M Get a drink beforehand.

(Sarah, int 1, 257:259)

Nicole, Rachel, Fiona, Sarah, and Ted all had something to eat or drink during their interviews. Tyra added to what she had said in her research interviews in her member check by saying she also would like some food during her counselling session. To be able to eat or drink seemed to help participants feel more comfortable. As for the participants’ eating during or before the therapy sessions, they did not explain if they were in need of sustenance or whether they just enjoyed the opportunity to get a snack. However, they did appreciate the opportunity and said that it helped prepare or help them in therapy.
Two participants Fiona, Sarah, and Mark talked about how medication affected their counselling process (*Intervention that helps – medication*). It helped them focus. Fiona’s only comment was that it helped with focusing. However, Mark’s response showed that his ADHD medication didn’t only have an effect on focus. It increased his anxiety towards phobic situations.

*Pa* Um, mostly what helps me in counselling is either Concerta, which would definitely help.

*Int* Yeah.

*Pa* And um, well actually Concerta didn’t always help me. Sometimes it makes you more scared because you can’t ignore your fear.

*Int* Ok.

*Pa* Basically with some medications, it makes you concentrate on something.

*Int* Mm hmm.

*Pa* And sometimes the only way to conquer a fear is to ignore the fear, and let it just go away by itself.

*Int* Yeah, yeah. So the Concerta actually helped you concentrate on the fear which made it feel worse sometimes.

*Pa* Yeah.

*Int* Ok. Sometimes it did help with focusing when you were talking to somebody?

*Pa* Yeah, it helps with my focus but it worsens my fear

(Mark, int 1, 125:134)
In sum, the theme *Body/Mind Needs for Work* contained elements about environment, time of day for therapy, and two factors that affect physiology, medication and food. Although, participants did not always describe how these elements were helpful in therapy, they often said that a specific kind of environment did help. While the environmental variables seemed to affect those with ADHD, most elements such as time of day, medication and food were discussed by other participants as well.

*Therapist Expresses Understanding*

During the interviews, all participants talked about the ways that the therapist helped to improve communication between themselves and the participant (see Table 9 and Figure 5). Consequently, “Therapist express understanding” was identified, as another central theme. As seen in Table 9 and Figure 5, participants wanted some kinds of input from their therapist to make sure that they knew what each other were talking about. The participants wanted three kinds of input from their therapist: feedback from their therapist, questions asking for clarification (when the therapist didn’t understand the client) and questions or ideas reworded by the therapist (when the client didn’t understand the therapist). On the other hand, nine of the participants commented that it was critical as to when the therapist expressed understanding. The participant wanted to be able to put all their ideas on the table, when describing a concept or story, before the therapist expressed their understanding. Input at the wrong time derailed their thinking or made them feel that their therapist was missing part of their idea.

All the participants talked about how and when their therapist expressed understanding of that they had said (they gave 112 quotes). Participants had far more interest in talking about *Intervention that help – feedback/paraphrasing* (8 participants
who gave 49 quotes) and *Sharing ideas- therapist wait for client to put it on the table* (9 participants gave 49 quotes) than the other codes.

**Table 9.**

*Therapist expresses understanding that is appreciated by participants - code by participant*

<table>
<thead>
<tr>
<th>Therapist Express Understanding</th>
<th>Participant</th>
<th>Owen</th>
<th>Tyra</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th>Totals</th>
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<td>6</td>
<td>7</td>
<td>10</td>
<td>3</td>
<td>6</td>
<td>14</td>
<td>2</td>
<td>49</td>
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<td>2</td>
<td>6</td>
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<td>12</td>
<td>16</td>
<td>6</td>
<td>2</td>
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</tbody>
</table>

*Figure 5: Therapist expresses understanding that is appreciated by participants - network*
The therapist’s expression of understanding and questions helped the participant to be understood by the therapist. If the therapist remained quiet some participants felt lost and wondered whether the therapist did not understand them. They reported that sometimes they needed the therapist to express an understanding of what the client was saying, as described in the code *Intervention that helps – feedback/paraphrasing.* For others, just a non-verbal expression was all they needed.

Mary, who had ADHD talked throughout her interview about wanting validation and encouragement from her therapist. She felt that she wasn’t getting enough feedback from her therapist. She often felt that she wasn’t sure if the therapist understood what she was saying.

Pa Yeah, what’s not helpful is sitting there for fifty minutes or whatever, half an hour, whenever I have had counselling, it’s been a while, and just have someone sit there, hardly say a word. Like I had one sit there, and I’d say, “so what do you think?” She goes, “well…”, and she’d hardly ever give me feedback! Like, and I’m thinking, is she just thinking about her day? Like seriously.

Int Mm hmm.

Pa And, she used to write a lot, so I used to think, what are you writing?

Int Mm hmm.

Pa But, I hardly even got any feedback. I just found it’s not useful.

(Mary, int 1, 218:222)

Nicole, who had expressive and information processing deficits as well as ADHD, felt the same way about what she would like from her therapist: she also wasn’t sure if the
therapist understood her and wanted more feedback in order to make sure that the therapist understood what she was trying to say.

Pa  Um, yeah I guess her just repeating it, you know, in a way that I can confirm it, because sometimes I’ll say something, but it’ll take me a long time to explain what I mean, or I use the wrong word, or um, maybe it can be very brief but I take so long to explain it and I explain it in a long way, and then if she sums it all up then I can say “yes it’s like this”, or “no, that’s not right; what I meant was this”, so her kind of talking back to me I guess.

(Nicole, int 1, 21)

Unfortunately, for Nicole, she sometimes had a hard time soliciting this feedback.

Pa  Ok. Sometimes I, um, I think so, um, I’ve had times where I’m talking and um, I’ll just explain something, and then I can’t explain anymore, or I’m not getting anywhere and I’ll just say, sort of like, “um, um, um”, or “I don’t know, I don’t know”, and then I’ll just keep on going, “I don’t know”, but I don’t get any response from her so I don’t know if she’s quiet because she wants me to keep on talking and explain to her, or if she’s quiet because she understands. Like, I need her to talk to me more, like, “you mean like this?” or, “I’m not sure what you’re saying”, or “Oh yeah, I get what you mean”, but I don’t get any response, so I feel awkward, I guess, at times.

Int  Somehow, you feel you’re not getting your point across?

Pa  Um, yes.

Int  So, “I don’t know” might not mean you don’t know, but it might mean do you know. Like, does the counsellor--
Pa  Oh, yes, yes, yes.

Int  --like I, the counsellor, know?

Pa  I think sometimes I’m searching for her, a response from her, by saying “I don’t know”, but sometimes I don’t get anything.

Int  So, maybe her checking in with you, “does, I don’t know mean that you- what does ‘I don’t know’ mean for you? Are you trying to get something from me? What would you like with the ‘I don’t know’?” Yeah?

Pa  Yes, yes, exactly, yes.

(Nicole, int 1, 291:299)

Three participants also talked about how they would like to not only have feedback but also have the therapist ask them for clarification if they couldn’t understand them (Intervention that helps – question asking for clarification). Rachel, who had ADHD, was a social work student who was doing research on learning disabilities. She felt that she wanted a genuine relationship with a counselor, who was willing to tell her when he/she needed more clarification. For Rachel, it was also easier when the therapist was willing to model openness and honesty, and to admit if he/she was were confused.

Pa  You know um, and not being afraid to, to, to just be a little confused, to be like, well--

Int  Yeah.

Pa  --am I still, you know, like, following, or not?

Int  Yeah, yeah.

Pa  There’s a comfortability about that as well, you know.
Int  Yeah, so in other words understanding what you’re saying, and if not,
saying “I really”--
Pa  Yeah.
Int  --“it doesn’t make sense for me”--
Pa  Yeah.
Int  And then perhaps for you it will be the same.
Pa  Yeah.
Int  If what I’m saying doesn’t make sense for you--
Pa  Then I’m going to feel safe going “I don’t get it”.

(Rachel, int 1, 573:585)

Finally, three participants talked about how they appreciated their therapists’
rewording their questions or feedback, until the participants understood them

(Intervention that helps – questions or ideas reworded by therapist). Mark, who had a
deficit in verbal expression, found it frustrating and confusing when his therapist repeated
questions in the same way. When Owen talked with the researcher, he sometimes had
difficulty understanding what the researcher was asking, especially if the researcher used
more abstract language. For example, when he was asked to describe his relationship
with his counselor as a drawing, in the first alternate exercise, he preferred to draw a
picture of his ideal room for counselling. Therefore, it was understandable, that he may
have needed different kinds of questions from the therapist, in order to understand them.

Pa  When they don’t repeat the same thing.

Int  Ok.
Pa Sometimes it helps, because sometimes, if they’re on *(indistinguishable)* same thing over and over and over again.

Int Ok.

Pa And it kind of gets tiring.

Int Ok. So if the counsellor, you don’t like it when the counsellor repeats things over and over again. Or, it does help?

Pa No, it doesn’t. If it’s the same—if it’s in different form it’s ok, but if it’s the same exact--

Int Same exact wording, then that kind of gets annoying?

Pa Yeah.

Int So you prefer, so if somebody asked you a question, and you don’t get it the first time the way they say it, then you want them to say it a different way.

Pa Yeah.

Int Until you finally get it.

Pa Yeah.

Int You’re ok with that, if it’s a different way, but not if it’s the same way.

Pa Yeah, because then you just won’t get it again.

(Mark, int 1, 74:87)

So, in interview two, when asked what helped him most to be understood by his therapist, he said.

Pa Um what helped me the most...it was if I didn’t understand the question, he would repeat it in a different way.

(Mark, int 2, 9)
Rachel also had the experience of needing a question asked differently. Although she didn’t seem to have any expressive deficit or auditory reception deficit like Mark, she was suffering from depression and so often felt her thought processes were slower.

Pa Um, I would definitely say, um, just recognizing that sometimes the way a question is phrased may not be that useful to me--

Int Ok.

Pa --so to come at it with a different angle...

Int Ok.

Pa It’s like, different words, or different phrasing—

(Rachel, int 1, 41:45)

The participants who talked about needing reworded questions all said that without this support, they ended up becoming confused and lost in their conversations with their therapist.

On the other hand, it was critical as to when the therapist expressed his or her understanding. Eight participants talked about wanting to complete their idea before their therapist jumped in to paraphrase or help them process their ideas, as represented in the code Sharing ideas – put it all on the table). Fiona, who had working memory and processing speed deficits, wanted help talking about her ideas, but only after she had enough time to express her complete idea. Owen who said he had a working memory deficit said that he just wanted to let his ideas run, rather than have his ideas clarified all the way through.

Pa But to get there I think it’s important to kind of let things run, and not always have to clarify each--but she’s just a very talky person.
Int  Ok.
Pa  Yeah.
Int  So you didn’t need things clarified so much as to let yourself run with it and talk about it.
Pa  Yeah because I think I clarify things myself and then, I think that after that if she didn’t get it she could, we could figure it out and I think there would--, discrepancies would go away after that. But I think that to be understood it was very important for me at least to um, just because like I don’t know how other people think but like when I write an exam--
Int  Mm hmm.
Pa  I don’t write it from the start. Like that’s how, that’s why I write at the computer, because of my learning disability. And there’s no way I could ever sit down and write a paper from start to finish.
Int  Maybe I’m understanding it better now. So what, maybe what you’re saying is that you need to get everything down on the page so--
Pa  But not in any order and then finally--
Int  And then put it all together.
Pa  Yeah.
Int  So get everything out--
Pa  Yeah.
Int  --that you’re talking about. Get everything out of your mouth.
Pa  Yeah.
Int  And then you can play with it once it’s all out.
Pa  Yeah.

Int  You don’t need any clarification until it’s all down.

Pa  Yeah.

Int  Like it’s all on the table between you. And then--

Pa  It doesn’t have any organization until you can see all the pieces.

Int  Ok.

Pa  That’s how I feel about it.

Int  Ok.

Pa  Kind of being, at least understand it for myself, I think.

(Owen, int 1, 42:66)

Mark, who had problems with verbal expression, had a discussion with the researcher and his parents about how he enjoyed expressing all his ideas at once and then processing them. Owen’s parent had said that he liked to talk for a while without being interrupted. Mark’s parent responded that Mark wanted to continue to talk on and on even if the therapist was not able to follow Mark’s train of thought. The mother believed he was over involved in his idea. However, Mark said that he preferred to finish the expression of his idea and then he would go back and chunk it more workable parts that he and the therapist could process. Very much like Owen, he seemed to want to complete his idea rather than stopping at some point.

M  --and he sometimes, and I think other people with certain kinds of learning disabilities, will just “Bzzzzhhhhhh” and it’s just all out there without even acknowledging that there’s another person that you’re trying to get the idea across to.
F  Or tracking to make sure that the person is--
M  Yeah.
F  --still, still--
Int  Hmm.
F  --with you.
M  It’s like he doesn’t care, or people, some people just don’t care if the other person’s understanding them.
F  It’s not a case of, they’re not--
M  They’re making--
F  Sorry.
M  I don’t know! But, I just don’t know what it is, but I think it’s the-no it’s not like they don’t care--
Int  No.
M  It’s that they don’t realize that there’s someone else that needs to understand and they may be looking at things differently.
Int  Ok.
Int  So can I check in with you ‘J’ about this?
Pa  Yeah.
Int  When you’re trying to explain something to somebody, what is it that makes you want to keep on going and going and going and going?
Pa  Oh just that I have an idea.
M  Yeah, he’s just so into the idea.
Int  And you want to get it all out?
In general, participants felt that they did not want to be distracted by the therapists’ thoughts, while they were trying to express their ideas. They wanted to get all their ideas on the table, and then sort out the component parts in order to process them. Even if the therapist was starting to lose track of what they were trying to say, they still wanted them to wait until they were finished and then they would be willing to go over the story so the therapist could understand it. Sometimes, if they were interrupted they felt as if their therapist was not getting the complete picture or was getting the wrong picture of what they were trying to say. At other times, if they weren’t allowed to complete their thoughts they felt that they were knocked off track or forgot what they were trying to say when the therapist jumped in too soon.

Three participants talked about this theme in their member checks. Tyra confirmed what she had already said, that wanted her therapist to talk slower, because she had auditory memory problems, and it took her some time to process what the therapist was saying. She also wanted her therapist to repeat what he or she had said when she
asked for it and needed the therapist to paraphrase her ideas, throughout the process, for clear communication. Ted, confirmed what he had already said, that he only wanted feedback at a natural break; otherwise he found that would totally get derailed in his thinking and couldn’t get back to where he wanted to be in his conversation. Both Owen and Mark confirmed that they wanted their therapist to wait until they were finished what they were trying to say before jumping in with their input. John said that he agreed with all of the comments from others in the data summary table, in addition to what he had said. As a whole, the participants’ feedback in their member checks was consistent with what they had said in their previous interviews.

Overall, the efforts of the therapist to make sure that there was clear communication helped the participant feel a partnership with the therapist. It was helpful for the participant to know that the therapist was willing to work with the client to make sure that they came to a mutual understanding. For example, Nicole, who experienced verbal expression difficulties and working memory problems, needed feedback or she would start to wonder whether the therapist understood her. On the other hand, Rachel, who didn’t have the same kinds of memory or expressive problems, still wanted more feedback than she was receiving. Likewise, Mark, who had expressive problems, needed reworded questions much like Rachel, even though they had different disabilities. Participants may have needed similar support of communication, albeit for different reasons. However, nearly all the participants cautioned that there was a right time and a wrong time for feedback. Sometimes, even if the therapist felt that they were losing track of what the participant was trying to say, they didn’t want to be interrupted. As a compromise, they were willing to go back and recap or chunk the story or idea when they
were finished, so the therapist could express understanding. So, there was constant
process of negotiation between the therapist and the client about when and where the
therapist would be most effective in expressing his or her understanding.

*Client Feels Known*

All participants talked about how they didn’t just want to feel that they had
communicated clearly, but they wanted to feel known. They said that this is when the
therapist intuitively understands what they are meaning to say, even if they can't
completely say it, and knows how the client wishes to precede, even if the client doesn't
completely express it in words (see Table 10 and Figure 6). Thus, another theme, *Client
feels known*, was identified as central from the interviews. As seen in Table 10 and Figure
6, participants described how much it meant to them for their therapists to really know
who they were and what they needed in therapy. The main barrier for the participant to
feel known was not being able to express their ideas (see Stuck ideas). This struggle had
two components: not knowing how much to say and not finding the right words to
express their ideas. Participants also described how the therapist helped them feel
known. Feeling empathy from their therapist, their therapist’s sensitivity to broaching
different issues and being asked general questions about their life all contributed to the
participants feeling a deep connection with their therapist (see Table 10, *Knowing the
client*). The use of particular modalities and approaches in the therapy process also helped
them feel known and express stuck ideas, but these will be discussed in following themes.

All the participants had something to say about this theme. Moreover they spent
a lot of time talking about the therapist’s understanding of the client (143 quotes). Six
participants discussed how they had problems finding the right words for their ideas, but
only one talked about not knowing how much to share or not knowing how to approach a subject to talk about it. Most of the discussion, in this theme, was about basic empathy, in the code *Therapist -- empathy with client* (all the participants contributed and there were 48 quotes) and all the participants contributed to this code. Eight participants contributed the related code of *Therapist-empathy advanced* and six talked about problems with a lack of empathy from their therapists.

*Table 10.*

**Participant feels known by their therapist - code by participant**

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<thead>
<tr>
<th>Participant</th>
<th>Owen</th>
<th>Tyr</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th>Totals</th>
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**Stuck ideas.**

Participants in this study identified three different kinds of problems with trying to express their ideas: difficulty finding the right words, knowing if they had shared enough and finding a way to approach a topic of discussion. John and Ted both
Six participants talked about difficulties finding the right words to describe their ideas. In the literature this is sometimes known as a ‘tip of the tongue problem’, as represented in the code *Sharing ideas – tip of the tongue*. There was some discussion about how to resolve this issue. Owen, who was gifted but had reading, writing and self-reported working memory deficits, explained that many times he felt he had the ideas in his head, but he couldn’t find the right words to describe his ideas. He found this frustrating in school when trying to write and when he was talking to his therapist. He said that sometimes words came out in a way that he thought others might find offensive, but it was because he couldn’t find the right words to express his ideas.

Pa It is the most frustrating thing, when you get something really well but you can’t communicate it. That’s also a huge thing. So that’s, like it’s, like I think my uncle, when he was growing up he couldn’t write fast enough, so when he
was in grade school, he would write letters from the next word. He was already thinking, like--

Int Yeah.

Pa He would be sentences ahead of where he could write--

Int Yeah.

Pa Because he couldn’t, his writing hadn’t caught up. And I feel that a lot.

Int That you’ve got the idea in your head, but the language somehow hasn’t caught up.

Pa And it’s like, you can feel it slipping through your fingers if you don’t get it down on paper.

Int Yeah and you can’t somehow.

Pa So you have to do with-like, it’s so hard, because you try and get it out.

It’s just hard that way.

(Owen, int 1, 886:894)

Sarah talked about struggling to describe how she felt when she was on her medication for her ADHD and why she didn’t like it. Her mother also said that she had difficulties expressing what exactly was bugging her, which Sarah confirmed. Fiona said that when she was trying to describe her emotions it was easier with her mum than the therapist because her mum understood her background. She thought it was as if she was thinking in pictures, rather than in words.

Pa But, I, like, I can be pretty descriptive, because I see things in my head

Int Yeah, yeah.

Pa But, I can’t…oh my gosh…I can’t…
Int  You can’t translate it into words.

Pa  Yeah. (laugh)

(Fiona, int 1, 818:816)

Pa  And like, places and stuff. But, it won’t come up in words. Like, like, my um, my, uh, helper in elementary school would always try to like explain to me how like she thinks in words, and I think in, in pictures, but she’s like trying, she was like trying to get better at seeing it as pictures.

(Fiona, int 1, 796)

John also said that he had a lot of problems describing how he was feeling, even though he understood what he was feeling. Nicole also said that she often was left searching for the words to describe her ideas. For the participants who described feeling stuck with their words, this was a very frustrating experience that each struggled with throughout their sessions.

Fiona had a particular problem not shared by other participants; she had the unique problem of not knowing how much to share with her therapist. She often felt that during the therapy session she had shared enough, but then when she left her session she was thinking that she had somehow missed describing something critical. She reported this problem of being able to picture things in the head but not being able to express them completely in words, as represented in the code *Sharing ideas – incomplete sharing of ideas*.

Pa  And like I…it was always like I was constantly missing something, I was telling them what I thought wasn’t important. Like, after every session, I was
like, I feel like it wasn’t like finished. It was like…oh my gosh it’s hard to explain.

Int Yeah.

Pa It like, um, like, um, like…she didn’t understand like exactly what I meant. I guess?

(Fiona, int 2, 65)

Sometimes Fiona believed that although she was unable to express things completely, it wasn’t necessary, for her to say everything given the needs of therapy, as represented in the code *Sharing ideas - incomplete sharing of ideas but sufficient for needs of client.*

Int So is it…are you feeling that not everything is getting to her? Or it’s just a…

Pa Everything I want to get to her is.

Int Yeah.

Pa But just, there’s always going to be like thoughts going through my head that like…just like day to day like: “I’ve got to get the groceries”. I’m not going to like tell her that. And stuff like that.

Int Yeah. Yeah. So it’s not everything, it’s the parts you need to tell her that are there.

Pa Yeah.

Int So, there’s… everything is here. And only the parts that you need…you need to tell her are over here.

Pa Yeah.

Int In her hand.
At other times, Fiona thought she hadn’t shared enough, as represented in the code

*Sharing ideas – incomplete sharing of ideas but not sufficient for client.* Fiona drew a picture of two hands with the ideas moving from one hand to the other (Figure 8). There were less vibrant colors in the therapist’s hand then the clients and she discussed why this was the case:

Pa  Maybe a little bit more color on her side. *laugh). A Little bit more*

like…maybe I… I’m just like, maybe I should have like said the things I just thought were irrelevant. I should have just like, talked.

Int  Ok.

Pa  But, but like, I did just talk, but like, things that, I just like assumed were irrelevant, I should have just like thought more carefully about like, maybe that isn’t irrelevant, like.

(Fiona, int 1, 420:422)

She left the interview with the researcher wishing she had shared more with her therapist, as she thought she may have been more productive if she had shared more. She said that she didn’t share the same way with her mother as her therapist. Her therapist somehow did not understand her the way her mother did and as a consequence, it was hard for her to really feel understood by her therapist. She thought that perhaps she didn’t fill the therapist in on enough of her life so that the therapist really understood how she was feeling.
Fiona also had another problem with expressing her ideas; she had difficulty working out where to start describing the issue (Approach the subject – can’t start - stuck).

Pa  Ok, um. (laugh). Uhm. (pause) It would be like…I don’t know, it would be like, I’d be talking, and then they’d be like quiet, so I’d continue talking, and then, I’d like say something, and I’d think about it, and I’d be like, I’d think…it would be in my head, then I’d just be like, ok, whatever. I can’t think of anything to say for that. Because like, I didn’t know, I didn’t know how to like approach a subject, and like, it’s just, it seems weird for me, because I, in other circumstances it seems like any subject that came…that I felt like I needed to talk about, I would be able to. But just, I guess in front of a stranger and…like after a while it wasn’t really a stranger, but still, in front of someone who I didn’t, like, have a like, personal connection to, like a, like, a (laugh), it’s hard to explain!

(Fiona, int 1, line 236)

Fiona also had this problem in the interviews with the researcher. This could be seen in the transcripts as she started to talk about a new topic and she said several incomplete sentences before she was able to complete her thought. The researcher came back to the same topic a number of times, after talking about something else, so that she had additional opportunities to express her ideas when she became stuck.

Knowing the client.

There were a number of essential components that participants said helped the clients bridge the gap between what was said and what the client’s meant to say:
empathy, advanced empathy, sensitivity to know what topic to address, and general questions (to help the therapist get to know the client).

The *Therapist- empathy with client* code describes how the therapist expresses their knowledge of what the client is thinking and feeling. Tyra, who had various kinds of memory problems and a long experience of struggling with professors and others understanding her disability, such as family members with mental illness. She had difficulty finding empathy with her situation, even from her family members, even though she had previously said that she didn't have any problems with self-expression. The researcher heard about at least three counselors who she had seen, including two at her university’s counselling centre, some empathetic and some not. She also knew much of the professional language of psychology. When asked what helped her to be understood by her therapist she talked about empathy.


Int Empathy.

Pa Yes.

Int So what parts of empathy did she have, or how did that work?

Pa Um, she was a counsellor at UBC.

Int Mm hmm.

Pa And I think because she was trained to understand students’ problems, she was more empathetic than someone not at school.

(Tyra, int 1, 6:12)

When asked what empathy looked like for her, she described an experience she had with a therapist.
Yeah. They actually care. Versus that you’re paying them, and they kind of have to care.

Mm. so what kind of things tell you that somebody’s empathetic for you? What helps to know?

The fact that you can tell that they’ve never had the same situation, but at the same time they’re still able to say “oh that does sound bad!”, when you say that you’re not feeling well. Rather than saying, “oh, well actually, it’s not that bad”.

Oh, ok.

Like I had that happen, Like I had some problems with some people and I mentioned how it was very hard on me because they were actually friends of mine, and they did some things that I didn’t appreciate, and then, like I don’t know, different people have different sensitivities and I was essentially told that wasn’t an important issue by the other person. And I just didn’t think that was fair. (laughs)

Rachel also had a level of depth of understanding of learning disabilities. She lived with her boyfriend who had dyslexia and was working on a thesis about learning disabilities. She believed that she was having difficulty finding someone to understand the relationship between her ADHD and her struggles in life. She often found that therapists and clients wanted to treat her depression, but she believed that the cause of much of her depression was her ADHD. She wanted her therapist to have empathy that was optimistic
but not miss her struggles in life because of ADHD, as that was missing a big part of who she was.

Pa And so, like I think a counsellor, a good counsellor, should be able to provide us with a realistic image--

Int Hmm.

Pa --with no sugar-coating, and no um, you know, no, um-just to you know, provide a realistic--

Int Yeah.

Pa --image. So I mean--

Int Of who you are.

Pa Yeah. And that’s, and to reflect back to you, you know, through listening, through clarifying, through repeating, through active listening--

Int Yeah.

Pa --to provide something--

Int And it sounds like they’re missing quite a bit of-they’re getting to the optimistic part, but there’s a part that’s totally missing about how insecure and vulnerable--

Pa Yeah!

Int --and weak you felt.

Pa Yeah, and it, and because, I mean, it’s not comfortable, but I don’t think that counselling should be comfort-I mean, there’s--

Int Yeah.

Pa There should be, there’s nothing comfortable about it--
Int Yeah, yeah.

Pa --so that, you know, I think that like, you know, a counsellor should, you know, be willing to, to say like, you know, um, like to be realistic with you--

Int Yeah, yeah.

Pa --and to be like, “you know what? The fact is that you have a lot invested, you know, in this” or whatever, “and the fact is, is, you know you feel lonely and, you know, that makes a lot of sense. And you’re angry, and that makes sense too”. But you know--

Int Mm hmm.

Pa --“but this, this other bit, this doesn’t make sense” or whatever!

(Rachel, int 1, 1141:1161)

However, many of the comments about empathy were very brief. For example, Sarah, a teenager with more limited experience in counselling, did not have anything detailed to say about how her counsellor was able to understand her.

Pa Well the thing that made it easier is that my counsellor, like, she understands me, she gets me, and she’s nice and friendly and outgoing and all that,

(Sarah, int 1, 54)

Sarah, who had ADHD and both auditory and visual memory problems, was able to see her therapist’s empathy for her condition in her therapist’s body language.

Int What helps you know you’re understood by your counsellor? How do you know that she gets ya?
Pa  Well like, when she--like how, she’ll say something and you can tell that she gets it, or like the look on her face and that. You can just…you can tell when somebody understands what you’re saying.

Int  Oh ok.

Pa  And other, and then, you can tell when they don’t understand what the heck you’re saying.

Int  Oh ok.

Pa  ‘Cause just the look on someone’s face is--

Int  Oh, ok so--

Pa  --it always gives it away.

Int  So non-verbal kind of, kind of--

Pa  Yeah.

(Sarah, int 1, 23:32)

Many of the participants believed they were able to tell when their therapist knew them. They saw this both in what therapists said and in their body language. All of the participants, at one time or another, felt that at least one of their therapists did have empathy and were able to express that empathy during therapy, in a way that was made them feel known.

It was one thing for the therapists to be able to express content that the clients were able to directly express. But, some of the participants wanted the therapist to understand what they were getting at straight away, despite their particular mode of communication; for the therapist to be intuitive in understanding them. This intuitive communication was coded as Therapist - empathy advanced.
Pa --like some other people. I'll just say it once, and she’ll get it. And that-- and like I barely ever have to rephrase something to get the point through. So I guess it’s just, she understands.

Int She understands you.

Pa Mm hmm…

Int And has that always been the case, or is it…has it changed throughout time, or--?

Pa It’s, always been the case with this counsellor.

(Sarah, int 1, 10:14)

Some participants were frustrated if the therapist couldn’t understand them immediately. Owen expected his therapist to be intuitive, in order to keep up with his speed of thought. He was diagnosed as gifted in abstract thinking, which was apparent in his descriptions of his counselling sessions. The researcher also experienced the speed at which he expressed his thoughts. Often during the interview, the researcher had to review with Owen what he had expressed. Then once he understood what Owen was saying, Owen could be asked additional questions. Even though Owen’s expression was very fast, he felt he needed a therapist who could stay with him in his thought processes. Owen felt he needed an intuitive therapist, in order to be able to understand what he was thinking right away. It would be a barrier for him not to have a therapist who could intuitively understand what he was expressing.

Pa But other than-the mechanics of-I guess like, with anything that I do, like there’s a frustration if somebody doesn’t get it right away, if someone doesn’t
think like, I don’t know if that’s just, I don’t know, because some things I get so fast--

Int Yeah.

Pa I just, it’s like, you know the best math teachers are the ones that just get it?

Int Yeah.

Pa Because they’re the ones who understand the learning process.

Int Yeah.

Pa If the--, sometimes I just don’t think that way, I just think that someone should get it, and that’s it, and, you know, because it makes sense to me. So I think that’s also a barrier that, and I have to slow down, and, and, and--

Int You have to slow down because--?

Pa So that, so that my counsellor can understand what I’m going through and what--, not that they don’t have lots of experience with that--, but so the counsellor can really find out what is the most useful avenues to take, I guess.

(Owen, int 1, 422:430)

Ted, who experienced working memory problems, felt he needed advanced empathy because of his vague way of discussing things. He confirmed, in his member check, that he appreciated being able to use quite vague language with a therapist and still have his therapist understand what he was trying to say.

P: You know, it’s gonna have, kind of a, I almost want to call it like an emotional intelligence, like, to be able to read, I don - I don’t know, I’d like somebody to read me to some degree, and know that I don’t want too many
questions, or two minutes, um... and just, you know, if I have to write a manual for me, that would be something I would say, it was, um, don’t ask too many questions that, - that - that, and I can be very vague in my answers which will probably [laughs] figure out when you’re learning this, I don’t, very general, and I, find it hard when a counselor is like ah “I don’t understand. Explain more, explain more, explain more…”

(Ted, int 1, 236)

So, advanced empathy was more about the client wanting the therapist to bridge the gap. When participants had difficulty communicating precisely or in the optimal style for the therapist to understand, they believed that the onus was on the therapist to intuitively sense what the client was attempting to express.

Not only did the participant want the therapist to be sensitive enough to understand what they were trying to communicate, five participants expressed how they wanted their therapist to be sensitive as to their readiness and willingness to address an issue. They needed their therapist to know when to address an issue, when to stay with an issue and when to leave an issue (Safety – therapist sensitivity to client’s willingness to talk about an issue). Fiona had a productive relationship with her mother and she expressed that her mother knew when to address a particular subject. In her second interview Fiona and her mother talked about what the best time was to talk about difficult issues. Fiona had difficulty with her working memory and processing speed. She felt she needed a therapist who would be sensitive to when and how she needed guidance (when to keep her on a topic, and when to not give her too much direction).
Pa: Yeah. If it was like vaguer questions. It’s like, precise when it should be precise, but like vague questions when…when vague is necessary.

Int: So, open questions is what you’re saying.

Pa: Yeah. Yeah.

Int: Questions that provide room for you to move so that…

Pa: Yeah, and, like, without it leading somewhere, and like, too much guidance in one direction.

Int: Yeah. Cause you need to go where you need to go, it sounds like.

Pa: Yeah. And then, once, once I get there, I need like, direction to keep me there. (*laugh)*

Int: Oh, ok.

Pa: But.

Int: So, when you feel like you are in the spot where you need to work, then if the counselor knew, this is the spot where you need to work--

Pa: Yeah

Int: --it sounds like you’re getting to the spot where you need to be.

Pa: Yeah.

Int: And then questions around that area when you’re ready for them.

Pa: Yeah. Yeah. But if you just jump to those questions, I would be like…I don’t think I’d say the same thing. I’d be (*laugh*) anxious probably (*flaugh*).

Int: Yeah. So, so, getting you to that…waiting for you to get to that point…

Pa: Myself.

(Fiona, int 1, 544:560)
Owen, who had working memory problems and was gifted in abstract reasoning, felt that his therapist needed to be sensitive to what he wanted to talk about. He felt his therapist’s sensitivity helped him to be understood by his therapist.

Pa But um, you kind of go where it takes you. That’s what it seems like. Her method at least was to kind of go where it takes you. And I think that’s a very important part of being understood at least, is that to get to the issue you have to go, like, ‘cause obviously, if you take off one layer and then you, all of a sudden you expose this whole other deeper kind of layer.

Int Ok.

(Owen, int 1, 38:39)

Even though it might be hard for the therapist to work at knowing the client, the consequence of a therapist’s lack of empathy could be devastating for the therapeutic alliance (Therapist – empathy with client – lack of). Six of the participants talked about experiencing a lack of empathy. Sarah, a teenager with ADHD who had regular arguments with her mother and father, experienced an intense contrast between her current therapist who she described above and her previous therapist, described below.

Pa It’s just kind of, who cares, suck it up, it’s life, you’re, you’re just a teenager who doesn’t know what they’re talking about, and kind of like that, so.

Int So not valuing your opinion.

Pa Yeah.

Int Not accepting who you were, not--

Pa Just not caring, kind of, just like, suck it up, live with it, and that, idiot, kind of attitude.
Overall, six participants talked about having adverse reactions towards their therapists that caused them to feel more distant to their therapist. In contrast to warm quotes from the participants about empathic responses from their therapists, the comments, like the ones above showed feelings ranging from defensiveness to animosity.

In order to start the process of empathizing with the client, two participants explained how in their experience, their therapists’ general questions were helpful in starting conversation (Intervention that helps – general questions) in a way that helped them be understood by their therapist. These questions seemed to have two purposes. First, they helped to open up the conversation about what was going on in the participants’ lives. Nicole, with verbal expression and processing speed problems, wanted general opening questions to direct the conversation productively, as sometimes she had problems with starting her conversations.

Pa Um, the, “so we worked on this, this and this”, and um, I think that, that’s good.

Int Ok, so a summary of--

Pa Yeah, a summary.

Int --of what’s going on.

Pa Um, yeah. Um...

Int Or would you like to pick from three? Like, I mean, pick from all those?

Pa Um...
Int  Have a summary--

Pa  I think it’s good to ask, like uh, “is there anything you want to talk about
in the week?” because maybe--

Int  Ok.

F  Because maybe something special came up this week?

Pa  Yeah.

Int  Yeah.

Pa  Um, because I don’t think I would bring it up, just by myself.

Int  Oh so, so if I said “what brought you here today?”

Pa  Uh, yes. I guess it, yeah I um, because sometimes I go in quite regularly.
Like, every two weeks we just make--

Int  Yeah.

Pa  And then sometimes I just go in whenever I feel like it. Like I won’t, I
won’t see her for like a month.

Int  Yeah.

Pa  And then I just call and make my own appointment, but um...

Int  So when you call and make your own appointment that would be—I’m just
thinking, that would be because you have something--

Pa  Yeah or I haven’t seen her for a while. And then usually um, usually it’s
um, “so fill me in with what’s happening”, and, I just tell her what’s been going
on, but um—

(Nicole, int 2, 410:431)
Second, general questions lead to the therapist knowing the world of their client. For Mark, who had difficulties with verbal expression, this meant his therapist could discuss ideas with language that Mark already understood. Mark said, what helped him to be known by his counselor:

Pa Yeah, like um, also, the small general questions, because sometimes they are good. Like “what are you doing?” is ok--

Int Mm hmm. But you’d prefer questions that are related to your problem.

Pa Yeah.

Int Related to what you want to focus on?

Pa And sometimes interesting questions based on their-what they like.

Int Mm.

Pa Like, if they like Star Trek, for example, like me, sometimes it’s good to reference Star Trek.

Int Ok.

Pa Like uh, one of the main references: ‘shield goes up, shield goes down’.

Int Ok.

Pa Like, that’s one of the main counselling references I heard.

Int Which is--?

Pa ‘Shield up’ you raise your shield so there’s--

Int Oh ok.

Pa --defence against the fear, and then when you lower them, that’s when you’re fear-driven.
Int Oh, cool. So then, it’s good to ask general questions if they might help you with your problem.

Pa Yeah.

Int So to get to know you better.

Pa Yeah.

Int So they can talk in your language, and the way you know how to do things?

Pa Yeah, and also reference, you should also reference examples of what they like. Like, if they like a show you would research that show and try using references--

Int Mm.

Pa --in comparison, and make it relevant.

Int Hmm. That makes it really-really a lot of sense to me.

Pa Mm hmm.

Int So if the counsellor gets to know you in a way so that they can help you with your problem--

Pa Yeah.

Int --so that if they know you better, then they can talk to you in your language.

Pa Yeah.

Int And the way you understand things.

Pa Mm hmm.
But then if it’s just a general question for the sake of asking a general question, but it won’t necessarily help you with your problem, then that’s not very helpful.

Sometimes it is, sometimes it’s not.

Mm.

Depending on what the fear is.

Oh, depending—so can you tell me about when it is, and when it isn’t?

Um it is good if it’s during the beginning, but if it’s in the middle it’s not as good. It’s good at the beginning or end--

Yeah.

--but it’s not as much in the middle.

Ok, can you tell me why that might be?

Because in the beginning, you’re not fully deep in the swing--

Ok.

--of the counselling, so you’re more open to general questions.

Ok.

So at the end, you’re not as deep anymore, and you can tell them what you’re going to do after,

It was these open questions, to start the counselling process, at the start of the therapeutic relationship, and at the start and the end of a session, that helped to introduce the therapists to their clients’ way of thinking about their problems. Both for Nicole and Mark, general questions, helped them to be known by their therapists.
In sum, all the participants talked about certain aspects of the theme *Client feels known*. While the majority of participants had difficulties expressing themselves in a way that they could become known, this feeling known seemed to be a primary indicator for what the participants thought of their therapists. For many participants it was feeling known that helped them feel free to express their ideas. A number of participants especially appreciated therapists who could bridge the gap between their capacity to express themselves and their therapists’ need to understand intuitively. To improve their therapist’s ability to be empathetic, two participants suggested the use of open general questions. On the other hand, some participants found it difficult to open up to therapists who weren’t empathetic.

*Safety / Comfort*

Each of the participants in this study spent a significant amount of time talking about what enabled them to feel safe enough and comfortable enough to share their innermost thoughts (see Table 11 and Figure 7). Therefore, “*Safety/comfort*” was recognized as another central theme in the discussions with the participants. As seen in Table 11 and Figure 7, all of the participants in the study talked about safety and comfort in the context of the nature of the relationship between therapist and client. Participants described aspects of this relationship: sense of safety, sense of the therapist’s respect for the client and the therapist’s personality. On the other hand, some participants described the challenges of their relationships with their therapists. A few participants brought up some miscellaneous elements that affected their *Safety and Comfort*: one wanted to have positive sessions, another wanted continuity of care with the same therapist and some discussed barriers to starting therapy.
Participants also commented on ideas represented in other themes that were linked to codes in this theme. The therapist’s respect of the client is related to the theme *Client feeling known*, as the participants felt that the therapist needed to know them in order for them to respond in a way that would make them feel safe. Participants also recognized that the feedback therapists gave, discussed in the theme *Therapist expresses understanding*, helped them feel safe enough to express their own ideas.

Participants identified Safety/Comfort to be of prime importance. All the participants contributed and his theme had the most quotes (410 quotes). Some participants discussed this more than others. Tyra, Sarah, Rachel, and Ted spent more time talking about this area than any other. For example, Sarah had 72 quotes and Ted had 75 quotes in the *Safety/Comfort* theme. Two codes that were discussed the most in the entire study were *Therapist Character - openness - adapt therapeutic interventions to suit learning style* and *Therapist – client relationship*. The therapist client relationship included many other codes inside it, such as trust building, being treated as an equal partner, and safe confidante, among others. However, the therapist’s willingness to adapt therapeutic interventions to suit learning style did not have any other codes that were included under it. To ensure that quotes did not get incorporated twice into the total number quotes for this theme, the therapist-client relationship quotes that overlapped with other codes were not incorporated into the totals for participant or for the theme.

All the participants talked about what it meant to have an effective working relationship with their therapist (*Therapist-client relationship*). These comments ranged from simple comments from Sarah, Fiona and John that they felt understood, to more detailed descriptions of these relationships.
### Table 11.

**Safety and comfort of participants in therapy - code by participant**

<table>
<thead>
<tr>
<th>Participant</th>
<th>Owen</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Robin</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th><strong>Totals</strong></th>
</tr>
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<tbody>
<tr>
<td><strong>Safety / Comfort</strong></td>
<td></td>
<td></td>
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<tr>
<td>Therapist -- client relationship</td>
<td>6</td>
<td>9</td>
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<td>Safe to express ideas</td>
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<tr>
<td>Therapist -- safe confidante</td>
<td>3</td>
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<td>2</td>
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<td>Safety -- privacy</td>
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<tr>
<td>Safety -- safe place</td>
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<td>Therapist's respect for the client</td>
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<td>Safety -- wanting to be treated as normal</td>
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<td>Intervention that helps -- normalization</td>
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<td>2</td>
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<tr>
<td>Intervention that helps -- validation</td>
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<td>6</td>
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<tr>
<td>Therapist character -- unconditional positive regard of client</td>
<td>7</td>
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<td>Therapist -- equal partner with client</td>
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<td><strong>Therapist Character - openness - adapt therapeutic interventions to suit learning style</strong></td>
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<td>Therapist character -- patient</td>
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<td>Therapist character -- openness -- sharing of own learning style/thinking style</td>
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<td>Therapist character -- pigeonholing -- therapist labels client and treat them accordingly</td>
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<td>Safety -- power dynamics between therapist and client</td>
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<td><strong>Miscellaneous aspects of safety</strong></td>
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<td>Intervention that helps -- positive sessions</td>
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<td>Situational variables -- continuity with same therapist/environment</td>
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<tr>
<td>Counselling more difficult because -- having to face the issue</td>
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<tr>
<td>Counselling more difficult because -- felt that needed help to fix issue</td>
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<td><strong>Total</strong></td>
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<td><strong>Total</strong></td>
<td>28</td>
<td>60</td>
<td>72</td>
<td>31</td>
<td>24</td>
<td>57</td>
<td>21</td>
<td>27</td>
<td>75</td>
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</tbody>
</table>
Figure 7. Safety and comfort of participants in therapy - network.
Some of the most creative descriptions were expressed in the first and second alternate exercise. Fiona’s drawing (Fiona’s drawing, see Figure 8), shows a symbolic representation of the relationship she had with her therapist.

*Figure 8: Fiona’s drawing*

She had received care from two therapists and found that the relationship with the most recent one was the deepest. She described this relationship after she had completed the drawing.

Pa  Um, I guess it was just like…it was the easiest way for me to show like, a connection that’s like solid. Like, just like, a process like, physical. And it’s like, there. And, like, the colors are just like, they’re just what I thought, like thought…if thoughts had a colour, those are the colors that they would be.

Int  Ok. So the many different kinds of thoughts, many different kinds of things (*indistinguishable*)

Pa  Well, it’s three.

Int  Ok.

Pa  There’s blue, there’s red, and there’s yellow.
Int Is there any symbolist that…besides that? Or…

Pa Um. I guess, ok, yellow’s like thoughts I haven’t made up my mind on. Red is like thoughts that like make me mad, and blue’s thoughts that like calm me down.

Int Ok. So, ones calming you down. One…one’s the thoughts making you angry, and uh, yellow you haven’t made up your mind on.

Pa Yeah.

Int And each one of those (indistinguishable) goes her way.

Pa Yeah.

Int know about.

Pa Yeah.

Int So, um, and, and it’s a solidity that you have between her and you that you wanted to represent. That strong connection.

Pa Yeah. Yeah.

Int It looks like a strong connection between you.

Pa (laugh) Good!

Int Yeah.

Pa That’s what I was going for.

Int Yeah. So, is there any symbolism between the fact that her hand’s on the bottom and yours is on the top? Or is that just because …

Pa No, I just…I wanted to show the thoughts, like, going through, so.

Int Yeah, so, your hand is (indistinguishable).
Pa I just thought that hers would be above, for some reason. It just seemed like.

Int Your...hers...yours is above?

Pa Well, hers is above mine.

Int Oh, ok, above.

Pa Hers is like higher up.

Int Higher up, oh, ok. So what...what is...?

Pa Because it just seems like, once those thoughts are out, I'm like getting lifted up. I'm getting, like, pulled up.

(Fiona, int 1, 386:414)

Fiona’s description went on to talk about how not all her ideas were understood by the therapist (the therapist’s hand had weaker colors). However, most of the ideas she wanted to express were understood by her therapist. She felt close to her therapist, as represented by the touching hands. Owen also drew a picture that represented the same type of close relationship, (see code Safety-safe place). Many other participants expressed similar feelings of closeness with their therapist, and feelings of connection, using symbolic drawings in their first alternate exercise.

There were three elements of the relationship that the participants described: the sense of safety, the sense of respect and the personality of their therapist. These elements are described below and grouped in Table 11 into sets of codes.

Safe to express ideas.

Participants described four characteristics of the session that gave them sense that it was safe to express their ideas. First, five participants talked about the therapist being
a safe confidante (*Therapist – safe confidante*), and explained that they felt safe saying anything at all to their therapist. Fiona and Sarah, both teenagers who had experiences where they had not felt safe with professionals, specifically discussed how they appreciated that their therapist wouldn’t turn what they said against them. Consequently, they felt free to say whatever they wished. Nicole, as described before, had a number of different therapists, since she was young. As she described earlier, she often did not feel close to her therapist. She really wanted to be able to express her needs and desires, but found it hard. She described what she would have liked to change.

Pa And if you feel more comfortable in the sessions, I’ll feel more comfortable saying, like, speaking my mind, or speaking freely. Like, “I don’t like this exercise” or, “no, you’re not right about this” because of the relationship between, because I feel more comfortable around my counselor.

Int Yeah.

Pa But if the um, relationship isn’t that strong, or it’s, you know, um, I might-I’m more like to just say yes, even though that’s not really how I feel.

(Nicole, int 2, 718:720)

Second, three participants expressed the need to feel that the therapeutic session was private, and that others weren’t going to get a hold of the information that was gathered (*Safety- privacy*). Fiona often talked to her friends about her problems, but felt that she needed to have someone that she could say anything to, without it affecting the rest of her life. She wanted to feel normal and not be treated differently and so it was difficult for her to talk about her struggles with her learning disability with her friends. Her therapist,
on the other hand was a safe person to tell, as she was going to keep their sessions confidential.

Pa  And her being, like, just knowing that she was not going to…she couldn’t tell anyone, like, she wasn’t legally allowed to tell anyone anything.

Int  Ok.

(Fiona, int 1, 17)

Third, five participants expressed that they needed to feel that the therapist was actively working at maintaining a trusting relationship during the process (Safety – trust building effective). Owen, who had a number of traumatic incidents and expressed difficulty with his working memory, needed to develop trust over time with his therapist, in order to process these events. It was the building of this relationship that helped him trust enough to uncover his struggles.

Pa  But once you’re in, um, it, the trust thing, it’s a huge trust thing. You gotta, cause, again when I was in the car accident and other stuff came up. I just, I wasn’t ready to deal with it, and I didn’t feel pressed. But finally after a long period of time, that was built up so you could get into it. So I think that definitely areas of--

Int  Yeah.

Pa  -- trust are important to develop the relationship, um--

Int  Yeah.

(Owen, int 1, 418:421)

Finally, seven participants talked about the space where the work is contained (Safety – safe place). This safe place helped some of the participants feel protected; in this place
they were separate from the rest of life, so that things could be processed under safe conditions. Owen and the researcher talked about how this place, which he had developed with his therapist, was a safe container, as depicted in his picture (Figure 9).

*Figure 9: Owen’s drawing*

This was a place to work on issues without feeling that he had to work a particular way on things.

Pa  It’s more a place not to be judged. It’s a place, you know, it’s a place to, um, where you can, yeah, definitely there’s no, there’s a sense of there’s no, um, right or wrong, there’s just kind of how you feel and how you, like you can, it’s nothing fit into a box, it’s not going to fit into a structure, it’s very, um, it’s very free. Like you can do, you can go where you need to go; you can come back from there. Like it’s, there’s no rush. There’s no--again it’s kind of like a timeless--

Int  Mm.
Pa  I don’t know if that makes sense.

Int  Kind of like a protected space from all the other stuff--

Pa  Yeah.

Int  --outside.

Pa  That’s, that’s-- yeah. That tries to enter into it.

Int  Yeah.

Pa  It’s kind of like a space once you go into there. You can deal with everything else on the outside. And then you can go back out there and deal with the world, but yeah, so I don’t know. I don’t know if that helps--

(Owen, int 1, 698:705)

In summary, the sense of safety wasn’t discussed as much as these other areas of their therapeutic relationship, such as the sense of the therapist’s respect or the therapist’s personality (eight people contributed 50 quotes). But, a sense of safety was a mentioned by all but two of the participants. Nicole talked about all of these codes. Tyra didn’t talk at all about safety in therapy and Mark only talked once about his therapist being a safe confidante. Nevertheless, all but two of the participants felt that safety was an important issue in therapy. Feeling safe, they believed, helped them to open up more and therefore progress faster in therapy.

*Therapist’s respect for the client.*

The second aspect of the participant’s relationship with the therapist was the sense of the therapist’s respect (*Therapist character -- respect for client*). Although some participants talked about respect only, some participants talked about seven different ways that the therapist showed respect to the participant. Participants talked about
wanting to be treated as normal (Safety -- wanting to be treated as normal), the therapist’s ability to make them feel normal (Intervention that helps – normalization), the therapist’s ability to validate them (Intervention that helps – validation), the therapist’s acceptance of all parts of them (Therapist character -- unconditional positive regard of client), the therapist’s treating them as an equal partner (Therapist -- equal partner with client), and the therapist’s willingness to cater to the participants’ learning style (Therapist Character - openness - adapt therapeutic interventions to suit learning style).

The first way participants wanted the therapist to show respect was showing acceptance for them, as an individual (Therapist character-acceptance of client). Eight of the ten participants mentioned this code. Sarah, Fiona and John, who were all teenagers in school, appreciated having their ideas accepted by their therapist, something which they often didn’t feel in school. Often they found that their learning assistance teachers were very directive. Sarah, specifically, experienced struggles in the learning assistance room where the resource teacher was more interested in telling her how to study, rather than listening to her needs. She really appreciated being treated as equal by her therapist.

Pa  She, um, she treats you like you aren’t just a teenager, and your opinions count, and stuff like that, and she treats you like you’re actually mature, and like you know what you’re talking about and stuff.

Int  Oh, so she gave you a lot of respect.

Pa  Yeah, she gives you lots of respect, and she’s nice and…

Int  Mm.
She like doesn’t ever--I don’t know how to explain it, like she’s never mean. I’ve never seen her be rude--

Int  Mm.

Pa  --at all.

Int  So she cares very much--

Pa  Mm hmm.

Int  --about, about you, and, and, and she’s careful to be kind and to be respectful.

Pa  Mm hmm.

Int  And treat you like an adult, basically.

Pa  Mm hmm. Yeah.

Int  You feel like a grown-up. I guess it’s easier to talk to somebody when there’s--

Pa  Mm hmm.

Int  --expecting that.

(Sarah, int 2, 108:123)

The second way for the therapist to show respect was discussed by five of the participants. These participants described how they didn’t want to feel different from others. Although they knew they might need extra help, because of their learning disability, they did not want to be treated as strange or weird (Safety- wanting to be treated as normal). For example, Fiona, who had working memory and processing problems, had great struggles in a French immersion program and had to leave because of her challenges with dyslexia. She needed specific kinds of help, particular to her learning
disability in her counselling sessions; but she didn’t want to be treated as if she wasn’t as intelligent as others. She wanted to be treated as normal by her therapist.

Pa I, I want like a little bit, like *(laugh)*, a little bit of wiggle room, but like, but, I don’t want to be treated like I’m…I’m like, stupid, or like, like, I’m…I need help or anything.

Int Yeah. Yeah.

Pa Because I need just as much help as everyone else there. I just need sometimes a different way of interpreting this.

(Fiona, int 1, line 644:646)

The third way participants felt that therapists showed respect was to help them feel normal *(Intervention that helps – normalization)*; that they weren’t unique and alone in their experiences. Five participants described their need to feel normal irrespective of their disabilities. Throughout her conversation with the researcher Rachel felt different that her peers at university. She wished her therapist could help her accept that she wasn’t the only one that felt this way on campus. Her disability often made her feel like she was so different from the others around her at university, as she struggled with staying focused when many others found it easy. The researcher had checked in with her about a number of aspects of therapy that other participants had discussed. She had confirmed that she had some of the same experiences. But, then she described how it helped her feel to have those similar experiences.

Pa Yeah, yeah, because I mean like, and for me, it’s like, it’s like I feel insecure, and sometimes it’s just like-see, I mean, see and I don’t know how much I can project onto a counsellor, and how much is coming from me, but I
certainly feel like, you know, I’m talking about all this weird gushy stuff, and is it weird, or is it ok, or like, what do other people say? So anything like, I don’t know, anything that can, you know like, one thing I appreciated for instance is that you had mentioned that, and you know, I know this is a different scenario, this is an interview, but you’d mentioned that other people you had talked to had mentioned so and so--

Int Yeah, yeah.

Pa --which makes me feel like a normal human being.

Int Yeah.

Pa Right? And so I really like, I really like when commonalities are drawn. When you know, a counsellor can say like, you know, “oftentimes other people feel this way too” or just, just to sort of bring it on the ground—

(Rachel, int 1, 755: 759)

The fourth way which participants said therapists showed respect was to validate the participants’ experiences (Intervention that helps – validation). Five of the participants wanted to feel that indeed they were acceptable as individuals, irrespective of their particular needs in therapy. Rachel described how she wanted to feel validated because she sometimes felt that others had treated her as incompetent. They couldn’t see beyond her disabilities and see her as able in many areas.

Pa --you know like, sometimes I feel like I need, um, I don’t want to say coaching, I don’t know if that...

Int Mm hmm.

Pa But something along those lines. Like I need, I need to feel safe--
Int Yeah.

Pa --because often times I don’t feel supported so, you know, if I’m going to go talk to a professional, I want to feel--

Int Mm hmm.

Pa --you know, validated, and um, so I guess it’s really um, I mean for me it would be um, an awareness that people communicate differently--

Int Ok.

Pa --and you know, that doesn’t have anything to do with, like intelligence or anything like that, but just like recognizing that sometimes people talk quickly and sometimes they slow down, and just letting them do—

(Rachel, int 1, 27:35)

Owen, when in grade school, often experienced disrespect, because of his struggles with his learning disability. Consequently, he appreciated the validation that he was giving his very best.

Pa So, you know, all this discussion about affirmation and all, I mean, you know, like I said before, like in a way it’s just about, you know, it seems more like coaching than counselling, but in a way, I mean, it is an important piece--

Int Yeah.

Pa --because, you know, as it, I mean hell, I’ll tell you, you know, like so many times, you know, when I was growing up, you know, I, I, I was, I was really made to feel that I was lazy, and that I wasn’t trying, and that couldn’t be further from the truth.

(Owen, int 1, 917:919)
The fifth way that participants thought their therapist showed respect was unconditional acceptance. In counselling theory this is described as unconditional positive regard (Therapist – unconditional positive regard for client). Validation and unconditional positive regard were seen as different. Validation, for the purposes of this thesis, was defined as an active verbal expression of acceptance of an element of what the client was doing. Unconditional positive regard was the active acceptance, through all the therapist did, of the participant in all that they are. For example, Ted’s first therapist did not take into his account his learning disability when counselling him. He also described how his teachers in high school thought he wasn’t trying hard enough and put him in a separate room to work. His psychologist, who specialized in adaptive learning, helped him feel intelligent, accepted and capable. He was a paramedic when he met his current therapist. He went on to attempt pre-med. courses and felt capable of becoming a doctor.

Pa With - with comments like that and with body language like that, whereas with, uh, the adapted learning specialist, it was just like, the fact that she didn't have any hesitation, it was instantaneous, “Oh - oh that's what you want to do, that's awesome. You know what we can do, we'll do this and this and this and this and this and this and this, come closer [in a quiet voice], and these are the things we'll do, and, uh, it'll be great, and that solidified the tie that we had so far that I was looking at the date on my assessment, it had been so long, um, I still feel that, uh, I'm not sure if she's still even in the business or if she's retired, but, um, I still feel we could sit back down and go back into where we were at...

(Ted, int 1, 504)
The sixth way that participants saw their therapists treating them with respect was to treat them as an equal partner in therapy (*Therapist – equal partner with client*). The three participants explained how they wanted to work with their therapist to develop an effective process for therapy. Tyra, Rachel and Ted talked about wanting to have their therapist value their ideas about their process of therapy. They wanted to work together with their therapist to provide an approach that takes into account the needs of both the participant and their counselor. Tyra discussed how she would like to have her therapist use her ideas about what does and doesn’t work for her in her therapy process. Rachel, who is taking her Masters in social work, felt that she wanted to have more of a say about the effect of her ADHD on her depression, rather than her therapist just wanting to deal with her depression. Ted talked about the contrast he saw between his two therapists.

**Pa** Put him counselling so, um, but, as far - for me to answer that question um, my most, probably the most effective counselors in that actually a, an Adaptive Learning Specialist ? [raises his voice almost like question]. So she- that was her PhD was in adaptive learning

**Int** Um-hmm.

**Pa** and, and LDs, and, uh, the fact that she had training in it, and that, she had such a good understanding of it, cause I can compare her to another counselor that was, ah, he had a Masters level counselor to, um, uh, the Adaptive Learning Specialist, and it’s like night and day, it’s like she understood how I was and she would - she would almost adapt the - the, uh, sessions around me cause she could see what - she could tell when I was drifting off, and she could tell when I was getting tired of listening, of answering questions, so she would -
she would change things a bit, and, where as the other - the other, uh, Masters
level counselor was - was not responsive at all to my needs, she - she didn’t
really understand where I was, and she wasn’t there to, to figure that out, she
was more there to - to figure out why are you not getting along at home, I’m
uh, and this is, I’m 31, this is years ago, we’re talking fifteen years ago, twelve,
thirteen years ago, so, um, she - she just wasn’t really - she wasn’t really
respectful of the fact that I couldn’t concentrate and I, and there was something
underlying my, my, ah, behavior---
(Ted, int 1, 34:36)

Finally, the seventh way participants thought their therapist showed respect was
having a say in the process of therapy. All of the participants talked about how they
needed the therapist to cater the therapeutic process to fit to their learning style (*Therapist
Character - openness - adapt therapeutic interventions to suit learning style*). This code
was the only code in this theme where all the participants had something to say. Rachel
described how frustrated she was that her therapist didn’t take into account her ability to
concentrate during her sessions. She had lots of experience trying to help her ex-
boyfriend with communication skills. She saw this with her therapist. For her she wanted
her therapist to be open to her counselling needs.

Pa Well yeah, or, or recognize that, I mean, recognize that, you know, well
the labels themselves are-mean nothing, but I think that the various learning
disabilities do mean something, and to like recognize that you know what? If I
want to be an effective counsellor, I need to recognize that, you know, that
certain types of conversations aren’t going to work. Certain types of strategies aren’t going to work.

(Rachel, int 1, line 843)

Tyra talked about the depressing challenge of trying to help her therapist understand her learning style. She thought of herself as a global thinker (she described herself as thinking in gestalts) and she had great difficulty with her therapist that was more of a linear thinker. This struggle with her therapist made it difficult to help her feel understood.

Pa  Exactly. You’d just chop of one section and say this is what you’re talking about, right.

Int  Yeah.

Pa  And you’re like, no, actually no.

Int  Yeah, there’s more to this. There’s all these other parts that need to be related to this.

Pa  And you can see how this could drive someone who generally thinks straight nuts,

Int  Yeah.

Pa  This drove someone absolutely crazy. And I felt kind of, I felt-so then here I feel guilty for being the way that I am.

Int  Mm.

Pa  I actually felt very guilty. So can you imagine going in for counselling and you’re depressed, and at the same time you feel guilty because the counsellor can’t understand what you’re talking about.
Mary, who had ADHD and struggled with school in many different ways, felt her friends were frustrated with her way of going over and over issues in order to process them. She appreciated her therapist’s openness to her learning style.

Pa And I’d say “oh my god”, this was before I got diagnosed with ADHD, I’d go, “oh my god, I had something in my mind that I was going to talk to…talk to you about in this session”, and I’ve talked about everything else, and then it’s like in an hour I get to the end, and she’s say “well, don’t worry about it, you’re a circular thinker”, and she says “you know, most women are like that, and also, you’re juggling a lot of things.”

Int Mm hmm.

Pa “--You’re a single parent, you know, you’re working…” and I don’t know what else I was doing.

Int Mm hmm.
Pa And she goes, “you get to it eventually”. Ok, and I…I still remember that because she was so validating, she was great.

Int Mm hmm.

Pa She made me feel normal, and I said, but you know what the problem is? Most people don’t have the time to wait and listen to me.

(Mary, int 1, 252:258)

Mary’s comment shows much of how respecting her way of learning left her feeling validated and accepted. For Rachel this helped her open up to her therapist about her issues and be willing to try different approaches in therapy.

In summary, all of the participants talked about the therapist respecting their needs. For many respect was shown in the ability of the therapist to help the participant feel normal, validated and unconditionally accepted for the way they thought or worked through issues. In the therapeutic process, participants thought this was represented in the willingness of their therapist to accept their ideas and work with them to apply them to clinical choices about how best to address an issue.

*Therapist’s personality.*

The therapist’s personality was the third aspect of therapy that helped participants to feel safer and more comfortable. Some characteristics were discussed by as much as five participants while others were only discussed by one participant. Participants discussed seven personality characteristics of their therapists. As described further below, they wanted a therapist with warmth, caring, patience, optimism, genuineness, and openness about their background and learning style.
The first characteristic that participants appreciated about their therapist’s personality was warmth (Therapist character – warmth). Five participants talked about this feeling. This feeling of warmth was similar to the feeling evoked for some participants by the therapy room. For Tyra she described her therapist as reassuring and calm, and kindhearted. Mary, who often was seeking validation, talked about her therapist’s willingness to give a hug, after knowing her for a good length of time. Even though she had the therapist a few years ago, she still had strong feelings about her therapist’s personality.

Pa  It’s like, I went to see this one woman for a while, um, at, like this was a few years ago.
Int  Mm hmm.
Pa  Um, at um, Greater Vancouver…Family Services of Greater Vancouver.
Int  Ok.
Pa  And she was a great counselor. I mean, she used to hug me, which is great; I never had a counselor that hugged me. She was a lov--…a really lovely, warm person.
Int  Mm hmm.
(Mary, int 1, 246:251)

The second personality characteristic that participants noted was the caring nature of their therapist (Therapist character- caring nature). Five participants expressed how they valued their therapist’s concern about their life. Tyra talked about struggling with trusting one of her therapists because she thought the therapist was faking caring about her. Ted believed that the therapist caring meant that she had his best interest in mind
with anything that they did. Sarah, who had therapy for family issues and difficulties at school, had two therapists, one private therapist she respected and one from school that she didn’t.

Pa  Like the attitude they, they show, like if they’re, they seem like they don’t care, then that’s kind of harder. But then if they seem like they care and they really want to understand you, then…

Int  Mm.

Pa  It’s easy.

(Sarah, int 1, 58:60)

The third personality characteristic that was appreciated was a therapist’s patience (Therapist character – patient). Ted, with his working memory and auditory memory problems, sometimes found therapy laborious. He said that it often took him some time to think through his problems and he needed his therapist to wait before talking. His most recent experience with a therapist’s patience helped him to learn how to become more patient with himself.

P: [Short pause] I think that fact that she is - was really patient, um, that certainly made it easier. She would give me a - she would give me a task and, you know, she was just - she used to write all these notes down and she was just, she was super patient with…how I was…when I was getting frustrated, she just let me get a little frustrated and trying to get myself back on track, um…m, I still feel we could sit back down and go back into where we were at…

(Ted int 1, 94)
The fourth personality characteristic that was discussed by four participants was the therapist’s optimism (*Therapist character – optimistic*). Tyra, Mary and Ted all talked about having problems with being pessimistic. All three said that their disabilities sometimes left them feeling frustrated and struggling to keep working on their issues. Both Tyra and Mary said that their feelings of depression were related to having difficulty overcoming the symptoms that were a consequence of their disabilities. Tyra, specifically, phoned the researcher up after the interview and was feeling hopeless. The researcher provided community resources where she could get support for her learning disability. She said that this was a regular feeling that she felt lost in pessimism. She described her therapist’s optimism in terms of focusing on her strengths.

Pa  Motivation, I think, because I find that when people focus on your weaknesses, it makes you unmotivated and you think you’re stupid. And then the counsellor at school was the other way, she went with the strengths and that really helped.

Int  So she went with strengths.

Pa  Rather than weaknesses.

Int  Mm hmm. So this was the one at UBC right?

Pa  Yeah.

Int  Ok. So it helped for you to have somebody who focused on all of the things that you could do as opposed to couldn’t do?

Pa  Yeah.

Int  It helped you to talk more--

Pa  Yeah.
Int  And think about things more--

Pa  Well, and also kind of, it was more realistic than just saying, uh, you have all these weaknesses and this is how you’re going to fall, and all this kind of stuff. Because if you look at that side of the picture it looks like it will happen, but there’s so much other sides to it that those over-ride the negatives.

(Tyra, int 1, 16:26)

On the other hand, Ted described how a lack of his therapist’s optimism ended any rapport that Ted had with his therapist.

Pa  Whereas, so many times, it was just like, “You're not - you may not be set for that, you may need to find something a little - a little lower - a little lower on the scholastic scale”, and - and, just a lot of questioning and you can - people can come up and say things, uh, that - were, uh, people are intuitive too, they can read, people's body language and their expressions

Int  Yeah.

Pa  And you can tell right away and you can tell, obviously this person doesn't think I can do what I just said I'm gonna do, and they're gonna try and talk me out of it and, you know what, to me - if there was ever - if there was ever a connection between the - the counselor and the student or the counselor and the patient, it's, severed, and it's - it's severed for life.

(Ted, int 1, 500)

In the last three personality characteristics of the therapist, participants wanted a therapist who was willing to share themselves. Five participants described how they wished to have a therapist that was open and honest with their own feelings and ideas
(Therapist character – genuineness). Rachel wanted more than a professional that hid themselves behind their professionalism. Rachel depicted this in a drawing that described her relationship with her counselor (Figure 10).

*Figure 10: Rachel’s drawing*

What she wanted in the relationship was depicted in the two figures in front of the judge’s box, she wanted to be face to face with her counselor, in a way that she knew the therapist and the therapist was open to listening to her.

Pa  So face to-they would be face to face.

Int  They’d be face to face.

Pa  Yeah. Certainly, they’d be face to face.

Int  So would you like to put them on this side maybe if you can’t fit them in here or where would you like--?

Pa  Ok. And I’ll use green.

Int  Sure.
Pa  Because I think green would be good. So I think... *(Humming)* I don’t know why it’s a ‘him’, but anyways, it doesn’t matter.

Int  Hmm.

Pa  Arms would be here...good, good body language.

Int  Ok. Opens himself.

Pa  Yeah, open, open body, and like kind of like relaxed, and like, yeah ok. And um, huh. Yeah, that makes kind of sense to me.

Int  Ok. So the green one is the one that has the ideal connected-knows you.

Pa  Yeah! Yeah, and like he’s, he’s facing me, and, and his, his chest is open, so, you know, um, he’s open to hearing what I have to say.

Int  Yeah.

Pa  Um, and he’s kind of like relaxed, which is different than the kind of professional, um, posturing, of this um, grey counsellor here.

Int  Mm hmm.

Pa  Right? He’s um, he’s just like “hey!” you know? “That’s life” you know, he doesn’t have a tie, you know. *(Laughs)* But yeah, I guess it would be more like that, except for that they’d both be sitting or something, but yeah, I mean, like literally

*(Rachel, int 1, 1167:1183)*

Three participants talked about knowing more about the therapist than a genuine expression of their reactions to the here-and-now; they wanted to know about their therapist’s background *(Therapist character– disclosure of self)*. Tyra talked the most about this need to have the therapist share more of themselves. One therapist she had hid
behind a level of professionalism that left her feeling cautious about what she wanted to share. She felt that she wanted to know more about her therapist. She seemed to be aware of a difficult balance between the therapist’s need for privacy and needing to know a bit more about her counsellor, in order to be comfortable with her therapist. It felt like it showed that they had more invested in their relationship with her when they shared something of themselves.

Pa  That brown part is just kind of, ‘cause everyone lives-I don’t know, it’s kind of like they have their shadow, or they have their self that’s hidden or whatever, but it just, you know, it doesn’t have to be much. It can just be bits. Because of course you have to respect their privacy, and part of what helps you heal is that they’re not someone you know that well. Right? Like you need to know them but not, you know. Because if you knew everyone like you knew your parents or you knew your friends--

Int  Mm hmm.

Pa  Then it would be harder to have that distance when you need it.

Int  Mm.

Pa  Because you would become more dependent, because it would be like your friend…

Int  Yeah, so that distance helps you grow?

Pa  A bit, but not too much distance, because I find that often there’s too much distance, and then you, you, it feels like you’re not connecting.

Int  So how does that help, that connecting? What does that do for you?
It just feels like they care, even if they really don’t care, right. It just feels more like they care; care enough to share a little bit of who they are.

(Tyra, int 1, 875:883)

Finally, the last aspect of the therapist’s personality that participants believed would be helpful was the willingness for the therapist to express their learning style. 

(Therapist character – openness – sharing of own learning style). Only Tyra and Mary talked about their learning styles. While Mary talked about how her therapist capitalized on her more visual learning style, Tyra experienced a clash in learning styles with her therapist. Tyra had taken some training, related to understanding her own learning style and talked a lot about the effect of her learning style on therapy. She believed it would have made it easier to work through problems as she didn’t feel she could adjust to her therapist’s way of thinking through problems, until they talked about learning styles.

Or I could know their learning, like, you know--

Yeah. 

--bits, because if I could understand it then that would make sense, like that’s actually what helped me with this person that I had some trouble with, is I started realizing that we just thought in completely different ways. It was funny that I had to do that, but I had to connect the dots and go, oh, I understand why you don’t get it. Let me break it down for you. And I would do this! I would break it down into parts so he would understand and it would make complete sense for him.

(Tyra, int 1, 929:937)
In summary, all participants except one talked about the effect of the therapist’s personality on their feelings of comfort and safety in their sessions. Participants described their preference for therapists who were willing to share themselves, and had personalities that encouraged participants to feel welcome to share themselves. Warm, caring, patient and optimistic therapists, who were open about themselves, to the level that the participants needed, set the conditions where participants knew that it would be a safe place to work.

*Insults to therapist client relationship.*

On the other hand, eight participants also expressed qualities of their therapists that caused them to shut down and be unwilling to work. There were six ways that participants believed their therapist damaged their relationship with them. Participants found it difficult to work with a therapist when they were cold/distant *(Therapist Character - cold/distant)*, not genuine with them *(Therapist character -- genuineness – not)*, treated them according to label *(Therapist character -- pigeonholing -- therapist labels client and treat them accordingly)*, were rigid with their approach to therapy *(Therapist -- rigidity with approach)*, and created a significant a power imbalance between them and the participant *(Safety -- power dynamics between therapist and client)*. Six participants talked about how these impairments to their relationship with their therapist affected their feelings of safety and comfort to the extent that they had difficulty with openly expressing their ideas and feelings to their therapist *(Safety -- not open)*. Participants usually discussed the impediments to a close relationship with their therapist as a contrast with the components they described above that improved their relationship with their therapist. Sometimes they expressed what they would have liked
in contrast to what they experienced. At other times they contrasted a positive relationship with one therapist with a negative experience with another.

One element that affected the participants’ relationship with their therapist was their therapist’s professional distance (Therapist Character– cold/distant). Tyra, who had an experience with a psychologist who was not interested in getting to know her, talked about how when she didn’t know her therapist she saw him as a “stony person” (Tyra, int 1 905). In Rachel’s first alternate exercise (see Figure 10), she pictured the therapist that she didn’t like in a formal wood paneled room, sitting high on a judge’s podium, full of professional opinions. Sarah, who had ADHD and difficulty in school with teachers who didn’t accept her disability, said that she wanted a therapist who was “not some robot” (Sarah, int 2, 66). She had a therapist who seemed to hide behind his profession and was intent on advice giving, and did not accept that many of her difficulties were because of her disability. She experienced this as a therapist who was unsympathetic to her struggles with her disability. Sarah described how this coldness affected her.

Pa: I’ve seen other counsellors and that, and some of them are just not nice, and not friendly, and shouldn’t even be in that profession because they’re so cold, and…

Int Mm.

Pa …it just turns you off, and that’s difficult.

(Sarah, int 1, 54:56)

The second way three participants expressed how therapists adversely affected their relationship with when they were not being genuine with them (Therapist character
Nicole, when she had therapy funded by ICBC, talked about her therapist sitting behind a piece of paper and looking at her watch. She felt that her therapist was waiting for the session to be over and not really interested. Nicole found it difficult to open up to her because her therapist was not really sharing her experience with Nicole. Tyra felt that the counselor was rushed and just going through the motions, rather than spending time getting to know the client. For example Tyra said:

Pa Yeah, like I had um, I saw someone else out of school and I just didn’t feel…very nice fellow, done a lot of research, especially with epileptic kids and stuff like that, and has certified LD and all this sort of stuff, but he just didn’t seem to sort of have the empathy, and really listen, and I think some people are better at that than others. Like yeah sure, he had all the pieces of paper, he had all the years of experience, which he kind of said over and over again but I just don’t believe people who aren’t sincere. I remember seeing him running down the street once, like, boy, this person is overworked, stressed out, and probably, you know, enjoyed his job and likes helping people, but there’s a bit of a tension that I can pick up, because I’m really--

Int Mm.

(Tyra, int 1, 65)

The third way the participants did not build a safe or comfortable relationship with their therapist was when the therapist treated them according to a diagnostic label (Therapist Character - pigeonholing - therapist labels client and treats them accordingly). Four participants had experiences with therapists defining their problems in terms of their disability. Ted had a therapist in high school who decided his problem
was opposition at school and depression. She didn’t look into any of Ted’s problems with learning. He didn’t feel that she had asked him any questions about his struggles in school before starting on a course of therapy for his depression. Tyra described how she felt her therapeutic relationship with her psychologist was difficult, because he had written her psycho-educational assessment. She thought that he was judging her because of her assessment. In the few months before the interview with the researcher Tyra had been doing a lot of research about her learning disability and had seen a number of psychologists. Some told her that her disability was unique and that they had a hard time thinking how to help her. Because of her visual memory problems and auditory memory difficulties, along with her reading and writing problems, she was having problems finding professionals that knew how to find ways to help her compensate for her disability. The standard approaches didn’t necessarily work for her. Consequently she became frustrated with professionals who tried to label and then treat her as these approaches didn’t seem to fit for her. Consequently, she had similar feelings about her therapist.

Pa I think it’s harder if you, um, and I think this is probably not good that they did this…I had an assessment done at the same time as I was being counselled, which I think is ethically wrong, but I won’t go into that. I think it’s important that your counsellor, I guess, will know about your learning issue, but at the same time won’t, you won’t kind of feel this undertone of this, that’s how they’re judging you through the counselling.

Int Oh, due to the learning disability you’re like this kind of thing?

Pa Or because I saw this, or you are this, and you’re just like, no, you didn’t
pick that up. So it’s kind of, you don’t trust them because they just focus on the score rather than who you are.

(Tyra, int 1, 105:107)

The fourth way six participants felt that their relationship with their therapist was adversely affected was when their therapist was tied to a particular approach to therapy, rather than adjusting the approach to the participant (*Therapist – rigidity with approach*). Owen, who had some working memory problems, went to one session of cognitive behavioural therapy, which he felt did not fit with his needs. He went on to try Eye Movement Desensitization Reprogramming, where his ability to process his trauma through visualization worked much better for him than talking. Ted’s experience with his first therapist was similar. He felt his therapist, who only would do cognitive behavioural therapy, had a rigid style that didn’t really fit with his needs. Tyra described this problem with one of her therapists.

Pa Yeah, exactly. And I don’t think people do it on purpose. Again I just think that they know that their method has worked on thousands of people so they try to do that on you, and when you want to break out of it they think you’re being, um, you know, rebel-like, and you’re not trying to rebel you’re just trying to help yourself.

Int So it’s that difference, that one in many, that is a problem sometimes in counselling.

(Tyra, int 1, 472:473)

The fifth way that they believed that the therapeutic relationship was adversely affected was talked about by Rachel. The therapeutic relationship was top down, rather
than an egalitarian approach discussed earlier (*Safety – power dynamics between therapist and client*). For Rachel, she felt that she was weird and different from others she knew because of her disability. Because of her disability, she struggled with trying to express herself in therapy, which made her feel unequal with her therapist. She felt this left her in a more vulnerable situation, because she had to put her trust in somebody when she was feeling not as competent as she wanted.

Pa Well it’s just like, I don’t know, like yeah, it’s like, if I look at the, the head, the head’s kind of looking down and um, maybe you know, like I was saying before, like sometimes I felt like weird, or something.

Int Mm.

Pa Right? You know, and like there’s the power dynamic, obviously. There’s always that power dynamic, but it’s even more than that because as I’ve said before, you know, having a learning disability and, you know, and finding that interactions are difficult for me sometimes, generally, because I’m kind of different--

Int Yeah.

Pa --in some ways, and then coming to see a counsellor, and, and not expecting that weirdness to be there, and it being there and it even being worse, because, here I am, you know, I’m trying, here I am knowing that I need to be vulnerable if I want to change something--

Int Mm hmm.
Pa --and so then I even feel scareder because, you know, I’ve put my trust in this sort of professional or something.

(Rachel, int 1, 1039: 1055)

Six participants described how having difficulties creating a safe and comfortable relationship with their therapist made it difficult for them to be open about their problems with their therapist (Safety -- not open). Sarah, a number of times got angry, and even swore, when talking about her first therapist. She felt that her therapist wanted to tell her to just get going with her life and stop complaining. This left her with an oppositional relationship with her therapist that ended quickly. Fiona, who had working memory and processing speed difficulties, talked about getting stuck with talking to her therapist as she felt she didn’t have a personal connection with her. This left her with feeling it was harder to get the right words out and think about what to say, compared to talking with a friend. Nicole (Pa), who expressed problems with her therapist earlier in this theme, described her relationship in a pose from the 2nd alternate exercise. Her significant other (F) tried to help her express her ideas.

Pa Yes, um, because I felt, I feel awkward, like I don’t feel very comfortable. Like, I could have been leaning back and relaxed, but I don’t always feel that way. Um, I don’t feel, um, um, I don’t feel relaxed and comfortable, so I was trying to show that. And then um, I was um, scratching my head because, um, I think sometimes when she asks me questions, um, I don’t understand it, or, maybe I don’t understand our sessions.

F You don’t see how her questions are helping you or how they are relevant to you?
Yes. And I don’t see how the session, I’m scratching my head because I’m thinking ‘why am I here?’ maybe.

Int Mm hmm.

And uh, I’m scratching my head because um, I feel like, um, I’m thinking of the answer, or I have thought of the answer but I can’t think of how to say it, or word it out. So I’m um, maybe confused, frustrated, um, not comfortable and the relationship seems distant, and um, like she’s not being attentive enough, and um—

(Nicole, int 2, 931:935)

This description led her into explaining why she didn’t feel open and what might help her feel open. Instead of her therapist sitting quietly behind her clipboard, Nicole wanted her therapist to interact with her.

I think the counselor could, um, over time. Like um, the way things are going between me and my counselor now, I don’t think that she’ll-I’ll open up any more to her, because, I don’t know, something different needs to be done so that um, maybe she needs to interact with me more and then maybe I’ll open up more.

(Nicole, int 1, 865)

In summary, participants described six different ways the therapist made their relationship more difficult. They saw that the ways their therapist weakened their relationship were the antithesis of what their therapists did that helped them open up. Participants thought of those therapists who were difficult to relate with as more professional and less warm and genuine. On the other hand, therapists who the
participants liked tended to me more warm, caring, patient, optimistic and genuine. It was more difficult for participants to develop a close relationship with their therapist if they decided on a process for therapy based more on a label that they gave the participants, rather than a close relationship, and did not adapt their approach to therapy based on their participants’ needs. On the other hand, participants preferred therapists who were more open to the participants’ ideas and were willing to work with the participants to find a counselling process that worked for them.

Miscellaneous aspects of safety.

Participants described four additional ideas about how they could have safety and comfort in their sessions that didn’t fit into any of the four broad areas above (sense of safety, sense of respect for the client, therapist’s personality, and difficulties with client/relationship). One participant, Owen, discussed how he wanted some positive sessions, to talk about what was working in his life (Intervention that helps – positive sessions). Other participants, when they had a good relationship with their therapist, discussed how they wanted continuity, as they had developed a sense of safety and familiarity in their client-therapist relationship (Situational variables -- continuity with same therapist/environment). Others discussed two barriers to starting therapy (Counselling more difficult because -- having to face the issue and Counselling more difficult because -- felt that needed help to fix issue).

Owen suggested that he would like sessions that were focused on not only removing what was not working in life, but also on celebrating the truly great things that were going on (Intervention that helps – positive sessions). In his sessions he had
processed the traumatic experiences, and decreased his social anxiety. Further, he wanted to add some more positive elements to his life.

Pa  It should have, I felt it should have done more. Like it should have gone further, like, why not have a few EMDR sessions that are really positive, and really great.

Celebrate, you know, how great life is. I don’t know.

Int  Yeah.

Pa  Like why not?

Int  Like things that are positive. Not just replace-- getting rid of stuff that you don’t like.

(Owen, int 1, 574: 578)

Three participants briefly discussed how they wanted to keep the same therapist for a while (Situational variables -- continuity with same therapist/environment). Ted said that he appreciated having a therapist available whom he had worked with before; he didn’t have to waste time telling the same story over again, if he needed help with a small problem. He had spent a lot of time with his therapist getting to know the complexity of both his learning needs and his issues at school. He thought it might take a long time to familiarize another therapist with his needs and it might be difficult to find another therapist who would know how to work with him. Rachel said that she needed to be familiar with her therapist to know how he or she would react to what she was going to say. She didn’t want them to get upset. Nicole had struggles with being passed from therapist to therapist. She found it frustrating to have to retell her story over and over
again. Recently she changed therapists and again was having a hard time opening up to her new therapist.

Pa But it’s good to stay with the same for a while, because uh, I was bounced around from a few because, I went from like, youth, or like, from children to youth to adult and then to ICBC paying for it, so I went to a few, but it’s kind of like, then when you go see a new person you have to kind of tell them your story again so they know you, and it’s kind of nice when you go to the same one.

(Nicole, int 1, 375)

Finally, a number of participants talked about the difficulty of starting therapy. Counselling, for two of these participants, started with the initial feelings of wishing that they didn’t need the help (Counselling more difficult because – felt that needed help to fix the issue). John needed help to graduate from high school and was tired of trying to work on his life. In addition, he was struggling with his relationship with both his mother and father.

Pa And made it harder? Well, I have to go there, and it’s a hassle sometimes. And that kind of almost makes me feel that I can’t do it by myself.

(John, int 1, 48)

Two participants found that facing the issue itself was very hard (Counselling more difficult because- having to face the issue). Owen talked about his struggles at starting therapy. He was very busy at school and it took a lot of work to manage his time table. He felt that it was a huge load of work to go to therapy, piled along side a huge load of work at school.
Well I think, I’m probably preaching to the converted here, but you know, getting into counselling is one of the hardest things to do. It’s like facing that, and facing actually going into it.

(Owen, int 1, 414)

The four miscellaneous issues were only discussed by a few participants. But, they brought up issues about positive sessions, continuity with the same therapist and difficulties starting therapy that they felt significantly affected their safety and comfort in therapy.

Two participants had comments to make in the member checks about this theme. Tyra, confirmed what she had said before, that the therapist needed to be creative, in order to deal with the needs of an individual with a learning disability. They need to be able to cater the session to fit with the client’s learning style. She also appreciated when her therapist was optimistic and talked with her about the great things that she had done in her life, to help her improve her self-esteem. John also confirmed that he couldn’t work with a therapist who wasn’t nice. He felt he needed a therapist open to his learning needs. The participants’ comments, in the member check, were consistent with what they had already contributed in their previous interviews.

Not surprisingly, considering the participants were asked what made counselling harder or easier and what helped you compensate for your disability, all of the participants had something to say about what helped them feel safe and comfortable in therapy. Many expressed how they appreciated being treated with respect, and feeling acceptance and cared for by a therapist who was accepting of their needs. All of the participants talked about their relationship with their therapist and appreciated when their
therapists were open to their learning style. All ten participants talked about this theme and participants talked about this theme more than any other, with 410 quotes and 29 codes. Participants talked again and again about how safety and comfort needed to be present if they wanted to maintain a working relationship with their counselor. Without a close relationship with a personable counselor, participants became unwilling to share their innermost thoughts. In the worst cases, participants became hostile and angry toward their therapist and never went back for another session.

Client /Therapist Co-created Structure

During the interviews all of the participants talked about working with their therapist to create a therapeutic process that worked for them (See Table 12 and Figure 11). Therefore, “Client/Therapist co-created structure” was recognized as another central theme. As can be seen in Table 12 and Figure 11, participants discussed the various aspects of negotiating with a therapist to create a therapeutic process that worked for both them and their therapist. All of the participants expressed a need for some kind of structure in therapy and many talked about how they wanted to participate in directing the process of therapy. Participants wanted help from their therapists to understand their learning style and purpose of a different interventions or exercises, so that they could work with their therapists to make appropriate choices about their therapeutic process. They also wanted their therapist to give them options about what they could do in therapy. Finally, after undertaking that process, many participants talked about using what they learned from the process and the structure that they had created with their therapist to guide future decisions and goals for therapy.
All the clients wanted some kind of structure in counselling, as represented in the code *Structure – in counselling wanted by client*. Mary talked about how she needed some kind of structure from the therapist, to sort out her ideas. Sometimes she would get lost in the details of her story and not be able to organize it. She said she wished that her therapist had provided her with a way to organize her thoughts, as she felt she was sometimes talking without getting anywhere. Nicole, also, in her first alternate exercise, drew a picture of her and her therapist holding onto opposite ends of a rope (see Figure 12).

*Table 12.*

**Client-therapist co-created development of therapeutic structure - code by participant**

<table>
<thead>
<tr>
<th>Participants</th>
<th>Owen</th>
<th>Tyra</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client / Therapist Co-created Structure</strong></td>
<td>Codes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Structure - in counselling wanted by client</strong></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>8</td>
<td>4</td>
<td>3</td>
<td>17</td>
<td>8</td>
<td>1</td>
<td>46</td>
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<tr>
<td><strong>Client directed therapy – helpful</strong></td>
<td>18</td>
<td>4</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>8</td>
<td>6</td>
<td>44</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Client directed therapy - express counselling needs</strong></td>
<td>4</td>
<td>8</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>2</td>
<td>28</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Client directed therapy - express learning style</strong></td>
<td>9</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>15</td>
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<td><strong>Client directed therapy - difficulty expressing needs</strong></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Intervention that helps - discussion/assessment about learning style/communication style/thinking style</strong></td>
<td>14</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>1</td>
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<td>5</td>
<td>5</td>
<td>2</td>
<td>38</td>
<td></td>
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<tr>
<td><strong>Intervention that helps - discussion about the purpose of an intervention</strong></td>
<td>1</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19</td>
<td></td>
</tr>
<tr>
<td><strong>Structure - options given to clients</strong></td>
<td>1</td>
<td>10</td>
<td>1</td>
<td>2</td>
<td>13</td>
<td>7</td>
<td>2</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Structure - options not too specific</strong></td>
<td>1</td>
<td>5</td>
<td></td>
<td></td>
<td>9</td>
<td></td>
<td></td>
<td>15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Client directed therapy - more open options</strong></td>
<td>1</td>
<td>3</td>
<td></td>
<td></td>
<td>1</td>
<td>8</td>
<td></td>
<td>13</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Structure - guides assessment for what has been done and goals for the future</strong></td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>9</td>
<td>5</td>
<td>24</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td><strong>Totals</strong></td>
<td>23</td>
<td>41</td>
<td>6</td>
<td>38</td>
<td>16</td>
<td>23</td>
<td>8</td>
<td>91</td>
<td>35</td>
<td>6</td>
<td>287</td>
</tr>
</tbody>
</table>
She said that this symbolized the ways that her therapist gave her direction in the sessions, directing her to go one way or the other. However, in the picture she drew about her typical therapy sessions she found that the rope was a bit slack and she would have liked her therapist to pull a bit harder on the rope. She was looking for more direction from her therapist. Ted, who had one therapist who was directive and another that worked with him cooperatively, explained how the structure that he wanted was something that should be co-created by therapist and client.

*Figure 12: Nicole’s drawing.*

He earlier had said that he liked structure, and then had said that he preferred to not be directed by his counselor.
The way they work is that structure is my structure, and, uh, I'm not more conforming to your structure. You know what I mean. So the structures, they're on different sides of the table.

You may have a structure that's, uh, counselling psychologist that you need to go by - you need to have questions answered so you can diagnose, uh, symptoms

And come up with a solution, uh, whereas I'm not going to - I'm not necessarily going to want, 25 questions, that I think I can answer, uh, in telling you a story, uh, in 5 minutes, I'm not gonna want 25 questions, probing and digging, cause - cause you may be able to come up with a solution but that doesn't help me come up with a solution.

So it's not your so

Yeah, it's not my solution, so, I don't own it. So you own it, and it's your structure whereas if you let me able to move in the, uh, like, the ebbs and flows of my personality, if you will, you know, moving back and forth, then, you know, you can see the train of my thought, my train of thought as I'm talking here, you can see, that I'm moving around, trying to think about, if you allow me to come up with it myself, then, by coming up with my own structure, then I - then I've come up with a solution, and, fortunately, you're along for the ride.

(Ted, int 2, 214:220)
In providing structure for therapy, many of the participants talked about how their needs directed the process, as represented in the code *Client directed therapy – helpful*. As Ted said above, he needed a structure, but it was a structure provided by his own choices. Nicole, who struggled with verbal processing, said that she needed the therapist to ask her how she wanted to proceed with expressing her ideas, if she was getting stuck. Tyra said that she appreciated it when the therapist asked her if she needed any ways of recording her ideas. But, she felt that she would have liked some more choices about what exercises would work in the sessions, and sometimes felt that it was difficult to verbalize her needs if the therapist didn’t feel comfortable with carrying out a particular exercise. Owen, who said he had difficulties with his working memory, but was gifted in both abstract and verbal reasoning, said he needed to determine his direction in his therapeutic process.

Pa  But um, you kind of go where it takes you. That’s what it seems like. Her method at least was to kind of go where it takes you. And I think that’s a very important part of being understood at least, is that to get to the issue you have to go, like, ‘cause obviously, if you take off one layer and then you, all of a sudden you expose this whole other deeper kind of layer.

Int  Ok.

(Owen, int 1, Line 38)

For Fiona, a teenager with a reading disability, sometimes this meant that the therapist needed to let the client use a process that might seem counter-intuitive, based on their learning disability.
Yeah, I don’t know if that would be, like, every dyslexia person, because lots of people like…I have friends that are dyslexic, or, have a, like, reading disorder, or whatever it is…

And…learning disorder…and they don’t like reading books at all. They, like, won’t. But, I…that’s how I learn. Like…

Okay. So then, it’s…don’t take things at face value. Not every person with a, a…dyslexia has the kind of reading problem where they don’t want to read.

Yeah

In fact some people with dyslexia do want to read, and it’s really important to them to read.

Yeah, yeah.

Yeah. So, um.

But I think it’s just like, who you, like, like, cutting out the dyslexia, like, whoever would have it, or doesn’t, I think it’s still like, the person--

Yeah.

--would like reading. Do you know what I mean?

Yeah, absolutely.

Another way the clients helped to direct the course of their therapy was by talking about their specific counselling needs and their learning styles. Some participants talked about how they needed to talk about their counselling needs in therapy, so that they could work through their issues more efficiently, as represented in the code Client directed
therapy – express counselling needs. Some participants talked about adapting an intervention to suit their particular deficits. For example, Fiona, who had working memory and processing speed problems talked about working on an exercise with her therapist where she was supposed to draw a picture. She was frustrated with the process because she felt she needed to have more time to work on her exercise. She only had enough time to draw stick people. While, Owen, who was gifted and learning disabled, described a more general problem of describing his needs. He found it frustrating to explain to his therapist, in a way she could understand, that some things he really understood quickly and other things he really struggled with. Somehow, he felt that his therapist should be able to understand when they needed to slow down to help him understand. He felt that it may have been harder for the therapist to understand why he didn’t understand some things, and had to process them in a slower way, because he was so gifted in other areas.

Pa  Because um, because sometimes I felt like I, you know, it’s so obvious, they should just know. Like, you know, getting at those underlying beliefs that might not be very good. Like, it’s one of those things where if it just makes sense to me I just go right to it, and maybe I shouldn’t. I think it’s important for a counsellor to--., like I don’t know, like, are you dealing with kids with learning disabilities that are--? Like I feel like I’m a very, like, <sigh>, like it’s really hard to be understood when you have a learning disability when you’re also intelligent.

Int  Yeah.
Pa That’s the hardest part. So that’s how I feel. Like I feel like I get some stuff really well; like I’m two extremes of not getting stuff, and getting stuff.

Int Ok.

Pa For a counsellor it’s important to—it’s hard because maybe they have to spend the extra time explaining stuff.

Int Yeah.

Pa And also have to spend extra time catching up to understand stuff. Does that make sense?

(Owen, int 1, 432:438)

Seven of the participants talked about how they needed to discuss their learning style with their therapist, in order to help the therapist determine what kinds of interventions would be appropriate, as represented in the code *Client directed therapy - express learning style*. Mary talked about being a circular thinker, with her therapist. Her therapist’s validation of her learning style helped her to feel comfortable to work through an issue without having to worry about being judged for her approach to the process.

Owen, who was a more visual learner, and had auditory and working memory problems, described how he worked on using his own way of drawing diagrams to describe things with his therapist, otherwise he found it difficult to remember what he had learned in therapy. Tyra, who had worked on finding a learning style that worked for her over the course of her university education, described how a discussion about her learning style could fit into a therapy session.

Pa So I think, ‘cause I understand why you maybe would be interested in interviewing people about um, their, their learning styles and counselling,
because you have to re-learn, um, new strategies and things to overcome problems.

Int Yeah, so it’s basically, and, and so learning style, how somebody learns, you were saying, makes a big difference because--

Pa In counselling, yeah.

Int Because counselling’s about learning.

Pa Exactly. Because you’re relearning, you’re retraining your brain to think of different things.

Int And so how you learn, the approach that you, that everybody has to learning is different--

Pa Mm hmm.

Int And so different people learn in different ways better.

Pa Exactly. Especially I don’t, I’m sure people who are deaf, or depressed at times, and you’d have to interact with them differently, so why shouldn’t you do that with a learning disabled person?

(Tyra, int 1, 214:222)

However, five participants struggled with describing their counselling needs, as represented in the code Client directed therapy – difficulty expressing needs. Tyra struggled with expressing her needs. She felt that some of her therapists felt that they knew her needs better than herself, because of their years of experience.

Pa Exactly. But I think my problem is, is ‘cause I do know what I need, but then at the same time I’m not in a position of power to be listened to.

Int Mm.
Pa  So that’s why maybe some counsellors might be like, well, I know better.
I’ve been doing this for 40 years, and da da da da da, whatever. So.

(Tyra, int 1, 414:416)

Rachel, on the other hand had a hard time saying that she really wasn’t feeling all that
good about her life, when her therapist was trying to point out the positive aspects of her
life. She also wouldn’t ask for clarification sometimes. She felt like she didn’t want to
feel worse about herself or look bad to the therapist.

Pa  And sometimes what happens in counselling is, you know, a counsellor
will affirm that I’m actually making good choices, and that I, you know, it
seems like I have a good network, and you know, all this kind of stuff, and I
will agree, um, because, because I won’t, because I don’t want, uh, because I
don’t want to feel bad about myself--

Int  Yeah, yeah.

Pa  --Or, or I, you know, or a question will be asked and I won’t ask for
clarification or whatever, right?

(Rachel, int 1, 341:356)

For, Ted, who had working and auditory memory problems, had a hard time expressing
his needs in a way that could be understood by his therapist and in the end he just shut
down. He had great difficulty with a Cognitive Behavioral approach to his therapy that
involved a lot of words.

Pa  Yeah, it was more - and as soon as I came across that in a 3rd year Psych
course, I immediately thought of her. It wasn't that she was being... uh, the
word is argumentative or, certainly trying to get into conflict with me, but,
trying to, “Well, no, it wouldn't be like that.” And I - I was more of a, what's that word, no, I'm telling you how it is. You're just - you're just not seeing it. And so I - I was - I continually went, you know, both of my parents really wanted me to continue going, to see her

Int   Yeah.

Pa   In the meantime I - I saw her in my mind and I saw the red flags in my mind you don't know what you're looking at but with me and I just fed her the lines that she needed to continue the counselling.

Int   Yeah.

Pa   And, unfortunately, it turned out to be a waste of my time. But it was a waste of my time.

Int   So

Pa   I don't know if it was a waste of her time because she gets paid

Int   Yeah, but it sounds like she didn't really kind of, try and take your perspective at all, and try to figure out what was going on in your mind.

M   She didn't connect it - connect it to learning. Is that what you think

Pa   No, she didn't connect it

(Ted, int 2, 59:66)

Participants described how they would like their therapist to help to both teach them about their learning style and the purpose of interventions, so that they would have a more productive therapy process. Nine of the participants talked about the utility of the therapist working with them to assess their learning style, as represented in the code

*Intervention that helps – discussion/ assessment about learning style/ communication*
John talked about how he enjoyed analyzing how things work, and therefore his therapist worked with him through a more solution-focused approach. Mary talked about getting lost in the details of therapy and she appreciated when therapists helped her to think about the big picture of her therapy. Tyra thought that a discussion about learning style was essential. She seemed to have a clash between her learning style and the learning style of her counselor; she found that she was a global thinker while her therapist was more sequential in his thinking patterns:

Pa  Yeah.

Int  You’d want it--

Pa  I wouldn’t be easy to counsel.

Int  No.

Pa  That’s why I felt kind of bad for the person who was very sequential, and he tried very hard.

Int  Yeah.

Pa  And he did a good job. He helped me out quite a bit, but there were times when it wasn’t very useful.

(Tyra, int 1, 396:402)

In the same way, five participants wanted their therapists to educate them about the purpose of an intervention, as represented in the code Intervention that helps discussion about purpose of an intervention. Mary, who drew a picture of her feelings in an art therapy process, was trying to paint a beautiful picture, as she was an artist. She wasn’t happy with the artistic value of her piece. After learning about the purpose of the exercise she felt freer to paint. Nicole, who had verbal expression, working memory and
processing speed problems, sometimes didn’t understand the value of certain interventions. For example, she felt a bit childish when she did play therapy, was confused about the purpose of doing a Two-Chair exercise and felt silly when drawing pictures in an art therapy exercise.

Pa   Um, it was made a little bit difficult because I didn’t understand sort of what the point was at the time. Well, it could have been because I was younger too, um, I don’t know, 18, 19, but I didn’t really understand what the point was. I didn’t understand why we should be doing this-like I was talking about the art therapy, like, drawing my emotions-I thought that was something you do when you’re a child, like, I don’t know, 7 or something.

Int  Oh, ok.

Pa   So it just didn’t seem right for me who’s 18, and then to be playing with, um, little figures in the sand, that didn’t seem appropriate for my level, so.

(Nicole, int 1, 78:80)

She took a psychology class at school and learned some of the theory about play, art and gestalt therapy. She thought that she would definitely want to try them again. Now that she knew more of the purpose of these interventions, she might feel freer to try some of those exercises. For most participants, when they knew about their learning style (sometimes also discussed the learning style of their therapist) and the purpose of interventions they were felt more capable of creating a productive process for therapy.

When participants were able to have some control over their process of therapy, by understanding more about how they learn and understanding the purpose of certain interventions, they were looking for options in therapy from their counselor. Participants
said that they would like some options for what they could do in therapy, especially when they got stuck, as represented in the code *structure – options given to client* about which way to go in therapy. Nicole, who had problems with verbal expression, explained that when she was stuck she wanted her therapist to provide her with different ways to express her ideas. Fiona, who had a close relationship with her therapist, described times she was stuck in describing her ideas. She would like to be given options strategies to describe her ideas. When she felt more comfortable with her therapist she might choose one of the strategies that had been suggested to her.

Pa  I’d probably, I’d probably say that like, I’d probably try to say that if I ever felt stuck, I’d want to like…I want to be able to, um, to talk in different ways…like, express my feelings in different ways.

Int  Yeah.

Pa  But like, I, I, told my mom about like, her being silent for a really long…a long, while I’m like--

Int  Yeah.

Pa  --talking. And she said that like, that’s supposedly what they do, so I’m assuming they continue doing it, but.

Int  So, what you’re saying is if you’re feeling stuck, and you’re not sure where to go, or how to express stuff, and it’s not coming out quite the same way, you would like to have different avenues, different ways of exploring that…

Pa  Yeah.

Int  Instead of just going on and on and on.
Yeah. Yeah.

And kind of feeling like you’re wasting time because you’re not getting it out, you really wish you would.

But it would be hard to say that, like, I’m so bad at confronting people (laugh). Um, like, if she…if, she or he [laugh], just like, knew that I needed that (laugh). Like.

Ok.

I guess I need to do my part too, but.

So, if they felt that you were stuck. If they felt that you weren’t going anywhere, would it be better to say, “ok, let’s…can we try one of these three things.”

Yeah. That would be good.

“Which one would you like?”

That would be good. But like saying “this is what we’re going to try” might make me feel a little bit more, like, cramped instead of like, release (laugh).

Like Fiona, many of the participants wanted options for the kinds of process that they could undertake, but wanted open choices, rather than set choices, as represented in the code *Structure-options not too specific – options for what to do.* Participants varied on how much choice they wanted. Nicole preferred a general list of options, rather than leaving it completely open. Nicole and her significant other discussed how she wanted some general exercises and then she could choose what she wanted to do. She felt that
sometimes she didn’t feel she was productive in her therapy sessions if she didn’t have some kind of structure in her therapy, and felt directionless without the help of her therapist. Mary also felt that she needed some options from her therapist to find the most effective way to address her issues, but also wanted some choices so she that didn’t leave feeling that her therapist was controlling her therapeutic process. Fiona, a teenager who felt she was trying to become more independent, wanted more open ended questions. She didn’t want to be pushed in any particular direction in therapy.

Pa Yeah. Yeah. A bunch of questions are like, that way it would make me feel like I should, like, (laugh), transform like, to make it…oh my gosh, I’m so bad at explaining this! It would make me like, want to, like, say things that weren’t like completely, like, exactly on. It would be little bit off, to like make the, make it more relevant. You know what I mean? Like, things that I’m trying to say.

Int Ok, so maybe the, even the questions wouldn’t really fit what you’re about--

Pa Yeah.

Int --or where you’re going with them.

Pa Yeah. If it was like vaguer questions. It’s like, precise when it should be precise, but like vague questions when…when vague is necessary.

Int So, open questions is what you’re saying.

Pa Yeah. Yeah.

Int Questions that provide room for you to move so that…
Pa Yeah, and, like, without it leading somewhere, and like, too much
guidance in one direction.

(Fiona, int 1, 540:549)

Seven participants talked about the therapist giving them options to structure their therapeutic process, especially when they were having difficulty expressing their ideas. While they appreciated having some options that would help them direct their therapy, four described how they wanted to be sure that the options that their therapist gave them didn’t limit their choices for which direction they needed to follow in their therapy (Structure –options not too specific).

In the member check, participants talked about the need to structure therapy. Tyra, added to what she had said in her interviews for the research questions. She believed therapy needed to be highly collaborative but that she definitely needed some kind of structured therapy. Both John and Ted confirmed that they wanted to work with their therapists to create some kind of structure for their process in therapy. Sarah confirmed what she had said before, that she didn't really want therapist imposed structure in therapy, but she did want her therapist to provide some different options about what kinds of processes she could undertake in therapy. Those that did participate in a member check all confirmed that some kind of structure that was created with the therapist would be helpful.

In sum, participants in this study were able to discuss how they would like to have a structure to therapy that was created both by therapist and client. Many believed that they needed to express their learning needs and that the therapist should be in careful in ensuring that their learning style was taken into account. Some believed therapists
needed to ensure that they investigated both the client’s learning style and discuss the purpose of interventions, so that clients could make educated choices. But, participants said that even though they wanted choice in therapy, they wanted some options and help to create a structure in therapy, rather than leaving it completely open. On the other hand, some participants were guarded about having options for their direction in therapy, as they didn’t want it to limit the possible directions. As Ted said, most wanted some kind of structure in their therapeutic process, but they wanted it to be a structure of their own making.

Change Process

Every participant talked about their change process in therapy (see Table 13: and Figure 13). Therefore, “Change Process” was determined to be another central theme present in interviews with participants. As seen in Table 13 and Figure 13, participants talked about what kinds of change they saw in their therapy and how their therapist helped them with change. Participants wanted to look at ways to solve problems in their lives and to assist them in living with their learning disabilities. They addressed their feelings and beliefs in counselling. Participants said that their therapists were empowering and acted as agents of positive change, as they helped them find solutions to their problems, work with their feelings and change their view of the world.

Even though all the participants talked about their Change Process, they didn’t spend much time talking about this theme (61 quotes). This is not surprising as the researcher did not directly ask about their change process. However, most participants, except for Tyra and Owen, discussed finding a solution to a problem, and four
participants talked about how they appreciated it if or when therapists addressed strategies to help manage their learning disability.

Table 13.

Participants' views of their change process - code by participant

<table>
<thead>
<tr>
<th>Change Process Codes</th>
<th>Owen</th>
<th>Tim</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th>Totals</th>
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<tr>
<td>Intervention that helps - finding a solution that works</td>
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<tr>
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<td>Therapist - role: agent of positive change</td>
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<td>Therapist - empowering</td>
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<td>1</td>
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<td>61</td>
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</tbody>
</table>

Figure 13: Participants’ views of their change process - network

Eight out of ten of the participants were looking for some kind of solution to a specific problem, as represented in the code *Intervention that helps - finding a solution*
that works. But often they found it difficult to find a solution and then found therapy pointless. For some this solution was more of a plan of action, rather than something that was tested. It wasn’t surprising that John, an eighteen year old, was looking for a solution in his therapy, as much of the focus in therapy was a solution-focused approach to help his family manage their friction with each other. John’s parents were separated and part of his work with his therapist was to work with John’s family to find out where John should live. John and his mother also worked with the therapist to help John’s mother release him to control his own life.

Pa Well, if I know there’s going to be a result that comes out of it, it makes me want to go more, but sometimes there’s no result, and it just kind of-why the heck did I do that?

(John, int 1, 162)

John, during his member check, confirmed what he had said before, that he felt like the therapy was all worth it when the solutions that he came up with in therapy actually worked. Mary, who was ADHD and often found it difficult to make decisions, wanted help from her therapist to find a resolution to her problems related to her confidence and managing college life. She believed that her ADHD hindered her ability to stay on track and reach her goals. She had bipolar disorder that also contributed to her difficulties reaching her goals. She also found that this was a similar problem in therapy, where there was lots of talk about her problems but she didn’t feel she was finding a way to a solution to her problems.

Pa I’m really super frustrated because I hardly got anything done--

Int Yeah.
Pa --in my life. Or you know you have those moments, right?

Int Yeah.

Pa Or those days, or those weeks. Or those years.

Int Mm hmm.

Pa And so I’m going, “ohh, I’m so frustrated”, or whatever, and then they just listen, fine, but, I vent it, but I don’t feel like I found a solution—

(Mary interview 1 100-106)

Pa But I need a little more clarity in the sense that I need, at the end of the day--

Int Mmm.

Pa --at the end of the session, some sort of structure to say, “well, what I see, you know, is that you need to have these things in place.

(Mary, int 1, 236:238)

Rachel, who had the symptoms of depression and also seemed to feel that she got off track in life because of her ADHD, felt that she needed a plan in how to organize her life so she could compensate for her ADHD.

Pa Yeah, yeah, but I mean there have been times where I’ve you know like, I’ve left counselling and just felt like, oh, you know like, someone like me really needs a plan, right?

(Rachel, int 1, 151)

Ted, who had working memory and auditory memory problems, was also looking for an approach to find solutions in therapy. He thought that he would find solutions through
developing concrete goals. Ted met with a psychologist, a learning specialist, who helped him find ways to develop realistic and achievable personal and educational goals.

Pa Yeah. I- I - to me, I'm very goal - orientated. Like I, I've learned to adjust, sort of a, uh, the imperative or what you will of what my goal is, to kind of suit my ability, my aptitude but, like, everything I do is, uh, is not just to kind of float through life as a [inaudible] so a lot of things are like that for me [very loud music]. Throughout my day, my studying, so if I have a goal, you [inaudible], I'm angry, not to get upset with my grandma or my brother, you know, try to, you know, get it down to 50%. That works really well for me, for my perspective, you know.

(Ted, int 1, 151)

However, for Nicole, missing out on developing goals and solutions to her social and academic issues meant that she was reluctant to meet with her therapist; she missed appointments and was late because she wasn’t sure about the purpose of the sessions.

Eight of the participants measured at least some of their success in therapy by the level of success they had in finding specific solutions or plans to resolve personal issues.

Four participants wanted some help managing their learning disability during the counselling process, as represented in the code Intervention that helps - strategies about learning disabilities discussed. Ted, who had a psychologist who was an Adaptive Learning Specialist, that worked with him on both scholastic and life struggles related to his learning disability.

Pa Yeah, like, I , uh, I feel like I have - I have such a repertoire for - a toolbox, with me all the time, it's just like, um, uh, you know... I'll - I'll write
that sometimes if I feel myself fading off, in a lecture. It stands for... like, like you're here in lecture for the next 45 minutes, 50 minutes, be here now in the lecture, like, be in lecture the entire time. Do not - do not let your mind go elsewhere. Do not let your mind go to... trouble with you - with your parents or, what are you gonna do this weekend or, uh, going to Tofino.

Int: Yuh.

Pa: Something, whatever. Whatever, that 50 minutes. You know, and that

Int: So you really need to have that toolbox and that's what is - is helps that line keep on going up.

Pa: Yeah. And this is - and this is what's helped the, now that I've - I would never would have gotten back here without th- this person.

(Ted, int 1, 815:819)

Rachel talked about wishing for support with her learning disability. She wanted a therapist to help her to learn how to accept herself, even with her disabilities, so that she could effectively advocate for herself. Moreover, she wanted a therapist to help her understand how the disability affected her life and help her manage the effects of the disability in her life. John in his member check confirmed what he had said before, that it was helpful for his first therapist to teach him strategies to manage his learning disability.

A number of participants talked about how to address their feelings and beliefs, but a far fewer number discussed making changes through working on solutions to problems or addressing issues related to their learning disability. Participants talked about catharsis of emotions, understanding how their emotions related to beliefs, changing their beliefs and sticking beliefs into their memory through a cognitive construct. Two
participants described how they were able to experience relief from their symptoms while others found the process frustrating, as represented in the code *Process of counselling - catharsis through expression*. Fiona, when describing her relationship with her therapist in the alternate drawing exercise, appreciated expressing her thoughts and feelings to her therapist because it helped her calm herself:

Pa  And then it’s like, the thought is like the colors throughout my body.

Int  Mm hmm.

Pa  And then it’s like going into hers, so I’m like, I was like, it like calms me down, because I would like…it’s less like…stressed out, and like, there’s less inside me because there’s like, it’s being moved out, and like, it just like calms down once it’s out. You know what I mean? That’s, the colors of the like thought lines, I guess. And just like…Do you know what I mean?

Int  Yeah.

(Fiona, int 1, 346:249)

On the other hand, Mary, who has a bipolar disorder, talked about her feelings, but she didn’t seem to feel that it helped her to resolve any of her issues.

Pa  But sometimes I don’t know what it is. And often, what overshadows everything is either anger.

Int  Mm hmm.

Pa  Or hurt, or disappointment. Like, those are my three sort of emotions in counselling.

Int  Yeah

Pa  And, and it does help to, to rant.
Int Yeah. It’s a kind of a cath--

Pa But, I don’t know how to get beyond it.

(Mary, int 1, 148:154)

Another participant, Owen, who had Eye Movement Desensitization Reprogramming, talked about the different aspects of the change process as this was part of the discussion between him and his therapist. His therapist described theory behind EMDR and how this approach was supposed to help with changes in feelings and beliefs. None of the other participants in the research interviews said that their therapist described the kinds of changes they might experience in therapy. However, Ted, in his member check added to what he had said in his interviews about the research questions. He said that his patterns and beliefs changed as he was able to process his feelings. In Owen’s therapy, for a trauma, his therapist explained to him how his beliefs related to emotions, as represented in the code Process of counselling –emotional processing forms beliefs. Owen, who expressed that he had working memory problems, said that he connected his feelings to beliefs by going out and doing something to change those beliefs. It was the resolution of those emotions in the creation of a new belief that Owen appreciated about EMDR.

Pa And also you have to go also to the emotional level I think, which is less verbal, but you have to still, it’s like you have to connect those words to something--

Int Yeah.

Pa --to connect those words to the--

Int The feelings.
Pa --the emotional base; and I think that’s also hard to do without actually kind of seeing results.

Int Yeah.

Pa Or going out and doing something, and even, like, going and doing something that scares you--

Int Yeah.

Pa --and realizing it’s not that bad. You can tell yourself it’s not that bad all you want but until you go out and do it, and you’re like, that wasn’t so bad, you know.

(Owen, int 1, 554:562)

Two participants discussed how they changed their beliefs. Tyra discussed how her beliefs about herself changed when her therapist talked about what was working well in her life, rather than looking at what was not working with her life. Owen believed that EMDR helped him change from feeling comfortable being sad and powerless to having sense of optimism about his life, as represented in the code Process of counselling change in thought patterns/change in beliefs.

Pa Yeah and like there’s definitely a feeling, like, sometimes when I get, like, like everybody gets sad I guess. I don’t know. When I get sad or whatever, like I feel now, like I can’t, you know I just can’t, like I can’t stay sad. Like it’s weird! It’s also, you want to. Like you want to, like it’s comfortable. It used to be comfortable.

Int Mm hmm.
Pa  Now I’m just, like I don’t feel sorry for myself. Now I can’t feel sad but I can-I just don’t feel it. I don’t know how to describe it other than that. Like I just, like, you know, this, this is my life, I can make it better.

(Owen, int 1, 583:585)

Owen explained how his therapist tried to stick his new beliefs into his head, using a cognitive construct, as represented in the code *Intervention that helps - stick in memory a cognitive construct*.

Pa  Because at the end of EMDR, you’re supposed to, or what she does is, she gets through the emotional stuff and then she wants to, she puts on at the end kind of the good, I don’t know, the kind of thing she likes to do, and they kind of stick in your brain.

Int  Mm hmm.

Pa  And they just click in sometimes. But they’re like very verbal, like they’re very, like they’re kind of a command almost or a--

Int  Yeah.

Pa  -like a, almost, like you can’t--

Int  Yeah, yeah, yeah.

Pa  And that’s where it’s hard, because sometimes it’s-- like it’s very important, I think it’s one of the most important things, to get like a life that’s better than just kind of like--

Int  Yeah.

Pa  Like, if you want to make your life better, it’s very important to deal with these--
But they’re very linguistic. They’re very-- like they’re attached to emotions--

--but they’re very thought-driven.

Participants appreciated two different aspects of encouragement, from their therapist, that helped them make changes. Four participants talked about how their therapists were agents of positive change, as represented in the code Therapist role: agent of positive change. They felt somehow lifted up or shown that they were capable of change. Fiona drew a picture of her therapist’s hand above hers, in her first alternate exercise; Fiona described how this meant that her therapist was pulling her up as Fiona’s ideas traveled from her to her therapist. Mary also described the way her therapist helped her in her first alternate exercise; she explained that her picture meant that her therapist was supportive, facilitating, validating and taking her detailed thoughts and organizing them into a big picture. Tyra also described how her therapist helped her grow, in her first alternate exercise (see Figure 14).

Figure 14: Tyra’s drawing
She had great struggles at school and with her family that left her often feeling depressed and helpless. She described the therapist holding her hand as a kind of reassurance that she would be able to find her own way.

Pa So you have a counsellor and then they’re holding my hand, and then it allows me to kind of grow my own wings and to fly, and to push off the black cloud of sadness.

Int So that, holding your hand, and there’s some kind of energy or yellow light?

Pa Yeah. It’s not holding your hand in terms of like, trying to guide you through things, it’s sort of giving you reassurance that you can do what you know you can do.

(Tyra, int 1, 819-829)

Pa But, what I’m trying to kind of put it in, what I’m thinking at the same time, although that’s not normally what I do when I draw, but this is supposed to show the uh, dark cloud.

Int Ok.

Pa That kind of covers you up when you’re feeling depressed.

Int Mm hmm.

Pa And then, what happens is the counsellor lets you kind of push the cloud away.

Int Mm.

Pa So like, I don’t know, if the counsellor’s sort of this…there’s kind of this light that crawls up you, and then tries to…
It’s the sunshine.

Because often, I’ve explained this before, this is sort of a metaphor I use, is that often, you’re this glowing ball.

Mm hmm.

Like you have all this strength and all this motivation and you’re always clouded by this cloud, and if you could just poke through the black cloud and let your light shine out…

(Rhya, int 1, 837:839)

Rachel and Ted both talked about how their therapists empowered them to become agents of their own change, as represented in the code Therapist – empowering. Ted talked how he tended to be more dependent on his mother and the school system during his school years. But, his most recent therapist helped him to become more independent.

Think - not - don't get too - the patient or the candidate shouldn't get too dependent on the - the counselor, because, at some point, they're not - they're only going to be able to go halfway, that's my own opinion, they're only going to be able to go halfway, you have to go the other half. But, this - this, I think the counselor should be prepared and they should constantly be, um, priming - priming that person to, okay, you know, what are some ways, there are some ways, where, is that going to work for you

Yeah.

As opposed to, them depending completely on

Yeah, so empowering.
Yeah, fully empowering

(Ted, int 1, 883:883)

Tyra confirmed what she had said before, in her member check, that empowering therapists were the key for her. She needed a therapist who was intelligent, active, and creative in her approach and willing to listen to her way of thinking.

In conclusion, all the participants talked about their change process. While most participants talked about therapy as a way to find a solution to their problems, only a few talked about changing beliefs or feelings. Owen talked the most about changing beliefs or feelings (16 quotes). Owen’s therapist discussed at length the process of his therapeutic change, unlike the therapists of other participants. Moreover, the researcher did not ask any questions about their process of change. Four participants discussed their therapist’s role in helping them change. They talked about how therapists facilitated the participants in working through problems and managing their learning disabilities.

**Approach to Therapy**

All participants, except for one, talked about particular approaches their counselors used and the difference it made to their sessions (see Table 14 and Figure 15). Therefore, “Approach to Therapy” was identified as another central theme in the conversations with the participants. As can be seen in Table 14 and Figure 14, participants described many different approaches to therapy. Participants thought of an approach to therapy as a therapist thinking of a particular way to interact with them that had readily identifiable exercises and goals that they could easily identify.

Participants discussed a number of approaches to therapy, some of which they had experienced personally and some that they had learned about, but had not yet
experienced. Participants had experienced play therapy, Eye Movement Desensitization Reprocessing (EMDR), Gestalt therapy, art therapy, solution-focused therapy and family therapy. Moreover, some participants didn’t get the opportunity, but thought that they would have liked to have tried family therapy and Bibliotherapy.

Approaches to therapy were discussed by all participants except Sarah. However, compared to some of the themes described earlier, participants did not talk as much about the different approaches to therapy. There were only 75 quotes for Category of Approaches codes and only 66 quotes for the Specific Approaches. Many of the participants were not informed or educated about the approaches that they experienced. They only knew about a particular approach if it was discussed by the therapist, if they were introduced to the idea by the researcher, or if an approach was a particularly distinctive intervention (such as art, play therapy or EMDR). Therefore, there were only six participants who talked about approaches seven times or more. Mary and Nicole had far more to say in the Approach to Therapy theme than others. They had both spent time searching for unique therapeutic experiences. Mary had experiences both with play therapy and art therapy, while Nicole had experiences in art therapy, play therapy and Gestalt therapy. Of note is that of the three individuals who only had ADHD and no other disability, only Mary participated in the non-verbal and experiential types of counselling.

The codes for the Approach to therapy theme were divided up into two sections. The first section contained two general codes representing two Categories of Approaches to therapy: nonverbal therapy and experiential therapy.
Table 14.

Approach to therapy that participants liked or disliked - code by participant

<table>
<thead>
<tr>
<th>Participant</th>
<th>Owen</th>
<th>Tyra</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
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Figure 15: Approach to therapy that participants liked or disliked - network
These categories were developed as participants described in more general terms their need to have more experiential types of therapy or therapies that didn’t rely on talking with their therapist. Nearly all of the approaches to therapy, discussed by the participants fit into these two categories. Nonverbal therapy, as represented in the code *Approach that helps – nonverbal therapy*, was therapy that did not rely on verbal discourse at its start. For example, play therapy, art therapy, and Eye Movement Desensitization Reprocessing (EMDR) therapy relied at first on a particular kind of activity to express what is inside the client, without talking. Experiential therapy, as represented in the code *Approach that helps - experiential therapy*, was as a type of therapy where the client was brought back to the particular situation or issue through visualization, enactment or reenactment. For example, Gestalt therapy and some kinds of family therapy are therapies that may use these kinds of activities. The second section lists the specific approaches that were discussed by the participants.

*Nonverbal therapies.*

The nonverbal category of approaches was discussed by participants as a way of expressing and processing their ideas, at least at the start of the therapeutic process, (see the code: *Approach that helps - nonverbal therapy*). Participants saw how they could express ideas without needing to depend on a verbal description of the internal process. Ted said that he would like to try play therapy. Mary, who described herself as being more visual, said that she enjoyed both play and art therapy to express her ideas, and that she needed more than auditory processing to understand her issues. Verbal expression did not seem to be as connected to her emotions. There were three specific approaches
discussed below that were more nonverbal: art therapy, play therapy and Eye Movement 
Desensitization Reprogramming (EMDR).

Five participants talked about art therapy, as represented in the code *Approach that helps - drawing/art therapy*. Five participants discussed their experience in art therapy, while the fifth, Ted, talked about art therapy in the context of doing the alternate exercise and finding it helpful in expressing his ideas. Nicole, who had problems with verbal expression, drew pictures with her psychologist to express her feelings. She found it difficult and almost childish at first, but when her therapist interpreted the pictures she found it to be helpful. Tyra talked about drawing as a way to express her feelings on her own. She drew a lot when she was having difficulty with her family. Sarah, who had visual memory problems, also did art therapy, but she wanted to add a lot of words to her drawings. On the other hand, Tyra, who also had a visual memory deficit, believed she couldn’t picture things in her head. Therefore, when she drew, she felt that by drawing it was expressing things that were more sub-conscious and didn’t use words in her drawings.

Pa So I can explain this. It’s not really kind of thinking. When I draw it’s 
kind of like, it feels like it’s disconnected from what I’m thinking.

Int Mm hmm.

Pa It just is a different mode. That’s why I think I find it very therapeutic 
because my brain kind of disconnects my arm from my head.

Int Mm hmm.

Pa Which is weird. So you’re actually not, you’re going to kind of get at more 
of my sub-consciousness.
Mary, although not diagnosed with a verbal or memory disability, reported the same difficulty at expressing her feelings as those with verbal disabilities, such as Nicole. Her familiarity with the medium, because she was majoring in art at college, made it a fitting way for her to describe her feelings. She thought the therapy was very effective. Mary said that both art therapy and play therapy helped her to retrieve feelings that were otherwise inexpressible.

Pa  It’s not about making a pictures, it’s just putting what you feel.

Int  Yeah.

Pa  Like, I was remembering some really bad experiences that happened to me, and I tore up papers, and I clumped them up and I glued them, and (indistinguishable) “what is that??” And uh, I said, that’s how I feel inside. I’m just shattered to pieces that were all crumpled and thrown at something, you know? It was black and red, it was just like, I could express, like, how I was feeling.

Int  Mm hmm. Yeah.

Pa  And then at the end, I actually had a representation and it was outside of myself.

Int  Mm hmm.
Art therapy helped many participants, whether they had difficulties with verbal expression, visual memory difficulties or were more visually oriented learners. As a whole, they appreciated expressing their feelings and ideas in another medium.

Four participants talked about their experiences with play therapy, as represented in the code *Approach that helps - play therapy*. This approach involves working with different kinds of objects in a sand tray to work on issues. Owen, who was working through family issues, had play therapy in Grade 4. He didn’t think that play therapy helped him develop insight, but it helped in developing trust and gave him something to do while he was talking with his therapist. On the other hand Mary, who had ADHD, found play therapy helpful, because she found talking quite abstract. When she saw the photos of what she had created in the sand tray, she felt she had something to talk about that was more concrete. Play therapy, by keeping her focused on talking about her creation, helped her stay on task. She also found that this approach helped her connect more with her emotions.

Pa  Um, so I think it really helped. And also if I wasn’t just, like you say, I’m realizing that I need more than just auditory blah, blah blah. I find that one of the most effective things I did was sand play. I don’t know if you ever heard of it.

Int  Mm hmm.

Pa  But, I really went back to my childhood. My pre uh… I don’t know what was the grade, maybe pre-verbal?

Int  Mm hmm.
Pa And um, and that was actually one of the most, I found, emotional…that I really worked through some stuff. Um, because I can talk. I’m hyper-active, right?

Int Yeah.

Pa Like, “blah, blah, blah”. And I’m very into language and words. Very oral. But sometimes I feel like it’s just, it’s not really connected to inside. You know what I mean?

Int Yeah.

Pa So, what I find helps is when the counselor does more than just listen to me going “blah, blah, blah, blah” for an hour.

Int Mm hmm.

(Mary, Int 1, 14:23)

Nicole, who had a verbal expression and working memory deficits, believed when she talked to therapists she felt nervous and bottled up her feelings. With play therapy, she could just focus on the table first, release what was inside, and then she wasn’t as nervous to talk about what she had created. She talked about struggling with eye contact and she had difficulty with eye contact during the interview with the researcher. Consequently, she found sand play an effective way to express her feelings.

Pa Um, and then we did things in the sand, so. Um, I remember, I don’t know what the instructions were, but I ended up doing something with, she had a few little toys, and maybe figures, and some plastic grass, and I did something where I did a fence with grass or some rocks, and there was a, I just put a figure of a bird inside, and I, um, then she would, I don’t know, I just did that, like out
of—I’m not sure what I was thinking, but then, later on, I guess um, it kind of represented, or so she kind of explained that maybe I’m, I felt that I was, uh, being held back or trapped, or I couldn’t fully, I don’t know, my potential, like I couldn’t fully, um, I couldn’t move forward, because I felt I was trapped, so. And then she would ask things like “Is that how you feel?” And then I would say “yes” or “no”, so. Um, I remember when I finished doing that and she took a picture of it and I got to take it home, I kind of felt um, I felt good about it. I mean I thought it was really interesting that um, you can, that something that I made like that, you could kind of um, interpret something how I was feeling.

Int  And did it work for you? Did it feel right?

Pa  At the beginning no, again I found it corny, but um, later on I felt it was, I think it was useful.

Int  Mm hmm.

Pa  Yeah.

(Nicole, int 1, 138:142)

The preference for play therapy did not seem to be linked solely to a specific cognitive deficit or issue. But, participants with different kinds of deficits, such as verbal processing, visual memory, and ADHD all found reasons to appreciate the ability to create before talking about their creation.

Only Owen experienced EMDR, as represented in the code *Approach that helps – eye movement desensitization reprocessing*. In this exercise he did a specific eye exercise while slowly and cautiously visualizing increasingly traumatic aspects of a traumatic experience, while using processes to manage the associated distress. Owen felt especially
suited to this approach to deal with his trauma as he had exceptional talent for visual/abstract processing. He talked about sometimes struggling to find words to describe his traumatic experience, although he wasn’t diagnosed with a verbal expression disorder. He appreciated the ability to not have to describe what he was experiencing in order to process his trauma. He also appreciated his therapist’s capacity to not need to understand completely what was being experienced by Owen, in order to know the therapy was effective.

Pa Yeah. Not-- yeah. It’s, def--, and you don’t have to physically go do things-- part of it would be going into your mind and--

Int Visualizing.

Pa --visualizing or hearing a sound, or--

Int Yeah.

Pa --what would it feel like to do this, what would it feel like? You know.

Int Yeah. What would it feel like? What would it look like, what would it taste like, what would it smell like?

Pa Because even if the counsellor doesn’t, like I think people try and relate almost to your words, but--

Int Mm hmm.

Pa I think that you don’t necessarily have to--

Int Yeah.

Pa Everyone has got those experiences, and they can draw on that bank of experiences in themselves. So I think, if a counsellor lets go of that need to
comprehend in language, and just trusts themselves to know that they’re feeling the same thing--

(Owen, int 1, 664:674)

In summary, art therapy, play therapy, and EMDR all allowed the client to first experience their ideas, without the use of language. Then, once they had developed some kind of structure, such as a drawing, diorama in the sand, or mental picture, they had something that they could discuss with their therapist.

Experiential therapies.

Six participants talked about wanting or enjoying experiential therapies, as represented in the code Approach that helps - experiential therapy. This category of therapies relies on an embodied experience and so again, like the non-verbal therapies, did not wholly rely on verbal expression in order to process issues. It also allows for more physical movement, which was appreciated by many of the participants with ADHD. Sarah, Ted, John and Mark, who all had ADHD, needed some time move regularly during their interview with the researcher. Some participants talked about experiential therapy without reference to any specific intervention. For example, Mary, who only had ADHD, had a preference for experiential therapy.

Pa Well, more experimental…What’s that word again?

Int Experiential

Pa Experiential, more “experimental” works for me. More stuff where I…Like, I’m already starting to feel like I need to get up and move around. I’m getting sore and achy, and, I also live with some chronic pain from a car accident, so that doesn’t help.
The two specific approaches to therapy that participants discussed that were experiential were Gestalt therapy and family therapy.

Only two participants talked about Gestalt therapy: Tyra and Nicole. Tyra, who had working memory problems, discussed how she asked her therapist if she could try a Gestalt intervention called Empty Chair, where she would sit in one of two chairs, and talk to the empty chair as if it was someone with whom she needed to resolve an issue. However, she did not get the chance to try it out. She thought that it might be helpful as she felt she wanted to move around more in therapy. Nicole, who had problems with verbal expression and working memory, was given the opportunity to experience the Gestalt intervention of Two Chair. She sat in one chair and then moved to another. The two chairs each represented the two sides of a problem that she was trying to resolve. This enabled her to physically experience the two sides of the dilemma and helped her process the dilemma without solely having to rely on words. Moreover, she had ADHD and the movement was helpful in enabling her to stay on task. She described the process of Two-Chair.
Pa  Um, it got me thinking in a-I don’t know, sometimes I found that I have difficulty making choices in real-life situations, so um, I was very, um, had trouble with decision-making, so that, um, I would sit in the chair and talk about the pros and cons of doing it this way and then I sat in the chair and talked about the pros and cons of doing it a different way, and it kind of made me, I think it’s kind of almost easier if, um, how shall I say this? If you’re in a situation and you don’t know what to do, and you’re thinking about it, um, it’s easier if you’re almost, if somebody told me that this-they were in a situation like that, and they said, “what should I do? What advice?” Um, it’s almost easier to give them advice on how to do something than it is for me to think of how I should act in the situation.

Int  Ok.

Pa  I don’t know if that makes sense, but, um, and I found that to be sort of similar with the chair thing. It wasn’t so much like I was thinking of it for me; it was like I was trying to lay out the pros and cons of a situation for another person.

(Nicole, int 1, 44:55)

Four participants talked about family therapy. Ted and his mother talked hypothetically about how family therapy would have been for Ted as a child. His mother said that she would have liked help to learn how to work with him when he became frustrated at school. But, Ted did not want to have therapy with his family as he did not want to be seen as different or share his feelings of incompetence with his family. Sarah also didn’t want family members in session with them, as she said she had a special
relationship with her therapist that might be broken if a family member came to their sessions. Fiona said that she might have somebody close to her come in to her sessions, but only for few minutes to help communicate an idea, if she was struggling, not for family therapy. Nicole was on the fence as to whether she wanted someone else in therapy; she thought it might help her with describing her ideas, but it might impair her feeling of safety with her therapist. Moreover, she didn’t want family therapy. The only participant that did experience family therapy was John. He had a psychologist who used structural family therapy to change the power dynamic between them. John was only diagnosed as ADHD, but he said he also needed help expressing his feelings. John’s mother said that she was asked to disassociate herself somewhat, by the therapist, so that she would allow John to find his way. His therapist helped to mediate the discussion between John and his mother. Through the mediation, the therapist aimed to restructure the balance between them, so that both mother and son could hear each other.

Int So, so, the way he approaches it, the way he tells you things. Um, is there anything else that helps you to be understood? So, that you don’t feel--
Pa Um...
Int --lack of communication with him in the way that you work through things?
Pa Um, I don’t think so, not really. But like, he can sometimes be a mediator in situations, which helps, because it controls the environment. It’s like, if it’s me and my mom in the room, he’ll mediate the situation so that it doesn’t get out of control, and-nothing gets done if it gets out of control, so.

(John, Int 1, 37:40)
Although this type of therapy was experiential, it was more language based than the other non-verbal approaches described above. However, without his mother in session John believed that it would find it difficult to work on the issues in his family, as he would have had to describe his relationship with his mother, rather than demonstrate it in session. However, John expressed that it was interesting as he worked through issues with his mother in the therapy process. It was this active, moving engagement that kept him working through the process.

*Miscellaneous approaches to therapy.*

There were three approaches to therapy that did not fit into the two big categories above. These were approaches that were only discussed at the most by three participants each, but were described in enough detail to be worth including in this thesis. Participants talked about solution-focused therapy, cognitive therapy and Bibliotherapy.

Two participants talked about using a solution-focused approach to address their problems, as represented in the code *Approach that helps - solution-focused therapy.* Rachel, who had ADHD, said that sometimes her problems seemed overwhelming and she needed her therapist to break her problems down into manageable chunks. She wanted to focus on one particular problem in a given session, resolve it and then move on to the next one. In the theme *Change process* participants talked about wanting to find a solution to a problem as a way to measure their productivity in therapy. Rachel felt that this approach of breaking her problems down into resolvable parts might help her see some movement in her therapy sessions also. John, who was diagnosed with ADHD, not only received structural family therapy, he was also given solution-focused therapy to help him quickly come up with different options to solve his problem. Sometimes it
provided a temporary solution to his problems. He described the process that he undertook with his therapist.

Pa   Like, he’ll ask me a bunch of different questions about how I’m feeling, and not just, he’s not actually going to ask me “how are you feeling?” He’ll ask me about it, and like ask me what’s been going on in my life, and then he’ll kind of make a hypothesis and explain it to me after.

Int  Ok. So then he gathers information, it sounds like, and then through gathering information he comes up with a hypothesis of what’s going on--

Pa   Yeah.

Int  --in your life?

Pa   Yeah. And then he explains it to me and I sort of agree with it or don’t, or make changes. And it just helps get, helps get it out there a lot quicker.

Int  Ok. So is that kind of a, kind of a regular routine or pattern that you go through with the counselor?

Pa   At the start.

Int  Gather information.

Pa   Yeah.

Int  And then figure out what’s going on.

Pa   Or do something about it.

Int  And then have a hypothesis about what could be done, or what couldn’t be done.

Pa   Yeah. Discuss different solutions and pros and cons of those solutions.

(John, int 1, 70:82)
However, in the end he didn't believe it was very effective as the solutions that were derived often did not work for him, as represented in the code *Approach ineffective - solution-focused*. In contrast, the family therapy that worked on re-structuring relationships was more productive, as John was able to have more time without his mother trying to control all his decisions. Although, he and his mother were able to come to a temporary solution to their problems, they were unable to come to an agreement that worked in the long-term.

**Pa**  Well, because to get there we try different things and those things sometimes failed.

**Int**  Ok.

**Pa**  That stops it from getting it to where I want it to be.

**Int**  Mm. So what kinds of things did you try?

**Pa**  Living at my grandma’s house. Because it wasn’t working out here.

*(John, int 1, 183:195)*

John was now back living with his mother, in an uneasy truce. Neither was really satisfied with the present state of affairs.

As many of the participants said that they were looking for solutions, solution-focused therapy might have been used to resolve some of the participants’ issues. However, only two talked about solution-focused therapy and the one participant that did experience this kind of therapy found that much of the time it was ineffective.

Three participants talked about Cognitive Behavioral therapy (CBT), as represented in the code *Approach ineffective - Cognitive Behavioral therapy*. These participants tried different CBT interventions, with mixed results. Ted, who had working
and auditory memory problems, didn’t like structured approach of CBT. He needed his therapist to let him explore his ideas (see the theme Client/Therapist co-created structure), rather than his therapist direct his thinking. Tyra, who had memory problems, did not like the rating scales of cognitive therapy, but she did enjoy the metaphors that were used in some exercises (see the theme Modality/Process to promote thinking). She confirmed, in her member check, that Cognitive Behavioral therapy did not suit her learning style.

Pa One thing I’ve found really annoying, because I think I’m more of a global thinker, like I like open-ended things, and one thing that I tried for a little bit was Cognitive Behavioural Therapy, but I hated it because it was so much, like, check this box; put this number in. It’s just, I don’t know what number it is, it’s somewhere in the middle, and so I found it was easier when, what I did instead was kind of used a metaphor.

Int Mm.

(Tyra, int 1, 194:297)

Fiona, who had working memory and processing speed problems, explained why she might enjoy Bibliotherapy, as represented in the code Approach that helps – Bibliotherapy. She described how she enjoyed reading a lot of books and she liked it when the characters in the books had similar problems to her. Consequently, the researcher asked her if she might enjoy using books as a way to help her describe her problems. She said she would like to try it even though she had dyslexia. She thought that she might have liked it as a way to better understand her issues and help her describe her issues to her therapist.
Pa Yeah. And the thing is like, I like reading…like I’d rather read a book than, like, watch TV. I would like read…(*laugh*), my mom’s mad, like she won’t buy me books anymore, like I…like read a ridiculous amount of books, but, like, I don’t know. I just…(*laugh*), I…it’s just like. I don’t know. It’s like, reading is really important to how I, like, deal with thing, and like, it like affects how I think about things, so, like…it really strongly affects how I think about things.

Int Okay.

Pa So, it’s like important that, maybe not a ton like, in counselling, but like, just like, I don’t know…I think I would have liked something that like, reminded me like, other people have the same problems, and it’s not like a huge deal.

Int Ok, so, so, books would have helped you to kind of--

Pa Yeah.

Int --help you understand.

Pa Probably.

(Fiona, int 1, 138:144)

As a whole, participants talked more about approaches that did not rely solely on talking to resolve their issues. It seems that some preferred to act, rather than just talk about their issues. Nonverbal therapies, such as art therapy and play therapy, that helped the client to express ideas nonverbally first seemed to help those participants with expressive and memory deficits disabilities, as well as participants who preferred a visual style to learning. Experiential therapies, such as Gestalt and family therapy, seemed to
help many of the participants. The movement inherent in experiential therapy was enjoyed by some of the participants with ADHD and it helped some participants, such as Nicole, and to express their ideas. Other therapeutic approaches were described by a smaller number of participants. Solution-focused therapy and CBT had mixed results with participants and Bibliotherapy, although discussed by one participant, had not been attempted by any. The amount of discussion by participants in this theme was limited. This may have been because they had limited knowledge about the different approaches or because of the lack of distinctive interventions that marked the process as coming from a particular approach. This may also be why participants were able to describe Play, art, EMDR, Gestalt and Family therapy, rather than others. Nevertheless, participants did describe some approaches that they enjoyed and some they did not.

*Modality/Process to Promote Thinking*

During interviews, every participant made at least a couple of comments that spoke to the modalities or processes through which they prefer (or don’t prefer) to express their ideas and think through their problems (see Table 15 and Figure 16). Thus, “*Modality/Process to promote thinking*” was identified as another central theme in participants’ comments. As can be seen in Table 15 and Figure 16, participants talked about their many different ways of thinking through the issues that they brought to counselling. Some participants preferred drawing or writing to express their ideas, either inside the session or as homework outside the sessions. Some participants enjoyed picturing their problems and finding solutions through metaphors, visualization or systematic desensitization. Finally, others said they were helped by elements in therapy that involved physical activity, like role play, or movement. There were also some
miscellaneous ways to promote thinking that couldn't be grouped with others. While some enjoyed certain ways of expressing their ideas, others had difficulty with those same methods. Overall, participants described a variety ways that helped them think through the issues that they brought to counselling.

Not surprisingly, given the participants were asked directly about the forms of expression they preferred, a lot of the conversation during interviews focused on this theme (all the participants, a total of ten, contributed 141 quotes in all). All the participants talked about this theme, but some were less interested in this topic than others. John, Rachel and Sarah talked much less about this topic compared to their discussions about the theme of Safety/Comfort.

Processes including writing.

The first type of processes described by participants involved some kind of writing. Seven of the ten participants, in one way or another, discussed the need to draw diagrams, or pictures, to describe their thoughts, as represented in the code Intervention that helps-drawing/diagrams to describe. For example, Tyra, who had been assessed as having working, visual, and auditory memory problems, appreciated drawing diagrams throughout our time together in order to express her ideas. She described herself has having no real visual memory and difficulties with her auditory memory. She asked for paper about half way through the interview, and kept on drawing as she went along.
Tyra felt strongly that she needed to have the choice and wanted her therapist to be more supportive in her fulfilling her need to write things down. She felt that it helped her to work through things if she could write them down.

Int Ok. So on the other side, we talked about what helped you become more in sync with your counsellor; it’s the motivation and empathy part. Is there
anything else that happened in your counselling, to make life easier in your counselling?

Pa Well I think that it was nice that the um, counsellor that I saw at school was-if I said that I needed to write something down then she would let me do that. Like I think often some people, again, I’m not trying to be negative, I think counsellors are great, but I think some people get power-trips or they want you to do things their way.

Int Mm.

Pa And they go “oh you don’t need to write it down”. Well, it would help me, actually. People need to listen more to what people feel like they need to do, especially people with different learning styles, or even people that have emotional issues. They really need to listen to how they need to be counselled.

Int Mm, so it’s more about you have particular needs of counselling, of ways of doing things to help you learn--

Pa Yeah.

Int And she, in order to learn through that, you needed to do things in a certain way.

Pa Yeah, like write it down so I could see it, rather than just hear it.

Int Ok, so you needed to have it written down, and then you could see it…

Pa By myself, yeah, and most of the time, like you’ll find that the counsellor will be the one writing.

Int Ok.
Figure 16: Modalities and or processes that help or hinder thinking in participants - network

Ted also enjoyed using diagrams throughout our sessions together to describe his ideas. He also had superior spatial reasoning, visualization and simultaneous processing. But, he had problems with his auditory and working memory. When asked what he would like to use from his academic world, in counselling, he said that he would like to use drawings. He talked about how he used drawing and charts in school. While he described the process he was drawing a diagram.

Pa Yeah, cause that's how and - that's how I do a lot of things, I don't remember a lot of things in words, to describe them, I remember diagrams and charts really well, and, uh, and, you know, arrows and blocks and boxes and circles, and fill-in-the-blank and, whatever may be the case. [inaudible - loud coffee machines] So these are the things I fill in around
it, using the hormones, using whatever, neurotransmitters or what-not, and then
when I go to tell a story, I can picture that whole diagram and then I can
actually say everything that, uh, everything in it just as if, there was - it's a
paragraph on a piece of paper. But if, if you ask me to recite that piece of paper
or to remember things from that piece of paper, for the - for the, big paragraph.

(Ted, int 1, 333)

Three participants talked about getting help from their therapist to record their
ideas in writing, as represented in the code Intervention that helps - write notes with
client. For example, while the participants above preferred to write themselves, Mary,
who had been diagnosed with ADHD, wanted her therapist to write for her. She
commented on how she had difficulty focusing on her writing, because she has a hard
time listening. The researcher asked her if it would help to have the therapist write for
her.

Pa   Well, like, a journal, yeah. If I were to do counselling again, I would, you
know, when I did counselling, let’s put it that way, I’d write down what…what
I would want to talk about.

Int   Mmm.

Pa   And then write, if I can, it’s hard for me to write and, like, like I told you,
like, for example, when I do a lecture, I need some help with the note taking.

Int   Yeah.

Pa   Because it’s hard for me to listen…

int   So, it would be good for the counselor to take notes for you. On a, on a
board. Like, maybe you have a visual board next to, next door.
Pa Yeah!

Int And they can write, and then you can say, no, no, no, that’s not the part I want on the, yeah, yeah yeah, that’s.

Pa Yeah! That would be really cool. Yeah.

(Mary, int 1, 662:672)

Writing or drawing, for three participants, was done not so much to describe their ideas, but more to relieve stress and free their minds, as represented in the code Intervention that helps - drawing to relieve stress /free mind. Fiona, who had ADHD and working memory problems, spent much of her time during the session doodling as a way of helping her focus on the task at hand. At times doodling helped her to relieve her stress.

Pa Sometimes I like draw and stuff, but it’s not like…I…I just do it when I’m stressed out, not like. Not as a way of, like, expressing myself, just a way of like relieving stress.

(Fiona, int 2, 232)

Sometimes writing had a dual purpose. For Fiona, sometimes drawing helped her to calm down and refocus on what she was trying to express. She believed that it was the physical and visual combination that helped her.

Int Did the picture help you when there was a piece that was difficult to talk about, or…?

Pa Um, it’s just, I think it just like helped me, like, calm down. Like, it wasn’t like I was anxious or anything, I just like, it helped me like, just like, “ok, this
is what happened”, like, or, this is what it is. And like, I don’t know. Just like life (laugh).

Int Yeah.

Pa Like, this is, like, this is it. And it …it’s just (laugh)...it’s like…

Int Yeah.

Pa It’s more like physical, it’s more like visual.

(Fiona, int 1, 263:268)

Other participants said that they would like to do some writing at home to both work on their ideas between sessions whether it was a diary or some kind of homework. On the other hand, Mark talked about how difficult it was to think about his issues before therapy (see discussion in the theme, Preparation for therapy).

Another way to gather ideas that participants discussed was using a diary, as represented in the code Intervention that helps-diary. Tyra, Fiona, Mary, Rachel and Nicole talked about the use of a diary. Fiona also said that she wished that the counselor had told her to write things down between sessions, but did after she had completed her therapy.

Pa Yeah, I kind of, I kind of wish that she was, that she told me to like write in a diary and like, just, like, I kind…like, I kind of did that on my own after, like, a little while later. But I wish like, I would have written in my diary and like talked to her about it, and like some of the issues…not everything, obviously, but like, some of the issues I…I don’t know, I kind of would have liked to just have that as a, like, reminder of like…cause once she was quiet, I’d
just talk about everything, and like, I wouldn’t always stay on the subject that I really wanted to like, talk about.

(Fiona, int 1, 37)

In Nicole’s case, using a diary was something she and the counselor had already put into practice. She had significant verbal expression and memory problems, as well as processing speed difficulties. She had been having regular therapy over the last three years and her most recent therapist had suggested that she use a diary.

Pa Yes. I do find that sometimes, if I think about things that I want to work on, or if I jot things down I can talk, I can ask her about it for the session—
(Sound of electronic beeping) --and we can go over it. I find that that kind of helps.

(Nicole, int 1, 180)

When asked more about the nature of her diary use, she talked about her difficulty with forgetting what to bring up in session.

Pa Yes, that’s what I was going to say about—I think a diary is a very good idea, or a journal, and um, to bring that with you even, yeah I think that’s a great idea.

Int What kinds of things do you think you’d put in it? What kinds of things would be helpful for you to put in it?

Pa Um, maybe a thought that I’ve had, or that crossed my mind, or maybe that I’d like to get some advice on, or some feelings that I’m having, or, some doubts, or, I don’t know, just, or, um, if I notice something I can write it down,
and I just have it there that I can bring it up and see it, and retrieve it from my memory.

Int  Do you find that that’s difficult for you sometimes to get that piece back?
Pa  Yeah, sometimes I have a thought and I think oh I should ask X that when I see her next time, or I should bring that up, and you just forget, and it never comes up again.

(Nicole, int 1, 207:221)

On the other hand, Nicole and Owen did homework, as represented in the code Intervention that helps – homework, as a way of gathering information to use in therapy. Nicole talked about this in both of her interviews with the researcher. Sometimes she did the homework, and sometimes she didn’t.

Pa  And um, anything that like, um, exercises from the book or her asking me, doing um, exercises in a book, or, I found it helpful like, even her assigning me some homework, and a lot of times she’d assign, or say do it, but I never did it, because I just didn’t, but I found that if I did and I brought it back and we went over it, you get a lot more out of your sessions more, if you-because then you have more to talk about, and you go over things and...um, I kind of wish that um, I would have done it more, and I kind of, I hope to bring that up to her, to do that, and maybe to have some homework after each session, and so I can think about things from the last session and then bring them up next session.

(Nicole, int 1, 193)

Pa  Oh yes, yeah. I like it, she hasn’t done that anymore, but she’s, like when she kind of tells me something like um, I don’t know, I’m just making this up.
Maybe “so, for the next, during the week, try to think about this”, and um, I
don’t know, “if you notice yourself getting angry, try doing these exercises” or
something like that. She gives me some sort of homework sort of in a way, or
she’ll give me some sheets and she’ll tell me to write down, like, some sort of
homework or something.

(Nicole, int 2, 528)

However, homework wasn’t just comprised of written work. Mark did Systematic
Desensitization with his therapist and did some exposure homework during the week,
between therapy sessions. For Mark, experiential homework was favored, instead of
written homework. He had verbal expression difficulties and was unable to symbolically
draw his relationship with his counselor. His conversation with the researcher was more
about the concrete surroundings of the classroom and concrete interactions with the
counselor. Therefore, the concrete experiences seemed to suit Mark better than a written
exercise. Mark (Pa) and his mother (M) described what they did as homework.

Int  So I’m wondering if this kind of homework wasn’t all that helpful, like,
because it was all about the reading stuff. Is there any kind of homework, do
you think, that would be helpful? Anything that he could do?

M    Oh absolutely, and we were assigned it--

Int  Ok.

M    --and we did it and it was like ok, you’re going to- ’J’ used to not go
outside--

Int  Mm hmm.
M --in the summer, because he was so afraid and it was just like, ok, this week-end I want you to go to a park.

Int Ok.

M Just go. Get out there, you know?

Int Yeah.

M There’s going to be bees, there’s going to be dogs. I mean, his phobia was so bad, that there was several occasions where he almost ran into the street and got hit by a car because he was trying to run away from a bee.

Int Ok.

M It’s like a loss of perspective.

Int Yeah, yeah.

M It would hurt a lot more--

Int To be hit--

M --to be hit by a car, than to be stung by a bee.

Int So back, back, now you-looking back on it, it seems like kind of like, whoa, you’re going to be hit by a car because you’re so scared of a bee?

Pa No, but what I find weird is that I was always, always scared of breaking bones, even before I knew a little bit about bone density, and now it could be like what I’m scared of is actually what I’m running toward.

(Mark, int 2, 100:117)

On the other hand, Mark’s written homework, though assigned was never done, as represented in the code Intervention that is ineffective – written homework. For Mark, he
had a significant writing disability, which Nicole didn’t have. Also, Mark’s mother said
that he was too busy to work on written homework.

M --of course. But I can see less written homework even though I think that
theoretically it’s a good idea, but it doesn’t work for everybody.

Int Did he do the writing or did you do the writing, or--?

M We basically ended up not doing it.

Int Ok.

M Because we already had all these other things that--

Int To do.

M --we had to do. His regular homework, his speech therapy homework. It’s
just there’s only so much time in a day.

Int Ok, so kind of, I guess what you’re saying is the counsellor should
actually check in with what’s doable.

M Yeah.

Int With what’s reasonable and realistic.

M Right.

Int Did, did he check in with you about what was--?

M Well he noticed we weren’t doing the homework, and he never-I don’t
know what he thought, maybe that we were lazy or something. It certainly
wasn’t that, it was just everything was overwhelming. There was just too much
going on.

(Mark, int 2, 640:657)
So, while some participants were able to use the written word to express their ideas, some found this difficult.

*Pictorial/visual representation.*

Other participants, like Mark, were able to find alternate ways of working through their issues that didn’t involve writing. Pictorial representation was the second kind of process that participants used to represent and process their ideas that replaced verbal discourse. For example, some participants pictured certain concepts in their minds or sought to experience them in the real world. Participants used metaphors, visualization and Systematic Desensitization to help them work through some of their issues and sometimes help them communicate.

For example, four participants discussed about how they used a metaphor, as represented in the code *Intervention that helps – metaphor*, in therapy to help understand certain concepts. Fiona and John used them as a way to describe what they were thinking. For example, Fiona who had working memory and processing speed problems, but not ADHD, described how she sometimes got stuck in how to explain things. She found that using metaphors might help. She used the example of a brick wall, as an example of a metaphor for how to process a blockage in therapy.

*Pa* It’s like…he. Brick wall. Like, I could explain what a brick wall like…but I couldn’t exp--….I might not be able to explain what I mean without using like, the symbolism of a brick wall.

*(Fiona, int 1, 770)*

Later she explains it as:
Pa  I can translate it into words, but not detailed… the thing is, is I can do
details, I just can’t…I can’t make you feel it.

Int  Yeah, yeah.

Pa  Like, if I’m talking about a brick wall, I can feel a brick wall, but I can’t
make you feel it.

Int  So what… so what you’re saying is the language is not as precise a way of
trying to describe what’s going on.

Pa  A picture is worth a thousand words! (*laugh*)

(Fiona, int 1, 824:828)

Mark and Tyra, on the other hand, were given metaphors by their therapists to help them
process different concepts. Tyra liked the metaphor, used in a Cognitive Behavioral
approach to anxiety, called Taming Her Gremlin, even though she reported that she had a
limited capacity to visualize concepts her head. The researcher asked her why she liked
the Taming the Gremlin metaphor, even though she said she had difficulty with
visualization.

Pa  Well you can kind of draw it out, and also you can kind of come up with
descriptions for metaphors, right?

Int  Mm hmm.

Pa  Because extended metaphors often require colourful language. Or you
could visualize. It just depends, right.

Int  Ok, so you have some capacity for visualization or description.

Pa  Well yeah, I don’t know really what people label visualization as. It’s kind
of vague in my mind, but--
Ok, so what do you label it as then?

I don’t see pictures, but I do kind of feel, um, objects or something of sorts, so. I probably have some sort of rough sort of motor pre-I can’t remember what the name of it is.

Rough motor kind of idea about what stuff kind of feels like.

Yeah.

As opposed to what stuff looks like.

Yeah, so I’m probably having the more subjective, um, emotional response that people would associate with, not quite visualization, but pre-visualization.

Mm so it’s an emotional response rather than a visual one.

It’s a feeling and kind of an emotional one, so.

Mm.

If I was, like I can flip you over in my head, but I won’t really see you, it’ll just feel like you’re flying.

So that, it kind of connects to the emotions then, a lot of the time, this metaphor stuff.

I think so. I think so.

Mark found a metaphor helpful during Systematic Desensitization. His therapist learned about Mark’s interest in Star Trek and used that to his advantage.

So you would kind of try using references of, like metaphor, you use metaphors of their life.
Int Oh, use metaphors. Ok that’s helpful. Can you tell me more about those metaphors?

Pa Yeah like, like what I said earlier, the “raising the shields”.

Int Ok.

Pa That would be a metaphor for raising your mind defences against your fear.

Int Ok. So, were there any other metaphors that he used?

Pa Um, none that I can actually remember.

Int Ok, but that one really stuck with you.

Pa Mm hmm.

On the other hand, using metaphors was not something enjoyed by all. Sarah had visual memory problems, like Tyra. So, the researcher asked her about metaphors, as he had just interviewed Tyra, who had said that she too had visual memory problems and still liked metaphors. But unlike Tyra, Sarah found metaphors unhelpful, as represented in the code Intervention that is ineffective- metaphors.

Int Yeah. Do you, have you heard about word pictures, or--? A way of explaining it in a metaphor, or any of that kind of stuff?

Pa I suck with metaphors.

Int You suck with metaphors. So that’s something you have a hard time with.

Pa That probably wouldn’t help too much.
Visualization, as represented in the code *Intervention that helps-visualization*, was used by five participants in this study. In particular, Owen’s therapist used this as part of EMDR. Owen, who had excellent abstract and visual spatial reasoning, with no problems in visual memory, used EMDR to address a traumatic event that he experienced while sailing.

Pa  Yeah. Not-- yeah. It’s, def--, and you don’t have to physically go do things-- part of it would be going into your mind and--

Int  Visualizing.

Pa  --visualizing or hearing a sound, or--

Int  Yeah.

Pa  --what would it feel like to do this, what would it feel like? You know.

(Owen, int 1, 664:666)

For Nicole, visualization helped her to gather information to talk about, as she regularly became stuck when trying to express her ideas. This was sometimes apparent in the research interviews when she struggled with finding a way to say things. She also reported that it sometimes took her a long time to explain herself in therapy, if she didn’t get suggestions from her therapist.

Int  Um, one of the other things that one of my other clients did, I don’t know if you’ve done it, but maybe you have, is visualization, where you kind of picture something in your head--

Pa  Oh I think so, I believe so.

Int  You think so. How did that work for you?

Pa  Um, I think it felt corny again.
Int  Yeah?

Pa  But um, I don’t know, I haven’t done it for a while, so, but I, again, I think that’s another useful tool, because um, she’s um, asking me questions I guess, like, um, “now, can you picture yourself doing this?” Or, um, “what do you picture happening if you were to do this?” So it gets me talking again.

(Nicole, int 1, 394-399)

Alternately, Systematic Desensitization, as experienced by Mark, used real as well as imagined experiences to decrease anxiety towards a phobic situation. This was coded as *Intervention that helps - systematic desensitization*. This process was both a pictorial and a body-centered process. Mark preferred direct experience with the phobic objects, unlike Owen, using EMDR, found that he could reprocess the anxiety producing situation in his head. Mark did not get as much relief from visualization of the phobic objects as from real-life exposure. This was described by mother (M) and confirmed by Mark (Pa).

M  And had him visualize situations and what he could do in those situations with a different um, with a successive approach to it. Where it’s like, ok, there’s a dog, you know, twenty feet over there, how, how’s your body feeling?

Int  Mm hmm.

M  That kind of thing.

Int  Ok.

M  But I think there was nothing like his walks around the block. He would just take him out and they would look at the different plants, and what the bees
were doing and the different plants, what bees are for, all the benefits of bees, and--

Int  So that was--

M   --how to act calmly around them.

Int  So that was the best part.

M   Yeah, I think, the actual exposure.

Int  So not visualization. Did that help, just thinking about this stuff, as much?

Pa   Yeah, it didn’t help as much, but it did help.

(Mark, int 2, 360-370)

Mark believed that physically experiencing the actual phobic event or object was more effective in reducing his reactivity.

Int  Um, how did it, so how did it progress? Did you like kind of work on one phobia first, and then the next one?

Pa   Um, both about the same time.

Int  Both about the same time?

Pa   Yeah.

Int  So in one session, would you work on both of your phobias?

Pa   Mm hmm.

Int  Yeah? Um, so, and what kinds of things did you do? You went for walks in the park...

Pa   We went walks around the campus.

Int  Oh ok. Around the campus. Anything else did you do?

Pa   Um, when we got back in the building um, we’d talk some more.
Int  Ok. So you talked first before you left--
Pa  Yeah, then we would go on the uh, walk.
Int  Ok.
Pa  Then we’d come back and talk again.

(Mark, int 1, 448:461)
Pa  No, we would go on the walks then--
Int  You’d just go on the walks.
Pa  Yeah, because that way it’s actually real life.
Int  Yeah. That worked better for you--
Pa  Yeah.
Int  --to do real-life stuff.
Pa  Because I’m not scared of, I’m not scared of the pictures; I’m actually scared of the real thing.
Int  So, the pictures, you weren’t that scared of.
Pa  No
Int  It was just the real thing you got scared of.
Pa  Yeah.

(Mark, Int 1, 1024:1034)

So for some, one way of processing an issue may be to see it and work with it in the visual realm, rather than by talking about it. For seven of the participants metaphors or visualization worked. Even Tyra, who didn’t have a good visual memory, still enjoyed metaphors. However, Sarah, who also had visual memory problems, didn’t enjoy metaphors. Only Mark experienced Systematic Desensitization. For him the
visualization didn’t seem to be as effective. He thought the bodily experience helped him more than visualization.

*Physical activity.*

Finally, the third kind of process involved physical activity of the body. Other than Systematic Desensitization, described above, there were two types of counselling processes that included the body that were described by the participants: role play and movement. Three participants talked about using role play to help them work through particular issues in therapy, as represented in the code *Intervention that helps – role play.* Tyra and Mark both wanted to try it but hadn’t had a chance. However, they didn’t describe the particulars of how it would work in therapy. For example, Tyra wanted to do role play but her therapist said that it wasn’t appropriate.

Pa  Well that’s what I wanted to do and I actually had a counselor say, well let’s not do that, because I wanted to role play something.

Int  Mm hmm.

Pa  And I think it’s just because, again, the power-trip mentality of like, no I want to do it my way. And just, like, that would help me if I could role play my problem.

*(Tyra, int 1, 406:408)*

On the other hand, when Nicole talked about using what she called role-play, she seemed to mean that she experienced an intervention that is generally called Two Chair, in Gestalt therapy.

Pa  Yeah, play therapy, yes. I thought that was kind of interesting. Um, I thought it was—we also did role playing games were there was two chairs, or
sometimes I’d pretend to be, um, myself, and then maybe another person that
I’d have to talk to in the future, but I’m anxious about it, or, um, I’m nervous
about the talk, so I practice kind of a role playing. Or if, um, there’s a situation
and I’m not sure how to deal with it, I would almost sit in one chair and talk
about the pros of it, and then switch chairs and then talk about the pros of doing
it a different way. So, stuff like that, I guess.

Int How does that work for you? Doing those kinds of things?

Pa I found it very awkward to start, because it seemed kind of childish, but I
think it helped out in the end. Um, once I got past the ‘this is stupid’ part—

(Nicole, int 1, 202:213)

While it was unclear whether a role play, in the classical sense, with actors and an
informal script, is what the participants would like, or there was some indication that role
play meant that it was acting out what was in their heads was a useful way of working
through their issues.

The other action-based process described by participants was the need for
movement in a session, as represented in the code *Intervention that helps – movement.*
Six participants wanted to make sure that they could move around during their therapy
sessions. In some instances, participants talked about the need to fidget in order to stay
focused (see below for the theme, *Focusing/on Task*). Here I focus on how participants
considered movement as a modality for expressing ideas. Reasons for the movement
varied among participants. Sometimes movement was said to promote different kinds of
thinking and at other times it helped prepare the way for thinking. For example, Mary
felt she needed to move around because she got stiff as she had been in a car accident.
Nicole had ADHD along with processing and memory problems and had problems with verbal expression. She liked moving around in therapy as she found it boring to just be sitting for long periods. Owen, who had ADHD and often felt restless during the research interviews, found that he wanted the freedom to move around as he thought of himself as animated in his communication. Tyra talked about needing to move, because she felt under-stimulated if she didn’t. But, Tyra was one of the few participants without ADHD. She didn’t believe she needed to move in order concentrate. Still, she just preferred to be able to move during therapy. She felt this need was a consequence of her age.

Pa  Well like I always feel um, very nervous sitting.

Int  Mm hmm.

Pa  For a long period. Like I don’t feel bad and it’s not like I’m fidgeting, or my brain needs activity, or it’s under-stimulated, I just don’t like sitting for a long period of time in one position. Like I like to move a little bit--

Int  Mm hmm.

Pa  --and then they feel nervous that I’m shifting. So I’m not fidgeting, I’m just shifting. But here I am, like when I was little I fidgeted all the time, but over time, my dad was telling me he used to bound all over, and now he’s a principal and perfectly normal.

Int  Mm.

Pa  So I think just some people have more energy when they’re younger and then they grow out of it.

Int  Mm hmm.

Pa  But still I’m in my twenties, so, I’m still pretty active.
Int   And you like to move around.
Pa    Yeah, and it’s not that, to move-I can concentrate sitting still.
Int   Mm hmm.
Pa    That’s what I do on tests and things, but it still, when I’m talking to someone it feels just so unnatural. What I’d really like to do, which wouldn’t be something you could do because you’d have to have your office, is just to walk down the street talking to someone.
Int   Mm.
Pa    It just feels so much more natural.
Int   So if you were actually actively doing something whilst you were counselling with your body, it might actually work better.
Pa    Yeah, or just being able to say, ok, I need to get up and stretch. Like I tutor kids, and they always need to go up and stretch.
Int   Yeah.
Pa    And what’s nice is they’re comfortable enough with me that they can say, I need to stretch. And I’m like sure, go ahead. You can’t just sit there the whole time.
Int   Yeah.
Pa    Like people my age, you know, like in their teens and twenties, they need to move
Int   Yeah. So it helps to move around.
Pa    Yeah, we’re not in our 30’s or 40’s where we like to sit, because we’re-the day waxes out too, we’re tired.
On the other hand, Mary, who was at art school and was more of a visual learner, talked about movement as a way of helping her process her ideas. The researcher asked her if there was anything she did at home that she might apply to therapy. She said that at home she sometimes walks around in order to get to flashes of pictures about her day, which would then help her process the events of the day.

Pa  Like say I walk, noticing as people are walking, and I’m thinking and processing, and you know what else happens, which isn’t such a good thing sometimes, but at night, which is terrible because it’ll keep me up. It’s like my brain is downloading like a computer.

Int  Mm hmm.

Pa  That’s the best analogy I can make.

Int  Mm hmm.

Pa  And I actually get flashes of thing--.. visuals of the day.

Int  Mmm. If you…if you’re walking and moving, doing something.

Pa  Or even at night.

Int  Yeah?

Pa  If I haven’t done that. I will… I will flash, like, download what’s happened in my day, but in a… not in a thinking kind of way, like, more of a visual
These action-based processes seemed to help for many reasons. For Nicole and Mary physical activity helped them process information. However, for others movement was needed for pragmatic reasons, such as boredom, use of body language and the physiological need for activity.

**Miscellaneous processes.**

One process that didn’t seem to fit in any other code or grouping of codes was Owen’s experience of the exercises of worst case scenario, as represented in the code *Intervention that is ineffective – worst case scenario*. Owen had working memory problems and was very good with visual and abstract processing problems. He found the visualization process of EMDR fit his way of working, but the worst case scenario he found overwhelming.

Pa And they did like the, you know, well what could have happened. What was the worst think that could have happened? Like that very cognitive--

Int Cognitive Behavioral.

Pa Yeah. Like, well, what’s the worst think that could have happened. Let’s think through that. But it really didn’t work.

Int Mm.

Pa It was too overwhelming. I really didn’t like it. So I think it was more important to step back and deal with the smaller pieces and like that that’s why I find with the EMDR, you can do-is you can deal with the pieces, like even if it doesn’t deal with the foundational like emotional problems-

(Owen, int 1, 81:92)
So, this worst case scenario didn’t work for Owen as he felt he needed things broken
down into parts, in order to process it.

The code with the most participants (nine participants) contributing in this
theme, that had also had the most quotes, *Intervention that Helps- Modality/Process to
promote thinking* (see Table 13, row 1) was a general code that included any comments
participants made that pertained to the medium or mode of expression that did not speak
specifically to one of the modes of expression included in the more specific codes
discussed previously (e.g., because a specific mode of expression wasn’t specified, or
because a medium was only discussed by one or two participants). There were three
modalities for expressing ideas subsumed in this category that was not teased out into
separate codes: bringing media into a session to tell a story representative for the client,
reality testing and using self-talk. Each was discussed by a different participant. Fiona,
who had working memory, reading and writing problems, talked about having problems
with finding ways of expressing her ideas. She talked about the potential value of
bringing in books (discussed in the *Approach to therapy as intervention that helps –
Bibliotherapy above*) that described similar circumstances to hers as a way of describing
her condition. She also mentioned that she might be able to use examples through songs
and movies to help her describe different parts of her life.

Owen suggested that after processing ideas in his sessions, he needed to test his
ideas in real life. Owen had experienced both play therapy and Eye Movement
Desensitization Reprogramming (EMDR). This intervention involved a lot of
visualization of traumatic events. He had gifted visual and abstract reasoning and
believed that EMDR worked well for him because of his gifts. But, in order to solidify
what he had learned he felt that he had to go out into the world and experience what he had learned.

Pa  --um, that it’s hard work meeting people, but it’s hard work in the sense that it’s so draining. It’s such a taxing experience. And I spend hours by myself, and I love it. But it’s always that push pull. Like, it’s almost like you’re fighting with yourself. Because you want to go out, but then it’s so exhausting. So, in the summer, like, I had like, a, I don’t know how to put it other than limiting beliefs, um, and like the only way to change them, like I can talk all I want to myself, but--

Int  Yeah.

Pa  The only way to change them was to go out and--

Int  Just do it.

Pa  -do it yeah.

(Owen, Int 1, 544:548)

Mary, who had been assessed as a visual learner, also used what she learned in therapy in a process during every-day life. She used the scripts she had learned in therapy as self-talk. She described herself as a circular thinker who talked about things over and over again in order to process them. She seemed to do this in interviews with the researcher as she brought up topics again and again. Much like her circular thinking she liked to use repeated script, self-talk, enacted in real life experiences, to help her transfer her learning from her therapy sessions.

Pa  Yeah. Well, what I’ve discovered is I get angry really easily when I’m hurt, or I’m mistreated, or I’m not validated, or my needs aren’t met, you
know? And sometimes I have to go, ok, so my needs aren’t met, what can I do to meet my needs? Like, that’s what I’m learning, I’m doing a lot of self-talk, and I go, ok, what’s going on here, why are you so pissed off? Why are you just like…what do you need. And I go, I have to say that to myself a lot.

(Mary, int 1, 1009)

In member checks, three participants gave feedback about different kinds of processes that help them work through their issues. Tyra confirmed what she had said in other interviews; she said that she doesn't like therapy where she just listens and talks. She liked role play, metaphors and writing during therapy, but her needs were variable depending on the day. She liked all alternate modalities, especially those that involved movement during her session. She thought that it would definitely be helpful to have some kind of homework to think about what she wanted to do in therapy. Ted added to what he had said before; he said that he would like drawing metaphors and informal homework (that helped him prepare material to bring to therapy). John also added to what he had said before. Unlike the others above, he said that he didn’t like role play, but that drawing and visualization might help. In general, the participants’ comments were consistent with what they had already expressed in their previous interviews.

In summary, when discussing Modality /Process to promote thinking, participants talked about three general areas and a number of more specific processes. The three main types of processes were described: writing/drawing in therapy, representing in visuals (through metaphors or visualization or systematic de-sensitization), or physical action-based processes. For some of these processes such as metaphors and written homework, some participants found that these processes worked well for them but others did not.
Some participants had experiences that were not shared with others, such as Systematic Desensitization, reality testing and worst case scenario, while most of the processes were shared by more than one participant.

*Focusing/on Task*

Eight of the participants, during the interviews, made at least a couple comments about staying on task or trying to focus in their sessions (see Table 16 and Figure 17). Therefore, “*Focusing/on Task*” was identified as another central theme in the interviews. As can be seen in Table 16 and Figure 17, participants discussed how it was difficult for them to focus in their sessions and what made it more difficult. They also talked about what made it easier to focus and how their therapist helped them manage their distraction.

For most of the participants with ADHD, focusing was a significant issue in therapy.

*Table 16.*

*Problems or solutions to help participants focus in session - code by participant*

<table>
<thead>
<tr>
<th>Codes</th>
<th>Owen</th>
<th>Tyna</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th>Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focusing / on Task</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focusing in session -- problems with</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>20</td>
</tr>
<tr>
<td>Focusing in session -- hinders</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>4</td>
<td></td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Focusing in session - easy on the important stuff</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>6</td>
<td></td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focusing in session -- get back on task ADD/ADHD</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>6</td>
<td></td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Focusing and session -- helps with -- fidgeting/ sensory stimulation</td>
<td>5</td>
<td>7</td>
<td>4</td>
<td>16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist -- keeps client-centered on problem</td>
<td>4</td>
<td>1</td>
<td>4</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intervention that helps - focus development</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Intervention that helps -- distraction from obsession</td>
<td>1</td>
<td></td>
<td>1</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Totals</td>
<td>22</td>
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<td>1</td>
<td>21</td>
<td>2</td>
<td>14</td>
<td>13</td>
<td>81</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
All the participants, except two contributed to this theme. But, most participants spent only a small amount of time talking about this theme (81 quotes in all), compared to others. But, some talked much more about this area than others. Sarah, Mark, Ted and John, who had ADHD, talked more than ten times each about different aspects related to focusing.

Figure 17: Problems or solutions to help participants focus in session-network

All of the participants with ADHD commented on how they had problems with focusing in their sessions, as represented in the code *Focusing in session - problems with*, and all talked about particular things that helped them stay on task. But, the severity of symptoms varied across participants. Mary talked about how she had to go in to the art studio at school at times when others weren’t there so she could get her work done. She found this difficulty of focusing in therapy also. Sarah, who had ADHD, talked about how her difficulty with focusing affected may different areas of her life. She had
assistance from a psychologist and two different therapists to help her with her ADHD. However, she reported that, along with her reading disability, ADHD was still affecting her ability to achieve up to her potential at school.

Pa Sometimes I can’t stay focused, and that.

Int Yeah.

Pa Sometimes, like I’ll just, things will, I just can’t stay focused to what I’m saying, or trying to say.

(Sarah, int1, 204:207)

On the other hand John, who also had ADHD, was only rarely off focus in counselling. It was only when he was tired or distracted by something he was thinking about before the session started that he had difficulty in focusing.

Pa Uh, not really, I don’t think it affects my counselling, ‘cause it’s trying to help. The counselling helps me, and it doesn’t really bring it down.

Int Like ADD, what, for you, is ADD?

Pa Not being able to concentrate--

Int Mm hmm.

Pa --on things. That’s pretty much it.

Int Does that ever happen in counselling?

Pa No, not really, just in school and stuff.

(John, int 1, 94:100)

In this study, certain elements hindered the participants in being able to concentrate in their sessions as represented in the code Focusing in session – hinders. This code was a catch basket of miscellaneous elements that made focusing more
difficult. As discussed above, many individuals with learning disabilities are tired with their busy schedules. John said that he rarely had problems with focusing. He only found it difficult to focus when he was tired.

Int Ok. So in counselling, do you think there might be a possibility sometimes that, that um, it might be hard to focus, or--?
Pa Um, when I’m tired.
Int When you’re tired.
Pa Yeah.

(John, int 1, 101:104)

Sarah, Fiona, and John had difficulty focusing when they were distracted by topics that they were thinking about from outside therapy. Sarah said:

Pa Yeah. Sometimes like, I won’t be on track if I, I’m in, I just watched a bunch of TV or something; then I’ll be thinking about what I’ve been watching and that.

(Sarah, int 1, 397)

While participants who had ADHD talked about how the environment had a significant effect on how comfortable they felt in counselling (see theme Body/Mind needs for work), it also seemed to affect their ability to concentrate. John’s comments about his environment were put in Body/Mind needs for work, because it was unclear whether the particular environment he wanted made him feel more comfortable or also helped him focus. This may have been because he had deficits in verbal expression, and so couldn’t explain why he preferred a particular environment. But, he did describe how he preferred different lighting, flooring, furniture, placement of windows and even a computer in his
environment. He also said that he wanted to have a computer in the room because he enjoyed watching the screensavers while talking to his therapist. For others, however, it was clear that the environment had a significant effect on their ability to concentrate. For example, Sarah found lighting distracting. When she had her interview at her house, she was particular about having her interview in a room lit by incandescent light, rather than fluorescents.

Pa Mm hmm. So that’s one thing that kind of gets my focus off, because I’m always like this, ‘cause I’m getting a-sometimes I’ll get a migraine from the light, or whatever.

(Sarah, int 1, 329)

In addition Sarah and Nicole found clocks distracting and Nicole found noises outside the session room distracting.

Pa Mm, I don’t know, like sometimes, like if I have a clock, and I notice the time, then I’ll get fidgeting because I’ll notice, oh, there’s this much time left, or whatever. That’s why I hate when I, when I know how much longer I have on a test. I hate when there’s a clock right there, or something like that.

(Sarah, int 1, 339)

Pa Oh um, um, I know that um, for example, like sometimes um, I, I’ve seen someone where we’re talking and um, she’ll glance at her watch several times during the session and that kind of throws me off, because I don’t know if I need to-I don’t know if that’s a sign that I need to hurry up, or time’s running out, or she’s checking the time because she’s hoping, “oh, I hope this is over because I don’t want to listen to her”, so, that throws me off a little bit.
Int  Ok.

Pa  And then I think I’ll lose track of what I’m saying, um, so little things like that, like, or um, I guess the room is important too, but I guess the room is pretty good, but um, if there’s too many interruptions like phone calls or knocking or stuff like that, that throws me off and I can’t get back on track. Like, I’ve been in a room with a therapist where her phone went on and on and, yeah, she would just let it ring and keep on talking, but it, the ring throws me off.

(Nicole, int 1, 255:257)

Some participants described elements that enabled them to be more focused in therapy. They talked about the content of the session making it easier to focus. In addition, they discussed what they could do that would help them focus. Finally they discussed how the therapist helped them focus in their sessions.

Three participants described how it was easier to focus on content that was more important to them, as represented in the code Focusing on session – easy on the important stuff. Sarah said that when she found it boring it was hard for her to concentrate. Mark described how it was much harder to work with his therapist, over a long period of time, when he was bored. On the other hand, John almost never found his counselling boring and so, he didn’t find it hard to focus.

Pa  I’m usually really focused on it, because it’s important to me.

Int  Oh, ok. Ok, so, let me get this straight. Because counselling is important for you, it’s much easier for you to stay focused on it--

Pa  Yeah.
Some participants talked about how they helped themselves focus. Three participants talked about forcing themselves to stay on task, as represented in the code *Focusing in session -- get back on task ADD/ADHD*. The researcher asked Sarah how she stayed on task, given that she had problems with focusing.

*Int* What do you, what do you do?

*Pa* Just, like, in, try to continue.

*Int* Ok. So do you re-focus somehow?

*Pa* I try to make myself focus, and that.

*(Sarah, int 1, 213:216)*

Three participants talked about fidgeting in order to help them focus, as represented in the code *Focusing in session - helps with - fidgeting/ sensory stimulation*. Not only did the right environment effect their ability to focus, Sarah, Mark, and Ted reported that being able to fidget or play with different objects during counselling helped them to focus. This was also apparent during the interviews. Sarah enjoyed doodling and Mark played with a jewelry box. Both reported that it helped with their ability to focus. Sarah reported that they appreciated their counselors allowance for their fidgeting. She described what kinds of things that helped her focus.

*Pa* Well I always shake my legs. Like, I always have my knee like this, like moving.

*Int* Ok.
And, sometimes I’ll just pick, pick at stuff. Like I’ll start peeling my skin.

Yeah.

Because it’s just something to do.

Mm hmm.

That’s why—when you stopped getting at me to pick at my skin? ‘Cause it’s just something to do.

Mm hmm.

And then, I don’t know, just like if there’s something to fidget with, I’ll just fidget with it. Like...

(Sarah, int 2, 22:31)

Mark described how it helped his ability to focus if he could play a labyrinth game or with Lego during his session. His mother commented that he usually liked having something in his hand to fiddle with if he was having a conversation with her. He described how these things in his hands helped him concentrate.

— and things to do with my hands, because sometimes it helps if you have like a ball, or something, because (indistinguishable). So you either have to see it, hear it, or feel it.

Ok.

And sometimes people just need to have something in their hands to help them concentrate.

(Mark, int 1, 59:62)

However, although they often worked hard in their sessions to stay on task, Sarah described how tiring it sometimes was to stay focused. They felt that they weren’t always
able to stay on task without help of their therapist. Participants talked about two different ways their therapist helped them stay on task. Three participants appreciated their therapist’s help in staying focused on their topic, as represented in the code Therapist – *keeps client-centered on problem*. Sarah talked about being kept on task. The commonly commented on approach was for the therapist to guide her client back on topic.

Pa Yeah, I think she helped with that though, because whenever I was like. Whenever she…I guess she thought that I was getting to the meat, but I was drifting off, she’d ask me a question, and so…

Int Mm hmm.

Pa I just like, so she kind of kept me on track a little bit.

(Sarah, int 1, 23:232)

Alternately, Ted described how his therapist helped him to train himself to stay focused, as represented in the code Intervention that helps – *focus development*. He described how he worked outside his sessions. In lineups when shopping, his therapist helped him learn how to stay in the line even though he found it hard to focus. In conversations with friends, he learned how to stay on task with conversations. Ted found it empowering that his therapist helped him learn how to improve his ability to stay on task.

Pa And I know when I’m clear, I’m just like, I go off a bit of a tangent, and then I’ll come back. She never really was like, okay, “I don’t want to hear about that. Let’s come back to here.” She was always, she always kind of let me find my way back and let me learn, and I - I always respected that because of the fact that she was letting me - letting me find my way back, and patient
with the fact that it was taking me so long to, to, ah, what’s the word, express myself better, I guess. [Very noisy machinery, coffee machines, in background] Uh, kind of taught me how to get myself back, because even, even sitting here talking to you and, I’m trying to think of all these things about I want myself, ah, “What exactly is he saying, what is he...

Int Yeah…

Pa What exactly is the point here? Okay, I’m back - I’m back and then I talk a bit more and I go off in a tangent and then, you know, okay well, I kind of lost my train of thought like that. So, what was I thinking, you know, I’m, so, cause I do, like it doesn’t maybe appear that way but I’m definitely…

(Ted, int 1, 110:112)

The participants appreciated having the therapists’ support to stay on task and learn how to stay on task. However, while Tyra’s therapist wanted to help her stay on task she resisted the help. She talked about her lateral thinking and more global, rather than linear thinking style. Her therapist, she thought, had more of a linear thinking style. Therefore, they had a struggle with each other as sometimes her therapist tried to keep her on subject and she wanted to talk about something seemingly unrelated (see the theme Client/Therapist co-created structure). Eventually, she had to have a discussion with her therapist to explain that she wasn’t going off task and that she was just describing an element that she would link into the issue of the moment some time later. She wanted her therapist to wait to find out if an idea that she was describing was relevant to the current conversation. When she gave her member check feedback, she confirmed the story told
above. So, while some participants needed help with staying on task, others preferred to be left to stay on their own train of thought.

While many of the participants talked about having problems staying on topic, two participants reported that they needed help from their therapist to get off a topic, as represented in the code Intervention that helps-resolution of obsession. Mark’s father said that sometimes he would perseverate on a topic long after he felt he had resolved the problem. Mark also admitted he had a problem with staying on a topic long after the issue had been resolved. Owen’s counselor helped him by repeating what he had said and then asking if there was anything more to add. Sarah talked with her mother about having an obsession that consumed her thoughts. Sarah confirmed that this also happened in therapy. She explained how her therapist worked with this where appropriate, to let her go where she felt comfortable, until she moved on.

M  Has she used any techniques?
Pa  Well like, it’s more or less like, it’s not a big deal if I keep coming back to it. She doesn’t mind--
Int  Hmm.
Pa  --and that.
M  How about--
Int  So then, it’s more, if you need to come back to it, you’ll come back to it, until you’re all done with it, kind of thing.
Pa  Mm hmm. Until the session’s done.
Int  Until the session’s done.
M Or does it help if she comes up with a solution? Can you let it go then or does it still kind of consume your mind.

Pa It still somewhat consumes my mind.

M Yeah.

Int So it’s kind of like your brain will be done, when it’s done with it. And, and, for the counselor to let you go--

Pa It’s usually done when I’ve found something else to continually think about.

(Sarah, int 2, 368:380)

It seemed that different therapists had different approaches to help the participants manage their perseveration.

Three participants talked about staying focused during the member checks. As she had described earlier, Tyra wanted her therapist to see if what she was saying was relevant, before trying to get her back on task. Ted confirmed what he had said before; he said he didn’t need to fidget or draw in order to stay on task, because he had trained himself to stay on task. John also confirmed what he had said before, he said that the only times he had problems with focus during his therapy was when he was bored, tired or had something else on his mind. Otherwise, if he found therapy interesting he had no problems with focusing. As a whole, these participants confirmed what they had already said in the previous interviews.

In summary, while all the participants with ADHD found that attention was affected during the counselling process, only one without ADHD, Sarah, needed help staying on topic. Many participants were aware of what could help them focus on the
The environmental conditions of therapy and other distracters sometimes made it more difficult to stay on task. While some participants were able to help themselves to stay on task, by forcing themselves or fidgeting, some needed the help of their therapist. On the other hand, two participants needed help to stop perseverating on a topic that had already been resolved. Overall, participant’s difficulties with focusing did have a significant effect on counselling and they appreciated the opportunity to address this difficulty in therapy.

*Therapist Supported Thinking*

During interviews, six participants talked about activities that their therapists undertook to help them bring clarity to their client’s thought processes (see Table 17 and Figure 18). Consequently, “Therapist supported thinking” was identified as a central theme in participants’ comments. As seen in Table 17 and Figure 18, participants talked about four different ways that their therapist helped them think through their issues. Therapists used these supports to help the clients organize their thinking, according to the needs presented by their learning style.

Six participants only contributed 45 quotes, but they were important because of their relation to the participants’ learning styles. The participants who needed these supports felt that they had specific learning styles that needed particular kinds of support from their therapist so that they could resolve their issues. Different participants said that they needed different kinds of questions in order to organize their ideas so that they could be processed. Some participants experienced these kinds of questions or statements and often recognized how they helped them compensate for some of their disabilities. Others wanted particular kinds of help in future sessions. There were four particular kinds of
interventions that were meant to support thinking; while three were useful and one was decidedly unhelpful.

Table 17.

*How participants thought therapists helped or hindered their thinking - code by participant*

<table>
<thead>
<tr>
<th>Participant</th>
<th>Owen</th>
<th>Tyn</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
<th>Totals</th>
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<tbody>
<tr>
<td>Therapist Supported Thinking Codes</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Intervention that helps – making meaning from stories</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>13</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Intervention that helps -- summarize ideas to comment on a theme or gestalt</td>
<td>12</td>
<td>1</td>
<td>7</td>
<td>1</td>
<td></td>
<td></td>
<td>21</td>
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<tr>
<td>Structured -- process description -- general to specific</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>7</td>
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<tr>
<td>Intervention that is ineffective -- questions multiple</td>
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<td>4</td>
<td>4</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Total</td>
<td>1</td>
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<td>5</td>
<td>10</td>
<td>13</td>
<td>2</td>
<td>45</td>
<td></td>
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</tr>
</tbody>
</table>

*Figure 18: How participants thought therapists helped or hindered their thinking - network*

First, six participants were very good at telling stories about their life, but had a hard time pulling back to make find the relevance of their story to their present situation,
as represented in the code *Intervention that helps – making meaning from stories*. They wanted their therapist to help them make sense of their stories, to help the client understand what their story could tell them about their life or themselves. For example, Nicole, who had difficulties with her verbal expression and working memory, talked about enjoying the therapists way of helping her make meaning from her play therapy stories.

Pa  I guess that’s what the art therapy did. It prompted me more to talk, like to, “Why did you do this?” “Why did you-I noticed you did a little barricade-why did you do that?” So it kind of prompted me to um, talk more.

(Nicole int 1, 158)

Second, four participants described how they would get lost in the details of their story, as represented in the code *Intervention that helps – summarize ideas to comment on a theme or gestalt*. Ted talked about how his therapist summarized what he had learned from his sessions so he could take them away with him to use. Mary talked about how she lacked the ability to move in and out from a global overview of her life and then move in to look at details and back again. Instead, she was sometimes lost in the details. As a consequence, she felt she was were unable to process her experiences in terms of their overall pattern. She ended up feeling that she had told a nice story, but not found a way to make a change in her life. Mary wanted her therapist to check in with them by making a summary of what she had said.

Pa  Yeah, exactly. Where I’m getting the big picture. You know? Like someone was saying, well, sounds like to me, like, what I hear is that, you
know, you do these things, and you get into that place. But you…that’s not a
good place for you. Because you get really, you know?

Int Yeah.

Pa Although, what could you do to avoid that?

Pa Mm hmm.

(Mary, int 1, 973:976)

Nicole also felt that she was sometimes lost in the details of her story and she couldn’t
remember what she had said and what she still wanted to say. She needed her therapist to
summarize it, in order to trigger her memory to recall what she still wanted to say.

Pa Um, and she’s also organizing the…

Int Ok.

Pa You know, like, just sort of, getting the big…organizing the big picture.

Int Mm hmm.

Pa How’s that? The big picture (writing down words). So I don’t have to get
lost in the details.

(Nicole, int 1, 929:933)

In summary, participants appreciated the therapist summarizing what they had said; as it
helped them see where they needed to go next and what they could take away from their
session.

Third, Ted described how he needed to work in therapy from describing a general
outline of his issues to focus on the specific details, as represented in the code *Structure -
process description - general to specific*. This was different than the therapist creating a
summary of what was said, because outlining was done before the details were described,
rather than after. Moreover, this is not the same as what Ted discussed in the theme

*Client/therapist co-created structure*. There he talked about a structure in terms of

negotiating a framework for his therapy process with his therapist. In relation to this
current code, Ted explained how, when describing part of his life, he wanted to outline a
general plot and then flesh out the details. Ted described how he learned this skill at

school by explaining how he used an Anagram, where each letter stood for part of a
concept, to provide him with an outline to organize the details. He said that because of

his memory problems he needed an outline of what he was going to discuss, so that he
didn't miss things. He explained how once he had the outline he could talk about the
details.

Pa  But I can - if I have the structure down, I'll - I can - I'm very detail-

orientated, as long as I don't get off of this structure, or as long as I don't get off
of this structure. I can start - I can start going through elaborate, like, you

know, I think about some of the things that I - some of the way I work with

things, um, you know, a lot of it is symbols and what-not, and arrows.

Int  So all of those other words will come out.

Pa  Yeah, oh, yeah. Totally

Int  Once you have got that basic structure

Pa  Yeah.

Int  Or scaffolding of

Pa  Yeah

Int  Some kind
Pa: Cause then - cause then I can - I can build on this, this thing's huge or I can - or I can build on my, you know, uh, I've a bunch of fr - frustration... on - on things. And, uh, oh, and that leads me to be unhappy. I'm just - I'm trying to think of it, counselling is to - to help you out there. If I can start on that, then - then I can maybe start to go on what frustrates me or school does, what else, my parents. My parents frustrate me, okay, so, and then I have a lost track of where I am,

(Ted, int 1, 661:670)

On the other hand, Ted, who had working memory and auditory memory deficits, described how the therapist he had was very unhelpful when she asked a large number of questions, as represented in the code Intervention that is ineffective – questions multiple. He talked about this problem throughout both of his interviews with the researcher. This issue was briefly described in the Approaches to therapy theme. He had a clinical depression and his therapist used multiple questions to attack particular kinds of unproductive thoughts. But he found this quite overwhelming and eventually he just said what he thought the therapist wanted to hear. He described how he felt rigidly structured by his therapist’s multiple questions.

Pa  You may have a structure that's, uh, counselling psychologist that you need to go by - you need to have questions answered so you can diagnose, uh, symptoms

Int  Yeah.

Pa  And come up with a solution, uh, whereas I'm not going to - I 'm not necessarily going to want, 25 questions, that I think I can answer, uh, in telling
you a story, uh, in 5 minutes, I'm not gonna want 25 questions, probing and digging, cause - cause you may be able to come up with a solution but that doesn't help me come up with a solution.

(Ted, int 1, 216:218)

The more he had to try and clarify his thoughts the more frustrated he felt.

Pa  And when your frustration increases the more - the more the counselor says, “I'm not sure what you mean here, can you describe this” or, you know, keeps asking you questions about, um, you know, prying and prying and prying and meanwhile you're - you're trying to focus on trying to, how do I - how do I make this person understand so I could ask them new questions

(Ted, int 1, 303)

Ted thought that he could only handle a few questions at once, without getting lost and confused. This was apparent during the interview with the researcher, where a number of times he had to clarify the question with the researcher. He sometimes found that he couldn’t remember what the researcher had asked and had to ask him to repeat it.

Two participants gave feedback about this theme in their member checks. Ted confirmed what he had said before. He said that the therapist needed to be adaptable, and sometimes creative in their adapting approaches to fit the needs of client if they have a learning disability. Clients with learning disabilities should choose a therapist who is eclectic, flexible and open to creative ways for them to express their ideas. John also confirmed what he had said before. He said he appreciated how, when he told the therapist a story, the therapist could put all the pieces of the story together to make sense of it. He also really appreciated clear and concise feedback, so that he knew what the
In sum, participants found it helpful when therapists supported them in making sense of their lives and challenges. When the participants were able to verbalize their learning style, they were also able to describe ways in which their therapist could complement their thinking. While some participants were stuck in looking at details of their story, others were having difficulty making personal meaning out of their story. Still others had difficulty recalling the details of their personal issues without an outline to guide their therapy. On the whole, participants gave a strong message that support in their thinking was critical to processing their issues.

Finding Opportunities for Therapy

During interviews, the majority of participants expressed a need for more opportunities for therapy (see Table 18 and Figure 19). Thus, “Finding opportunities for therapy” was identified as a central theme in participants’ comments. As can be seen in Table 18 and Figure 19, participants felt they needed more services that catered to issues that they faced with their learning disability, more sessions to process their current issues, and the availability of additional appointments for later use.

Eight participants contributed to this theme but did not spend much time talking about finding opportunities for therapy (76 quotes in all). Eight participants contributed comments in only four codes. Not surprisingly, Ted spent the most time of all participants talking about this issue. He worked with a psychologist who specialized in
working with individuals with learning disabilities, but had only a limited time with her
due to funding issues.

Table 18.

Finding opportunities for therapy - code by participant

<table>
<thead>
<tr>
<th>Participant</th>
<th>Owen</th>
<th>Tyr</th>
<th>Sarah</th>
<th>Fiona</th>
<th>Mary</th>
<th>Rachel</th>
<th>Mark</th>
<th>Nicole</th>
<th>Ted</th>
<th>John</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finding opportunities for therapy Codes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situational variables -- services for counselling LD needed - additional</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>5</td>
<td>18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist - experience/knowledge in counselling those with LD</td>
<td>4</td>
<td>6</td>
<td>1</td>
<td>11</td>
<td>13</td>
<td>3</td>
<td>38</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapist -- give space time - need additional sessions to process issue</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>5</td>
<td>12</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Therapists - additional appointments available</td>
<td>6</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>8</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>10</td>
<td>12</td>
<td>4</td>
<td>5</td>
<td>16</td>
<td>3</td>
<td>23</td>
<td>3</td>
<td>76</td>
<td></td>
</tr>
</tbody>
</table>

Figure 19: Finding opportunities for therapy - network

Five participants expressed the need for therapy that addressed their struggles
with their learning disability, as represented in the code Situational Variables - services
for counselling LD needed – additional. Tyra found that it was hard to find professionals
who both knew about learning disabilities and counselling. She went to psychologists
that helped her with her learning problems, but didn’t know how to help her address her emotional struggles. She also went to therapists who knew how to help her with her emotional problems but not how to manage her learning disabilities. She felt that she needed a therapist who understood her learning and communication needs. Moreover, she regularly had difficulties during exam time; she often had anxiety attacks that left her feeling like she was going to fail everything. However, the availability of counsellors was limited at her university and she felt that they were quickly coming to the end of their benevolence towards her. She had one counsellor whom she really liked, who had been open to learning about how her learning disability affected her life, but this counsellor was very busy and eventually became inaccessible. She had a discussion with the researcher about where she could find regular care during these times. Tyra wanted to have access to a therapist who understood what she was going through to help her learn to manage the anxiety associated with her learning disability and be able to provide continuous care during her time at university.

Pa  Helping out with some people there, and I just think there needs to be more services. Even for people who aren’t at…and things, even people with mental illnesses too that are more available and are free.

Int  So, like, counselling are you talking about?

Pa  Counselling, yeah. There needs to be more free counselling. There’s not.

Int  Yeah, not nearly enough.

Pa  Especially, and I think there needs to be more services at, at university, to help um, have a hotline or a special, because like during exam time, if you have a learning disability, you’re more likely to need help than some--
Int  Mm. So somebody--

Pa  And it’s not an emergency. Like I go in, and they’re like is it an emergency, no, it’s not, so I always gets sent back home. But really I needed to talk to someone about how, about how much frustration I had, but I wouldn’t get services because I wasn’t willing to hurt myself to get them.

(Tyra, int 1, 737:743)

Rachel, who had ADHD, had a number of experiences with therapists who had difficulty understanding how her learning disability affected her self-esteem and self-efficacy. She had depression, but felt that her therapist did not realize how her issues were related to living with a learning disability. She felt that she couldn’t find a therapist who could understand how her learning disability affected her life. Thus, five participants felt that they needed not only more services, but services better suited to their needs that they had as a result of their learning disabilities. Rachel, Mary, Ted and Tyra were all looking for free services that were both appropriate for their needs and consistently available. However, none of them seemed to find services they could afford that would fit their needs.

Consequently, six of the ten participants pointed out that they appreciated or needed their therapist to have a deeper understanding about how their learning disability affected their life, as represented in the code *Therapist – experience/knowledge in counselling individuals with LD*. Tyra had an educational psychologist that tried to counsel them regarding her learning disabilities, with little counselling training, and a counselor with very little ability to understand the experience of an individual with a learning disability. Sarah and Ted had had therapists that had experience with both
learning disabilities and counselling, which resulted in them receiving a counselling that was adapted to their learning style. Sarah said that her therapist had dealt with students with all types of problems, including learning disabilities. On the other hand, some had therapists that were skilled counselors, but didn’t have enough knowledge about learning disabilities to ensure that they felt safe and comfortable in therapy (see Safety / Comfort). Rachel had a counselor that missed how her ADHD affected so many aspects of her life that it left her searching for more understanding.

Pa Well yeah, or, or recognize that, I mean, recognize that, you know, well the labels themselves are-mean nothing, but I think that the various learning disabilities do mean something, and to like recognize that you know what? If I want to be an effective counsellor, I need to recognize that, you know, that certain types of conversations aren’t going to work. Certain types of strategies aren’t going to work. So I mean, and I don’t know what the goal’s of your research are exactly, but, you know--

(Rachel, int 1, 843)

Sarah felt that her therapist really understood what she needed. She thought that it was because of her therapist that she was so successful at school. Sarah’s mother saw how well Sarah’s therapist understood her daughter’s experience.

M Ok, well, what I, what I would think is, I think for something to work with kids that have learning disabilities in a counselling session, they would obviously have to really understand how their brain works with a learning disability.

Int Mm hmm.
And I would say to be very um, non-judgmental and just to really kind of just get into their brain and just see how they feel, and just kind of re-feel their frustrations and what a day looks like for them in school when their brain functions differently, and just the challenges that they come up against every day that other kids don’t.

(Sarah, int 2, 498:500)

Indeed, at the end of the study four participants asked for help in looking for a therapist that had some level of experience counselling individuals with learning disabilities.

Five participants felt that they needed more sessions in order to resolve their issues, as represented in the code *Therapist – give space/ time additional sessions to process an issue*. For Tyra this was a problem as the university counselling services were time limited and it took her some time to move into a close empathetic relationship with her counselor. Because she couldn’t find a therapist who understood her disability, it took her some time to help her therapist understand her experience.

Well the, the counsellor at school was the best at that. And um, there was one that was out of school that’s free but again, I think what’s problematic for people like myself is the paradigm right now of short-term counselling. I don’t work well with short-term counselling; I need long-term, because in order to fit the whole thing together you need a long time.

(Tyra, int 1, 591)

Ted was able to find effective therapy that helped him address his learning needs. But he felt he wanted to continue having appointments occasionally, when needed. He
experienced back sliding when he had an experience for which he felt unprepared. He felt he needed some additional therapy to be able to manage these unique experiences.

Pa Yeah, and that was really - really on one of my answers here, the duration, not only of the actual sessions, but, um, you know, in the continuing sessions...

I found that, um, I would have liked it, actually, if I kept on seeing that person, I wouldn't - I w- [inaudible] funding for me to see, you know, every for the entire, term,

Int Yeah.

Pa I saw her quite a bit for the first little while. Twelve sessions [inaudible] I don't know,

Int So, you mean, a long, not a longer session, but more - more opportunities

Pa More opportunities, yeah, more, just, you know, you get so far, and then, you stop, and then, the longer you - you wait till your next session with, this little line kind of slips back and you have to start all over

(Ted, int 1, 422:431)

These five participants all had the experience of feeling that their therapy was unfinished, when they left their therapist. This was usually because of the availability of limited number of sessions. Given the length of time that it took for therapists to become familiar with the participants’ needs and the participants’ difficulties in communicating their ideas, they all felt that it was a significant loss when they had to leave their therapist when they still had unfinished business.

Two participants wished for additional appointments with their therapists, as represented in the code Therapist –additional appointments available. Both of these
participants were high school students. Sarah had difficulties with her family as well as in school, while Fiona’s issues were more to do with self-esteem and struggles at school. Sometimes they had issues that came up during the week and they wanted additional appointments, other than the ones they had received. For example, Sarah deeply valued the relationship she had with her second therapist. Sarah’s mother stated that Sarah became upset when the counsellor was unavailable.

M  I know (anonymous) come home from school frustrated and down a few times because her counselor wasn’t available, or she ended up having to cancel because something came up, she had to fit somebody else in, or--

Pa  Or it was snowing and she couldn’t come in.

M  --come to school.

Int  Mm.

M  And I know it really, really upset (anonymous) a number of times because, for a lot of times that would be the highlight of her week, getting to meet and talk with (anonymous), and just talk and be understood.

Int  Uh huh.

M  And when it didn’t happen, it really crushed her. And a few times she felt, I would say almost hurt.

(Sarah, int 2, 820:824)

Fiona wanted the therapist at her school to make some walk-in appointments available, as she had pressing issues that affected the rest of the week if they weren’t addressed immediately. Sarah also would have liked the same. For both, it was apparent how much
they relied on their therapist to help them work through issues in their everyday lives and would have liked their therapist to be more available.

Three participants gave feedback, in their member checks, about this theme. Tyra confirmed what she had said in other interviews; she needed free or at least long-term affordable counselling. She would also appreciate her therapist checking in with her between sessions, especially with someone that understood how her learning disabilities affected her life. If a crisis arose between sessions, she would have liked to be able to e-mail her therapist. Ted also confirmed what he had said before, he didn’t believe he needed more opportunities for counselling, when he had a therapist, but would like to be able to go back some time in the future. In addition, he did need to have a therapist that understood how his learning disabilities affected his life. On the other hand, John confirmed what he had said in his previous interviews; he felt that he had more than enough counselling and didn’t have a problem accessing it as his mother could afford to pay. On the whole, the participants’ comments in their member checks were consistent with what they had said during previous interviews.

In summary, participants were looking for more services, and therapists who understood needs related to their learning disability. It was hard for some to find counsellors who understood the effect of their learning disabilities on their lives. When they did find the appropriate therapists, they often felt that they needed more sessions, given their difficulties with making themselves understood and the complexity of their needs. They also wanted ongoing support as they often had continuing struggles with their learning disabilities.
Summary of the Themes

Participants described an enormous variety of aspects of their therapy. This was not surprising, given the openness of the questions that were asked and the methodology used to gather data. Twelve themes were described that covered issues such as relationship with the therapist, preparation for therapy, communication issues, interventions and approaches to therapy. Each theme included an overview of which participants contributed to the conversation about an issue and a detailed overview, including quotes, of the key issues presented in the theme.

Participants had both enjoyable and difficult times in therapy; each felt they learned much in therapy but most were left wanting more. While many enjoyed their therapy process and their close relationship with their therapist, some participants needed a different kind of process to learn from their therapy, had poor relationships with their therapist and struggled with communication. A few were still looking for therapy that would support their particular needs. This is understandable as only a few found therapists that had experience working with individuals with learning disabilities. For most of the participants it was a process of exploration, shared by both participant and therapist, which lead them to a mutual understanding of what they needed in order to progress in therapy.

Participant’s Paragraphs

Inserted below are paragraphs written by the participants. The researcher promised not to analyze or compare them in any way to what they said in the interview sessions. The researcher offered to put these paragraphs in the essay as a way of enabling participants to have their own voice and also give participants an alternate modality to
express themselves. Paragraphs are inserted word for word; there is no change in grammar, spelling or punctuation. The researcher changed only the font and the line spacing, for readability sake.

*Owen’s Paragraph*

As with all clients, a counselor must tailor his or her style to a person with a learning disability. Perhaps the first aspect to focus on is that a person with a learning disability is simply different and not in some way deficient. A counselor then needs only to use the strengths of that person to help them deal with whatever they are in counselling for. A person, like myself, with a short-term memory problem may be a frustrating client because they seem to jump around a lot. This is how I was made so have faith; we will get to the core of the problem eventually. Those with verbal disabilities may take longer to articulate what it is that they are feeling.

Be patient and don’t rush them, it is just as frustrating for them as it is for you. Most importantly though, build trust and understand your client.

*Sarah’s Paragraph*

My learning difficulties have been very frustrating and challenging for me to deal with. I love to learn and enjoy school for the most part, but certain areas of learning are very hard for me. I find it very difficult to memorize things and this is a very big part of school. I can go over and over things again and again but it is very hard for this information to stick. If it makes sense to me and I understand the concept I seem to have a easier time remembering the information. I also have a hard time concretating, keeping focused on what I am learning or reading. This is very challenging especially when the
teacher is leiasuring in class and I cannot stay focus on what she is talking about. I find that when I am under stress I do not function very well. My brain will not work.

Counselling has helped me because I have found that the counselor understands how my brain works and how my brain processes information. They can explain things to me that make sense to me and that is understandable to me. The counselloring has been a big help in my life.

*Rachel’s Paragraph*

Often I find it difficult to express myself. It is not common for me to feel misunderstood and frustrated. Many of personal and academic difficulties arise from my learning disability; however, conventional counselling does not seem to recognize this. Therefore, I have found myself alienated and hesitant about pursuing more counselling. However, it has become increasingly clear to me that I require counselling that recognizes and accommodates my own unique needs. Specifically, it is important for me to work with a professional who either has a learning disability, or, at the very least, trained to counsel people with learning disabilities.

*John’s Paragraph*

Learning Disability Research

Prepared for Piers Samson

November 7th, 2007

My experiences in counselling can basically be classified two ways, productive and non-productive. During High school and my first few years in University I attended counselling to address both anger and frustration problems and learning difficulties respectively. I have struggled with school due to attention, auditory processing and
memory retrieval problems from an early age and I initially found counselling very awkward and non-productive. This sort of counselling was intended to focus on my frustration towards various situations and the counselor was not receptive to my dynamic and unique thought processes. Due to the rigid format in this counselling style it was very difficult to properly establish the source of my issues. It is my opinion that I was not permitted to use my own coping techniques to properly lay the framework of my thoughts and slowly fill in the detail at my leisure. This is my preferred method for explaining myself and when I did not feel comfortable exercising this method I simply held back my feelings and shut down. It was not until I found a psychologist that specialized in adaptive learning that I was able to freely explain my thoughts and problems. This productive counselling was geared toward improving my scholastic approach to university and encouraged me to embrace my learning style by taking into consideration my unique attributes. The obvious acceptance and patience exhibited by the psychologist were instrumental in helping me address my goals and coping mechanisms to maneuver through the barriers.

B.Sc. General Science Candidate

Additional Feedback from the Member Checks

While four participants contributed detailed feedback on the summary of data, which was sent to them, some just wrote one sentence replies in an email. As described earlier, this summary was a data table containing each theme and, in a sentence, an overview of the codes for the given theme. The three sentences, below, are the one sentence replies given by three of the participants as feedback.

Owen’s feedback:
I just reviewed the data; you did a great job Piers. Everything was spot on with my counselling experiences.

Fiona’s feedback:

While not all the opinions expressed by others were my opinions, I found their opinions valuable.

Mary’s feedback:

Everything I said and felt about counselling is reflected in your written remarks. There are no further comments I could make.

These comments were the only ones that these participants were willing to make. They were offered an interview to go over the summary table of results, at their convenience and none of them thought that it was necessary. They believed their comments to be sufficient.
CHAPTER 5
Discussion and Conclusion

There are a number of studies that have investigated the effect of different kinds of counselling on individuals with learning disabilities (Howard Abikoff et al., 2004; Amerikaner & Summerlin, 1982; Bergin & Bergin, 2001; Burden, 2006; Decker, Polloway, & Decker, 1985; Diament & Colletti, 1978; Dinklage, 1991; Elbaum & Vaughn, 2001; Franklin, Biever, Moore, Clemons, & Scamardo, 2001; Geib et al., 1981; Gieb & Others, 1981; Gilmore, 1971; Gold & Richmond, 1979; Grande & Bayne, 2006; Hishinuma, 1993; L. S. Johnson & Others, 1981; Lombana, 1992; Lutwak & Fine, 1983; Meyers, 1985; Miranda, PresentaciÀ’n, & Soriano, 2002; Morse, 1977; Ohler, Levinson, & Sanders, 1995; Omizo et al., 1985; Packman & Bratton, 2003; Pope, 1985; Reis & Colbert, 2004; Rosenberger, 1991; Rosenthal, 1992; Schulman, 1984; Shechtman & Katz, 2007; Shechterman & Pastor, 2005; Swart, 1991; Thomas & Ray, 2006; Thompson & Littrell, 1998; Trimble, 2001; Vogel & Forness, 1992; Wasserman & Vogrin, 1979; Wetherley, 1985; Whitford, Chapman, & Boersma, 1982; Wilchesky & Reynolds, 1986; Wren & Einhorn, 2000). No researchers differentiated between the experiences of individuals with different kinds of cognitive deficits in their studies. Moreover, only a few have interviewed individuals with learning disabilities to look at their experiences (Reiff, Ginsberg, & Gerber, 1995; Rosenberg, 2003; Zambo, 2003, 2004; Zambo & Brem, 2004). And no research was found where individuals with particular learning disabilities had been interviewed about their experience of their counselling.

To address these gaps in the literature, this thesis looked at the experience of individuals with particular kinds of learning disabilities, specifically in communication,
processing, memory and attention difficulties. It was thought that individuals with different kinds of learning disabilities might have different kinds of experiences in counselling. For example, individuals with verbal communication disorders might have difficulties expressing their ideas in therapy while those with simple written output disorders may not. This study was not developed to be able to work out if certain kinds of deficits had a particular influence on participants’ therapeutic process. Rather, it was hoped that this study could tell a story of what participants with these particular kinds of learning disabilities liked about their therapeutic process and what they would prefer to change. It was thought that these participants’ deficits might have some effect on the therapeutic process, but that the preferences in therapy might also have something to do with personal experiences and the issues that they were attempting to address in therapy.

This thesis gave ten participants multiple kinds of opportunities for sharing their ideas. Sally Thorne’s Interpretive Description (Sally Thorne et al., 1997) method was used as a way of allowing the researcher to use a variety of ways for the participants to express their ideas, in order to cater to the needs of the participants. Participants were able to talk alone with the researcher, include a significant other to help them express their ideas in interviews with the researcher, draw a picture and describe its meaning, create a pose and describe its meaning, and contribute a paragraph to the thesis. Each participant, either at the end of the two interviews about the research, or in the member check, said that they had felt understood and that they were accurately represented.

There were five research questions that were asked in the thesis. In this discussion each question will be addressed separately. The answers to each question were similar and often interrelated to each other. Therefore, the researcher will refer
back to the information already discussed in previous questions if it is applicable to the question currently being discussed. The first question gives a general overview of the participants’ experiences in therapy. The next four questions give a more in-depth review of particular parts of the participants’ experiences.

The Research Questions and Answers

Question 1

For individuals with particular learning disabilities (who have particular difficulties in at least one of: communication, processing, memory and/or attention), what is their experience in the counselling process?

Participants came to therapy for a variety of reasons and had various levels of success in therapy. They had issues with family members, school, life transitions, self-esteem, trauma, and mood. These are many of the issues commonly faced by individuals with learning disabilities, as described by others (Grolnick & Ryan, 1990; Margalit & Heiman, 1986; Stone & May, 2002). The teenagers, Mark, Sarah and Fiona, all reported that they had great support from their families and were thriving because of it, both at school and in their social lives. However, John was still having problems with his relationship with his mother. He was having difficulty graduating and didn’t have plans for the future. These kind of outcomes are consistent with the research on resilience for those individuals with learning disabilities (C. Murray, 2003). Many of the participants received relief from their symptoms during therapy. Owen no longer was haunted by a traumatic experience. Mark no longer felt restricted by his phobias. Ted felt far more capable of doing well in school and was looking forward to entering medical school. Sarah and Fiona felt far more capable at school and Fiona had a better relationship with
her mother. However, many were still searching for more effective counselling during the time they were participating in the study.

Participants talked about different aspects outside of therapy sessions that affected their counselling process. A number talked about how being tired made it more difficult to focus in therapy. As seen in the research (Stein et al., 2002), some individuals with learning disabilities may have difficulties with sleep, due to their medication or ADHD symptoms. In addition, participants sometimes felt distracted at the start of therapy and found it hard to refocus themselves on the task at hand. This has been seen elsewhere with individuals with ADHD, because of difficulties in executive function (Fuggetta, 2006; Shallice et al., 2002). In addition, many participants thought it might be good to write notes, during the week of what they wanted to bring to therapy, as they often found it difficult to remember the details of the week. Many of the participants who wanted to record their ideas had working memory disorders, as well as auditory and visual memory disorders. However, some had very busy lives, because of the demands made on them by their learning disabilities, which made it more difficult to remember the details of their week. In addition, some participants’ physiological and sensory systems affected their experiences in counselling. For example, Mark spent a considerable amount of time describing how parts of the environment affected his counselling process. Others talked about the kind of environment that made them feel most comfortable, or made it easier for them to focus in therapy. This is consistent with other research (Imhof, 2004) that shows that visual stimulation increases performance on tasks for individuals with ADHD and the sensitivity of some individuals with ADHD to certain kinds of tactile sensory stimulation (Broring et al., 2008). These issues will be addressed again in question 5.
Most of the participants had received support from more than one therapist. Participants said that their relationship with their therapist was a key determining factor in their success in therapy, which is consistent with the research on therapeutic alliance (Horvath & Luborsky, 1993). Some of these experiences had been uplifting, where they received all the care they needed. Others had been very frustrating; participants found that some therapists didn’t understand their needs. Participants’ comments indicated that the two determining factors that led to a good working relationship were the therapist’s character and their ability to be open and adaptable to the needs of the participants. Therefore, therapists had to be empathetic to the clients’ needs and creative enough to find a way to make the process fit the participants’ needs. Ted and Rachel had experiences with therapists that they believed didn’t understand that their issues related to their learning disabilities. These issues are discussed more fully in question 4.

Participants listed various kinds of approaches and interventions which they had experienced in therapy. The approaches which participants experienced which could be identified specifically were Play therapy, art therapy, Gestalt therapy, Eye Movement Desensitization Reprocessing (EMDR), solution-focused therapy, Cognitive therapy and family therapy. Two participants talked about wanting to try Bibliotherapy, as one had thought about bringing stories to her sessions that had characters with similar experiences to hers and another had seen Bibliotherapy as an option when reviewing the summary of the data for the member check. These approaches are ones that had already been used with individuals with learning disabilities (DuPlessis & Lochner, 1981; Odell-Miller et al., 2006; Packman & Bratton, 2003; Ray et al., 2007). Participants enjoyed interventions such as drawing to describe their thoughts, writing notes to remember their ideas, using
metaphors, visualization, systematic desensitization and role play as interventions in their sessions. The use of metaphors (Callow, 2003) for individuals with learning disabilities was discussed in the research. However, individuals in the study with particular deficits didn’t necessarily prefer certain interventions or approaches. Participants strongly preferred certain approaches over others, most likely because of a combination of needs that came both from their personal issues and their cognitive deficits. More of this issue will be addressed in question 2 and 4.

Participants also had various different kinds of experiences negotiating with their therapist to receive particular kinds of support in three areas: they needed to work with their therapist to create a structure to communicate effectively, think through their problems and find a resolution to their issues. The issues, which are briefly described below, will be described more in depth in question 2.

In one area, participants needed support to express what they were thinking. Many participants struggled to find the right words to express their ideas. This has been seen elsewhere with individuals who have these kinds of learning disabilities (Faust et al., 1997; Faust, Dimitrovsky, & Shacht, 2003). But, this was apparent both for individuals with diagnosed deficits in verbal expression and ones that did not have these diagnosed deficits. Various kinds of adaptations were made by therapists to help the participants overcome these problems. In addition, some participants took longer to express a story or idea and needed their therapist to remain quiet, until they had done so. This issue has not been discussed in the literature.

In the second area, participants needed help to process their stories and ideas. Some participants told stories but then needed questions to help them take a step back to
make meaning from their story. Other participants felt that they became lost in the details of their stories and needed summaries from their therapists so that they could organize and make sense of them. Participants also talked about how they needed to work according to their learning style. Ted talked about being more of a linear thinker who talked about the general topic area before going into details and Tyra talked about being more of a global thinker and needing to be able to go off on tangents, when necessary, to bring other aspects of her concept into the conversation. Tyra had a conflict with her therapist about how to address a problem as he was a more linear thinker.

Finally, participants needed help finding a resolution to their presenting issues. Most participants were simply looking for solutions to a problem in their lives or strategies about how to live with their learning disability. Owen, who was gifted learning disabled, had EMDR. His therapist described the theory behind EMDR and therefore, Owen looked at his therapy as examining his feelings about his traumatic event, through visualization, and then using new found understanding of his feelings to come up with new beliefs to help him learn how to react differently to the world around him. Nicole, however, felt that sometimes she was unable to work out what she was getting out of her therapeutic process. She came late or missed sessions as a consequence. Given the varied views of what participants felt they received from their therapeutic process, participants thought they might want to discuss the structure and process of therapy to work out both what they wanted from therapy and how to get there.

Only two participants, Ted and Tyra, had some knowledge from their academic experience about how their own learning style could inform their counselling process. Tyra had a particularly atypical learning disability that she described as having both
reading, as well as working, auditory and verbal memory deficits. Consequently, she had been to many psychologists and therapists to help her manage the effects of her disability on her life and approach to learning. Ted’s therapist that he most preferred was a psychologist who had been trained as an Adaptive Learning Specialist. He learned from this therapist about his learning style and this informed his ideas about what kind of structure he would like in therapy. Both used examples from their academic lives to inform their ideas about what kind of processes they wanted in counselling. This issue will be addressed in more detail in question 3.

**Question 2:**

Given their particular difficulties (particular learning disability and presenting problems), what elements in the process do they believe helped/hindered them in their change process?

Participants talked about three areas that helped or hindered the therapeutic process, other than the relationship with the therapist and elements outside the therapy process, which are described in questions three and four below. First, participants described certain approaches to therapy that they preferred and some that did not help. Second, participants expressed their preference for certain interventions, over others. Third, they expressed other supports particular to their learning needs, to help them resolve their issues.

First, while participants talked about a variety of different approaches to therapy, it was apparent that their preferences for therapy depended on a combination of needs, experiences and interests. An approach was defined earlier in the topics coding as a comprehensive theory that contains a view of human nature, a structure of personality a
therapeutic process (therapeutic goals, therapist's role, client's experience and relationship between client/therapist) and application of the theory (possible techniques and procedures). The researcher gathered some of the approaches into two groups. In one group were approaches that involved non-verbal creative work first, before talking about what had been created. The second group was experiential and involved doing a physical activity, as well as talking at the same time. At the outset of this research it was hypothesized that individuals with expressive disorders and/or working memory problems might prefer nonverbal activities. Therefore, individuals with expressive disorders might find it easier to talk about what they had created, and that individuals with working memory problems might like non-verbal approaches as it might create less of a load on their working memory (they would be able to get their ideas out first and then process the ideas represented in the objects that they had created). Participants with these disorders, such as Nicole, did like these processes, but so did others who did not have these disorders. For example, Mary, who was an art student, said that she preferred to express her ideas visually. She believed she could express ideas from childhood which were ‘preverbal’ in play therapy and her feelings which she found hard to describe verbally in art therapy and then talk about them when they were in the sand or on the easel. Play therapy has been used with individuals with learning disabilities with success (Guerney, 1979; Packman & Bratton, 2003). It was also hypothesized at the start of this study that individuals with ADHD would prefer experiential activities that included more movement. Many participants with ADHD did indeed like more experiential therapies. Some said that it added interest to the therapy, like Nicole, who liked the Two Chair and Empty Chair exercises of Gestalt therapy. This approach has been used elsewhere with
individuals with learning disabilities ((DuPlessis & Lochner, 1981; Omizo & Omizo, 1988). Two participants, even though both had problems with reading, said that they would like to have tried Bibliotherapy, this interest was consistent with the literature on Bibliotherapy and learning disabilities (Forgan, 2002; Lenkowsky, 1978; Lenkowsky et al., 1987).

Participants had mixed reactions to Cognitive Behavioral, family and solution-focused therapies, among others. Many of the participants did not want their parents in their sessions and so they didn’t experience family therapy. John had mixed results with his therapist in family therapy and solution-focused therapy. He felt his mother was less controlling, but there were still outbursts between them and one happened during the second interview about the research questions. But in previous research (Barkley, Guevremont, Anastopoulos, & Fletcher, 1992; Eisenhauer, 1991; Ray et al., 2007) family therapy has been effective with those with ADHD and learning disabilities.

So, in summary, it seemed that participants liked different approaches for many reasons, including needs created by their cognitive deficits. But, participants also had other reasons for preferring the some approaches. Indeed individuals with particular deficits do enjoy approaches that enable them to express and represent their ideas in ways other than just sitting down and talking with their therapist. On the other hand individuals without those particular deficits may like the same approaches for different reasons.

Second, certain types of supports were also preferred by participants. Interventions were defined, when coding the topics, as particular activities that the counselor carries out or gives the client to do that helps the client in counselling. Only some interventions were discussed in literature (Broad & Wheeler, 2006; Callow, 2003;
Seubert, 2005; R. Shapiro, 2005; Wagner-Moore, 2004). However, again, the desire for a particular intervention wasn’t necessarily related to the specifics of an individual’s cognitive deficit. Some participants felt they needed to write things down. Some wanted to write in order to record ideas that they thought they would forget. Most of these participants had working memory or expressive problems, but others did not. Some participants wanted to draw during the session in order to relax. All of these participants had ADHD. Some of the participants that wanted to write also thought it might be easier if they wrote notes with their therapist. None of these participants had writing disabilities, but two out of three had working memory problems. Many of the participants talked about keeping some kind of diary at home in order to record their ideas; as they said that they had difficulty remembering what they wanted to bring up in therapy. The use of writing in psychotherapy has been described elsewhere (Kerner & Fitzpatrick, 2007). As discussed above, participants wanted other ways to express themselves and process their ideas; metaphors, visualization and role play were some of the interventions that participants thought might be helpful. For example, Owen said that he enjoyed the use of visualization in EMDR because he didn’t need to fully express what he was experiencing in order to process his trauma. Fiona said that she could use the metaphor of a wall to describe a barrier to her therapy, without fully having to describe all the qualities of the metaphor. Visualization (Gately & Siperstein, 1992), and metaphors (Goss, 2001) have been used by individuals with learning disabilities to manage and describe their experiences. On the other hand, Tyra, who didn’t have diagnosed ADHD, said that she wanted to do role play and felt she needed to be able to move around in therapy. She said that as somebody in her twenties that was always
moving, and she had a hard time sitting still for the session. Tyra found that she enjoyed using an extended metaphor to help her manage her anxiety, but on the other hand Owen didn’t like talking about a worst case scenario. Although only two of the participants had a diagnosed deficit in verbal expression, Mark, Mary, Ted and John all said that sometimes they had a hard time expressing what they were thinking. Therefore, it was not simply the diagnosed disability that determined if a participant wanted an alternate way to express themselves. The participants who struggled with trying to express their ideas also looked for alternate ways to express themselves other than verbally.

Third, participants also expressed the need for additional support in three areas: communication, focusing and thinking through their problems.

Participants had problems with communication and had problems such as word finding and completing their thoughts in therapy. Many participants said that they had difficulties finding the right words to express their ideas. This is a common problem for some individuals with learning disabilities (Faust et al., 1997; D. German, 1984; German, 1979; Miller & Felton, 2001; Rubin & Johnson, 2002; Rudel et al., 1981). Although, as explained above, this wasn’t just a problem for individuals diagnosed with deficits in verbal expression. Participants came up with four ways to address this problem of word finding. The first way, described by Sarah, Fiona, Nicole, and Ted, was for the therapist to provide options for what they wanted to say. The researcher commented to Nicole and Fiona that they were concerned that the therapist might be leading them in a certain direction when they provided options. They both said that when they were really stuck they needed some open questions about what they were trying to say, that at least provided some possibilities. The second way came up as an idea from participants when
they were given the option to invite somebody who knew them well to include in their interview for this study. Some participants discussed this idea of bringing somebody with them to their therapy sessions. Each had difficulties knowing if they wanted to include others in their therapy session. Some didn’t mind having another in their session, because they had issues to resolve involving the other person. Others could see the value of including another person in their interviews, if they were stuck with what to say, but only for small portions of their sessions, as they wanted to maintain their safe and private relationship with their therapist. Ted said that he definitely wouldn’t have wanted it as a teenager, and now he expected that he might like another person in his sessions, but only at the beginning. Third and most importantly, most of the participants expected their therapists to be intuitive and have advanced empathy, in order to work out and precisely express what they were trying to say. Finally, the fourth way to help participants with expressing their ideas was for therapist to try and help clarify communication, with questions asking for clarification and rewording of their comments until the participant understood them. Although many participants, at some point said that they were stuck with what to say, they each said these ways could help them address the problem of being stuck for words to express their ideas.

Another aspect of communication is talked about below in question 4. Here Owen and Mark wanted to tell their whole story before the therapist responded with a paraphrase or question. This was an interesting problem as often, under these conditions, a therapist may lose track of the participant’s story. However, they both said that if they stopped they would lose track of what they were trying to say. Both had working
memory deficits and this may have been why they needed to keep going. They thought that the therapist needed to be willing to be silent.

The second area needing additional support was focus during therapy. All the participants with ADHD varied in their ability to focus during therapy. Individuals with ADHD have problems with focusing in many situations (Fuggetta, 2006; Krueger & Kendall, 2001; Nigg et al., 2002) In question four there are four ways that participants found to help them focus in therapy: forcing themselves, getting a redirect from their therapist and training themselves to be able to stay on task. In addition, three participants talked about fidgeting, with objects, body parts or doodling on pencil and paper, and how it helped them focus. This allowance to fidget has been discussed elsewhere (Hild, 1997). The needs of individuals with ADHD was consistent with the research about how auditory and visual stimulation may help those with ADHD keep on task (H Abikoff et al., 1996; Imhof, 2004). On the other hand, environmental stimuli also affected participants’ ability to focus (see question 5 for details), both for the worse and the better. So, while participants did sometimes struggle with focusing in therapy they found ways to overcome this difficulty.

Participants also became lost in trying to find a way to think through their problems. Problem solving capacities of individuals with learning disabilities (Copeland & Weissbrod, 1983; Slife, Weiss, & Bell, 1985; Wansart, 1990) and the development of strategic learning approaches with individuals with learning disabilities (Butler, 1995) have been discussed elsewhere. In this study, many were looking for some kind of support with their thinking or learning style, as discussed above, including Tyra, with her global thinking style, and Owen, with his need to go from a general outline to talk about
specific parts of his problems. Others preferred some kinds of interventions over others, as seen above. Some found that therapy was a way of them solving their problems or finding out how to manage their learning disability. But, taken together, all the participants wanted to negotiate a structure for their therapy with their therapist. Most had quite strong opinions about their needs in therapy and wanted a therapist who was willing to work with them to create a process and structure for therapy that fit their needs.

Although participants felt that they did struggle with finding approaches and interventions that helped them work through their issues, through communication, focusing and structuring their therapy, most were able to express ways that their therapist could help them overcome their difficulties. Participants knew what kinds of ways that they preferred to express themselves and they were able to be specific about what helped and what hindered their therapeutic process.

*Question 3:*
Given their level of experience in receiving academic adaptations and their experiences in counselling, what kinds of adaptations would they like to have added to their counselling process?

Two participants, Tyra and Owen were able to use their knowledge about how they worked in academic situations to inform their counselling process. These examples demonstrated how therapists might use their client’s skills that they had developed in school to help the process of therapy. For example, Owen had worked with his therapist to improve his approach to academic problems. He described how he had a problem with working memory, and auditory memory and relied more on his visual memory. This meant that he described and processed his ideas more efficiently in written form. Owen
used drawings and diagrams throughout his interviews about the research questions to
describe his ideas. He explained that once he drew an outline of his ideas he was much
more capable of filling in the rest of the details.

Tyra, on the other hand, had learned much about her learning style and cognitive
deficits from the psychologist who assessed her. Therefore, she had learned about her
own learning style and developed strategies that helped her communicate. Because of
her deficits in working, visual and auditory memory, she felt that she needed to write
things down in order to remember them. In addition, as described earlier she had to sort
out with her therapist conflicts between their thinking styles. Once she had discussed her
thinking style with her therapist he could work with her in the way she needed.

For these two participants, therapists were able to cater to the client’s learning
style because they had helped the participants explore their learning style. However,
their seems to be no research looking at how individuals with learning disabilities can use
their knowledge about their learning style to improve their counselling process. This was
also shown above, in question 2, in participants’ desire for certain interventions and
supports with communication. When therapists were able to cater to their needs, the
participants were more efficient in the use of their time in sessions.

Question 4:
Given their past experiences in counselling, what kind of relationship do they need with
their counselor?

Participants’ experiences in counselling seemed to be colored by two major areas
of their relationship with their therapist, which participants felt affected all areas of
counselling. Participants talked about the character of their counselor and the ability of
their therapist to be open and adaptable to their needs in therapy. This was not surprising as one of the questions was "what helped you the most to be understood by your counselor". As described earlier, the therapeutic alliance is essential to good working relationship between client and therapist (Horvath, 2001). Moreover, individuals with learning disabilities often have an external locus of control (Grolnick & Ryan, 1990; Ohler et al., 1995; Omizo & Cubberly, 1983; Omizo et al., 1985), which means that they may need unconditional positive regard so that they can internalize their locus of control. Validation, normalization, therapist encouragement, looking for the positive in their stories was something that many of the participants wanted in therapy. In order for the participants to start to feel more positive in their outlook, they needed a specific kind of relationship with their therapist and a flexible process that catered to their learning needs. Most of the discussion about this topic was represented in the theme Safety/Comfort.

All participants, except for Owen, talked about the character of their therapists. The characteristics prioritized by participants were ones that have been appreciated by many others in therapy (Bedi, 2006; Bedi, Davis, & Williams, 2005; Horvath & Luborsky, 1993; L. N. Johnson & Wright, 2002; Kaplan & Shachter, 1991; Kirschenbaum & Jourdan, 2005; Satterfield & Lyddon, 1998; Sharpley et al., 2000). But, individuals with learning disabilities may be especially sensitive to this rapport, because of their self concept (Elbaum & Vaughn, 2003; Grolnick & Ryan, 1990; Krueger & Kendall, 2001; Ryan, Nolan, Keim, & Madsen, 1999; Vaughn, Haager, Hogan, & Kouzakanani, 1992). Participants were looking for a therapist with warmth and a caring nature, who was patient enough to wait for participants who have a hard time expressing themselves, and who was optimistic, genuine, and willing to share about themselves.
Therapists with qualities were necessary for the participant to have in order to be able to express their thoughts fully. When they found therapists that had these qualities they found it much easier to open up and talk about their own needs because they felt they would not be judged.

A number of the participants talked about experiences in school that left them feeling cautious about talking about more sensitive issues because they felt they would not be taken seriously. But, many had very positive experiences with therapists. Sarah, a student soon to graduate from high school, felt comfortable and self-assured with her most recent therapist. She appreciated that her therapist treated her as a grown up and capable of making their own decisions in life. Ted felt that for the first time in his life, with his psychologist who is an Adaptive Learning Specialist, he had somebody who understood how he thought and was able to help him learn how to manage his life, his relationships, and his schoolwork. Mark, who had Systematic Desensitization for his phobia, said that his therapist was warm and caring; he made sure that he found out about Mark’s interests and family background, in order to understand how he thought about the world. So, participants who had experiences with the kinds of therapists that they enjoyed felt that they were able to open up enough to work on their issues.

On the other hand, four participants had poor experiences with therapists. Participants did not stay with therapists who they felt were cold, distant, or businesslike, and/or who pigeonholed them according to their learning disability. For example, Tyra had a therapist who assessed her for her learning disability who she found to be quite professionally distant. Sarah said that she had a therapist who really didn't understand her struggles with her learning disability and told her to stop complaining about her
struggles. She was angry about how she felt belittled and disrespected by her therapist. Rachel said that she was depressed because of the struggle she had with her ADHD and yet her therapist didn't really see the connection. As a child, Ted felt barraged by a large number of questions from his therapist. He also felt angry and frustrated that she didn’t link his oppositional behavior to his learning disability. In general, participants didn’t feel comfortable with these therapists and often ended up leaving the relationship before their issues were resolved.

The other general topic was the participants’ experience of their therapists’ ability to be open to the needs of the participant and to meet those needs. Participants commented that they needed their therapists to be sensitive and respectful enough to understand their needs and be capable of fulfilling them. Many participants talked about their therapist’s capacity to be empathetic. For example, Ted demanded that even though he was vague in his communication, his therapist should completely understand what he was trying to express. Participants also expected that their therapist be able to help them fulfill their needs in therapy, and be intuitive about what they needed and when.

It was apparent from the interviews that it was not possible to determine what participants needed in therapy merely by looking at their assessments. The participants experienced varying needs, which were more specific to a particular participant rather than a certain kind of deficit. Four specific issues were uncovered in the experiences of the participants. Each highlighted the need of therapists to be flexible and open in assessing the needs of individuals with learning disabilities.

First, although some participants were diagnosed as having ADHD, there was a wide range of capacities to focus for those diagnosed with ADHD and different
participants wanted different kinds of support with their ability to focus. For example, Ted explained that his therapist was able to help him learn how to focus his mind in therapy to stay on the topic. Attention training may be a promising intervention to help individuals with learning disabilities to work more productively. It has been used to help parents train their children, who had ADHD, to improve their attention (Anastopoulos et al., 1991; Pisterman et al., 1989; Ringeisen, 2000; Sonuga-Barke et al., 2001). Sarah said that she forced herself to stay on topic, but appreciated when her therapist assisted her to focus. However, Tyra, who didn’t have ADHD, really didn’t appreciate it when her therapist wanted to bring her back on topic. She thought of herself as a global thinker, while her therapist’s thinking was more linear. While Tyra was trying to bring another facet of her story into the conversation, her therapist was unable to see how it was related and tried to refocus her.

The second issue in relating to the therapist was that participants had varying needs for their therapists to stay silent. Others have described the effect of silence in therapy also (Ladany, Hill, Thompson, & O'Brien, 2004; MacDonald, 2005). It has been shown to be helpful under some circumstances, but distancing between therapist and client in others. Owen, who may have had working memory problems and said that he sometimes had problems finding the right words to express himself, appreciated that his therapist stayed silent, but at times he had to talk over her, because he felt he needed to get whole idea out before his therapist gave feedback. Mark’s parents said he often told long stories and he wanted them to stay silent. But then they had difficulty following his story. He too said that he really needed to get his whole idea out first and then he would break it up so they could understand him. On the other hand, Nicole, who had deficits in
verbal expression, working and auditory memory, she said she was unsure if the therapist was following her if she didn’t receive regular feedback from her therapist. Each participant felt it would be useful to discuss with their therapist about when their therapist’s silence might be helpful.

Third, participants varied in their need for help when they were stuck with what to say. Fiona and Nicole sometimes were both stuck with what to say. When Fiona and her mother were interviewed together Fiona, who didn’t have a deficit in verbal expression, said that she sometimes in therapy was stuck with how to broach a subject or find the right word to express her ideas. At home she asked her mom to provide questions (do you mean to say this, that or the other) in order help her express her ideas and she appreciated when her therapist did the same. Nicole, who had deficit in verbal expression, appreciated when her therapist gave her options in the same way as Fiona. On the other hand, Tyra, when giving her member feedback, said that she also sometimes had difficulty finding the right words, but didn’t like it when her therapist provided her with options. She wanted to struggle to express herself on her own as she felt that the therapist might be putting words in her mouth.

Fourth and finally, different participants experienced success with different kinds of interventions and approaches. Their specific preferences may have been based on needs arising from their deficits or preferences. This issue was discussed further as an answer to the second question.

The four issues, the need or lack of need for help with focusing, the silence of the therapist and the options from the therapist for what they were trying to say all demonstrated the requirement for the therapist to be flexible, sensitive and able to fulfill
to the needs of their clients when they have learning disabilities. It was also apparent that a participant’s diagnosed deficit did not determine the kind of support they needed in therapy. Participants with similar deficits wanted different kinds of support, while some individuals with no diagnosed communication deficits wanted support similar to participants who did have those deficits.

A discussion about the structure of therapy was suggested by participants as a way of managing the confusion over the kinds of support that were needed. Nicole said that because she didn’t talk to her therapist about what to do when she was stuck for what to say, she didn’t get enough feedback from her therapist. She sometimes felt like she wasn’t sure why she was going to therapy. Mary said that she tended to go on and on telling a story and ended up feeling like it didn’t help her resolve her problems. Ted said that he needed some kind of structure in therapy, but that it should be the kind of structure that he developed with his therapist.

Question 5:
What elements or activities, outside the therapy process, make the therapeutic process more or less productive?

Three basic elements were discussed that were external to the therapeutic process that changed its productivity. First, participants talked about factors that happened outside the session that affected the process. Second, the participants discussed how the environment of the counselling session affected the counselling process. Third, participants discussed the availability of therapists who knew how to work with individuals with learning disabilities.
Participants described how their lives outside therapy affected their counselling experience. Some participants with ADHD said that when they were tired or distracted they had a hard time focusing in their sessions. In the literature sleep has been shown to be a problem with individuals with ADHD (Stein et al., 2002). In addition, research about the life course of individuals with dyslexia showed that many individuals with dyslexia felt insecure and had low self-esteem (McNulty, 2003). It became apparent when trying to make dates with Owen, Tyra, Ted, Fiona, Rachel, and Mary, that they were all busy trying to keep up with their schoolwork and found it difficult to make time for the research interviews. Moreover, the three who didn’t manage to give feedback on the summary of results all said that they were very busy at school. A number of the participants in this study seemed to work extremely hard on their school work and struggled with their career choices. Sarah and Mark, as students in their last year of school, both were feeling discouraged about their future plans after school. Some participants would not have interviews during the school year because of their work load. It took Tyra about 3 months before she was available for a research interview. Consequently, many commented that they were tired. Mary, Sarah, Fiona and others wanted their sessions at a particular time of day, generally in the afternoon, because they felt less alert at other times of the day.

Another factor external to the therapeutic process was that seven participants had problem with their mood. Tyra had anxiety attacks around exam times and was anxious and worried about finding the next step in her career path. The general mood that the researcher felt from the participants was that they were feeling overloaded and stressed. It became apparent, when talking to Mark and his mother that it was sometimes difficult
to fit therapy into the busy life of an individual with a learning disability. Mark had speech therapy, special tutoring for his learning disability, as well as the other demands of after school activities and the whole family found it difficult to make time to go to Mark’s therapy. Mark’s mother suggested that it might be useful for individuals with learning disabilities to look at the demands of their life and try to make room in their life to spend on the therapeutic process and the follow up work that they needed to complete between sessions.

A number of the participants talked about how their environment affected the counselling process. Research has shown that individuals with ADHD are affected by environmental distracters and may have a need for sensory stimulation (Howard Abikoff et al., 2004; Antrop & Roeyers, 2000; Imhof, 2004; Landau & Others, 1992). Mark, in particular talked about many of the environmental factors including: lighting, chairs, carpeting, windows, size of the room and computer screen savers. He said some of these factors helped him focus or helped him feel more comfortable. Other participants noticed how lighting, noise, or the presence of a clock all had a significant effect on their ability to concentrate. Mark, like others described in research (Broring et al., 2008), had tactile sensitivity and felt comfortable with specific kinds of clothing, furniture and flooring that was soft and warm, rather than hard. Others also commented on how a less formal environment helped them to feel more comfortable in therapy. Some participants said that having food either before or during their sessions would help them feel more comfortable in their sessions. Two participants, Tyra and Owen, said that they would like to try having their session in a park, where they could walk and the session would feel less formal. Many of the participants with ADHD, including Owen, explained how, as an
individual with ADHD, he was sensitive to any environmental changes and that it affected his ability to concentrate in his sessions.

Briefly, only a couple individuals talked about the effect of their ADHD medication on their therapy. Mark said that it helped him concentrate, but then his phobias felt worse. Mary felt that she only needed her medication to concentrate at school. The effect of ADHD medication on therapy might be a good topic for further research.

Finally, although there was a limited amount of discussion about how factors external to the therapy process affected the sessions, it was apparent that they may have a significant effect. Life’s pressures, for many participants, left precious little space for working on making changes. Other studies have talked about significant levels of stress, and greater workload in individuals with learning disabilities (Goldberg et al., 2003; Raskind et al., 1999). Although many participants did make time for therapy, it may be useful for therapists to investigate how their clients’ work loads are affecting the therapy process. While it was expected that individuals with ADHD would find it difficult to focus in therapy, it was a surprise to see how sensitive some were to different environmental variables. Finally, it was expected that medication might be more of a topic for discussion with participants, but this didn’t seem to be something that any participants thought either helped or hindered their therapeutic process.

In conclusion, in the answers to the questions above, participants covered a huge range of issues that affected their experience in the counselling process. They felt that their relationship with their therapist was the single most important part of their process; they were looking for a therapist with a warm, kind and patient character, who respected
their client and was open and able to provide the kind of experiences that they needed. Then, the participants felt that they wanted active, engaging approaches to therapy; play therapy, art therapy, EMDR, Gestalt therapy, among others, were preferred over just sitting and talking to their therapists. Many of these therapies have been tried with individuals with learning disabilities, as discussed above. In addition, most participants wanted help with communication. For example, they needed more time to express their ideas and they needed help to express ideas when stuck. Finally, in order to be successful in therapy, they thought it would be helpful to have a discussion about what kinds of support they needed and as Fiona put it, know their options in therapy, in case the were having difficulties. They wanted to discuss the structure of their therapeutic process and what kinds of tools they could use to achieve their goals.

Limitations

There were a few limitations to this thesis. However, they did not take away from the results of people with particular learning disabilities having an opportunity to tell their story of their counselling experience. First, participants were diagnosed with learning disabilities but some did not offer the researcher comprehensive psycho-educational assessments. Therefore, as the researcher did not have comprehensive psycho-educational assessments for all the participants, some individuals may have had additional learning disabilities, other than the ones that were already described. For example, Mary was only given an assessment for ADHD. Although, she reported difficulties with reading and writing she had no documented testing done in this area. Also, Mark was only given academic assessments rather than tests that measure particular kinds of deficits (such as the WAIS or WISC or Stanford-Binet). Second, it may be that
other participants with similar disabilities may not have had the opportunity to experience or be able to identify these adaptations, while others may have wanted these adaptations, due to disabilities that were undiagnosed. Third, as there was no control group, there was no way to know if the challenges of individuals with particular learning disabilities are specific only to this group; it may be that many individuals without these particular learning disabilities many face some similar challenges. Fourth, the participants might have needed certain elements in counselling either because of their disability or their personal issues. The researcher used the active interview technique to try and improve the link between the deficits and needs in the process of therapy. Yet because participants had so many different kinds of disabilities and issues it was impossible to link these two. Consequently, the study was able to simply describe the experience of individuals with particular kinds of learning disabilities to show their particular preferences in the therapeutic process.

Contributions

There has been little study about the experience of individuals with specific cognitive deficits of individuals with particular learning disabilities on their counselling process. Consequently, this study was designed to explore the counselling experiences of individuals with particular cognitive deficits. As little was known, very general questions were asked to see what kinds of issues these individuals had in their counselling process. This study gave the participants a voice to tell their stories about their experiences in counselling; in order to find what worked, what didn’t and what needed to change in their therapeutic process.
The primary finding from this study was that the participant’s counselling experiences and preferences were essentially complex and particular to those individuals. For the participants in this study, the complex combination of life experiences (in school and in relationship with others), cognitive deficits/gifts, personal issues, mood disorders, assets (relationships, money, time), age, and many other participant attributes combine together to create their specific needs and preferences in therapy. There was no single answer to the participants’ difficulties with the counselling process.

Second, it was very apparent how crucial the rapport between therapist and client was necessary for them to manage the complexity of the clients needs; clients needed to feel safe and understood. To make this possible their therapists need to be sufficiently experienced to manage the complex needs of the participants; participants didn’t want to be pigeon-holed as to their needs, based on their learning disability, or restricted to certain approaches based on the limitations of their therapist. In addition participants felt that they had significant understanding to contribute about what helped and what hindered their counselling process. So, they felt they needed to negotiate with their therapist about their process, in order improve communication and find approaches and interventions that worked for them.

Third, a great range of data was gathered about what worked and what didn’t in counselling, for individuals with particular learning disabilities; various approaches, modalities/processes, supports to communication/thinking, and environmental conditions, were discussed.

Considering that eight out of the ten participants had an unsatisfactory experience with at least one therapist that it seems, at least for some individuals with
learning disabilities, this data may be of utility in finding a better process to counsel individuals with learning disabilities.

This thesis represents one of the first times individuals with particular learning disabilities (with deficits in communication, memory, information processing and attention) have been given a voice in explaining what they needed in therapy. They presented powerful testimony as to their courage and determination in advocating for themselves and others. They described the joy and pain that they felt while trying to find a way to overcome their personal issues, in the face of great struggle to be understood. It is hoped that this study helps counselors have greater empathy for and sensitivity to work with individuals with these kinds of disabilities, so that they know more about the kinds of issues they might need to address with their clients that have particular learning disabilities.

Moreover, in order to give researchers a strong foundation to start the study the counselling needs of individuals with particular learning disabilities, this thesis was designed to gather the widest range of ideas about how individuals with particular learning disabilities experience the counselling process. Much the same way that researchers have sought to find ways to help individuals with learning disabilities adapt their learning process in order to find success in school, this researcher wishes that this thesis will start an area of study to find ways to adapt the counselling process to the needs of these individuals.

There are at least four specific questions that need further investigation on this topic. First, what methodologies would be most effective in conducting research into effective counselling processes for individuals with learning disabilities? Second, what is
the experience of individuals with non-verbal learning disabilities and auditory processing deficits in counselling, as individuals with those deficits weren’t included in this study. Third, what other kinds of modifications to the counselling process can be made that would make the process more effective? Fourth, what strategies can be used to negotiate an effective counselling process? Fifth, how can a therapist and counselor evaluate the most effective counselling process for a client? Sixth, and finally, what kind of training should therapists have to work with individuals with learning disabilities?

In conclusion, the participants’ primary wish for this study was that their contribution would help therapists approach their clients that had learning disabilities in more productive ways and spur researchers to explore avenues that might improve the counselling process for those same clients.
REFERENCES


Giamp, J. S. (2004). Honoring their voice: Eye movement desensitization and reprocessing through the eyes of inmates with developmental disabilities., ProQuest Information & Learning, US.


*Therapy Today J1 - Therapy Today, 17*(3), 31-34.


Ringleisen, H. L. (2000). *Compliance and attention training in children with Attention-Deficit/Hyperactivity Disorder.* ProQuest Information & Learning, US.


*Memory J1 - Memory, 15*(1), 34-56.


APPENDICES

APPENDIX 1

Poster for Participant Recruitment

Department of Educational and Counselling Psychology,
and Special Education Faculty of Education
2125 Main Mall Vancouver, B.C., Canada  V6T1Z4

For those of you who have a learning disability and have had counselling, we are interested in your story... We are hoping to talk to people with a diagnosed learning disability about their experience in counselling. Many individuals with learning disabilities have required specific kinds of support in the academic realm to reach their full potential. We hope to discover what kinds of supports in counselling would be helpful for individuals with learning disabilities.

This research is done as part of a Masters thesis.

How will you participate?

As part of this study, you would participate in one, possibly two one-hour interviews at a time and place of convenience to you. In the second you would be given the option to bring somebody who knows you well to help you express your ideas. You will also be offered an opportunity to include 100 words of your own writing as part of the thesis and a follow up telephone interview to discuss the results of the thesis. Total time of participation: 3 hrs.

How will you benefit?

You will have the opportunity to describe your experiences with an interviewer that is a counselling student and who also has a learning disability. Through your participation in this study you will be helping to highlight the particular needs in counselling of individuals with learning disabilities and have the opportunity to reflect on your own experience in counselling. You will be sent a copy of the study's results if you desire.

Investigators: Dr. Deborah Butler and Piers Samson

For more information contact:
Co-investigator: Piers Samson 604 270 4850 Cell: 604 317 9878 & ldresearch@telus.net
APPENDIX 2

Pamphlet for Recruitment

Department of Educational and Counselling Psychology, and Special Education
Faculty of Education
2125 Main Mall
Vancouver, B.C. Canada  V6T1Z4

The Experience of Individuals with Learning Disabilities in Counselling

For those of you who have a learning disability and may have experienced counselling, we are interested in talking with you...

What is this study about?
We would like to talk to people with a diagnosed learning disability about their experience in counselling. Many individuals with learning disabilities have required support in the academic realm to reach their full potential. We hope to discover how counselling can also be provided to best support individuals with learning disabilities. This research is done as part of requirement for a Masters thesis.

How will you participate?
You would participate in one or two interviews at a location convenient to you. The study will have four parts.
Part one would be an interview for approximately one hour about your experiences in counselling. As well as being asked a number of questions about your experience, you will be offered the opportunity to draw a symbolic picture about your relationship with your counselor.
Part two would be an optional interview, for about an hour, offered as a way to help you explore issues that you found difficult to express in the first interview. You could bring somebody with you who knows you well enough that they could help you express your ideas. In this interview you
would be offered the opportunity to describe your experience in a pose (where you will portray yourself and the other person you bring will portray the therapist).

**Part Three** you will be offered the experience to write a short 100 word paragraph about your experience in counselling that would be published in the researcher’s thesis. This paragraph would be an uncensored piece (apart from removing identifying information) where you could describe your experience in counselling as someone with a particular learning disability, given your experience in the preceding interviews.

**Part Four** Finally, you would be asked to participate in a follow up telephone interview or an Email to check on the results of the thesis. This may take up to about half an hour.

Total time for the whole process, parts one to four, would be up to three hours.

*How will you benefit?*

If you choose to participate, you will have the opportunity to describe your experiences to an interviewer who is a counselling student and who also has a learning disability. By participating, you will be helping to highlight the needs in counselling of individuals with learning disabilities and have the opportunity to reflect on your own experience in counselling. Refreshments will be provided, along with reimbursement for parking/public transit costs. You will be sent a copy of the study’s results if you desire.

**Investigators: Dr. Deborah Butler and Piers Samson**

**For more information contact:**

**Co-investigator: Piers Samson**

☎ Ph 604 270 4850

✉ Cell: 604 317 9878

✉ Email: ldresearch@telus.net
APPENDIX 3

Kwantlen Certificate of Ethics Approval

RESEARCH ETHICS BOARD

Certificate of Approval
Exempted

<table>
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<tr>
<th>Researcher</th>
<th>Department</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deborah Butler</td>
<td>Education and Counselling Psychology, and Special Education University of British Columbia</td>
<td>2006-042</td>
</tr>
</tbody>
</table>

Institution where Research will be carried out:
Kwantlen University College

Co-Investigators:
Piers Samson

Sponsoring Agencies:

Title:
The Experience of Counseling for Individuals with Particular Learning Disabilities

Exemption Date:
March 10, 2007

Term (Years):
One Year

Documents Included in the Exemption:
Application for Exemption from Ethics Review Cover Page and a copy of the Certificate of Approval from Behavioural Research Ethics Board, University of British Columbia.

Certification:
The protocol describing the above-named project has been reviewed by another institution and the certificate of acceptability was supplied to our Research Ethics Boards.

Warren Bourgeois
Chair, Research Ethics Board

This Certificate of Exemption is valid for the above term provided there is no change in the experimental procedures.
APPENDIX 4

Certificate of Approval from Behavioral Ethics Board UBC

Certificate of Approval

E thriller, B, L.

Pseudot & Count Psych & Spec Tech

BIC-0235

Sponsor: James Pierre, Pseud Psych & Spec Tech

The Department of Counseling for Individuals with Learning Disabilities

AUG 16 2005

approved

The application for ethical review of the above-named project has been reviewed and the procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approved on behalf of the Behavioral Research Ethics Board

by the following:

Dr. Peter Stoddard, Chair,
Dr. Jim Rapson, Associate Chair
Dr. Annmarie Konijn, Associate Chair

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.
APPENDIX 5

Assent Form for Participants Younger than Age 18

THE UNIVERSITY OF BRITISH COLUMBIA

Department of Educational and Counselling Psychology,
and Special Education
Faculty of Education
2125 Main Mall
Vancouver, B.C. Canada V6T1Z4

ASSENT FORM

The Experience of Counselling for Individuals with Particular Learning Disabilities

Principal Investigator(s): Dr Deborah Butler
University of British Columbia
Department of Educational and Counselling Psychology, and Special Education
(604) 822-5513

Co-Investigator:
James Piers Samson
MA student in Counselling Psychology
University of British Columbia
Department of Educational and Counselling Psychology, and Special Education
Ph. (604) 270 4850

This project is designed to increase awareness about difficulties that may be experienced by individuals with learning disabilities during the counselling processes. This study is designed so that individuals with learning disabilities can express their needs, wants and desires about the counselling process. You have been identified as a potential participant because you have a learning disability and have had counselling. Also, you have stated that you have some ideas about what counselling is like for an individual with a learning disability.

This research is done as part of a Masters thesis.

If you agree to participate you will be asked to be involved in up to four parts of the study. The first two parts, two interviews, will be audio taped.

Part one of the study is a one-hour interview where you will be asked questions about your experience in counselling.

Part two is a second one-hour interview. You will only have this interview if you struggled with expressing your ideas during the first interview. This would be conducted with you and somebody who knows you well (who can help you express your ideas without adding his or her own point of view).

During the second interview, to make it easier for you to describe your experience in counselling, you will be offered the opportunity to create a sculpture pose with the individual you bring with you. To create this physical sculpture, you would pose a way that would symbolize your relationship with your counselor.
In part three you will be offered the opportunity to write a short 100-word paragraph that expresses your thoughts about your experiences in counselling. You can ask somebody else to help you write this. Mistakes in grammar and spelling are not important. This will be included in the thesis, without alteration, if you so desire.

In part four, you will also be asked either to participate in a short telephone interview or reply to an email, in order to help me check that I have summarized your ideas accurately. I will send you a copy of my main findings, and ask you to add any element that you think may be missing or correct any information that you feel misrepresents your experience.

If you were referred to this research by a professional please be assured that that individual will at no time be told if you took part in the study.

Interviews will be held at a time and location that is convenient for you. We will pay you back for public transportation costs to and from the site where the interview is being conducted, if there are any. The researcher will provide food and drinks during the interviews. You will be emailed a copy of the findings at the end of the study, if you like.

The researcher is aware that as a result of talking about your experiences in counselling you may realize that you want or need some more counselling. As a result, the researcher will provide you with a pamphlet listing references to literature, counselors, educational psychologists and agencies that can help you.

If at any time you have questions regarding this research, contact Piers Samson, or my supervisor (Dr Butler) at the phone number provided above. If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office or Research Services at 604-822-8598.

Your participation in this study is entirely your own choice and you may refuse to participate or withdraw from the study at any time without any penalty. All information will remain strictly private. Only research personnel will see the data collected. Your name will not be reported in any research reports or descriptions. When writing up the research, we will erase any details that might reveal your identity.

Your signature below indicates that you have received a copy of this consent form for your own records and that you consent to participate in this study.

I would like to receive a report of this study after data have been analyzed (circle and, if yes, provide address below): Yes  No

_______________________________________________________________  __________________________
Participant Signature                                            Date

_______________________________________________________________
Printed Name(s) of the Participant

Address if Yes: __________________________________________________________
APPENDIX 6

Consent form for Parent or Guardian of Participant

THE UNIVERSITY OF BRITISH COLUMBIA

Department of Educational and Counselling Psychology, and Special Education
Faculty of Education
2125 Main Mall
Vancouver, B.C. Canada V6T1Z4

CONSENT FORM
The Experience of Counselling for Individuals with Particular Learning Disabilities

Principal Investigator(s): Dr Deborah Butler
University of British Columbia
Department of Educational and Counselling Psychology, and Special Education
(604) 822-5513

Co-Investigator:
James Piers Samson
MA student in Counselling Psychology
University of British Columbia
Department of Educational and Counselling Psychology, and Special Education
Ph. (604) 270 4850

This project is designed to increase awareness about challenges that may be experienced by individuals with learning disabilities during the counselling processes. This study is designed so that individuals with learning disabilities can express their needs, wants and desires about the counselling process. Your son or daughter has been identified as a potential participant because he/she has been diagnosed with a learning disability, has experienced the counselling process and feels that he/she has something to contribute to the discussion of what the counselling process is like for an individual with a learning disability.

This research is done as part of a Masters thesis.

This document asks for your permission for your son or daughter to participate in up to four parts of the study. In the first two parts, two interviews will be audio taped.

Part one of the study is a one-hour interview, where your son or daughter will be asked questions about his or her experience in counselling.

Part two is a second one-hour interview, which will be conducted only if your son or daughter has difficulties expressing his or her experience during the first interview. This will be conducted with your son or daughter and somebody who knows them well (someone who can help your child express his or her ideas without adding their own point of view).

During the second interview, in order to enhance your ability to describe your child’s counselling experience they will be offered the opportunity to create a sculpture pose with the individual they bring with them. To create this physical sculpture, they would pose a way that would symbolize their relationship with their counselor.
Part three is offered as a follow up to the two main interviews. Here your child will be offered the opportunity to write a short 100-word paragraph that expresses his or her thoughts about his/her experiences in counselling. This will be included in the thesis, without alteration.

In part four your son or daughter will be asked to participate in a short telephone interview or reply to an email, in order to help me check that I have summarized his/her perspectives accurately. I will send your child a copy of my main findings, and ask for him or her to add any element that may be missing or to correct any information that misrepresents his or her experience.

If your son or daughter was referred to this research by a professional, please be assured that they will at no time be given any information regarding your child’s participation.

Interviews will be held at a time and location that is convenient for your child. Your child will be reimbursed for any public transportation costs to and from the site where the interview is being conducted. The researcher will provide refreshments during the interviews. You and your child will be emailed a copy of the findings at the end of the study, if so desired.

The researcher is aware that discussing the nature of experiences in counselling may bring up unresolved issues for your child. As a result, the researcher will provide your child with a pamphlet listing references to literature, counselors, educational psychologists and agencies that can provide support to discuss any outstanding issues.

If at any time you have questions regarding this research, contact Piers Samson, or my supervisor (Dr Butler) at the phone numbers provided above. If you have any concerns about your child’s treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office or Research Services at 604-822-8598.

Your child’s participation in this study is entirely voluntary and he or she may refuse to participate or withdraw from the study at any time without any consequence or obligation. All information will remain strictly confidential. Only research personnel will see the data collected. Your child’s name will not be reported in any research reports or descriptions. When writing up the research, we will erase any details that might reveal your child’s identity.

**Your signature below indicates that you have received a copy of this consent form for your own records and that you consent, on behalf of your child, for him or her to participate in this study.**

If your child is 18 years of age or under and both you and your child are willing for them to participate in this study, please reply to the statement below and sign your name.

I would like to receive a report of this study after data have been analyzed (circle and, if yes, provide address below): Yes No

Parent or Guardian Signature (when participant less than 18 years) Date

Printed Name(s) of the Parent or Guardian signing above

Address if Yes: ____________________________________________
APPENDIX 7

Consent Form for Participants Older than Age 18

THE UNIVERSITY OF BRITISH COLUMBIA

Department of Educational and Counselling Psychology, and Special Education
Faculty of Education
2125 Main Mall
Vancouver, B.C. Canada V6T1Z4

CONSENT FORM

The Experience of Counselling for Individuals with Particular Learning Disabilities

Principal Investigator(s):
Dr Deborah Butler
University of British Columbia
Department of Educational and Counselling Psychology, and Special Education
(604) 822-5513

Co-Investigator:
James Piers Samson
MA student in Counselling Psychology
University of British Columbia
Department of Educational and Counselling Psychology, and Special Education
Ph. (604) 270 4850

This project is designed to increase awareness about challenges that may be experienced by individuals with learning disabilities during the counselling processes. This study is designed so that individuals with learning disabilities can express their needs, wants and desires about the counselling process. You have been identified as a potential participant because you have been diagnosed with a learning disability, you have experienced the counselling process and you feel that you have something to contribute to the discussion of what the counselling process is like for an individual with a learning disability.

This research is done as part of a Masters thesis.

If you agree to participate you will be asked to participate in up to four parts of the study. The first two parts, two interviews, will be audio taped.

Part one of the study is a one-hour interview where you will be asked questions about your experience in counselling.

Part two is a second one-hour interview, which will be conducted only if you have had difficulties expressing your experience during the first interview. This would be conducted with you and somebody who knows you well (who can help you to express your ideas without adding their own point of view).
Part three is offered as a follow up to the two main interviews. Here you will be offered the opportunity to write a short 100-word paragraph that expresses your thoughts about your experiences in counselling. You can ask somebody else to help you write this. Mistakes in grammar and spelling are not important. This will be included in the thesis, without alteration, if you so desire.

In part four, you will also be asked either to participate in a short telephone interview or reply to an email, in order to help me check that I have summarized your perspectives accurately. I will send you a copy of my main findings, and ask you to add any element that you think may be missing or correct any information that you feel misrepresents your experience.

If you were referred to this research by a professional please be assured that that individual will at no time be given any information regarding your participation.

Interviews will be held at a time and location that is convenient for you. You will be reimbursed for public transportation costs to and from the site where the interview is being conducted, if any. The researcher will provide refreshments during the interviews. You will be emailed a copy of the findings at the end of the study, if so desired.

The researcher is aware that discussing the nature of your experiences in counselling may bring up unresolved issues. As a result, the researcher will provide you with a pamphlet listing references to literature, counselors, educational psychologists and agencies that can provide support to discuss any outstanding issues.

If at any time you have questions regarding this research, contact Piers Samson, or my supervisor (Dr Butler) at the phone number provided above. If you have any concerns about your treatment or rights as a research subject, you may contact the Research Subject Information Line in the UBC Office or Research Services at 604-822-8598.

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without any consequence or obligation. All information will remain strictly confidential. Only research personnel will see the data collected. Your name will not be reported in any research reports or descriptions. When writing up the research, we will erase any details that might reveal your identity.

Your signature below indicates that you have received a copy of this consent form for your own records and that you consent to participate in this study.

I would like to receive a report of this study after data have been analyzed (circle and, if yes, provide address below):  

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Participant Signature    Date

Printed Name(s) of the Participant

Address if Yes:  

___________________________________________________________
APPENDIX 8

Interview Protocol

Interview 1

Basic Questions:

1. What helped you the most to be understood by your counselor?
2. What, for you, made the process of counselling harder or easier?
3. What helped you compensate for your disability and allowed you work through your problems during counselling?
4. How would you like the counselling process to have been different?

Extra Kinds of Questions:

1. Questions to structure the interview-
2. Questions to clarify what was said-
3. Interpretive questions - to clarify the researcher's concept of the clients meaning.
4. Iterative questions - to return to matters previously raised, in order to ascertain the accuracy of previous answers.
5. Follow up questions - to encourage the participants to connect thoughts together and uncover missing elements when researcher is unclear about how things fit together).

Extra Exercise:

Draw symbolically how they see themselves in relation to the counselor.

Questions:

Describe what this drawing is about.
What made you decide to draw the relationship that way?
What could you change about the drawing to show the relationship as you would prefer to be? Describe how that would change things for you.
**Interview 2**

**Basic Questions:**

1. What helped you the most to be understood by your counselor?
2. What, for you, made the process of counselling harder or easier?
3. What helped you compensate for your disability and allowed you work through your problems during counselling?
4. How would you like the counselling process to have been different?

**Extra Kinds of Questions:**

1. Questions to structure the interview-
2. Questions to clarify what was said-
3. Interpretive questions - to clarify the researcher's concept of the clients meaning.
4. Iterative questions - to return to matters previously raised, in order to ascertain the accuracy of previous answers.
5. Follow up questions - to encourage the participants to connect thoughts together and uncover missing elements when researcher is unclear about how things fit together).

**Extra Exercise:**

I want you to create a pose, with insert name of extra participant here, to represent how you see your relationship with your counselor; with yourself, as the client, and x as the counselor. If it is okay, I will take a photo, as a record of your pose; this will be included in the thesis, with your faces marked out.

Questions:

Describe what this pose means to you.

What made you decide to pose yourself and your significant other in this way?

In what way could you change the sculpture to show the relationship as you would like it to be?

Describe how that would change things for you.
APPENDIX 9

Additional Questions Asked in Interview

Art therapy
Int  Or art therapy, where you're drawing a picture and then you talk about that picture. Like, would it be helpful

Play therapy
Int  As well as - as what you're doing with words. So the other approach to therapy that I was thinking of was play therapy.

Bibliotherapy
Int  Bibliotherapy, there's two kinds of-narrative, or Bibliotherapy, where you can actually either watch a movie, or read a book, or read a section in a book that relates to your problem.
Pa  Ok.
Int  And I'm thinking of this in relation to what you just said, right? It's another story--
Pa  Yes.
Int  --that's related to what you've gone through. Yeah?

Asked about metaphors:
Int  Yeah. Do you, have you heard about word pictures, or--? A way of explaining it in a metaphor, or any of that kind of stuff?

Visualization/guided imagery
Int  Mm. So some kind of vehicle to start out with. Some structure, some process. Um, one of the other things that one of my other clients did, I don't know if you've done it, but maybe you have, is visualization, where you kind of picture something in your head—

Structure
Int  So do you think that, is there any kind of structuring or things he does to structure the process of counselling that makes it, like, a good process for you to go through? Like, the way he does it?

Fidgeting
Int  So, I guess we were talking about, I guess, along the lines of what you were saying just now, when you're, when you're, when you're being, having a counselling session--
Pa  Mm hmm.
Int  --was, in order to focus, you said you were fidgeting or moving around.
Pa  Yeah.
Int  So, what does that look like? What kind of fidgeting, or what kind of moving around do you do when you're in a counselling session?

Preparation for therapy
Int  Is there any particular things you guys do together before counselling sessions? Is there anything your family can help you with so that you're ready?

Having another individual in session to help:
Int  Now, would...is there any kind of times that you would like to bring other people into your sessions? Or other things into your sessions, or other?

Environment
Int  It's like being, well let's maybe talk about the environment then, of the counselling room, or, is there anything in the room or, or, you know—

Time of day
Int  Yeah? So let's see where we are. Um, so, uh, let's see, what else? Um, um, is there anything about the time of day, or length of session, or anything like that that would make things harder or easier for you?

Length of session and availability of counselor
Int  We've talked a lot about counselling, and stuff. So are there any kind of plans-if you were to say-maybe we should talk just a little bit about length of counselling, or how much you would want or how often, or, um--
APPENDIX 10

Transcriber Confidentiality Agreement

THE UNIVERSITY OF BRITISH COLUMBIA

Department of Educational and Counselling Psychology, and Special Education
Faculty of Education
2125 Main Mall
Vancouver, B.C. Canada V6T1Z4

I agree to prepare transcriptions of audio/videotaped interviews for Piers Samson at a rate of $__/hour. I understand that the audio/videotapes contain personal and confidential information. As part of this contract, I agree to keep this information confidential and to not disclose or discuss the participants' names or the content of their interviews.

____________________________
Transcriber’s full name (Please Print)

____________________________
Transcriber’s Signature                      Date