MINDFULNESS-INTEGRATED, RESILIENCE, TRAUMA-INFORMED
AND SOCIAL PEDAGOGY (MIRTS).

A HOLISTIC TREATMENT CURRICULUM FOR PROFESSIONALS WORKING
WITH YOUNG PEOPLE WITH FETAL ALCOHOL SPECTRUM DISORDER (FASD)
AND SUBSTANCE USE ISSUES

by

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A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF

DOCTOR OF PHILOSOPHY

in
The Faculty of Graduate and Postdoctoral Studies
(Interdisciplinary Studies)

THE UNIVERSITY OF BRITISH COLUMBIA
(Vancouver)

August, 2016

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Abstract

Over the past ten years, the service needs of young people with FASD have been the subject of considerable interest. This interest has been triggered, in large part, by a growing recognition of the fact that addiction and mental health service do not adequately serve young people with FASD. The purpose of this dissertation was to develop a curriculum for professionals working with young people with FASD within the addiction settings, with the general aim of improving holistic outcomes for young people with FASD.

A modified version of Intervention Mapping (IM) was used to guide the development, formative evaluation and implementation plan of the curriculum. Findings from the evaluation indicated that in early drafts of the curriculum the level of detail would need to be modified for clinicians to use it effectively and that concepts also needed to be simplified so that young people with FASD would be able to engage more freely with the material that a clinician presents. Later stages of the evaluation reveal the degree to which the framework illuminated new or unconsidered areas, the extent to which goals and objectives were better defined and understood and the degree to which clinician’s information needs were addressed. The review and consultation process indicated that clinicians found the material engaging, effective, appropriate and beneficial to the work they do. All the clinicians consulted noted that they would use the curriculum, and recommend it to colleagues. The results of this evaluation further strengthen and support the necessity for more appropriate resources and services to nurture the strengths and address the needs of young people with FASD.

IM provided a useful framework for developing an appropriate theory-based curriculum for professionals working with young people with FASD. Although the process was time-consuming, it provided a systematic and rigorous approach to developing a quality curriculum. This in turn provided a clear framework for the process of analysis and therefore, increases the potential of the curriculum to realize the desired outcome.
Preface

This dissertation is submitted in partial fulfilment of the requirements for the degree of Doctor of Philosophy in the Faculty of Graduate and Postdoctoral Studies. I was solely responsible for all aspects of the research project, data collection, analysis, and writing the theory. I worked under advisement of my research committee.

This curriculum would not be possible without consultation with some key stakeholders and input from other key professionals. The content and structure of the chapter on change was inspired by conversations and discussions with Lori McKweon, program manager at The John Howard Society of North Island, BC. The chapter on Trauma was refined based on discussion and consultation with Judith Hayes, clinical consultant at John Howard Society North Island and Sarah Badgero, behavioural consultant, as well as the coordinator of clinical services at MacDonald Youth Services, Winnipeg. The ‘Mindfulness’, as well as the ‘quiet moment’ and ‘guided meditation’ sections were developed based on mindfulness coaching and consultation with a mindfulness consultant and yoga instructor. Using my written logs, Luci Djuanadi did the tape recording for the quiet moment and guided meditation, while Ben Badgero edited the recordings. The audio version of the informed consent was audio recorded by Sarah Badgero. Nikola Ivanovic worked with my sketches and concepts to refine the diagrams and other visual images.
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<th>Description</th>
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<tbody>
<tr>
<td>FASD</td>
<td>Fetal Alcohol Spectrum Disorder</td>
</tr>
<tr>
<td>ARND</td>
<td>Alcohol Related Neurodevelopmental Disorder</td>
</tr>
<tr>
<td>FAE</td>
<td>Fetal Alcohol Effect</td>
</tr>
<tr>
<td>FAS</td>
<td>Fetal Alcohol Syndrome</td>
</tr>
<tr>
<td>ARBD</td>
<td>Alcohol Related Behavioural Disorder</td>
</tr>
<tr>
<td>IM</td>
<td>Intervention Mapping</td>
</tr>
<tr>
<td>BC</td>
<td>British Columbia</td>
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<tr>
<td>MIRTS</td>
<td>Mindfulness-Integrated, Resilience, Trauma-Informed and Social Pedagogy</td>
</tr>
<tr>
<td>IEP</td>
<td>Individualized Education Plan</td>
</tr>
<tr>
<td>SFF</td>
<td>Sentinel Facial Features</td>
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</table>
Acknowledgments

“It always seems impossible until it’s done." - Nelson Mandela

This journey has been long and at times tremendously difficult. I am grateful to have had this opportunity, and realize that it could not have happened without the assistance of many generous people. I want to acknowledge their contributions of time, encouragement, wisdom and overall support. First, I give thanks to God for granting me the strength, determination, courage and wisdom to complete this degree. To Dr. Amy Salmon, my research supervisor I owe you my deepest gratitude. Your vision, wisdom, encouragement and continued support through this process was phenomenal. The confidence you instilled in me is a gift that will last a long time. You are an incredible mentor, and I could not have gotten to the finish line without your inspiration, fortitude, astute guidance and unwavering support in the difficult times.

To my committee members: Dr. Christine Loock, your guidance, knowledge and continual encouragement, and support especially throughout the final months of this dissertation was great. Your invaluable knowledge of FASD, insights, alternative suggestions, support and enthusiasm for the work are unparalleled. The positive comments and encouragements you provided in difficult moments will stay with me forever; they were instrumental in me completing the work. To Dr. Richard Sullivan, your thoroughness and attention to details have given this dissertation a polish it otherwise might not have seen. Your incredible knowledge of theory has been instrumental in my growth and development as a doctoral student, and your insightful questions have led me down many learning paths. I truly admire the passion with which you work. Thank you for your support, encouragement and words of wisdom. Your insights have been invaluable to this process. Dr. Grant Charles was a valuable member of my committee at one point; I want to extend my appreciation to him as well.

To Dr. Goelman, Chair of Interdisciplinary Studies, I thank you for the support and
encouragement you offered over the past few years. You have been so incredibly supportive of me throughout my doctoral studies, your insights and direction was helpful. Many thanks also to Interdisciplinary Studies for awarding me the ‘Four Year Doctoral Fellowship’, without this financial support this would not have been possible. Scholarships like this make it possible for students like me to continue to grow and nurture their talents, gain knowledge and impart knowledge.

Many others contributed to this process. I would like to acknowledge Lori McKeown for her valuable insights into program development. I also want to extend sincere appreciation to Sarah Badgero, for her insight and feedback on trauma. Thanks to all the professionals who provided valuable insights into the various topics covered in the curriculum, as well as their expertise. Heartfelt thanks to Luci Djunaidi for recording my quiet moment and guided meditation scripts. Thank you to Gary Hartford, my friend and colleague who supported me in many ways. Some strategies described in this curriculum were refined based on long conversations with you about the philosophy of practice and ethics of care principles. Your exceptional skills, built on a platform of integrity and authentic presence with your clients, represents some of the richest lessons I have learned in being the best clinician I can be. To Leila, thanks for opening your home to me to avoid the long commute. I also wish to acknowledge the people who have helped to realize this final submission. Candace Tarr, for her contribution to the editing process and Nikola Ivanovic for bringing my sketches and ideas to live in the cover and graphic design. Nikola, thanks for your genius in graphics design. Thanks also to Ben Badgero for editing the audio recordings for me.

I would like to thank my family and friends who believed in me and supported me throughout this process. To my amazing sister Mwansa, I am so grateful to know that you will be there at the end, your unwavering support, and encouragement, especially in the difficult moment gave me the motivation I needed to persevere. My brother Tyron, thank you for all the laughter in the difficult moments. To my Aunty Chris thanks for your support and for continuing to believe in me. To Judith, your support, inspiration, wisdom, pep talks and you just being available was instrumental in this journey. Your words of inspiration in the difficult moments will always be part of my life journey. I am indebted to you for the many ways you have contributed to my thinking,
research and practice. Thanks for refusing to let me give up, and for helping me find joy in the
difficult moments. Stein Henry provided some insights at the beginning of my doctoral journey,
thank you for your support and insights. Last, but not least, to my dad, thanks for those long hours
with me at the hospital and for cheering me up and reading to me. This curriculum is a culmination
of many therapeutic encounters with young people with FASD over the years, and I am indebted to
every young person who thought it worthwhile to teach me something.

I would like to acknowledge the work of the many researchers who pioneered in the field of
Resilience, Trauma-Informed, Social pedagogy and Mindfulness. They charted the course in these
exciting territories, and their research provided the basis for the development of the MIRTS model.
In conclusion, a big thanks you to my committee for guiding me through the completion of this
curriculum. I also want to express my appreciation to all those not mentioned who made this entire
curriculum possible—Thank you.
Dedication

I dedicate this entire work to the three women who were instrumental in getting me to this point; my sister Mwansa, my aunt Chris and my friend Judith, your unconditional support and persistence gave me the courage to persevere. This is possible because you were willing to be at my side cheering me on, especially in the tough moments. Your magnanimity is inspiring. This achievement is as much yours as it is mine; I hope you will celebrate the ‘flowers’ of the seeds you planted.

I would not have been able to do this work without an enormous amount of laughter. So this curriculum is also dedicated to my brother Tyron, for taking the time to be available to me and for making me laugh. This work is also dedicated to my supervisor Dr. Amy Salmon for encouraging me to believe in what I have to contribute and for providing the space for me to do so. I also dedicate this to the many young people with FASD, who have inspired me to be the best clinician I can be.
Chapter 1: Introduction

1.1. Background

Young people with Fetal Alcohol Spectrum Disorder (FASD) have become part of the landscape in most substance use treatment programs. Although the number of youth with FASD utilizing addiction treatment is not well known, anecdotal reports are that high number of young people with FASD access addiction services each year. Research (for e.g., Clarke, 2003; Kodituwakku, 2007; Kodituwakku, 2009; Siklos, 2008; Streissguth, Barr, Kogan, & Bookstein, 1996; Streissguth, Bookstein, Barr, Sampson, O’Malley, Young, et al., 2004; Todorow, 2011) indicates that there are high rates of substance misuse among this population. More alarmingly, anecdotal evidence indicates that young people with FASD tend to develop a revolving door relationship with addiction services.

Over the last decade an upsurge of interest in FASD both internationally and here in Canada, has resulted in significant progress in the realm of policy improvements, research, government funding and other initiatives with regard to intervention and prevention. Looking at the FASD research landscape in general, a range of strategic planning initiatives, call for actions and recommendations from agencies and professionals (for example The Institute of Health Economics, and CanFASD) have highlighted the needs for the development of appropriate service, supports and resources to meet the needs of individuals with FASD. By all account, reports from clinicians indicate that there are pockets of good practice, much of which has not been formally documented. However, significant gaps remain, and there is a substantial disconnect between policy, theory and practice. Promoting the holistic needs of young people with FASD continues to be a challenge.

From discussions with substance use treatment counsellors, detox and supportive recovery workers, other clinicians, as well as my own clinical/practice experience, this group of clients presents with problems that are complex and wide-ranging, including the effects of trauma,
intergenerational trauma and intergenerational substance misuse. In many communities few adequate employment opportunities exist. Compounded by all these challenges and in the absence of safety nets, and appropriate supports the majority of these young people have strained their capacity (and that of the system) to respond to their psychological, emotional, social, and spiritual needs. As a result, they are engaging, or are more likely to engage in socially deviant and risky behaviours such as alcohol and drug use, petty crimes, as well as depression and other self-harming activities. Many of the young people with FASD I work with experienced overwhelming feelings of shame and self-hatred, guilt, low self-esteem and self-blame. If these challenges continue and are not addressed comprehensively, they pose a serious threat to their psychosocial wellbeing and development.

Young people with FASD are largely overlooked in many addiction programs, and there is no continuity of service provision for young people with FASD once they have completed treatment. Many young people with FASD still fall into the ‘pot holes’ in the service system. Existing addiction treatments are typically generalized to all young people without specific focus on those with multiple needs, who are in adversity, deprived, and most vulnerable. Additionally, youth addiction and mental health services do not provide adaptive approaches to deliver comprehensive services to young people with FASD. The current service delivery appears too piecemeal, short-term or inadequate to respond to the multiple and complex needs of youth with FASD. Further, a number of clinicians consulted noted that some services have remained stagnant. Anecdotal reports are that clinicians working with young people impacted by FASD within most addiction treatment settings are facing substantial challenges; and many are not confident on how to apply meaningful and well-informed FASD-informed practice.

Moreover, the need for substance use treatment interventions to assist young people impacted by FASD is recognized widely among clinicians, agencies committed to care and rehabilitation and researchers (for e.g., Chatterley-Gonzalez, 2010; Gelb & Rutman, 2011; McLachlan, 2012)
working in this field. McLachlan, Wyper, and Pooley (2013) propounds that substance use
treatment interventions to address the needs and psychosocial challenges for young people affected
by FASD are severely lacking.

To move forward towards developing services that are appropriate and that respond to the
multiple needs of young people with FASD, substance use treatment programs must adopt an
FASD-informed lens, utilizing resources that address the broad range of issues prevalent in young
people with FASD. The gaps in treatment open the door to explore alternative approach: an
integrated model. Considering the scope and nature of FASD and substance-related problems, it is
important that effective programs and treatments curriculums be developed. Up to this point, no
specific treatment models have been proposed; and there is a dearth of programming that has been
shown to be effective in addressing substance use among youth with FASD. Nor is there curriculum
designed to help professional in providing care and support for these young people.

The purpose of the following dissertation study is to develop a substance use treatment
curriculum for professionals working with young people with FASD that is responsive and relevant
to young people with FASD, so that more of them will not only complete substance use treatment
program, but also continue to have good outcomes post treatment. The curriculum will be informed
by the FASD literature, the information and recommendation from the literature on effective
treatment and best practice, current multi-disciplinary psycho-social research and practice in the
fields of children’s and youth mental health, juvenile criminology, community development,
neuropsychology, and substance abuse prevention and treatment, consultation with professionals in
the field, and my practice-based evidence. The overall framework is grounded in mindfulness
philosophy, resilience, trauma-informed practice and social pedagogy theory. The overall function is
to address the needs of young people with FASD in a holistic manner. The goal is to create an
integrated curriculum that promotes the well-being of youth with FASD comprehensively. Central to the framework is a view of young people with FASD lives as characterized by being, becoming, and belonging.

1.2. Being, Belonging & Becoming

As young people with FASD navigate the service system it is critical they receive guidance and support that fosters resilience, nurture growth and recognizes their agency. FASD is multifaceted, and the interplay between FASD and substance misuse has the potential to alter the landscape for young people. Listening to them share their lived experiences and observing their complex struggles, begs the question: in what ways are we ensuring that we are considering the belonging, being and becoming of young people with FASD?

A sense of being, belonging and becoming is fundamental to and intersects with many important aspects of a young person’s identity, as well as, facets of needs, rights, development, wants, desires and well-being. It is important that clinicians provide responsive service that facilitates many protective factors for wellbeing. In my practice experience, when young people with FASD feel respected, valued, and recognized for their uniqueness and expertise about the complexities of their realities, their engagement in service is sustained, and improved outcomes are realized.

The well-being and sense of being, belonging and becoming of young people with FASD can be undermined by such things as intergenerational histories of trauma, addiction, emotional dysregulation, stigma, exclusion (most often reflected when young people with FASD fall through the ‘potholes’ of services) and negative peer pressure. Moreover, when young people with FASD

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1 A comprehensive approach intends to integrate the various perspectives in defining who and what young people with FASD are, how and what to communicate to them, which role they can play and how their environment can support them. Comprehensiveness also includes the promotion of well-being, the rights of young people with FASD, their development, self-esteem and self-reliance. Addiction programs are most likely to be effective if the therapeutic context is embedded in a broader perspective of human well-being, quality of life, skills, self-awareness and self-esteem. They will also be effective if an exclusively fear-based or problem-based approach is avoided. Comprehensiveness in this context also means supporting the holistic well-being of young people with FASD.

2 Agency: being able to make choices and decisions, to influence events and to have an impact on one’s world.
encounter new situations and settings; including, transition into foster homes, transition between foster home, transition out of care, transition to adult service, school transitions and service that is disempowering, they often struggle to feel they belong. Consequently, their sense of being and becoming are also impacted. When we provide services and supports that scaffold new skills, inculcate resilience, nurture growth and acknowledge the agency and competencies of young people with FASD, we can facilitate the restoration of a sense of being, belonging and becoming.

The concept of being, belong and becoming is fundamental to this curriculum. Bringing my understanding of the concepts into the conversation about how to meaningfully work with young people with FASD opens possibilities for conceiving or re-conceiving them differently—as people with agency and capabilities. The goal is for clinicians to strive to promote a sense of being, belonging and becoming into young people with FASD.

1.2.1. Being

The concept of being is about valuing, perceiving and having an understanding and acceptance of young people with FASD for whom they are rather than seeing them as their diagnoses. It is about seeing them as young people doing the best they can to navigate and engage with the complex layers of their life—experiences, needs, interests, and other contextual factors; rather than seeing them as difficult. It is also about young people with FASD building and maintaining positive relationships with themselves, seeing the possibilities inherent in their experiences, and being aware of their emotions, thoughts and behaviour without judgment. For young people with FASD, understanding and accepting who they are, and knowing that others understand and accept who they are, as well as care for them is empowering. Within the therapeutic context, a young person’s sense of being can also relate to how clinicians show respect to the young person through conversations and actions. Helping young people with FASD to develop a sense of their identity and place in the world is fundamental to their mental health, as well as their social and
emotional wellbeing. It also helps them to identify values that can guide them into the future and resist impulsive actions or negative peer pressure.

1.2.2. Belonging

There are many ways to understand and describe a sense of belonging and there are many dimensions to belonging. Knowing where and with whom you belong is integral to human existence and fundamental to the well-being of a young person with FASD. Many young people with FASD belong to a family, a cultural group, a religious group, a neighbourhood and a wider community, a circle of friends and a substratum of their broader circle of friends. They belong to a school and sometimes a recreational group. Belonging acknowledges the interdependence of young people with FASD with others and the basis of relationships in defining identities (Department of Education, Employment and Workplace Relations, 2009; Hadley, & De Gioia, 2008). Because belonging is most often experienced as a positive feeling; the importance for young people with FASD can be easily taken for granted, particularly as many can appear to be connected to services such as the foster care and youth justice systems.

From my practice experiences and observations, in situations where a young person’s emotional investment in belonging to a parent, extended family, or foster family is not reciprocated, belonging can be experienced as negative and the balance between belonging and separateness can become difficult for a young person with FASD to manage. When friendships and romantic relationships become stressed, possessive, or one-sided, feelings of belonging can become complicated. Because many youth with FASD can be gullible, they are likely to be in relationships where they are manipulated, controlled or abused. Their need to belong to a particular social group can stem from life experiences in which the youth with FASD has been shown over and over that they don’t belong anywhere (separated from family, rejected by peers, in conflict with institutions, etc).
This belonging need can easily lead to rejection, thus, the dynamics of inclusion and exclusion can have implications for their perception of where or whether they belong. This, in turn, will influence the social behaviours they engage in and impact their overall well-being. Therapeutic support that incorporates resilience thinking, and builds on respect and recognition of agency can work towards ameliorating these risk factors and help to restore confidence and competence in young people with FASD.

In a broad sense, belonging within the context of MIRTS is about clinicians first acknowledging the multiple belongings and lack thereof of young people with FASD. It is also about recognizing young people with FASD for who they are, helping them to understand themselves, and how they figure within their multiple belongings and encouraging them to participate in matters that affect them. It is about young people with FASD being able to relate to people (e.g., family and friends), to places, to beliefs and ideas, to ways of being and experiencing. Belonging is also about needs and rights being recognized and met, about being protected and provided for, about feeling cared for, respected and included. Belonging entails opportunities to express personal agency and creativity, feeling able to contribute in meaningful ways, including to their treatment planning. When young people feel a sense of positive belonging, they are more likely to learn effective ways to relate to themselves, invest in their well-being; engage with others and engage in healthy social behaviours. Belonging is central to ‘Being’ and ‘Becoming’ in that it shapes who young people with FASD are, and whom they can become (Beck & Malley, 1998; Bourdieu & Wacquant, 1992; Brooker & Woodhead, 2008; Gordon, O’Toole & Whitman, 2008; Woodhead, & Brooker, 2008).

1.2.3. Becoming

Young people with FASD are intimately interwoven with family and system structures that are continually changing and evolving. Likewise, their needs, experiences, identities, knowledge,
understandings, capacities, skills and relationships are simultaneously evolving. Becoming reflects the changes they experience as they grow, learn and develop (Department of Education, Employment and Workplace Relations, 2009). Within the context of MIRTS it is also about facilitating processes for young people with FASD to enhance their self-resilience, nurture their strengths and growth, become effective communicators, meaningful contributors, and confidence about their ability. The focus on becoming looks to the future of whom young people with FASD want to be, what they want to do and how they can develop the skills to get there.

1.3. Rationale

The impetus for developing this curriculum came from observations I made a few years ago while working as the coordinator for youth detox and supportive recovery in Nanaimo, British Columbia (BC) Canada. While working as a coordinator I used to go to meeting with young people and their families and other professionals (social workers, probation officers, addiction counsellors, etc.) I would notice that many times at meetings that the entire time was taken up looking at and discussing what was wrong with the youth, or what he/she could not do. Upon reflection I became aware that my one-on-one sessions were taking that same format. One day I experienced a shift in perspective. I began to wonder what would happen if I explored a young person’s strengths as oppose to his/her weaknesses. Since then, before each meeting I would ask myself ‘what can this young person do well’. This thinking began a new focus in which I started to work with ‘difference’ more efficiently and appropriately. I discovered that when my starting point focused on what a young person with FASD can do, more engagement was possible and this often open things up to more discussions—and often solutions to challenges based on outcomes that matter to the young person.

This little exercise of mine pointed to something more significant about the actual nature of a young person living with FASD. What became clear to me is that as clinicians there is sometimes a
tendency to ‘pigeon hole’ individuals with FASD into ‘can’t do’ categories, which limits their opportunities, potentials and overall resilience capacities. However, once we start to look more deeply into their lives and experiences, we begin to see strengths, talents, abilities, intelligences and hidden resilience. This process can make a world of difference to their sense of being, belonging and becoming. It is because of this work, and the importance of this work that I am convinced we need to shift the focus of our attention and embrace a more holistic and resilience thinking approach that embrace a more positive view of who young people with FASD are, and whom they can become.

Moreover, although the last decade has been marked by an upsurge of interest, intervention and prevention effort with regards to FASD, the quality and scope of service is still limited, in part, by a ‘deficit approach’ and many gaps still exist in the addiction and mental health support and service systems. Many young people with FASD have been overseen by various systems of care, yet their strengths and needs have been largely overlooked. For the most part, young people with FASD remain a largely underserved population and have been invisible in youth addiction and mental health program development and implementation. To provide services that are appropriate and respond to the multiple strengths and needs of young people with FASD what seems clear is that a broad approach is needed. A broad approach sees numerous paths and influences into and out of the challenges and numerous ways to inculcate resilience, build on existing strengths and scaffold new learning. In essence, a broad approach is holistic and works with ‘difference’ or ‘diversity’.

Young people with FASD are living, learning, navigating, and negotiating transitions to adulthood and independence in an increasingly complex and challenging environment, in which they face myriad choices and opportunities, but also unparalleled uncertainty and risk. This calls for empowered, confident, motivated and creative young people, who play an active role in negotiating and navigating these paths. There is growing recognition (Beauchemin, Hutchins, & Patterson, 2008; Harper, Webb, & Rayner, 2013; Loock, Sulemanb, Lynamc, Scott, & Tylere, 2016; Ungar, 2011b; Werner, 2000, 2005) that developing social and emotional capabilities, building resilience, promoting
mindfulness and positive engagement supports the achievement of positive personal outcomes; including self-awareness, improved interpersonal skills, mental health, educational attainment, and employment. Capabilities such as resilience, communication, and problem-solving are also noted as being the fundamental to improved quality of life and well-being (C. Loock, personal communication, 2014; A. Salmon, personal communication, 2014; Ungar, 2011b). Indications are that approaches that focus on these competencies can have greater long-term impact than ones that focus on direct deficits.

Supporting the development of psychosocial competencies in young people with FASD is also a strong theme, in a number of FASD strategic plans and mental health and addiction initiatives, which encourages a stronger focus on help to support all individuals with FASD to succeed. The importance of providing service that is responsive and appropriate has been well articulated by researchers and other professionals in the field (Gelb & Rutman, 2011; Loock, 2014; McLachlan et al., 2013; Salmon, 2014; Streissguth, Barr, Kogan, & Bookstein, 1997; Streissguth et al., 1996). There is a significant need for supports that are appropriate to meet the holistic needs of young people with FASD. Without appropriate treatment, young people with FASD will continue to experience decreased adaptability to changing environments, decrease psychological functioning, lower decision making, all which can contribute to increased relapse. In order for young people with FASD to make good decisions about substance use, they need good information, values and attitudes consistent with healthy goals, skills to behave consistently with their knowledge and values, and access to quality and appropriate support.

A curriculum-based approach can contribute to providing what young people with FASD need in a structured format, while offering flexible approaches that can be implemented in a variety of settings. With these features, a curriculum-based approach can constitute an important strategy for addressing the substance use treatment needs of young people with FASD. Program evaluations and overview studies in other related fields and even within the broader addiction field have found
that curriculum-based education can be effective in widely differing geographic areas, various cultural settings, and among youth at different income levels and both sexes.

When we look at the dynamics of FASD and the interface between FASD and substance misuse, it is easy to see why it can be challenging for clinicians. Working with these young people to enhance their competencies is what is needed; yet the service model in addictions and mental health settings is not designed to respond in this way. An FASD-informed approach in many agencies is slow in coming. Undoubtedly, FASD crosses many disciplines, but clinicians play a significant role in providing young people with FASD with some intangible foundations and introducing them to skills necessary for successful outcomes. I have learned from working with young people with FASD that they expect a safe therapeutic environment—one that supports them to work through issues of confidence, motivation, relationships and more importantly, one that cultivates many of their skills and interests. This curriculum addresses this intervention gap by providing clinicians with a more holistic and comprehensive approach to address the challenges of working with youth with FASD. This will likely reduce the number of youth who ‘fall through the cracks’ of the service system and significantly impact the cycle of vulnerability and substance use prevalent among young people with FASD.

The development of MIRTS is a valuable resource for clinicians working with young people with FASD. Currently, no resource exists for clinicians that provides a comprehensive and holistic way of working with young people with FASD. Also, no substance use program to date has incorporated an FASD-informed framework that incorporates resilience, trauma-informed, mindfulness and social pedagogy for this population. Thus, I believe that an integrated, holistic, FASD-informed curriculum for young people with FASD could facilitate a sense of being, belonging and becoming.
I would like to provide a framework that clinicians\(^3\) can utilize to respond to the needs and strengths of young people with FASD more comprehensively. Positive outcomes start with recognizing that young people with FASD have a range of needs, but also have many strengths. This curriculum emphasizes working with young people with FASD holistically—taking into account the stages of growth, development and maturity of each person, their individual circumstances and barriers, along with their social and community context. It also underscores the necessary skills in inculcating resilience and mindfulness, working through substance use challenges and managing change. Addressing well-being comprehensively ensures that young people with FASD develop the knowledge and understanding, skills, capabilities, and attributes that they need for psychosocial well-being now and in the future. This will, in turn, promote confidence, positive attitudes, autonomy and the capacity to regulate their emotions and manage the changes they experience. In general, overall well-being, and the development of the coping and living skills required for youth living with FASD to be successful in their communities will be enhanced.

MIRTS is novel, and it is built around some key concepts and principles, which require clinicians to use particular understandings and practices effectively to achieve outcomes that matter to young people with FASD. I see this as a valuable opportunity to promote creative approaches to the FASD, mental health, and addiction services fields, to focus on the strengths, needs, potential, and development of each young person with FASD. This curriculum will adopt a flexible designed, as this will allow for use in a wide variety of settings; including substance abuse treatment (outpatient, inpatient, residential), correctional facilities, health and mental health centers, etc., as well as for group and individual format, females, and males. As such it can add to the research base on substance use and FASD, and further, bolster the awareness of the need for FASD-informed treatment programs for young people with FASD and substance use.

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\(^3\text{Clinician}\)- a person qualified in the clinical practice of psychology, psychiatry, addiction, mental health, or social work.
1.4. Purpose and Aims

The purpose of this dissertation is to develop a curriculum for professionals working with young people with FASD within youth addiction services. The aim is to:

- Provide a holistic and comprehensive model that supports the psychosocial needs of young people with FASD.
- Provide clinicians and service providers with a tool to aid in providing more appropriate service and support to young people with FASD
- Develop the underpinning qualities and skills that help promote positive behaviour, self-management, participation, resilience and mindfulness.
- Empower clinicians to improve the quality of their services, so as to improve outcomes for young people with FASD
- Support clinicians to encourage young people with FASD to become reflective learners, who can make informed choices and take responsibility for their actions.
- Promote an FASD-informed practice
- Build on effective work already in place in the many addictions and mental health settings

1.5. Organization of the Thesis

In this introductory chapter, I provided background information, addressed the significance of the study, summarized the purpose and aims, and briefly introduced the theoretical basis for the study. I concluded with a short description of my background. This section serves to orient the reader to the organization of the thesis. In Chapter 2, I synthesize the literature to provide the context and to demonstrate the need for the curriculum. In Chapter 3, I discuss the theoretical perspective I used to inform the study and the methodological implications that flow from the underlying theoretical perspective. In Chapter 4, I illuminate the research methodology used for the study. I describe the study design and method. In Chapter 5, I present the result of the formative
evaluation and iterative process. I discuss the findings in Chapter 6, as well as the implications for the field and the limitations of the curriculum design and evaluation.
Chapter 2: Literature Review

2.1. Overview of FASD

Fetal alcohol spectrum disorder (FASD) refers to a variety of the broad array of physical, developmental, neuro-cognitive and neuro-psychiatric differences experienced across the lifespan by individuals who were prenatally exposed to alcohol (Loock, personal communication, 2015; Schechter et al., 2004). Current literature suggests that the effects of alcohol exposure in utero are complex and pervasive, as alcohol tends to affect the brain and impair development, often resulting in significant long-term morbidity and functional impairment. FASD is a permanent disability, and has been recognized as one of the leading environmental (and hence, preventable) causes of birth defects and developmental intellectual disability. Prenatal alcohol exposure is one of the most serious causes of non-genetic developmental disorders in the western world (Olswang, Svensson, & Astley, 2010; Premji, Benzies, Serrett, & Hayden, 2007). FASD crosses all barriers of race, culture, and class.

The adverse effect of alcohol on the developing child can result in a range of structural, physiological, neurocognitive and behavioural anomalies in individuals, as alcohol interferes with many molecular, cellular, and neurochemical events during brain development. The neuropsychological, neuroanatomical and behavioural deficits resulting from prenatal alcohol exposure are wide-ranging and vary substantially between individuals (Bohjanen, Humphrey, & Ryan, 2009; Olson, Jirikowic, Kartin, & Astley, 2007).

In Canada, FASD is now an umbrella ‘diagnostic’ term used to describe the broad range of significant alcohol related neurodevelopmental and neuropsychiatric outcomes and disabilities that are associated with maternal use of alcohol during pregnancy (Cook et al., 2016). The various clinical pictures of FASD will depend upon a combination of the different levels of exposure to alcohol
(dose and timing), as well as other prenatal and postnatal environmental factors including other
drugs exposures, environmental adversity and maternal stress (Chudley et al., 2005).

The FASD continuum ranges from the more physically recognizable diagnosis of full Fetal
Alcohol Syndrome (FAS), with sentinel facial features as originally described by Jones and Smith
(1973) to the less easily recognizable, but often more challenging to manage, neurodevelopmental
disorders associated with few or absent ('invisible') physical features. These have been previously
described as “possible fetal alcohol effects (FAE) (Clarren and Sokol, 1978), partial FAS and alcohol
related neurodevelopmental disorder (Stratton et al, 1996)

The most recent Canadian diagnostic criteria for FASD (Cook et al., 2016) have been
developed to incorporate new research on the predictive value of physical features including growth,
microcephally and facial features, to be more evidence-based regarding prenatal exposure to alcohol
(PAE), to remove barriers to diagnosis for infants, adolescents and adults, and place more emphasis
on the reliably and consistency of describing the diffuse and significant neurodevelopmental (brain
injury) profile associated with PAE.

As in previous guidelines, the current Canadian guidelines stipulate that a diagnosis requires
a history of confirmed and significant PAE unless all three sentinel facial features (SFF) of short
palpebral fissures, thin upper lip and indistinct philtrum are present. These SFF show a very high
specificity of over 95% for FASD (Astley, 2014). A diagnosis of FASD can only be made in the
absence of known PAE when these features are present, and other causes such as more rare genetic
conditions have been excluded. The need for this category is to provide appropriate diagnosis and
support for the infrequent presentation of full FAS (e.g., individuals with SFF findings) for whom
no PAE history is obtainable due to maternal death or permanent separation. (Note: This diagnosis
of FASD with SFF cannot be considered when there is evidence for no prenatal exposure.)

Although some individuals have the sentinel facial features (SFF), that can be a “biomarker”
for PAE (prenatal exposure to alcohol), most do not. Because there are often few if any
distinguishing physical characteristics of the disability, the invisibility of the brain damage can create many more challenges for the individual with more “invisible” presentation. Many young people with prenatal alcohol exposure do not meet the criteria for full fetal alcohol syndrome (FAS) (Chudley et al., 2005). However, along the whole spectrum, one characteristic is common to all FASD children: difficulty in social communication, with varying degrees of severity (Jones & Streissguth, 2010) and other adaptive behaviours e.g. making choices (C. Loock, Personal Communication, 2015).

In other parts of the world, professionals in the field may still be applying older diagnostic guidelines and criteria, such as the 1996 Institute of Medicine criteria (Stratton et al, 1996). Unlike Canada, FASD remains an umbrella concept (not a diagnostic term) used to describe the broad range of outcomes and disabilities that are associated with prenatal alcohol exposure (Burd, Klug, Martsolf, & Kerbeshian, 2003; Guerri, Bazinet, & Riley, 2009; Kodituwakku, 2007; Rasmussen, 2005; Streissguth, 2007; Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004). The FASD continuum ranges from the most severe diagnosis of Fetal Alcohol Syndrome (FAS) to Partial Fetal Alcohol Syndrome, (pFAS), to Alcohol Related Neurodevelopmental Disorder (ARND), and to a diagnosis of Alcohol Related Birth Defects (ARBD). Despite these different approaches, all are in agreement that persons affected by FASD experience significant challenges, in areas such as learning, memory, attention, executive functions, communication, mathematics, vision or hearing. (Caley, Shipkey, Winkelmena, Dunlap, & Rivera, 2006; Chudley et al., 2005; Streissguth & O’Malley, 2000). For the purpose of this dissertation, I will be using the most current and streamlined 2015 Canadian diagnostic guidelines, where FASD is used as a diagnostic term.

2.2. Primary Disabilities and Secondary Disabilities

**Primary Disabilities.** Primary disabilities are functional deficits that result from central nervous system dysfunction (Mattson, Crocker, & Nguyen, 2011; Miller, 2006; Olswang et al., 2010).
It has been suggested that deficient executive functions such as planning, organizing, abstracting, impulse control, sensory processing, integration across space and time, strategic plan of action sequences, interference control, selecting appropriate responses in the face of competing and contextually inappropriate alternatives, and working memory may be primary cognitive deficits of FASD (Streissguth et al., 1997). Since executive functions such as planning, organizing, and integration are integral to the normal processing of information in the environment; the impact of executive dysfunction may be great for this population. The physical, cognitive, and behavioural deficits observed among individuals with prenatal alcohol exposure are not dichotomous, that is either normal or clearly abnormal. Rather, the outcomes, and the prenatal alcohol exposure, all range along separate continua from normal to clearly abnormal and distinctive (Astley et al., 2009; Kodituwakku, 2007). Other clinical manifestations of FASD may include cardiac anomalies, urogenital defects, skeletal abnormalities, and visual and hearing problems (Aragón et al., 2008; Canadian Pediatric Society, 2002; Chudley et al., 2005; Green et al., 2009; Nicholson, 2008; Streissguth, 2007).

**Secondary Disabilities.** Secondary disabilities are disabilities that the individual is not born with but which manifest progressively with development, particularly when there are inadequate interventions in place to provide support around primary disabilities (i.e., they are additional disabilities or conditions that may result from having a primary disability) (Kodituwakku, 2007; Kodituwakku, 2009; McGee, Fryer, Bjorkquist, Mattson, & Riley, 2008; Pei, Job, Kully-Martens, & Rasmussen, 2011; Rasmussen & Bisanz, 2009; Rasmussen, Horne, & Witol, 2006; Sampson et al., 1997; Streissguth et al., 1997; Todorow, 2011).

Individuals with FASD may exhibit secondary disabilities such as: behavioural problems (internalizing and externalizing) and social problems, problems with recognizing and respecting boundaries, limited social skills, problems with the legal system (e.g., theft, assault, noncompliance with court mandates, vandalism, and mischief), learning challenges and compromised school
experiences, substance abuse, post-traumatic stress disorder (PTSD), depression, reactive attachment disorder, oppositional defiant disorder, anxiety, conduct disorder, and inappropriate sexual behaviour (Streissguth et al., 1997; Streissguth et al., 1996).

According to Stade and her colleagues, individuals with FASD often display characteristics such as extreme hyperactivity, aggressiveness, poor judgment, and speech and language difficulties (Stade, Stevens, Ungar, Beyene, & Koren, 2006). The level of maladaptive behaviour among this population is high and presents a significant challenge to service providers (Streissguth et al., 1991; Streissguth et al., 1997; Streissguth et al., 1996). However, this behaviour cannot be looked at in isolation without also considering the social, cultural, environmental, and developmental factors that are likely to have a significant impact on the expression of both psychiatric and behavioural disorders in young adults with FASD. Young people with FASD are reported to have significantly higher rates of substance use, homelessness and criminal justice engagement than the general population (Baumbach, 2002; Chudley et al., 2005; McLachlan, 2012; Miller, 2006; Streissguth et al., 1996). Deficits in behaviour problems (internalizing and externalizing) and social problems have been noted (e.g., Steinhausen & Spohr, 1998; Streissguth & Kanter, 1997).

2.3. FASD a Paradigm Shift

Below I present an overview of FASD from a resilience and strengths based perspective. It is my contention that FASD is dynamic in nature and that the research literature supports a more rounded approach to youth, which builds on strengths and resilience rather than focusing on just deficits.

2.3.1. A Resilience and Strength-Based view of Young People with FASD

Traditional approaches to understanding FASD have dominated our clinical, academic, and research forums for the past few decades, and are based primarily on medical models. Traditionally,
research and many of the human service agencies have focused on trying to understand better the biological/cognitive, psychological or psycholinguistic factors that are challenging for an individual with FASD. This research is based on the deficit, problems, or pathologies of individuals with FASD. Although, this has been very helpful in understanding the impact of prenatal alcohol exposure and useful strategies and techniques have emerged from this research, there are also potential disadvantages. These approaches tend to place much of the burden for FASD on the individual. What has been apparent over the years is that policies and programs (youth mental health, youth addiction or youth justice programs) seem to report on what is wrong with the young person and to a lesser degree, the strengths of these young people.

Many professionals may be led to perseverate on a “deficit” view. The emphasis on deficits, or what a young person with FASD is challenged by, has the potential to lead professionals to a cycle of focusing only on what might be ameliorated through adapted educational strategies or treated pharmacologically - the view of a young person with FASD as the mere sum of his/her challenges. When professionals or organizations focus solely on what is ‘wrong’ with any young person, we deny and limit them the opportunity to explore what strengths and capacities they have. By utilizing a resilience perspective to talk about FASD, I attempt to account for the drawbacks of traditional models and have reframed FASD in broader social, relational and cultural contexts. This is an attempt to bridge the traditional and post-modern perspectives on FASD. Hopefully, clinicians will engage ‘differences’ in ways that explore possibilities for productive and positive learning, and consequently better outcomes.

Dubovsky, (2006) has coined the term NURMU (non-complaint, uncooperative, resistant, manipulative and unmotivated) to describe how professionals and caregivers often perceive young people with FASD. Many young people with FASD may not be well understood by professionals due to limited knowledge about the disability, lack of training and the non-existence of an FAS-informed approach within most youth addiction, youth mental health and other young adult service
Leading researchers and clinicians in the FASD research field are beginning to call for a shift in the way we view young people with FASD. Researchers such as Malbin (2002) have refocused our attention on the strengths of individuals with FASD. In fact, Kaitlyn McLachlan discussed the strength-based approach to viewing youth with FASD at the 2015 International FASD Conference during her presentation. Moreover, personal discussion with Dr. Amy Salmon and Dr. Christine Loock revealed that in addition, youth and adults with FASD, have requested a reframing, with more focus on the strengths and inclusion of individuals with FASD and more so, the promotion of developmental trajectories that capitalize on these strengths. These individuals with FASD are also requesting that we address the other health aspects associated with their condition, with clear links to the long term health consequences (e.g. cancers, heart diseases, mental health) of having experienced early life adversity (Felitti & Anda, 2009).

Researchers have suggested that the development of secondary disabilities associated with FASD can be prevented or moderated by protective factors such as early and accurate diagnosis (Astley, Bailey, Talbot, & Clarren, 2000; Streissguth et al., 1997), timely access to appropriate interventions and supports (Streissguth et al., 1997), living in stable home environments, (Duquette, Stodel, Fullarton, & Hagglund, 2006; Streissguth et al., 1997) and the presence of adults who can act as advocates to guarantee a supportive school environment (Duquette et al., 2006; Streissguth, 1997). When protective factors (internal and external) such as healthy relationships, appropriate housing, safety, availability of prosocial activities, good social problem-solving skills, high self-esteem, and stable and appropriate support at school are absence, many young people affected by FASD tend to experience complex challenges. Notwithstanding a young person’s experiences of learning problems, academic failure, and mental health and substance use issues (Streissguth et al., 1997), many youth do well. Some do persist with schooling and graduate (Duquette et al., 2006; Duquette, Stodel, Fullarton, & Hagglund, 2007; Duquette & Stodel, 2005).
Many hope to shift the focus of discourse from atypical ways of thinking and learning away from the usual focus on deficits and focus more on the ‘neuro-diversity’ that includes resiliency and strengths. In that FASD impacts the brain, we should also seek to appreciate the individual’s additional skills and aptitudes. Young people with FASD will all have strengths and abilities; they grow and develop from their strengths and adapt to their challenges. For instance, many of the young people with FASD with whom I have worked are capable of focusing on tasks that take advantage of their performance (non-verbal) aptitude and interest in art. With stronger visual reasoning abilities, and they may work well with visual cues and structure. Other more performance based aptitudes and enhanced skill development includes computers and music. Other assets garnered from my clinical observation include:

- Creativity
- Responding well to structure – consistency and repetition
- Strong concrete and experiential learners
- Visual learners
- May have areas of relative strength in overall ability (e.g., drawing, music, computer technology, mechanical)
- Friendly and outgoing
- Helpful
- Determined
- Generous and caring about others

Many young people with FASD are chronically unemployed or underemployed. Employers can often be hesitant to hire workers who act, or communicate in non-neurotypical ways. In my experience, part of the challenge of doing poorly at school is also due, in part, to the fact that, many Individualized Education Plans (IEP) are made without inclusion and consultation with the youth and without taking the time to ascertain his/her strengths. One
A metaphor for neuro-diversity is to recognize that just because a clock is digital, does not make it less of a clock than one that is analog. It is just ‘different’.

A resilience and strength-based approach encourages clinicians and youth with FASD to engage ‘differences’ in ways that explore possibilities for productive and positive learning. Clinicians, who are knowledgeable and open to making adjustments to therapeutic practices and ‘spaces’ while maintaining high expectations, can produce great gains with young people living with FASD. We attribute a multitude of accomplishments to innovators who were gifted in non-neurotypical ways. By using the concept of cognitive diversity to account for individual neurological differences, we will be able to create a discourse whereby young people with FASD may be seen in terms of their strengths as well as their challenges. Unless an individual’s strengths have been recognized, celebrated, and worked with, nothing formative may be done to address their difficulties.

Young people living with FASD should be supported to develop skills to learn, work, adapt and aspire for successful and fulfilling lives. The challenges of achieving and maintaining gains may at times seem overwhelming but by building their resilience capacities, better outcomes can be achieved.

It is important to understand that a resilience approach does not deny that young people with FASD experience problems and challenges and that these issues need to be taken into consideration. Instead, the approach shifts the frame of reference to focus on what is working well for the young person. The focus is on the individual, not the ‘FASD’. When a problem becomes the starting point, with emphasis on what youth are lacking, a dependency is created on the helping professions with lowered positive expectations and blocked opportunities for change. A process of disempowerment occurs that often results in the following:

- Labelling and therefore, limiting of options.
- Obscuring the recognition of a youth’s unique capabilities and strengths.
- Focusing on the “can’ts” as opposed to the “cans”.
• Ignoring other potential resulting from ‘cognitive diversity’.

A resilience approach views young people with FASD as both having agency and being constrained. Some individuals have more agency or are more constrained than others. It is critical we pay attention to the interplay between their agency and the constraints. Explanation that attends to either exclusively will be inadequate. A resilience approach is fluid and considers individuals as dynamically evolving and always becoming. As a psychological being, an individual is constantly in flux, and changes depending on the sorts of resources available for appropriation in their sociocultural contexts.

Chimamanda Adichie in her Ted Talk speech ‘the danger of a single story” said, “Show a people as only one thing over and over again and that is what they become” (Chimamanda, 2009). Researchers and clinicians may assume a static, binary, or even single lens approach when comparing individuals with and without FASD. A resilience thinking approach calls for a multi-faceted (multi-lens) conception of FASD. Understanding that the learning for a young person with FASD is dynamic, complex and holistic, that they demonstrate their learning and coping in different ways and the importance of starting with what is present, not what’s absent is relevant to the work we do as clinicians.

2.4. Prevalence of FASD

To date in Canada, there have been limited specific studies conducted on the prevalence of FASD in young people. Consequently, the prevalence data based on the general population will be considered. The available prevalence figures are likely to underestimate the true prevalence of FASD due to issues of data collection and the methods of ascertaining cases. It is therefore not known how many families are caring for children, teenagers or adults impacted by FASD in Canada. May (2015) estimates a prevalence rate of 2 – 5%.
Estimates derived from some prospective longitudinal studies in the US suggest FASD occurrence rates ranging from 0.2 to 2.0 per 1000 live births, and 9.1 per 1000. It has also been estimated that 9 in every 1000 babies born in Canada have FASD (Breen & Burns, 2012; Clark, 2004; Fast, Conry, & Loock, 1999; Guerri et al., 2009; Koren, Nulman, Albert, Loocke, & Loocke, 2003; McLachlan, 2012; Olsen, 1994; Streissguth, 2007; Streissguth et al., 1996; Todorow, 2011). In some Aboriginal communities in northern British Columbia, estimated rates of FASD are said to be significantly higher than the national rate ranging between 25 and 200 cases per 1,000 live births (e.g., Motz, Leslie, Pepler, Moore, & Freeman, 2006; Public Health Agency of Canada, 2005b; Umlah & Grant, 2003). However, it is important to note that socioeconomic status could be a factor. That could explain these results rather than ethnicity alone.

According to (Caley, 2006; Chudley et al., 2005) prevalence rates tend to vary by setting and context, with much higher rates found in vulnerable populations. As such, establishing the prevalence of FASD has been a challenge May et al. (2009). The majority of the studies on the prevalence of FASD are from the United States (US), and most have utilized clinic (Davis, Desrocher, & Moore, 2011; May & Gossage, 2001; Premji, Benzies, Serret, & Hayden, 2006) or record-based data collection (Astley, 2004; Sampson et al., 1997). It has been noted that such methods under-report the general prevalence and describe only the most severe cases (Chavez, Cordero, & Becerra, 1988; Egeland et al., 1998). Without active case ascertainment, many children with FASD are neither detected (Leversha & Marks, 1995; May et al., 2009), nor referred for diagnosis (Clarren, Randels, Sanderson, & Fineman, 2001; Little, Snell, Rosenfeld, Gilstrap, & Gant, 1990).

### 2.5. Substance Misuse Among Young People with FASD

Investigations of substance abuse in the general youth population in Canada, USA, Australia and Europe have highlighted the misuse of substances among young people. A significant number
of youth manifest problems with substance use, and may even meet diagnostic criteria for substance use disorder. Young people make up a substantial percentage of individuals accessing non-residential treatment (Abel, 1995; Stratton et al., 1996). Estimates for the use of alcohol among Canadian students indicate that between one-half to about three-quarters (51.6–70.0%) of them report having consumed alcohol at some point. Between 20.9–36.8% of Canadian students report they have used cannabis in their lifetime; use among those in Grade 12 was 39.8–62.6%. Other drugs such as hallucinogens, heroin, and cocaine among others were also reported to be used by youth in BC and across other provinces (Beasley, Jesseman, Patton, & National Treatment Indicators Working Group, 2012). Similar reports on youth substance use were also reported in the McCreary Centre Society study on adolescent health in BC.

Substance use in young people with FASD has been a largely understudied area and as such no current data could be found on the exact prevalence of young people with FASD and a concurrent substance use problem. Given the extent of substance use in the general youth population, it would be a mistake to assume that young people with FASD do not misuse substances, or utilize addiction services.

Limited empirical evidence exists, however, with respect to patterns of drug use, or misuse by young people with FASD. To a considerable extent, this reflects methodological difficulties in studying a diverse and heterogeneous group such as this. Simple incidence rates regarding use of alcohol and/or other drugs are difficult to establish and reveal little about the actual psychosocial benefits and/or harms which accrue for such young people. This scant evidence base is relevant to the fact that services for young people with FASD are typically not well equipped to deal with drug and alcohol problems, and drug and alcohol facilities tend to be equally reticent with respect to providing services to people with FASD.

Although there is a general paucity of research in the field of substance misuse treatment about people with FASD; anecdotal reports suggest that as a group, these young people face at least
the same overall risk of substance misuse related harm as their mainstream counterparts, if not an elevated risk. Despite the scant literature on this topic, substance use has been noted among people with FASD (Grant, Brown, Dubovsky, Sparrow, & Ries, 2013). It has been noted that rates of substance abuse problems are substantially higher among individuals with FASD relative to, the general population, and the connection between PAE and susceptibility to addictive behaviours, particularly substance abuse (Clark, 2004; McLachlan, 2012; McLachlan et al., 2013; Streissguth et al. (1997); (Streissguth et al., 1996). In one of the most extensive studies examining the occurrence of secondary disabilities, Grant et al. (2013) found that adolescents and adults with FASD have problems with their psychosocial adaptation. Of the 415 participants in their study, 35% had alcohol and other drug problems. Other, smaller studies report consistent findings. In a study of secondary disabilities conducted on 62 individuals with FASD aged 17-43 in BC, Streissguth et al. (1996) found that 22% had a problem with substance misuse. More recently, Clark (2004) found high rates of substance abuse among a sample of justice-involved youth with FASD.

2.6. Cognitive Functioning and Substance Misuse Problems

The presence of attention deficit/hyperactivity disorder (ADHD), when accompanied by a conduct disorder, as well as, other mental health issues have been found by a number of workers to be associated with an elevated risk of substance misuse McLachlan (2012). Cognitive functioning has also been implicated in substance use by young people. Compromised executive functioning, problem solving, behaviour regulation and coping skills are thought to predispose an individual to engage in high-risk behaviour such as substance use (Biederman et al., 1997; Kenneson, Funderburk, & Maisto, 2013; Lee, Humphreys, Flory, Liu, & Glass, 2011; Whitmore et al., 1997). Equally, impaired decision making and inability to attend to phenomena on a moment-to-moment basis, nonjudgmentally, have been reported in individuals who misuse substances (Bates, Bowden, & Barry, 2002; Bates, Buckman, & Nguyen, 2013; Bates, Labouvie, & Voelbel, 2002; Rogers & Robbins,
Young people with FASD have difficulty maintaining voluntary attention to stimuli that are predictable, particularly in situations where this is required to fulfill a social contract e.g. in substance use treatment. A range of cognitive/executive function disturbances have been identified in young people diagnosed with FASD, e.g. poor planning and organization, poor self-monitoring, reduced impulse control, and difficulties sustaining attention and concentration (Dakwar, Mariani, & Levin, 2011; Groman & Jentsch, 2012; Passetti et al., 2011).

Young people with FASD can experience the standard consequences of substance misuse/abuse, including social isolation, the experience of stigma, reduced social functioning, and the development of serious health conditions. In addition, young people with FASD may also be at increased risk of victimization (i.e., assault, robbery) or justice system involvement (Clark, 2004; Streissguth et al., 1997; Streissguth et al., 1996). This information is critical in as much as there is some evidence to suggest that individual with FASD are at risk of problematic substance misuse. Further, it is important that young people with FASD whether in custody or in non-custodial contexts are not overlooked in the consideration of drug misuse and related harms. The potential for increased risks associated with the correlates of substance abuse among young people with FASD is of concern.

2.7. Summary

In summary, the exact Canadian prevalence rate of FASD remains unclear, either for the population as a whole or specific population. The limited availability of information regarding young people with FASD means that epidemiological detailed data are difficult to find. For example, data concerning the number of individuals with FASD who access addiction services are not routinely collected, and at present, there are no national survey data available about the number of young people with FASD with a concurrent substance misuse problem. Anecdotal evidence indicates that diagnosing FASD in young adults can be a complex process requiring special
considerations (Chudley et al., 2005). Fetal alcohol spectrum disorder causes significant problems for many young adults, particularly in areas of school, work, and intervention programs. Behaviourally, many young people with FASD experience difficulty with attention, impulsivity, hyperactivity, aggression, delinquency, substance misuse, stealing, and cheating, as well as problems with learning from mistakes and linking cause with effect (Koren et al., 2003; McLachlan, 2012). It is important to keep in mind that there are several issues that arise in the collection of epidemiological data on prenatal alcohol exposure. The invisible nature of the disability, a lack of understanding about the nature of the disability, challenges with diagnosis, research design, and small sample sizes influences the assessment of the prevalence rate of FASD among young people.

2.8. Key Findings in Mindfulness Research

2.8.1. Mindfulness-Based Interventions with Adolescents

Although mindfulness as an intervention has approximately 40 years of empirical support targeting a diverse array of issues, populations research investigating mindfulness-based interventions with youth and adolescents only began to emerge over the last decade. There have been a number of pilot studies investigating the impact of mindfulness on adolescents, including treatment of adolescent psychiatric outpatients, adolescents in public middle school, HIV-infected teenagers and incarcerated adolescents (Davis et al., 2011; Rasmussen, Andrew, Zwaigenbaum, & Tough, 2008).

In a review of the efficacy of meditation for children and adolescents, (Biegel, Brown, Shapiro, & Schubert, 2009; Himelstein, Hastings, Shapiro, & Heery, 2012a; 2012b; Sibinga et al., 2008; Wall, 2005) examined 15 studies employing mindfulness-based interventions. Although there was a broad range of age groups and settings reviewed, results indicated that mindfulness-based interventions were safe, feasible, and enhanced a wide spectrum of mental health concerns including improved sleep issue. Likewise, Wall (2005) combined MBSR with the practice of Tai Chi with 11
nonclinical, parapubertal children (ages 11–13 years) and found that participants reported increases in well-being, including calmness and relaxation, as well as greater self-care (e.g., improved sleep and concentration), greater self-awareness, and less emotional and behavioural reactivity.

In another review, Burke (2010) examined the efficacy of the current state of sitting meditation interventions among youth. Approximately half of the 16 studies reviewed, involved mindfulness forms of meditation as the intervention under study (Mindfulness Base Stress Reduction (MBSR), Mindfulness Base Cognitive Therapy (MBCT), or other forms of mindfulness). Their findings suggested that sitting meditation may be an effective intervention for physiological, psychosocial, and behavioural issues.

In a randomized clinical trial with adolescents psychiatric outpatients, Black, Milam, and Sussman (2009) found significantly lower levels of reported anxiety, stress, depressive symptoms, interpersonal problems and obsessive symptoms and significantly higher levels of self-esteem and sleep quality in mindfulness meditation participants compared to a control group. Similarly, Biegel et al. (2009) found significantly greater levels of psychological well-being in those who practiced the mindfulness meditation intervention more frequently outside of class than others in the treatment group who practiced less often, although there were no significant differences found overall between treatment and control groups.

In another pilot study, 5 children ages 7 to 8 years with anxiety-related academic difficulties received a 6-week mindfulness training program. Participants showed improvements in academic performance and teacher reported problem behaviour Huppert and Johnson (2010). Further, Napoli, Krech, and Holley (2005) used an integrative program of mindfulness and relaxation with 194 children in first to third grade with high anxiety. Participants showed a significant increase in selective attention and decreases in both test anxiety and ADHD behaviours. This research suggests that a mindfulness-based intervention may have value for the treatment of psychological symptoms in adolescents. Together, these studies provide indication that young people are both able to and
interested in learning Mindfulness Meditation. Additionally, these studies provide evidence for the feasibility of providing Mindfulness Meditation training to adolescents in a variety of settings with no indications of unintended negative effects.

There are other reasons to suggest that an intervention such as MBSR may be effective in a symptomatic adolescent population. First, as already noted, the MBSR program appears to be adaptable to a range of psychological (and physical) conditions (e.g., Baer, 2003b). Second, as training in “present-centered” attention, MBSR may foster more adaptive processing of thoughts and emotions that underlie stress and the psychological and behavioural problems associated with it in adolescents and adults. Specifically, much stress is generated by particular cognitive and emotional responses that involve “time travel” into the remembered past (e.g., rumination) and the imagined future (e.g., anxiety). Through its focus on training, MBSR is thought to foster acceptance, metacognitive awareness, and other processes that help to disengage from cognitive and emotional events that fuel stress and consequent psychological problems (Baer, 2003b; Brown, Ryan, & Creswell, 2007). Finally, the MBSR emphasis on experiential practice in the deployment of attention in meditative contexts appears to be well tolerated by adolescents (e.g., Barnes, Davis, Murzynowski, & Treiber, 2004).

2.8.2. Mindfulness and Substance Use

A significant number of reported studies show that mindfulness procedures have beneficial effects on a range of disorders, including substance use disorders (Semple, Reid, & Miller, 2005a). Understanding factors that may reduce the risk of relapse and improve treatment outcomes is of critical importance. Recently, there has been increased attention on the role of mindfulness deficits in contributing to substance use and how mindfulness-based interventions can be implemented in addiction treatment. (Keng, Smoski, & Robins, 2011; Zgierska et al., 2009). One of the major forms of stress reduction that is beginning to be widely used is meditation (Pruett, Nishimura, & Priest,
The impacts of meditation on substance abuse populations have had positive effects, from reducing drug and alcohol use, to utilizing coping skills to managing cravings (Chen, Comerford, Shinnick, & Ziedonis, 2010; Special, 2010). Developing coping skills and problem-solving skills as a component of substance abuse treatment can begin to be found through a meditation practice.

Some of the benefits of a meditation practice when treating substance abuse are that individuals begin to develop more self-awareness regarding their impulsive behaviours and often unhealthy and counterproductive reactions to stress (Pruett et al., 2007; Special, 2010).

According to Zgierska and Marcus (2010) “Mindfulness-based therapies have been shown effective or potentially effective for a variety of medical and mental health disorders, including stress, anxiety, depression, emotion dysregulation, and avoidance coping” (p.78). A typical goal of substance abuse treatment is identifying triggers for use and changing behavioural patterns in an effort to avoid triggers, thus, special claims that mindfulness and meditation begin to teach individuals with substance misuse problems, not how to avoid triggers and cravings, but, rather begin to cope with the triggers and cravings they experience (Special, 2010).

Further, Special (2010) noted that incorporating meditation into treatment has shown that people have been able to reduce the number of days they used alcohol or other drugs. In terms of long-lasting change for individuals who suffer from substance misuse, meditation can also promote spiritual development, create a reduction in stress responses to certain cues, promote acceptance of both self and situations, and begin to extinguish maladaptive and destructive behaviours (Dakwar & Levin, 2009).

This has been shown to be consistent with incarcerated populations as well (Bowen et al., 2006). When incarcerated individuals who had substance use disorders used meditation as part of their substance abuse treatment, the amount of their substance use decreased after being released and they had better psychosocial outcomes than their peers who did not engage in meditation as part of their substance abuse treatment (Bowen et al., 2006; Simpson et al., 2007).
In line with some of the findings mentioned above, Marlatt (2002) indicated that practicing mindfulness techniques is an antidote to substance use because it allows individuals to slow down and bring awareness to their thoughts, feelings, and bodily sensations associated with triggers. Utilizing these techniques has been shown to be successful when struggling with cravings and urges associated with the use of a substance (Marlatt, 2002). It has also been stated that using a “mindful lens” may counteract addictive behaviours and help develop an understanding of internal and external cues (Witkiewitz, Marlatt, & Walker, 2005). Moreover, Temme (2010) suggested that mindfulness techniques such as meditation and breathing techniques promote self-monitoring, control, and self-acceptance, which have been known to interrupt the automatic response and better assist individuals in coping with the situation as well as regulating their mood. It was also stated that this type of increase in awareness has given individuals the opportunity to pause and observe what they are thinking or feeling, and avoid reacting in a habitual manner.

Bowen, Witkiewitz, Dillworth, and Marlatt (2007) mentioned that mindfulness meditation and breath awareness were shown to reduce anxiety, negative affect, and were associated with a significant decrease in substance use. Concordant with several findings, Bowen et al. (2007) also stated that incorporating meditation among other mindfulness techniques in the treatment of addiction has demonstrated promising results. Bowen et al. (2007) conducted a study of 173 diverse subjects residing in jail, 79.2% of which were males and 24% were females, all between the ages of 19 to 58. During the length of the course, the subjects self-reported a significant decrease in unwanted thoughts in comparison to the individuals who did not take the meditation course.

Saddichha (2011) indicated interventions such as deep breathing may delay and be used as a distraction when experiencing a craving. Yoga, a practice that involves doing a series of stretches and maintaining posture while concentrating on breathing, has been known to increase muscle tone, flexibility, sense of balance, and overall psychological wellbeing (Kissen & Kissen-Kohn, 2009). Kissen and Kissen-Kohn (2009) stated that most individuals who misuse substances do not exercise,
as such practicing yoga might create high levels, which may be associated with self-soothing. It was concluded that the ritualistic aspects of yoga and breathing practices have been shown to assist in self-soothing along with creating an atmosphere of comfort without the self-harming aspects inherent in addictive behaviour.

The integration of these mindfulness-based interventions with other evidence-based practices may enhance treatment outcomes by assisting clients in connecting with their emotions, cognitions, and behavioural patterns on a deeper level. It may also aid in recognizing their triggers to build the skills necessary to overcome cravings associated with chemical dependency and relapse (Kissen & Kissen-Kohn, 2009).

Additionally, a pilot study tested the efficacy of a brief intervention using motivational interviewing (MI) plus mindfulness meditation (MM) to reduce marijuana use among young adult females. Thirty-four female marijuana users between the ages of 18 and 29 were randomized to either the intervention group (n = 22), consisting of two sessions of MI-MM, or an assessment-only control group (n = 12). The participants' marijuana use was assessed at baseline and at 1, 2, and 3 months posttreatment. Participants randomized to the intervention group were found to use marijuana fewer days at Months 1, 2, and 3, respectively, than controls. Findings from this pilot study provide preliminary evidence for the feasibility and effectiveness of a brief mindfulness technique for young people who abuse substances (Eisenlohr-Moul, Walsh, Charnigo, Lynam, & Baer, 2012; Marcus & Zgierska, 2009).

2.8.3. Mindfulness-Based Relapse Prevention

Mindfulness-based relapse prevention (MBRP) was developed for individuals struggling with substance use disorders and is an 8-week chemical dependency program that is consistent with MBCT and MBSR in content and structure. This particular approach integrates mindfulness meditation and relapse prevention (RP) techniques (Bowen, Chawla, & Marlatt, 2011). Chawla et al.
(2010) described the RP techniques as including having an individual practice identifying high-risk situations, developing effective coping skills such as practicing mindfulness, increasing self-efficacy, and learning to recognize the precursors of substance use and relapse, which continue to be an important component of MBRP. These mindfulness-based interventions (MBRP, MBSR, and MBCT) are all exercise to increase coping skills with stress and depression symptoms, along with the treatment of substance use disorders (Bien, 2011). de Dios et al. (2012) stated, “In behavioural terms, mindfulness-based approaches for substance abuse are described as a process of desensitization to negative affect through exposure, which helps to extinguish automatic avoidance of negative emotions and consequential substance use.” “The goal of MBRP is to develop awareness and acceptance of thoughts, feelings, and sensation through practicing mindfulness, to observe both pleasant and unpleasant experience, and to accept whatever is present without judgment” (Marlatt, Bowen, Chawla, & Witkiewitz, 2008, p. 5). Bien (2011) further explained that MBRP educates individuals on how to practice formal meditation techniques, which allow an individual to experience thoughts, feelings and emotions with greater acceptance and awareness, and most importantly without any form of judgment. Bien (2011) also stated that “We practice sitting meditation to have liberation, peace, and joy, not to become a hero who is capable of enduring a lot of pain. This process allows openness and acceptance to all experiences, including unpleasant emotional states” (p. 19). The authors concluded that the avoidance of unwanted thoughts might be an important component in the relationship between meditation and alcohol use.

2.8.4. Mindfulness Based Intervention in Correction (with incarceratered youth)

Mindfulness meditation may be an effective intervention for incarcerated youth because the mechanisms through which mindfulness meditation impacts the individual include an increase in self-regulation, an ability that is negatively associated with delinquent and other risk behaviours (Steinberg, et al., 2008). Mindfulness Meditation is an intervention that is amenable to
experimentation, feasible with incarcerated youth and appropriate as an intervention to address the issues that incarcerated youth face both in and out of state custody.

Mindfulness meditation as an intervention may be uniquely suited for use in the juvenile justice system given its successful use with adolescents and as an effective treatment for behavioural and emotional problems similar to those reported by youth leaving custody, including suicidal ideation, anger management, anxiety and depression (Biegel et al., 2009; Semple, Reid, & Miller, 2005b; Williams, Duggan, Crane, & Fennell, 2006). Additionally, the increased emotional and behavioural control is shown to be associated with mindfulness meditation may be protective against the emotional responses associated with the life stressors incarcerated youth face outside of custody (Greeson, 2009). There is also evidence suggesting that mindfulness meditation would be accepted by young people in custody as a practice both during and after incarceration as reported anecdotally by a program manager for a youth justice program on the Vancouver Island (L. McKeown, personal communication, 2014).

de Dios et al. (2012) study of 10 adolescents aged 15-18, who were court-mandated to participate in the detention camp’s drug and alcohol psychotherapeutic intervention, revealed improved decision making, improved sleep and enhanced psychological mindedness and well-being. Psychological mindedness is defined here as the increased ability to self-regulate and make autonomous choices. Although there are limitations to this study, the results suggest that there is a conceptual framework for the teaching of mindfulness to incarcerated substance-abusing adolescents. This research lends support to past research, and the data also suggests that mindfulness is a feasible intervention for adolescents in general (Himelstein, Saul, Garcia-Romeu, & Pinedo, 2014) and incarcerated youth specifically (Himelstein et al., 2012a; 2012b).
2.8.5. Mindfulness and FASD

Research has shown that mindfulness-based treatment interventions may be effective for a range of mental and physical health disorders in adult populations, but little is known about the effectiveness of such interventions for treating adolescent with FASD. (Black et al., 2009) conducted a mindfulness-based training program for adolescents with FASD; the study used a pre-post-test design that included ten children with FASD (ages 12- to17-years). Participants were assessed using experimental measures of social cognition at baseline and 8-week follow-up. Also, caregivers completed measures that assessed children’s emotionality and social skills at both time points. Analysis revealed that mindfulness training may be effective in improving perspective taking skills in children with FASD. Psychotherapeutic treatment of adolescents with FASD can be difficult. For example, in my service engagement with youth with FASD, some adolescents do not view psychotherapy as a beneficial treatment option. In addition, the level of response to treatment has also been less than desirable.

Mindfulness training has been shown recently to benefit both mental illness (such as depression) and substance use disorders, suggesting that this approach may target common behavioural and neurobiological processes. However, it remains unclear whether these pathways constitute specific shared neurobiological mechanisms or more extensive components universal to the broader human experience of psychological distress or suffering. The degree of mindfulness may enhance an individual’s sense of agency through its effects on increasing awareness of internal and external stimuli occurring in the present moment, and through increasing acceptance of distressing cognitions, emotions, perceptions, and sensations that occupy awareness. Thus, mindfulness may enhance flexibility in responding and ultimately expand perceived options for handling high-risk situations.

There is anecdotal evidence, as well as my practice observation suggests that individuals with FASD can use self-control strategies to manage some of their behaviours. The research literature on
cognitive behavioural strategies indicates that individuals with mild intellectual and developmental disabilities can utilize some cognitive behavioural strategies, including relaxation training, self-instructional training, and problem-solving techniques Baker (2011). Thus, there are reasons to expect that individuals with FASD will be able to use mindfulness strategies to help modulate some of their behaviours.

Customized mindfulness-based meditation strategies have been used to teach individuals with intellectual and developmental disabilities to control their maladaptive behaviour (Singh et al., 2006). For example, meditation on the Soles of the Feet has been used successfully by individuals with mild and moderate levels of intellectual and developmental disabilities to control their anger and aggressive behaviour over several years (Singh, Lancioni, Singh Joy, et al., 2007; Singh, Lancioni, Winton, et al., 2007; Singh, Wahler, Adkins, Myers, & The Mindfulness Research Group., 2003).

In summary, there has been increased global interest in mindfulness practices in recent decades. It is primarily due to the expectancy that mindfulness practices (for example, yoga, guided meditation, tai chi, Pilates, etc.) can calm the mind and increase overall health and well-being. A young person’s mental health and well-being include developing healthy relationships with family, peers, teachers and counsellors, and being able to self-regulate emotionally, mentally, and behaviourally.

As already mentioned, mindfulness practices have been used to promote mental health and to increase resilience and self-regulation. It has been researched in a wide range of areas such as anxiety, depression, life-span development, prison populations, human attachment, ADHD, eating disorders and addiction, and psychological fields, the medical field and more recently some work are beginning to emerge on FASD. Mindfulness practices have predominantly been researched in the adult population, only over the last ten years have some researchers been engaged in the study of the beneficial effects of mindfulness on the youth’s health and well-being, and this area needs further development. Mindfulness research is promising. The evidence of mindfulness practice among
young people indicates improved benefits in attention and concentration, stress alleviation, self-regulation, improved memory, self-understanding, behavioural and emotional maturity, and self-confidence in everyday life.

What is still needed is a set of recommendations on how to introduce mindfulness practices to young people’s lives, based on a cultural perspective on child development, and cognitive diversity. Further, the pedagogy of mindfulness needs to be context specific and adjusted to the specific audiences of practitioners. Clinicians in the addiction and mental health field who work with youth with FASD need training on how to effectively incorporate aspects of mindfulness to their practice. Moreover, I believe that mindfulness practices need to be based on the needs of young people with FASD and everyday lives, with a fun and creative approach.

Decades of research have recognized that individuals with FASD have distinct processing Problems. When talking about mindfulness, the ideas about self-awareness, self-control, and attention may perpetuate the belief that it cannot be done with an individual with FASD since it in direct conflict with what the research evidence indicate that is difficult for a person with FASD.

However, my work with young people with FASD suggests that mindfulness has efficacy for young people with FASD.

The beauty of mindfulness is that its benefits are available to diverse populations. For youth with FASD mindfulness practices, for example, yoga can create a framework for total body movement and relaxation. Youth with FASD can also greatly benefit from mindfulness as the practice allows for self-study and self-care. In my practice, I have observed that youth with FASD who engage in the practice of mindfulness have improved on-task time and attention, as well as reduced symptoms of anxiety.

Mindfulness practices work by engaging the whole body and mind, providing activities that incorporate learning styles such as visual, kinesthetic, musical, intuitive, and naturalist (the awareness of one’s personal environment and interaction with nature). By providing young people with FASD
with inner resources—such as calming, centering, and self-acceptance—mindfulness practice such as yoga or guided meditation helps them feel connected and whole.

Young people with FASD can actively participate in their development process. They interact with everyday life situations with worldviews that could be different from those of others. As such they have the capacity to function as an agency for their own well-being. My work with young people suggests that mindfulness is an effective, and perhaps underused strategy working with young people with FASD. It has potential as a tool for young people with FASD to deal with stress and regulate themselves. It provides training of mind and body to bring emotional balance. I argue that young people with FASD need such tools to listen inward to their bodies, feelings, and ideas. Mindfulness practices may assist them in developing in sound ways, to strengthen themselves and this is why I have developed the MIRTS model.
Chapter 3: Theory

Young people with FASD share many of the same needs of youth without FASD but face additional disadvantage due to their cognitive disabilities. For this reason, young people with FASD need to be viewed holistically. This recognition has resulted in the development of a more comprehensive curriculum. The frameworks to be used in the curriculum have been selected to best reflect the realities and experiences of young people with FASD.

This dissertation has been informed and enriched by using an interdisciplinary approach. However, this work rests primarily on a philosophical foundation of mindfulness, resilience, trauma and social pedagogy theory. The chapters in the curriculum draw on these four approaches to inform the methods used to produce knowledge during the multiple stages of the research. The frameworks stress the importance of relationships, awareness, identity and personhood and viewing young people with FASD as holistic beings. Several internal developmental assets, planning and decision making, self-esteem, positive view of personal future, and personal resilience are characterized by both individual factors and relational factors, and this integrative framework will allow me to address those issues.

3.1. Theoretical Underpinnings of the Curriculum

3.1.1. Mindfulness

Mindfulness-based interventions are increasingly being adopted to treat an array of subgroups as interest in the application of mindfulness training in psychotherapy and intervention has grown over the last two decades. Examination of the literature (for e.g., Baer, 2003a; Cayoun, 2011; Dimidjian & Linehan, 2003) indicates that there is significant interest in mindfulness, and its use in psychotherapy and substance use treatment interventions. Indeed, mindfulness has been referred to as a potentially effective coping technique for negative affect (Arch & Craske, 2006; Feldman, Hayes,
Mindfulness has its roots in Buddhist teachings. It can be described quite simply as moment-to-moment awareness. Kabat-Zinn (1994, p. 4) defines mindfulness as “paying attention in a particular way: on purpose, in the present moment, and nonjudgmentally”. Bishop et al. (2004) note that mindfulness is used as a mean to increase awareness and to facilitate a considered response to mental processes that may contribute to dysfunctional emotions and maladaptive behaviour. Similarly, Cayoun (2011) stated that “as a mental state, mindfulness is experienced as a heightened sensory awareness of the present moment, free from judgment, reactivity and identification to the experience. He noted that as a training, mindfulness requires a deliberate sustained attentional focus on sensory processes with unconditional acceptance of the sensory experience”.

Practicing mindfulness is to completely “own” each moment of one’s experience, no matter good or bad, and to do so with non-judgmental acceptance. Mindfulness approaches encourage individuals to step out of the struggles with their thoughts and feelings and give up ineffective avoidance strategies. The general orientation of mindfulness approaches is on helping clients to stay in contact with private experiences so that they can behave more effectively. Since mindfulness practice requires one to observe his/her present experience rather than respond to it; it, therefore, seems like it might be useful in facilitating impulse control. By definition it is opposite to avoiding one’s emotional experience, which the literature suggests is largely ineffective. Moreover, by simply asking young people with FASD to pay attention to their present experience without judgment, it does not require them to try to alter their experience in any specific manner, such as by applying cognitive control processes, which has also been shown to be challenging when experiencing negative affect. Therefore, mindfulness does appear to have the requisite components for a truly effective coping tool for negative affect for the recovering alcoholic population.
**Theories of Self-Awareness.** According to Sedikides and Strube (1997), the ability to evaluate one's self is an essential part of recognizing parts in the self that can be improved. If self-awareness is low, the relationship between the self and internal standards is inconsistent and therefore, internal standards become unclear and disrupted. Attention has to be put on the self to be able to make connections. If a person is unaware, then any unbalance between the self and internal standards will be ignored and have no affective and motivational consequences to the self that would encourage self-improvement or change in behaviour (Sedikides & Strube, 1997). So by being self-aware young people with FASD can start analyzing the cause of their behaviour, and thus, will be more able to modify their behaviour and therefore, themselves hopefully in a positive way (self-improvement).

As a result of the range of challenges and given the life circumstances of many young people with FASD, most clinicians may be inclined to challenge the notion that a young person with FASD can benefit from mindfulness and may have difficulty with self-awareness. However, through the practice of teaching a young person to refrain from judging what he/she thinks or feels, I have been able to help my clients learn that their thoughts are not necessarily the reality or the truth. For example, when clients are feeling afraid or experiencing intense level of anxiety, I have been successful in using guided breathing strategies to help them calm down and realize that it does not necessarily mean that danger is forthcoming, and thinking things like ‘I am not good enough’ does not make it true.

Moreover, young people with FASD are cable of practicing self-management by sitting and attending their thoughts—becoming aware of what they are thinking. For example, a young person who is experiencing anxiety can sit and become aware of what they are worrying about, without the pressure to change. Those who use substances know their urges, as well as the desire for substances, or fix that will facilitate avoidance. By sitting and talking about what’s happening at the moment, the
urges emerge; the triggers and stressors tend to come into awareness and discussion, and this helps in facilitating more active problem solving.

The fact that young people with FASD appear to be slower thinkers or concrete thinker may also serve as an advantage as they seem to be able to think about one thing at a time. A major component of mindfulness is the calming of the mind and being in the present moment. In my practice experience, young people with FASD are capable of doing that. Moreover, the difficulty with generalization that is often noted in young people with FASD can further serve as an advantage to prevent rumination and other stresses. Thus, the dissertation and MIRTS is looking to bridge the gap to assist clinicians to give the opportunity to realize the benefits of mindfulness.

The most extensive treatments of the role of attention in day-to-day life come from theories of self-awareness represented within the work of Buss (1980); Carver and Scheier (1998); Duval and Silvia (2002); Duval and Wicklund (1972); Aronson, Wilson, & Akert, (2012) and others describing various forms of reflexive consciousness, which connotes taking oneself or one’s experiences as an object of attention. Self-awareness theory is the “idea that when people focus their attention on themselves, they evaluate and compare their behaviour to their internal standards and values” (Aronson et al., 2012).

The conceptualization of mindfulness outlined already shares both similarities and differences with discussions of attention in these self-awareness theories along three dimensions: strength, direction, and quality or kind of attention deployed. Attentional strength varies widely, from its virtual absence, as in daydreaming, to acutely active alertness, and there is general agreement that a sufficient degree of attention is necessary for effective self-regulation to occur. People need to be attentive to their inner states and behaviour to pursue reflectively considered goals, and failing to bring sufficient attention to oneself tends to foster habitual, overlearned, or automatized reactions rather than responses that are self-endorsed and situationally appropriate. Effective functioning demands that attention is directed towards both inner and outer events, but there is also scholarly
agreement that directing attention to subjective mental, emotional, and physical experience is key to healthy self-regulation.

Mindful awareness and attention serve a monitoring or observer function. The mindful mode of processing simply offers a “bare display of what is taking place,” rather than generating “accounts of semantic, syntactic or other cognitive functions” (Shear & Jevning, 1999, p. 204). As a form of data-driven processing, direct, receptive contact with inner and outer stimuli is predominant. Here, accuracy in the present is more important than direction toward future goals (Kunda, 1990). The effect of such processing is the introduction of a mental gap between attention and its objects, including self-relevant contents of consciousness. This de-coupling of consciousness and mental content, variously called decentering, disidentification, and de-embedding, among other terms, means that self-regulation is more clearly driven by awareness itself, rather than by self-relevant cognition (Martin, 1997).

3.1.2. Resilience

During the past two decades, increased research attention has been directed toward understanding fetal alcohol spectrum disorder (FASD). More recently, however, researchers and clinicians are increasingly becoming interested in understanding the neurobehavioural outcomes of children and adolescents with FASD. There is a growing body of literature showing that young people with FASD display a range of cognitive diversity and behavioural challenges, which suggest that there is potential for vulnerability in young people with FASD that may strain their capacity to accomplish normal developmental tasks, cope with life (personal, family, generational, community and cultural) challenges, or cope with the experience of having FASD (Kelly, Day, & Streissguth, 2000; Kodituwakku, 2007; Kodituwakku, 2009; Mattson & Riley, 1998; Riley et al., 2003; Spohr, Willms, & Steinhausen, 2007; Steinhausen & Spohr, 1998; Streissguth et al., 1991; Streissguth et al., 1997; Streissguth, Bookstein, Barr, Press, & Sampson, 1998). Service providers quite often find it
difficult to understand the responses, or reactions of a young person with an FASD diagnosis, or a young person suspected of having FASD. This is partly because historically the majority of adolescent developmental theories focused on the ‘healthy’ or typically developing adolescent. Further, the deficit model, for the most part, seems to have underpinned the thinking of professionals, policy and service providers, who have focused predominantly on treating problems presented by youths with FASD. The failures of many young people with FASD have overshadowed the success of others who have experienced successful outcomes. More recently, researchers and professionals have recognized the need to shift from a deficit-centered model to a more optimistic one that is focused on strength, coping, competence, adjustment, and goodness-of-fit, or adaptation when working with these young people. Although this general point has been raised, it is not yet typically reflected in the research on youths with FASD, or the service and support they receive. There has been little investigation assessing resilience among young people with FASD. I think resilience is an important construct as it not only identifies how young people with FASD and their families cope despite challenges but also how opportunities for growth and capacity building are promoted. Masten and O'Connor (1989) eloquently pointed out that resilience and maladaptations are “different parts of the same story” (p.248); in this sense, the construct of resilience in this model focuses on enhancing strengths as oppose to undoing deficits.

Many young people with FASD encounter multiple risk factors before coming into contact with addiction services, or other social services systems. Youths with FASD are a heterogeneous group with varying levels of risk factors and outcomes across the continuum. Thus, one means of nurturing their growth and building their competencies, as well as understanding such diverse outcomes, I believe, is to examine processes through which particular protective factors can interact with other variables to predict adaptive or maladaptive outcomes. In this sense, effective substance use treatment begins with identifying the young person’s strength or protective factors and using this as a building block for growth and development.
To me, one important objective of substance use treatment component should be to build some protective factors (for example, skill & information acquisition, education, emotional and social capital) with the aim of inculcating resilience. Resilience as a component of this treatment model is particularly relevant for young people with FASD, who use drug and/or alcohol as a coping strategy to deal with their complex life challenges and/or unmet needs. For example, one young lady once indicated to me that she drinks because it helps her to forget her pains and the fact that everything around her is falling apart. Strengthening the capacity for resilience in young people with FASD will likely reduce or remove the need for them to rely on substance use as a coping mechanism. The idea is to enable young people with FASD to develop a sense of agency and mastery—gain as much control as possible over their well-being and in particular, their substance misuse, and manage their risk. The hope is that clinicians will be able to establish a range of sustainable alternatives to drugs and alcohol use as a way of meeting needs and coping with life’s challenges. In this way, the agency of each young person is recognized and respected, maximizing their likelihood of engagement and minimizing their potential for resistance (Mitchell, 2012). A young person’s capacity to be resilient can be protected by altering exposure to risk, managing risk, influencing the experience of risk, averting chain reactions of negative experience and fostering healthy adaptation and growth.

**Social-Ecological Perspectives on Resilience.** Social-ecological perspectives assist in understanding the complex set of interrelationships between the developing human being and the multiple settings and contexts in which he/she is embedded (Lounsbury & Mitchell, 2009). A social, ecological perspective of resilience recognizes the fact that resilience is too complex to be understood adequately from single levels of analysis and, instead, requires more comprehensive approaches that integrate psychological, organizational, cultural, community, family, and regulatory perspectives. There is attention to the social, institutional, and cultural contexts of people-environment relations, as well as human ecology's emphasis on biologic processes and the
geographic environment in which they occur. The emphasis on people—environment relationships with cultural, institutional, and social components is reflected in the core principles of the social ecology paradigm: multiple dimensional, dynamic interplay, and interdependence of environmental conditions.

To Bronfenbrenner, the environment is an interactive set of systems that are nested within one another. The interactions between the various spheres of influence are important because they shape the environmental context that either fosters or inhibits resilience. Bronfenbrenner posited that people develop positive and negative behaviour through their interactions, both direct and indirect with these systems (Bronfenbrenner, 1977; Bronfenbrenner, 1979). The levels of systems that Bronfenbrenner discussed include a microsystem (which consists of individuals’ interactions with the immediate environment such as interpersonal relationships and interactions, and the physical setting). The mesosystem (which involves connections among microsystems such as family, school, and neighbourhood). The exosystem (which consists of settings that do not contain the individual directly—social and political agencies and economic structures, yet still affect them); the macrosystem (broader systems of values, laws, customs, and resources); and the chronosystem (systems and markers of time, such as life transitions) (Bronfenbrenner, 1979; Bronfenbrenner & Morris, 2006).

Resilience, like development, is said to arise from processes of interaction across multiple levels of functioning (e.g., from genes to neural systems to relationships to individual media interaction) (Masten & Obradovic, 2007). In addition, this model emphasizes the mutual influences of systems and reciprocity of transactions such as bi-directional relations between individuals and the environment. Thus, the congruence and fit between individuals and the environment are regarded as the important predictor of human well-being and coping (Bronfenbrenner, 2008; Lerner, 2006; Ungar, 2011b, 2012). For instance, exposure to family dysfunction such as parental substance use or living with a developmental disability such as FASD
may influence a youth’s mental health and consequently their coping and adjustment. Thus, a youth’s resilience may be influenced by the reciprocal actions of the five levels of interrelated systems.

Bronfenbrenner later reformulated his original model to attend to a bio-ecological approach to the study of lives. Bronfenbrenner & Ceci, (1994); Bronfenbrenner & Ceci, (2004) propose empirically testable basic mechanisms called proximal processes through which the gene-environmental potential for effective psychological functioning is realized. These proximal processes, they believed, lead to particular developmental outcomes, including controlling one’s behaviour, coping successfully with stress, acquiring knowledge and skill, establishing mutually satisfying relationships and modifying one’s physical, social and symbolic environment.

Bronfenbrenner’s model predicts systematic variation in the extent of such outcomes as a result of the interplay between proximal processes, their stability over time, the contexts in which they take place, the characteristics of the persons involved, and the nature of the outcome under consideration (Bronfenbrenner, 2005; Bronfenbrenner & Morris, 2006).

The quality of relationship a youth has with his/her caregiver can be cited as an example of a proximal process variable. For example, Werner (2000) found that affectional ties that encourage trust, autonomy and initiative provided by stable caregivers were a common characteristic among resilient children. Moreover, the presence of a supportive and stable caregiver has been identified as one of the most important factors that distinguishes abused individuals with good developmental outcomes from those with more deleterious outcomes (Houshyar & Kaufman, 2005; Kendall-Tackett, Williams, & Finkelhor, 1993).

Parallel to Bronfenbrenner, Ungar (2011b) noted that resilience is a quality of a child’s social and physical ecology; he posits that these dual ecologies provide a context in which an individual can realize resilience. Positive outcomes are mostly the result of facilitative environments that provide children with the potential to do well. To elaborate this social-ecological understanding of resilience,
Ungar proposed four principles to help better define and operationalize resilience: decentrality, complexity, atypicality, and cultural relativity. Combined, these four principles he asserts, contribute to an understanding of resilience as facilitated growth amid environmental variability where adversity has been experienced (Ungar, 2011b).

In describing his principle of decentrality, Ungar emphasized that resilience should not be explained solely by an individual trait, but how the environment facilitates it. In this sense, Ungar contends that the responsibility for resilience will not be wrongly placed on, for example, victims of toxic environments, with change hypothesized as a measure of how well the child is individually able to take advantage of environmental resources. According to Ungar, by decentering the child, it becomes much clearer that, when growing up under adversity, the locus of change does not reside in either the child or the environment alone, but in the processes by which environments provide resources for use by the child. By extension, the youth’s individual resources (e.g., a sense of humour, optimism, above average IQ, or musical talents) are only as good as the capacity of his or her social and physical ecologies that facilitate their expression and application to developmental tasks.

According to Walsh (2006), organizational processes refine relationships and regulate family behaviour. For [youth] to function healthily and be resilient, there must be flexibility and commitment through collaborative support. Without a developed position of human agency, questions can be raised as to whether his model can take forward models of empowerment and active citizenship which are so necessary in a current environment beset by social injustice, political wars, racism and discrimination and social exclusion. What are we to make of youth who live in politically, religious or cultural oppressive societies? Are they not resilient? The self-determination theory (Deci & Ryan, 1985b) may elucidate our understanding of the human process of perseverance or its counterpart “giving up”.
**Attachment Theories.** Attachment theory has much to contribute to an understanding of the processes underpinning resilience. Attachment research focuses on the relationship between the youth and the caregiver, rather than the individual characteristics of either party (Ainsworth & Bowlby, 1991). Attachment perspectives are essentially models of stress and emotion regulation and how children and youth use significant persons in their lives to down-regulate negative affective state and up-regulate positive or rewarding states (Cassidy & Shaver, 1999). Masten and Coatsworth (1998) noted that “infant competence is embedded in the caregiving system” (p.208) and identify attachment as one of the fundamental developmental tasks of the early period. They identify self-regulation as the other critical task in this period, and this is closely linked to the quality of the attachment relationship. They also identified critical developmental tasks as social competence with peers, socially appropriate conduct, academic achievement, and involvement in activities and work. They conclude by identifying three crucial protective factors: caring and effective parent-child relationships, good cognitive development and self-regulation of attention, emotion and behaviour. Security of attachment and internal working models influence all of these aspects of development.

Schore (2001) emphasizes the link between attachment and the development of self-regulation. He maintains that exposure to the primary caregiver’s regulatory capacities facilitate the infant’s adaptive ability. Schore argues that when severe difficulties arise in the attachment relationship, the brain becomes inefficient in regulating affective states and coping with stress and that this engenders maladaptive infant health. Stress arises with asynchrony between caregiver and youth and sustained stress compromises development (Schore, 2001). Stroufe (2005) adds yet another dimension, arguing that disturbances in an early parent-child relationship (reflected in such things as child abuse & neglect) contribute to an increased risk of developing internalizing and externalizing disorders and in consequence, their capacity for resilience functioning.

In Ainsworth’s categories of attachment, the secure pattern provides the context for optimal development. The consistent, sensitive responsiveness of the primary attachment figure facilitates
the development of an internal working model in which the self is perceived as worthy, others are perceived to be reliable and available, and the environment is experienced as challenging but manageable with support. The attachment figure provides a stable base that facilitates the exploration of the environment so crucial to early brain development. When faced with threat a youth can respond with both affect and cognition to elicit a supportive and timely response. Neural integration is promoted, allowing flexible and complex networks to develop. The youth achieves balance, and mastery is the primary strategy when confronted with new situations. The secure youth acquires an understanding of the mind and the capacity to reflect on the internal state of self and others. Thus, adolescents with a history of secure attachment will present as confident, outgoing, and able to access support when necessary. In contrast, avoidant adolescents will present as sullen and withdrawn with intermittent outbursts of rage. Peer relationships tend to be superficial, and aggressive behaviour may be triggered in close relationships because experience has taught them that you cannot trust others, especially those close to you (Ainsworth, 1979; Allen & Land, 1999).

Research indicates that significant problems in childhood and later life are most frequently linked with patterns of insecure attachment. By adolescence, significantly increased rates of psychopathology and violent crime has been found in longitudinal studies of children classified as disorganized in infancy (Carlson, 1998; Lyons-Ruth, 1996; Rosenstein & Horowitz, 1996; Van Ijzendoorn, 1997). Consequently, implications for resilience are clear. A secure internal working model encompasses all of the factors that can likely contribute to resilience. On the other hand, while the avoidant and ambivalent patterns are adaptive and demonstrate a degree of resilience in less than optimal circumstances, allowing children to manage relationships and emotions. Those children with a disorganized attachment are the most vulnerable, lacking a coherent strategy for managing relationships, feelings or experience, transitional period, adolescents’ success is partly dependent on the strength of their perceived self-efficacy (Bandura, Pastorelli, Barbaranelli, & Caprara, 1999).
Attachment can help us understand mechanisms through which babies grow up to be resilience youth and the challenge of those who have not had this secure attachment early in life. However, theories of attachment also suggest that one can learn to develop new and better attachment patterns later in life. Through relationship-based approaches to working with a young person with FASD the potential is there to assist youth with FASD to develop those healthier attachment patterns and expectations to get them to a point where they can form secure attachments, so that they can, according to attachment theory go on to become healthier people, as well as enhance their resilience capacity. The attachment theory is informing MIRTS. The curriculum supports the intentional support of healthy attachment and relationship between clients and clinicians, which is important. The attachment and healthy engagement that is developed by the client can be used by the client as he/she go forward into his/her relationships.

Because the research has suggested that young people with FASD have difficulty in forming meaningful relationships and that they can sometimes display avoidant and ambivalent patterns of attachment, one may wish to deduce that the relational component of resilience seems impossible when working with young people with FASD. Further, many feminists criticize attachment theory for its potential to blame mothers and regard it as an apolitical and decontextualized theory of personality and parenting (Allan, 2004). Similarly, attachment theory has been criticized for its lack of attention to cultural differences concerning family and couple dynamics (Johnson, 2002). Situating attachment theory within systemic practice requires examination of the social, environmental, cultural and political context besides individual intrapsychic development or parenting styles.

Despite its shortcomings, attachment theory is well positioned to serve as a foundation for assimilative psychotherapy integration. It has an exceptionally strong empirical base and provides a life-span developmental framework often absent in current treatment models. Attachment theory focuses on the need for proximity to a sensitive caregiver in childhood who offers a sense of security
and a safe base from which to explore. Affect regulation and relational behaviour in later life are significantly affected by the vicissitudes of attachment relationships, with significant implications for psychopathology and psychotherapy. Consequently, attachment theory can help bridge the current gap between young people with FASD and practitioners because it underscores the centrality of relationship in the therapeutic process.

Part of what I want to do here is help aid the development of those healthy attachment patterns that are suggested to be valuable in promoting resilience. The curriculum acknowledges that avoidant and ambivalent patterns of attachment as something that may be informing a youth’s engagement and, therefore, something that requires some attention as an area of growth. Helping young people with FASD establish secure attachment is a worthwhile endeavor. A clinician can have an influential role in the behaviour patterns of an individual over time and can, therefore, impact the later attachment process.

**Conceptualizing Resilience.** Resilience in this treatment model will be conceptualized through a biopsychosocial-spiritual (BPSS) orientation, drawing on substantial evidence to identify a range of resources and assets that are demonstrated to foster both resilience and healthy development. This will provide a framework for young people with FASD to learn how to locate relevant resources and assets and develop the knowledge and skills to apply them in order to meet their needs and achieve their goals. As clinician we should focus on helping our clients and their families use their strengths and capacities to achieve enhanced resilience. Service providers and clinicians should, therefore, seek to build on a young person’s strength, and maximize the possibility that relevant resources and assets are available and accessible for young people through understanding their culture and working with families and communities (Masten, 2009; Ungar, 2011).

This approach highlights critical areas to be alleviated; however, we have largely neglected strengths (e.g., acceptance, optimism) or resilient capacities that can be fostered in young people with FASD to optimize living with FASD. Using a BPSS conceptualization, I propose a cross-
cutting definition of resilience for FASD-informed care that expands on the previous definitions of Masten (2001) and Ungar (2011) with the varied components of resilience reflected in their definition, which I hope can serve as a foundation for ongoing work in the FASD field. In the context of FASD and substance use treatment, resilience is conceptualized as nurturing growth, working collaboratively and creatively to advance the skills of young people with FASD by building on their strengths and early learning, and scaffolding new learning. It is helping young people with FASD understand, negotiate and navigate resources. It is also about developing their coping resources, building their capacity to self-regulate and manage change, reinforcing & sustaining positive behaviours and relationships, validating their concerns and feelings, and providing opportunities for them to thrive and become contributors to society. Further, resilience also encompasses their personal resources, effective responding, and intentionality that protects them from life challenges and results in wellbeing. Young people with FASD with enhanced resilience capacities will demonstrate better social, emotional, behavioral, or health outcomes that reflect a healthy sense of being, belonging and becoming.

Thus, this component of the MIRTS model is focused on recognizing the strengths of young people with FASD, and creating the condition, or space that facilitates, nurtures and supports the development of competencies (physical, emotional, social, cultural & spiritual). One important objective of substance use treatment components should be to build some protective factors (for example, skill and information acquisition, education, emotional and social capital) with the aim of inculcating resilience. Resilience as a component in this treatment model is particularly relevant to young people with FASD who use drugs and/or alcohol as a way of coping with complex life challenges. Building on a young person’s capacity for resilience will likely reduce, or remove the need for him/her to rely on drugs and/or alcohol to cope. The idea is to enable young people with FASD to develop a sense of agency and mastery, and gain as much control as possible over their own well-being and, in particular, their drug and alcohol use.
When a young person is confident he/she will be more open to being aware of what he/she is good at, as well as, cope better with unexpected changes and adversities (e.g., moving homes or family disruptions)

consequently, creating positive life cycles for themselves. Essential to the fostering of resilience is a secure base where the young person with FASD feels a sense of belonging, good self-esteem and a sense of self-efficacy. The Resilience component aims to promote at least one secure attachment, to cultivate a safe environment and provide young people with FASD with a range of emotional and social supports. It also seeks to develop self-esteem by fostering a young person’s talents and interests.

3.1.3. Trauma

Many young people with FASD have experienced traumatic events in their lives, due to exposure to psychological or physical abuse, neglect, and dislocation. The relationship between FASD, interpersonal violence/trauma and substance use disorders is significant and complex. Although the exact prevalence of physical and sexual abuse among young people with FASD in substance use treatment program is not known, anecdotal reports suggest that a large number of young people with FASD experience trauma. McLachlan et al. (2013) identified complex histories of trauma as a barrier to effective substance use treatment in justice-involved youth with FASD. It is acknowledged that workers often struggle to address the needs of clients with FASD and/or histories of abuse within the context of alcohol and drug treatment.

There is a critical need to address trauma as part of drug and alcohol addiction treatment, unidentified trauma-related symptoms co-occurring with FASD complicates a young person’s treatment experience. From my practice experience, it would appear that these young people are less engaged in treatment, drop out early, and seem to be more likely to relapse. In the general public, research has also suggest that misdiagnosed trauma-related symptoms interfere with help seeking,
hamper engagement in treatment, lead to early dropout, and make relapse more likely (Brown, Read, & Kahler, 2003; Najavits et al., 2003).

There are a plethora of conceptual and empirical findings that can be used to explain the impact of trauma on the functioning, health, and well-being of young people with FASD. Multiple theories help to explain how contextual risk and traumatic experiences impact the individuals, dyads, and groups within families. Common theories used to explain the complex mechanisms and mediators that impede or support a young person with FASD processes in the face of trauma.

**Trauma Theory.** Trauma theory provides the scaffold to understand and unravel the intrusive re-experiencing, avoidance and physiological hyper-arousal that many victims of abuse experience as flashbacks, panic attacks, volatility, or flat affect. By focusing on neurophysiology within a broader counselling framework, trauma theory, offers the most powerful explanation of why the victim of abuse struggle to get over it (Mataskis, 1996). Psycho-education with young people with FASD about the impact of traumas can shed light on some ways they have suffered because of the abuse/trauma, often leading to greater compassion for themselves and each other. Young people with FASD, who have shared knowledge and understanding between them about impacts of, for example, child sexual abuse, such as flashbacks or panic attacks, are much more equipped to deal with these stressors.

Although trauma theory enables the clinician to address the symptoms of individuals, it has been criticized for decontextualizing people’s trauma responses and focusing on symptoms (Briere & Scott, 2012; Courtois, 1999; Herman, 1992). Therapists who draw on feminist theories beside trauma concepts need to find non-reductionist ways of using trauma theories, including awareness about bio-physiological and neurological trauma responses. Feminist practitioners often focus on normalizing coping mechanisms and recognizing skills in surviving overwhelming experiences.
**Intergenerational Transmission of Trauma.** One potential explanation for the vulnerability of young people with FASD with a trauma history is the theory of intergenerational transmission of trauma, which hypothesizes that trauma and its impact will be passed between generations. Posttraumatic stress disorder symptoms may negatively affect a trauma survivor’s ability to maintain relationships with family members. The research in this area suggests that traumatized adults may be emotionally or functionally (or both) unavailable for their infant, increasing the likelihood of enhanced symptomatology within the child (Walker, 1999). Parents with a trauma history may “pass on” their trauma symptoms or reactions to their children, either through the children’s direct exposure to the parents’ symptoms or the parents’ potentially traumatizing (e.g., abusive) behaviour. Additionally, depression, anxiety, psychosomatic problems, aggression, guilt, and related issues may be common in the children of trauma survivors (Felsen, 1998). These findings suggest the complexity of understanding the effects of trauma that may impact family members across generations. The phenomenon of intergenerational transmission of trauma during infancy has been well documented in clinical reports within the infant mental health field.

Fraiberg, Adelson, and Shapiro (1975) groundbreaking work, Ghosts in the Nursery, described how past traumatic experiences may compromise a parent’s ability to offer adequate physical and emotional caregiving. Fraiberg and colleagues suggested that specific vulnerabilities, such as the trauma of domestic violence or abandonment, may limit a mother’s ability to understand and respond sensitively to her infant, resulting in the repetition of her painful past. Disturbances in the caregiver–child relationship has been associated with the maternal perception of the “child-as-threat” (Schechter et al., 2004, p. 321). This may be related to the frightened and frightening behaviours that may often be exhibited by the traumatized caregiver (Iyengar, Kim, Martinez, Fonagy, & Strathearn, 2014; Lyons-Ruth & Block, 1996; Schechter, Brunelli, Cunningham, Brown, & Baca, 2002; Steele, Steele, & Fonagy, 1996).
Understanding of intergenerational trauma is useful, as many young people with FASD have a history of generational trauma and an understanding of how these processes function and impact their development is vital. Parents whom themselves have experienced complex and/or multiple trauma are not always able to support their child’s emotional and social development. They are also not able to manage resources and stressful life event; and as such, young people exposed to this environment are likely to experience trauma that is likely to be un-noticed.

3.1.4. Social Pedagogy

A surge in knowledge development and advances in mental health and substance use service delivery have taken place in BC over the last decade and have placed a priority on evidence-based practice. However, considerable skill is needed to manage the most challenging health care scenarios, and thoughtful comportment is vital for successful intervention. Innovative approaches must be incorporated to help address population needs.

It has been contended that interpretive methods, like social pedagogy, promote a kind of thinking that prepares practitioners to use evidence thoughtfully and to develop skills necessary for working with diverse sub-groups. Cannan, Berry, and Lyons (1992) defined social pedagogy as a perspective which aims to promote human welfare; and to prevent or ease social problems by providing people with the means to manage their lives and make changes in their circumstances (p73). Social pedagogy in practice is a holistic and personal approach to caring for young people – this approach suggests that young people should be understood holistically. It provides the possibility to engage in physical and mental health, in relationships, in living conditions, in the young person’s school situation, in what goes on within the family and also in the community and the promotion of children’s rights. Social pedagogy has its roots in Europe, and the framework has been implemented in a extensive range of services, including the early years, schools, residential care,
family support and youth work, disability services, and in some countries support for older people (Children in Scotland, 2008; Connelly & Milligan, 2012; Kornbeck, 2009; Storo, 2012).

According to Cameron and Moss (2011), social pedagogy emphasizes reflective practice, and promotes the idea of workers seeking to understand the child’s worldview. They noted that ‘the diamond model of social pedagogy provides a simplified conceptual framework outlining the conceptual foundations, their relevance, and interconnectedness—well-being, learning, relationship and empowerment.

Similarly, Boddy et al. (2005) supported social pedagogy as a basis for workforce reform in England because it can provide a strong foundation for an approach to young people that embodies ideals of active citizenship, rights and participation, and working with the whole child and his or her family. The CPEA Associates (2007) emphasized this when examining the positive aspects of social pedagogic practice:

- It provides a holistic approach to working with children and young people – focusing on the ‘whole child/young person’ and support for their overall development;
- It emphasizes relationship building with children and young people including the development of practical skills to facilitate this;
- It focuses on children and young people’s development and, in particular, on their emotional health and well-being;
- It highlights the importance of reflection and the ability to bring both theoretical understanding and self-knowledge to the process of working with young people;
- It promotes children’s rights, participation, and empowerment;
- It shows the importance of team working and valuing the contributions of other people including families, communities and other professionals.

Research evidence found that young people in residential care in two other European countries had a better quality of life and outcomes and that in these countries social pedagogy
provided the dominant framework for policy, training and practice (Petrie, Boddy, Cameron, Wigfall, & Simon, 2006). An evaluation conducted by the National Centre for Excellence in Residential Child Care in England also reported successful outcome by both practitioners and young people (Bengtsson, Chamberlain, Crimmens, & Stanley, 2008). Since 2006, a number of pilot projects have been undertaken with the aim of introducing social pedagogy into residential childcare in the UK (Bengtsson et al., 2008; Bird & Eichsteller, 2011; Cameron, 2007).

Professionals recruited mainly from Germany and Denmark, worked with residential workers from selected residential homes in England for up to two years. Their role was to practice as residential workers but drawing on their social pedagogy training to model and explain their approach. In Scotland, the Scottish Institute for Residential Child Care (SIRCC) has promoted interest in social pedagogy and funded the delivery of a 10-day training course for groups of residential workers from a number of agencies. Evaluations of these projects and courses have been carried out, and indications are these have been successful. Participants report the biggest impact of this project was either a reconfirmation or gaining of new perspectives on how to meet the needs of young people in residential care without having to discard the knowledge and experience they had already built up. As one participant put it ‘over the years, ‘the head’ for example, staff policies, risk assessments, children coming in as the last resort, has dominated how I perceive and work with the young people. I have rediscovered ‘the heart’ and can see working with these young people with a renewed perspective’ (Bengtsson et al., 2008, pp. 3-4).

One Scottish evaluation was based on the views of a group of staff from a large voluntary organization, which undertook the training. The evaluation used questionnaires and interviews to explore participants’ opinions. All 16 of the participants gave the training the highest score on a 5-point scale (the training was ‘very useful, highly relevant’). This was a staff group, which included staff with varied levels of qualifications from none (foster-parent) to social work degrees (residential
unit managers). They all reported new learning although for some this amounted to new ways of thinking about existing practice.

Some of the proponents of social pedagogy within the UK have also proposed the notion of developing ‘risk competence,’ rather than ‘risk-assessment’ in work with children and young people (Eichsteller & Holthoff, 2009, 2011, 2012). This approach locates the appropriate management of risk within a wider frame of the developing child and their rights to learn and participate. Because they are driven primarily by their responsibility to promote children’s development, the worker is more likely to understand that just as you cannot learn to roller-skate without falling a few times, so children need to learn how to fall, not to avoid it altogether. This provides a positive model, or basis for practice, which replaces the rather limited and unreflective idea of ‘service and support.’

3.2. Implication for FASD Intervention

Young people with FASD are noted as presenting a complex clinical, social and behavioural picture. Young people with FASD, like those without FASD, quite often have stressful life circumstances - internal or external conditions that trigger the perception of distress. They face similar, but also different challenges from their peers as having FASD have the potential to add a different dynamic or what some may consider a layer of complexity to a situation. In essence, they are likely to have specific needs and perspectives connected to their developmental and social context and to their experiences of having FASD. These young people often face stigmatization; bullying and they are apt to experience social isolation, relational challenges, anxiety, depression, and other mental health challenges. Our service system does not always adequately take account of the specific strengths, needs, context, nor the FASD specific stressors that young people who are living with FASD experience.

Thus, when distress is not managed effectively, this has the potential to disrupt the functioning of youth with FASD. As such young people with FASD are likely to develop
maladaptive response patterns, taking the form of avoidance of, or over engagement with the distressing situation to reduce distress. For example, a young person with FASD may seek to numb feelings of family disconnection by engaging in risky behaviour (e.g., drug or alcohol use). Distress is temporarily lessened, and the maladaptive behaviour is reinforced, strengthening dysfunctional patterns. Maladaptive behaviours provide momentary relief (positive reinforcement) and serve to permit escape from emotional pain.

Hence, practicing mindfulness technique may restore balance when strong emotions arise by increasing metacognitive awareness of mental processes that contribute to emotion dysregulation. Mindfulness practice offers the opportunity to develop resilience in the face of uncomfortable feelings that otherwise might provoke a behavioural response that may be harmful to self and others. Furthermore, mindfulness practice strengthens attention by repeatedly orienting attention to a particular object of focus while consciously letting go of distractions.

Through mindfulness practice, automatic processes may come under more conscious control, fostering reflective decision making and reducing impulsive reactions. The practice of orienting to experience with curiosity, patience, and non-judgment strengthens tolerance for distress and may reduce the youth’s tendency to over-appraise threat, providing a potential protective factor against stressors. There are indications that mindfulness may also enhance self-management, problem-solving skills, attention and focus and the development of those with brain areas whose maturation have been impacted by childhood trauma that directly impact delinquent and other risk-taking behaviours. This possibility is particularly important with youth with FASD and whose risk-taking behaviour can sometimes result in incarceration in the juvenile justice system. Everybody has learning style preferences. Mindfulness has demonstrated efficacy with diverse groups. It is a promising approach and may be helpful to young people with FASD who misuse substance to become more intentional about how they think and behave.
Attachment theory adds weight to resilience theory by clearly outlining the significance of relationships as the key to all aspects of resilience—culture, community, relationships, and individual. It clarifies the adaptive nature of behaviour and refines our understanding of the types of relationship experiences necessary to promote positive adaptation. The conceptual contribution from social-ecological perspectives can complement the individual and biological focus in theorizing about resilience. An implication of the social-ecological perspective is that resilience is transactional in nature, evident in qualities that are nurtured, shaped and activated by a host of person-environment interactions. Resilience is the result not only of biological and psychological traits but also of youth’s embeddedness in complex and dynamic social contexts, contexts that are, themselves more or less vulnerable to harm, more or less amenable to change, and apt focal points for intervention (Harvey, 2007; Theokas & Lerner, 2006; Williams & Lindsey, 2005).

Spiritual development has been linked with the deepening and expanding of a person’s perspectives, thus, creating a context for reframing adversity into opportunity for personal growth and learning. It is of particular importance for helping professionals to be cognizant of the possible presence and importance of spiritual beliefs in lives of youth. Spirituality provides a framework for youth to find acceptance of self and other. This can be utilized as a powerful vehicle for transference, seen as key in many relationally-based psychotherapy models, which can transform a sense of need and dependency into the inner core of personal strength (Williams & Lindsey, 2005).

It has been acknowledged in the literature that clinicians are often not trained in understanding the perspective of young people with FASD, leading to misjudge or inappropriate responses by clinicians and withdrawal or lowered adherence to treatment regimens by these young people. Young people’s adherence to treatment and self-care is complicated by many of the factors already mentioned. These can be magnified for young people from poorer backgrounds, who may have difficulties with travel and appointment-keeping and those with additional background issues, such as family conflict or break-up, chaotic home lives or abuse. The pressure of coping with these
challenges can manifest itself in avoidant behaviour by some young people, in which they isolate from service, neglect their self-care and engage in antisocial behaviours. The struggle to cope with these problems and the desire to live a ‘normal’ life can mean that young people with FASD hold different treatment goals from the service system they access.

Moreover, clinicians can be disconnected from young people’s perspectives, and communication, treatment decisions, and consent-seeking can become treatment focused at the expense of being client-focused. For example, some young people have indicated that clinicians’ responses can at times be unsympathetic to their conditions, or even arrogant in their dismissal of their knowledge, wishes and experience. This can have adverse effects on young person-clinician interactions; care outcomes, and youth satisfaction.

Social pedagogy begins from a young person’s personal and social space and respects the importance of their wider networks of peers, communities, cultures and other relationships. It aims to promote young people’s social functioning, their inclusion, participation, social identity and social competence. It raises young people’s awareness of the decisions and choices open to them, and to offer the capacity to learn to develop their agency in making their decisions and choices; and it emphasizes respect for the decisions and choices that they do make (Hämäläinen, 2003). These values are more in line with a principle of genuine and active consent.

Further, there are thus, a number of areas where young people can experience relationships with professionals as problematic. This is precisely the type of situation in which social pedagogy might achieve positive impacts. The relatively passive picture of young people ‘adherence’ and deficit-focused models of intervention can represent ‘much of what these young people strive to rebel against’. Social pedagogy, by contrast, aims to engage young people in an active manner, to promote their own participation, to raise their awareness of important issues, and to develop their own capacities and confidence to make decision.
Also, a large number of young people with FASD seem to engage in self-harming behaviours, and they usually leave substance use treatment without getting the help and support that they need to address their wider welfare and reduce the likelihood of future self-harm. Self-harm is usually initially a private activity and a part of an individual’s coping mechanisms and is apt to elicit misunderstandings and inappropriate and harmful responses from others. Young people with FASD may feel stigmatized by the responses of clinicians/professionals; they may be labelled as attention seeking or manipulative, and they may meet indifference or even punitive responses. These responses can undermine young people’s self-confidence, increase their distress and the likelihood of future harming incidents, and lead them to avoid services in the future. One strength of social pedagogy is the flexibility of approach that allows these problems to be handled sensitively. Its responses emphasize respect for young people’s personal, social and cultural contexts; it aims to work with them holistically and facilitate their personal and social development and their engagement in decisions and choices that affect their lives. In a sense, social pedagogy is learning and action-orientated, aiming to enable personal and social development for all young people as well as working with specific cases on specific needs. It is driven by a concern for the perspectives of young people themselves and a critically informed understanding of the social and institutional practices that provide a context for their experiences and perceptions. Social pedagogy also calls for professionals to be reflexive in their practice. From this viewpoint work with young people should seek to redress exclusionary and negative structural impacts on their lives, to engage them as partners in their change and learning the process, and to increase their sense of agency with respect not only to their substance use treatment, but also the wider contexts of their lives.

Transitioning from programs, as well as from care, also appears to be complex. Social pedagogy seeks to address problematic social issues. In my practice experience, social immaturity and disassociation and non-integration has been observed in young people with FASD. This has been particularly evident among aboriginal youth, whose culture and traditional social structures
have been destroyed, and the education potential of their families weakened. While mental health and addiction programs have helped some of these young people navigate their individual and social dilemmas, there is still a paucity of programs and treatments appropriate to meet the complex and changing needs that are often presented. Because treatments are not adequate many young people with FASD tend to report feeling trapped within systems that are limiting for them as the following statement from a young woman involved in substance use counselling suggests:

They assessed me, and tell me I have FASD, but no one tells me what this thing is…so now I believe I have something, and I am mad, but I do not know what it is…I’ve been diagnosed with stuff ... and that is just the way I am. I have been in foster care since I was four years old. I’ll probably be like that for the rest of my life’ (personal communication with youth).

The way I see it, our current substance use programs have the potential to ‘suppress difference’ and pathologize and wrongly idealize these young people. Youth with FASD may have some similar treatment needs as a mainstream youth, but will likely have additional needs and a more complex interplay of treatment needs. Beyond this, we also need to consider the issues surrounding treatments that address the psychological impact of poverty, but do nothing to improve the material conditions of life for young people with FASD. We have to, therefore, remember that ‘human qualities, needs, and motives are in large part the product of social development’ (Giddens, 1971, p. 226). It is perhaps for this reason that I believe that social pedagogy will play an instrumental role in enhancing programs for youth with FASD. Indeed, ineffective treatment may even reinforce the barriers these young people must struggle to overcome.

For example, creative activities like music and arts, as well as mentoring could be useful in the treatment of young people with FASD. The literature asserts the importance of relationship as the primary tool through which growing, learning, and healing activity take place. It has been noted that mentoring can reconnect marginalized youth to their families (Pawson, 2004), peer network
(Philip & Spratt, 2007) and the wider community. It also enriches the social fabric by connecting marginalized youth to reliable and responsive people (Daly & Silver, 2008; Philip & Spratt, 2007) from across status groups (Pawson, Boaz, & Sullivan, 2004), so they develop mutual understanding through discourse (Morris, 2009). These reliable and caring individuals may be able to offer these young people ‘support, counsel, friendship, reinforcement and a constructive examples to help with issues arising from day-to-day living (Rose & Doveston, 2008).

Social pedagogy can be characterized by its flexibility of approach to young people, and often works best through processes of participative engagement tailored to the needs of each presenting situation. A clinician practicing from a social pedagogical framework will provide support, advice and guidance, and communicates information in ways that young people understand and respond to. Advice and support will not be limited to just substance use issues, but concern the whole range of young people’s personal and social development. They involve young people in valued joint activities and provide an environment, in which group support and advice can be accessed (regarding self-care, addressing common or shared fears and anxieties, and so on). Social pedagogy provides a theoretical and practical framework for understanding young people with FASD. It facilitates opportunities for learning depending on where the young person is; viewing the young person as competent and a resourceful agent – A child has a 100 languages⁴. Further, social pedagogy has a particular focus on building relationships through engagement with young people using skills such as art, photography, journaling, cultural dances, and other activities. It provides a

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⁴ The child is made of one hundred. The child has a hundred languages a hundred hands a hundred thoughts a hundred ways of thinking of playing, of speaking. A hundred always a hundred ways of listening of marveling of loving a hundred joys for singing and understanding a hundred worlds to discover a hundred worlds to invent a hundred worlds to dream.” (Loris Malaguzzi, translated by Lella Gandini, cited in Edwards, Gandini & Forman, 1998, p. 3) - “In his poem on the ‘hundred languages of children’, Loris Malaguzzi expresses in just a few words a profound ethical and philosophical orientation underpinning social pedagogy. His notion conceptualizes children as competent and resourceful, as imaginative and creative, as active inventors and discoverers. In Reggio Emilia, Italy, Malaguzzi has developed an entire pedagogical approach to working in the early years based on the concept of the ‘rich child’ (Eichsteller & Holthoff, 2011)
foundation for training those working with young people and brings particular expertise in working with group and using group as support. This has fundamental implications for the relationships and interactions necessary to substance use treatment programs—respectful, compassionate listening, with solidarity to a young person’s strategies and ways of thinking.

A mindfulness, resilience, trauma-informed and social pedagogical framework, therefore, has the potential to promote better outcomes for young people with FASD. Looking at youth addiction services, a range of policy statements and initiatives has highlighted a need for more adequate services to meet the needs of diverse groups. Providing a more holistic service is vital. To this end drawing from MIRTS –combining knowledge and skills could support progress towards the ideal of more integrated services called for.
Chapter 4: Methodology

4.1. Method Overview

This chapter discusses the research process and method used to develop the MIRTS curriculum. A curriculum addressing the needs of young people with FASD should be based on a complete analysis of the existing situations; that should be interpreted according to the views, knowledge, skills, needs, interests and activities of parties concerned.

This research utilized a mixed methods and integrative approach. Most of the needs of young people with FASD relate to problems that are dynamic, complex, unique and value-laden; therefore, they cannot be solved by one approach. Complex situations require a strong and dialectical relationship between theory and practice, and research and practice. Fundamentally, I believe in clinical work grounded in research and research grounded in clinical practice. This research operates at the nexus between curriculum design research, education design research, evaluation research, intervention Mapping and Donald Schön’s idea of the reflective practitioner (Schon, 1983, 1987). Reflection-based approach is central to the project-orientation of the research.

Starting Point

I started with an exploration into the epistemic and heuristic nature of curriculum-based research, by way of preparing the ground for the questions of how to design a flexible, scalable curriculum that can evolve with change? How will the curriculum be used (for, e.g., individual, groups, etc.)? How will it fit into daily life and support social behaviour?” Some conceptual clarifications were also required. This was crucial to learning what I needed to know to develop relevant, practical and effective curriculum. Moreover, curricula can be represented in various forms; clarification of those forms was particularly helpful for me in trying to understand the task at hand.
To develop an initial blueprint for the curriculum planning and development process, a modified version of features of design research, as outlined by Wademan (2005) was utilized as a guide to structure the planning (see Figure 1). This sketch provided some direction and guideline about the curriculum development process. It has been noted that systematic intervention planning contributes to the effectiveness of intervention, by providing insight into the steps and decisions to take during the preparation, design, implementation, and evaluation of the intervention. After discussion with my dissertation supervisor, and based on the feedbacks received from her, I decided to utilize Intervention Mapping (IM) protocol to help me expound the steps outlined in figure 1 to design the curriculum and to ensure it was grounded in evidence and theory.

Intervention Mapping is a comprehensive planning tool that maps a step-wise path: from recognition of need or problem to the identification and application of a solution and it acknowledges that intervention planning is not static, but rather an iterative process (Bartholomew, parcel, Kok, Gottlieb & Fernandez, 2011; Bartholomew, Parcel, Kok & Gottlieb, 2006; Bartholomew, Parcel & Kok, 1998). While traditionally used to develop health promotion programs; IM has also been used for designing interventions, particularly complex interventions such as health treatments and behavioural treatment for young people. It has also been used for adapting an existing intervention to meet the needs of a different population. This is because such interventions require a tailored and multi-factorial approach directed at various settings and stakeholders and IM provide a structured, systematic framework within which to develop, implement and evaluate an intervention. Although I am not implementing or designing an intervention per se, but designing a curriculum that may be used for intervention purposes, IM is well suited for this process.

IM has been used to develop similar intervention tools for other health conditions such as school—based intervention to prevent obesity in children, occupational health guidelines to prevent weight gain, or to help parents manage their child’s behavioural problems.
Figure 1: Blueprint for the Curriculum Planning with Questions for Consideration

<table>
<thead>
<tr>
<th>Questions:</th>
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<th>Questions:</th>
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<tbody>
<tr>
<td>What is the identified gaps/problem in practice?</td>
<td>What are the learning &amp; behaviour targets?</td>
<td>Will the curriculum be usable, valid and relevant?</td>
</tr>
<tr>
<td>What information can be gleaned from existing data or research?</td>
<td>What principles, outcomes or strategies may be applicable?</td>
<td>Will the curriculum be accessible and efficient in delivering instruction or supporting learning?</td>
</tr>
<tr>
<td>What does existing research say about the issue?</td>
<td>What theories apply to the problem?</td>
<td>What factors will influence adoption and adaptation of the curriculum?</td>
</tr>
<tr>
<td>How are client’s needs or problem conceptualized?</td>
<td>To what extent does the design embody the theories?</td>
<td>What are the pragmatic demands of the program environment that influence adoption?</td>
</tr>
<tr>
<td>What are the systemic social, cultural and organizational influences or constraints on the curriculum design &amp; development?</td>
<td>What does FASD—-informed practice look like?</td>
<td>What type of assessments should be used?</td>
</tr>
<tr>
<td>Are there related studies that provide a rationale for this curriculum?</td>
<td>How do clinicians and agency adopt FASD—informed practice?</td>
<td>Who are the evaluation stakeholders and primary intended users and their associated organizations?</td>
</tr>
<tr>
<td>Are there programs that offer similar or complementary services?</td>
<td>What are the characteristics an effective curriculum?</td>
<td>Does the curriculum components reflect the needs of young people with FASD?</td>
</tr>
<tr>
<td>What are the characteristics of the target audience?</td>
<td>How do I align the curriculum to match clinicians and agency needs and those of young people with FASD?</td>
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<th>Methods:</th>
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<tr>
<td>Problem/situation analysis</td>
<td>Task Analysis</td>
<td>Professional usability testing</td>
</tr>
<tr>
<td>Consultation with professionals</td>
<td>Contextual analysis</td>
<td>Expert/Professional review</td>
</tr>
<tr>
<td>Clinical observations</td>
<td>Researcher logs</td>
<td>Practice-based observations/reflections</td>
</tr>
<tr>
<td>Document review/analysis</td>
<td>Professional review</td>
<td>Content analysis</td>
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<tr>
<td></td>
<td>Supervisor review</td>
<td>Formative evaluation, meta-evaluation</td>
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</table>
IM consists of a number of steps: (1) involvement of relevant stakeholders, (2) needs assessment/situation analysis, (3) specification of program objectives, (4) program design, including the use of theory and pretesting, (5) planning for adoption, implementation, and sustainability and (6) planning monitoring & evaluation (Bartholomew, Parcel, Kok, Gottlieb, & Fernandez, 2011). In the context of this curriculum a modified version of IM was utilized (See Table 1). I found Intervention Mapping a very useful tool to develop the framework for the curriculum. The most useful aspect of it is that for every decision I took, I had to think ‘why’.

4.2. Intervention Mapping

The following sections provide a summary of the steps of the IM process used to produce the MIRTS curriculum. Step 8 involves program implementation, however, what has been presented here is not the implementation, but rather an implementation plan. Although presented as steps, IM is a flexible process, which makes it possible to oscillate between steps as new perspectives are gained. For example, defining a more specific behaviour change objective (e.g., a young person with FASD need to develop emotional regulating strategies) might lead to the consideration of additional behavioural determinants (those which affect the young person’s thought process and behaviour).

4.2.1. Step 1: Involvement of Relevant Stakeholders

Based on the IM tool, one condition for successful intervention development is the participation of and consultation with various stakeholders, such as users of the intervention (e.g., clinicians), the target population, decision-makers and policymakers, relevant service providers and organizations, program designers/curriculum developers; trainers, experts, and creative sources. A stakeholder analysis was developed to identifying people, groups, service providers and agencies that can influence the curriculum (either positively or negatively); to anticipate that influence; to develop strategies to get the most effective support possible for the curriculum and to get an
The Process of Developing the Curriculum

| 1. Consulted with relevant stakeholders in the field. |
| 2. Problem/situational analysis to assess relevant needs of target group and gaps in service provision |
| 3. Develop principles, outcome, and objectives. |
| 4. Develop curriculum theoretical framework |
| 5. Selecting the main topic areas—develop outline of table of content |
| 6. Generate curriculum ideas; develop curriculum content and designed activities consistent with needs and challenges of the target population. |
| 7. Evaluation plan—formative evaluation |
| 8. Develop an implementation plan |

The Contents of the Curriculum Itself

**Curriculum Goals and Objectives and outcomes**

1. Focused on clear goals and objectives
2. Focused narrowly on specific needs, challenges, and behaviours leading to these goals.
3. Addressed multiple psychosocial risks and protective factors affecting young people with FASD (e.g., knowledge, perceived risks, values, attitudes, and self-efficacy)
4. State expected changes in behavior and environment
5. Specify determinants
6. Establish outcomes

**Activities and Therapeutic Methodologies**

1. Create a safe therapeutic environment for young people with FASD to participate.
2. Included multiple activities to help reinforce topics.
3. Employ methods that actively involve the participants and that helped participants.
4. Employ activities, instructional methods and behavioural messages that were appropriate to the experience of young people with FASD

Evaluation of the curriculum

| 1. Determination of what to evaluate and how to evaluate it. |
| 2. Consultation to receive feedback about content, effectiveness, usefulness and appropriateness of curriculum content and activities. |

Table 1: Summary of Curriculum Development Process using Modified IM

<table>
<thead>
<tr>
<th>The Process of Developing the Curriculum</th>
<th>The Contents of the Curriculum Itself</th>
<th>Evaluation of the curriculum</th>
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</table>
| 1. Consulted with relevant stakeholders in the field. | **Curriculum Goals and Objectives and outcomes**
1. Focused on clear goals and objectives
2. Focused narrowly on specific needs, challenges, and behaviours leading to these goals.
3. Addressed multiple psychosocial risks and protective factors affecting young people with FASD (e.g., knowledge, perceived risks, values, attitudes, and self-efficacy)
4. State expected changes in behavior and environment
5. Specify determinants
| 2. Problem/situational analysis to assess relevant needs of target group and gaps in service provision | **Activities and Therapeutic Methodologies**
1. Create a safe therapeutic environment for young people with FASD to participate.
2. Included multiple activities to help reinforce topics.
3. Employ methods that actively involve the participants and that helped participants.
4. Employ activities, instructional methods and behavioural messages that were appropriate to the experience of young people with FASD | 2. Consultation to receive feedback about content, effectiveness, usefulness and appropriateness of curriculum content and activities. |
| 3. Develop principles, outcome, and objectives. | | |
| 4. Develop curriculum theoretical framework | | |
| 5. Selecting the main topic areas—develop outline of table of content | | |
| 6. Generate curriculum ideas; develop curriculum content and designed activities consistent with needs and challenges of the target population. | | |
| 7. Evaluation plan—formative evaluation | | |
| 8. Develop an implementation plan | | |

overview of the agencies in the local region that provide addiction and mental health service and support that young people with FASD access. I developed a worksheet that map out all people and agencies that are relevant to be involved in any stage of curriculum planning and development (see Table 18, Appendix 1). Examples of some relevant questions that guided this process are:

1. Who can help in specific tasks within the process (e.g., curriculum development, clinician
training, implementation, data collection, etc.?)

2. Who can take over the dissemination of the curriculum (e.g., addiction and mental health key personnel, clinicians, service providers?)

3. Who has experience in doing a project like this and can advise me (e.g., other NGOs, specialist, experts, peers, etc.)?

4. From whom do I need support if I want to implement, or pilot the curriculum?

I also took into consideration each stakeholder’s authority, responsibilities, availability, and possible contribution to the curriculum development and design. I mapped out their characteristics (e.g., attitudes, structure of the agency), their interest and expectations (e.g., rewards), sensitivity to, and respect of cross-cutting issues (e.g., how do they understand or conceptualize the needs of young people with FASD), their potentials (e.g., knowledge, influence) and deficiencies and the implications and conclusions for the curriculum (e.g., possibilities for professional training in the material, any agreements, expressed interest in piloting the curriculum). See Table 19, Appendix 1.

Once the stakeholder analysis was completed, I consulted with three program managers, a behavioural consultant, a youth forensic professional, two clinical manager and consultant, a clinical coordinator, an outreach worker and four clinicians in the mental health and addiction service field about the idea to ascertain some feedback about the relevance of such a resource. A professional with a wealth of experience and expertise in curriculum development was also consulted to ascertain concept clarification, and curriculum elements important in the development and design of a curriculum (see, Table 24, Appendix 3). My dissertation supervisor also provided useful information and feedback to guide this process.

4.2.2. Step 2: Situational/Problem Analysis

It is important to explore gaps in service provision, needs, situation people live in, as well as, their ideas about solutions. A problem/situation analysis was conducted. The purpose of the
situational/problem analysis is to assess the current situation that is of concern to the target population. This phase involves gathering information specifying the target population to be served, determining the needs of the target population, and delineating the relevant context in which those needs are embedded. This was a seven-stage process that included: 1) a stakeholder analysis; (2) a general review of the existing literature regarding work; (3) a review of existing documentation about FASD; (4) a review of documentation about needs, rights and behavior of young people with FASD; (5) a review of documentation about addiction services; (6) review of existing interventions and (7) a context analysis. The purpose for such a guidance tool (curriculum) was identified through these consultations and the literature review.

**Stakeholder Analysis.** Findings from guideline implementation research suggest that it is good idea to identify carefully and address contextual factors that can impede or facilitate the development of a curriculum. I utilized a modified combined model based on the PRECEDE-PROCEED concept and the theory of planned behaviour. The modifications were done to assist me in integrating behavioural and non-behavioural factors with theory and best practices in the actual curriculum design. On the macro-level, this provides me with a conceptual overview of the different steps necessary to create an evidence-informed theory-driven curriculum. On the micro-level, stakeholder consultations are useful to assess the relevance of the curriculum to clinical practice, to evaluate the quality of research available upon which the desired changes are to mitigate any barriers to knowledge uptake and knowledge utilization. Integral to this process was the need to integrate current knowledge, practice based evidence and therapeutic pedagogy about working with

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5 Findings from guideline implementation research suggest the need to carefully identify and address contextual factors that can impede or facilitate utilization. One of the most important and most often used planning models in health promotion is the PRECEDE-PROCEED model. PRECEDE-PROCEED are acronyms for determinants of behaviour change. PRECEDE stands for Predisposing, Reinforcing and Enabling Constructs in Educational Diagnosis and Evaluation. PROCEED considers additional elements in planning, implementation and evaluation recognizing that other institutional factors such as Policy, Regulatory, and Organizational Constructs in Educational and Environmental Development influence behaviour change. The model provides a systematic approach to identifying and organizing behavioural and non-behavioural factors influencing knowledge uptake and knowledge utilization (Green & Kreuter, 1999). Intervention Mapping builds on this model, and particularly explores the phase of ‘intervention development’.
young people with FASD as a precursor to the construction of an evidence-informed curriculum theory. See Figure 2 and Figure 3 below, and Table 20, Table 21, Table 22, Table 23, Appendix 2 for worksheet used in the situational analysis process. I reviewed the capacity, strength and resources of agencies and clinicians to address the needs of young people with FASD. Predisposing factors (e.g., clinician knowledge of FASD, attitude, values, and perceptions), enabling factors (e.g., supports, availability of resources, skills, referrals, linkages, training) and reinforcing factors (e.g., attitudes and behaviours of clinicians, young people with FASD) were also analyzed. To be able to promote the psychosocial needs and rights of young people with FASD in this curriculum; it was also important for me to explore who young people with FASD are: what are their needs, what are their daily activities, what is important to them, their competencies, what motivates them, who influences them, and what is their youth culture. Clinicians working with these young people are in an excellent position to provide critical information about who these young people are. The clinicians I consulted were asked to share their understanding about their roles as clinicians working within the youth addiction context with young people with FASD, their training as it relates to FASD, their perception of the treatment needs of youth with FASD, and their perception of program strength/weakness. I asked them to reflect on what they understood about their clients, what services and supports their clients were receiving, and how these services were being delivered. We discussed gaps in the service and resources they provide, program policies, appropriateness of service and support provided; as well as, their ideas for reinforcing success and creating more opportunities for young people to achieve positive outcomes (see, Table 25, Appendix 3, for a review of sample questions). Barriers to FASD—informed practice, service providers’ needs, training and new skills required were also discussed. Their stories were rich with insights into the lives of individuals with whom they work and some of the unmet needs they have observed.
Figure 2: Modified PRECEDE—PROCEED Framework for Planning Situational Analysis
Reviewing the Evidence Base. After consulting with relevant stakeholders in this step, a rigorous literature review was conducted. The purpose of the literature review was to explore additional gaps not addressed in the consultation phase. The also informed the content and structure
of the curriculum and FASD—informed practice guidelines.

I explore whether others have already conducted research and whether there are any reviews or other publications that are relevant to the project. I identified any reports or papers in Canada and internationally, which have reported on the nature of the relationship between FASD and substance use and effective program model. This served to ensure that the review captured research and service development initiatives, which exist outside of the scientific literature. I collected, and analyzed existing data related to a number of topics including: (1) problems among the target population; (2) the needs and quality of life and well-being in general of young people with FASD, their behaviour and environment, behavioural determinants, social context, and rights; (3) existing structures and resources to address issues with addiction and co-occurring mental health; (4) relevant documentation, reports and policies with regard to individuals with FASD; (5) therapeutic pedagogical techniques and practices\(^6\) with young people with FASD; and (6) to identify critical gaps in service.

The literature review was based in large part on peer-reviewed journal articles and supplemented by additional sources from relevant books and grey literature. Websites relating to learning environments that support self-regulation, especially for children who experience cognitive challenges, addiction policies, treatment and learning models, as well as, ethics of care were also reviewed. In addition, various ways clinicians need and use support resources in their individual or group sessions, including the use of curriculum materials were also explored. As an example, I consulted empirical data in which scaffolding techniques to guide interventions were used. I also

\(^6\) Therapeutic pedagogical Techniques

Pedagogical techniques are the interactive processes that take place between the client and the clinician that support learning and personal development, for example, assessment, and scaffolding. Pedagogy refers to the instructional techniques and strategies which enable learning to take place and provide opportunities for the acquisition of knowledge, skills, attitudes and dispositions within a particular social and material context. To support young people with FASD as ‘active agent’ in their community, we need to be aware of their experiences and what have helped them to develop as confident, powerful, competent individuals. Clinicians can draw on a wide repertoire of pedagogical techniques and strategies during their interactions with young people with FASD.
watched video on clinicians conducted group sessions.

**Using Grey Literature.** In reviewing grey literature documents, I was seeking to identify unpublished studies and unpublished data supplemental to published studies. Just as excluding studies can cause systematic variation, different approaches to finding and including or using grey literature can also affect the literature included and thus the conclusions of a review. While there may be variation in definitions of grey literature in general, in the context of this dissertation grey literature is defined as all unpublished materials: thesis and dissertation, program manuals, tools, and policies, as well as other documents that were of relevance to developing this curriculum. By reviewing grey literature, I was able to identify data and studies that I did not find through published literature search. In assessing whether to included grey literature I looked at whether the document or studies have sufficient data and are of sufficient quality to be included in my literature analysis. If not, then I considered whether the presence of such documents or studies suggests that any of the published literature was biased and should be “downgraded” for publication bias in assessing the strength of evidence.

**Guidance for Setting Inclusion Criteria.** In the review process, I began with a very broad search designed to identify every possible article and material about my topic. My search resulted in a large number of abstracts. I began with a list of 657, which included articles, books, documents, and other grey literature. The first step was to quickly read and scan each abstract, executive summary, preface, and other summaries and to make a "first cut" to exclude any materials that were obviously unrelated to my topic, or area of focus. I quickly identify materials that had no bearing for a clinically oriented systematic review, or materials that would not inform the curriculum development process. Next, I develop a set of inclusion criteria for my systematic review (see Table 2) Systematic reviews are the reference standard for synthesizing evidence in health and care context because of their methodological rigor.
Although setting inclusion criteria based on key questions may seem straightforward, my experience in conducting a literature review and working with program managers in program development has shown that this is often not the case. As I was not working with a research team, I wanted to make sure that potential bias in the development of the inclusion criteria was also minimized. I asked key stakeholders what criteria they would use when looking for published and grey materials on developing a holistic intervention for young people with FASD. I also consulted with a clinical manager and a program manager on the key questions and inclusion criteria I developed. This was time consuming, but a worthwhile endeavour, as it provided a useful comparison regarding phrases to use and sub-question to address. I wanted to develop a process of systematic review development called topic refinement. The goal was the development of inclusion criteria based on the key questions via a process that involves key stakeholders.

**Selection Process.** Even with clear, precise inclusion criteria, elements of subjectivity and potential for human error in material or data selection still exist. For example, inclusion judgments may be influenced by personal knowledge, training, and understanding of the clinical area (or lack thereof). One of the main goals in developing inclusion criteria is to minimize ambiguity. Greater ambiguity in inclusion criteria increases the possibility of poor reproducibility due to many subjective decisions regarding what to include. There is a balance to be struck between making the inclusion criteria so narrow that it is unlikely that eligible evidence will be found and so loosely defined that it increases the possibility of poor reproducibility; I attempted to strike this balance. The selection process was done in two stages; the first stage involves a preliminary assessment of only the titles and abstracts of the search results, which was mentioned above. The purpose of this step was to eliminate efficiently all obviously ineligible publications. The second stage involves a careful review of the full-text publications. See below for selection flow chart (see figure 4).
Criteria used in prioritizing/selecting the materials in the literature review

- Material on FASD in general
- Material that provide insights about young people with FASD
- Materials that have shown to be effective in achieving their objectives (e.g., good practices)
- Innovative materials used with populations with developmental disabilities
- Materials that are based on a situational/problem analysis and/or are developed in collaboration with young people with FASD, or professionals.
- Materials about substance use and FASD
- Materials about the rights of youth with FASD
- Materials on FASD—informed practice
- Material on treatment approaches
- Materials on policies, program development, strategic planning as it relates to substance use and FASD
- Materials that not only address knowledge, but also other behavioural determinants, such as value and attitude development, skills training, dealing with social influence, and risk factors.
- Materials that have a variety of participatory exercises and activities (e.g., small group work, role plays, etc.) instead of materials with knowledge-transfer only
- Materials that address FASD a positive way (not fear-based)
- Materials that address relevant information related to young people, including self-awareness & self-esteem; decision-making; physical, emotional, and communication; rights of young people with FASD.
- Material on mindfulness and FASD
- Material on mindfulness and substance use
- Material on mindfulness and young people

<table>
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<tr>
<th>Table 2: Sample Selection Criteria</th>
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The overarching questions this review engaged was:

- Which therapeutic practices, in which contexts and under what conditions, most effectively support young people with FASD?

This was explored through seven sub-questions:

1. What evidence on the quality of treatment program from policies, policy guidelines, relevant strategic documents, conceptual frameworks, and documented experiences from programs and practice, can be synthesized and provide a knowledge base to draft conceptual
framework(s) on the quality of treatment to meet the needs of youth with FASD?

2. What are the substance use policy and strategic plans in BC?

3. How is current treatment program delivered and designed?

4. What are the secondary disabilities that are prevalent amongst young people with FASD?

5. What are the needs of young people with FASD?

6. What are the emotional and social well-being needs of young people with FASD?

7. What are the contextual challenges that you people with FASD face?

The literature was sourced using standard scientific databases, notably:

1. Universities’ electronic library catalogues: using string and keywords (e.g., Medline, Science direct, Sage, SpringerLink, Web of Science, Academic Search Complete, PsychInfo, Project Muse, EBSCOhost Databases, ProQuest Dissertations and Theses, Social Services Abstract, Social Care Online (SCO), ERIC, Social Sciences Citation Index, Social Work Abstracts, System for Information on Grey Literature in Europe (SIGLE), Wilson Social Science Abstracts, ZETOC, JSTOR; ERIC); and searching journals, mainly peer-reviewed.


3. Main references cited in the collected literature.

4. Unpublished policy documents obtained from personal contacts, fellow researchers, and professional colleagues.

5. Program reports, data and other documents and studies obtained through personal contacts

6. Conference papers, policy documents, presentation slides and by personal attendance to conferences.

7. The Internet: Google, Google Scholar in general.

8. Personal communication with research fellows, practitioners and other professionals.

Where possible, literature involving the experience of young people with FASD in Canada was utilized, and in the absence of this, research on young people with similar disabilities, as well as research from other countries such as the USA, Australia, and Europe was used.

**Review Documentation about FASD.** To be sure that I addressed the needs of young people with FASD, I needed to know about the prevalence of FASD, the number of young people with FASD who access youth addiction and mental health services, as well as, the number of young people with FASD with co-occurring substance use. I began with formulating questions about statistics I wanted to collect. This helped me to focus on data collection. Specific questions were formulated about specific groups of young people with FASD, for example, are there differences in needs and experiences between girls and boys, between rural and urban young people with FASD, in or out of school, or with different economic and cultural backgrounds. I then look for existing reviews that are relevant to the context. It was also relevant to look at the document about protocol or criteria for developing an FASD-informed practice.
Review Documentation about the Behavior, Needs, and Rights of Young People with FASD. Secondly, I explored existing literature, reports and other documentation about young people with FASD, in a particular context, their needs, concerns, well-being, quality of life, mental
health, behaviour, determinants of behaviour, and the social context they live in. I also analyzed existing information about the views of the social context of young people, for example, their family, parents, foster parents, and their access to health services and counselling.

I used a reflective approach to focus on the following topics: substance use of young people, including reasons for using, how often they use, the type of substances used, and their perceived benefits of using. Behavioural determinants (causing aforementioned substance use behaviours), including knowledge, values, attitudes, social/cultural norms, skills, peer influence; awareness, attitude, skills, social influence related to substance use; environmental constraints for young people with FASD, especially related to the therapeutic settings, and access to and use of addiction and mental health services were analyzed. The needs and interests of young people with FASD were a focal point. Collective reflection from clinicians consulted about the expressed needs of youth with FASD, as well as, reflection on my engagement with young people with FASD about their needs form the foundations of a continuous process of assessment and analysis of the needs of young people with FASD. Analysis of service-wide data collection and other statistical information relating to young people with FASD and their needs was also done. Research about needs, in general, was also conducted.

**Review Documentation about Addiction Services.** The third category of information consists of the existing policies, recommendations and strategic plans, structures and others resources to address issues about substance use. I needed to get a good idea of the addiction service system to be able to develop the curriculum. I started with the identification of question before starting the document review. Topics I explored include:

- Current activities in addiction service about FASD
- Counseling process at both individual and group level
- Program policy related to services provided
- National and provincial policies on substance use and treatment
• Reports and recommendations of addiction strategies
• Access to information, access to resources, and services
• Current challenges for clinicians and service providers to implement provide psychosocial support
• Awareness of clinicians of rights of young people
• Strategic planning
• Unpublished reports that may provide significant detail and background about the context of drug use
• Review any data from epidemiological studies and behavioural surveillance surveys that may have been conducted among young people who use drugs and/or alcohol.

The policy review served various purposes:

• To ascertain information about how young people are being perceived by clinicians and how their rights are reflected in service and support provided
• To gain insights into criteria and service delivery approaches of existing programs
• To make sure the curriculum fits within current policies, which make it more acceptable to agencies and clinicians to use it.
• If the curriculum is used on a broader scale, it may be more acceptable to, for example, a youth and family addiction service counsellor or service provider, if the curriculum is reflective of policies and strategic plans. This may contribute to the sustainable implementation of the curriculum later on.

**Review Existing Interventions.** As part of the situation analysis, I reviewed existing materials, such as:

• Program curriculums
• Program manuals
• Evaluation reports
- Program logic model
- Assessment and measurement tools
- Therapeutic and treatment models programs prescribe to
- Organization vision, mission and strategic plan
- Literature on best practices that current program services are based upon
- Mindfulness teachings

To identify the existence of any interventions and related guidance tools, I used the search terms: ‘tool’, ‘curriculum’, ‘intervention’, ‘treatment’, ‘program’ ‘manual’, and combined each of these with ‘young people with FASD’. Any program materials I found interesting or relevant, or materials that have shown to be effective in achieving their objectives (e.g., good practices). Where possible, I either ask for or review background information about the materials, including the objectives they were hoping to achieve with the materials, the approach used, and description of how the materials can be used. I also reviewed any existing program evaluation, limitations from these programs and recommendations for improvements, as this is useful for avoiding similar pitfalls. See Table 26, Appendix 3 for sample sheet description of existing program and checklist analysis of existing programs.

**Context Analysis.** An analysis was done to examine the context in which addiction program exists so that the likely influence on the curriculum acceptance and implementation can be identified. I identified all addiction programs in the local region—their organization culture, resilience capacity, program sustainability measures, and other social and environmental factors that influence the existing programs. I explored how programs’ importance and quality was perceived.

**4.2.3. Step 3: Identifying Practice Principles, Outcomes, and Objectives.**

**Practice Principles.** One of the greatest challenges in providing service and support to young people with FASD is how to providing comprehensive and optimal care for these young
people that address their changing and complex needs and multimorbidity. A vast majority of young people with FASD have two or more comorbid disorders. By definition, young people with FASD are heterogeneous regarding severity of FASD, functional status, and risk, and protective factors. Multimorbidity is associated with many adverse consequences, greater use of health and social care resources, poorer quality of life, and psychosocial problems. Priorities for outcomes also vary. Thus, not only the individuals themselves, but also the engagement that clinicians have with clients will differ. To provide service that is appropriate, and inclusive it seemed relevant to develop some principles to guide the use of the curriculum. The goal of was to develop general practice guidelines for engagement with young people with FASD. The practice principles developed are based on the understanding that change, healing, learning and growth are active processes. They are also based on my experience of listening to what young people with FASD want and the outcomes they hope to achieve. When clinicians establish respectful and caring relationships with young people, that are responsive to their needs and considerate of the micro and macro factors that shape the experiences of youth with FASD; they are better able to deliver effective therapeutic, learning and development experiences relevant to a young person. These experiences will, in consequence, expand the young person’s understanding and knowledge of his /her circumstances and environment and promote health, safety and wellbeing. The literature reviewed was examined to ascertain evidence about the best ways to support the holistic well-being of young people with FASD. The principles enshrined in the UN Convention on the Right of the Child (United Nations Children’s Fund, 1989) and the UN Convention on the Rights of Persons with Disabilities (United Nations, 2006) were also analyzed. Initially 10 practice principles were developed, however, upon further discussions with my dissertation supervisor it was later edited and refined to seven.

**Outcomes.** Young people with FASD learn at different rates, and in different ways. Their growth and development are not always easy or straightforward. For some young people with FASD and their families, their lives involve considerable struggle and requires much perseverance.
Therefore, different kinds of support and engagement will be required, and addiction programs operate in a wide range of context with differing demand and complexities. At the heart of the curriculum is the aim of improving outcomes for young people with FASD. The intention is to ensure that young people with FASD expand their horizon and discover what they can achieve and how they can self-regulate now, and in the future. The purpose of Step 3 of this IM procedure was to specify what would change. First, I defined the desired behavioural outcomes for the target group that needs to occur to affect the determinants of the overall behavioural objectives identified. The following questions were used to review the outcomes; (1) which attributes are desired for young people with FASD and how will these be promoted in the curriculum? (2) What are the desirable outcomes? (3) Which skills and competencies should they acquire through the curriculum? (4) Do the outcomes represent meaningful benefits or change for participants/clients? (5) Will the outcome help communicate the benefits of the curriculum? (6) Are the outcome goals clear and understandable? (7) Are the outcome goals realistic and relevant to the needs of young people with FASD now and in the future? (8) Are the outcomes participant/client focused? (9) Are these outcomes the ones of greatest importance to key stakeholders? (10) How will the curriculum motivate, engage and challenge young people with FASD? As the curriculum cannot address everything, I needed to make decisions about what to address and what not to address. The results from Step 2 were used to identify outcomes and objectives. I developed a provisional or ‘priority list’ describing the needs identified by the stakeholders consulted, as well as the needs identified from my reflective-based approach. The needs that are most relevant and reflective of the guiding principles were also listed, as they are fundamental to providing the support necessary for every young person growth and well-being. Additionally, in discussions with my dissertation supervisor, we included client-centered outcomes such as quality of life, mental health (e.g., depressive symptoms, and Stress). Similarly, I was also interested in potential antecedents to, or mediators of those behaviors, such as self-efficacy and client empowerment. These complemented our theoretical basis and the
principles. Outcome measures were also analyzed to ascertain appropriate measures that can be used.

**Objectives.** The creation of the objective also required breaking down the desired outcome, into parts that influence or are required to achieve the desired outcome. I then examined the situational/problem analysis (IM step 2) to find evidence that supported or rejected these objectives. Second, I assess whether the objectives were specific, measurable, achievable, relevant and realistic. The importance and changeability of the objectives were also evaluated, and the list of objectives was narrowed to those that will have the most effect on the holistic well-being of young people with FASD and concurrently can be changed. Further consultation with the stakeholders was done to refine the list of specific desired behavior change, in this phase, the final and most important changeable behavioural determinants were identified. By combing these, a matrix of change objectives was constructed. Matrices are a grid of performance objectives (row headings) and behavioral determinants (column headings) for each behavioral outcome.

### 4.2.4. Step 4: Selecting a Theoretical Framework.

The fourth step of this IM process involved identifying suitable theoretical methods to change behaviour and translating these into practical strategies. It is widely recognized that programs are poorly designed, and often not based on sound knowledge. Bartholomew et al. (2011) state that the goal of step 4 is to use a conceptual model or theory (for example, socio-cognitive theory) to guide the identification of appropriate intervention methods and delivery strategies related to the objectives stated in step 3. Developing the curriculum theoretical framework gave me the opportunity to address the problems, the complexities, and the gaps that exist within existing programs. It also allowed me to think about how these issues can be monitored and evaluated. A theory presents a systematic way of understanding events or situations. It is a set of concepts, definitions, and propositions that explain or predict these events or situations by illustrating the relationships between variables. I identified the key service components and utilized the expected
outcomes noted in step 3, to make explicit the underlying assumptions about how these service components will lead to the desired outcomes. These services, outcomes, and the hypothesized links between them became the basis for developing the curriculum model or theory. This model then became the framework to guide the development, implementation plan, and interpretation of the evaluation. Below I outline the detailed steps taken to develop the curriculum theoretical framework.

To help in developing the theoretical frame, or model the following key questions were considered.

1. What am I trying to address? (E.g., problem statement)
2. Which pedagogy and assessment practice should lie at the center of the therapeutic engagement?
3. How are the planned activities and outputs going to lead to the intended changes in the target population(s)?
4. What assumptions have been made about the program components and how do they link together?
5. Am I clear about what I want to achieve?
6. Do I understand how change might happen in the context I am working?
7. What are the potential benchmark and indicators? Moreover, do I have a good understanding?
8. How can others affect outcomes?
9. What influential factors (protective and/or risk) could influence change in young people with FASD?
10. What change processes are already underway in the field, and how do they influence the outcomes that the curriculum hopes to achieve?
11. What are the implicit or explicit assumptions about how using the curriculum will lead to program outcomes?
These questions were critical when viewed within the context of therapy where curricula become the vehicle for translating theoretical descriptions into prescriptions for practice. This last question is key to developing a curriculum theory, as it addresses the question of why and how the services provided are expected to lead to a change in young people with FASD.

Based on the previous consultation with some program managers, review of existing addiction program theory, practice experience, as well as other literature in the field, an initial list of all theories considered to apply to the issue I am trying to address was developed (see Table 3 below). People bring emotions, values, and cognitive models to their experience. Social, cultural, and organizational behaviour patterns shape how things are picked up from “subconscious” experience. When people interact, they bring attention to issues, insights, and observations. Thus, it was important for me to think about how some things become noticeable and memorable for individuals. A rich array of theory can give curriculum design research plenty of depth. Therefore, it was necessary to review a broad range of theory before establishing an approach.

After completing the list above, I created summaries of the core assumptions of each theory and noted any similar programs that have utilized them, the program goals and outcome. I then evaluated each theory. The objective was not only to build the curriculum’s theory, but also to test it and understand the finer mechanisms\(^7\) that lead to the outcomes. Some researchers have noted that testing the theory before entering more deeply into the evaluation process can provide valuable insights into the validity of the intervention’s means of action (Page, Parker, & Renger, 2007; Pawson, Greenhalgh, Harvey, & Walshe, 2005; Renger & Hurley, 2006).

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\(^7\) Finer causal mechanisms—the links between resources, processes and results—need to be examined to ensure there is strong internal validity and potential applicability to other contexts.
4.2.5. **Step 5: Selecting the Main Topic Areas—Developing the Table of Contents.**

Utilizing the information in the steps one through four, I developed a draft outline of the table of contents. A more thorough review of the table of content was done to help focus the content and sequencing of the curriculum components; this was later reviewed with two program managers, a behavioural consultant, and a youth addiction clinical supervisor via consultation. Their suggestions were used to refine the table of contents, which was later discussed and reviewed with my dissertation supervisor and further adjustments were made.

4.2.6. **Step 6: Developing Curriculum Components and Materials.**

One aspect of planning the curriculum is choosing the combination of the subject areas to be covered and their sequence. I utilized two means of documentation. Firstly, I documented any related experience about the topics in the table of content. Secondly, I kept a running journal and folders throughout the creative processes and collected various textual and visual materials related to the topics. I developed my ideas by sketching diagrams. I also made notes, clarifying my thoughts and developing the ideas in a written format. The curriculum must be content-rich and useful to the clinicians and clients alike. One of the major challenges for curriculum improvement is creating

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<table>
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<tr>
<th>THEORIES REVIEWED</th>
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<tr>
<td>Constructivist</td>
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<tr>
<td>Learning theory</td>
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<tr>
<td>Critical Realism</td>
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<tr>
<td>Social Pedagogy</td>
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<tr>
<td>Critical Pedagogy</td>
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<td>Developmental theory</td>
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<td>Motivation interview</td>
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<td>Solution Focus</td>
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<td>Social cognitive theory</td>
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<td>Social interactionism</td>
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<td>Systems theory</td>
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<td>Communication theory</td>
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<td>Theory of reflective practice</td>
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<td>Trauma theory</td>
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<td>Resilience theory</td>
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<td>Mindfulness</td>
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<td>Self-determination theory</td>
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<td>Self-efficacy theory</td>
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<td>Dialectic Behaviour theory</td>
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<td>Theory of planned behaviour</td>
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<tr>
<td>Ethnomethodologies</td>
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<tr>
<td>Theory of reasoned action</td>
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*Table 3: Table Showing Theories Reviewed in the Initial Process*
balance and consistency between the various components of a curriculum (i.e. plan for learning). The experts suggest that the content should include the following characteristics: Validity, significance, interest, learner’s ability, and consistency with social reality. It has been noted that classical problem of curriculum organization, are those of establishing the sequence of cumulative learning or continuity, and of integration. Thus, care was taken to make sure that all relevant issues were addressed appropriately so as to preserve and protect both the logic of the subject matter and the psychological sequence of the learning experience. I utilize the suggestions from van den Akker, Gravemeijer, McKenney, and Nieveen (2006); van den Akker (2003); Walker (2003) With regards to ten components that address ten specific questions about the planning a curriculum (see Table 4). Questions about what to include in and exclude from the curriculum helped to establish a balance between four integrated orientations. Answers to these questions along with data documented from the reflection of my practice helped in building the content of the curriculum.

4.2.7. **Step 7: Formative Evaluation.**

In this step, I referred to original blueprint created to guide the curriculum development—the questions in the evaluation section were attended to in this process. An evaluation plan was created. Table 5 below illustrates the formative evaluation plan with planning comments for each step. For the purpose of this dissertation, and based on feedback from my dissertation committee a thorough literature review was conducted to determine how to incorporate an effective formative evaluation process at every stage of the development of the curriculum. The literature review also focused on evaluation models with the intention of finding a model comprehensive of the formative evaluation process on which the evaluation tools could be based. Instead of finding one comprehensive model, a synthesis model was created based on the material reviewed.
Below I described the formative evaluation process, which was used to provide data to guide decisions about the content of the curriculum. The systematic and comprehensive methods of formative program evaluation are in line with reflective practice and the integration of key stakeholders into the process. At the basic level formative evaluation is a judgment of the strengths and weaknesses of the curriculum in its developing stages. Formative evaluations can create clinician “buy-in” since clinicians’ opinions regarding curriculum contents are solicited, and their ideas valued as part of the overall iterative process.

Formative evaluation holds a prominent place in curriculum design research. The key contribution of formative evaluation is to produce ongoing feedback, findings, conclusions and recommendations that will help improve and refine the quality of the curriculum effectiveness and appeal (van den Akker et al., 2006). Over the life of an established [curriculum], there should be a balance of both formative and summative evaluations, but when a [curriculum] is new, a formative (ongoing) evaluation is preferable (Fitzpatrick et al., 2004).

<table>
<thead>
<tr>
<th>Rationale or Vision</th>
<th>Why will they be learning?</th>
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<tr>
<td>Aims &amp; Objectives</td>
<td>Toward which goals will they learn?</td>
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<tr>
<td>Content</td>
<td>What will they be learning?</td>
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<tr>
<td>Learning activities</td>
<td>How will they learn?</td>
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<tr>
<td>Clinician’s role</td>
<td>How will the clinician facilitate learning?</td>
</tr>
<tr>
<td>Materials &amp; Resources</td>
<td>With what will they learn?</td>
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<tr>
<td>Grouping</td>
<td>With whom will they be learning?</td>
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<tr>
<td>Location</td>
<td>Where will they learn?</td>
</tr>
<tr>
<td>Time</td>
<td>When are they learning?</td>
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<tr>
<td>Assessment</td>
<td>How to measure how far learning has progressed?</td>
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</table>

Table 4: Questions to Help Guide Content Development.
<table>
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<tr>
<th>Evaluation Plan and comments for each step</th>
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<tbody>
<tr>
<td><strong>Defining the purpose of the evaluation</strong></td>
</tr>
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</table>
| *a. Clarifying the evaluation type*  
  Formative evaluation for curriculum improvement  |
| *b. Clarifying evaluation goals and objectives*  
  The purpose of the evaluation is to improve the curriculum through feedback regarding design, desired outcomes, content, usability, and usefulness.  |
| **Clarifying curriculum outcome and objectives**  |
| To aid in the process of formatively evaluating the instruction and materials.  |
| **Determine evaluation questions**  |
| In line with standard practice in conducting formative evaluations Rossi, Lipsey, and Freeman (2004) four overarching questions guided the evaluation:  
  1. What is the curriculum logic model, and does it have a valid basis in research?  
  2. To what extent does the curriculum address the identified needs of young people with FASD?  
  3. What is the link between the needs of youth with FASD, curriculum activities, and objectives?  
  4. Is the curriculum usable, valid and relevant? These questions were further broken into sub-questions categorized into input, process, and outcomes.  |
| **Selecting evaluation criteria**  |
| Criteria were selected: relevance, consistency, practicality, and effectiveness.  
  Nieveen (1999), proposed four generic criteria for high-quality interventions (see Table 6). She explains these criteria as follow: The components of the intervention should be based on state-of-the-art knowledge (content validity) and all components should be consistently linked to each other (construct validity). If the intervention meets these requirements, it is considered to be valid. Another characteristic of high-quality interventions is that end-users (for instance the clinicians and clients) consider the intervention to be usable and that it is easy for them to use the materials in a way that is largely compatible with the developers’ intentions. If these conditions are met, Nieveen calls these interventions practical. A third characteristic of high-quality interventions is that they result in the desired outcomes, i.e. that the intervention is effective  |
| **Plan the evaluation**  |
| Determine evaluator’s role(s)  
  - My role is as the internal formative evaluation planner and facilitator.  
  - Stakeholders engage in reviews will be external formative evaluators  
  Identify evaluation design:  
  - Qualitative in nature: utilizing questions  |

*Table 5: Table Illustrating Evaluation Plan*
Nieveen (1999) proposes four generic criteria for high-quality interventions (see Table 6). She explains these criteria as follow: The components of the intervention should be based on state-of-the-art knowledge (content validity) and all components should be consistently linked to each other (construct validity). If the intervention meets these requirements, it is considered to be valid. Another characteristic of high-quality interventions is that end-users (for instance the clinicians and clients) consider the intervention to be usable and that it is easy for them to use the materials in a way that is largely compatible with the developers’ intentions. If these conditions are met, Nieveen calls these interventions practical. A third characteristic of high-quality interventions is that they result in the desired outcomes, i.e. that the intervention is effective (Nieveen, 1999).

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Relevance (also referred to as content validity)</td>
<td>There is a need for the intervention, and its design is based on state-of-the-art knowledge</td>
</tr>
<tr>
<td>Consistency (also referred to as construct validity)</td>
<td>The intervention is 'logically designed.'</td>
</tr>
<tr>
<td>Practicality</td>
<td>The intervention is realistically usable in the settings for which it has been designed and developed</td>
</tr>
<tr>
<td>Effectiveness</td>
<td>Using the intervention results in the desired outcome</td>
</tr>
</tbody>
</table>

Table 6: Criteria for High-Quality Interventions Adapted from Nieveen, 1999.

These four criteria have different emphasis in various stages of the curriculum development as is illustrated in Table 7. For example, during the preliminary research where the emphasis was on analyzing the problem and reviewing the literature, the criterion of relevance (content validity) was the most dominant, with some attention to consistency (construct validity) and practicality, while in that state, no attention was given to effectiveness. On the other hand, in the prototyping stage, much attention was paid to the practicality of the curriculum, while effectiveness became increasingly important in later iterations. Finally, in assessment stage of the evaluation, the focus was on practicality and effectiveness (see Table 7 for the stages). In the curriculum development and adaptations, formative evaluation serves different functions, or - in other words - is aimed at different criteria (or combinations of these) in the various development cycles, each being a micro-
Formative evaluation takes place in all phases and iterative cycles of curriculum development, as illustrated in Table 7.

<table>
<thead>
<tr>
<th>Stage</th>
<th>Criteria</th>
<th>Short Description of Activities</th>
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</thead>
</table>
| 1 Preliminary Research | Emphasis is mainly on content validity, not much on consistency and practicality | - Reviewed literature, similar projects addressing questions analogous to the ones in this study  
- Use of reflective practice  
- Program reports and other documentations |
| 2 Prototyping Stage | Initially: Consistency (construct validity) and practicality. Later mainly practicality and gradually attention for efficiency. | - Development of several drafts of the curriculum revised on the basis of formative evaluation.  
- Self-evaluation is looking for obvious errors and congruency base on my practice experience.  
- Formative evaluation also took place via stakeholder review  
- One-to-one consulting of the curriculum modules their units with a behavioural consultant and program managers in the youth justice and youth addiction field to identify and remove the most obvious errors in the instruction and to obtain initial reactions to the content by key stakeholders  
- Revisions were also done with my research supervisor. |
| 3 Assessment Phase  | Practicality and efficiency                         | Evaluate whether target users can work with the curriculum (practicality) and a willing to apply it to their individual or group sessions with young people with FASD (relevance & sustainability) Also whether the curriculum is effective |

Table 7: Evaluation Criteria Related to Stages in the Curriculum Development
4.2.8. Step 8: Implementation Plan.

It has been acknowledged that an implementation plan is vital to clinicians and agencies adopting a new curriculum. The focus of the eighth step of the IM protocol was to create a plan for the adoption and implementation of the curriculum amongst the target group. This meant developing an implementation plan and training for clinicians, program managers, service providers and other professionals in the field who could direct those working with young people with FASD to the curriculum.

The introduction of this curriculum to professionals working with young people with FASD can be regarded as the introduction of an innovation (an idea, practice, or product that is new to the adopter, which may be an individual or an organization). This usually demands changes in individual’s behaviour, pedagogic and didactical skills, and the willingness and capacity of agencies to adopt new practices. Every clinician is unique and will be at a different stage in his/her evolution; some will be starting up while others will be evaluating where they are with a view to improving their skills, knowledge and practice.

The adoption of the curriculum by clinicians, as well as facilitation of clinicians to be able to utilize MIRTS effectively are perhaps the most important factors in using the material to work with young people with FASD. To plan the adoption and implementation of the curriculum, a task list was developed (see, Table 8). An important step was already taken at the start of the curriculum development by involving relevant stakeholders. Thus, I utilize information collected from Step 1 and 2 to assess who will adopt and implement the curriculum, what exactly they will need to do and what will determine the adoption and implementation behaviour. The behavioural determinants of clinicians or organisations who are the intended adopters and users of the curriculum was analysed. The capacity and readiness of organizations for implementation are important conditions for this step. Because in my experience, programs, new approaches or theoretical model adapted with the agency’s support seem to have an increased chance to be institutionalized.
Steps are being taken to pilot the curriculum with an agency, as well as individual chapters with various clinicians. Furthermore, steps for sustainable implementation was also considered; in essence, it was already started at the very beginning of curriculum development: by involving relevant stakeholders. Sustainability can be defined as the continued use of the curriculum by clinicians and service providers. Sustainability can imply working collaboratively with government agencies, health authorities and other FASD designated entities to acknowledge the curriculum as one of the tools that can be used by professionals working with young people with FASD. Steps will also be taken to present at conferences. In addition, a PowerPoint presentation outlining the central components of the curriculum was developed.
<table>
<thead>
<tr>
<th>TASK</th>
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</tr>
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</table>
| Analysis of relevant stakeholders | - Identify intended users who can directly benefit from the curriculum  
- To ascertain who have power to make decision about adoption of the curriculum  
- Clinician level of knowledge, skills and social context that influence their practice  
- Assess demand for information about the curriculum  
- Are professionals and service providers supportive of the curriculum? |
| Assess possibilities and barriers for adoption and implementation | - Explore and analyze any barriers to curriculum adoption of curriculum  
- Reasons why organizations, or individuals do not want to adopt the curriculum  
- Do clinicians have the skills and knowledge to use it effectively  
- Organizational and individual willingness and readiness for change in approach  
- Are clinician attuned too and aware of the needs of young people with FASD  
- Clinicians self-efficacy—do they feel confident to use the material?  
- Feasibility, resistance, low fidelity |
| Set objectives and timetabling for adoption and implementation | - Develop objectives for training, adoption and implementation  
- How many clinicians and agencies will be targeted and for how many hours will training take place?  
- How will flexibility in content delivery be balanced? |
| Training and Dissemination | - To provide familiarity with content and theoretical framework.  
- Describe how the curriculum is supposed to function and fit into current practice  
- Efficacy concerning skills—the extent to which clinicians feel confident to use the curriculum  
- To promote the benefits and relevance of the curriculum  
- To ensure effective planning and delivery  
- How will clinicians be encouraged to self-reflect on their current therapeutic practices and new learning?  
- Practice improvements |
<table>
<thead>
<tr>
<th>TASK</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Task list for Adoption &amp; Implementation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Adoption &amp; Implementation Plan</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Focus Group</strong></td>
<td>–</td>
<td>To ascertain feedback for further evaluation</td>
</tr>
<tr>
<td><strong>Evaluation and Revision of the Curriculum</strong></td>
<td>–</td>
<td>Develop evaluation questions to be used after training with clinicians</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Refine the curriculum</td>
</tr>
<tr>
<td><strong>Pilot test the curriculum</strong></td>
<td>–</td>
<td>Utilize an agency willing to pilot test the entire curriculum with its clinicians</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Utilize clinicians willing to pilot test different chapters of the curriculum that are appropriate to their practice context.</td>
</tr>
<tr>
<td><strong>Evaluation and Revision</strong></td>
<td>–</td>
<td>Develop evaluation questions</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Refine the curriculum</td>
</tr>
<tr>
<td><strong>Plans for Sustainable adoption</strong></td>
<td>–</td>
<td>Continuous training</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Develop a train the trainer module</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Availability in various format (e.g., print, electronic etc.)</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Development of e-learning training packages</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Conference presentations</td>
</tr>
<tr>
<td></td>
<td>–</td>
<td>Consultation with relevant government personnel and key FASD professionals in the field</td>
</tr>
</tbody>
</table>

Table 8: Task list for Adoption & Implementation
Chapter 5: Results

5.1. Outcome of the Intervention Mapping Process

5.1.1. Step 1: Consultation with Key Stakeholders.

The stakeholder analysis identified key stakeholders and agencies that will influence the development of the curriculum. A number of relevant stakeholders were consulted to provide feedback (see, Table 24, Appendix 3). The feedback from the consultation indicated that there is a lack of appropriate support for young people with FASD and that intervention that targets a broad range of needs would serve young people with FASD more appropriately as they have multiple and complex needs.

5.1.2. Step 2: Situational/Problem Analysis.

Through consultation with relevant stakeholders behavioral, social, and environmental factors thought to trigger substance use among young people were identified. For example, challenging home situations, family trauma and parental substance use were some of the factors highlighted. They also made recommendations for what interventions that address the needs of young people with FASD should look like. There was a clear message to focus on the sense of being, belonging and becoming of young people, during a consultation meeting with a program manager she noted that most programs do a good job at promoting a sense of belonging, but little attention is paid to a young person’s sense of being and becoming. Clinicians also articulated the need to place those behaviors in the context of the family and community and noted individual and social factors that influence substance use and other risk behaviors in young people with FASD. Other consistent themes that emerged from the consultations included a need for: emotional regulating and coping strategies, ways to promote resilience and mindfulness, FASD information and ways to help young
people work through stigma; ways to help young people with FASD manage and sustain change. Better education and training for clinicians regarding risk factors, resilience, and mindfulness were also highlighted. The clinicians consulted also discussed optimal client responsiveness, engagement and motivation to change, as well as reasons for decreased compliance: depression, anxiety, trauma, cognition, family relationships and transportation. One clinician spoke about the lack of transition planning—“it feels like it is a big component of care and their ability to sustain change after treatment, but it is not always done.” The consultative process also revealed that young people with FASD have competencies that go unrecognized and underutilized and that they also have hidden resilience.

I identified the capacity, strengths, and resources of agencies and clinicians to address the needs of young people with FASD. Using the Precede-proceed framework, predisposing factors, enabling factors and reinforcing factors (e.g., attitudes and behaviours of clinicians, young people with FASD) were identified. The consultation process also revealed that many clinicians and service providers do not understand the full impact FASD can have upon the young person, and that most do not utilize FASD— informed approach. Some clinicians and program managers cited lack of awareness, training and guidelines that are too vague. None of the clinicians or program managers consulted used FASD— informed approached in their clinical practice. However, all the stakeholders consulted endorsed the fact that an FASD— informed approach is essential in providing enhanced interventions that are appropriate to the needs of young people with FASD. Concerning an FASD— informed approach, clinicians also highlighted a need for better information. An FASD— informed guideline and clinician checklist to help provide some directions for working with young people with FASD was developed (refer to Appendix 4). The guide can be used to facilitate discussions through a set of questions individuals can utilize to help them work towards implementing and FASD— informed approach in their agencies or individual practices. See
Appendix 4 for information on an FASD— informed approach. These topics and emergent themes were used to support IM steps. A summary of the emergent theme is available in Table 9.

<table>
<thead>
<tr>
<th>Consultation Topics</th>
<th>Supporting Theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Stakeholders’ perceptions of the needs of young people with FASD</strong></td>
<td>Substance use and mental health; sense of being, belonging; becoming; resilience, emotional regulation, and coping; mindfulness; empowerment; trauma— informed care; FASD related information and support; relapse management strategies; self—esteem and self—worth; transitional and vocational skills; self—management</td>
</tr>
<tr>
<td><strong>Predisposing factors</strong></td>
<td>Utilization of FASD— informed practice; attitude; values and perceptions; clinicians lack of knowledge or training; amenableness, engagement, and motivation of young people with FASD; lack of information and self—efficacy</td>
</tr>
<tr>
<td><strong>Enabling factors</strong></td>
<td>Supports, availability of resources, skills, referrals, linkages, training. Important aspects of responsive care: empowerment and encouragement of young people, increase participation and inclusion, positive relationships</td>
</tr>
<tr>
<td><strong>Suggestions on how to enhance interventions</strong></td>
<td>Desired resources: clinician/provider education, handouts and implementation of FASD— informed practice. Training about mindfulness and client—centred approach. Important aspects of responsive and holistic care, empowerment and inclusive practice. Resources and materials that are engaging</td>
</tr>
</tbody>
</table>

Table 9: Summary of Emerging Themes from Consultation

Documents reviewed revealed the challenges faced by young people with FASD (both primary and secondary disabilities were identified). The scientific and academic literature points to a broad range of secondary disability likely to impact a young person with FASD. High rates of school dropouts, inability to communicate appropriately, poor problem—solving ability, a range of mental health issues and substance use among others have been noted. Other needs identified were related to information about FASD, homelessness, poverty, relationships, attention, advocacy, advancing resilience, emotional regulation, and issues of trauma. Risk factors known to hinder successful adjustments, and adaptation and/or work ability (for example, age, educational attainment, and family histories of trauma, addiction, and emotional dysregulation) were also noted. Another potential need identified in the extant literature is the spiritual needs of young people in general. Other studies have focused on cognitive ability, social and behavioural issues. A range of studies and
conference presentations, however, has called for better treatment and has highlighted the gap in service. In reviewing rights, it became necessary also to review the UN Convention on the Rights of a Child and the UN Convention on the rights of persons with disability. This along with an analysis of the ethic of care, in particular, ‘responsive care’ provided the impetus for developing the curriculum principles.

Statistical data from specific programs, as well as, data from the Health Authorities provided some key information about the use of substance use treatment by young people. Although very few programs are collecting specific statistical data about the number of youth with FASD who access their program; nonetheless, the general statistical data (for example, type of program, for how long, gender, and age) was valuable. Program criteria and manual for addiction treatment, as well as, more in depth literature reviewed exposed a gap in service provided. Further, analysis of policies, service models and provincial standards, and FASD and addiction strategic plans showed priority areas, and recommendations to improve addiction service for diverse populations. For example, Canada’s National Anti-Drug Strategy, Treatment Action Plan supports innovative approaches to treating and rehabilitating those with illicit drug addiction. The Treatment Action Plan:

- Supports efforts to improve treatment systems, programs, and services to address illicit drug dependency for at-risk youth and drug users in high-needs areas;
- Enhances treatment and support for First Nations and Inuit;
- Supports treatment programs for youth in the justice system with drug-related problems;
- Provides support for the use of drug treatment courts, which offer an alternative to the traditional justice system for offenders who have committed non-violent crimes motivated by their addictions; and
- Supports research on new treatment models and the consequences of illicit drug use

A key recommendation of the National Treatment Strategy Working Group (2008) is the development of a tiered continuum of services and supports to address the broad spectrum of risks
and harms conferred by substance use. Such an integrated and holistic system-level model is also articulated in the academic literature reviewed and has been implemented in other countries. A review of program evaluations and other materials found counselling to be associated with some increase levels of well-being.

5.1.3. **Step 3. Principles, Outcomes, and Objectives.**

The literature reviewed suggested that the learning, growth, and development of young people with developmental disabilities is advanced when they are provided with opportunities, support, responsive engagement, encouraged to make meaningful contributions to their life and are included in processes that impact them. Base on the research identifying best practice for the creation of a service model for young people with FASD, as well as, my practice reflection about core pedagogical principles and values that successfully guide my therapeutic approach to working with young people with FASD, a number of common themes emerged. Discussions with my supervisor and key stakeholders also echoed some of the common themes I identified in my practice observations. These themes were refined and used to provide fundamental principles for the curriculum. Ten principles were initially developed; these were subsequently refined to eight after further consultation with my dissertation supervisor. In general, these seven principles are based on the understanding that when professionals establish respectful and nurturing therapeutic relationships with young people with FASD, they will be able to deliver effective, appropriate and responsive therapeutic sessions relevant to the young person’s need. Subsequently, these experiences will progressively expand the knowledge and understanding of young people with FASD, about FASD and the way it impacts their lives, as well as, promote their health, safety, and wellbeing. An analysis of the principles reveals that these can be applied in many addiction setting. They reflect the core idea of being; becoming and belonging. The principles are outlined below in Table 11.

The next task was to state the outcomes that need to be achieved to reach the overall
program objective. Young people with FASD will take many different pathways in their growth and change process it was clear that the outcomes needed to be developed so that there was relevance to all young people with FASD so that they will make progress towards meeting the outcomes in their way and in their own time. Base on the literature reviewed consultation with key stakeholders and observation from my practice engagement with young people with FASD, some of the common themes identified were: resilience, self-management, self-confidence, belonging, relationship, substance use, well-being, communication, problem-solving, and mindfulness. Clinicians also reported that encouragement, inclusion, promoting a sense of agency and creativity, transitional and vocational training, and self-management and awareness skills, among others, as outcomes that should be explored. Using a list of questions (see Table 10) as a guide, I was able to develop a list of potential outcomes.

1. What am I aiming to achieve?
2. What are the most relevant outputs and outcomes?
3. Which clusters of capabilities (e.g., self-esteem, awareness, communication, emotion regulation) relate most closely to the outcome selected?
4. Are the outcomes aligned with the principles and goals?
5. Do the outcomes describe and reflect the expected abilities, knowledge, values and attitudes of young people with FASD?
6. Can the outcomes be measured? Are the outcomes stated so that it is possible to use a single method to measure the outcomes?
7. Are they stated so that outcomes requiring different assessment methods are not bundled into one statement?
8. Are they stated so that more than one measurement method can be used?

Table 10: Checklist for Developing and Analyzing Outcomes.

Through this analysis process, as well as the perspectives, which emerged from discussions with my dissertation supervisor, I was careful in selecting outcomes that reflected the broad spectrum of areas identified for improvement. The outcomes were grouped into nine interlinked clusters that cover major issues young people with FASD face (the selected desirable outcomes are
presented in Table 12 below). In general, they are good capabilities for individuals to possess, and in particular young people with FASD. They are also valuable for young people with FASD in the long term as the evidence from the literature reviewed and practice-based evidence demonstrations that they have long-term impacts on the range and quality of the life choices young people with FASD make, their relationship with themselves and other, educational achievements, employment prospects and overall wellbeing. Each cluster has varying sub-outcomes that can be more specific and personalized to an individual. This being said, I also wanted the outcomes to reflect the underpinning ideas of being, belong and becoming.

This stage addressed what should ideally change as a result of the curriculum. For each outcome, I specified an observable subset of behaviours and objective; then I specify what change is necessary for the behavioural outcomes by stating performance objectives. Performance objectives refer to the effects of the intervention regarding behaviour that should be learned or changed (behavioural outcome). In a brainstorming session, I listed all the steps that would need to be taken to achieve the outcomes. My applied knowledge, consultation with my dissertation supervisor and key stakeholders and the theoretical knowledge about the determinants of behavior change informed this process. Various cycles of scrutiny and amendments were undertaken to narrow down the extensive list to a set of performance objectives that could be reasonably achieved. Table 13 presents an example of performance objectives for Mindfulness.
Underlying Principles

**FASD—Informed**—young people with FASD are heterogeneous and FASD is an invisible disability that can quite often be overlooked. Becoming FASD-informed requires clinicians to have a basic understanding of FASD and the neurological, biological, and psychosocial impact of FASD on young people. It also means that clinician should recognize that young people with FASD often have co-occurring challenges and many may have experienced trauma. Clinicians, who are committed to providing services in a manner that is responsive and appropriate to the complex and multiple needs of those impacted by FASD, will promote confidence, a sense of wellbeing and safety and willingness to engage in the therapeutic process. Having an awareness of how FASD impacts young people is essential to their sense of being, belonging and becoming, as well as overall wellbeing. Fundamentally, an FASD— informed approach replaces the labeling of clients as being “resistant” or “difficult” with that of being impacted by FASD.

**Responsive Engagement**—clinicians who are attuned to the feelings, thoughts, interest, strength and culture of young people with FASD will interact positively with them, in a manner, they feel safe, empowered and secure. When clinicians give priority to nurturing growth by building on a young person’s strengths, culture and interest, as well as, respecting the views of youth with FASD; young people develop confidence and feel respected and valued.

**Promote a Sense of Agency**—when clinicians view young people with FASD as active agents and decision markers/collaborators they will move beyond preconceived suppositions and expectations about what young people with FASD can do or learn. Clinicians who are attuned to the ‘agency’ of young people with FASD will support a strong sense of being. Learning outcomes are most likely to be achieved when clinicians believe in the capacities of young people with FASD to succeed, regardless of diverse circumstances and abilities.

**Promoting Resilience**—In many ways, resilience is linked to a sense of being, belonging and becoming. Inculcating resilience within the curriculum means building on the strengths and capacities young people with FASD and nurturing their growth. Clinicians, who focus on enhancing protective factors, help young people to negotiate and navigate resources, provide opportunities to thrive and support social and emotional learning will enhance ‘self-resilience’ of young people with FASD.

**Holistic**—clinicians who are attuned to the connectedness of the body, mind and spirit recognize that the overall growth, development, and well-being of a young person is holistic. When clinicians adopt a holistic approach, they are mindful that what is going on in one area of the young person life can impact many other areas of the young person’s life. In particular, clinicians should ensure that practical health; welfare and accommodation needs are met so that the client can effectively address behavioural change—focus on the ‘whole person’ not just the problem.

**Individual and Competence-Centered**—clinicians who appreciate the uniqueness of a young person with FASD and provide support that is appropriate to him/her fosters his/her motivation to engage. Being mindful of the combination of skills, knowledge, and attitude that a young person with FASD needs to effectively negotiate challenges and resources. By providing the support to help them manage both their environment and learning of new skills will reinforce a young person’s sense of self as a competent learner.

**Promote Mindfulness**—young people with FASD, will enhance their emotional regulating skills, self-awareness, and attention when clinicians consistently promote mindful practices.

**Scaffolding**—clinicians who build on the existing skills of young people with FASD will promote resilience and overall well-being. In response to the changing and complex needs, ideas and interest of young people with FASD, clinicians assess, anticipate and extend the learning, growth, and development via open-ended questioning, providing feedback, challenging their thinking and guiding their learning. They enhance the competencies by; teaching skills that are missing or maladaptive and creating opportunities for young people with FASD to practice these skills.

Table 11: Principles Underlying the Curriculum
<table>
<thead>
<tr>
<th>Clusters of Desired outcome</th>
<th>Description/Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resilience</td>
<td>Social and emotional learning; self-management; hope; self-motivated; having a sense of purpose; self-controlled; negotiating and navigating resources.</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>Concentrating; focus; meditating, self-regulating; self-compassion; self-acceptance; stress management.</td>
</tr>
<tr>
<td>Personal &amp; Social Development</td>
<td>Building a positive self-identity; self-efficacy; self-belief; friendships and relationships; empowerment; listening and communicating; assertiveness and dealing with conflict.</td>
</tr>
<tr>
<td>Emotional Regulation</td>
<td>Stress management, managing thinking and thought patterns, understanding emotions</td>
</tr>
<tr>
<td>Health &amp; Well-being</td>
<td>Drugs; smoking and alcohol; food and fitness; trauma issues, FASD, mental health and wellbeing</td>
</tr>
<tr>
<td>Participation &amp; Inclusion</td>
<td>Sense of agency; confidence; decision making; rights and responsibilities; safety; belonging; planning; mentoring; advocacy</td>
</tr>
<tr>
<td>Problem-solving &amp; Planning</td>
<td>Organizing; setting and achieving goals; decision-making; Navigating resources; managing conflict</td>
</tr>
<tr>
<td>Creativity &amp; Independence</td>
<td>Applying learning in new contexts; visual arts; creative writing; craft and design; sport and leisure; developing skills for independent living; transition planning; housing and homelessness; planning for the future; Imaging alternative ways of doing things; open to new ideas and doing new things; expressive; imaginative.</td>
</tr>
<tr>
<td>Communication</td>
<td>Assertiveness, expressing; listening; questioning; articulating; engaging; interacting</td>
</tr>
</tbody>
</table>

Table 12: Table of Desirable Curriculum Outcomes Clusters.
Overall Objectives—Young people with FASD will:
- Understand what mindfulness is
- Differentiate between mindful and unmindful thoughts and action
- Apply mindfulness practices in their daily living

<table>
<thead>
<tr>
<th>Behavioural Outcome</th>
<th>Performance Objectives</th>
</tr>
</thead>
</table>
| Young people with FASD will demonstrate Mindfulness skill | 1. Young people with FASD will develop physical tolerance to perform mindful exercises  
2. Young people with FASD will be able to develop self-regulation strategies  
3. Young people with FASD will be able to identify the barriers to committing to mindfulness practices  
4. Young people with FASD will develop confidence in their ability to perform and use mindful practices.  
5. Young people with FASD will be able to engage in mindfulness activities |

Table 13: Example of Performance Objectives for Mindfulness Outcome

By breaking down each performance objective into its learning and change objective; important and changeable behaviour determinants were selected. This resulted in matrices of change objectives that are specific to each performance objective. Determinants chosen in this current analysis are based on those set out by (Bartholomew et al., 2011) Bartholomew et al., (2011) as well as those used by other researchers. The determinants of attitude, skill and self-efficacy, motivation, outcome expectation, and knowledge were selected. de Vries ASE model of behavior intention suggested that a person’s intention to perform a certain behaviour is determined by personal conceptions regarding the behaviour (attitude), and personal belief in one’s ability to engage in the behaviour (self-efficacy) (de Vries, Dijkstra, & Kuhlman, 1988). The realization of the behaviour is dependent on a positive intention, but it also requires the young person having the skills/abilities to carry out the behaviour. The external determinants were selected based on evidence from the literature, as well as ideas generated from consultation with key stakeholders related to determinants. These include support, perceived norms, resources, and safety and inclusion. The concepts norms are used to refer to the norms of the client’s social environment; most notably, related to
oppositional culture, that of a friend or the ‘streets’ (informal rules governing interpersonal behaviours) whose norms are often consciously opposed to those of mainstream society. Safety and inclusion refer to feeling secure and included in therapeutic session and treatment planning. It includes an environment, which is psychologically safe from re-traumatization, and where everyone is treated equitably and given the support he/she needs to succeed. Table 14 and Table 15 presents an example of learning and change objectives that are associated with the performance objective (for mindfulness): Determinants of behaviour change are presented across the top of the matrix. For each determinant, a change objective is created that links that determinant to the performance objective. The same process is applied with each of the other performance objectives resulting in a matrix being created by linking each determinant with each performance objective.

Once outcomes were selected, it was relevant to select measurements that focus on all aspect of aspect of the holistic learning and development that are helpful in showing progress. I believe that young people with FASD are at their best when they are interested, supported and motivated. Young people understand and learn when things are meaningful and real to them. Therefore, outcome measures of their actual performance while engaged in meaningful learning activities and situations in their day-to-day setting are a reliable way of building a picture of what young people with FASD can do. As such a broad list of outcome measures were reviewed to ascertain what outcome measure may be suited for use by a clinician. Based on my review of various outcome measures, I have outlined a list in Table 28 that I believe fits well with the MIRTS curriculum.
<table>
<thead>
<tr>
<th>Performance Objectives</th>
<th>Learning Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Young people with FASD will be able to engage in mindfulness activities</strong></td>
<td><strong>Attitude</strong></td>
</tr>
<tr>
<td></td>
<td>Feel positive About engaging in Mindfulness activities</td>
</tr>
<tr>
<td></td>
<td>Client understands the nature of mindfulness and has a positive attitude towards it</td>
</tr>
<tr>
<td></td>
<td>Describe the impact of for example yoga on their lives</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Table 14: Matrix of a Performance Objective and Personal Determinants for Mindfulness
<table>
<thead>
<tr>
<th>Performance Objectives</th>
<th>Change Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Young people with FASD will be able to develop self-regulating strategies</strong></td>
<td><strong>Norms</strong></td>
</tr>
<tr>
<td>Clinician set-up a mindfulness schedule, or homework</td>
<td>Clinicians review mindfulness strategies with clients and addresses questions/concerns</td>
</tr>
<tr>
<td>Clients can put aside any negative perceptions their friends express about mindfulness practices (e.g., yoga)</td>
<td>Receives reinforcement from clinicians</td>
</tr>
</tbody>
</table>

Table 15: Matrix of Performance Objectives and External Determinants for Mindfulness

5.1.4. **Step 4: Selecting a Theory-Based Method and Practical Strategies.**

The task involved in this stage of this IM process was choosing the theoretical underpinning of the curriculum. I identified theoretical determinants useful in predicting and explaining the performance of the behaviours the curriculum aimed to target was conducted, and various theories were selected for consideration. Thus, various cycles of analysis were undertaken to help in identifying the theory that would be most appropriate to address the holistic and comprehensive needs of young people with FASD.

After completing the initial list, I created summaries of the underpinning assumptions and core components of each theory and noted any similar programs that have utilized them, as well as how they fit with the desired the curriculum outcome. I also considered to what extent each model makes clear its ‘theory of change’. The checklist below (see Table 16) was then used to assess the quality of my initial draft. A second list was then produced (see Figure 5).
<table>
<thead>
<tr>
<th>Checklist</th>
<th>Yes</th>
<th>Not Yet</th>
<th>Comments and Revision</th>
</tr>
</thead>
<tbody>
<tr>
<td>The theory addresses problems to be solved/or issues</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The desired outcomes are in line with the theory’s core assumption.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Theory is in line with the needs and concerns identified by clinicians</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Core assumptions of the theory reflect the strategies and activities to be developed</td>
<td></td>
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<td></td>
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<tr>
<td>The assumptions held for how and why identified change strategies should work, are clearly supported by the theory.</td>
<td></td>
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<td></td>
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<tr>
<td>The theory accurately reflects the purpose of the curriculum and its intended results.</td>
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<tr>
<td>There is agreement among key stakeholders/clinicians consulted about the usefulness of the theory for the intended goals, objectives, and outcome.</td>
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<tr>
<td>The theory reflects, or supports the principles and guideline for an FASD-informed practice</td>
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Table 16: Checklist for Constructing the Curriculum’s Theoretical Framework
Figure 5: Figure Outlining the Second Draft of Theory Selection

I then evaluated each theory in greater details. The objective was not only to build the curriculum’s theory, but also to test it and understand the finer mechanisms\(^8\) that lead to the outcomes. A number of researchers have noted that testing the theory before entering more deeply into the evaluation process can provide important insights into the validity of the intervention’s means of action (Pawson, Greenhalgh, Harvey, & Walshe, 2005; Renger & Hurley, 2006; Page, \(\ldots\))

\(^8\) Finer causal mechanisms—the links between resources, processes and results—need to be examined to ensure there is strong internal validity and potential applicability to other contexts.
Parker, & Renger, 2007, Donaldson, 2007, Pawson & Tilley, 1997, 2005). An analysis of the theories in the second draft was made, evaluating for significance, internal consistency, parsimony, testability, underpinning concept, theory of change and adequacy. The list was further refined, see Figure 6. In so doing, a better understanding of the theoretical underpinnings that can explain the intervention outcome is achieved.

![Figure 6: Third list of Theories](image-url)
Throughout the consultation with my dissertation supervisor, we discussed the best approach to achieving the desired outcomes and relevant capabilities. We reflected on the activities that are likely to help young people with FASD build up their capabilities in the clusters of outcomes I have focused on. It was then noted that a theory of change logic model would be useful to illustrate this. A logic model linked the intended outcomes of a curriculum with the planned activities, processes, and inputs. This proved to be a valuable way of helping to structure thinking about the desired outcomes. Furthermore, it allows me to assess the strength of the causal link between the intervention and the intended effects.

I also used reflective-based approach to refine further the theory selected in the third draft. According to Schon (1983); (Schon, 1987) reflective practice is the integration of theory and practice, a critical process for refining one’s artistry or craft in a particular discipline and bringing to the conscious level those practices that are implicit. Schon further describes the reflective practitioner as not just skillful or competent, but thoughtful, wise, and contemplative.

To be able to reflect the overall process, I used the following questions: (1) What theoretical approaches have guided my practice and interaction with my clients? (2) How relevant have those approaches been in helping clients achieve stated goals and outcome? (3) What information has been valuable to my clients? (4) What activities have my clients found most useful and relevant to their needs? (5) To what extent is there evidence to support theories? (6) To what extent does the theory support the outcomes?

Many theories can be selected to guide an intervention, as this is proposed to be an integrated model. However, given the identified outcomes and objectives, mindfulness, resilience, trauma-informed and social pedagogy were selected as the theoretical framework best suited to underpin the curriculum (Figure 8 illustrates the model). The approaches share similar underpinning concepts (see Table 17) and components (see Figure 9). The theories provide a way of thinking about the challenges of working with young people with a range of social, emotional and
intellectual difficulties. Each provides a framework whose constituent theories are intended to help clinicians to understand:

- The importance of mindfulness in helping young people with FASD develop awareness and self-management skills
- How to navigate and negotiate resources.
- How trauma impacts on young people with FASD.
- How and why their ways of coping might be maladaptive.
- How and why agencies and clinicians respond in ways that are not always helpful.
- How they might change.
- Each emphasizes the importance of helping clinicians develop the knowledge and skills necessary to help those they care for.
Clusters of outcomes referred to her for examples:

- Resilience
- Mindfulness
- Personal & Social Development
- Emotional Regulation
- Health & Well-being
- Participation & Inclusion
- Problem solving & Planning
- Creativity & Independence
- Communication

Figure 7: Example of Logic Model.
Figure 8: Theories of the Curriculum

<table>
<thead>
<tr>
<th></th>
<th>Mindfulness</th>
<th>Resilience</th>
<th>Trauma-informed</th>
<th>Social Pedagogy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Awareness and attention</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma-informed</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>Attachment theory</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Biopsychosocial</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
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<tr>
<td>Competencies</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Strength-base</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Empowerment</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Social &amp; Emotional learning</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

Table 17: Examples of some Underpinning Concepts
5.1.5. Step 5. Developing the Table of Contents.

The next challenge in the curriculum development process was developing a table of contents that will make a real difference in the lives of young people with FASD. At this point, the primary questions I asked were: "If the desired outcome is to be attained, what will young people with FASD need to know? What knowledge, skills, attitudes, and behaviours will need to be acquired and practiced?" The scope (breadth of knowledge, skills, attitudes, and behaviours) and the sequence (order) of the content were also discussed with my dissertation supervisor and in
consultation with key stakeholders. I reviewed all relevant literature gathered in the problem analysis as well as the information in step three above. I then brainstorm a list of content area that reflected the desired outcomes and objectives. The list was then organized into some semblance of order, using logical principles appropriate to the curriculum. I then wrote down all the questions I think clinicians might ask about the topics I have identified, or about the subject in general. This brought to mind some things that I left off the first list. I inserted one-paragraph notes under each topic headings, to remind me of what I intend to discuss that topic. I then consulted with a few stakeholders, after consultation with stakeholder I refined the list. The list was then further refined to its final version after feedback from my dissertation supervisor. See Table 27, in Appendix 5 for the table of content.

5.1.6. Step 6: Developing the Curriculum Content and Materials.

Decisions about what contents to include in curriculum hinge on many things ranging from my practice experiences, spur of the moment inspiration and sometimes to painstaking deliberation base on the principles, objectives and outcome, literature review and discussions with my dissertation supervisor. The first task in step 6 was to devise a structured curriculum plan that accounted for the scope and limits of the curriculum. The evidence from the situational/problem analysis was used, as well as step three and an extensive list of barriers was found to be associated with the desired outcomes. To determine the structure of the curriculum, I carried out another literature review to identify existing materials relating to the topics in the table of content, as well as outline all my existing knowledge and practice activities about the topics.

The curriculum content and activities were designed with particular attention to developmental level, cultural appropriateness, and long-term sustainability. Curricular components were drawn from successful, evidence-based programs on mindfulness for school children, mindfulness in youth juvenile justice programs, social pedagogy in group homes, trauma-informed
and homeless young people, resilience based program and other mental health and substance use treatment programs. To address the objectives, I developed certain components and activities, as well as adapted other activities I used in my practice using the theory based strategies and methods as a guide (i.e., linking the activities and components back to the original theory and framework). Although the chapters can be covered non-sequentially, there is integration, and some chapters build on the concepts of earlier ones. The following questions were relevant to the process. (1) Why do young people with FASD behave as they do? (2) What curriculum components and activities could effect desirable change? (3) Given the way they behave, what would motivate them to change behaviour? (4) What are the kinds of balance that need to be considered? These questions were expanded to include organizational issues and information needed by clinicians. For example, the section on FASD— informs practice was developed and refined to provide some guidance to effectively using the curriculum.

Learning activities needed to represent a balance of various means of learning: reading, observing, writing, experimenting, manipulating and constructing. I wanted to ensure that there wasn’t a heavy reliance on one particular mode of learning. Providing a rationally balanced variety of learning experiences not only increase the capacity to learn, and engage in service, as well as motivation for change, it is also one way of deciding on the problem of individual differences and heterogeneity.

To ensure that the content met the desired outcome and change objectives, I scrutinized the data collected. This allowed me to engage with the material to remove those that are not reflective of the desired outcome and address those that I believed to be incomplete. This was then discussed with my dissertation supervisors and her feedbacks and suggestions were implemented.
5.1.7. **Step 7: Formative Evaluation.**

The formative evaluation stage of the process was used to evaluate the curriculum effectiveness, relevance and practicability. This process was extensive and cumbersome. In reality, however, formative evaluation began during the needs problem/situational analysis and continued throughout the intervention mapping process. Evaluating both the process, curriculum’s content and carefully checking all the decisions and assumptions made within the Intervention Mapping process allowed me to determine whether the performance objectives were met and whether the techniques and strategies chosen were effective. The quality assurance component that this step added to the curriculum was valuable. Several refinement phases were conducted. Below is a description of the refinement phases and ways the curriculum was improved and changed throughout it phase.

**Refinement of Draft 1: Draft 2.** After synthesis of all the curriculum components, and activities a content analysis was done to the curriculum content for errors, appropriateness, and clarity of materials. Each chapter components were examined as a separate unit and then as a collective whole to ensure the scope and logical sequence of the topics and activities. Aspects of the chapters were compared to my reflective documentations of activities I have tried in the past and those I am still currently utilizing with my clients with FASD. I also assessed for consistency with the needs, behaviour and context of young people with FASD. Reflecting on how I develop an alliance with my clients and how they can communicate the relevance of the work I do with them. I developed capstone questions to end each session; these were intended to support clinicians in understanding how to engage these young people in sense making around particular lesson concepts, but also to allow clients to engage in their narrative reflective process. I conducted an evaluability analysis to:

- Ensure that the curriculum fit the needs or problem areas of young people with FASD
• Ensure the goals and objectives were clarified, and feasible
• Ensure the theory were appropriately operationalized to the curriculum’s activities, and activities were linked to the objectives
• Determining which curriculum objectives are most attainable.
• Identifying priority needs and which objectives are most important?
• The strengths and weaknesses of the curriculum
• Improving curriculum design
• Examine the logical consistency between the curriculum components.
• Assess the extent to which the curriculum design fits the knowledge base of the discipline

These activities resulted in draft 1 being revised into draft 2.

**Refinement of Draft 2: Draft 3.** I provided different sections of the curriculum module to three professionals consulted earlier for their review and feedback base on their area of expertise. The three professionals utilized were: (1) a program manager with expertise in addictions, program planning, and development; (2) a clinical manager with expertise in youth forensic, mental health and addictions; and (3) a behavioural consultant with expertise in trauma and experience working with young people with FASD, foster parents and clinicians in the social service system (Table 24, in appendix 3 for experience and expertise of the individual consulted.

The feedback received was used to simplify materials. For example, with regard to the chapter on change, feedback about the potential difficulty in understanding the stages of change, by young people with FASD was used to simplify discussions about change. The trauma section was also revised extensively. I also developed more extensive literacy educative features for the unit. These literacy features provided enhanced discussion guides for the material, highlighted key content ideas, provided discussion questions and supported the interpretation of graphics in the curriculum. This was important to help clinicians better engage clients in discussion and for allowing clients opportunities for meaningful discussion and participation.
In addition, indepth discussion took place with a mindfulness consultant and a yoga and Pilates instructor (with over 15 years of experience) with regards to mindfulness, meditation and the practice of yoga and Pilates to gain useful insight and greater knowledge. I was allowed to observe and be part (at times) of several yoga classes. While observing, I pay attention to how many young people attended classes, their acceptance, and enthusiasm for yoga. My random conversations with some of these individuals were also very insightful—I paid attention to aspects of the class individuals found most useful and why. I attended some Buddhist teachings (Dharma) to gain more detailed knowledge about guided meditation and its benefits. I also wanted to gain some firsthand experience as I felt; I would be able to capture the nuances of meditation much better than simple reviewing research. To complement those teachings, I listened to many hours of progressive muscle relaxation and body scanning techniques by Dr. Bruno Cayoun of the Mindfulness-integrated Cognitive Behavior Therapy Institute, Australia. I also spent a few weeks listening to many hours of guided meditation, and participated in two twenty-one-day meditation challenges by the Chopra Center. I watch many YouTube videos (for e.g., yoga for youth from Niroga Institute, yoga for beginners) and DVDs (for example, Shanti Generation: Yoga Skills for Youth, Breathe: Yoga for Teens, Teen Yoga, Kids World Yoga, Yoga: Power/Flexibility/Balance) on young people and children doing yoga, observing for attention, as well as interaction with their senses. The knowledge gained from these allow for enhancing of the wording in the quiet moment segments, and the guided meditation. I also made significant changes to the mindfulness module and the unit on self-acceptance and self-compassion, as well as the chapter on emotion and distress tolerance. Also, based on my reflection of how I incorporate mindfulness in my practice with young people with FASD, I was able to make use of grounding strategies and other mindfulness strategies they have reported to be useful in reducing anxiety and stress and increase in their general self-care.

Refinement of Draft 3: Draft 4. Revision by my dissertation supervisor and subsequent discussion about the curriculum also led some other significant changes. Modifications were also
made to some of the diagrams. Suggestions were made with regards to utilizing some of the mindfulness acronyms throughout the curriculum, as it would likely enhance the mindful practice of young people with FASD. I created mindful flashcards as tool to help with the learning of mindful acronyms, see Appendix 6. Revisions were made to all chapters, some greater than others, to sharpen the focus of the content to make sure that the idea of ‘being’, ‘becoming’ and ‘belonging is reflected throughout the curriculum. Through this analysis, self-efficacy (and its impact on one’s belief in one’s ability), as well as empowerment emerged as critical success factors; however, it became apparent that no standardized measurement tools were implemented to measure outcomes. Outcome measures were further examined; measures deemed most appropriate were suggested and is represented in Table 28 in Appendix 7. The suggestion of appropriate outcome measures emerged as a curriculum improvement that will help clinicians and clients gauge their improvements over time. Alternatively, a ‘blank’ outcome measure tool was created so as to allow clients the opportunity to be more self-directed about what outcomes they hoped to achieve. This is also presented in appendix 7.

Refinement of Draft 4: Draft 5. The curriculum was distributed to my research committee. Based on the comments received, further revisions were made on number of chapters. For example, the information and activities in the ‘resilience’ chapter was extensively reviewed because of the comments from one committee member.

Refinement of Draft 5: Draft 6. A one-to-one consultation was also done with two other program managers (a youth justice rehabilitation program manager and a youth and family addiction program manager) looking at the entire curriculum in detail. This led to more improvements in the educative features and overall presentation of the curriculum (e.g., clarifying wording, being more explicit, developing an index and glossary). In addition to this, questions to evaluate the appropriateness, effectiveness, relevance and practically of the curriculum was developed (see
Appendix 8). Using my practice experienced I analyzed the curriculum content using the list of questions and then making appropriate changes. These questions, along with the curriculum were later given to four key stakeholders (a youth service clinical coordinator, a youth and family addiction clinical manager, and two youth addiction counsellors) who were engaged in various consultation processes, along with a copy of the curriculum for a more detailed review. The feedback provided was used to refine the curriculum contents. See Table 29, in Appendix 8 for examples of comments from stakeholders.

**Refinement of Draft 6: Draft 7.** The stakeholders who provided feedback on draft five were sent a summary of all the comments on draft five of the curriculum, along with the newly revised draft—draft six and some formative follow-up questions see Appendix 8. The purpose of this was to verify that I correctly interpreted their comments on draft five and to give them an opportunity to comment on all changes made to draft five as reflected in draft six. In general, the stakeholders acknowledged the efforts made to address their comments from the previous round of review and stated the change made improved the curriculum. One stakeholder commented more specifically on the graphic and visual content that were not made in the previous round. Also, there were two comments about particular wordings and a request to rephrase those wordings. All the feedbacks were later used to refine the curriculum to draft seven.

**Refinement of Draft 7: Draft 8.** To help in reviewing the quality of the curriculum, a quality checklist was developed. This task was done to ensure that the curriculum was relevant, suitable and usable. Three stakeholders (one counsellors, a clinical consultant and a clinical coordinator) were consulted about the quality checked and agreed to lend their expertise. The quality check questions and feedback are presented in Table 27, Appendix 9. A stakeholder— (the clinical coordinator) also indicated that after having read the curriculum she wanted to engage in a more indepth question and answer discussion with me. This process was valuable and provided rich information. The two-hour
discussion revealed possible questions clinician would have after engaging the curriculum material and potential gaps in the knowledge of clinicians. This provided context and impetus for enhancing the clinicians’ notes section of each unit, as well as additional units in chapter 16. Some units were merged to create better flow in the material. Another development to come out of this process was the development of an audio version of the sample informed consent form; as it was pointed out that an audio/video version would enhance MIRTS and provide clinicians and subsequently youth with more options and opportunities for engaging the informed consent process.

**Refinement of Draft 8: Draft 9.** The curriculum was presented to my dissertation supervisor for in-depth review and feedback. Her feedback was used to further refine the curriculum contents to ensure issues of relevance; consistency, practicality, and effectiveness were addressed appropriately. The curriculum was then distributed to my supervisory committee for further feedback and a final review. The general layout, technical and grammatical editing of content material were made.

**Refinement of Draft 9: Draft 10.** The curriculum was revised and edited based on the feedback from my committee members, this was then passed on to my dissertation supervisor for a final review. A recommendation was made to include the section—FASD-A Paradigm Shift in the chapter on FASD so as to present a more balance view of young people impacted by FASD. A few changes were made to the theory section. The overall curriculum was thoroughly reviewed for content and grammar.

**5.1.8. Step 8: Implementation planning.**

The next stage was to create a plan for the adoption and implementation of the curriculum by clinicians and service providers. This meant developing an implementation plan. Training clinicians who have direct engagement with young people with FASD is currently being addressed.
Consultation meeting with relevant service providers and addiction personnel has been conducted to discuss the relevance and possible benefit of the curriculum. The curriculum is currently being circulated to clinicians and service providers who have expressed interest in adopting the curriculum, and or staff training. I have also been invited to two agencies to present the curriculum and its content, as well as answer any questions clinicians have. Two other agencies have also invited me to deliver training on various chapters they deem more relevant to their staff professional development (for example, resilience, mindfulness and social pedagogy sections formed the main topic of one training). One clinical director requested a one-on-one meeting to review the curriculum and the relevance to his staff and the work they do. I have also had discussions with a senior member of Island Health Authority youth and family addiction program. The outcome of these meetings were positive. A request was made by the clinical director consulted to train clinicians at his agency in specific areas like resilience and social pedagogy. Further, an overview of MIRTS was requested from one agency in Eastern Canada, who is currently in a transition phase and seeking resources to help build the capacity of their clinicians to better serve young people with FASD. The PowerPoint developed about MIRTS was sent to this individual for her review.

Presently, discussions are taking place to have curriculum piloted in an agency and consultations with various clinicians are on the way with regard to piloting different chapters in their practice context. To aid implementation and adoption, information from the pilot will be used to modify both the curriculum and the training sessions.

The provision of downloadable PDF version of the curriculum is available. Printed copies of the curriculum will be available in the near future. Continuous training and consultation with clinicians and agencies about how to use FASD-informed care and how to use the curriculum to provide support to young people with FASD is available. An abstract submission has been made for the 7th international conference on FASD.

A crucial element of the training stage will be to ensure that clinicians received appropriate
training and instruction to implement and use the curriculum in the intended way to ensure fidelity. It also vital that train the trainer modules are developed so that agencies will be equipped with individual that are knowledgeable in using MIRTS. In the future, training will involve an evaluative component of the material. Clinicians will be informed that they will be requested to complete an evaluation form at the end of each session to provide an overview of the practical intervention applications delivered, information about how the session was received, what worked well, what did not, and what could be improved.
Chapter 6: Discussion

In this dissertation, I have described the development of a curriculum for professionals working with young people with FASD, using intervention mapping. To my knowledge, this is the first study to use IM to develop a curriculum for professionals focusing on the holistic well-being of young people with FASD. The modified 8-step IM framework resulted in a curriculum that was informed by mindfulness, resilience, trauma-informed and social pedagogy theory and context to be responsive to the needs of young people with FASD. The resultant intervention is client-centered and focuses on building the capacities of young people with FASD.

The situational/problem analysis revealed gaps in service provision and information about the needs of, and risk factors affecting, the young people with FASD. Consultation with some key stakeholders on existing service provision and the issues they are concerned about with regards to young people with FASD within addiction services. The analysis highlighted a number of issues: the need for belonging, self-management skills, confidence, managing feelings, communication, relationship, resilience, substance use, trauma issues, internalizing and externalizing behaviours, change and transitions, and mental health among others. It was also suggested that for clinicians to be able to meet the needs of young people with FASD, they must have a sound knowledge FASD and FASD-informed approaches, and improved attitudes and beliefs about people with mental illness, together with adequate skills (particularly communication skills) and confidence to apply that knowledge in their practice. The curriculum was developed to address the holistic and comprehensive needs of young people with FASD. Central to the framework is a view of youth with FASD lives as characterized by being, becoming, and belonging.

Resilience, personal and social development, and management, health and well-being, participation and inclusion, problem solving and planning, creativity and independence, communication and mindfulness were identified as the cluster of desired outcomes. Personal factors such as self-efficacy, perception, knowledge, and attitude were identified as determinants of behavior.
change. Regarding outcomes, the hope is that young people with FASD will be able to realize their individualized goals and outcome within this broader cluster of the desired outcome. The hope is that they will enhance their resilience, sense agency, develop a range of skills, increase self-confidence and self-compassion, better equipped to make decisions about their future and improve their emotional well-being, among other competencies.

The thinking process associated with using the MIRTS was illustrated using a logic model. A logic model links the intended outcomes of a service or program with the planned activities, processes or inputs. The logic model was a valuable way of helping to structure thinking about curriculum objectives, activities, inputs, outputs and intended outcomes.

I found IM to be a useful planning template as it enabled a curriculum to be developed that is theoretically grounded and evidence-based, with independent, systematic involvement from key stakeholders to ensure the curriculum met all its objectives. This is one of the key strengths of using IM; by using conceptual models, I was able to construct a curriculum that is pragmatic and tailored to the needs of young people with FASD.

The structured IM process provided a roadmap for the detailed situational analysis and development of curriculum contents, as well as establishing performance objectives and change objectives. Matrices were developed that linked determinants of behaviour change to performance objectives resulting in change objectives that were then mapped to some of the tools developed that are the basic elements of the curriculum. Application of the IM protocol enabled the linking of strategies and tools to theories to analyze the curriculum’s underlying mechanisms that are believed to impact the desired outcome.

In addition, IM promotes consultation and discussion with a range of different professionals, agencies, and support services. This is a unique aspect of IM, which is made distinctive by the involvement of key stakeholders in confirming the appropriateness and relevance of the curriculum’s content and activities. Intervention mapping has been used to provide a systematic process to
develop new interventions as well as to adapt existing interventions to new populations in culturally appropriate way. Most of the literature on IM includes the methods and process, but none has described integrating the IM process into a framework for professionals working with young people with FASD.

I chose IM because it facilitated a process whereby I was able to draw on my practical experience, theory, and pedagogical techniques, as well as consult with key stakeholders throughout the process. Many of the stakeholders consulted are far more versed than university researchers in what is feasible and culturally acceptable in their communities—they understood both the individual and collective capacities of young people with FASD, resources, informal relationships and which strategies would likely be most successful in effecting change. This allowed me to learn more about the social relationships and practice-base evidence and how to creatively and effectively integrate this reality into the research design for the curriculum to be successful. This was addressed throughout the entire IM process, through stakeholder input and involvement at every step, as well as reflection-in and on-action. I believed that the participatory and reflective approach to IM enabled me to address better the needs of young people with FASD and to design a more comprehensive curriculum that addresses the needs of young people with FASD, the information needs of clinicians working with this population, and broadly speaking a curriculum that was acceptable to all the stakeholders consulted and many clinicians who have reviewed it.

Early formative work enabled depth of the data to be gathered; it also proved essential for meeting the information needs of clinicians. The overall formative evaluation allowed exploring the curriculum’s relevance, usability, practicality, and effectiveness. The evaluation provided data that guided decisions about the future direction of the curriculum. The systematic and comprehensive methods of formative evaluation are also in line with reflective practice and the integration of stakeholders into the process provided valuable insights into how to revise, modify and refine the curriculum. This approach resulted in raising awareness of the curriculum and a number of agencies
requesting presentation and training to their clinicians. I conducted three 3 hours of training on the curriculum upon request from two agencies. After completion of the training, clinicians asked questions and initiated discussions about the curriculum. Overall, the curriculum was well received, and the contents and activities were deemed relevant. Many inquired about availability for use and requested further training.

6.1. Strengths and Limitations

A perceived strength, and perhaps the most vital and novel aspect of this curriculum is the use of holistic, multidimensional approaches to inform the design and content of the curriculum and ensure it is relevant and appropriate for the target population. The use of mindfulness, resilience, trauma-informed and social pedagogy theory to such a comprehensive curriculum for professionals who work with young people with FASD to enhance self-management, motivation and behavior change, is also a likely strength. Given the evidence that indicates emotional dysregulation, intergenerational histories of trauma, substance use, and other mental health challenges among young people with FASD. Furthermore, using IM has enabled me to develop a theoretically underpinned and evidence-based curriculum, the contents of which are pragmatic.

This is one of the few studies to describe in detail the theoretical basis, intervention techniques, and strategies for an intervention for working with young people with FASD. Through the use of IM methods, the theoretical basis, desired outcome, objectives, behavior change techniques and implementation strategies can be seen to fit together as a coherent intervention model. However, it is important to acknowledge several challenges encountered. Although there were common themes that arise from the consultative process, the differences in stakeholders’ view of appropriate service had to be balanced. For example, stakeholders’ also had varying perspectives about conceptions of needs and varied in their practice pedagogical techniques and theory. Some were more grounded in behavioural theories while others were grounded in narrative theory and
social constructivism, as well as research and program planning methods. I had to find a way to carefully manage the perspectives of all parties involved, to create a curriculum that balances practice-based evidence, evidence-based practice and pragmatism effectively. After developing the theoretical framework, I developed a synopsis of it to address any challenge as it relates to social pedagogy as most of them were not familiar with the concept. This was time intensive, but a necessary process.

Using IM to develop such a curriculum, which addresses multiple needs and behaviours proved to be cumbersome and at time consuming process, especially because the curriculum was being developed from scratch. The tasks often involved a considerable amount of time spent reviewing, revising and refining (e.g., to performance objectives, practical intervention applications, formative evaluation, etc.) based on suggested amendments from my dissertation supervisor and committee, consultative process, and double checking that each step in the process has been undertaken in the correct way. The need for significant key stakeholders’ time and resources was also a challenge. However, I profited considerably from these labour-intensive contacts, obtaining reassurance on intervention fidelity, having opportunities to reinforce the framework, conduct training, and deepening bonds with colleagues. Although IM is a complex and time-consuming process, the benefits of its consistent application seem to outweigh its costs by ensuring more effectiveness and efficient learning through its evaluation processes.

Though systematic and evidence-based, the IM process has an element of subjectivity due to the need to merge stakeholders’ perception, practice-based evidence and psychosocial research evidence, matrix mapping, and the reflective-based approach in facilitating comparison, documenting and analyzing activities may be considered a further limitation. However, many researchers have contended that data are themselves narrative constructions of experience, and we can only claim to have interpreted a reality, as we understood both our experience and our clients’ portrayal of theirs.
Another weakness reported by others using intervention mapping is that some will view it as a protocol (an inflexible set of rules) rather than a guide that is flexible and assists with the decision-making process to meet developers’ needs and circumstances. In general, I found that the framework was very useful as a planning tool, assisting in setting time frames, and providing a clear outline of how the curriculum content will be developed.

The situational analysis and formative consultation provided key qualitative data. Moreover, formative feedback led to real-time refinements to the curriculum, which maximizes the chances of success. However, it also raises a question as to whether the curriculum would work if replicated without the formative evaluation component. Clearly there is limited generalizability. In addition, as the providers in the study are from a specific area, there may be different sets of issues experienced by very different context; however, taking into account the broader literature review, the issues addressed in this curriculum are likely to reflect concerns of clinicians and needs of young people with FASD on a larger scale.

Finally, although some training has been conducted, due to the nature of the training the feedback could not be utilized. Pilot testing the curriculum will be significant as this will provide greater details on the effectiveness, efficiency, and impact of the curriculum.

6.2. Implications & Conclusion

Application of a modified IM enabled the linking of strategies and tools to theories to analyze the curriculum’s underlying mechanisms and desired outcomes. Empirical study of the efficacy of the curriculum and client feedback on useful curriculum elements will be the next phase underway, and findings should provide added insight and understanding about the curriculum.

A curriculum for professionals working with young people with FASD will add to the body of work for individuals with FASD. This curriculum has the potential to provide professionals with a broad range of information, activities, and training when working with this population. It also
expands the body of literature on FASD—informed practice and provides more comprehensive information on what is required. Interventions to address FASD and co-occurring disorder and other complex behavioural interventions in young people with FASD could adopt similar methods to clearly outline their intervention methods and the causal processes hypothesized to underlie the desired changes in the behavior of children and young people with FASD. I believe that this framework allows a deeper understanding of the processes through which such interventions work, improving our ability to design and deliver consistently effective interventions. I completed a modified IM to develop the curriculum, although time consuming, the use of IM has allowed me to determine my goals, the determinants, change objectives, practical strategies, and formative evaluation of the curriculum. This will guide me as I work towards implementation—piloting the curriculum.
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Appendices

Appendix 1: Analysis of Key Stakeholder

### Analysis of key Stakeholders

<table>
<thead>
<tr>
<th>Key stakeholders:</th>
<th>Interest</th>
</tr>
</thead>
</table>
| **Clinicians**    | ▪ Increase knowledge and skills in working with young people  
                     ▪ Create better dialogue with young people with FASD  
                     ▪ Develop positive attitudes towards young people with FASD  
                     ▪ Promote resilience  
                     ▪ Promote mindfulness  
                     ▪ Promote sense of agency  
                     ▪ Ensure access to appropriate and comprehensive service and support  
                     ▪ Improve quality of service  
                     ▪ Contribute to positive choices and decisions in young people’s life  
                     ▪ Adopt an FASD— informed approach |
| **Service providers** | ▪ Support quality of service provided  
                        ▪ Incorporate an FASD— informed practice  
                        ▪ Support innovative projects  
                        ▪ Provide wide ranging resource and training  
                        ▪ Increase resources  
                        ▪ Build linkages and partnership  
                        ▪ Increase training for clinicians |
| **Government ministries (addiction, mental health, youth justice)** | ▪ Develop treatment curricula  
                          ▪ Use integrated and comprehensive resource material  
                          ▪ Reduce risk factors  
                          ▪ Enhance protective factors  
                          ▪ Improve services  
                          ▪ Support innovative projects |

<table>
<thead>
<tr>
<th><strong>Primary Stakeholders</strong></th>
<th><strong>Interest</strong></th>
</tr>
</thead>
</table>
| **Young people with FASD** | ▪ Have reliable information  
                            ▪ Increase knowledge and develop skill  
                            ▪ Improved service  
                            ▪ Improved resilience capacity  
                            ▪ Improved social & emotional learning  
                            ▪ Increase participation  
                            ▪ Improved relationships  
                            ▪ Improved sense of agency |

Table 18: Key Stakeholder Analysis
### Work sheet: Stakeholder Analysis

**Instructions:**
- Describe the stakeholders on various levels that are involved in service provision for young people with FASD.
- Describe the reasons and interest for these stakeholders to be involved in one way or another.
- Describe the roles and responsibilities (clinicians, agency, expert…) of the targeted key.
- Who can help with specific tasks within the process?
- Who have experience in doing similar projects?
- From whom do I need support if I want to implement and pilot this curriculum?

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Role</th>
<th>Description</th>
<th>Interest</th>
<th>Responsibility</th>
<th>Organization/Agency</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Table 19: Worksheets IM Step 1: Expanded Stakeholder Analysis.
**WORKSHEET**  
Analyze the therapeutic environment

**Instruction**
- *Describe the possibilities and constraints in the addiction system and clinicians to implement the curriculum.*

**Worksheet:**

<table>
<thead>
<tr>
<th>Capacity -</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths -</td>
</tr>
</tbody>
</table>

**Predisposing Factors**

**Enabling Factors**

**Reinforcing Factors**

**Table 20:** Sample Worksheet used for Analysis of the Therapeutic Environment.
WORKSHEET
Behavourial Determinants

**Instruction**
- What are the determinants of behaviour of young people with FASD?
- What are the determinants of behaviour of actors in the environment who are responsible for the environmental factors?

**Worksheet:**

Behaviour -

Actor -

Determinants:

1) Knowledge

2) Perception

3) Attitude

4) Social influence

5) Skills and self-efficacy

6) External barriers

**Table 21:** Sample Worksheet of Behavioural Determinant
## WORKSHEET
Assess the behaviour and environment of young people with FASD

### Instruction:
*Which behaviours and environmental factors influence the needs of young people with FASD?*

### Worksheet:

**Problem:**

1) **Behaviour**
*Which behaviours of young people with FASD either put them at risk or protect them?*

2) **Environment**
*Which environmental factors contribute to, or protect young people with FASD?*

---

**Table 22:** Sample Worksheet for Assessment of Behaviour and Environment
**WORKSHEET**
Exploring the agency, needs, rights, well-being and quality of life of young people with FASD

**Instruction:**
- Describe the most important needs of young people with FASD with regard to their quality of life, and well-being.
- Describe the psychosocial needs of young people with FASD.
- Describe the rights of young people with FASD.

**Worksheet:**

1) **Quality of life**
*What are the major quality of life concerns of young people?*

2) **well-being**
*What do young people with FASD need to improve well-being?*

3) **Rights**
*What are the rights of young people with FASD?*

4) **Psychosocial needs**
*What are the psychosocial needs of young people with FASD?*

---

**Table 23:** Sample Worksheet for Exploring the Needs, Rights and Well-being
<table>
<thead>
<tr>
<th>Stakeholders Consulted</th>
<th>Number</th>
<th>Qualifications</th>
<th>Experience &amp; Expertise</th>
</tr>
</thead>
</table>
| Program Managers       | 5      | ▪ 1—Masters degree in program planning and development  
▪ 3—Masters degree in social work  
▪ 1—Masters degree in psychology  | Experience and expertise in:  
▪ youth mental health and addiction  
▪ Youth justice  
▪ Program planning  
▪ Working with youth with FASD  |
| Youth Forensic professional | 1      | BA- Psychology  | Youth justice rehabilitation program  |
| Behavioural consultant  | 1      | MA- Psychology  | Experience and expertise in:  
▪ Trauma, FASD  
▪ Working with youth in foster care and foster parents  
▪ Working with social workers and other clinicians  
▪ Youth justice program  
▪ Youth addictions  |
| Clinical Manager and consultant | 2      | Masters degree Social work  | Expertise in:  
▪ Youth mental health and addiction  
▪ Youth forensic  
▪ Trauma  
▪ Working and collaborating on treatment planning for young people  
▪ Supervising clinicians  |
<p>| Outreach worker        | 1      | BA-Social work  | Working with youth struggling with mental health, addiction, homelessness, FASD and other legal issues  |</p>
<table>
<thead>
<tr>
<th>Stakeholders Consulted</th>
<th>Number</th>
<th>Qualifications</th>
<th>Experience &amp; Expertise</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinicians</td>
<td>4</td>
<td>▪ 2—MA, Psychology,</td>
<td>Youth addiction</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ 1—BA, Psychology,</td>
<td>Youth mental health</td>
</tr>
<tr>
<td></td>
<td></td>
<td>▪ 1—BA, Socialwork</td>
<td></td>
</tr>
<tr>
<td>Clinical coordinator</td>
<td>1</td>
<td>MA, Psychology</td>
<td>Experience and expertise in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ youth mental health and addiction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Working with youth with FASD</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Youth addiction</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Trauma</td>
</tr>
<tr>
<td>Mindfulness Consultant</td>
<td>1</td>
<td>Certification in mindful practices and Ayurveda practice</td>
<td>▪ Working with families</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>▪ Teaching mindfulness techniques to clinicians</td>
</tr>
<tr>
<td>Yoga &amp; Pilates Instructor</td>
<td>1</td>
<td>Certification in teaching yoga and Pilates</td>
<td>Teaching yoga and Pilates</td>
</tr>
<tr>
<td>Curriculum Expert</td>
<td></td>
<td>PhD, Education</td>
<td>University Associate Professor</td>
</tr>
</tbody>
</table>

**Table 24:** List of Individuals Consulted
### Consultation Questions

#### Needs

1. *What are some of the most important issues for young people with FASD?* — *What are the needs of young people with FASD?*
2. *What are the needs of professionals working with young people with FASD?*
3. *What has been your experience in working with young people with FASD with co-occurring substance use problems?*
4. *What are your lessons learned for effectively working with young people with FASD?*

#### Health and well-being of young people with FASD

1. How healthy is the development of young people with FASD?
2. What are the ideals of young people with FASD and what are the conditions for young people to reach their ideals and desired outcomes?
3. What are successes and opportunities and what are the barriers?
4. What do you recommend for reinforcing the successes and creating more opportunities and positive outcomes?
5. What are in your view the problems young people with FASD today?
   i. How is that when you look to their physical, psychological and social development?
   ii. Are gender differences important? Why?
6. How important is puberty in defining adolescents’ health needs?
7. Is substance use increasing? Is this reflected in problems and needs of young people with FASD?

#### Supportive environment

1. Are policies at national level supportive for improving outcome young people with FASD?
2. Are international policies relevant as well?
3. Are children’s rights relevant? Why (not)?
4. Are program policies supportive?
5. What kind of supports do young people with FASD need?
6. Do the existing addiction treatments offer appropriate services?
7. What in your view can best be done to improve service and support for young people with FASD?
8. Are you already actively using an FASD—informing approach?
9. Is your agency using an FASD—informed approach?
10. What information and support do you need to contribute to appropriate interventions for the young people with FASD?

Table 25: Sample Questions Addressed in Consultation.
<table>
<thead>
<tr>
<th>Existing programs/curriculums and description</th>
<th>Desired program Outcomes</th>
<th>Objectives</th>
<th>Evaluation recommendations (if any)</th>
<th>Limitations</th>
</tr>
</thead>
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Table 26: Sample Worksheet of used to Analyze Existing Program
Appendix 4: FASD-Informed Practice

FASD-informed practice assumes that young people with FASD are doing the best they can at any given time to cope with the challenges they are experiencing. Young people with FASD quite often have multiple and interlocking needs that span social and health issues; many problems including substance misuse, mental health, and self-injury are usually attempts to cope with overwhelming feelings. The challenge for substance use treatment providers and clinicians is to provide services and supports that address multiple needs.

To meaningfully facilitate change, promote resilience and wellness, it is important for substance use treatment providers, mental health, and youth justice workers to make the connections between a young person’s experience of having FASD, possible trauma experiences and his/her problematic substance misuse and psychosocial concerns.

In particular, the youth justice system and substance use treatment programs are becoming increasingly aware of the need for integrated approaches to better respond to the acuity and chronicity of these types of problems among young people with FASD. FASD-informed practice builds on this by recognizing the need to respond to an individual’s intersecting experiences of disability, physical health, mental health, substance misuse, trauma and relational and social concerns. Being FASD-informed means that agencies and clinicians have an understanding of FASD and how FASD can impact a young person’s life and are prepared to provide services that are appropriate to the individual’s needs. Positive outcomes can, and do occur when programs for young people with behaviours or characteristics of FASD are designed with FASD-informed approaches.

Substance use treatment programs vary widely across regions and service provision. While some agencies will already have an FASD-informed approach in place, others may not. The list of questions below can be used to help you to begin to reflect on your practice while the table provides FASD-informed practice considerations for agencies and clinicians to contemplate. They are intended to guide and support the translation of FASD-informed principles into practice. For the clinicians’ checklist, if you answer No to more than half of the questions, you may wish to consider some training and professional development related to FASD. More generally, ongoing training, guidance and supervision are useful to help support an FASD-Informed practice. The guide is based on findings from the literature reviewed; lessons learned from my practice experience; and, ideas
offered by many of the young people with FASD I have worked with throughout the years.

A good place to start is to discuss with colleagues what FASD-informed practice is, and what it is not. You may also wish to use the opportunity to reflect on your own beliefs, values, attitudes and assumptions. It is important that you are aware that your attitudes and values about individuals with FASD will influence your perception and how you work with a young person. Spend some time reflecting on how your values, beliefs, attitudes and assumptions are evident in the philosophy of the service the agency offers and in your daily work with young people and their families.

Questions to consider:

1. How can we respect the uniqueness of the young people with FASD we serve?
2. How do we deal with ‘difference’ at our agency, or as individual clinicians? Are young people with FASD encouraged to be themselves? Are they invited to participate in processes that impact them?
3. Is the potential for every young person to become valued, fostered and enhanced by them accessing our service?
4. What do we do now and what can we do to make every individual feel safe, welcome, and valued?
5. What is evidence of being, belonging and becoming in our action here?
6. What would an environmental audit of our setting show about our ability to adapt and create an environment conducive to the needs of individuals with FASD?
7. Are we providing resources that can foster sustainable change?
8. What opportunities do we provide for families to communicate with us about their children so that we can learn from them; and for us to explain what we do, as well as, provide adequate support or linkages?
9. How do we empower young people with FASD?
<table>
<thead>
<tr>
<th>FOCUS AREA</th>
<th>APPLYING FASD—INFORMED PRACTICES</th>
</tr>
</thead>
</table>
| Holistic Approach              | - Recognize that what is going on in one part of an individual’s life can affect many other areas of his or her life. Social context can create particular psychosocial vulnerabilities. It is, therefore, important to understand the social dimension of FASD.  
- Well-being includes many different aspects of an individual’s life, such as physical, and material aspects, psychological, social, cultural and spiritual aspects. Thus, the focus of treatment need not be just on the individual, but can also include families and communities. Support, wherever possible, those who know the young person well, know what they need, what works well for them and what may not be helpful. |
| Respect & Inclusion            | - Maintain the position that the individual and his/her family are resourceful. Be willing to work with them as partners in building safety, nurturing growth, and sustaining change.  
- Create a space where individuals feel safe to voice their concerns and feel esteemed.  
- Treat a person with FASD as an individual, not a condition.  
- Be attentive to their need for autonomy and inclusion. If the basic rights of a young person are ignored, even a young person who is resourceful and confident risks being overwhelmed. |
| Recognizing Capacity           | - Use an individual’s abilities, existing networks, and support where possible.  
- It is more useful to assume an individual’s or family situation to be ‘complex’ rather than characterized by risk. This will help shift the focus from one of deficits and risks to one which actively appreciates individual, family and situational strengths and capacities.  
- Identify and highlight positive aspects of the individual. Focus on what the individual is doing well to build the individual’s sense of self.  
- Provide opportunities for young people to thrive, nurture their development, mentor and teach life skills.  
- Create an environment that encourages |
| Valuing Diversity              | - Individuals with FASD should feel valued in all circumstances.  
- Understand the multiplicity of experiences among individuals with FASD (i.e., History of abuse, and Child Protection service involvement, victimization, youth justice involvement, mental health involvement, education, GLBT, employment).  
- Appreciate and nurture the uniqueness of each individual.  
- Try to find ways of helping individuals with FASD without stigmatizing them. |
| Linkages and Circles of Support | - Recognizing individuals with FASD and their families need practitioners to work together, when appropriate, to provide the best possible help. Establish an open mind and always engage in critical thinking and maintain a position of inquiry.  
- Strengthen the relationship that an individual has with a trusted care-giver  
- Promote within the individual and his/her family a sense of control (versus helplessness)  
- Encourage individuals to utilize other community resources and help individuals to access other support.  
- Make use of local capacity, for example by consulting and building alliances with other community organizations or clinicians |
<table>
<thead>
<tr>
<th>Guideline for FASD-Informed Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Empowerment and Resilience</strong></td>
</tr>
<tr>
<td>- Help clients to discover their personal strengths and capacity and support their efforts to take control of their lives and achieve their goals.</td>
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<tr>
<td>- Encourage participation to bring about ownership and continuity of any change.</td>
</tr>
<tr>
<td>- Consult individuals about what types of supports they need and what works best for them.</td>
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<tr>
<td>- Build resilience in individuals and their families to address their own challenges.</td>
</tr>
<tr>
<td>- Make assessments and evaluation of progress and include individuals in the process.</td>
</tr>
<tr>
<td>- Focus on what people are already doing well and build on this.</td>
</tr>
<tr>
<td>- Help them to recognize choices and encourage independent decision making.</td>
</tr>
<tr>
<td>- Work to remove gaps and barriers in service.</td>
</tr>
<tr>
<td><strong>Assist the young person in becoming solution—focused</strong></td>
</tr>
<tr>
<td>- Explore with individuals their preferred future, rather than just be focused on and fixing a problem. Identify resources, strengths and goals to attain the preferred future (and in doing so change the problem).</td>
</tr>
<tr>
<td>- Use of conversations centered on clients’ concerns.</td>
</tr>
<tr>
<td>- Engage in conversations focused on co-constructing new meanings surrounding clients’ concerns.</td>
</tr>
<tr>
<td><strong>Consider culture and Structural determinants of health</strong></td>
</tr>
<tr>
<td>- There are strong continuities in the structural factors that condition an individual’s life chances, including gender, class, race, economic status and geographic location; be mindful of these factors and how they impact an individual.</td>
</tr>
<tr>
<td><strong>Sustainability</strong></td>
</tr>
<tr>
<td>- Develop and use approaches that ensure results in lasting and fundamental improvements in the lives of individuals with FASD, rather than only offering support that creates dependency.</td>
</tr>
<tr>
<td>- Focus on the quality of what is given and how it is given as opposed to the quantity (statistic) of what is given. Individuals will respond better when supports appropriately match their needs.</td>
</tr>
<tr>
<td>- Enhance self-resilience and empower individuals with appropriate coping, mindfulness and self-reliance skills.</td>
</tr>
<tr>
<td>- Provide opportunities for transition planning.</td>
</tr>
<tr>
<td>- Strengthen the capacity of families and other support network to support individuals with FASD.</td>
</tr>
<tr>
<td>- Develop the capacity of individuals to manage change.</td>
</tr>
<tr>
<td><strong>Trauma—Informed</strong></td>
</tr>
<tr>
<td>- Take into consideration the impact of intergenerational histories of trauma, as well as the individual own possible history of trauma.</td>
</tr>
<tr>
<td><strong>Knowledge of FASD</strong></td>
</tr>
<tr>
<td>- Understanding of, and knowledge of FASD, as well as it impacts on individuals and family.</td>
</tr>
<tr>
<td>- Continuous training and service improvement to meet the needs of individuals with FASD.</td>
</tr>
</tbody>
</table>

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Creating an FASD—Informed Agency

Given that current systems of care have not adequately addressed the needs of individuals with FASD, it is important that service providers and clinicians’ conceptions of young people with FASD be informed by an approach that appreciates the complexity of their lives, and respects their lived experiences. For many service providers and clinicians working with individuals with FASD, a commitment to FASD-informed practice can represent a paradigm shift in culture, value and attitude. A solemn commitment to FASD-informed practices will ensure that all young people receive services that are suitable and sensitive to their multiple needs. Getting started with an FASD-informed approach will require making an internal audit. An agency can begin this inquiry process by thinking about what they are thinking and identifying gaps in their service provisions; then making changes to an organization’s culture and practice.

Each service and agency tend to be characterized by a professional culture. Changing the organizational culture and practice will offer individuals and families a way of working with them that is based on recognizing the impact of FASD on their lives. Through an FASD-informed lens, some of the forces at play in the lives of individuals with FASD can be more effectively brought to light. At the individual level, an FASD-informed approach can help to understand, in a non-pathologizing way, the range of coping strategies that individuals with FASD adopt in order to work through their challenges.

<table>
<thead>
<tr>
<th>Reflect</th>
<th>Questions to consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critically think about and assess what you are currently doing.</td>
<td>Who in the agency can influence an FASD— informed practice?</td>
</tr>
<tr>
<td>Evaluate how things are done.</td>
<td>What are our organization’s culture and policy as it relates to FASD?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reframe</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Look closely at the practice approach and guiding principles.</td>
<td>What adjustments need to be made to address the identified gaps?</td>
</tr>
<tr>
<td>Look at how individuals with FASD are conceptualized.</td>
<td>How do we understand individuals with FASD?</td>
</tr>
<tr>
<td>Identify strengths and gaps in your current approach.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Act</th>
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<tbody>
<tr>
<td>Decide what changes, big or small, need to be made.</td>
<td>How can we find out how young people with FASD feel about the service we provide?</td>
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<tr>
<td></td>
<td>What might we change after our conversation?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Revisit</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe how a shift to an FASD—informed practice is impacting individuals, families and clinicians.</td>
<td>Where can we see the impact of an FASD-Informed practice with our engagement with individuals with FASD?</td>
</tr>
<tr>
<td>Amend aspect of change as needed.</td>
<td></td>
</tr>
</tbody>
</table>
Change in organizational culture includes:

- Change in policy statements that reflects the diversity of clients’ served
- Changing culture through training
- Shift in organizational philosophy
- Adaptations to current guiding principles
- Examination of the agency and individual clinicians’ values, norms and ways of doing things

Change in practice includes:

- Clinicians support for changing practice.
- More comprehensive practice guidance.
- A clear understanding for every one of what the change means for them and their individual practice.
- Making practice individual-centered
- Integrate existing evidence with professional expertise to provide optimal service.
- Consider how the best available research findings relate to individual practice situations.
- Ensure that good practice in engaging individuals and families impacted by FASD becomes the norm.
- Ensure that staff have the skills and tools to engage effectively with individuals and families
- Use training and supervision to reinforce the importance of an FASD-Informed practice
- Make use of a trauma-informed lens.
- Appreciate the context with which interactions with individuals with FASD takes place
- Healthy dialogue about the principles and shared beliefs that relate to inclusion, diversity, and equity. Clinicians must recognize every young person with FASD as having a voice and unique views about how to participate in processes that involve them.
## A Clinician Checklist

**Knowledge**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you know what FASD is? Can you explain it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you taken any FASD related training?</td>
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</tr>
<tr>
<td>Can you explain to a client what FASD is, including the impact?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you recognize the secondary and primary disabilities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you comfortable talking about FASD?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you familiar with community resources for individuals with FASD?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Strength-Based**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you believe that individual with FASD can learn and change?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you believe that individuals with FASD are resilient?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you encourage and support an individual’s agency and self-efficacy?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you believe you can work collaboratively with a client and/or his/her family to affect positive change?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you quell the myths surrounding FASD in your work with people?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you demonstrate respect towards client?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>So you advocate on behalf of clients who need assistance in accessing resources?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Cultural Responsiveness**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you respect and value a client’s cultural way of being and doing?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you make the effort to provide culturally appropriate services when requested?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you consider cultural background when making referrals and out-sourcing resources?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Relationship Building & Therapeutic Alliance**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you make sure clients are comfortable with questions you ask them?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you try to establish a genuine, caring connection with clients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you work collaboratively with clients regarding the purpose, goals, and tasks needed for positive change in the client’s life?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you avoid jargons when communicating with a client?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you establish a sense of safety for clients?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Assessments**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you ask about the impact of FASD in their life?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ask about what’s challenging and what’s easy for them?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are you flexible by allowing the client to discuss issues, which are important to them?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ask about any mental health or trauma issues?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ask about past or current drug and/or alcohol use?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ask about safety issues?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you acknowledge the cultural and health determinants?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Coping**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you acknowledge the link between FASD, mental health, substance misuse and trauma?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ask clients how they cope with difficult behaviours that may result from trauma experiences or substance misuse?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you ask clients about how they cope with the difficult feelings/emotions they experience?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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Appendix 5: Table of Contents

<table>
<thead>
<tr>
<th>Chapter 1: Introduction</th>
<th>This section introduces clinicians to the curriculum, guiding principles and theoretical components are presented.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chapter 2: How to facilitate MIRTS Modules</td>
<td>This chapter provide details of how to use the material and some techniques for engaging clients.</td>
</tr>
<tr>
<td>Chapter 3: FASD overview</td>
<td>This section provides clinicians with an overview of FASD</td>
</tr>
<tr>
<td>Chapter 4: FASD-Informed Approach</td>
<td>This chapter focuses on developing and FASD-informed approach and what clinicians and agencies can do too become FASD-informed</td>
</tr>
<tr>
<td>Chapter 5: Other considerations</td>
<td>This chapter explore various topics relevant to MIRTS and the therapeutic process. Topics explored are; needs, diversity, being, belonging and becoming.</td>
</tr>
<tr>
<td>Chapter 6: Client Orientation</td>
<td>This chapter review issues of safety, rights and responsibilities—the informed consent process.</td>
</tr>
<tr>
<td>CURRICULUM UNITS:</td>
<td></td>
</tr>
<tr>
<td>Chapter 7: Identity</td>
<td>Fundamental to this curriculum is the concept of being, becoming and belonging. This section provides the opportunity for clients to explore who they are, their sense of being, and their needs. This section looks at the young person as an individual. It examines the different aspects of growth and development that he/she goes through. It is meant to help young people with FASD understand themselves better.</td>
</tr>
<tr>
<td>Chapter 8: Promoting Mindfulness</td>
<td>This section provides the opportunity for clients to cultivate non-judgmental awareness and attention. It is about observing ‘the self’— (thought, behaviour, feelings and actions). As we pay attention, we begin to see ourselves more clearly. And based on our clear seeing, we are able to make wiser choices – so we can respond rather than react.</td>
</tr>
<tr>
<td>Chapter 9: Change</td>
<td>This section focuses on the process of change, what change is; and what change means to a young person. It provides opportunity towards greater self-awareness, alignment, and growth by providing the opportunity to share experiences, learn, and explore new possibilities.</td>
</tr>
<tr>
<td>Chapter 10: Fetal Alcohol Spectrum Disorder (FASD)</td>
<td>This section provides clients with a basic overview of FASD. Young people will be encouraged to discuss their subjective experiences of having FASD and the meaning they ascribe to it.</td>
</tr>
<tr>
<td>Chapter 11: Resilience Thinking</td>
<td>This chapter provides a discussion about sources of strengths, resources and relationships in the lives of young people with FASD. It provides the opportunity for participants to build on their capacity and strengths. It involves beliefs, thoughts, behaviours, and actions that can be learned and developed by anyone. It also explores the resources that are available to individuals and the relationships that nurture growth and development.</td>
</tr>
<tr>
<td>Chapter 12: Emotions</td>
<td>This section provides the opportunity for clients to learn about and understand the value of their emotions, and better understanding of how to cultivate coping skills and ways to manage their emotions without reacting. This section provides the opportunity for participants to learn various strategies to work through their thoughts and emotions so that they can feel better and tolerate moments of distress without feeling extremely overwhelmed.</td>
</tr>
<tr>
<td>Table of Contents</td>
<td></td>
</tr>
<tr>
<td>-------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 13: My Use</strong>—This section provides the opportunity for clients to explore their relationship with substance misuse, reasons for using, as well as, the impact of substance misuse on their life and their relationship.</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 14: Trauma (hurting feeling, hurting thinking &amp; hurting behaviours)</strong>—Drawing from trauma-informed literature, this section provides clients the opportunity to explore hurt feelings and beliefs as it relates to trauma.</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 15: Relationship and Skills</strong>—This section provides the opportunity for clients to explore hurt feelings and beliefs as it relates to trauma. The ability to work well with other and the ability to communicate are important social skills.</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 16: Mindfulness Integrated Change Management</strong>—This section focuses on helping clients to become aware of all incoming thoughts and feelings and accepting them, but not attaching or, reacting to them. Clients will learn to apply mindful concepts along with other change management strategies to help in sustaining their change with regards to substance misuse.</td>
<td></td>
</tr>
<tr>
<td><strong>Chapter 17: Transition Planning &amp; Support</strong>—This section discusses the process of transition and prepares clients for life after substance use treatment. Clients will work collaboratively with their support team to develop transition plans that are appropriate to their needs.</td>
<td></td>
</tr>
</tbody>
</table>

**Table 27:** Table of Contents with Descriptions.
Appendix 6: Mindfulness Flashcards

**SIT**
- Stop
- Identify the negative thought
- Try a different perspective

**CAR**
- Calm down
- Adjust your thinking pattern and breathing
- Re-evaluate how you feel
Appendix 7: Blank Outcome Sheet & List of Outcome Measures

Figure 10: Blank Outcome Wheel
**Outcome Wheel**

Use this sheet to record where you are and the reasons for giving the score chosen or any points you want to record base on our discussion of your progress.

<table>
<thead>
<tr>
<th>Goal:</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current score:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal:</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current score:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal:</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current score:</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal:</th>
<th>Notes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current score:</td>
<td></td>
</tr>
</tbody>
</table>
Table 28: Table with Examples of Outcome Measures

<table>
<thead>
<tr>
<th>Angus Council Well-Being Web</th>
<th>Outcome Stars</th>
<th>SACS, Drug Taking Confidence Questionnaire</th>
<th>Behavioural and Emotion Rating Scale</th>
<th>Mindfulness Attention Awareness Scale</th>
<th>The Rogers Empowerment scale</th>
<th>Brief Trauma Questionnaire (BTQ)</th>
<th>Resiliency Scale</th>
<th>The children Society Well-Being Tool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mindfulness</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Resilience</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing Feelings &amp; Emotions</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Planning and Problem Solving</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Relationship</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Creativity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Empowerment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Mental health and well-being</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drug and alcohol misuse</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-care</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical health</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Managing money</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Motivation and change</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Relapse management</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-confidence</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trauma-Informed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

Table 28: Table with Examples of Outcome Measures
Stakeholder Formative Evaluation Questions

For each of the questions below, please provide feedback based on your assessment of the curriculum. Thank you for taking the time to consult with me on this curriculum.

1. To what extent does the curriculum address identified needs of young people with FASD?
2. What did you think about the main ideas, or components in the curriculum?
3. Is the overall flow of the session appropriate for the intended audience to learn the material?
4. Are the activities in the curriculum engaging? If not, please specify suggestions to improve it.
5. Are the activities appropriate? If not, please specify.
6. Is the information presented relevant?
7. How effective are the instructions in the curriculum modules?
8. Is the amount of instructional content available adequate? If not, please explain what else should be provided.
9. Did you have any problem with understanding the instructions or the material as presented? If instructions weren't clear, please suggest where improvements could occur.
10. What aspects of the curriculum do you perceive to not be working well?
11. What else would you have liked seeing as part of this session?
12. What was the most significant takeaway point that you got from the training session?
13. Would you use this curriculum with your client or group? Why or why not?
14. Would you recommend the curriculum to colleagues? Why or why not?
15. Please add any additional comments or suggestions.
### Summary Examples of Stakeholders’ Formative Evaluation Responses

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
</table>
| To what extent does the curriculum address identified needs of young people with FASD? | – I think the curriculum is very comprehensive and addresses the range of needs that FASD youth can present with. I like the fact that you state at the beginning that individual practitioners should conduct an initial assessment and determine which modules would be most appropriate for a particular group. Ultimately, I think that all the modules are likely to be appropriate for most youth but time constraints will undoubtedly determine which modules are given greater priority.  

– The MIRTS Model extensively addresses the needs of young people with FASD by equipping practitioners with current, well-informed and evidence-based research and curriculum to meet the needs of youth whom they are working with. This work is dynamic and inspiring as it draws the practitioner on a journey of understanding how building on the foundational principles of mindfulness, resilience, trauma-informed practice and social pedagogy allows the youth to explore change and growth in their lives. The curriculum meets the youth where they are at currently, valuing their current coping strategies, while allowing them to explore new ways of considering change, through a holistic perspective. I particularly appreciated this approach, as too often, material can be simplistic in nature, thus under-valuing the multifaceted needs and perspectives that participants bring with them.  

– The needs of youth with FASD in this document are extensive, thorough and address the needs of youth with FASD. It also explains how FASD is multifaceted and how to address the needs for an individual where he/she is functioning.  

| What did you think about the main ideas, or components in the curriculum? | – In my view, the ideas and components reflect current research and evidence (which you have obviously identified very clearly). The fact that the modules are experiential is important in terms of encouraging youth engagement in the material, application to themselves and their situation and it also reflects the way in which they are most likely to learn.  

– The MIRTS Model presents research and thoughtful guidance for clinicians to truly understand and grasp the process that change takes with individuals living with FASD. This curriculum and facilitator’s guide assists practitioners in understanding the youth as an individual who is a dynamic person with multifaceted needs,  


desires and value. Using a lens of Mindfulness, Resilience, Trauma-Informed Practice and Social Pedagogy, Ms. Mockett assists in understanding the framework which wellness is based upon and provides the structure for participants to explore their centralized need of being, becoming and belonging in an appropriate and holistic way.

- The main components of the curriculum were well articulated and simple to follow. It touches on important portions of FASD using mindfulness, visuals, and simplified tools for use with a person who identifies as having FASD. This would work well with other individuals who struggle with other cognitive differences as well.

<table>
<thead>
<tr>
<th>Is the overall flow of the session appropriate for the intended audience to learn the subject? Are there any suggested improvements?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- I have made some specific comments in question 10 below. Depending on the needs of particular youth, some may need more direct assistance or to proceed at a slower pace. Generally speaking, however, the pace and flow seem appropriate. There is a good mix of activities from individual to group, from reflective to active, but all within a predictable and safe framework. The changes in pace will help those who have attention challenges.</td>
</tr>
</tbody>
</table>

- The overall flow of the sessions provided work well. I have facilitated groups with youth for 18 years in a variety of settings. The content is easily outlined for the facilitator, and appropriate for a variety of young people with complex needs. Activities that are suggested are thoughtful, and allow for the intended audience to explore the subjects that are delivered with each module as a group, and individually. Many agencies, such as not-for profit or government-funded agencies that are working with youth do not have extensive budgets to facilitate their groups. Materials and activities that are suggested suit the needs of a variety of agencies, which I believe will allow a greater number of youth to benefit from this program.

- The flow of the curriculum moves with fluidity and is well laid out in sequences that are interchangeable for those who may need to alter the program accordingly.

<table>
<thead>
<tr>
<th>Are the activities in the curriculum engaging? If not, please specify suggestions to improve the activity or alternate activities that could be used.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- As above, I found the activities varied and engaging as well as demonstrating the core concepts of the session well.</td>
</tr>
</tbody>
</table>

- Ms. Mockett has a creative, thoughtful and engaging mind, which is evidenced from the outset and throughout. Activities welcome participation from youth with a variety of needs, which not only assists with developing positive group dynamics, but also assists, with youth learning to understand, value and celebrate their
| Are the activities appropriate? If not, please specify. | -- Yes, most appropriate. I really like the way you begin and end each session with mindfulness or quiet moments. The constant repetition will make it much more likely that youth will use these skills in the real world or that they will benefit from them as a result of doing the sessions.  
-- Activities are appropriate, thoughtful and interesting. My Clinical Consultant at the agency with whom I am employed has seen the curriculum overview and encouraged it’s use with our clientele.  
-- The activities are great and appropriate, they are laid out so that those who may struggle can ask for aid from any individual and may easily identify with the activities |
| Is the information presented relevant? | -- As above, the curriculum address needs in a very comprehensive way. All the material is relevant. As you indicate, some modules might not be as relevant to some youth but this would be determined at assessment or become more apparent during the sessions  
-- Information is thorough, and relevant. I appreciate the in-depth nature of the material that has further assisted me as a therapist in understanding the needs of youth living with FASD. I also particularly appreciated the information, which assists agencies to begin exploring how their clinicians and agencies increase their FASD-informed practice. This encourages curiosity and a culture of learning, which is important for any agency to continue to grow and change based on their client’s needs. |
| How effective are the instructions in the curriculum modules? | -- The instructions are clear.  
-- Instructions are clear, concise and easily understood.  
-- The instructions are easy to follow, and well laid out. |
| Is the amount of instructional content available adequate? If not, please explain what else should be provided. | -- It is adequate. I have made a couple of specific suggestions in #10 below.  
-- The amount of instructional content exceeded my expectations. I have referred to the content on several occasions as I have found... |
the expertise a useful guide for my practice as a therapist. I also appreciate the extensive use of visual aids and the diagrams. With youth who are often dealing with language and memory challenges, the visual aids will increase and assist with understanding and retention.

- The instructions are adequate and are created in a way to enables a person to utilize what they have to offer the program.

<table>
<thead>
<tr>
<th>Did you have any problem with understanding the instructions or the material as presented? If instructions weren't clear, please suggest where improvements could occur</th>
</tr>
</thead>
<tbody>
<tr>
<td>- No problem understanding.</td>
</tr>
<tr>
<td>- After reading the entirety of the curriculum, I am looking forward to the opportunity to facilitate a group. The instructions are clear, concise and easily understood.</td>
</tr>
<tr>
<td>- Clear concise instructions.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What aspects of the curriculum do you perceive to not be working well?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- <strong>Being</strong>—A lot will depend on the individual youth, of course, but sometimes traumatized youth do not have a coherent view of themselves and can have difficulty providing descriptions. If youth are clearly struggling, they may need prompts or assistance and it might be worth mentioning in the instructions—particularly as the rest of the session depends on them having generated some characteristics initially.</td>
</tr>
<tr>
<td>- <strong>Understanding &amp; Expressing Emotion</strong>—Youth can often have a difficult time recognizing and naming emotions because this has not been part of their experience (mad, sad, happy pretty much covers it for some). I think the module is very worthwhile but, depending on the youth, they may need more time or more help with the first part of the session and in generating the list. The relationship between emotion and action is also quite complicated for some to grasp so it may need more time too. Perhaps this could be added to the instructions at the beginning of the session.</td>
</tr>
<tr>
<td>- Some changes need to be made to the trauma section so that clinicians with little training have more information.</td>
</tr>
<tr>
<td>- I cannot identify any aspects of the curriculum that are not working well. I appreciate that the material is designed to be flexible, as I am also interested in using this with youth in our programs who have complex needs, but may not have necessarily been exposed prenatally to alcohol.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What else would you have liked seeing as part of this session?</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Nothing additional comes to mind.</td>
</tr>
</tbody>
</table>
| - The thorough nature of the material allows me to feel confident in
delivering this material as is. I was not left feeling that there were missing portions of content for the group to explore. Again, the adaptability and creativity of the material is an asset, and the material itself is visually interesting and engages readers and participants.

| What was the most significant take away point that you got from the training session? | – Helping youth to develop reflective and practical skills in a very non-judgmental, fun and strength-based way.  

– While there were a number of key aspects that I appreciated from this material, I found the incorporation of social pedagogy into the model particularly thought provoking. This theory is a new concept for me to grapple with in my practice. The components of the theory resonated with me, and I have deeply appreciated this knowledge, insight and perspective that Ms. Mockett brings to the FASD community. This theory has allowed me to become curious about how my clients consider themselves in their family, culture and community and how to incorporate holistic education and well-being in their journey of empowerment. The more an individual is given the opportunity to explore these areas and celebrate, the less they may find the need to rely on substance use or other mal-adaptive behaviours. Anxiety and resistance to change can be safely explored and thus, the being, belonging and becoming are connected. I have attended many trainings over the years, and the social pedagogy portion of the curriculum is unique and a welcome aspect to add to a curriculum such as this. Thank you for this fresh perspective! I also appreciate that this material can be used with a variety of cultural backgrounds with clients. The inclusiveness and cultural safety that is built into the curriculum will work well with the diverse client population that we work with.  

– LOVE the reflection circle and check out questions. Appreciate the questions that you have compiled for clinicians. The responsive engagement and mindfulness components are the portions that “stuck out” for me  

– I very much appreciate that there is no time assigned to components of any given chapter. This is useful so that this is not rushed and as clinicians we can spend the appropriate time that is right for each client. |

| Would you use this curriculum with your client or group? Why or why not? | – Yes  

– Our agency’s Clinical Consultant has viewed the curriculum and is
supportive of our therapy team offering a group for youth in our program service area. We have been looking for an appropriate, effective, and responsive curriculum for the youth we work with. We hope to begin the referral process in September 2015, if possible.

<table>
<thead>
<tr>
<th>Would you recommend the curriculum to colleagues? Why or why not?</th>
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<tbody>
<tr>
<td>- Yes, I would recommend it because it is a) research based; b) comprehensive; c) engaging</td>
</tr>
<tr>
<td>- I have already asked permission to share this curriculum with other professionals here in Manitoba. I have been given permission to share the summary with the Manitoba FASD Centre, as well as with Macdonald Youth Services, the large, not-for-profit agency with whom I am currently employed. The summary has also been a topic of discussion between the therapists that I work with, as a way to assist with our process of becoming further FASD-informed in our practice. Some of our clinicians are new graduates. After discussion, we agreed as a team to attend a regional FASD conference in March 2015, as well as interview clinicians at the Manitoba FASD Centre. Exposure to well researched; thoughtful material such as MIRTS Model increases the desire for thoughtful engagement and clinical judgement within our clinical team and service area. I foresee that at our agency; this research and curriculum will assist with therapy groups for youth, increase the capacity of the caregivers and professionals who are caring for the youth, as well as inform the type of referrals we may make for therapeutic services for the youth in the care homes that we support.</td>
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<tr>
<td>- I would use this with my client group, however I may not utilize each session and only use the sessions that apply and not use it in a group setting. Sometimes clients may not engage for the full group sessions therefore I would work with the person on the components that meant the most to them or the portions that they needed the most. I think its a great curriculum and any person working in the field would benefit from this.</td>
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<table>
<thead>
<tr>
<th>Please add any additional comments or suggestions.</th>
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<tbody>
<tr>
<td>- Because the curriculum is so comprehensive, it could be used in a variety of different settings by a variety of people. Perhaps there should be a comment at the beginning of the trauma module, in particular, that this module should only be delivered in smaller groups when counsellors will be available immediately afterwards. Your curriculum really brings this body of work together</td>
</tr>
<tr>
<td>- I look forward to using this material in the work that I do as a</td>
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</table>
therapist who works with youth in foster care. I am also looking forward to the future research and development that Ms. Mockett will add in the field of FASD. Thank you for the opportunity to interact with and learn from such compelling work!

- I think it’s wonderful, I would love to have a training session with a group of colleagues.

Table 29: Summary Examples of Stakeholders’ Formative Evaluation Responses
Formative Evaluation
(Second Review Questions)

Thanks for providing feedback and suggestions about MIRTS Curriculum. I have summarized all the comments received and delved into the literature more. From this, I have revised the curriculum. In this second review, I would like your comment on the revised curriculum. Please think about the following questions below as you review the revised curriculum. Again, I thank you for consultation.

- Do the changes in this revised version of the curriculum adequately address your concerns and review comments from the previous version?
- Are the changes represented in this new version that you feel are inappropriate? Why?
- Are there changes that you think still need to be made to this current revised version?
- Do you have any other comments you would like to make?
### Table 30: Quality Checklist Questions

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<tr>
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<td>Is the purpose of the curriculum apparent?</td>
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<tr>
<td>Is the content comprehensive?</td>
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<tr>
<td>Is the content clear and understandable?</td>
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<tr>
<td>Is the curriculum well designed?</td>
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<td>Is the overall flow of the sessions appropriate for the intended users to</td>
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<td>learn the subject?</td>
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<tr>
<td>Are there activities that appear to be unrelated to the curriculum's</td>
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<td>objectives and that might have to be dropped?</td>
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<tr>
<td>Does the logic model illustrate the theory of change? Do the curriculum</td>
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<tr>
<td>activities logically follow one another?</td>
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<tr>
<td>Do the targeted outcomes represent meaningful changes or benefits for</td>
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<td>curriculum participants?</td>
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<td>Does the evidence suggest that the activities, if implemented, will</td>
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<td>produce desired outcomes?</td>
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<tr>
<td>Is the theory clearly articulated and based on evidence to illustrate how</td>
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<td>and why the curriculum will succeed?</td>
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<tr>
<td>What is great about the curriculum’s theory? (newly specified targets,</td>
<td></td>
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<td>new delivery mechanism?)</td>
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<tr>
<td>Is there evidence of use of current knowledge, research and/or practice in</td>
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<td>the area/discipline?</td>
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<tr>
<td>Are the outcomes clear and assessable? Do they reflect appropriate depth</td>
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<td>and complexity relative to needs of young people with FASD?</td>
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<td>Are there opportunities for transference of learning from one context to</td>
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<td>another?</td>
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<tr>
<td>Do the outcome measures fit with the learning outcomes? Are they relevant?</td>
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### Summary answer for Quality Checklist questions

<table>
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<tr>
<th>Key Questions</th>
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<tr>
<td>Is the purpose of the curriculum apparent?</td>
<td>- The purpose and use of the curriculum is clearly stated for the reader at the outset of the document, and is particularly succinct in the “Description of MIRTS”. In that section, Ms. Mockett describes the curriculum as follows. The MIRTS model is an integrated manualized curriculum for working with young people with FASD with co-occurring substance use and other mental health issues.” She outlines the use of mindfulness, resilience, trauma-informed and social pedagogy as a way to accomplish the goals of the curriculum. “The overall goal of the curriculum is to ensure the comprehensive fulfilment of the complex needs of young people with FASD and the realization of psychosocial outcome for young people with FASD.”&lt;br&gt;&lt;br&gt;- The curriculum consist of beautifully crafted and engaging diagrams, figures, and visual aids throughout the curriculum assists the clinician to use a variety of learning styles - and allows one the opportunity to fully understand the material at hand. Truly, the goal of engaging the clinician in using their hands, head and heart.&lt;br&gt;&lt;br&gt;- It is very clear and you’ve outline what the purpose is</td>
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<tr>
<td>Is the content comprehensive?</td>
<td>- This material is very comprehensive. Ms. Mockett’s use of theory and evidence-based research is interwoven throughout the material. She invites the clinician to understand complex theories, demonstrating how theories complement each other and can be used to assist those with FASD and substance use and/or other mental health needs. Her material breaks concepts down into interesting and manageable units.&lt;br&gt;&lt;br&gt;- Very much so, it is very comprehensive, most complete curriculum I have seen, very well laid out. It is clear why you are moving through the topic.</td>
</tr>
<tr>
<td>Is the content clear and understandable?</td>
<td>- The language is very accessible</td>
</tr>
<tr>
<td>Is the curriculum well designed?</td>
<td>- The MIRTS curriculum is well designed, with excellent visuals and graphic design, which allows for a greater understanding of the theory and model itself.&lt;br&gt;&lt;br&gt;- The curriculum flows well, is interesting and offers realistic material that the clinician could use with young people who are accessing this program. The material is also adaptable to the group, which it is delivered to, as it encourages the youth’s creativity, imagination and skill development in a safe and respectful context.&lt;br&gt;&lt;br&gt;- It is very logical, well designed. Description is good, and modules are clearly laid out</td>
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<tr>
<td>Key Questions</td>
<td>Comments</td>
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<tr>
<td>Is the overall flow of the sessions appropriate for the intended users to learn the subject</td>
<td>▪ The overall flow is appropriate for young people participating in a group. The sessions presented are again, thorough, creative and interesting. The sessions flow well and build upon each other with each progressive week. This is done by providing the opportunity for the participants to look inward and ultimately understanding themselves first, manage emotions and accept themselves in their world, using mindfulness as a way to ultimately be able to make healthier choices for themselves. The young people can then understand how change works and what that means, while linking education and understanding about what FASD is, and how they experience it. The participant can then look at their resilience, the value of their emotions and their substance use and its impact in their lives, developing alternative ways to manage emotions and manage distress. As the participants gain a better understanding of who they are, in these capacities, they can begin to look at how to interact with others, and integrate mindfulness with change. Finally, the participants can explore social pedagogy and prepare them for the process of transition planning as they look at what they would like their relationship to look like outside of substance use, and what supports they would like to use within this context. ▪ I also like that you explain in the beginning that each person and each group is unique. ▪ It gives option for starting at a youth points of need. Content and pace can be flexible. ▪ Taking breaks and explaining at the person’s level. ▪ Co-facilitator as an assist is a great idea.</td>
</tr>
<tr>
<td>Are there activities that appear to be unrelated to the curriculum’s objectives and that might have to be dropped?</td>
<td>All activities are related to the curriculum and its objectives. None that I thought that about.</td>
</tr>
<tr>
<td>Does the logic model illustrate the theory of change? Do the curriculum activities logically follow one another?</td>
<td>▪ The logic model clearly illustrates the theory of change. This is done differently than the typical transtheoretical model of change. The process is understandable, and honours the youth and the process of change that they are identifying, without judgement. When the young person is better able to understand change and their relationship with change, they may be better equipped to make healthy choices in line with their understanding of who they are,</td>
</tr>
<tr>
<td>Key Questions</td>
<td>Comments</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>Does the logic model illustrate the theory of change? Do the curriculum activities logically follow one another?</td>
<td>• their thoughts, their emotions, their values, and their role within their community.</td>
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<td></td>
<td>• Curriculum activities logically follow one another. The activities are engaging and creative, and can be accomplished without a large budget, which could have made it difficult for not-for-profit agencies to accommodate.</td>
</tr>
<tr>
<td></td>
<td>• Yes, it does illustrate the theory of change</td>
</tr>
<tr>
<td>Do the targeted outcomes represent meaningful changes or benefits for curriculum participants?</td>
<td>• The curriculum’s core outcome is reflective of the scope of challenges many young people with FASD face. The clinician will be able to respectfully engage with the youth where they are at, and allows the youth to explore on their own terms what they would like this change to look like, at what pace, and with whom they would like to engage in this process of change. They can also recognise, without judgement, when and how their substance use is impacting them. If a youth is able to explore alternative means of finding fulfillment, they may have a reduced need to use substances. Their use becomes less enticing when they see that it leads them away from their goals, dreams and visions for their own life. Some may have never had a concentrated time in their life to imagine what these goals, dreams and visions for their life may be - and the curriculum can provide the context in which they can safely explore these concepts. This, in itself, creates change.</td>
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<td>• I think that there is a wide range of outcome, it allows youth to individualize to their needs and it addresses the subject matter well</td>
</tr>
<tr>
<td>Does the evidence suggest that the activities, if implemented, will produce desired outcomes?</td>
<td>• Ms. Mockett outlines the evidence with regards to Mindfulness and positive outcomes when used with those living with FASD, and with those who have engaged in substance misuse. Benefits cited are in areas such as increasing emotional and social skills, relaxation training, self-instructional training, problem solving techniques, controlling maladaptive behaviour, reducing cravings, relapse, stress, amount of use, identifying triggers, etc. Ms. Mockett also identifies research, which indicates an increase in coping strategies, self-awareness, promotes spiritual development, psychosocial outcomes, and enriches the participants’ emotional, cognitive and behavioural patterns.</td>
</tr>
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<td></td>
<td>• In terms of resilience, Ms. Mockett unfolds the theory, which is thoroughly cited, and indicates the benefits of building in a resilience-focused curriculum, as she cites, “All young people can develop their capacity to be resilient given the right conditions and opportunities”</td>
</tr>
<tr>
<td>Key Questions</td>
<td>Comments</td>
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</table>
| Does the evidence suggest that the activities, if implemented, will produce desired outcomes? | ▪ (Johnson & Howard, 2007).”  
▪ The curriculum also indicates the importance of using a trauma-informed lens and a social pedagogy framework with those who live with FASD. The highlighted portion of Trauma-Informed Perspective that is interesting for this clinician is on page 23. The purpose, intent and implementation of this perspective is cited – along with the benefits for the client and clinician when working within a trauma-informed context. Cited research with regards to Social Pedagogy are included.  
▪ The curriculum begins with good description about cognitive processes, stress reduction etc. it is clear that that the activities address the need identified. |
| Is the theory clearly articulated and based on evidence to illustrate how and why the curriculum will succeed? | ▪ Yes - the theory does suggest this. See response above.  
▪ The MIRTS Model is an interesting and engaging work of literary art. The clinician can clearly understand multiple complex theories, and understand how these theories work in harmony with each other for the benefit of the group participants.  
▪ Yes, the theory is articulated in the beginning and the modules flow from that. The literature review is thorough |
| What is great about the curriculum’s theory? (newly specified targets, new delivery mechanism?) | ▪ Typically, a curriculum such as this would rely on one, or potentially two particular models. Instead, Ms. Mockett ties in Mindfulness, Resilience, Trauma-Informed Practice and Social Pedagogy. This is a unique perspective found in the materials available for clinicians working with this field.  
▪ The writer of this feedback form appreciated Ms. Mockett’s perspective on resilience. Instead of perceiving certain individuals as ‘more resilient’ than others, MIRTS will allows the clinician to appreciate the resilience that all the participants already possess, and the focus is instead placed on the participant building on their existing resilience.  
▪ This writer was also unfamiliar with the framework of Social Pedagogy and its importance when supporting young people with FASD. The integration of these theories is unique, and comes with solid research.  
▪ The material itself is incredibly engaging. The graphics and illustrations assist in the learning process for the clinician, and the numerous activities presented in the curriculum itself are fresh, unique and honour the individual process that each participant will encounter when participating in the group. |
<table>
<thead>
<tr>
<th>Key questions</th>
<th>Comments</th>
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</table>
| What is great about the curriculum’s theory? (newly specified targets, new delivery mechanism?) | ▪ I think it’s about the comprehensiveness of it. It covers the bio-psychosocial aspect. The delivery is engaging—mixture of educational, and experiential.  
▪ Youth are developing a variety of skill set and further strengthen their existing strengths |
| Is there evidence of use of current knowledge, research and/or practice in the area/discipline? | ▪ Ms. Mockett illustrates evidence, current knowledge, research and practice throughout this body of work. This is indicated by the numerous citations of current literature and practice reviews. Ms. Mockett cites on numerous occasions how this research is being developed in the areas of mindfulness, resilience, trauma-informed practice and social pedagogy.  
▪ Yes. The review is extensive and covers recent research.  
▪ Very comprehensive review |
| Are the outcomes clear and assessable? Do they reflect appropriate depth and complexity relative to needs of young people with FASD? | ▪ The outcomes are clear and accessible. Ms. Mockett clearly indicates and cites the benefits for youth living with FASD. Again, this is done in a number of ways – both within the description of the model, as well as in diagrams, visual aids and highlighted portions of text. The material reflects a complex marriage of theories, in a way that a clinician could both understand and implement. This task is a difficult one; however, Ms. Mockett makes this an interesting and engaging process for the reader.  
▪ Yes, they clear and there is a range and because the curriculum is comprehensive, it reflects the complexities well |
| Are there opportunities for transference of learning from one context to another? | ▪ Transfer of learning occurs across contexts as the material builds upon itself. Therefore, the clinician gains a fluid knowledge of the pillars built within the curriculum (MIRTS)  
▪ I think a lot of the material is not exclusive to one situation or set of needs so to that extent, emotional regulation for example is a very transferable skill from one context to the other |
| Do the outcome measures fit with the learning outcomes? Are they relevant? | ▪ Due to the highlighted sections within the document, Ms. Mockett allows the clinician clear access to the outcome measures which can be used both pre and post intervention. The suggested assessments available for clinicians to use when delivering the materials are both useful and appropriate – and the areas, which these measures evaluate, are in line with the purpose of the curriculum.  
▪ The suggested measures are appropriate and are relevant  
▪ They definitely fit. You have a range to pick from. |

Table 31: Summary Example of Stakeholder Response to Quality Checklist
Appendix 10: MIRTS Curriculum

MIRTS

Mindfulness-Integrated, Resilience Trauma-Informed & Social Pedagogy
MIRTS
Mindfulness-Integrated, Resilience, Trauma-Informed and Social Pedagogy

A Holistic Treatment Curriculum for Professionals working with young people with Fetal Alcohol Spectrum Disorder (FASD) and Substance use Issues

Velma Mockett
MIRTS

Mindfulness-Integrated, Resilience
Trauma-Informed & Social Pedagogy

VELMA MOCKETT
Disclaimer:
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<td>Independent Living</td>
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<td>Glossary</td>
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Acknowledgment

"No one who achieves success does so without the help of others…”—Alfred North Whitehead

This journey has been long and at times tremendously difficult. I am grateful to have had this opportunity, and realize that it could not have happened without the assistance of many generous people. I want to acknowledge their contributions of time, encouragement, wisdom and overall support. First, I give thanks to God for granting me the strength, determination, courage and wisdom to complete this degree. To Dr. Amy Salmon, my research supervisor I owe you my deepest gratitude. Your vision, wisdom, encouragement and continued support through this process was phenomenal. The confidence you instilled in me is a gift that will last a long time. You are an incredible mentor, and I could not have gotten to the finish line without your inspiration, fortitude, astute guidance and unwavering support in the difficult times.

To my committee members: Dr. Christine Loock, your guidance, knowledge and continual encouragement and support especially throughout the final months of this dissertation was great. Your invaluable knowledge of FASD, insights, alternative suggestions, support and enthusiasm for the work are unparalleled. The positive comments and encouragements you provided in difficult moments will stay with me forever; they were instrumental in me completing the work. To Dr. Richard Sullivan, your thoroughness and attention to details have given this dissertation a polish it otherwise might not have seen. Your incredible knowledge of theory has been instrumental in my growth and development as a doctoral student, and your insightful questions have led me down many learning paths. I truly admire the passion with which you work. Thank you for your support, encouragement and words of wisdom. Your insights have been invaluable to this process.

To Dr. Goelman, Chair of Interdisciplinary Studies, I thank you for the support and encouragement you offered over the past few years. You have been so incredibly supportive of me throughout my doctoral studies, your insights and direction was helpful. Many thanks also to Interdisciplinary Studies for awarding me the ‘Four Year Doctoral Fellowship’, without this financial support this would not have been possible. Scholarships like this make it possible for students like me to continue to grow and nurture their talents, gain knowledge and impart knowledge.

Many others contributed to this process. I would like to acknowledge Lori McKeown for her valuable insights into program development. I want also to extend sincere appreciation to Sarah Badgero, for her insight and feedback on trauma. Thanks to all the professionals who provided valuable insights into the various topics covered in the curriculum, as well as their expertise. Heartfelt thanks to Luci Djunaidi for recording my quiet moment and guided meditation scripts. Thank you to Gary Hartford, my friend and colleague who supported me in many ways. Some strategies described in this curriculum were refined based on long conversations with you about the philosophy of practice and ethics of care principles. Your exceptional skills, built on a platform of integrity and authentic presence with your clients, represents some of the richest lessons I have learned in being the best clinician I can be. To Leila, thanks for opening your home to me to avoid the long commute. I also wish to acknowledge the people who have helped to realize this final submission. Candace Tarr, for her contribution to the editing process and Nikola Ivanovic for bringing my sketches and ideas to live in the cover and graphic design. Nikola, thanks for your genius in graphics design. To Ben Badgero thanks for editing the audio recording for me, your help was very much appreciated.

I would like to thank my family and friends who believed in me and supported me throughout this process. To my amazing sister Mwansa, I am so grateful to know that you will be there at the end, your unwavering
support, and encouragement, especially in the difficult moment gave me the motivation I needed to persevere. A heartfelt thanks to my brother Tyron, thanks for all your laughter in the difficult moments. To my Aunty Chris thanks for your support and for continuing to believe in me. To Judith, your support, inspiration, wisdom, pep talks and you just being available was instrumental in this journey. Your words of inspiration in the difficult moments will always be part of my life journey. I am indebted to you for the many ways you have contributed to my thinking, research and practice. Thanks for refusing to let me give up, and for helping me find joy in the difficult moments. Stein Henry provided some insights at the beginning of my doctoral journey, thank you for your support and insights. Last, but not least, to my dad, thanks for those long hours with me at the hospital and for cheering me up and reading to me. This curriculum is a culmination of many therapeutic encounters with young people with FASD over the years, and I am indebted to every young person who thought it worthwhile to teach me something.

I would like to acknowledge the work of the many researchers who pioneered in the field of Resilience, Trauma—Informed, Social pedagogy and Mindfulness. They charted the course in these exciting territories, and their research provided the basis for the development of the MIRTS model. In conclusion, a big thank you to my committee for guiding me through the completion of this curriculum. I also want to express my appreciation to all those not mentioned who made this entire study possible—Thank you.
Dedication

I dedicate this entire work to the three women who were instrumental in getting me to this point, my sister Mwansa, my aunt Chris and my friend Judith, your unconditional support and persistence gave me the courage to persevere. This is possible because you were willing to be at my side cheering me on, especially in the tough moments. Your magnanimity is inspiring. This achievement is as much yours as it is mine; I hope you will celebrate the ‘flowers’ of the seeds you planted.

I would not have been able to do this work without an enormous amount of laughter and so this curriculum is also dedicated to my brother Tyron, for taking the time to be available for me and to my supervisor Dr. Amy Salmon for encouraging me to believe in what I have to contribute and for providing the space for me to do so. I also dedicate this to the many young people with FASD, who have inspired me to be the best clinician I can be.
Chapter One
Introduction
Mindfulness-Integrated, Resilience, Trauma-Informed and Social Pedagogy (MIRTS) is an integrated, manualized curriculum for working with young people with FASD and co-occurring substance misuse between the ages of 15-24. The curriculum was developed to provide clinicians with the tools and resources they require to address the broad range of needs with which young people with Fetal Alcohol Spectrum Disorder (FASD) and co-occurring substance misuse present. It provides a holistic framework, which combines practice-based evidence with evidence-based practice. The curriculum is flexible and pragmatic. The format allows professionals to implement only those parts that are relevant or feasible or it can be implemented, in full, over an extended period.

In my experience, working with young people with FASD and co-occurring substance misuse is never a straightforward process. It is often punctuated by the emotional and life crises experienced by these young people due to their past and present life circumstances. Forward momentum can sometimes seem elusive. The curriculum promotes a holistic approach — one that addresses the social, emotional, physical, cognitive and the wellbeing and agency of young people with FASD through inclusive, integrated and interconnected practice and learning materials.

The curriculum framework forms the foundation for ensuring that young people with FASD receive quality and appropriate therapeutic and learning opportunities. To this end, the framework is built around key concepts, which help to build capacity and to promote resilience. These core notions are: being, belonging and becoming. The approach used to reinforce these core concepts promotes the use of Mindfulness to increase cognitive and emotional control; it seeks to promote Resilience through building a range of social, emotional and life skills; it takes a Trauma Informed approach, recognizing that many young people with FASD have experienced trauma; and it uses Social Pedagogy to increase agency and competency. The connection between mindfulness, resilience, trauma-informed, and social pedagogy as a way of working with young people with FASD is recognized and integrated throughout the curriculum.

The concept of being belonging and becoming capture salient themes from the consultative process, my practice experiences, and the literature on improving the well-being of the diverse population of young people. Young people with FASD, like other young people, are connected to family, friends, community, institutions, culture and place. Being recognizes the importance of young people having an understanding and acceptance of who they are. It’s about building and maintaining positive relationships with themselves and others, engaging with their experiences, and realities and meeting challenges in everyday life. It is also about the present and them being aware of their emotions, thoughts and behavior without judgment.
Helping young people with FASD to develop a sense of their own identity and place in the world is fundamental to their mental health and emotional wellbeing. It also helps them to identify values which can guide them into the future and resist impulsive actions or negative peer pressure.

The well-being and sense of identity that is established through a young person’s early experiences is quite often undermined when young people with FASD encounter situations and settings, for example, school transitions, where they struggle to feel they belong. Parental substance use and neglect, and transition to foster care can also undermine their sense of identity and wellbeing. Most seriously, a sense of belonging is often threatened when young people with FASD experience trauma, or face stigma and exclusion. A sense of belonging is about young people with FASD relating to people (e.g., family and friends), to places, to beliefs and ideas, to ways of being and experiencing. Belonging is also about needs and rights being recognized and met, about being protected and provided for, about feeling cared for, respected and included. Belonging entails opportunities to express personal agency and creativity, feeling able to contribute in meaningful ways, and to care for others. Therapeutic support built on respect and recognition of agency can work towards ameliorating these risk factors and help to restore confidence and competence in young people with FASD. The focus on becoming, looks to the future of who they want to be, what they want to do and how they can develop the skills to get there.

In general, MIRTS aims to provide a comprehensive, pragmatic, and enriched tool firmly focused on the needs and experiences of young people with FASD and is designed to enable them to develop their sense of being, belonging and becoming. The major emphasis is on enhancing capacity for developing healthy coping skills, recognizing strengths, promoting resilience, strengthening relationship with self and others and helping young people integrate mindfulness into their everyday life. The idea is that clinicians will engage in all domains; practical skills and activities, thinking, and emotions. Within social pedagogy, these aspects associated with ‘heart’ are recognized as crucial to the care and development of a young person. When feelings are not well managed, thinking is impacted and conversely, when thinking becomes stuck, feelings and behaviour are impacted as well. In summary, the curriculum provides an opportunity for clinicians to work towards:

- Developing a reflective, intentional and responsive approach to working with young people with FASD
- Becoming FASD—infomed and using an FASD—informed approach
- Providing young people with FASD with the opportunities to develop the skills they need to enhance their wellbeing.
- Developing the sense of being and belonging of young people with FASD
- Nurturing growth, maximizing the potential and enhancing the resilience capacities of young people with FASD
- Building the confidence of young people with FASD
- Improving the quality of transitional support provided to young people with FASD
- Supporting young people with FASD to develop sustainable goals
Guiding and Practice Principles

Learning and growth occur within a framework that is responsive to diverse needs, sensitive to culture and history, safe, comfortable and nourishing. At every instance of service delivery, efforts must be made to ensure that the needs of young people with FASD are established and fulfilled. MIRTS model recognizes that the needs of young people with FASD are many, often complex, and interrelated. MIRTS is underpinned by values and principles that have been developed from knowledge, research and practice experience and observations. The principles are interrelated and intended to inform each other. The principles reflect the central ideas of being, becoming and belonging, and are based on the understanding that change, healing, learning and growth are active processes; and that when clinicians establish respectful and caring relationships with young people, are responsive to their needs, and consider the micro and macro factors that shape the experiences of young people with FASD, they are better able to deliver effective therapeutic, learning and developmental experiences relevant to a young person. These experiences will, in consequence, expand the young person’s understanding and knowledge of his /her circumstances and environment and promote health, safety and wellbeing. The principles are based on experience and current research findings on working with diverse populations. It also reflects the principles enshrined in the United Nation convention on the rights of a Child (1989) and The United Nation convention on the Rights of Persons with Disabilities (2006). The principles are foundations for professional practice for clinicians using the MIRTS framework while working with young people with FASD. The principles underpin practice that is focused on supporting all young people with FASD to achieve better outcomes. The following are the eight practice principles:

1. **FASD—Informed**—young people with FASD are heterogeneous and FASD is an invisible disability that can quite often be overlooked. Becoming FASD-informed requires clinicians to have a basic understanding of FASD and the neurological, biological, and psychosocial impact of FASD on young people. It also means that clinician should recognize that young people with FASD often have co-occurring challenges and many may have experienced trauma. Clinicians, who are committed to providing services in a manner that is responsive and appropriate to the complex and multiple needs of those impacted by FASD, will promote confidence, a sense of wellbeing and safety and willingness to engage in the therapeutic process. Having an awareness of how FASD impacts young people is essential to their sense of being,
belonging and becoming, as well as overall wellbeing. Fundamentally, an FASD—informed approach replaces the labeling of clients as being “resistant” or “difficult” with that of being impacted by FASD.

2. **Responsive Engagement**—clinicians who are attuned to the feelings, thoughts, interests, strengths and culture of young people with FASD will interact positively with them, in a manner that makes them feel safe, empowered and secure. When clinicians give priority to nurturing growth by building on a young person’s strengths and interests, as well as respecting the views of the individual, a young person with FASD will develop confidence and feel respected and valued.

3. **Promote a Sense of Agency**—when clinicians view young people with FASD as active agents and decision markers/collaborators, they will move beyond preconceived suppositions and expectations about what young people with FASD can do or learn. Clinicians who are attuned to the ‘agency’ of young people with FASD will support a strong sense of being. Learning outcomes will most likely be achieved when clinicians believe in the capacities of young people with FASD to succeed, regardless of diverse circumstances and abilities.

4. **Promoting Resilience**—In many ways resilience is link to a sense of being, belonging and becoming. Inculcating resilience within the curriculum means building on the strengths and capacities of young people with FASD, as well as nurturing their growth. Clinicians, who focus on enhancing protective factors, helping young people to negotiate and navigate resources; and those who provide opportunities to thrive and support social and emotional learning, will enhance ‘self-resilience’ of young people with FASD.

5. **Holistic**—clinicians who are attuned to the connectedness of the body, mind and spirit; as well as the confounding influence of many external factors; will demonstrate better recognition of the overall growth, development and well-being of a young person is holistic. When clinicians adopt a holistic approach, they are mindful that what is going on in one area of the young person’s life can impact many other areas of the young person’s life. In particular, clinicians should ensure that practical health, welfare and accommodation needs are met so that the client can effectively address behavioural change—focus on the ‘whole person’ not just the problem.

Resilience thinking clinicians creates the space for a young person with FASD to thrive when they recognize that young people with FASD are part of an interactive process, provide opportunities for them to negotiate and navigate resources and utilize strength strengths.
6. **Individual and Competence-Centered**—clinicians who understand the needs of young people with FASD, appreciate the uniqueness of a young person with FASD and provide support that is appropriate to him/her fosters his/her motivation to engage. Being mindful of the combination of skills, knowledge, disposition and attitude that a young person with FASD needs in order to effectively negotiate challenges and resources is critical to building the capacities of young people with FASD. By focusing on the young person's assets and potentialities rather than weaknesses or pathology, clinicians will be able to reinforce a young person's sense of self, self-esteem and self-efficacy. Also, clinicians using an individual-centered approach should be concerned with the importance of the experience for the individual receiving services. It is critical that clinicians acknowledge the young person’s individual and diverse development and natural disposition, as well as how they make sense of their world and the world around them. The development of an individualized plan is the point at which these values should be most evident in practice.

7. **Promote Mindfulness**—Mindfulness is a particular, purposeful way of being attentive, without judgment to internal states of feelings and thoughts, and external states of the environment and behaviours, from one moment to the next. Mindfulness practices offer clinicians a way to positively affect aspects of therapy. Clinicians who cultivate mindful awareness and practices in their client will enhance their emotional regulating skills, self-awareness and attention.

8. **Scaffolding**—As clinicians, it is our job to help young people with FASD reach their goals and become confident individuals making a meaningful contribution to society. Scaffolding is about clinicians meeting young people with FASD at their point of need and helping them to build on their existing skills. Clinicians who understand and observe emerging skills, and facilitate the development of strategies to support the practice and extension of those skills; will scaffold growth and development in young people with FASD. Scaffolding is also about responding to the ideas and interests of young people with FASD, by assessing, anticipating and extending the learning, growth and development via open ended questioning, providing feedback, co-constructing, challenging their thinking patterns and facilitating change. Through the support provided, young people with FASD can distance themselves from immediate experience and see beyond their problems and challenges.
The Theoretical Components

The heterogeneity among young people with FASD and diversity in family life and community means that young people with FASD experience being, becoming and belonging in many different ways. They bring their varied experiences, expectations, knowledge and perceptions and skills to their therapeutic encounters. A young person’s well-being and learning is dynamic, multifaceted and holistic. Social, emotional, physical, spiritual, cognitive, creative and cultural aspects of well-being and learning are all complexly entwined and interconnected. The curriculum is underpinned by four key theoretical concepts: Mindfulness, Resilience, Trauma-Informed, and Social pedagogy.

The use of Mindfulness will help clinicians to help young people with FASD become more attuned to their emotions and thinking patterns. Resilience thinking will foster the development of a range of social, emotional and life skills; trauma-informed practice will provide clinicians with awareness that many young people with FASD have experienced trauma; and Social Pedagogy helps in improving relationship, increasing agency and competency. All four elements are fundamental to providing service that is comprehensive and contextually appropriate to meet the complex needs of young people with FASD. Young people with FASD are receptive to a wide range of experiences; together the theoretical component can provide clinicians the basis for working with young people and their families to enhance their well-being. In sum, the theoretical foundation reflects a holistic understanding of the lives of young people with FASD who are influencing and being influenced by complex systems.
Mindfulness

Demands to meet the increasing and changing needs of young people with FASD are creating unprecedented challenges for clinicians and other professionals in the addiction, mental health and youth justice services. There is growing recognition that social and emotional skills and dispositions are essential for flexible decision-making, stress management, lifelong learning, and innovation required to maintain well-being. Competence in social and emotional skills provides the foundation for learning to manage one’s life effectively. It encompasses knowing how to channel attention and sustain motivation, working cooperatively with others, coping with frustration, responding to challenges with appropriate behaviour, and avoiding risky behaviours.

This component of the model will provide young people with FASD the opportunity to learn how their patterns of thinking, feeling, and limiting beliefs manifest in their experiences. They will also learn simple processes that will help them negotiate the symptoms of trauma without becoming overwhelmed. They will be guided to go ‘underneath’ the overwhelming emotions and touch the physical sensations, to experience a sense of flow. When a feeling of balance is established in the body, the effect spreads to the mind, emotions, and spirit. According to Siegel (1999; Siegel, 2003, 2007) how we pay attention promotes neural plasticity, the change of neural connections in response to experience. Mindfulness practices provide opportunities for young people with FASD to grow as they discover, learn and practice new ways of being comfortable with, and managing their emotions. When young people are emotionally balanced, they are more likely to test out new ideas, and build a new understanding of ways to be less reactive—they are better able to recognize and acknowledge what drives them and how they react to such forces that influence their behaviour. With its emphasis on focusing and refocusing attention, it can help to increase awareness of themselves, their reactions to others and to the world around them. Research has shown that practicing mindfulness can indeed have a positive impact on affect regulation, concentration, impulse control, decision making and self—care. Expressions of anger, compulsions, or anxiety are usually an intolerance for an existing situation or uncertainty. Thus, the development of self-awareness and decreased reactivity cultivated through mindfulness training can break the link between perseverating, or obsessive thoughts and automatic behaviours. Clinicians who are attuned to a young person’s thoughts and feelings support the development of a good sense of wellness and well-being.

In this component of the MIRTS model, the aim is not only to increase insight and awareness but to build resilience and develop the young person’s creativity and capacity to deal with pleasant and challenging emotions or experiences, both psychological and physical. It encompasses working with the mind and the body, sensations and thoughts, flexibility and rigidity. It allows for a more fluid and wider perspective of how they understand themselves and manage their emotions.
Making a case for Mindfulness

Mindfulness and FASD

Research has shown that mindfulness-based treatment interventions may be effective for a range of mental and physical health disorders in adult populations. Baker (2011) conducted a mindfulness-based training program for adolescents with FASD; the study used a pre-post-test design that included 10 children with FASD (ages 12- to17-years); participants were assessed using experimental measures of social cognition at baseline and 8-week follow-up. In addition, caregivers completed measures that assessed children’s emotionality and social skills at both time points. Their results suggested that mindfulness training may be effective for improving perspective taking skills in children with FASD. Individuals who experience mental illness (such as depression) have been noted to benefit from Mindfulness training. The degree of mindfulness may enhance agency through its effects on increasing awareness of internal and external stimuli occurring in the present moment and through growing acceptance of distressing cognitions, emotions, and sensations that occupy awareness. Thus, mindfulness may enhance flexibility in responding and ultimately expand perceived options for handling high-risk situations.

There is anecdotal evidence that individuals with FASD can use self-control strategies to manage some of their behaviours. The research literature on cognitive behavioural strategies indicates that individuals with mild intellectual and developmental disabilities, are able to use a number of cognitive behavioural strategies, including relaxation training, self-instructional training, and problem-solving techniques (Benson, 1994; Moore, Adams, Elsworth, & Lewis, 1997; Rose, West, & Clifford, 2000). Hence, there are reasons to expect that individuals with FASD will be able to use cognitive behavioural strategies to control some of their behaviour. Customized mindfulness-based meditation strategies have been used to teach individuals with intellectual and developmental disabilities to control their maladaptive behaviour (Singh, Lancioni, Winton, et al., 2007). For example, meditation on the Soles of the Feet has been used successfully by individuals with mild and moderate levels of intellectual and developmental disabilities to control their anger and aggressive behaviour over several years (Singh, Lancioni, Singh Joy, et al., 2007; Singh, Lancioni, Winton, et al., 2007; Singh, Wahler, Adkins, Myers, & The Mindfulness Research Group., 2003).
Mindfulness and Substance Misuse

A large treatment literature shows that mindfulness procedures have beneficial effects on a range of disorders, including substance use disorders (Keng, Smoski, & Robins, 2011; Zgierska et al., 2009). Understanding factors that may reduce the risk of relapse and improve treatment outcomes is of critical importance. Recently, there has been increased attention on the role of mindfulness deficits in contributing to substance use and how mindfulness-based interventions can be implemented in substance use treatment (Eisenlohr-Moul, Walsh, Charnigo, Lynam, & Baer, 2012; Marcus & Zgierska, 2009). The impact of meditation within substance abuse populations have had positive effects, from reducing drug and alcohol use, to utilizing coping skills to managing cravings (Chen, Comerford, Shinnick, & Ziedonis, 2010; Special, 2010). Developing coping skills and problem solving skills as a component of substance abuse treatment can begin to be found through a meditation practice. Some of the benefits to a meditation practice when treating substance abuse are that individuals begin to develop more self-awareness regarding their impulsive behaviours and often unhealthy and counterproductive reactions to stress (Special, 2010).

A typical goal of substance abuse treatment is identifying triggers for use and changing behavioural patterns in an effort to avoid triggers. Practicing mindfulness can teach individuals with substance misuse problems how to cope with the triggers and cravings they experience (Special, 2010). Further, Special (2010) noted that incorporating meditation into treatment has shown that people have been able to reduce the number of days they used alcohol or other drugs. In terms of long-lasting change for individuals who suffer from substance misuse, meditation can also promote spiritual development, create a reduction in stress responses to certain cues, promote acceptance of both self and situations, and begin to extinguish maladaptive and destructive behaviours (Dakwar & Levin, 2009).

This has been shown to be consistent with incarcerated populations as well (Bowen et al., 2006). When incarcerated individuals who had substance use disorders used meditation as part of their substance abuse treatment, the amount of their substance use decreased after release and they had better psychosocial outcomes than their peers who did not engage in meditation as part of their substance abuse treatment (Bowen et al., 2006; Simpson et al., 2007).

Equally, Saddichha (2011) indicated interventions such as deep breathing may delay, or be used as a distraction when experiencing a craving. Yoga, a practice that involves doing a series of stretches and maintaining posture while concentrating on breathing, has been known to increase muscle tone, flexibility, sense of balance, and overall psychological wellbeing (Kissen & Kissen-Kohn, 2009). Kissen and Kissen-Kohn (2009) stated that most individuals who misuse substances do not exercise, creating high levels of energy, as such yoga provides an opportunity to release accumulation of negative energy, and self-soothe. According to Kissen & Kissen-Kohn (2009) the integration of these mindfulness-based interventions with other evidence-based practices may enhance treatment outcomes by assisting clients in connecting with their emotions, cognitions, and behavioural patterns on a deeper level. It may also aid in recognizing their triggers in order to build the skills necessary to overcome cravings associated with chemical dependency and relapse.
The biopsychosocial model, conceived by (Engel, 1977, 1980), addresses the complexity of interactions between different domains of functioning, and argues that it is the interaction of domains that illuminates important processes. It posits that biological, psychological, and social factors all play a significant role in human functioning. Engel believed that factors influencing functioning and adaptation are nested within systems that extended from individual (e.g., cognitive functioning) to larger ecological influences (culture), and, as such, he offered a holistic alternative. Its expansion into the biopsychosocial-spiritual (BPSS) model Wright, Watson, and Bell (1996) has proven to be useful in understanding the interaction among the key components of various system levels. The expanded BPSS model reminds us, when working relationally with clients, to not lose sight of the individual’s experience of trauma and illness, his or her cognitive process (e.g., temperament, personality), and the often critical role of spiritual and religious belief systems in the experience of -- and attempts to cope with—illness (Watson, 1997; Wright et al., 1996).

Resilience

During the past two decades, increased research attention has been directed toward understanding Fetal Alcohol Spectrum Disorder (FASD). More recently, however, researchers and clinicians are increasingly becoming interested in understanding the neurobehavioural outcomes of children and adolescents with FASD. There is a growing body of literature showing that young people with FASD display a range of cognitive deficits and behavioural problems, which suggest that there is potential for vulnerability in young people with FASD that may strain their capacity to accomplish normal developmental tasks, cope with life (personal, family, generational, community and cultural) challenges, or cope with the experience of having FASD (Kelly, Day, & Streissguth, 2000; Kodituwakku, 2007; Kodituwakku, 2009; Matsson & Riley, 1998; Riley et al., 2003; Spohr, Willms, & Steinhausen, 2007; Steinhausen & Spohr, 1998; Streissguth et al., 1991; Streissguth, Barr, Kogan, & Bookstein, 1997; Streissguth, Bookstein, Barr, Press, & Sampson, 1998). Service providers quite often find it difficult to understand the responses, or reactions of a young person diagnosed with FASD, or a young person suspected of having FASD. This is partly due to the fact that historically the majority of adolescent developmental theories focused on the healthy adolescent. Further, the deficit-model, for the most part seems to have underpinned the thinking of professionals and service providers, who have focused predominantly on treating problems presented by youths with FASD. The failures of many young people with FASD have overshadowed the success of others who have experienced successful outcomes. I think resilience is an important construct as it not only identifies how young people with FASD and their families cope with challenges, but also how opportunities for growth and capacity building are promoted. Many young people with FASD encounter multiple risk factors prior to coming into contact with addiction, or other social services systems. Young people with FASD are a heterogeneous group with varying levels of risk factors and outcomes across the continuum. Thus, one means of nurturing their growth and building their competencies, as well as, understanding such diverse outcomes, I believe, is to examine processes through which particular protective factors can interact with other variables to predict adaptive or maladaptive outcomes. In this sense, effective substance use treatment begins with identifying the young person’s strength, or protective factors and using this as a building block for growth and development.

Resilience in this treatment model will be conceptualized through a biopsychosocial-spiritual (BPSS) orientation, drawing on substantial evidence to identify a range of resources and assets that are demonstrated to foster both resilience and healthy development. This will
provide a framework for young people with FASD to learn how to locate relevant resources and assets and develop the knowledge and skills to apply them in order to meet their needs and achieve their goals. As clinician we should focus on helping our clients and their families use their strengths and capacities to achieve enhanced resilience. Service providers and clinicians should, therefore, seek to build on a young person’s strength, and maximize the possibility that relevant resources and assets are available and accessible for young people through understanding their culture and working with families and communities (Masten, 2009; Ungar, 2011).

This approach highlights critical areas to be alleviated; however, we have largely neglected strengths (e.g., acceptance, optimism) or resilient capacities that can be fostered in young people with FASD to optimize living with FASD. Using a BPSS conceptualization, I propose a cross-cutting definition of resilience for FASD-informed care that expands on the previous definitions of Masten (2001) and Ungar (2011) with the varied components of resilience reflected in their definition, which I hope can serve as a foundation for ongoing work in the FASD field. In the context of FASD and substance use treatment, resilience is conceptualized as nurturing growth, working collaboratively and creatively to advance the skills of young people with FASD by building on their strengths and early learning, and scaffolding new learning. It is helping young people with FASD understand, negotiate and navigate resources. It is also about developing their coping resources, building their capacity to self-regulate and manage change, reinforcing & sustaining positive behaviours and relationships, validating their concerns and feelings, and providing opportunities for them to thrive and become contributors to society. Further, resilience also encompasses their personal resources, effective responding, and intentionality that protects them from life challenges and results in well-being. Young people with FASD with enhanced resilience capacities will demonstrate better social, emotional, behavioral, or health outcomes that reflect a healthy sense of being, belonging and becoming.

Thus, this component of the MIRTS model is focused on recognizing the strengths of young people with FASD, and creating the condition, or space that facilitates, nurtures and supports the development of competencies (physical, emotional, social, cultural & spiritual). One important objective of substance use treatment components should be to build some protective factors (for example, skill and information acquisition, education, emotional and social capital) with the aim of inculcating resilience. Resilience as a component in this treatment model is particularly relevant to young people with FASD who use drugs and/or alcohol as a way of coping with complex life challenges. Building on a young person’s capacity for resilience will likely reduce, or remove the need for him/her to rely on drugs and/or alcohol to cope. The idea is to enable young people with FASD to develop a sense of agency and mastery, and gain as much control as possible over their own well-being and, in particular, their drug and alcohol use.

When a young person is confident he/she will be more open to being aware of what he/she is good at, as well as, cope better with unexpected changes and adversities (e.g., moving homes or family disruptions) consequently, creating positive life cycles for themselves. Essential to the fostering of resilience is a secure base where the young person with FASD feels a sense of belonging, good self-esteem and a sense of self-efficacy. The Resilience component aims to promote at least one secure attachment, to cultivate a safe environment and provide young people with FASD with a range of emotional and social supports. It also seeks to develop self-esteem by fostering a young person’s talents and interests.
MIRTS - Biopsychosocial-Spiritual Model of Resilience

Psychology
- Attachment
- Behaviour
- Emotional well-being
- Self-efficacy
- Cognitive flexibility
- Psychological flexibility
- Stress & coping
- Personal resources (e.g., optimism, disposition)
- Trauma

Social
- Ecological factors (e.g., family, friends, service & support systems)
- Cultural factors
- Financial & social status of family
- Intergenerational Histories (e.g., addiction, trauma, emotional dysregulation)
- Living Conditions (e.g., living with family, homelessness, foster care)

Biology
- Cognitive & Executive Processes
- Physical Health & Well-being
- Nutritional Health & Well-being
- Epigenetics

Spiritual
- Mindfulness
- Spirituality
- Hope
- Faith
- Sense of purpose
- Compassion & Acceptance
- Gratitude
- Religiosity

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It is Important to remember that:

| a) | The promotion of resilience is not simply a matter of eliminating risk factors, as the successful management of risk is a resilience promoting factor in itself (Rutter, 1994). |
| b) | Resilience is not a trait -- characteristics that a person has that allows success in the face of adversity, but rather a dynamic process occurring under specific circumstances (Masten, 2001). It is not an all or nothing phenomenon and no young person (with or without FASD) is ‘invulnerable’. |
| c) | The differing abilities of individuals to cope with stressful situations can be attributed to a variety of factors. These include personal characteristics inherited or acquired in the early years of life, the timing, duration, sequence and frequency of stressful events and the reliability and availability of peer, family and community support. |
| d) | Protective factors may be related to the individual or to the situational context. |
| e) | All young people can develop their capacity to be resilient given the right conditions and opportunities (Johnson & Howard, 2007). The same factors that interact to foster and protect healthy development and optimal functioning also support resilience. |
| f) | Risk factors accumulate. A young person may often be able to overcome and even learn from single or moderate risks, but when risk factors multiply, without appropriate supports a young person’s capacity to thrive weakens (Fergusson & Lysneky, 1996). |
| g) | Risk factors are often inter-connected. For example, a young person with FASD living in a dysfunctional home may feel disconnected, experience a poorer educational outcome, as a result be drawn into dangerous peer-group activities, and limited job aspirations may follow. Risk factors will be intensified when the child lives in an environment where poverty, racism and low social capital are endemic. |
| h) | Transitional periods bring both threats and opportunities. Adversity, while challenging for a young person, involves a developmental progression, such that new vulnerabilities and/or strengths often emerge with changing life circumstance (Luthar, Cicchetti & Becker, 2000). |
| i) | Exposure to ‘bad’ experiences that constitute environmental risks varies among young people with FASD (Harvey & Delfabbro, 2004). |
| j) | The experience of social exclusion, or being disadvantaged means that not all young people have access to useful and necessary resources and assets (Johnston & Howard, 2007). For Ethnic minorities, LGBT youth, homeless young people, as well as, aboriginal young people, factors connected to cultural stigma, institutional racism, economic activity or acculturation make it difficult to maintain their cultural integrity. These stressors may express themselves in a range of outcomes, including high rates of school exclusion. |
| k) | Young people usually have more strengths than they realize. Negative social discourses characterizing young people with substance use as delinquent, disordered, dangerous or deviant can mask their strengths and efforts to meet their needs. Ungar (2005) calls this hidden resilience. |
Trauma-Informed

Young people with FASD are among the most vulnerable young people; they most often experience multiple foster home placements and several kinds of traumatic or adverse experiences. A number of young people with FASD experience sexual abuse or incest, emotional and physical abuse, repeated abandonments, poverty, sudden losses; may have witnessed violence and many have had problematic attachments with their birth parents or other carers. Many of the young people with FASD in substance use treatment have histories of trauma, or intergenerational history of trauma. However, they often do not recognize the significant effect of trauma in their lives; either they do not make the connection between their trauma history and their presenting problems, or they avoid the topic altogether. Likewise, clinicians may not always ask questions that elicit a client’s history of trauma, or may struggle to address trauma-related issues effectively within the constraints of their treatment program. The coping skills of young people with FASD who have been traumatized can become maladaptive, and their behaviours can appear irrational or perplexing. They are often unable to regulate their emotions. Some learn to cope with overwhelming stress by disconnecting from their feelings, while others lack awareness of the connection between specific emotions and body states (Cook et al., 2005; Kinniburg, Blaustein, Spinazzola, & van der Kolk, 2005). In addition, they tend to internalize responsibility for the trauma they have experienced, which predisposes them to feelings of shame, guilt, isolation and other negative feelings. They may also struggle to problem solve, or form stable relationships.

Research has also indicated that exposure to repeat traumas may result in learned helplessness and increase the risk of developing a range of secondary problems such as substance misuse.

In their review, McLachlan, Wyper, and Pooley (2013) identified complex histories of trauma as a barrier to effective substance use treatment in justice-involved youth with FASD. It has also been acknowledged that workers often struggle to address the needs of clients with FASD within the context of alcohol and drug treatment. Select research studies and ‘practice wisdom’ and experience of addiction, mental health and youth justice workers suggest that it is common for young people with FASD to present at programs such as substance use treatment, restorative justice program and/or mental health services with psycho-social problems associated with both current and/or past traumatic life event(s).

Trauma-Informed Approach involves understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been mistreated may have in a particular setting or service (Harris & Fallot, 2001). In the context of FASD, a trauma-informed approach recognizes the need to respond to a young person’s intersecting experiences of FASD, trauma, mental health, and substance use concerns.

Trauma refers to an experience that creates a sense of helplessness, and/or fear, and overwhelms a person’s resources for coping. The impact of traumatic stress can be devastating and long-lasting, interfering with a person’s sense of safety, ability to self-regulate, sense of being, sense of belonging, perception of control, self-efficacy, and with their interpersonal relationships.
This component of the model focuses on the effect of trauma on young people with FASD. Using a trauma-informed lens in the model will also help clinicians and service providers to develop relationships that cultivate safety, trust and compassion. Having an awareness of how trauma impacts young people with FASD is critical to the treatment process. Subsequently, working from a trauma-informed orientation has an effect on healing and the quality of service provided. At a more fundamental level, the trauma-informed component of this model will assist with replacing the labeling of young people with FASD as being difficult or uncooperative with that of being affected by an “event” or “injury.” This then, will shift the conversation from asking, why is the young person resistant and difficult to work with? To what has happened to this young person?

A Trauma-Informed Approach involves “understanding, anticipating, and responding to the issues, expectations, and special needs that a person who has been mistreated may have in a particular setting or service. In the context of FASD, a trauma-informed approach recognizes the need to respond to a young person’s intersecting experiences of FASD, trauma, mental health, and substance use concerns (Harris & Fallot, 2001). More particularly, research suggest that a trauma-informed approach to treatment should include clinicians’ recognizing that many of their clients’ seemingly maladaptive behaviours may have developed as ways for these young people to cope with overwhelming emotion (Harris & Fallot, 2001). It is an overarching framework that emphasizes the impact of trauma and that guides the general organization and behaviour of an entire system of care. Research (for e.g., Klinic Community Health Centre, 2008; National Center on Domestic Violence, 2011) indicates that using a trauma-informed approach does not necessarily require disclosure of trauma. Rather, services and support are provided in ways that recognize the need for physical and emotional safety, cultural ways of being, as well as choice and control in decisions affecting one’s treatment. Trauma-informed practice is more about the overall essence of the approach, or way of being in the relationship, than a specific treatment strategy or method. Based on the literature review, trauma-informed practice should:

FASD is brain-based and young people with FASD are often under constant stress, many live in foster care and are unsure of whether they will be able to be with their families. They often experience co-occurring mental health issues, lack a stable home and also the financial resources, life skills, and social supports to change their circumstances. In addition, an overwhelming percentage of young people with FASD and their families have been exposed to additional forms of trauma, including: neglect, psychological abuse, physical abuse, and sexual abuse during childhood and to other forms of violence. From observation and practice experience, early developmental trauma—including sexual abuse, and disrupted attachment—provides a subtext for the narrative of many young people with FASD and to their pathway to substance misuse. The impact of traumatic stress often makes it difficult for young people with FASD to cope with the innumerable difficulties they face.
1. Demonstrate an awareness of Trauma: Trauma-informed service providers and clinicians should incorporate an understanding of trauma into their work. This may involve altering staff perspectives, with providers understanding how various symptoms and behaviours represent adaptations to traumatic experiences. Staff training, consultation, and supervision are important aspects of organizational change towards a trauma-informed approach and organizational practices should be modified to incorporate awareness of the potentially distressing impact of trauma. For example, agencies may implement screening for histories of traumatic experience, may conduct assessments of safety, self-care assessments and may develop strategies for increasing access to trauma specific services.

2. Emphasize safety: Because trauma survivors often feel unsafe and may actually be in danger (e.g., of sexual abuse or violence), trauma-informed care works towards building physical and emotional safety. In addition, clinicians or agencies should be aware of potential triggers for young people and strive to avoid retraumatization.

3. Provide, create, and foster opportunities to rebuild control: Because control is often taken away in traumatic situations, and because having FASD can sometimes be disempowering, trauma-informed substance use treatment service should emphasize the importance of agency and choice. It should create an environment that allows young people with FASD to rebuild a sense of efficacy and personal control over their lives.

4. Focus on strength: Trauma-informed practice is strengths-based, rather than deficit-oriented. These will assist young people with FASD to identify their own strengths and develop coping skills. It is focused on the future and utilizes skills building to further develop resilience.

In order to effectively support young people with FASD, it is important that clinicians:

- Recognize the symptoms of trauma
- Understand trauma, its effects and how it relates to substance misuse
- Understand issues related to creating a safe treatment setting and establishing rapport
- Know how to recognize guilt and shame associated with the negative consequences of traumatic experiences
- Are able to explain to the client what trauma is
- Are able to listen to difficult feelings and emotions that may arise
- Understand how trauma affects the brain
- Understand trauma— informed consequences
Social Pedagogy

It has been contended that interpretive methods, like social pedagogy, promote a kind of thinking that prepares clinicians to use evidence thoughtfully and to develop skills necessary for working with diverse sub-groups. Social pedagogy as a framework has been implemented in a wide range of services, including the early years, schools, residential care, family support and youth work, disability services, and in some countries support for older people (Children in Scotland, 2008; Connelly & Milligan, 2012; Kornbeck, 2009; Storo, 2012).

According to Hämäläinen (2003), Social pedagogy begins from a young persons’ own personal and social space and respects the importance of their wider networks of peers, communities, cultures and other relationships. It aims to promote young people’s social functioning, their inclusion, participation, social identity and social competence. It raises young people’s awareness of the decisions and choices open to them and offers the capacity to learn to develop their agency in making their own decisions and choices, and it emphasizes respect for the decisions and choices that they do make. Social pedagogy in practice is a holistic and personal approach to caring for young people – the social pedagogical approach rests on an image of a young person with FASD as a complex social being with rich and extraordinary potential (Cameron & Moss, 2011). It provides opportunities for learning and enabling young people with FASD to empower themselves. This is a holistic process creating a balance between the head (cognitive knowledge), the heart (emotional and spiritual wellbeing) and the hands (practical and physical skills). It also aims to strengthen health-sustaining factors resulting in holistic wellbeing. Social pedagogy emphasizes reflective practice, and promotes the idea of workers seeking to understand the young person’s worldview (Cameron & Moss, 2011).

Social pedagogy can be characterized by the flexibility of its approach to working with young people. A social pedagogical approach works best through processes of participative engagement tailored to the needs of each presenting situation. A clinician practicing from a social pedagogical framework will provide support, advice and guidance, and will communicate information in ways that young people understand and respond to. Advice and support will not be limited to just substance use issues, but concern the whole range of a young person’s personal and social development. Young people are encouraged to engage in valued joint activities. Clinicians and service providers are

By incorporating elements of social pedagogy young people with FASD will:

1. Feel that they have a place and a right to belong to the group
2. Develop a strong sense of self and feel respected and affirmed as unique individuals
3. Be able to express their views and help make decisions in matters that affect them
4. Interact, and work cooperatively and help others
5. Be motivated and begin to think about and recognize their own progress and achievements
6. Demonstrate the skills of cooperation, responsibility, negotiation and conflict resolution.
7. See themselves as capable learners and show increasing confidence and self-assurance in directing their own learning
also encouraged to provide an environment in which group support and advice can be accessed (regarding self-care, addressing common, or shared fears and anxieties, and so on). Social pedagogy provides a theoretical and practical framework for understanding young people with FASD. It facilitates opportunities for learning depending on where the young person is; viewing the young person as competent and a resourceful agent—‘A child has a 100 languages’. Further, social pedagogy has a particular focus on building relationships through engagement with young people using skills such as art, photography, journaling, cultural dances, and other activities. It provides a foundation for training those working with young people and brings a particular expertise in working with group and using group as support. This has fundamental implications for the relationships and interactions necessary in substance use treatment programs—careful, respectful, tender listening, with solidarity to a young person’s strategies and ways of thinking.

In a sense, social pedagogy is learning and action-orientated, aiming to enable personal and social development for all young people, as well as, recognizing young people as active agents. It is driven by a concern for the perspectives of young people themselves, and a critically informed understanding of the social and institutional practices that provide a context for their experiences and perceptions. Social pedagogy also calls for professionals to be reflexive in their practice. From this viewpoint work with young people should seek to redress exclusionary and negative structural impacts on their lives, to engage them as partners in their change and learning process, and to increase their own sense of agency. A social pedagogical framework, therefore, has the potential to build social capital, as well as help young people with FASD find security in themselves. Looking at youth addiction services, a range of policy statements and initiatives have highlighted a need for more adequate services to meet the needs of diverse groups. Providing a more holistic service is vital. To this end drawing from social pedagogy – combining knowledge and skills could support progress towards creatively meeting the multiple and complex needs of young people with FASD. This component of the curriculum, therefore, has the potential to empower young people with FASD—giving them the power to develop a sense of inner confidence, self-image, resilience, courage and strength to successfully surmount whatever life presents.

A child has a 100 languages

The child is made of one hundred. The child has a hundred languages a hundred hands a hundred thoughts a hundred ways of thinking of playing, of speaking. A hundred always a hundred ways of listening of marveling of loving a hundred joys for singing and understanding a hundred worlds to discover a hundred worlds to invent a hundred worlds to dream. In his poem on the ‘hundred languages of children’, Loris Malaguzzi expresses in just a few words a profound ethical and philosophical orientation underpinning social pedagogy. His notion conceptualizes children as competent and resourceful, as imaginative and creative, as active inventors and discoverers (Eichsteller & Holthoff, 2011)
Assessments

For many young people with FASD the experience of seeking services promotes anxiety and uncertainty and they are likely to carry fears and misconceptions. As clinicians we have a responsibility to fully understand the young person’s strengths, needs, abilities, goals, past successes, along with their hopes, dreams, and problems in seeking help. This way, clinicians will be able to create a responsive and efficacious plan, which is consistent with the expressed needs, values, and wishes of young people with FASD.

Assessment refers to the process of gathering and analyzing information as evidence about what young people with FASD have experienced, are experiencing and what they need. It should form part of an ongoing cycle, as you continue to engage with a young person with FASD, that includes planning, documenting and evaluating progress towards goals. But assessment is more than the mere gathering of information; it is the beginning of building a trusting, helping, and therapeutic relationship; the building of an alliance upon which to build a plan responsive to the individual’s needs.

The goal of any assessment conducted should be to develop a holistic understanding of the nature and level of a young person’s functioning, gain an understanding of factors affecting the young person and his/her needs, develop partnerships, and prepare for additional support if necessary. The idea is to ensure that young people with FASD are at the heart of the process. Assessment should be planned in ways which reflect the guiding principles of the curriculum. Although forms and documents need to be completed and the accuracy and quality of information that we gather is important, practice experience has also taught me that how that information is gathered is perhaps even more relevant and that in some instances, it may be more appropriate to pursue a natural conversation rather than following a linear approach to completing these forms.

In line with the practice principles advocated, a highly individualized comprehensive approach to assessment and services should be used to understand each young person’s history with FASD, strengths, needs, abilities, and vision of their own recovery and change process including attention to the issues of trauma, culture, spirituality, and other personal and familial factors. With this in mind, treatment plans and outcomes should be built upon respect for the unique preferences, strengths, and agency of each young person. Understanding the unique attributes and needs of individuals and families is the essence of being individual and competence-centered.

Young people with FASD seeking help should be assisted to develop a plan for change that is reflective of their own expectations and goals. This is often in and of itself empowering and helps set the stage for successful outcomes. If done appropriately, assessment can be an authorizing experience for a young person with FASD. It can help to provide an emerging picture of a young person’s progress—how his/her skills are developing, and what goals have been attained. By participating in the assessment process and contributing and evaluating his/her own evidence, a young person will develop a better understanding of his/her efforts and develop a shared appreciation of what he/she is able to do, and how he/she can further improve. Ongoing assessment processes that include a diverse array of methods, capture and validate the different pathways that young people with FASD take toward achieving outcomes that matter to them. It is critical that clinicians do not focus exclusively on the endpoints; they should also give equal consideration to the ‘distance-travelled’ by the individual and recognize and celebrate not only the enormous leaps that their clients take in their learning and growth process but the small steps as well. This will shift the focus on
problems and deficits, which most often leads to feelings of shame, blame, and failure, to one of hope and possibilities.

This does not mean overlooking challenges or health and wellbeing issues, it does mean looking beyond these to describe the emerging abilities of a young person with FASD in order to plan new learning experiences. There is an opportunity to be empowering even in the process of gathering information from young people with FASD and it is the hope that utilizing MIRTS will facilitate the space for clinicians to be more effective in their assessment process.
An outcome is the meaningful and valued impact or change that occurs as a result of a particular activity or set of activities. For example, improved problem solving skills is an outcome and could be achieved as young people with FASD develop better relationships, learn to communicate assertively and become more aware of their emotions.

Young people with FASD are receptive to a wide range of experiences and have a multitude of needs. Based on the literature reviewed, consultation with key stakeholders and my clinical practice experience some common themes were identified. The outcomes developed reflect the broad spectrum of areas identified for improvement among young people with FASD. The outcomes are grouped into nine interlinked clusters and are designed to capture the integrated and complex needs of young people with FASD. The cluster of outcomes is listed in table 1 below.

The outcomes are broad and observable and allow for clinicians to work with their clients to identify what is important to them or what they want to achieve, and how to get there. Therefore, both clinicians and young people with FASD are encouraged to list specific examples of sub-outcomes they want to achieve and evidence of growth and progress that are pertinent to them. The points described within each outcome are relevant to young people with FASD. Knowledge of an individual young person, his/her strengths and capabilities will guide clinicians’ professional judgement to ensure their clients are engaging in a range of experiences across the outcomes in ways that optimize their competencies.

The opportunity for a young person with FASD to be involved in defining the outcomes they want to achieve can be empowering. Working with clients to develop treatment plans, and reviewing the outcomes achieved, can help enhance a client’s sense of being, belonging and becoming. It is important to, however, remember that there will be many other ways that young people with FASD can and will demonstrate growth and progress within and across the outcomes. It is also essential to keep in mind that there is no absolute list of outcomes appropriate to all young people with FASD. For many of these young people, there are fundamental outcomes that need to be achieved as a foundation for others. Effective communication is one fundamental outcome for many young people with FASD, but others vary according to their contextual environment and support system.
List of Outcomes and example of Indicators.

<table>
<thead>
<tr>
<th>Clusters of Desired Outcomes</th>
<th>Examples of Description/Indicators</th>
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</thead>
<tbody>
<tr>
<td>Resilience</td>
<td>Social and emotional learning; self-management; hope; self-motivated; having a sense of purpose; self-controlled; learning to control impulses; negotiating and navigating resources</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>Concentrating; focus; meditating; self-regulating; self-compassion; self-acceptance; stress management; self-awareness; being</td>
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<tr>
<td>Personal &amp; Social Development</td>
<td>Building a positive self-identity; self-efficacy; self-esteem; self-belief; being; friendships and relationships; empowerment; listening and communicating; assertiveness and dealing with conflict; expressing feelings; thinking patterns</td>
</tr>
<tr>
<td>Emotional Regulation</td>
<td>Stress management; managing thinking and thought patterns; understanding and expressing emotions; coping with feelings</td>
</tr>
<tr>
<td>Health &amp; Well-being</td>
<td>Drugs; smoking and alcohol; food and fitness; trauma issues; FASD; social, emotional and spiritual wellbeing; safety and connections with others.</td>
</tr>
<tr>
<td>Participation &amp; Inclusion</td>
<td>Sense of agency; confidence; decision making; rights and responsibilities; safety; belonging; planning; mentoring; advocacy; emerging autonomy; interdependence; becoming</td>
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<tr>
<td>Problem Solving &amp; Planning</td>
<td>Organizing; setting and achieving goals; decision-making; Navigating resources; managing conflict; interpersonal skills; empathy, respect; reflection on actions; social and emotional awareness.</td>
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<tr>
<td>Creativity &amp; Independence</td>
<td>Applying learning in new contexts; visual arts; creative writing; craft and design; sport and leisure; developing skills for independent living; transition planning; housing and homelessness; planning for the future; Imagining alternative ways of doing things; open to new ideas and doing new things; expressive; imaginative.</td>
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<tr>
<td>Communication</td>
<td>Assertiveness; expressing; listening; questioning; articulating; engaging; interacting.</td>
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Outcome Measures

A wide range of outcome measures used by services for young people, schools, and agencies across addiction, health and criminal justice were reviewed to ascertain the best fit for this curriculum. The table below provides a list from which clinicians can pick. Using appropriate outcome measures can be helpful in ascertaining vital information about the extent of a young person’s challenges, it can also be helpful to the young person themselves in helping them track their progress.

When young people with FASD are included in the process they can develop an understanding of themselves and an understanding of how far they have come. When undertaken in collaboration with the young person this can be a powerful way to motivate and support young people with FASD to continue to focus on the outcomes that matters to them. However, it is crucial that clinicians are transparent and objective, and that they provide young people with FASD information that is relevant.

Alternatively, in my practice, I have also found it very useful to provide clients with a blank sheet they can use to track their progress (see the second diagram below). I developed what I called an outcome pyramid that clients find useful. They are able to write in their own area for improvement and track their progress.
<table>
<thead>
<tr>
<th>Angus Council Well-Being Web</th>
<th>Outcome Stars</th>
<th>SACS, Drug Taking Confidence Questionnaire</th>
<th>Behavioural and Emotion Rating Scale</th>
<th>Mindfulness Attention Awareness Scale</th>
<th>The Rogers Empowerment scale</th>
<th>Brief Trauma Questionnaire (BTQ)</th>
<th>Resiliency Scale</th>
<th>The children Society Well-Being Tool</th>
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<tr>
<td>Communication</td>
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<td>Resilience</td>
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<td>Managing Feelings &amp; Emotions</td>
<td>X</td>
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<td>Planning and Problem Solving</td>
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<td>Relationship</td>
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<td>Creativity</td>
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<td>Safety</td>
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<td>Empowerment</td>
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<td>Mental health and well-being</td>
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<td>Drug and alcohol misuse</td>
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<td>Self-care</td>
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<td>Physical health</td>
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<td>Managing money</td>
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<td>Motivation and change</td>
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<td>Relapse management</td>
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<td>Self-confidence</td>
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Blank Outcome Wheel
Use this sheet to record where you are and the reasons for giving the score chosen or any points you want to record based on our discussion of your progress.

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<th>Goal:</th>
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</table>
Endnote

According to Davidson and Coniglio (2013), trauma-informed services consider an understanding of trauma in all aspects of service delivery and place priority on the individual's safety, choice, and control. These services engender a culture of nonviolence, learning, and collaboration. Services are provided in a way that recognizes the need for physical and emotional safety, as well as choice and control in decisions affecting treatment. Trauma-informed practice is more about the overall essence of the approach, or way of being in the relationship, rather than a specific treatment strategy or method. They noted that trauma-informed practice has been implemented in several child and adolescent mental health programs in Canada, including the Ontario Shores Centre for Mental Health Sciences and the St. Boniface Hospital in Winnipeg, Manitoba. The Mental Health and Substance Use Programs at the Children and Women's Health Centre of British Columbia have also implemented trauma informed care (Davidson & Coniglio, 2013). Trauma-informed services do not need to be focused on treating symptoms or syndromes related to trauma. Rather, regardless of their primary mission – to deliver primary care, mental health, addictions services, housing, etc – their commitment is to provide services in a manner that is welcoming and appropriate to the special needs of those affected by trauma (Harris & Fallot, 2001).
Chapter Two
How to Facilitate MIRTS Module
As clinicians we work very closely with young people with FASD, some for short periods and others longer. Whether facilitating a group or working with an individual client, we need to ensure that the services and support we provide is responsive to our clients’ needs. To use MIRTS, the clinician should have experience working with groups or individuals in a therapeutic setting. The curriculum is meant for use by clinicians who have worked, or are currently working with young people with FASD; or those working within addiction, mental health, and the youth justice system. Clinicians should have appropriate training, and have a reasonable familiarity with the subject matter. A clinician should have the following knowledge and skills:

- Working knowledge of the curriculum contents
- Experience working with the client population
- Be FASD, Trauma and Resilience informed
- Experience using a client-centered and strength-based approach
- Basic knowledge of Social Pedagogy concepts
- Basic knowledge and familiarity with Mindfulness concepts
- Basic ability to facilitate groups
- Understanding of, and sensitivity to, cultural issues and other population diversity
- Ability to work with participants in a positive, empathetic manner

Although detailed instructions for conducting sessions are included in this manual, a new clinician may not have acquired the facility or the skills necessary to make the most of the sessions and may need to get some added training in the subject matter. The clinician who is willing to adapt and learn new treatment approaches is an appropriate clinician to use MIRTS. As clinicians, you are responsible for integrating material in the curriculum in a way which provides a coordinated, enjoyable, efficient, effective and safe treatment experience. You are expected to:

- Be familiar with the material to which the client is being exposed
- Encourage, reinforce, and discuss material that is being covered
- Helps the client integrate concepts from their sessions

In facilitating sessions, the clinician should be sensitive to cultural, and other diversity issues relevant to the specific individuals or groups served. The clinician should demonstrate a willingness to understand clients within the context of their culture. However, it is also important to remember that each young person with FASD is an individual, not a homogeneous group, or merely an extension of a family, or a particular culture.
Young people with FASD have complex and multiple needs and can easily be reduced to their diagnoses. Further, the interplay of clients’ complex needs and strengths, clinicians’ preference, and institutional factors will influence how MIRTS is applied. Thus, care must be taken to ensure that clients feel respected and empowered. Importantly, a young person with FASD plays a significant part in mapping the direction of the journey. Ensure that conversations are interactive and always in collaboration with the young person. Seek to understand what is of interest to the young person and how the journey is suiting their preferences.
Individuals and Groups

The curriculum is designed to address the needs of young people with FASD ages 15-24. Clinicians can use it with an individual client, or in a group treatment setting. It is strongly recommended that when conducting group sessions young people age 15-18 be placed in a separate group from those aged 19 and older. Young people in different age groups have different capacities and different communication styles. In a group session, their learning and participation are most effective when grouped within a similar age range. It is also recommended that groups be separated by gender as male and females have different experiences of substance use, or trauma and young women tend to have needs that a different from young men. This will yield the most participation from all young people and allow for different perspectives to be heard. The session should provide a ‘safe space’ for a young person with FASD to voice his/her views and concerns, or explore solutions.

Difference between Group and Individual Sessions

An essential difference between individual and group sessions is the time allocated to each session. More time will be set when working in a group context as opposed to a person therapeutic session that usually last about fifty minutes. Individuals do not experience feedback from other group members—a process found to be valuable in some contexts based on my experience of conducting both individual and group sessions. In the individual sessions, the time spent exploring issues in depth may, however, make up for the discrepancy. Also, the process of checking in and checking out will look different and may be simplified for individuals by asking a client to identify how he/she is feeling at that moment. The difference in material for conducting individual sessions versus group sessions is minimal; however, some of the activities can only be used in a group setting while others may be adapted. Whether facilitating a group or conducting an individual session, it will be helpful for clinicians to review the material for each session first. Instructions that are more suited for conducting a group session may be ignored for the individual session. Throughout the manual, you will find useful tips, which will highlight any notable variation between individual versus group format. Ideally, sessions should be scheduled on at least a weekly basis, or previous learning may be lost.

Group Size

Numbers can have a big impact on the productivity of a group session. If there are a large number of attendees, consider other ways of working through the agenda, like working in smaller groups, so that everyone has an equal chance to participate. Keep in mind that sometimes trying to find your voice in a sea of voices can be intimidating. The exercises in this manual are best accomplished with groups of 4-10 young people. Most session activities may also be more efficiently accomplished with smaller groups; larger groups might be harder to facilitate due to the participatory nature of the activities. All participants need to be afforded the opportunity to speak, or not speak. This manual is flexible; the modules presented in this manual can be modified for use in different socio-cultural contexts.
Guidelines for Clinicians

Working with young people with FASD, who are quite often marginalized, can be challenging. Many young people with FASD may have experienced multiple and complex trauma, have internalized their marginalization and may have difficulty feeling qualified to participate, engage in group activities, or trusting people. It is vital that clinicians show respect and care to all participants, and figure out ways to draw them in and affirm their thoughts and opinions.

Tips for Planning your sessions

- Be very familiar with the entire curriculum before the first group or individual session so that you can re-order the sessions to match the needs of the group or individual as necessary.
- Familiarize yourself with any background reading and references.
- Before the activity begins, prepare any handouts or other materials that may be needed.
- Introduce each unit of the curriculum and each activity by talking about the objectives and what you hope to achieve during that activity.
- Have a Question Box or Anonymous Wall available throughout the group sessions for participants to “post” their anonymous questions. These are issues that they may be embarrassed to ask about in front of the group. Make sure, however, that any questions posted are addressed within the sessions or responded to accordingly.
- Clients with FASD and those in early substance use programs often experience varying degrees of cognitive impairment, particularly regarding short-term memory. Memory impairment can manifest in clients’ difficulty recalling words or concepts. Repeating information in different ways, in different contexts, and over the course of clients’ treatment helps clients comprehend and retain basic concepts and skills critical to well-being. This curriculum is flexible making it applicable to young people at all stages of clinical contact, from intake to transition. Key concepts are with games and exercises. Most of the materials can be adapted and used in different ways to make learning enjoyable and accessible to participants with varying cognitive abilities.

Small group discussions

Small group discussion in groups of twos, or threes, is useful. When working with young people with FASD, it is important to provide support to them in their discussion groups. Some participants may have never experienced this form of learning, and thus, will need direction and support from facilitators. Do not ‘give them the answers,’ but ask the right questions to keep the discussion flowing. Gradually during the sessions, they may require less support as they become accustomed to these learning methods.
Activities

Activities used to support the learning objectives, or as energizers, are important aspects of youth-friendly groups. When activities are used, clinicians should participate in the activities as much as possible, rather than standing as passive observers. All participants should be included in the process. Facilitators must be able to manage exclusion of participants, looking out for either the natural exclusion of more introverted individuals and the discouraging behaviour of other group participants towards each other (such as teasing). It is important to make accommodations for those who are not able to participate.

Time Allotment

This curriculum deviates from the traditional norm of others you may have used in the past. You will notice that no specific time allotment is given for covering the materials. This is because working with this population requires working at their pace and comfort level, as opposed to being time specific. Your task is to understand your participants, their needs, capacity, group dynamic and saturation level. Every individual is unique, and each group is different. Work through the material at a pace that is appropriate to the group. When conducting individual sessions, do not feel rushed to cover a unit in one session, be mindful of your client’s learning pace. In my experience, having a set time can create anxiety for group facilitators as they may rush through materials to ensure that they are working within the allotted time frame. Some material may need exploring in great details other materials may not. As a general guide, given the population you are working with, I would recommend giving short breaks after 25-35 minutes when conducting group sessions. Individual sessions are typically 50 minutes long, but in my experience, most young people with FASD will tap out after about 40 minutes.

How the Resource is Organized

The curriculum is presented in five parts. Parts one through four provide clinicians with valuable information while part five contains 13 chapters, each with sub-units of materials to explore with clients. Clinicians will have to determine which modules are most appropriate for a particular group or individual. The units in chapter seven through to chapter eighteen can be used alone or as a part of an existing program model. Choose the module/unit that best meets the individual’s, or group’s needs. Modules/Units in chapter seven through chapter eighteen are self-contained units that can connect to other units but do not necessarily rely on those other units for their stable operations. However, it is recommended that clinicians include the chapter on ‘identity’ and ‘resilience’ with any other chapter deemed appropriate to the individual or group. Not every group or individual will have trauma experiences, however, working from a trauma-informed lens is recommended. Concepts of social pedagogy and mindfulness resonate throughout the curriculum, but for a more in-depth focus, clinicians can incorporate this chapter with any cluster. Chapters can be grouped together in different clusters (see the table below for an example). Regardless of the number of sessions offered, young people should be encouraged to practice the mindfulness examples taught between sessions and to apply them to their daily living.
**Focus** | **Cluster**
--- | ---
**Emotions** | Emotions, Identity, Mindfulness, Resilience
**Relapse Management** | Identity, My Use, Change, Mindfulness—Integrated Change Management, Resilience, Mindfulness
**Communication** | Interpersonal Skills, Emotions, Mindfulness, Identity, resilience
**FASD** | FASD, Resilience, Mindfulness, Identity

**Tips for engaging with clients**

It is important to remember that the way you engage with the client from the onset may affect the therapeutic process and client engagement. Don’t begin with the assumption that you know and understand their needs, or what a particular challenge or change may mean for them. For example, if a client is expressing fear or anxiety about an impending relocation to foster care, don't assume you know how he/she feels. If you presume to know how he/she feels you will most likely get asked if you have been in foster care.

What I have learned from working with young people with FASD is that they want to feel confident about processes they engage in, as well as the help they are getting. They want to be heard and understood, and they want to be appropriately involved in discussions and decisions that affect them. In the initial moments of a group or individual session, I find it very helpful to chat with them about lighter non-threatening topics. When young people with FASD feel safe speaking with you, they are more likely to ask questions or be open to answering your questions. This way I can immediately begin to build a rapport.

**When you build a rapport, a young person**

- Will feel safe talking to you
- Will feel like you are interested in getting to know them and will be more confident in the process
- Will feel their concerns have been heard
- May likely return

Therapeutic engagement can stimulate physical, social, emotional and cognitive development. Young people with FASD need time, space, materials and the support of informed, thoughtful and skilled clinicians in order to experience better outcomes.
It is also a good idea to ensure you

- Check that you understand their concerns, needs or difficulties
- Communicate interest and attentiveness to what the client is saying or trying to say. Attending is crucial to creating a climate of attention and respect
- Clarify the young person’s goal in coming to the group or individual session
- Conclude, by asking if they have any questions or anything more to add

Active listening

Although we encounter situations where we teach our clients to develop active listening skills, as clinicians, we can become guilty of not practicing this crucial skill. Active listening is critical in building client alliance and the therapeutic relationship. The ability to be open toward the young person with FASD, attentive, empathetic and non-directive will help build positive feelings of trust.

The Art of Asking the Right Questions

Asking appropriate and encouraging questions are one of the most important skills of a clinician. Questioning is an active listening technique; it is an art that plays a critical role in therapeutic dynamics. Using simple and effective questions to guide session discussion will elicit the most engagement and feedback from young people. It is important to remember that all therapeutic interactions are forms of conversations. However, it is crucial what kind of questions you ask the client. Some questions may be a barrier to communication, by asking effective questions you will be able to open up a space where clients feel safe and comfortable. Consequently, conversations will be more directed towards developing and achieving the clients’ vision of solutions. Be mindful that questions authentically request the knowledge and opinions of the clients, and also reflect the contexts of their life. Several questions can be asked in each unit, and the number of questions should be proportional to the client’s or group participants’ need, narrative accounts, and overall goals. The questions (e.g., discussion, insight, reflection) in each unit are there to serve as a guide, do not try to ask them all in a session, you need to choose carefully. Asking the right questions should help lead clients to a clear understanding of the concepts being taught, and build an informed opinion about how they can contribute to resolving their problems in a way that is empowering. The following questions in the table below can be used as a guide to help with engaging clients.
<table>
<thead>
<tr>
<th><strong>TYPE OF QUESTION</strong></th>
<th><strong>DESCRIPTION</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scaling</td>
<td>Scaling questions are tools that are used to identify practical differences for the young people and may help to establish goals as well. The poles of a scale can be defined in an appropriate way each time the question is asked, but typically range from the worst the problem has ever been (zero or one) to the best things could ever possibly be (ten). The young person can be asked to rate their current position on the scale and questions are then used to help them identify:</td>
</tr>
<tr>
<td></td>
<td>- Resources: What stopped you from slipping one point lower down the scale?</td>
</tr>
<tr>
<td></td>
<td>- Exceptions: On a day when you were one point higher on the scale, what told you that it was a 'one-point higher day'?</td>
</tr>
<tr>
<td></td>
<td>- A preferred future: Where on the scale would be good enough? What would a day at that point on the scale look like? The preferred future question can form the basis for goal setting.</td>
</tr>
<tr>
<td>Exception</td>
<td>Exception seeing questions presume that there are always times when the problem is less severe or absent for an individual. The facilitator can seek to encourage the young person to describe what different circumstances existed, in that case, or what they did differently. The recognition of the difference may help the individual to repeat what has worked in the past and to help them gain confidence in making improvements for the future.</td>
</tr>
<tr>
<td>Miracle</td>
<td>The miracle question can help young people who may be stuck in their problem and cannot believe there is anything beyond the obstacles they see in front of them. For some, it can feel like it would take a miracle for their situation to improve. The facilitator can start by asking, “Suppose while you are sleeping tonight, a miracle happens. The miracle means your problem is somehow solved. What would be different tomorrow morning that would tell you a miracle has happened?”</td>
</tr>
<tr>
<td>Description</td>
<td>Description questions can help young people to explain or define what they see happening. The facilitator can start by asking, “what do you see happening?”</td>
</tr>
<tr>
<td>Analysis</td>
<td>The analysis question can help young people think about what is happening. The facilitator can begin by asking, “what do you think is happening?”</td>
</tr>
<tr>
<td>Reflection</td>
<td>The reflection question can help young people to look back on their behaviour or sequence of events and perhaps consequences of their behaviour and what lessons they may have learned from it. The clinician/facilitator can start by asking, “what can you learn from this experience? To help clients see potential solutions, you may ask, are there times when this has been less of a problem? What did you (or others) do that was helpful? What does this mean for you?”</td>
</tr>
<tr>
<td>Implementation</td>
<td>The implementation question can help young people to think about or consider what they can do. The facilitator can start by asking, “what can we do about it?”</td>
</tr>
<tr>
<td>Coping</td>
<td>Coping questions are designed to bring out the young person’s resources that may have gone unnoticed by them. Even the most hopeless story has within it, examples of coping that can be drawn out. For example, “I can see that things have been tough for you, yet even so, you managed to come here to attend this group. How did you do that?”</td>
</tr>
<tr>
<td>Funneling</td>
<td>Use clever questions to funnel the clients’ answer—ask a series of questions that becomes more or less restrictive at each step; starting with open questions and ending with close questions, or vice-versa.</td>
</tr>
<tr>
<td>Present and future-focused</td>
<td>These questions usually focus on the present or the future. This reflects some aspects of mindfulness, but also the basic idea that problems can be best solved by focusing on what is already working, and how a young person would like his/her life to be, rather than focusing on the past. For example, you may ask, what will you be doing in the next week that would indicate to you that you are continuing to make progress?</td>
</tr>
</tbody>
</table>
Other considerations to help promote client engagement in sessions

- Consider providing food, and transportation.
- Diversity of Experience—be mindful of young people’s diverse experiences. It is important to recognize that youth in care have historically had little involvement in the decisions that affect their lives; therefore, education about the right to participate can often bring up discussion about times when that has not been the case.
- Stigma—young people with FASD and, in particular, those in care face stigma about being in care. Young people with FASD have shared that sometime their peers and adults in their community assume things about them including being “troubled,” being “a problem youth,” criminals, just a statistic, not able to function in society, having mental health and addiction issues, etc. Many young people with FASD will not talk about their experience with others to voice this stigma. This social stigma can sometimes prevent young people with FASD from recognizing the amazing and unique personalities, accomplishments, skills, talents, and cultures.
- Culture—young people with FASD in and from care have a fundamental need and right to be rooted in their culture and traditions. Please ensure that you displaying cultural sensitivity when working with young people with FASD.
- Learning Needs—young people with FASD are heterogeneous and have different learning needs, it is important to be mindful of the various learning needs.
- Triggers—be aware of what situations, scenarios or actions may trigger personal reactions that may interfere with a young person’s ability to participate.
- Be mindful of your bias—young people with FASD offer a diverse and unique view of our world and communities. They offer a perspective unseen by most and challenge us to question our learned teachings, prejudices, therapeutic approaches, experiences, and our ideas disability. FASD occur on a spectrum, rather than just a black and white picture, comprising of young people whose experiences and needs are varied, interwoven and at times complex. It is important to recognize that young people with FASD have the same rights as all other youth and efforts must be made to ensure that the necessary action is taken to enable them to realize their rights and fulfill their potential.
- Recognize that some young people with FASD come from backgrounds of trauma, intergenerational trauma and intergenerational substance misuse, which may influence their perception of the world, their attitude, and behaviour (e.g. triggers, lack of trust, etc.). Develop supportive relationships through the use of power balance, respectful communication, following through with commitments, etc.
- Help group members to manage their feelings so they can participate
- Provide lots of opportunities for group members to get to know each other (ice breakers, check-ins, etc.) and personalize the experience.
- Send out meeting reminders via a combination of text, email, phone call, and social media sites, i.e., Facebook.
- Provide paper, pens and other materials to promote full participation.
- Keep resources for youth so that they do not have to carry binders of information with them to each meeting.
- Provide items for them to play or draw with as some people struggle to concentrate without them
- Use straightforward wording and keep it brief.
- Use examples and stories to emphasize key points.
- Summarize key points.
- Include interesting quotes.
- Provide details about where to find more information.
- Make documents available online.
Trouble Shooting – Group

Things do not always go as planned. Challenges can arise when clients start to be absent, late or appear disinterested. A dominant personality in the group can prevent equal participation of all group members. Negative group dynamics may develop if group participants are not getting along. Below are some strategies for dealing with these issues:

- Encourage participants to revisit ground rules and reinforce the agreed upon rules and boundaries. Make the complaint process accessible and understandable.
- Remind participants to treat everyone with fairness and respect. Tension can rise if people feel they are being treated differently.
- Ask why is this occurring? Do not assume that you know why a situation appears the way it does. It could be that school, sports, employment or hobbies are getting in the way of following through on the commitment to the group sessions. Maybe they have challenges trying to connect with family, a worker or a caregiver, and this is diverting their attention.
- Consider whether there’s something you could do better. It may be that certain skills need to be taught before a standard can be met.
- Aim to problem-solve rather than alienate. Issues in a group setting can be addressed through collective problem solving and avoid blaming or shaming. Look for win-win solutions.
- Recognize collective achievements. Provide positive reinforcement when youth work effectively. Highlight the positives.
- Change the dynamics of the group by splitting into smaller groups. This can help ease tensions and ensure that all youth get an opportunity to share their opinions.
- Challenge negative statements, actions and behaviours. Help youth explore what’s going on and relate it back to the group’s code of conduct.
- Develop activities jointly with group members this will promote team building opportunities.
Chapter Three
FASD: An Overview
Many of us know something about FASD, yet at times we continue to be somewhat perplexed by the disorder. The fact that you are taking the time to read this curriculum suggests that you are working with someone with the disorder and you want to know more about it, or utilize this curriculum. Young people with FASD are often described as unpredictable, complex, resistant and a challenge. However, they can also be fun and immensely rewarding to work with. By learning more about what FASD is and how it affects a young person, you can become a better clinician who can help a young person with FASD reach his/her potential.

The intent of this chapter is to provide clinicians with basic information regarding FASD. It is beyond the scope of this chapter to provide a complete understanding of FASD. In fact, in order to develop a more informed understand of FASD, it is highly recommended consult a variety of sources as the literature on FASD has been growing exponentially over the last decade. It is also recommended that appropriate training be done in areas where your skill is lacking.

**FASD—An Overview**

Fetal alcohol spectrum disorder (FASD) refers to a variety of the broad array of physical, developmental, neuro-cognitive and neuro-psychiatric differences experienced across the lifespan by individuals who were prenatally exposed to alcohol (Loock, personal communication, 2015; Schechter et al., 2004). Current literature suggests that the effects of alcohol exposure in utero are complex and pervasive, as alcohol tends to affect the brain and impair development, often resulting in significant long-term morbidity and functional impairment. FASD is a permanent disability, and has been recognized as one of the leading environmental (and hence, preventable) causes of birth defects and developmental intellectual disability. Prenatal alcohol exposure is one of the most serious causes of non-genetic developmental disorders in the western world (Olswang, Svensson, & Astley, 2010; Premji, Benzies, Serrett, & Hayden, 2007). FASD crosses all barriers of race, culture, and class.

The adverse effect of alcohol on the developing child can result in a range of structural, physiological, neurocognitive and behavioural anomalies in individuals, as alcohol interferes with many molecular, cellular, and neurochemical events during brain development. The neuropsychological, neuroanatomical and behavioural deficits resulting from prenatal alcohol exposure are wide-ranging and vary substantially between individuals (Bohjanen, Humphrey, & Ryan, 2009; Olson, Jirikowic, Kartin, & Astley, 2007).
In Canada, FASD is now an umbrella ‘diagnostic’ term used to describe the broad range of significant alcohol related neurodevelopmental and neuropsychiatric outcomes and disabilities that are associated with maternal use of alcohol during pregnancy (Cook et al., 2016). The various clinical pictures of FASD will depend upon a combination of the different levels of exposure to alcohol (dose and timing), as well as other prenatal and postnatal environmental factors including other drugs exposures, environmental adversity and maternal stress (Chudley et al., 2005).

The FASD continuum ranges from the more physically recognizable diagnosis of full Fetal Alcohol Syndrome (FAS), with sentinel facial features as originally described by Jones and Smith (1973) to the less easily recognizable, but often more challenging to manage, neurodevelopmental disorders associated with few or absent (‘invisible’) physical features. These have been previously described as “possible fetal alcohol effects (FAE) (Clarren and Sokol, 1978), partial FAS and alcohol related neurodevelopmental disorder (Stratton et al, 1996).

The most recent Canadian diagnostic criteria for FASD (Cook et al., 2016) have been developed to incorporate new research on the predictive value of physical features including growth, microcephally and facial features, to be more evidence-based regarding prenatal exposure to alcohol (PAE), to remove barriers to diagnosis for infants, adolescents and adults, and place more emphasis on the reliably and consistency of describing the diffuse and significant neurodevelopmental (brain injury) profile associated with PAE.

As in previous guidelines, the current Canadian guidelines stipulate that a diagnosis requires a history of confirmed and significant PAE unless all three sentinel facial features (SFF) of short palpebral fissures, thin upper lip and indistinct philtrum are present. These SFF show a very high specificity of over 95% for FASD (Astley, 2014). A diagnosis of FASD can only be made in the absence of known PAE when these features are present, and other causes such as more rare genetic conditions have been excluded. The need for this category is to provide appropriate diagnosis and support for the infrequent presentation of full FAS (e.g., individuals with SFF findings) for whom no PAE history is obtainable due to maternal death or permanent separation. (Note: This diagnosis of FASD with SFF cannot be considered when there is evidence for no prenatal exposure.)

Although some individuals have the sentinel facial features (SFF), that can be a “biomarker” for PAE (prenatal exposure to alcohol), most do not. Because there are often few if any distinguishing physical characteristics of the disability, the invisibility of the brain damage can create many more challenges for the individual with more “invisible” presentation. Many young people with prenatal alcohol exposure do not meet the criteria for full fetal alcohol syndrome (FAS) (Chudley et al., 2005). However, along the whole spectrum, one characteristic is common to all FASD children: difficulty in social communication, with varying degrees of severity (Jones & Streissguth, 2010) and other adaptive behaviours e.g. making choices (Loock, Personal Communication, 2015).

In other parts of the world, professionals in the field may still be applying older diagnostic guidelines and criteria, such as the 1996 Institute of Medicine criteria (Stratton et al, 1996). Unlike Canada, FASD remains an umbrella concept (not a diagnostic term) used to describe the broad range of outcomes and disabilities that are associated with prenatal alcohol exposure (Burl, Klug, Martsolf, & Kerbeshian, 2003; Guerri, Bazinet, & Riley, 2009; Kodituwakku, 2007; Rasmussen, 2005; Streissguth, 2007; Streissguth, Bookstein, Barr, Sampson, O'Malley, & Young, 2004). The FASD continuum ranges from the most severe diagnosis of Fetal Alcohol Syndrome (FAS) to Partial Fetal Alcohol Syndrome, (pFAS), to Alcohol Related Neurodevelopmental Disorder (ARND), and to a diagnosis of Alcohol Related Birth Defects (ARBD). Despite these different
approaches, all are in agreement that persons affected by FASD experience significant challenges, in areas such as learning, memory, attention, executive functions, communication, mathematics, vision or hearing. (Caley, Shipkey, Winkelmena, Dunlap, & Rivera, 2006; Chudley et al., 2005; Streissguth & O’Malley, 2000).

Primary Disabilities and Secondary Disabilities

Primary Disabilities

Primary disabilities are functional deficits that result from central nervous system dysfunction (Mattson, Crocker, & Nguyen, 2011; Miller, 2006; Olswang et al., 2010). It has been suggested that deficient executive functions such as planning, organizing, abstracting, impulse control, sensory processing, integration across space and time, strategic plan of action sequences, interference control, selecting appropriate responses in the face of competing and contextually inappropriate alternatives, and working memory may be primary cognitive deficits of FASD (Streissguth et al., 1997). Since executive functions such as planning, organizing, and integration are integral to the normal processing of information in the environment; the impact of executive dysfunction may be great for this population. The physical, cognitive, and behavioural deficits observed among individuals with prenatal alcohol exposure are not dichotomous, that is either normal or clearly abnormal. Rather, the outcomes, and the prenatal alcohol exposure, all range along separate continua from normal to clearly abnormal and distinctive (Astley et al., 2009; Kodituwakku, 2007). Other clinical manifestations of FASD may include cardiac anomalies, urogenital defects, skeletal abnormalities, and visual and hearing problems (Aragón et al., 2008; Canadian Pediatric Society, 2002; Chudley et al., 2005; Green et al., 2009; Nicholson, 2008; Streissguth, 2007).

Secondary Disabilities

Secondary disabilities are disabilities that the individual is not born with but which manifest progressively with development, particularly when there are inadequate interventions in place to provide support around primary disabilities (i.e., they are additional disabilities or conditions that may result from having a primary disability) (Kodituwakku, 2007; Kodituwakku, 2009; McGee, Fryer, Bjorkquist, Mattson, & Riley, 2008; Pei, Job, Kully-Martens, & Rasmussen, 2011; Rasmussen & Bisanz, 2009; Rasmussen, Horne, & Witol, 2006; Sampson et al., 1997; Streissguth et al., 1997; Todorow, 2011).

Individuals with FASD may exhibit secondary disabilities such as: behavioural problems (internalizing and externalizing) and social problems, problems with recognizing and respecting boundaries, limited social skills, problems with the legal system (e.g., theft, assault, noncompliance with court mandates, vandalism, and mischief), learning challenges and compromised school experiences, substance abuse, post-traumatic stress disorder (PTSD), depression, reactive attachment disorder, oppositional defiant disorder, anxiety, conduct disorder, and inappropriate sexual behaviour (Streissguth et al., 1997; Streissguth et al., 1996).

According to Stade and her colleagues, individuals with FASD often display characteristics such as extreme hyperactivity, aggressiveness, poor judgment, and speech and language difficulties (Stade, Stevens, Ungar, Beyene, & Koren, 2006). The level of maladaptive behaviour among this population is high and presents a significant challenge to service providers (Streissguth et al., 1991; Streissguth et al., 1997; Streissguth et al., 1996). However, this behaviour cannot be looked at in isolation without also considering the social, cultural, environmental, and developmental factors that are likely to have a significant impact on the expression of both psychiatric and behavioural disorders in young adults with FASD. Young people with FASD are
reported to have significantly higher rates of substance use, homelessness and criminal justice engagement than the general population (Baumbach, 2002; Chudley et al., 2005; McLachlan, 2012; Miller, 2006; Streissguth et al., 1996). Deficits in behaviour problems (internalizing and externalizing) and social problems have been noted (e.g., Steinhausen & Spohr, 1998; Streissguth & Kanter, 1997).

**FASD a Paradigm Shift**

Below I present an overview of FASD from a resilience and strengths based perspective. It is my contention that FASD is dynamic in nature and that the research literature supports a more rounded approach to youth which builds on strengths and resilience rather than focusing on deficits.

**A Resilience and strength-based view of young people with FASD**

Traditional approaches to understanding FASD have dominated our clinical, academic, and research forums for the past few decades, and are based primarily on medical models. Traditionally, research and many of the human service agencies have focused on trying to understand better the biological/cognitive, psychological or psycholinguistic factors that are challenging for an individual with FASD. This research is based on the deficit, problems, or pathologies of individuals with FASD. Although, this has been very helpful in understanding the impact of prenatal alcohol exposure and useful strategies and techniques have emerged from this research, there are also potential disadvantages. These approaches tend to place much of the burden for FASD on the individual. What has been apparent over the years is that programs (youth mental health, youth addiction or youth justice programs) seem to report on what is wrong with the young person and to a lesser degree, the strengths of these young people.

Many professionals may be led to perseverate on a “deficit” view. The emphasis on deficits, or what a young person with FASD is challenged by, has the potential to lead professionals to a cycle of focusing only on what might be ameliorated through adapted educational strategies or treated pharmacologically. When professionals or organizations focus solely on what is ‘wrong’ with any young person, we deny and limit them the opportunity to explore what strengths and capacities they have. By utilizing a resilience perspective to talk about FASD, I attempt to account for the drawbacks of traditional models and have re-framed FASD in broader social, relational and cultural contexts. This is an attempt to bridge the traditional and post-modern perspectives on FASD. Hopefully, clinicians will engage ‘differences’ in ways that explore possibilities for productive and positive learning, and consequently better outcomes.

Dubovsky, (2006) has coined the term NURMU (non-complaint, uncooperative, resistant, manipulative and unmotivated) to describe how professionals and caregivers often perceive young people with FASD. Many young people with FASD may not be well understood by professionals due to limited knowledge about the disability, lack of training and the non-existence of an FAS-informed approach within most youth addiction, youth mental health and other young adult service systems. Leading researchers and clinicians in the FASD research field are beginning to call for a shift in the way we view young people with FASD. Researchers have re-focused our attention on the strengths of individuals with FASD Malbin (2002). In fact, Kaitlyn McLachlan discussed the strength-based approach to viewing youth with FASD at the 2015 International FASD Conference during her presentation. Moreover, personal discussion with Dr. Amy Salmon and Dr. Christine
Loock reveals that in addition, youth and adults with FASD, have requested a reframing, with more focus on the strengths and inclusion of individuals with FASD and more so, the promotion of developmental trajectories that capitalize on these strengths. These individuals with FASD are also requesting that we address the other health aspects associated with their condition, with clear links to the long term health consequences (e.g. cancers, heart diseases, mental health) of having experienced early life adversity (Felitti & Anda, 2009).

Researchers have suggested that the development of ‘secondary disabilities’ associated with FASD can be prevented or moderated by protective factors such as early and accurate diagnosis (Astley, Bailey, Talbot, & Clarren, 2000; Streissguth et al., 1997), timely access to appropriate interventions and supports (Streissguth et al., 1997), living in stable home environments, (Duquette, Stodel, Fullarton, & Hagglund, 2006; Streissguth et al., 1997) and the presence of adults who can act as advocates to guarantee a supportive school environment (Duquette et al., 2006; Streissguth, 1997). When protective factors (internal and external) such as healthy relationships, appropriate housing, safety, availability of prosocial activities, good social problem-solving skills, high self-esteem, and stable and appropriate support at school are absent, many young people affected by FASD tend to experience complex challenges. Notwithstanding a young person’s experiences of learning problems, academic failure, and mental health and substance use issues (Streissguth et al., 1997), many youth does well. Some do persist with schooling and graduate (Duquette et al., 2006; Duquette, Stodel, Fullarton, & Hagglund, 2007; Duquette & Stodel, 2005).

Many hope to shift the focus of discourse from atypical ways of thinking and learning away from the usual focus on deficits and focus more on the ‘neuro-diversity’ that includes resiliency and strengths. In that FASD impacts the brain, we should also seek to appreciate the individual’s additional skills and aptitudes. Young people with FASD will all have strengths and abilities; they grow and develop from their strengths and adapt to their challenges. For instance, many of the young people with FASD with whom I have worked are capable of focusing on tasks that take advantage of their performance (non-verbal) aptitude and interest in art. With stronger visual reasoning abilities, and they may work well with visual cues and structure. Other more performance based aptitudes and enhanced skill development include computers and music. Other assets garnered from my clinical observation include:

- Creative
- Responding well to structure – consistency and repetition
- Strong concrete and experiential learners
- Visual learners
- May have areas of relative strength in overall ability (e.g., drawing, music, computer technology, mechanical)
- Friendly and outgoing
- Helpful
- Determined
- Generous and caring about others

Many young people with FASD are chronically unemployed or underemployed. Employers can often be hesitant to hire workers who act, or communicate in non-neurotypical ways. In my experience, part of the challenge of doing poorly at school is also due, in part, to the fact that many Individualized Education Plans (IEP) are made without inclusion and consultation with the youth and without taking the time to ascertain his/her strengths. One metaphor for neuro-diversity is to recognize that just because a clock is digital, does not make it less of a clock than one that is analog. It is just ‘different’.
A resilience and strength-based approach encourage clinicians and youth with FASD to engage ‘difference’ in ways that explore possibilities for productive and positive learning. Clinicians, who are knowledgeable and open to making adjustments to therapeutic practices and ‘spaces’ while maintaining high expectations, can produce great gains with young people living with FASD. We attribute a multitude of accomplishments to innovators who were gifted in non-neurotypical ways. By using the concept of neuro-diversity to account for individual neurological differences, we will be able to create a discourse whereby young people with FASD may be seen in terms of their strengths as well as their challenges. Unless an individual’s strengths have been recognized, celebrated, and worked with, nothing formative may be done to address their difficulties. Young people living with FASD should be supported to develop skills to learn, work, adapt and aspire for successful and fulfilling lives. The challenges of achieving and maintaining gains may at times seem overwhelming but by building their resilience capacities, better outcomes can be achieved.

It is important to understand that a resilience approach does not deny that young people with FASD experience problems and challenges and that these issues need to be taken into consideration. Instead, the approach shifts the frame of reference to focus on what is working well for the young person. The focus is on the individual, not the ‘FASD’. When a problem becomes the starting point, with emphasis on what youth are lacking, a dependency is created on the helping professions with lowered positive expectations and blocked opportunities for change. A process of disempowerment occurs that often results in the following:

- Labelling and therefore, limiting of options.
- Obscuring the recognition of a youth’s unique capabilities and strengths.
- Focusing on the “can’ts” as opposed to the “cans”.
- Ignoring other potential resulting from ‘cognitive diversity’.

A resilience approach views young people with FASD as both having agency and being constrained. Some individuals have more agency or are more constrained than others. It is critical we pay attention to the interplay between their agency and the constraints. Explanation that attends to either exclusively will be inadequate. A resilience approach is fluid and considers individuals as dynamically evolving and always becoming. As a psychological being, an individual is constantly in flux, and changes depending on the sorts of resources available for appropriation in their sociocultural contexts.

Chimamanda Adichie in her Ted Talk speech ‘the danger of a single story” said, “Show a people as only one thing over and over again and that is what they become” (Chimamanda, 2009). Researchers and clinicians may assume a static, binary, or even single lens approach when comparing individuals with and without FASD. A resilience thinking approach calls for a multi-faceted (multi-lens) conception of FASD. Understanding that the learning for a young person with FASD is dynamic, complex and holistic, that they demonstrate their learning and coping in different ways and the importance of starting with what is present, not what’s absent, is relevant to the work we do as clinicians.
Chapter Four
FASD-Informed Practice
FASD-Informed Practice assumes that young people with FASD are doing the best they can at any given time to cope with the challenges they are experiencing. Young people with FASD quite often have multiple and interlocking needs that span social and health issues; many problems including substance misuse, mental health, and self-injury, are usually attempts to cope with overwhelming feelings. The challenge for substance use treatment providers and clinicians is to provide services and supports that address multiple needs.

To meaningfully facilitate change, promote resilience and wellness, it is important for substance use treatment providers, mental health, and youth justice workers to make the connections between a young person’s experience of having FASD, possible trauma experiences and his/her problematic substance misuse and psychosocial concerns.

In particular, the youth justice system and substance use treatment programs are becoming increasingly aware of the need for integrated approaches to better respond to the acuity and chronicity of these types of problems among young people with FASD. FASD-informed practice builds on this by recognizing the need to respond to an individual’s intersecting experiences of mental health, disability, physical health, substance misuse, trauma and relational and social concerns. Being FASD-Informed means that agencies and clinicians have an understanding of FASD and how FASD can impact a young person’s life and are prepared to provide services that are appropriate to the individual’s needs. Positive outcomes can, and do occur when programs for young people with behaviours or characteristics of FASD are designed with FASD-informed approaches.

Substance use treatment program vary widely across regions and service provision. While some agencies will already have an FASD-Informed approach in place, others may not. The list of questions below can be used to help you to begin to reflect on your practice while the table provides FASD-informed practice considerations for agencies and clinicians to contemplate. They are intended to guide and support the translation of FASD-informed principles into practice. For the clinicians’ checklist, if you answer NO to more than half of the questions, you may wish to consider some training and professional develop related to FASD. More generally, ongoing training, guidance and supervision are useful to help support an FASD-Informed practice. The guide is based on findings from the literature reviewed; lessons learned from my practice experience; and, ideas offered by many of the young people with FASD I have worked with throughout the years.

A good place to start is to discuss with colleagues what FASD-Informed Practice is, and what it is not. You may also wish to use the opportunity to reflect on your own beliefs, values, attitudes and assumptions. It is important that you are aware that your attitudes and values about individuals with FASD will influence your
perception and how you work with a young person. Spend some time reflecting on how your values, beliefs, attitudes and assumptions are evident in the philosophy of the service the agency offers and in your daily work with young people and their families.

Questions to consider:

1. How can we respect the uniqueness of the young people with FASD we serve?
2. How do we deal with ‘difference’ at our agency, or as individual clinicians? Are young people with FASD encouraged to be themselves? Are they invited to participate in processes that impact them?
3. Is the potential for every young person to become valued, fostered and enhanced by them accessing our service?
4. What do we do now and what can we do to make every individual feel safe, welcome, and valued?
5. What is evidence of being, belonging and becoming in our action here?
6. What would an environmental audit of our setting show about our ability to adapt and create an environment conducive to the needs of individuals with FASD?
7. Are we providing resources that can foster sustainable change?
8. What opportunities do we provide for families to communicate with us about their children so that we can learn from them; and for us to explain what we do, as well as, provide adequate support or linkages?
9. How do we empower young people with FASD?
# GUIDELINE FOR FASD-INFORMED PRACTICE

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<th>FOCUS AREA</th>
<th>APPLYING FASD—INFORMED PRACTICES</th>
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| Holistic Approach           | – Recognize that what is going on in one part of an individual’s life can affect many other areas of his or her life. Social context can create particular psychosocial vulnerabilities. It is, therefore, important to understand the social dimension of FASD.  
– Well-being includes many different aspects of an individual’s life, such as physical, and material aspects, psychological, social, cultural and spiritual aspects. Thus, the focus of treatment need not be just on the individual, but can also include families and communities. Support, wherever possible, those who know the young person well, know what they need, what works well for them and what may not be helpful. |
| Respect & Inclusion         | – Maintain the position that the individual and his/her family are resourceful. Be willing to work with them as partners in building safety, nurturing growth, and sustaining change.  
– Create a space where individuals feel safe to voice their concerns and feel esteemed.  
– Treat a person with FASD as an individual, not a condition.  
– Be attentive to their need for autonomy and inclusion. If the basic rights of a young person are ignored, even a young person who is resourceful and confident risks being overwhelmed. |
| Recognizing Capacity         | – Use an individual’s abilities, existing networks, and support where possible.  
– It is more useful to assume an individual’s or family situation to be ‘complex’ rather than characterized by risk. This will help shift the focus from one of deficits and risks to one which actively appreciates individual, family and situational strengths and capacities.  
– Identify and highlight positive aspects of the individual. Focus on what the individual is doing well to build the individual’s sense of self.  
– Provide opportunities for young people to thrive, nurture their development, mentor and teach life skills.  
– Create an environment that encourages |
| Valuing Diversity            | – Individuals with FASD should feel valued in all circumstances.  
– Understand the multiplicity of experiences among individuals with FASD (i.e., History of abuse, and Child Protection service involvement, victimization, youth justice involvement, mental health involvement, education, GLBT, employment).  
– Appreciate and nurture the uniqueness of each individual.  
– Try to find ways of helping individuals with FASD without stigmatizing them. |
| Linkages and Circles of Support | – Recognizing individuals with FASD and their families need practitioners to work together, when appropriate, to provide the best possible help. Establish an open mind and always engage in critical thinking and maintain a position of inquiry.  
– Strengthen the relationship that an individual has with a trusted care-giver  
– Promote within the individual and his/her family a sense of control (versus helplessness)  
– Promote stability and routine.  
– Encourage individuals to utilize other community resources and help individuals to access other support.  
– Make use of local capacity, for example by consulting and building alliances with other community organizations or clinicians |
| Empowerment and Resilience | − Help clients to discover their personal strengths and capacity and support their efforts to take control of their lives and achieve their goals.  
− Encourage participation to bring about ownership and continuity of any change  
− Consult individuals about what types of supports they need and what works best for them.  
− Build resilience in individuals and their families to address their own challenges  
− Make assessments and evaluation of progress and include individuals in the process.  
− Focus on what people are already doing well and build on this.  
− Help them to recognize choices and encourage independent decision making.  
− Work to remove gaps and barriers in service  
| Assist the young person in becoming solution—focused | − Explore with individuals their preferred future, rather than just be focused on and fixing a problem. Identify resources, strengths and goals to attain the preferred future (and in doing so change the problem).  
− Use of conversations centered on clients’ concerns.  
− Engage in conversations focused on co-constructing new meanings surrounding clients’ concerns  
| Consider culture and Structural determinants of health | − There are strong continuities in the structural factors that condition an individual's life chances, including gender, class, race, economic status and geographic location; be mindful of these factors and how they impact an individual.  
| Sustainability | − Develop and use approaches that ensure results in lasting and fundamental improvements in the lives of individuals with FASD, rather than only offering support that creates dependency  
− Focus on the quality of what is given and how it is given as opposed to the quantity (statistic) of what is given. Individuals will respond better when supports appropriately match their needs.  
− Enhance self-resilience and empower individuals with appropriate coping, mindfulness and self-reliance skills.  
− Provide opportunities for transition planning  
− Strengthen the capacity of families and other support network to support individuals with FASD.  
− Develop the capacity of individuals to manage change.  
| Trauma—Informed | − Take into consideration the impact of intergenerational histories of trauma, as well as the individual own possible history of trauma.  
| Knowledge of FASD | − Understanding of, and knowledge of FASD, as well as it impacts on individuals and family.  
− Continuous training and service improvement to meet the needs of individuals with FASD.  

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Creating an FASD—Informed Agency

Given that current systems of care have not adequately addressed the needs of individuals with FASD, it is important that service providers and clinicians’ conceptions of young people with FASD be informed by an approach that appreciates the complexity of their lives, and respects their lived experiences. For many service providers and clinicians working with individuals with FASD, a commitment to FASD-informed practice can represent a paradigm shift in culture, value and attitude. A solemn commitment to FASD-informed practices will ensure that all young people receive services that are suitable and sensitive to their multiple needs. Getting started with an FASD-informed approach will require making an internal audit. An agency can begin this inquiry process by thinking about what they are thinking and identifying gaps in their service provisions; then making changes to an organization’s culture and practice.

Each service and agency tend to be characterized by a professional culture. Changing the organizational culture and practice will offer individuals and families a way of working with them that is based on recognizing the impact of FASD on their lives. Through an FASD-informed lens, some of the forces at play in the lives of individuals with FASD can be more effectively brought to light. At the individual level, an FASD-informed approach can help to understand, in a non-pathologizing way, the range of coping strategies that individuals with FASD adopt in order to work through their challenges.

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<tr>
<th>Questions to consider</th>
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<tr>
<td>Reflect</td>
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<td>- Critically think about and assess what you are currently doing.</td>
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<td>- Evaluate how things are done.</td>
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<td>- Who in the agency can influence an FASD—informative practice?</td>
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<td>- What are our organization’s culture and policy as it relates to FASD?</td>
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<tr>
<td>Reframe</td>
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<tr>
<td>- Look closely at the practice approach and guiding principles.</td>
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<td>- Look at how individuals with FASD are conceptualized.</td>
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<td>- Identify strengths and gaps in your current approach.</td>
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<td>- What adjustments need to be made to address the identified gaps?</td>
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<td>- How do we understand individuals with FASD?</td>
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<td>Act</td>
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<td>- Decide what changes, big or small, need to be made.</td>
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<td>- How can we find out how young people with FASD feel about the service we provide?</td>
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<td>- What might we change after our conversation?</td>
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<td>Revisit</td>
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<td>- Observe how a shift to an FASD—informed practice is impacting individuals, families and clinicians.</td>
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<td>- Amend aspect of change as needed.</td>
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<td>- Where can we see the impact of an FASD-Informed practice with our engagement with individuals with FASD?</td>
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Change in organizational culture includes:

- Change in policy statements that reflects the diversity of clients’ served
- Changing culture through training
- Shift in organizational philosophy
- Adaptations to current guiding principles
- Examination of the agency and individual clinicians’ values, norms and ways of doing things

Change in practice includes:

- Clinicians support for changing practice.
- More comprehensive practice guidance.
- A clear understanding for everyone of what the change means for them and their individual practice.
- Making practice individual-centered
- Integrate existing evidence with professional expertise to provide optimal service.
- Consider how the best available research findings relate to individual practice situations.
- Ensure that good practice in engaging individuals and families impacted by FASD becomes the norm.
- Ensure that staff have the skills and tools to engage effectively with individuals and families
- Use training and supervision to reinforce the importance of an FASD-Informed practice
- Make use of a trauma-informed lens.
- Appreciate the context with which interactions with individuals with FASD takes place
- Healthy dialogue about the principles and shared beliefs that relate to inclusion, diversity, and equity. clinicians must recognize every young person with FASD as having a voice and unique views about how to participate in processes that involve them.
## A Clinician Checklist

Answer ‘yes’ or ‘no’ to help you decide if you are practicing using an FASD lens.

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<th>KNOWLEDGE</th>
<th>Questions</th>
<th>Yes</th>
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<td></td>
<td>Do you know what FASD is? Can you explain it?</td>
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<td>Have you taken any FASD related training?</td>
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<td>Can you explain to a client what FASD is, including the impact?</td>
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<td>Do you recognize the secondary and primary disabilities?</td>
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<td>Are you comfortable talking about FASD?</td>
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<td>Are you familiar with community resources for individuals with FASD?</td>
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<tr>
<th>PERSONAL BELIEFS &amp; ATTITUDE</th>
<th>Questions</th>
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<td></td>
<td>Do you believe that individual with FASD can learn and change?</td>
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<td>Do you believe that individuals with FASD are resilient?</td>
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<td>Do you encourage and support an individual’s agency and self-efficacy?</td>
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<td>Do you believe you can work collaboratively with a client and/or his/her family to affect positive change?</td>
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<td>Do you quell the myths surrounding FASD in your work with people?</td>
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<td>Do you demonstrate respect towards client?</td>
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<td>So you advocate on behalf of clients who need assistance in accessing resources?</td>
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<th>STRENGTH-BASED</th>
<th>Questions</th>
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<td></td>
<td>Do you focus on clients’ strengths and resources?</td>
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<td>Do you engage in resilience promoting activities with your clients?</td>
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<td>Do you nourish positive feelings, hope and self-esteem?</td>
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<td>Do you build on clients’ capacity and help clients focus on ways to sustain resilience?</td>
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<td>Do you allow clients to speak to their needs and have a voice in treatment planning and general decisions about their care?</td>
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<td>Do you empower clients?</td>
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<td>Do you scaffold their development when needed?</td>
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<th>CULTURAL RESPONSIVENESS</th>
<th>Questions</th>
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<td></td>
<td>Do you respect and value a client's cultural way of being and doing?</td>
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<td>Do you make the effort to provide culturally appropriate services when requested?</td>
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<td>Do you consider cultural background when making referrals and out-sourcing resources?</td>
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<tr>
<th>RELATIONSHIP BUILDING &amp; THERAPEUTIC ALLIANCE</th>
<th>Questions</th>
<th>Yes</th>
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<td>Do you make sure clients are comfortable with questions you ask them?</td>
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<td>Do you try to establish a genuine, caring connection with clients?</td>
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<td>Do you work collaboratively with clients regarding the purpose, goals, and tasks needed for positive change in the client’s life?</td>
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<td>Do you avoid jargons when communicating with a client?</td>
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<td>Do you establish a sense of safety for clients?</td>
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<tr>
<th>ASSESSMENTS</th>
<th>Questions</th>
<th>Yes</th>
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<td></td>
<td>Do you ask about the impact of FASD in their life?</td>
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<td>Do you ask about what's challenging and what's easy for them?</td>
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<td>Are you flexible by allowing the client to discuss issues, which are important to them?</td>
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<td>Do you ask about any mental health or trauma issues?</td>
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<td>Do you ask about past or current drug and/or alcohol use?</td>
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<td>Do you ask about safety issues?</td>
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<td>Do you acknowledge the link between FASD, mental health, substance misuse and trauma?</td>
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<td>Do you ask clients how they cope with difficult behaviours that may result from trauma experiences or substance misuse?</td>
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<td>Do you ask clients about how they cope with the difficult feelings/emotions they experience?</td>
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Chapter Five
Other Considerations
As young people with FASD navigate the service system it is critical they receive guidance, service and support that foster resilience, nurture growth and recognize their agency. FASD is multifaceted and the interplay between FASD and substance misuse has the potential to alter the landscape for young people. Listening to them share their lived experiences and observing their complex struggles, begs the question: in what ways are we ensuring that we are considering belonging, being and becoming of young people with FASD?

A sense of being, belonging and becoming is fundamental to, and intersects with many important aspects of a young person’s identity, as well as, facets of needs, rights, development and well-being. It is important that clinicians provide responsive service that facilitates many protective factors for wellbeing. In my practice experience, when young people with FASD feel respected, valued, and recognized for their uniqueness and expertise about the complexities of their realities; their engagement in service is sustained and improved outcomes are realized.

The well-being and sense of being, belonging and becoming of young people with FASD can be undermined by such things as intergenerational histories of trauma, addiction, emotional dysregulation, stigma, exclusion (most often reflected when young people with FASD fall through the ‘pot holes’ of services) and negative peer pressure. Moreover, when young people with FASD encounter new situations and settings, including, transition into foster homes, transition between foster home, transition out of care, transition to adult service, school transitions and service that is disempowering, they struggle to feel they belong and consequently their sense of being and becoming are also impacted. When we provide services and supports that scaffold new skills, inculcate resilience, nurture growth and acknowledge the agency and competencies of young people with FASD, we can facilitate the restoration of a sense of being, belonging and becoming.

The concept of being, belong and becoming is fundamental to this curriculum. Bringing my understanding of the concepts into the conversation about how to meaningfully work with young people with FASD opens possibilities for conceiving or reconceiving them differently—as people with agency and capabilities. The goal is for clinicians to strive to promote a sense of being, belonging and becoming into young people with FASD.
Putting young people with FASD at the core of service provision: Promoting *Being, Belonging and Becoming*

Understanding *Being, Belonging and Becoming* within the context of MIRTS

**Being**

The concept of *being* is about valuing, perceiving and having an understanding and acceptance of young people with FASD for whom they are rather than seeing them as their diagnoses. It is about seeing them as young people doing the best they can to navigate and engage with the complex layers of their life—experiences, needs, interests, and other contextual factors; rather than seeing them as difficult. It is also about young people with FASD building and maintaining positive relationships with themselves, seeing the possibilities inherent in their experiences, and being aware of their emotions, thoughts and behaviour without judgment. For young people with FASD, understanding and accepting who they are, and knowing that others understand and accept who they are, as well as care about them is empowering. Within the therapeutic context, a young person’s sense of being can also relate to how clinicians show respect to the young person through conversations and actions. Helping young people with FASD to develop a sense of their identity and place in the world is fundamental to their mental health, as well as their social and emotional wellbeing. It also helps them to identify values that can guide them into the future and resist impulsive actions or negative peer pressure.
Ways you can promote a sense of being includes:

- Helping young people with FASD explore and understand ‘who they are’ and what they value.
- Providing opportunities for young people with FASD to explore self-awareness, self-acceptance, self-esteem, self-efficacy and self-compassion
- Understanding and reinforcing their uniqueness and individuality
- Focusing on their strengths—what they know and can do
- Nurturing characteristics such as their drive to learn, creativity, sense of wonder, motivation
- Exploring their interest and preferences
- Embracing differences: culture, beliefs, styles, expressions of themselves
- Celebrating their achievements
- Recognizing their expressed needs and priorities
- Honouring their agency
- Accepting and valuing their skills and experiences

**Belonging**

There are many ways to understand and describe a sense of belonging and there are many dimensions to belonging. Knowing where and with whom you belong is integral to human existence and fundamental to the well-being of a young person with FASD. Young people with FASD belong first to a family, a cultural group, a religious group, a neighbourhood and a wider community, a circle of friends and a substratum of their broader circle of friends. They belong to a school and sometimes a recreational group. Belonging acknowledges the interdependence of young people with FASD with others and the basis of relationships in defining identities (Department of Education, Employment and Workplace Relations, 2009; Hadley, & De Gioia, 2008). Because belonging is most often experienced as a positive feeling; the importance for young people with FASD can be easily taken for granted, particularly as many can appear to be connected to services such as the foster care and youth justice systems.

From my practice experiences and observations, in situations where a young person’s emotional investment in belonging to a parent, extended family, or foster family is not reciprocated, belonging can be experienced as negative and the balance between belonging and separateness can become difficult for a young person with FASD to manage. When friends and romantic relationships become stressed, possessive, or one-sided, feelings of belonging can become manipulative, troubled or abusive as young people with FASD can be very gullible. Their need to belong to a particular social group can easily lead to rejection, thus, the dynamics of inclusion and exclusion can have implications for their perception of where or whether they belong. This, in turn, will influence the social behaviours they engage in and impact their overall well-being. Therapeutic support that incorporates resilience thinking and builds on respect and recognition of agency can work towards ameliorating these risk factors and help to restore confidence and competence in young people with FASD.
In a broad sense, belonging within the context of MIRTS is about clinicians first acknowledging the multiple belongings of young people with FASD, recognizing young people with FASD for who they are, helping them to understand themselves and how they figure within their multiple belongings and encouraging them to participate in matters that affect them. It is about young people with FASD being able to relate to people (e.g., family and friends), to places, to beliefs and ideas, to ways of being and experiencing. Belonging is also about needs and rights being recognized and met, about being protected and provided for, about feeling cared for, respected and included. Belonging entails opportunities to express personal agency and creativity, feeling able to contribute in meaningful ways, including to their treatment planning. When young people feel a sense of positive belonging, they are more likely to learn effective ways to relate to themselves, invest in their well-being; engage with others and engage in healthy social behaviours. **Belonging** is central to ‘**Being**’ and ‘**Becoming**’ in that it shapes who young people with FASD are and whom they can become (Beck & Malley, 1998; Bourdieu & Wacquant, 1992; Brooker & Woodhead, 2008; Gordon, O’Toole & Whitman, 2008; Woodhead, & Brooker, 2008).

**Clinicians can foster a sense of belonging by:**

- Engaging in interactions with young people with FASD that is consistent, enjoyable, and involve genuine regard for their wellbeing.
- Encouraging participation or engaging in what I call participatory therapy—in my practice, I see young people with FASD as active participants and contributors, rather than merely recipients of the service I provide to them. Participating and contributing are critical elements of belonging, the sense of belonging of a young person with FASD can relate to how comfortable he/she is during sessions, and the feeling of trust and security the young person feels. A young person with FASD, who does not feel he or she belongs in any particular setting will not feel comfortable engaging, nor have a sense of his/her ability to make a positive contribution to the individual or group sessions. When clinicians reconceptualize their practice to reflect the meaningful participation of young people with FASD, they will feel empowered and efficacious.
- Encouraging healthy relationships and continuity of relationships—belonging and connectedness facilitates many protective factors for good mental health and wellbeing.
- Seeing young people with FASD as competent—acknowledging that they know their minds and preferences; and that they should be informed of matters relevant to them, and be listened to when decisions are being made about arrangements for their lives.
- Being respectful and accepting of diversity / difference
- Appreciating young people with FASD for their individuality
- Creating meaningful learning within the therapeutic environment
- Meeting their needs
- Providing a sense of security
- Being cognizant of the multiple belongings of young people with FASD and the influence of these belongings
**Becoming**

Young people with FASD are intimately interwoven with family and system structures that are continually changing and evolving. Likewise, their needs, experiences, identities, knowledge, understandings, capacities, skills and relationships are simultaneously evolving. *Becoming* reflects the changes they experience as they grow, learn and develop (Department of Education, Employment and Workplace Relations, 2009). Within the context of MIRTS it is also about facilitating processes for young people with FASD to enhance their self-resilience, nurture their growth, become effective communicators, meaningful contributors and confidence about their ability. The focus on becoming looks to the future of whom young people with FASD want to be, what they want to do and how they can develop the skills to get there. Clinicians can facilitate a sense of becoming by:

- Encouraging independence
- Focusing on the strengths of young people with FASD
- Enabling young people with FASD to be confident
- Reflecting on individual growth
- Accepting whom they are and encouraging them to develop self-acceptance and self-compassion
- Building self-esteem and self-efficacy
- Helping young people with FASD to become assertive communicators
- Helping young people with FASD to maintain and develop healthy relationships
- Expanding on their existing skills and scaffolding emerging skills
- Respecting their sense of agency
Being & Belonging
- Being connect with & contributing to their world
- Having health & meaning relationships and interactions
- Belonging to healthy family structures
- Taking part & contributing to culture and their society

Being
- Seeking & making meaning out of their world
- Knowing themselves
- Individuality of each young person with FASD (e.g., beliefs, values, interests, knowledge, experience and perceptions)

Belonging
- Interdependence with others (strong healthy relationships are vital)
- Being connected to family, culture, community, services
- Having healthy peer relationships

Being & Becoming
- Developing sense of agency
- Understanding who they are
- Being confident and involved

Belonging & Becoming
- Nurturing relationships
- Making meaningful contributions to relationships
- Feeling connected and having a voice in interactions with family, professionals, community etc.
- Having meaningful engagements

Being, Belonging & Becoming
- Strong sense of well being
- Enhance self-Resilience
- Being confident & involved
- Strong sense of Identity
- Healthy relationships

Becoming
- Preparing for the future
- Developing a sense of agency
- Becoming strong in social & emotional well-being
- Adapting to change & life challenges
- Emerging autonomy
- Becoming confident

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Conceptualizing Needs

It is axiomatic that any attempt to understand human needs is a complex task. Human needs are situated in particular biological, psychological, socio-cultural, spiritual and historical contexts. Indeed, they are embedded in human agency. Human needs do not only engage the ‘micro’ aspects of daily life; they embrace the ‘macro’ components of social divisions and inequalities. Despite the contentious nature inherent in the concept of need, it can be argued that it does have utility in mental health and rehabilitation areas such as youth justice and youth addiction services. The needs and lived realities of young people with FASD are multi-dimensional, and our understanding of them is pivotal if we are to provide appropriate service.

My analysis of needs revealed several aspects that should be taken into account when discussing the needs of young people with FASD:

- Maslow’s (1943) hierarchy of needs and Bradshaw’s (1972) Typology of Needs provide a useful starting point for this discussion. Maslow distinguishes five basic needs. The ‘lowest’, most dominant needs are the physiological needs, followed by the need for safety, love, esteem and self-realization (self-actualization in Maslow’s terms), respectively. According to Maslow, a need will manifest itself only if the ‘lower’ basic needs are met to a certain degree. Someone who has nothing in life will most strongly feel physiological needs – in particular be hungry for food and drink – far more than for love, for instance. All other needs do not ‘exist’ in that situation, or they are pushed into the background. Maslow also distinguishes a set of preconditions for basic needs satisfaction. He names conditions such as freedom to seek information and justice. According to Maslow, these conditions are not ends in themselves (like the needs) ‘but they are almost so since they are so closely related to the basic needs’ (Maslow, 1943, p.383). Maslow also distinguishes a desire to know and to understand. According to Maslow (1943), the thwarting of basically essential needs produces psychopathological results. He states that a conflict or frustration is not necessarily pathogenic – it becomes so only when it threatens or thwarts basic needs or partial needs that are closely related to basic needs.

- In contrast, Bradshaw splits the concept of need into four different types: normative, comparative, felt, and expressed needs. A normative need, according to Bradshaw, is a desirable standard imposed on a client by a professional who deems such a standard necessary. A comparative need is similar in that it is subjective, but the client—not the professional, perceives this type of need. A felt need is a deficiency experienced by the client but does not compel the client to action, whereas an expressed need does motivate action (Bradshaw, 1972).
Complex needs

Young people with FASD are said to have multiple and complex needs requiring at times both medical and social services and support from a wide variety of providers and caregivers.

The frustration of young people with FASD and the burden placed on their families and social systems is large. A range of terms are linked with the concepts of multiple and complex needs used by various disciplines, sometimes specifically and most often interchangeably. They include:

- Multiple disadvantages.
- Multiple disabilities.
- Multiple impairments.
- Dual diagnoses (i.e. someone diagnosed as having more than one condition).
- High support needs.

Rankin & Regan (2004)

According to Rankin and Regan (2004) complex needs imply both:

- The breadth of need: multiple needs (more than one) that are interrelated or interconnected.
- The depth of need: profound, severe, or intense needs.

Rather than use the term ‘complex needs’ to describe an individual’s characteristics, Rankin and Regan (2004) define it in terms of an active framework for response. They propound the term offers:

- Needs are expressed in individually perceived ways and are more than mere wishes
- The satisfaction of needs is shaped by conditions in society, such as resources, and available relationships—individuals depend on other persons, and institutions to satisfy their needs
- The ways in which needs are met varies across a lifespan

A framework for understanding multiple, interlocking needs that span health and social issues. People with complex needs may have to negotiate a number of different issues in their life, for example learning disability, mental health problems, substance abuse. They may also be living in deprived circumstances and lack access to suitable housing or meaningful daily activity. As this framework suggests, there is no generic complex needs case. Each individual with complex needs has a unique interaction between their health and social care needs…
With regard to young people with FASD, multiple and complex needs can, therefore, be conceptualized as needs that arise from various conditions and affect a young person’s socio-ecological, psychological, spiritual health and development. If substance use treatment providers and clinicians are to meet the challenge of treating increasing numbers of youth with FASD, they must consider ways to meet their needs appropriately. It is also important to recognize that young people with FASD are diverse and that differences in satisfying those needs are based on cognitive and psychosocial strengths and limitations. When it comes to assessing the needs of young people with FASD, it is essential to perform analyses that are sensitive to their experiences and culture. We should always remember that young people with FASD have a right to inclusion and participation in decisions that affect them. This is likely the first step towards satisfying their need for belonging, being and becoming. Taken into account the discussion of being, belonging and becoming in the sense of striving towards an adequate satisfaction of needs, I conceptualize needs into four simple categories. See the diagram below.
Working with Diversity

There are many ways of being, living, experiencing, making meaning, and of knowing. Individuals belong to a family, culture, community, peer network and sub-cultures of peer network which is influenced by values, experiences, rituals traditional practices, heritage and ancestral knowledge, and beliefs of individual families, culture, peer networks and communities. Respecting diversity means within the curriculum valuing and respecting the uniqueness of individuals, respecting how they make meaning, honouring the space of individuals, honour their histories, cultures, languages, traditions. It also means valuing the different capacities and abilities of individuals, their experiences and values.

Young people with FASD have complex needs, and their psychosocial well-being will vary. Being mindful of diverse constructions of young people with FASD is essential for responsive practice and can guard against stereotyped professional categorizations and practice assumptions. It is critical that clinicians appreciate the contextual diversity with which young people with FASD present.

Young people with FASD take in and process information in different ways as they construct and interpret their world. They also vary in their family values, religious beliefs, cultural practices, trauma experience, and family socio-economic backgrounds. These backgrounds will almost certainly reflect differences in beliefs and attitudes about gender roles, about the use and abuse of substances, about mental illness, violence, and even about victims of abuse. Social interactions are, therefore, determined by an understanding of the constructs of those with whom these young people interact. People act according to their picture of the world, even though they are not necessarily conscious of doing so.

Clinicians must be sensitive to differences in culture, parental status, sexual orientation, age, trauma history, intergenerational history of substance use and ways of being. It is recommended that facilitators demonstrate interest and a nonjudgmental attitude about the differences between young people with FASD. Clinicians should also cultivate respect and tolerance within group members for similarities and differences. By validating a young person’s strength, emotions, culture, needs and by using communication patterns familiar to them, clinicians will inculcate a much richer sense of being, becoming and belonging. Modeling recognition and appreciation for the diversity of backgrounds will help each member appreciate his/her uniqueness and strengths and develop empathy and understanding for others. Young people with FASD will feel validated in the group process if they are encouraged to be themselves and if they feel safe. When they feel validated, they will actively participate in expressing, sharing, and amplifying their experiences within the group.

Cultural Sensitivity

The clinician needs to understand culture in broad terms that include not only obvious markers such as race, ethnicity, and religion, but also socioeconomic status, the level of education, and level of acculturation for young immigrants. Each clinician brings his or her cultural perspective to the process. Each young person also brings his/her unique cultural perspective. This is both a blessing and a challenge, as each tries to reconcile new ideas about recovery with his or her beliefs about the world. Within each community, individuals struggling with substance abuse are influenced by cultural norms regarding substance use and their particular social group’s expectations about their behaviour. The clinician should demonstrate a willingness to understand clients within the context of their culture. However, it is also important to remember that each
client is an individual, not merely an extension of a particular culture. It is also important to remember that offering a culturally sensitive service is not just about getting vulnerable populations through the doors of your service. It is about ensuring that your efforts are effective and supportive in assisting individuals to build capacity and sustain their strengths to support relationships and a sense of belonging, being and becoming. Many of the concepts presented in MIRTS may vary from culture to culture. The emphasis on self-concept, for instance, may be valued more in some cultures than in others. Each counselor should encourage open discussion of the ideas presented here, and respond fluidly to each group’s needs.

### Gender Sensitivity and non-discrimination

Clinicians should promote non-discrimination, in particular with respect to age, gender, religion, socio-economic status, language, ethnicity, and disability. It is essential that service provided be appropriate for anyone in need. Clinicians should consider the gender needs of young women and young men at all levels.

### Developmental Perspective

1. **Domains of Development**

   When we consider development we quite often think of the categories emotional, social, cognitive, and physical. All aspects of human development are interconnected, thus, it is essential to keep in mind the interconnectedness of a young person’s development. Learning to communicate assertively, for example, is social, emotional, and cognitive.

2. **Understanding Development**

   The development of a young person with FASD happens within the context of his/her daily life in families, culture and communities. The development and learning patterns of young people with FASD are shaped by a complex array of biological and environmental factors. Cognitive development, the quality of interpersonal relationships within and outside their families and culture, the quality of their environment and experiences, and the range of programs and supports will impact a young person’s ability for self-resilience. Understanding the effects of alcohol on the brain, and the patterns of development will help clinicians to scaffold the learning of young people with FASD and interact positively with them. Clinicians should recognize the potential of young people with FASD rather than focus on their problems and should empower them to realize their full potential. As such clinicians should be attentive to the developmental level of the individual(s) they are working with and make necessary adaptations to the material. It is important to:

   - work with young people with FASD to transcend barriers to optimal development.
   - Support learning with experiences that extend their competence but do not overwhelm their abilities.
   - Support self-regulation because these skills lead to physical, social, emotional, behavioural and cognitive competence.
   - Encourage behaviours that promote healthy choices and well-being.
References


Chapter Six
Client Orientation
Clinicians Note

This session is conducted before the first group session to give the client an opportunity to meet the counsellor and learn about what individual or group sessions will look like. The clinician should also use this session to ensure that the clients are oriented properly to the therapeutic process. Provide orientation materials with a quick rundown of the organization, safety, confidentiality issues, meeting procedures and timelines to help your clients develop a good sense of what to expect. Avoid using jargon and acronyms or at least explain them first. Be welcoming and friendly. Ensure that all group facilitators are prepared to be friendly and accommodating of youth. Choose meeting times that work for the clients. Most adults work regular business hours (8:30 am to 4:30 pm Monday to Friday) however, these young people may attend school, work or have other commitments during those hours. To promote fairness and ensure a good turnout, consider holding meetings outside normal work hours at a time that accommodates both the clinicians and the young people.

Group

For the purpose of conducting groups, this session should be used to orient your clients to the nature and dynamic in taking part in group sessions. It gives the clients an opportunity to meet you the clinicians, to ask questions and to form rules they believe to be necessary to maintain safety and comfort in the group. It also affords you with the opportunity to review with clients, safety issues, their rights to privacy and confidentiality, as well as, exceptions to those rights. Informed consent is a very important aspect of any therapeutic process. Therefore, it is necessary that you take the time to review this carefully.

Individual

If you are working with a client individually, use the material in this section to review with your client issues of safety, confidentiality, privacy, and exceptions to his or her confidentiality. Allow the client sufficient time to ask questions about the process. I also find it useful to discuss with clients what their expectation are of this process, and how they work and learn best.
Safety

The group process should be non-threatening for clients so that they can feel comfortable and confident sharing their experiences. The idea is for clients to begin this process feeling safe, comfortable, secure, and empowered in the group. This session should address what each participant need to feel safe, empowered and respected. Clients may be nervous and suspicious at first; this is normal for any group but especially true for young people with FASD. Sometimes clients know each other from mutual friends, parties or even families. Their previous interactions may not have been pleasant, and they may feel unsafe. It is important to recognize that traumatic events rob individuals of a sense of control, possibly resulting in deep feelings of insecurity (e.g. ‘if I have no control it can easily happen again’). Young people with FASD might feel unsafe with other people. Their emotions and thoughts can reflect a feeling of insecurity towards the new situation. They may also have been forcefully separated from attachments/relationships. Establishing a sense of safety in this group setting is, therefore, significance. Be prepared to acknowledge this and reassure them that there will be an opportunity to address safety, confidentiality and basic principles of being in a group. It is important to always create an atmosphere of openness, equality and warmth.

A ‘safe space’ in this context is twofold. Create a youth-friendly meeting space. Ensure that the meeting location is not intimidating to youth. If possible, select a location where youth feel comfortable (i.e., community centre, youth serving agency, etc.) that is also accessible by public transportation, unless other arrangements have been made to get them there. It is also about creating an environment in which facilitators and clients can have rich and meaningful discussions about issues, and in which young people feel safe discussing those issues. This means ensuring young people feel safe to express their views, or how people may react to them. It could also mean young people are free and safe to ask questions without worrying about that question being ‘silly’ or ‘wrong’. Furthermore, a safe space might mean that a participant can say when he/she has found a view or a question from the group offensive or unacceptable. Creating a safe space for discussion is about allowing young people to have an outlet for their opinions and enabling them to talk about and explore their thoughts and feelings honestly and openly. A safe space for discussion also ensures clients are listened to and are able to hear a broad range of views and experiences.

Confidentiality

Facilitators should strive to protect and promote the rights, privacy and confidentiality of all clients. Facilitators should safeguard the rights of the clients in a manner that is responsive to each person’s age, developmental level, gender, social supports/preferences, cultural orientation/background, sexual orientation, physical condition, and spiritual beliefs. Communicate and share the clients’ rights in a manner that is clear and understandable to them. If clarification is needed, be sure to answer all questions pose by clients before obtaining any signed consent to participate in the group. Providing information is an important part of building trust in relationships. Clients must be aware of how their information is being used, how it will be kept private, who will have access to it, and when there are exceptions to confidentiality. This gives clients the ability to make decisions about what they will share. It is important to avoid surprises that can lead to a sense of betrayal, which undermine trust and safety.
**Risk Assessment**

Risk assessments should be conducted individually with each group member before doing any of the units of the curriculum. It is crucial for clinicians to be vigilant of the many risk factor clients faces and to look out for young people with FASD who may be at risk. Individuals who are experiencing consistently active suicidal thoughts or actively self-harming may not be suitable for group; they may, however, be more suited for one-on-one sessions.

<table>
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<th>Risk Factors Specific to FASD and Co-occurring Issues</th>
<th>Other Risk factor for Consideration</th>
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<td>• Depression</td>
<td>• History of previous suicide attempts (this includes self-harm)</td>
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<tr>
<td>• Impulsivity</td>
<td>• Family history of mental disorder</td>
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<tr>
<td>• Anxiety</td>
<td>• Family history of suicide or self-harm.</td>
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<tr>
<td>• Feelings of hopelessness</td>
<td>• Physical Illness</td>
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<tr>
<td>• Alcohol abuse and/or drug abuse</td>
<td>• Exposure to the suicidal behaviours of others</td>
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<td>• Past Trauma</td>
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**How to Assess Someone**

There is no definitive way to approach enquiring about suicide, self-harming, or trauma experiences, but it is essential to ask about the potential risk. In my experience, some young people will introduce the topic without prompting while others may be too embarrassed or ashamed to admit they may have been having thoughts of suicide, or self-harming. In general, open questioning is advisable although it may become necessary to use more closed questions as the consultation progress and for purposes of clarification. You may want to ask about some topics, starting with more general questions and gradually focusing on more direct ones, depending on the client’s responses.

Try to keep it simple, I often find it easier to broach this topic in the context of other questions about moods, experiences and thoughts over the course of the past few weeks. However, the topic is raised; it is essential that you exercise care, respect and sensitivity in questioning. Areas that you may want to explore include:

- Are they feeling hopeless, or that life is not worth living?
- Recent thought as it relates to self-harming?
- Previous history of self-harming
- Previous suicidal attempts if any
- Experiences of trauma
These are just a few suggestions; you may have other questions or things you wish to inquire. An example of questioning could be: how have you been feeling the past few weeks? Base on the client’s response, you could then say, “It must be difficult to feel that way – was there ever a time in the past weeks, when things were so difficult that you’ve thought about hurting yourself or even that you might be better off dead?”. Another approach is to ask the client about his or her sense of hopelessness or helplessness and then reflect back to the client. For, e.g., “You mentioned feeling hopeless—that nothing matters”. “Sometimes when people feel hopeless or are very low in mood they have thoughts that life is not worth living; have you been troubled by thoughts like this?”

**Managing Risk**

When a client is at risk of suicide, or self-harm, this information should be recorded clearly in the client’s notes. When you are working as part of a client’s support team, it is important to share awareness of risk with other team members. Be open and honest with the client about your concerns regarding the risk of self-harm or, suicide and develop a risk management/crisis plan with the client. Arrange timely follow-up contact to facilitate monitoring of their mental state and current circumstances. Clients should be encouraged to utilize their support group, or contact the crisis line. They should also be urged to utilize other urgent care contacts if they are experiencing a strong desire to act upon their suicidal thoughts.

**Cognitive Impairments**

Clients with FASD often experience varying degrees of cognitive impairment. Memory impairment can manifest as clients’ difficulty recalling words or concepts. Repeating information in different ways, in different group contexts, and over the course of a group or individual session will help clients comprehend and retain basic concepts and skills critical to the outcome they hope to achieve.

**Introduction & Icebreaker:**

Introduce yourself to the individual client. For group session, all facilitators should introduce themselves to the clients. In turn, clients can introduce themselves (saying only their names). As a fun extension to the introduction, an ‘icebreaker’ can be done. You can use Handout HB—Human Bingo, or you could use an alternate game of your choice. You are also free to use energizers/connection activities in subsequent sessions.

**Important Note:**

Remember that some clients may be triggered or traumatized as you discuss different issues and identify areas where support and services can be improved for the benefit of clients. Consider adding structures to your meetings so that people can check in at the beginning of the meeting and check out at the end so that you stay on top of what’s working and when additional support might be required When young people with FASD get the chance to address their concerns in real time they are more likely to feel safe and in a position to return and contribute to individual or group sessions.
Stating the purpose of the group

The purpose of the group is to provide an opportunity for you to work through your substance use concerns and to address the impact that your substance use has had on your life and your relationships. The group sessions will help you identify goals for change and will provide you with information, support and strategies to work through other challenges that get in your way. It is also to help you focus on the present and to have you think about how you would like to be.

Check-Ins & Check-outs

Check-ins are brief non-threatening, fun sharing of information by each participant. The purpose is to bring the group together at the beginning of a session. Tell them you will be going around the room doing a feelings check-in. Use Check-Ins & Check-Outs at the beginning and end of sessions. Sometimes things distract clients from being present and fully participating in a session. By providing an opportunity at the start of the meeting, your clients get the chance to share where they’re at and ways to support them or keep them engaged can be identified. At the end, ask how well they felt the group or individual session accommodated them, whether they found the session effective, what could be done to improve the session and offer additional support after the meeting.

1. Ask clients to introduce themselves: Have each participant share his/her first name only, and create a nametag.
2. Ask clients to pick an emotion that represents how they have been feeling most of the day and right now.
3. To help you get started use the FEELINGS chart/poster
4. Let clients know it is ok if they feel more than one emotion at the moment—tell them we often feel more than one emotion at a time

Reviewing Safety and Confidentiality

Safety

Let them know that: This group is a place where you can start talking about, and hopefully solving some of the challenges you are facing. Because people are going to be sharing things, it is important that we all agree that what discuss in the group stays in the group. As you feel comfortable with us and with each other, you may be sharing personal information, and we want to make it safe for everyone to talk about their issues, discuss topics and share information. Distribute the Safety Assessment and Planning handout, allow clients some time to work on it.
Confidentiality

Tell them: Something that is important for us to talk about is confidentiality. What we speak about throughout the group session should remain in the privacy of this room. We need your permission to talk to, or to release information to others outside of the group.

However, there are some limits to confidentiality:

- If you are going to harm yourself or others
- If there are concerns about a child being at risk of harm
- When the courts subpoena your records

If you a mandated to attend this group your Probation Officer may need progress report and attendance record from time-to-time; be sure to go over your probationary conditions with your probation.

Distribute handout on *Clients’ Rights and Responsibilities and Informed Consent form*. Spend some time reviewing these with clients before asking them to sign the consent form. To check for comprehension concerning, rights & responsibilities, confidentiality and limits to confidentiality. You may ask clients the following questions:

1. What are your rights?
2. What responsibilities do you have within this group?
3. What does confidentiality mean to you?
4. What will happen if your rights are violated?
5. How does that feel?
6. Under what conditions can your confidentiality be broken?
7. What happens if later on you decided you do not want to be part of the group?

Stating the Format of Group Sessions

Let them know that: The framework for today’s group will be similar to each of the remaining sessions. Each group session will begin and end with a quiet moment, as well as, check-in and check-out. We will then introduce the topic for the day. All of you will have the opportunity to take part in activities and talk about the topic as it relates to your experiences. As we will be engaging in mindful activities such as yoga, or Pilates, it is very important you wear sport-like clothing.

Important Note:

- Remember some of the clients may have experience being part of a group in the past and their experiences may vary from bad to very good. Be sure to explore common issues, or problems they have experienced in a group and ways to remedy those issues. It is important to establish a set of ground rules for this process to help create a respectful environment in which all clients can contribute equally. These rules form a ‘contract’ which will help inform the tone and dynamic of the interaction of the group.
- Remember young people are more likely to follow rules that they thought of and articulated
- Issues of regarding risk and safety should be done individually.
Establishing Group Rules

Let clients know it is important to establish rules, as it will help the group function more smoothly. The ground rules established clarity about what is considered positive behaviours for interacting with each other and what is seen as negative or unacceptable behaviours. They also provide clients equal rights and responsibilities in that space. An example of a right might be the right to ask a question without fear of ridicule, the right to express disagreement, etc. An example of responsibility might be the need to listen to others and to allow others to speak. These kinds of shared rights and responsibilities are essential for promoting equal participation. Remind them that for the group to function well and for each one of them to continue to feel safe it is important they each take seriously his or her role, responsibility and support each other while also following the rules they will now develop.

Instructions:

1. Ask clients to brainstorm and share ideas about how they wish to work during the session. Individuals can write suggestions on post it notes or the facilitator can record suggestions on whiteboard or flipchart.
   - Here are some examples for agreements for a successful session:
     - Respect differences in opinion
     - Listen when someone else is speaking/sharing
     - Share only what you are comfortable sharing

For more examples, see the handout on establishing group rules: Follow the instructions on ‘How to: Develop group rules’.

Debrief: Say to the group “Negotiating group rules takes time and is an important part of creating a safe collective, nurturing and supportive environment”.

Attendance: This group will be meeting for about [insert time, the number of days and number of weeks]. Please make every effort to attend all sessions. We’ll start at ___ a.m. /p.m.

Note:

- Expectation for abstinence may not be realistic for all youth. It will be important to incorporate relapse management harm reduction approaches in these instances.
- Expectation for arriving on time may also be a challenge for some youth, it a good idea to have reminder calls or arrange transportation to and from sessions.

Exploring clients’ expectations and concerns

Ask all of the clients to state in turn their hopes and expectations for themselves during this group process.

Use the following probing questions:

- What are you expecting from this experience?
What do you want to gain from this experience?
What was difficult about coming here today?

**Quiet Moment: BREATHE (REFER TO CD)**

Ending with quiet moment is a great way to help clients feel grounded. Encourage clients to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

**Tell clients:**

1. How we act and how we feel play a role in our breathing and conversely, breathing affects our actions and feelings.
2. Your ability to become aware of your breathing, and to sustain that awareness as you make adjustments to it, will be beneficial in the long run. You will be able to recognize good breathing, and you will begin to acquire a healthy breathing habit.
3. Learning to change your breathing habits can help to reduce general levels of anxiety. Once you have practiced the calming technique consistently, it can be especially helpful.
4. Over the next few minutes, we will walk you through a series of breathing techniques and way of adjusting your breathing.
5. Ask clients to relax on their mats by either lying on their backs or sitting—begins the guided breathing
1. Human Bingo
2. Feelings Chart
3. Safety Assessment and Planning
4. Sample Rights and Responsibilities
5. Sample Informed Consent Form
6. Establishing Group Rules
<table>
<thead>
<tr>
<th>B</th>
<th>I</th>
<th>N</th>
<th>G</th>
<th>O</th>
</tr>
</thead>
<tbody>
<tr>
<td>FIND SOMEONE WHO…</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Was born in the same month as you</td>
<td>Has been to another country</td>
<td>Went to bed after 11pm last night</td>
<td>Likes swimming</td>
<td>Posted a picture on Facebook yesterday</td>
</tr>
<tr>
<td>Has a brother</td>
<td>Is about the same height as you</td>
<td>Has a dog</td>
<td>Likes coffee</td>
<td>Likes hot chocolate</td>
</tr>
<tr>
<td>Likes vanilla ice cream</td>
<td>Has a cat</td>
<td>Has two sisters</td>
<td>Is as old as you</td>
<td></td>
</tr>
<tr>
<td>Does not like asparagus</td>
<td>Likes basketball</td>
<td>Likes to dance</td>
<td>Can play a musical instrument</td>
<td>Played video games last night</td>
</tr>
<tr>
<td>Has black hair</td>
<td>Has one favourite song in common with you</td>
<td>Has done yoga before</td>
<td>Is wearing brown shoes</td>
<td>Loves being in nature</td>
</tr>
<tr>
<td>HAPPY</td>
<td>OPTIMISTIC</td>
<td>SATISFIED</td>
<td>HOPEFUL</td>
<td>HURT</td>
</tr>
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<td>-------</td>
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</tr>
<tr>
<td>LONELY</td>
<td>OVERWHELMED</td>
<td>MISERABLE</td>
<td>PUZZLED</td>
<td>REGRETFUL</td>
</tr>
<tr>
<td>FRUSTRATED</td>
<td>SAD</td>
<td>FEARFUL</td>
<td>GRIEVED</td>
<td>EXHAUSTED</td>
</tr>
<tr>
<td>DISAPPOINTED</td>
<td>DETERMINED</td>
<td>DEPRESSED</td>
<td>CONFIDENT</td>
<td>CONFUSED</td>
</tr>
<tr>
<td>ANGRY</td>
<td>ANXIOUS</td>
<td>ASHAMED</td>
<td>CAUTIOUS</td>
<td>BORED</td>
</tr>
<tr>
<td>What are you worried about?</td>
<td>What do you need to happen to feel safe?</td>
<td>What do you think would work well?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>What are feelings of being empowered?</td>
<td>What are feelings of being powerless?</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
We want to encourage you to speak openly about your needs, take part in your treatment choices, and promote your safety, have all the information you need, and be involved in the service and supports you are receiving. Because we want you to think of yourself as a partner in your well-being; we want you to know your rights, as well as, your responsibilities. We invite you to take some time to review this with the counsellors or your individual counsellor. Ask as many questions as you need too. If there is something you do not understand or need clarity, ask your counsellor to explain to you until you are satisfied you have understood it.

### Sample Right & Responsibilities

<table>
<thead>
<tr>
<th>YOUR RIGHTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You have the right to receive considerate, respectful and compassionate service</td>
<td></td>
</tr>
<tr>
<td>2. You have the right to attend sessions in a safe environment free from all discrimination</td>
<td></td>
</tr>
<tr>
<td>3. You have the right to take part in decisions that are being made about you</td>
<td></td>
</tr>
<tr>
<td>4. You have the right to agree, or refuse to take part in the group session</td>
<td></td>
</tr>
<tr>
<td>5. You may withdraw from the treatment group at any time (except if you are court mandated to attend)</td>
<td></td>
</tr>
<tr>
<td>6. If you stop taking part, it will not affect any other service you are receiving.</td>
<td></td>
</tr>
<tr>
<td>7. You have the right to be given referrals for services as needed and assistance accessing those services if needed.</td>
<td></td>
</tr>
<tr>
<td>8. You have the right to ask a question when you do not understand information.</td>
<td></td>
</tr>
<tr>
<td>9. You have a right to learn more about the services you are receiving</td>
<td></td>
</tr>
<tr>
<td>10. You have the right to privacy and confidentiality. However, there are some exceptions:</td>
<td></td>
</tr>
<tr>
<td>• We are not permitted to tell anyone that you are attending sessions, or talk to anyone about you, your progress or challenges unless:</td>
<td></td>
</tr>
<tr>
<td>o It is court-ordered.</td>
<td></td>
</tr>
<tr>
<td>o You report any information regarding sexual, physical, or emotional abuse of a child or a vulnerable adult.</td>
<td></td>
</tr>
<tr>
<td>o We become aware that you may be performing a criminal act on the premises (i.e. driving under the influence of alcohol or drugs).</td>
<td></td>
</tr>
<tr>
<td>o You are threatening to hurt yourself or others</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>YOUR RESPONSIBILITIES</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You are expected to ask questions when you do not understand information or instructions.</td>
<td></td>
</tr>
<tr>
<td>2. You are expected to participate in the group sessions</td>
<td></td>
</tr>
<tr>
<td>3. You have the responsibility to attend group, and be on time.</td>
<td></td>
</tr>
<tr>
<td>4. You have a responsibility to respect each other’s privacy</td>
<td></td>
</tr>
<tr>
<td>5. You have a responsibility to be respectful to each other. (Shouting, excessive gesturing and threats are inappropriate and will not be tolerated)</td>
<td></td>
</tr>
<tr>
<td>6. You have a responsibility to attend groups free from the influence of drugs and/or alcohol.</td>
<td></td>
</tr>
<tr>
<td>7. You have a responsibility to treat the person who is providing service to you in a respectful manner</td>
<td></td>
</tr>
</tbody>
</table>

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### Informed Consent Form—Individual

**Confidentiality:** A situation in which you trust someone not to tell secret or private information to anyone else.

*Please Tick the items below if you agree*

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I we have spoken about what I can expect from therapy</td>
<td>□</td>
</tr>
<tr>
<td>2.</td>
<td>My rights have been explained to me. I have read, or listened to, and understands the information about my rights &amp; responsibilities, as provided in the Information Sheet</td>
<td>□</td>
</tr>
<tr>
<td>3.</td>
<td>I had the opportunity to ask questions. All my questions were answered about therapy and my participation in session</td>
<td>□</td>
</tr>
<tr>
<td>4.</td>
<td>I voluntarily agree to participate in therapy</td>
<td>□</td>
</tr>
<tr>
<td>5.</td>
<td>The procedures regarding confidentiality have been clearly explained to me.</td>
<td>□</td>
</tr>
<tr>
<td>6.</td>
<td>The exception to confidentiality has be explained to me, and I understand under what circumstance my counsellor does not need my permission to talk to someone</td>
<td>□</td>
</tr>
<tr>
<td>7.</td>
<td>I understand that my counsellor may talk to other professionals from time to time in an effort to help me better. However, my counsellor will not use my name when talking with others.</td>
<td>□</td>
</tr>
<tr>
<td>8.</td>
<td>I understand I can withdraw at any time without giving reasons and that I will not be penalized for withdrawing nor will I be questioned on why I have withdrawn.</td>
<td>□</td>
</tr>
<tr>
<td>9.</td>
<td>If I withdraw from therapy it will not affect other services; I am receiving</td>
<td>□</td>
</tr>
<tr>
<td>10.</td>
<td>I understand that my information will be stored in a locked filing cabinet to ensure my privacy</td>
<td>□</td>
</tr>
</tbody>
</table>

---

Name: ________________________ Signature: ___________________________ Date: ______________________

Counsellor Signature____________________________   Date: ______________________
### Informed Consent Form - Group

**Confidentiality**: A situation in which you trust someone not to tell secret or private information to anyone else. *Please tick the items below if you agree.*

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>We have spoken about what I can expect from therapy</td>
</tr>
<tr>
<td>2.</td>
<td>My rights have been explained to me. I have read, or listened to, and understands the information about my rights &amp; responsibilities, as provided in the Information Sheet or video</td>
</tr>
<tr>
<td>3.</td>
<td>I had the opportunity to ask questions. All my questions were answered about therapy and my participation in session</td>
</tr>
<tr>
<td>4.</td>
<td>I voluntarily agree to participate in therapy</td>
</tr>
<tr>
<td></td>
<td>Therapy is part of my probation requirement</td>
</tr>
<tr>
<td></td>
<td>Therapy is a part of my return to school requirement</td>
</tr>
<tr>
<td></td>
<td>I have been mandated by my work to attend therapy</td>
</tr>
<tr>
<td>5.</td>
<td>The procedures regarding confidentiality have been clearly explained to me.</td>
</tr>
<tr>
<td>6.</td>
<td>The exception to confidentiality has been explained to me, and I understand under what circumstance my counsellor does not need my permission to talk to someone</td>
</tr>
<tr>
<td>7.</td>
<td>I understand that my counsellor may talk to other professionals from time to time to help me better. However, my counsellor will not use my name when talking with others.</td>
</tr>
<tr>
<td>8.</td>
<td>I understand I can withdraw at any time without giving reasons and that I will not be penalized for withdrawing nor will I be questioned on why I have withdrawn.</td>
</tr>
<tr>
<td></td>
<td>However, if my sessions are mandated by the court, school or work, I am aware that there may be consequences if I withdraw without talking to, or coming to some arrangement with someone at school, work or the court system.</td>
</tr>
<tr>
<td>9.</td>
<td>If I withdraw from therapy it will not affect other services; I am receiving</td>
</tr>
<tr>
<td>10.</td>
<td>I understand that my information will be stored in a locked filing cabinet to ensure my privacy</td>
</tr>
<tr>
<td>11.</td>
<td>I understand that all matters discussed in the group sessions and the identities of all group members are confidential. I will not share this information with anyone outside the group</td>
</tr>
<tr>
<td>12.</td>
<td>If I decide to stop attending group sessions, I will continue to keep all information I learn about others private.</td>
</tr>
<tr>
<td>13.</td>
<td>After I have completed the sessions, I will still keep all information about others private</td>
</tr>
</tbody>
</table>

Name: ______________________  Signature: ______________________  Date: ________________

Counsellor Signature_______________________  Date: __________________
This is a list of questions you may wish to explore with the group

1. What do you want to do, as a group, to maintain confidentiality? (Refer participants back to the safety exercise)
2. How can we make each other feel they are welcome and belong and are part of a friendly environment?
3. What sorts of behaviour or comments make people feel bad about themselves?
4. What do you need from each other to feel comfortable and safe?
5. How do we build each other up, rather than break each other down when we speak?
6. How do we make sure everyone has an equal chance to ask questions and participate in activities?
7. Explore and clarify issues related to boundaries between the safe space and everyday life. [This is important for reassuring participants that their openness will not be used against them by their peers. An example would be views expressed in the room, staying in the room and being treated as confidential.]

Also, consider asking about:

1. Their expectation
2. Participation
3. Honesty
4. Respect for each other’s experience and listening while other speak
5. Punctuality
6. Attendance
7. Lapse or relapse
8. Unacceptable behaviours
9. Self-disclosure (is it ok to be quiet?)
10. How to handle when a group member becomes upset. [Ask what they would like to do, or what they would like others to do (comfort them, leave them alone, let them go to the bathroom, etc.).]
Chapter Seven
Identity
Understanding and acceptance of oneself are fundamental to being, belonging and becoming. The main theme of this chapter is about young people developing a sense of self. The units encourage them to think about the type of person they are; their values, attitudes, beliefs, and more generally how to honour themselves.

From my many discussions and sessions with young people with FASD, what I have observed, is that how a young person sees him/herself affects how he/she sees and reacts to situations. Having a sense of who one is, is the foundation for positive development and overall well-being. When young person with FASD know who they are, they see themselves as being valuable and good enough—as one young person once told me, ‘I need to know that I matter’. A young person with FASD who knows him/herself is also better able to reach his/her full potential. He/she tend to have more meaning relationships, engages in school. He/she is also better able to set goals for him/herself, make decisions, and will be keener to learn and try new activities.

A young person’s self-image and self-worth, as well as his/her needs, values, beliefs, attitudes, and self-compassion, serve as filters for how he/she will communicate with him/herself, as well as, others. As you develop and establish a therapeutic relationship with your group or individual client, you may become more aware of these filters, they use and will be in a position to help shape their desires and motivation to alter negative views about themselves.

In today’s digital world, young people are more connected than ever before, and while many adapt extremely well, others do struggle to find their sense of self—their feelings are strong, and their sense of self can be fragile. Being supported to explore who they are, I believe is fundamental to helping young people with FASD set themselves up for success. It also allows them to reflect on their strengths and limitations, giving them a greater understanding of the individual they are, promoting self-acceptance and enabling them to cope with disappointments.

In this section your role as a clinician is to help young people with FASD explore the essence of themselves—cultivate the understanding that there is something that ‘makes me, me’; just as there is something that makes a chair a chair. Help them to uncover and share their stories and successes to inspire healthy changes for themselves.
You can help them explore their sense of self by:

- Helping them explore the concepts they hold of themselves—what I have discovered is that many young people with FASD define themselves in concrete terms. Included in this core picture of the image that they have of themselves are such things as their physical attributes, names, ages, genders, social affiliations, and possessions. For some, their sense of who they are can be very descriptive, for many others it can be judgmental—many hold distorted views of themselves. As clinicians, we can help them to explore their competencies, beliefs, and values.

- Working with them to learn how to respond to situations, young people with FASD are growing and developing in many ways; they are in a position to acquire new skills and sharpen old ones.

- Helping them to communicate and differentiate between their feelings and who they are.

- Helping them to be able to define themselves within their group of friends. A sense of belonging is important to young people. Young people with FASD can be naive and wanting to be part of something means that they are more likely to end up becoming someone they are not to fit in.

- Teaching them to respect their uniqueness and to be confident about their values. Helping young people with FASD create a positive sense of self, requires a delicate balance between aiding them in developing in ways that are compatible with their innate qualities, having compassion for themselves and helping them function in their environment. Consequently, this will help them build the self-confidence they need for the life long processes.

- Helping them to differentiate between who they are versus what they may have done (behaviour).

Please Note:

1. Young people create a sense of self within loving relationships. FASD is not homogeneous; they are all unique individuals with varying personalities and characteristics. Some may be easier to build a therapeutic connection with while others are more particular about the therapeutic process. As clinician we are each also unique, responding to young people with FASD with our internal frame of reference and experiences. Thus working with a young person with FASD is about joining of two individuals who are searching to create a therapeutic alliance. As you work with these young people in exploring who they are, take every caution to be responsive to conception they hold of themselves.

2. The questions in the reflection and ‘let’s talk’ sections are simply here to guide you, you do not have to use them in the same order they appear, or utilize them all.

Reflection Questions

1. How can you prepare yourself for a session about who are you with your group/client?
2. Are you sufficiently comfortable and confident about the topic?
3. What resources can you utilize?
4. How do you consider their dispositions?
5. What does it mean to be human?
6. Can you imagine their feelings and listen to their verbalizations of their experience?
Resources Needed

• Name Tags
• Presentation slides
• Flipchart Paper
• Pens, Pencils, Markers
• Sticky Notes
• Laptop
• LCD Projector
• Yoga Mats or Towels

The Goal of the session is to:

• Help clients explore and understand who they are
• Help clients identify behaviours and feelings they use to define themselves
• Help clients recognize what they can do
• Help clients identify things that are essential to their concept of self
• Help clients explore what they like about themselves
• Help clients recognize what makes them special and share positive aspects of themselves.

Handouts

• Who I am vs. how I feel, or what I have done
• Who am I web-map
• Whom do I want to become?
Chapter 7
Unit 1

Session Guide

CHECK-IN

**Group:** Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

**Individual:** Conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to explore the essence of whom you are – how you see yourself as a person. People define themselves in many ways, including internal and external. Our sense of ‘who we are’ consist of various characteristics we use to categorize ourselves and various characteristics that people around us use to define us, as well as the experience we have. The questions we will discuss today will guide you towards becoming more aware of whom you are and help in forming ideas about who you are becoming. In preparing for change it is important to understand, recognize and know who you are.

Engage – what to do

**Tell them**—People define themselves in many ways, for example, what they do, where they come from, by their family heritage, the activities they take part in, how they look, how they feel among others. Our sense of ‘who we are’ consist of various characteristics we use to categorize ourselves, and various features that people around us use to define us.

Discussion questions

Let’s think about who you are for a moment…

- How do you define yourself?
- What makes you, you?
- What do you like about you most?
- What feelings and behaviours do you use to describe yourself?
- Do you love who you are?
- Talk about the word *identity*, what it means to them and the different instances where they have heard the word used.
- Do you value being unique?
Learning Activities

Activity 1: Creating a collage

Collages using a wide variety of textiles, papers, yarn, etc. can be used to represent ‘self’. They allow free expression and help young people with FASD communicate whom they see themselves to be.

Activity 2: Using Pictures

Give clients the opportunity to use a digital camera to take photos of things that are relevant to them and their lives. Encourage them to make a comic strip of themselves, or to create a picture of ‘who they want to become’. Pictures are an effective way of provoking discussion both in group and individual sessions.

Activity 3: who am I? vs. how I feel, or what I have done

In this activity, you can ask clients/participants to list all the beliefs, characteristics, interests and most important things about themselves in one column, and then list all the feelings and behaviours they use to describe themselves in the other two columns. See handout: who am I? vs. how I feel, or what I have done.

Activity 4: Web-Map

Encourage participant/clients to develop a web map exploring important questions about who they are and whom they want to become. You can provide some questions to help them begin. However, it will be useful to encourage them to create a list of questions that they feel will result in a better reflection of whom they believe themselves to be. See handout for example.

INSIGHTS

Use the following questions to debrief the exercise:

1. what was your experience of doing these activities?
2. Did you learn anything about yourself? what have you learned about your self that you had not realized before?
3. Are you feeling more confident about who you are?
REFLECTION CIRCLE

Today we talked about who you are, and how important it is to know who you are.

1. What stands out for you the most?
2. In what way was this discussion different than previous times you spoke about yourself?
3. Do you think differently about who you are?
4. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

HOMEWORK

Distribute Handout: Whom I want to become. Tell your clients they can work on it at home in their spare time.

KEY POINTS

- The concept of self is perhaps our most important possession.
- Knowing who we are is necessary for personal growth and development.
- Knowing who you are help you to relate to others better.
1. Who I am vs. how I feel, or what I have done
2. Who am I web-map
3. Whom do I want to become?
<table>
<thead>
<tr>
<th>WHO I AM?</th>
<th>LIST ALL THE FEELINGS/EMOTIONS YOU USE TO DESCRIBE YOURSELF</th>
<th>LIST ALL THE BEHAVIOURS</th>
<th>WHAT DID YOU NOTICE?</th>
</tr>
</thead>
<tbody>
<tr>
<td>List characteristics and important things about you</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Who am I?

How and why I am unique?

I am...

What are my beliefs?

What do I like about me?

What do I do well?
Describe the person you want to become. Consider what you would like to achieve and what adds meaning to your life, and then write a mission statement for your life.
Values are the fundamental beliefs of a person. They guide and dictate our behavior and actions, and decisions. There are many different types of core values and many different examples of core values depending upon the context. Values help define an individual’s ideas as to what is right, good, desirable, or acceptable. Although we may have our values, many of our values come from our family, culture, community and society at large. Values change over time in response to changing life experiences, recognizing these changes and understanding how they affect our actions and behaviours is important.

It has been noted in the research literature that values have both content and intensity attributes. The content attribute says a mode of conduct is important. The intensity attribute specifies how important it is. When an individual ranks his/her values regarding their intensity, we obtain that person’s value system. All of us have a hierarchy of values that forms our value system, and these influence our attitudes and behaviour.

Attitudes

Attitudes either positive or negative evaluation—about objects, people, or events. They show how we feel about something or someone. When a young person says, “I like hate school,” he/she is expressing his/her attitude about school. Specific attitudes tend to reflect specific behaviours, whereas general attitudes tend to predict general behaviours. For instance, asking a young person with FASD his/her intention to clean his/her room in the next hour is likely to predict better the action of that youth than asking him/her when is he/she is going to client his/her room.

Having a strong awareness of one’s values and attitudes can help in understanding the difference between themselves and other, understanding challenges such as poor motivation, reasons for behaviours, decisions and choices. As clinicians, it is important to help young people with FASD not only know values but develop a deep commitment to values. Values such as fairness, kindness and empathy for others should be an integral part of a young person’s self-concept or identity. They were acts that emerged from these individuals' basic self-concepts and dispositions. By reinforcing, for example, that young people be respectful to us, by talking to them about why values are important, clinicians can help them enhance their sense of self.
Clinicians can help young people with FASD nurture values and attitudes by:

- Helping them develop empathy
- Talking about values and why they are important
- Exploring why they make certain decisions
- Label and reinforce expressions of values
- Make discussion of values & attitude relevant to their ‘world’
- Encouraging initiatives that express values
- Guiding them to positive self-talk
- Encouraging them to make a difference
- Frame mistakes as learning experiences to become better
- Encourage active participation
- Work together to solve problems
- Remind them of good things in their life to be grateful for
- Provide ideas for positive talk
- Encourage them to find at least one thing to be grateful for each day

Reflection Questions

1. How can you prepare yourself for a session about who are you with your group/client?
2. Are you sufficiently comfortable and confident about the topic?
3. What resources can you utilize?
4. How do you consider their dispositions?
5. How can you help a client develop a positive attitude?
6. How can you help a client understand his/her values?
7. How can you help a client embrace the power of attitude and the changes it brings?
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients define values and clarify some of their own
- Help clients identify the values that are important to them
- Help clients identify how their value and attitudes influence their choices
- Help clients explore where their values come from
- Help clients explore how values affect behaviour

Handouts

- Identifying Value Rankings
- Core Values
- Prioritizing Values vs. Compromising Values
- Charting your values
Learning Intention

Let clients know that the intention of this session is to explore their values and attitudes—the things that are very important to them and the way they respond to things, people or events.

Engage – what to do

Start of by telling them that every day, each one of us encounter situations that require us to think, make decisions and take actions. Ask them what do they think guide their actions and decisions. Talk with them about their understanding of values and how important they are. Encourage them to reflect on events in their life and how they typically respond.

Guide your clients through self-exploration of their values and attitudes by asking questions about several topics:

Discussion questions

Let’s think about your values for a moment…

- Where do you think we get our values from?
- What is one example of a value your family feels is important?
- What value is important to you?
- Can you think of a value someone else has that you do not share? What is it?
- Which of your values come from what your friend believes, or your culture?
- What influences your attitude and how you behave?
- How would you describe your general attitude?

Values: Values standards that guide our choices and decisions. They are the ideas we have about what is important to us, and what is not what is good or bad and what is right or wrong. Values also encompass our attitudes towards things, e.g. crimes, schoolwork etc.

Attitudes: The ways we respond towards something, someone or an event—our likes and dislikes.
Learning Activities

Activity 1: Identifying Values

Using the handout—Identifying Values, ask clients/participants to identify values from the list that are important to them.

Activity 2: Core Value Ranking

Ask clients/participants to rank order their top 10 values from most important to least important from the list they have created. They can then become very creative with their ranked orders values by creating necklaces, icebergs, or flashcards.

Activity 3: Prioritizing Values vs. Compromising Values

Use handout—prioritizing values vs. compromising values to walk your clients through this exercise. Read a list of scenarios to them explore how they make decisions and behave.

Activity 4: Exploring Group Values

Place participants in groups, ask them to work out what the group’s top five values are. Then records the top five values from each group on the board to work out the most popular five values among participants. When doing this be careful to highlight that this does not imply that they are the most important, but the most common.

Activity 5: Charting your Values

Ask clients to rate how well they are currently living their top ten values

INSIGHTS

1. Did you learn anything about values that you have not considered?
2. what was your experience of doing the exercises?
3. How are the top five values similar or different?
4. Why do you think these values came out as the most popular?
5. Is there any link between rules systems, such as cultures, family, school rules or government laws, and the most popular values?
6. Are your important values influenced by other people in your life?
REFLECTION CIRCLE

Today we talked about your values and attitudes.

1. What stands out for you the most?
2. Is there anything about your values that you would like to challenge or change?
3. Do you think differently about your values and attitudes?
4. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

HOMEWORK

Ask clients to visualize how they would feel if their most significant value were taken away or violated? Alternatively, how would they feel if their top five values were greatly increased? You can ask them to journal their responses to be shared next session.

KEY POINTS

- Values include our ideas about good or bad, right and wrong, our spiritual and religious beliefs, opinions about politics and wellbeing. Human rights, gender issues, age issues and attitudes to disability are also part of our value system.
- We can increase our self-awareness by examining our own values and preferences. We all have ideas about right and wrong, good and bad, better and worse.
- Values have a major influence on our choice of behaviour. Some values we hold are internal e.g. our desire to fit in with a group of friends, our need for fun.
- External source—important people in our lives e.g. friends, family, culture influences our and values and attitudes.
Chapter 7: Unit 2

1. Identifying Value Rankings
2. Core Values
3. Prioritizing Values vs. Compromising Values
4. Charting your values
Select and tick **20** values from the list below that best reflect your values. Feel free to write any values that reflect you that may be missing from the list.

<table>
<thead>
<tr>
<th>List of Values</th>
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</thead>
<tbody>
<tr>
<td>– Loyalty</td>
</tr>
<tr>
<td>– Money</td>
</tr>
<tr>
<td>– School/education</td>
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<tr>
<td>– Family</td>
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<td>– Close relationships</td>
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<td>– Honesty</td>
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<td>– Change and variety</td>
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<td>– Adventure</td>
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<td>– Pleasure</td>
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<td>– Humour</td>
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<td>– Integrity</td>
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<td>– Stability</td>
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<td>– Quality relationships</td>
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<td>– Independence</td>
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<td>– Truth</td>
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<td>– Recognition</td>
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<td>– Personal growth</td>
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<td>– Peace</td>
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<tr>
<td>– Love</td>
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<td>– Gratitude</td>
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</tbody>
</table>
Select and tick **20** values from the list below that best reflect your values. Feel free to write any values that reflect you that may be missing from the list.

**List of Values**

<table>
<thead>
<tr>
<th>Value</th>
<th>Value</th>
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<tbody>
<tr>
<td>Loyalty</td>
<td>Compassion</td>
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<td>Money</td>
<td>Fairness</td>
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<td>School/education</td>
<td>Appearance, Beauty</td>
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<td>Family</td>
<td>Approval</td>
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<td>Close relationships</td>
<td>Friendship</td>
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<td>Honesty</td>
<td>Health</td>
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<td>Change and variety</td>
<td>Personal safety</td>
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<td>Adventure</td>
<td>Religion/spirituality</td>
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<tr>
<td>Pleasure</td>
<td>Exercise</td>
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<td>Humour</td>
<td>Achievement</td>
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<td>Integrity</td>
<td>Status</td>
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<tr>
<td>Stability</td>
<td>Travelling</td>
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<tr>
<td>Quality relationships</td>
<td>Courage</td>
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<tr>
<td>Independence</td>
<td>Power</td>
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<td>Truth</td>
<td>Happiness</td>
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<td>Recognition</td>
<td>Helpfulness</td>
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<td>Personal growth</td>
<td>Fame</td>
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<td>Peace</td>
<td>Self-respect</td>
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<td>Love</td>
<td>Cleanliness</td>
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<tr>
<td>Gratitude</td>
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</tbody>
</table>

From the 20 values, you ticked off, put a number 1 next to the value that is most important to you until you have ranked ordered your top five values.

<table>
<thead>
<tr>
<th>Value</th>
<th>Rank Order</th>
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Now you can use your top five values to create some things, for example, necklace, iceberg, etc.
Ask your client/participants to use the top 20 values to answer the questions below. Do not repeat a value, ensure they use a different value for each.

**Questions 1:**

One of your friends is having a difficult time at school. You want to make sure your friend feel supported, but it will cost you a value; what value would you use to be available to your friend?

**Question 2**

Your mother need some medical care; she will most likely need an organ donated to her. A match has been found. The donor does not want financial compensation, but they will require one of you values. What value would you give up for that?

**Question 3**

You have always wanted to go skydiving (or any other activities). You have been given the opportunity to go, but it will cost you a value; what value would you give up for that?

**Question 4**

Your friend stole some money and has now invited you to go to MacDonald for a burger if you decide to go, what value would it cost you?

**Question 5**

A group of friends have decided to skip school if you join them; what value would you have to give up for this?

**Question 6**

Some of your friends have been bullying a girl in your class. You have been thinking about saying something to them, if you do, what value will it cost you? If you decide to stay quiet what value will it cost, you?

**Question 7**

Your curfew is 10 pm and you are late for your curfew, what values do you typically give up when this happens?
For each of your top five values, rate and chart how well you are currently living that values.

- If you are fully living it to its limit, rate it as five
- If your behaviours and choices reflect your value most of the time, it may be a four
- If you are only using the value some of the times it may be a three
- If your behaviours and choices are totally out of alignment on your values, it may be a two or a one

See the example below.
Clinicians Note

Self-Esteem is a measure of self-worth and importance. When the feelings of young people with FASD are respected, their opinions valued and their abilities are recognized their Self-Esteem is reinforced. When their feelings are hurt, and their views are criticized, their self-esteem will be impacted. Positive self-esteem is a foundation that will help young people with FASD to practice the skills that are learned.

**Individuals with high Self-Esteem:**
- Know their strengths
- More confident
- Function effectively and with personal satisfaction
- Are more likely to succeed
- Have feelings of being valued and worthwhile
- Build healthy relationships and
- Tend to make better decisions
- Have positive mental outlook
- Have responsible behaviour
- Have a high resistance to pressures

**Individuals with Low Self-Esteem:**
- Feel that others do not respect/value them
- Don’t know their strengths
- Are less likely to succeed
- Are less capable of responding to others assertively
- Feel isolated
- Less capable of forming positive relationships
- Make good decisions
- Less able to resist pressures from their friend, family or the media, etc.
- More likely to smoke, abuse alcohol and other drugs
You can help raise your client’s self-esteem by:

- Reinforcing that their ‘difference’ is ok
- Inculcating resilience
- Empowering them
- Fostering collaborative processes that are meaningful
- Promoting self-determination
- Encouraging them to utilize their internal and external resources
- Encouraging mindfulness—feeling what one feels, without judgment, instead of what others want them to feel
- Promoting reasonable, flexible and achievable goals
- Encouraging them to ask for what they need and want, instead of waiting for someone to tell them what they need, or living with frustrated needs
- Encouraging them to express their ideas, instead of saying what others want them to say
- Reinforcing their uniqueness

Self-Efficacy

Many clinicians, substance use, and mental health programs stress the importance of healthy self-esteem for the well-being of young people. While working with young people in general and more specifically those with FASD, what became apparent to me is that young people with FASD need more than high self-esteem to do well in treatment and to realize positive outcomes. A young person with FASD may believe that he or she is a failure without disliking him/herself.

Self-efficacy can be defined as the beliefs, or self-perceptions that a young person with FASD hold about his/her ability to cope well with a particular situation, or fulfill a behavior necessary to produce a particular outcome. Self-efficacy reflects self-confidence in a young person’s capacity to exercise control over his or her motivation, behavior, and social environment. These cognitive self-evaluations influence all manner of a young person’s experience, including the goals for which he/she strive, the amount of energy expended toward goal achievement, and the likelihood of attaining particular levels of behavioral performance.

Social cognitive theorist believes that self-efficacy beliefs are at the core of human motivation, well-being, and personal accomplishment. Consequently, unless young people with FASD think that their actions can produce the outcomes they desire, they will have little incentive to do anything or to persist in the face of difficulties. These self-perceptions tend to influence every aspect of the lives of young people with FASD—whether they think creatively, negatively or positively. It also impacts how well they motivate themselves and continue in the face of difficulties; their vulnerability to stress, anxiety and depression; and the choices they make (Bandura, 1977, 1986, 1997; Bandura, & Locke, 2003; Kadden, & Litt, 2011). Self-efficacy influences the consistency with which young people with FASD apply what they know and according to Bandura high self-efficacy affects the quality of an individual’s thinking by increasing persistence (Bandura, 1997). Self-efficacy is also an important element of self-management and engagement. Further, Bandura and Locke propound that belief in one’s performance efficacy, that is, the belief that one’s efforts can achieve desired results, is necessary to mobilize and sustain coping behaviours.
With regard to substance use, it has been noted that self-efficacy plays a significant role in both treatment outcome and relapse prevention for individuals with substance use disorders (SUDs) (Trucco, Connery, Griffin, & Greenfield, 2007). Research indicates that individuals with higher abstinence self-efficacy at the start of treatment have better substance use outcomes at the end of treatment and at follow-up while those with lower abstinence self-efficacy have greater substance use following (Greenfield, Trucco, McHugh, et al., 2000; Witkiewitz, & Marlatt, 2004).

Base on my observation, the self-assurance with which a young person with FASD approaches a task or situation influences whether he or she make good or poor use of his/her abilities. Young people with FASD who are confident individuals anticipate successful outcomes. Young people with FASD who are confident in their social and interpersonal skills, as well as academically expect to do well. Those who lack confidence then to perform poorly. Young people with FASD, who doubt their social and interpersonal skills quite often foresee rejection of their ideas, for example from social workers, foster parents, teacher, or counsellors even before they engage in any discussion. Those who lack self-assurance in their academic skills predict low grade, have little motivation to enroll in new activities, participate in class, fail to voice their interest and quite often drop out of school. Effectively working with a young person with FASD should not only improve their self-worth, well-being or their ability to maintain sobriety in the face of high-risk situations but also help them to recognize their improved ability. I always find it useful to explore a young person’s idea of his or her belief in his/her ability, motivation, and ideas about progress (no matter how small the progress maybe).

Sources of Self-Efficacy Beliefs

According to Bandura (1995), individuals form their self-efficacy beliefs by interpreting information largely from four sources: mastery experience, vicarious experience, social persuasions, and physiological reactions.

1. **Mastery experience:** Most young people with FASD appraise the effects of their experiences and actions, and their analysis of these effects helps to create their efficacy beliefs. Success raises self-efficacy; failure lowers it.

2. **Vicarious experience:** by observing the successes, or failures of their peers which they perceived as similar in capability, their belief in their abilities can be reinforced or weakened. When young people with FASD are uncertain about their abilities, have limited previous experience, or have witnessed the failure and challenges of their friends they become especially sensitive to engaging in treatment or trying new thing. The comparisons that young people make to their friends can be powerful influences on self-efficacy beliefs.

3. **Social persuasions:** self-efficacy beliefs are also influenced by the feedback young people with FASD receive from others and social influences. When positive, these feedback loops can help them to apply the extra effort and diligence required to succeed, thus, resulting in the continued development of skills and personal efficacy. However, when negative, they can be demoralizing and overwhelming. Their social context is an important part in the formulation of their self-efficacy beliefs.
4. **Physiological reactions:** physiological, traumatic events and emotional states such as anxiety, depression and stress provide information about efficacy beliefs. Optimism, hope, and self-assurance along with a positive mood improve self-efficacy, whereas depression, despair, or a sense of dejection diminishes it. Thus, how a young person interprets the emotions, he/she is feeling, as well as his/her thinking plays a vital role in strengthening self-efficacy

**Building Self-Efficacy**

As clinicians we can help build self-efficacy by:

- Exploring what you people with FASD do well
- Encouraging them to recognize their progress no matter how small
- Providing them with the opportunity to develop new skills
- Building on their strengths
- Exploring their achievements and feelings
- Exploring their motivation and beliefs.

**Reflection Questions**

1. How can you support a client to develop his/her self-esteem?
2. How can you help your client develop his/her self-efficacy?
References:

Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients explore what self-esteem is
- Help clients to feel positive about themselves, and developing an understanding of their self-esteem, self-respect and confidence
- Help clients become aware of their strengths, abilities, qualities, their achievements, personal preferences
- Help clients appreciating ways they are similar and different from others
- Help clients identify things that build their self-esteem and things that destroy their self-esteem
- Help clients identify how self-esteem influence their behaviours and choices

Handouts

- Self-affirmation flashcards
- SWOT
- Self-esteem Volunteer
Session Guide

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Let participants/clients know that the intention of this session is to explore their self-worth.

Engage – what to do

Start off by telling them that the what we feel about ourselves will impact the way we treat ourselves and others, and the kind of choices we make.

Talk with them about their understanding of self-esteem and how important it is. Encourage them to reflect on moments in their lives when they had high self-esteem and moments when they had low self-esteem

Discussion questions

Let’s think about your values for a moment…

- What is self-esteem? And why is self-esteem important?
- Where things negatively affect your self-esteem?
- What things builds up your self-esteem?
- How does your self-esteem influence your behaviours and choices?
- Do you compare yourself with others?
- Do you wish you were different?
- What are the things you are good at?
- How do you feel when you accomplish a task?
Self-esteem

Self-esteem is an individual’s overall opinion of him/herself — how he/she feels about or value him/herself. Self-esteem is shaped by one’s thought, experiences and relationships.

Self-efficacy

Self-efficacy is an individual’s belief in his or her capacity to perform a task or behaviour necessary to produce specific performance achievement. Self-efficacy reflects confidence in the ability to exert control over one’s own motivation, behaviour and social environment.

(Bandura, 1986, 1997)
Learning Activities

Activity 1: SELF-ESTEEM AND COMMUNICATION

Remind participants the way we feel about ourselves affects how we behave and interact with other people.

- Now we are going to think about how people with low and high self-esteem communicate.
- How might a person with a high self-esteem communicate?
- How might a person with low self-esteem communicate?
- Are you currently struggling with low self-esteem?
- Have you struggled with low self-esteem in the past?

**Note:** Allow participants to brainstorm ideas: either divide flipchart paper in half and create a chart similar to the one below or have two separate flipchart papers. Let participants come up with their own ideas; do not simply didactically present the chart below. You can introduce ideas that the group may have missed or ask questions to prompt them.

Activity 2: STICKS AND STONES

- Give each participant a sheet of paper. Ask them to pretend that the paper represents their self-esteem.
- Read out a set of statements.
- Ask them to tear off a piece of the paper when you read statements that have affects them negatively. They should tear off bigger, or smaller pieces based on how badly the statement affects them.
- Read the following statements one at a time and allow a few seconds between each one for participants to respond.

**STATEMENTS**

- You asked a question in class, and the teacher made a comment; everyone laughed at you.
- Your parents are say mean things to you and often tell you they have no expectations that you will achieve anything.
- You have not seen one of your parent in a long time.
- Your best friend always competes with you and puts you down.
- A group of kids at school constantly ridicule and reject you.
- You do not leave with your parents
- Your life has been impacted by various illnesses or disability.

Activity 3: WHAT WE DO WELL.

- Provide participants, or your individual client with a poster paper, invite them to each write, at least, five things they do well. Encourage them to also consider how they feel when they accomplish something.
Learning Activities

Activity 4: Developing Self-affirmation flashcards

Encourage clients to identify their negative self-talk, as well as some of the negative views others hold of them. Then get them to create self-affirmation flashcard that are oppose the views others hold of them and the negative self-talk they engage in.

Activity 5: Self-esteem Volunteer

Tell participants to imagine they were volunteering for their school’s dear Jane self-esteem corner in the magazine. After reading the letters from some students about self-esteem, they are going to give advice for the next publication. Put posters in different sections of the room with various questions, probe them for answers and feedback, encourage them to walk around the room writing their feedbacks on all the posters. See handout for the questions.

Activity 6: SWOT (‘Strengths, Weaknesses, Opportunities and Threats’)

Help your clients appreciate the strengths of a situation or their strengths; - define their weaknesses, and what could be improved; - look to what they want to achieve in the future and help them identify how to make the most of the opportunities that present themselves; and recognize the barriers to their growth and wellbeing. See handout.

INSIGHTS

1. what was your experience of doing the exercise?
2. Did you learn anything different?
3. What mental picture do you have of yourself? How do others perceive you? Are these perceptions similar?
4. Can your self-esteem change? What kinds of things can you do to improve your self-esteem?
REFLECTION CIRCLE

Today we talked about self-esteem and your confidence in your ability.

1. What stands out for you the most?
2. Do you think differently about the way you feel about yourself?
3. How is your belief in your ability to do a task now that we have discussed it?
4. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

HOMEWORK

Think of someone you admire, what qualities about that person’s self-image impress you? Over the next week, take a few moments each day to reflect positively on who you are, what you’ve accomplished or things that made you happy. Write these thoughts on notes and stick them to your mirror, or another visible place in your bedroom. Read them aloud to yourself to remind yourself that you are special, especially when you are having a bad day. After a week, reflect on how you feel about yourself. Journal your experience.

KEY POINTS

- A positive attitude, positive self-talks, and a willingness to seek creative solutions make a great combination for good self-esteem.
- Self-esteem influences our behaviour and how we feel.
- Helping other people can help you boost your own self-esteem.
- When someone puts you down, if can affect your self-esteem.
Chapter 7: Unit 3

1. Self-affirmation flashcards
2. SWOT
3. Self-esteem volunteer
Most of you engage in Negative self-talk like...

- "I am not smart enough" or "I am such an idiot" or "I'll never get past the exam" or “I am not loveable.”
- Create flashcard-like the examples below to counter those negative self-talks.

```
I AM INTELLIGENT

I AM GOOD ENOUGH

I AM A GREAT COOK

I MATTER

I LOVE ME

I AM CREATIVE
```
<table>
<thead>
<tr>
<th>Strength</th>
<th>Weaknesses</th>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>what do I do well?</td>
<td>What do I struggle with?</td>
<td>What resources can you take advantage of?</td>
<td>Do my weaknesses pose a threat to my well-being and success?</td>
</tr>
<tr>
<td>What do others ask me for help with?</td>
<td>What resources are not available to me?</td>
<td>Are there opportunities immediately available?</td>
<td>What can I work on now?</td>
</tr>
</tbody>
</table>

How can I use my strength well?
Write your responses to the dear Jane column

Dear Jane

“I tried out for the debate team for the past 2 years and was cut both times. All my friends are on the debate team or in the science club and I don’t get to see them as much now. I feel alone and have no one to hang out with after school. I thought they were my friend, but every time I text them, they are busy. I feel so useless and stupid.

Dear Jane

“I told my best friend my secret, she has since told other people, now I get call names by my other friends. They call me a slot and a liar. I hate myself.”
Write your responses to the dear Jane column

Dear Jane

“I have a disability and the kids in my class make fun of me. The teachers don’t say much to stop them. If I tell my parents, they will make more fun of me and call me a cry baby. I don't like school anymore; I have started skipping school.”

Dear Jane

“‘No matter what I do, I don’t look like the girls in my class. I wish I could look as pretty as the girls in my class. They all have boyfriends. No one invites me to their party. My parents are poor so I cannot afford designer clothing. Any advice on how I can feel better about myself?”
The main themes of this unit are self-criticism, shame and self-kindness. This session is about exploring what it means to demonstrate compassion and loving kindness towards oneself. Being compassionate towards oneself is enhance our sense of being, belonging and becoming.

Young people with FASD, in particular, those who have experienced trauma have high levels of shame and self-criticism. They tend to have difficulty in being kind to themselves, feeling self-warmth or being self-compassionate.

In my experience, many young people with FASD struggle to feel relieved, reassured or safe. Research suggests that a specialized affect regulation system (or systems) underpins feelings of reassurance, safeness and well-being. It is believed to have evolved with attachment systems and, in particular, the ability to register and respond with calming and a sense of well-being to being cared for. Teaching young people to be self-compassionate draws on mindfulness theories to help these young people to cultivate inner warmth, safeness and self-soothing.

It is critical that clinicians demonstrate sensitivity and empathy toward their client and do everything possible to understand the process of meaning making of young people with FASD—this can sometimes provide some indications about why clients treat themselves poorly. Be careful that you do not show feelings of shocked by the way a client’s treat his/herself, contain it and act in an appropriate way. The skills of compassion involve creating feelings of warmth, kindness and support in a range of activities. Young people with FASD can be taught to engage mindfully with a whole range of therapeutic interventions that focus on thoughts, feelings and behaviours. It is of particular importance to teach the client to use these skills on themselves. When probed about the way they speak to, and treat themselves, most clients with high shame and self-criticism often reveal that they use a cold, bullying or aggressive inner tone to try to change their thoughts and behaviours. Clinicians should explore whether clients are attempting to force or bully themselves to change, in contrast to being supportive and encouraging of their efforts.
In therapy session, there are some key areas you could focus on to help a client builds self-compassion. Some examples are adapted from Gilbert (2009):

1. **Compassionate attention** is about helping your clients to focus their attention in a way that helps and supports themselves. For example, it may involve helping the client to remember times, when he/she, was kind to someone or others were kind to him/her, or you could use compassionate imagery. Further, when we are not getting along with someone, we often focus on the things that we dislike about them: by helping your clients to refocus their attention you can help them regain a more balanced view.

2. **Compassionate behaviour** is about helping your clients to focus on easing distress and facilitating development and growth. This does not mean helping them to explore their painful realities and behavior in meaningful ways so that they can learn to cope and adapt better.

3. **Compassionate feeling** is talking to your clients about experiencing compassion from others, for others and their self. It is important to help them explore what that looks like how it feels and how they can make a meaningful contribution to, not only the life of other but to theirs as well.

4. **Compassionate sensation** is about helping clients to explore feelings in their bodies without judgment or criticism and being able to tolerate and work through those sensations mindfully.

5. **Compassionate thinking** is about the physiological power of our thoughts, memories and images. For example, you can ask your clients to consider how they would feel if someone kept putting them down, or becoming angry with them when things did not go well. Usually, clients can identify feelings of frustration, anger anxiety and depression. In simple ways, you can help them understand how this signal stimulates their threat protection system (you can use something like the diagram below to demonstrate how our thinking impacts us). You can also help your client understand how switching to self-criticism, focusing/ruminating on self-criticism will stimulate the threat protection system and stress reactions. I once worked with a client her self-criticism was so constant that it harasses her into an anxious state.
Clinicians can teach self-compassion by:

- Harnessing the motivation to be caring.
- Teaching young people with FASD to be sensitive to distress and needs.
- Helping them recognize and distinguish the feelings and needs of the target of their caring.
- Teaching and reinforcing sympathy and empathy toward oneself.
- Teaching distress tolerance—Distress tolerance means being able to contain, stay with and tolerate complex and high levels of emotion, rather than avoid, fearfully divert from, close down, contradict, invalidate or deny them.
- Helping them develop self-compassion cards.
- Helping them to explore source of self-hatred.
- Encouraging initiatives in activities that nurture self-care.

Reflection Questions

1. How do you promote self-compassion in your clients?
2. How do you demonstrate behaviours that reflect self-compassion?
3. How can you help client navigate difficult areas of their lives without blaming themselves?

References

Resources Needed

• Name Tags
• Presentation slides
• Flipchart Paper
• Pens, Pencils, Markers
• Sticky Notes
• Laptop
• LCD Projector
• Yoga Mats or Towels

The Goal of the session is to:

• Help clients explore their self-criticisms, judgments, guilt, shames and fear and how they impact the way they treat themselves
• Help clients to identify ways to practice self-compassion and self-acceptance
• Practice mindfulness in their daily life

Handouts

• Self-Bullying
• Self-Compassionate Flower
• Mindfully Caring
Learning Intention
Let participants/clients know that the intention of this session is to explore clients’ self-criticisms and to help nurture love, kindness, self-compassion.

Engage – what to do
Start of by telling them that Everyone has something about himself/herself that he/she do not like; something that causes him/her to feel shame, to feel insecure, or not “good enough”.

Talk to them about their understanding of self-compassion and how important it is to their well-being. Encourage them to reflect moments in their lives when they have been very critical and moments when they have been kind to themselves.

Discussion questions
Let’s think about your values for a moment…

- Do you treat yourself as well as you treat your friends and family?
- What types of things do you typically judge and criticize yourself for? (appearance, school related, relationships)
- When you are highly self-critical, how does this make you feel inside?
- What does it mean to be accepting of who you are?
- When you notice something about yourself you do not like, what do you do?
- Are you often overwhelmed with negative thoughts or feelings towards yourself?

CHECK-IN
Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT
Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.
Self-Reflection

In what situations do you most get down on yourself or are most harsh with yourself?

When do you most feel defeated or like you are a failure?

In what situations are you most critical of yourself?

How do you so compassion towards yourself?

Self-Compassion & Self-Acceptance

- See possibilities for change
- Increase motivation for change
- Takes steps towards making change
- Make Changes and love yourself
Learning Activities

**Activity 1: Self-Bullying**

Most of you may bully yourself without even realizing it. Spend some time writing down some of the ways you bully yourself, especially when you are feeling low. Just write it all down exactly the way you speak to yourself, with the words you use – the name-calling, the self-blame, the shame. These are some examples (e.g., “I am such an Idiot! I am so emotional, no wonder people hate being around me.” “You’re always getting it wrong” “I am such a loser” “I can be such a lazy cow.” “I am pathetic” etc). See *handout—self-bullying*. Once they have completed the exercise, ask them to review what they have written and think about whether they would ever speak this way to someone else that they cared about, like a friend, or family member, especially if that person were feeling low?

**Activity 2: Compassionate Flower**

Encourage clients to draw flowers. Inside each flower get them to write compassionate, or kind things to themselves. See *handout—compassionate flower*.

**Activity 3: Mindfully Caring**

Use *handout—mindfully caring*. Ask clients to think of all the ways they can use mindfulness strategies to help improve their compassion for themselves.

**INSIGHTS**

- How do you think you would feel if you could truly love and accept yourself exactly as you are?
- Does this possibility scare you; give you hope, or both?
- When you are self-critical, what feelings go through your body?
- Now that we have explored your self-criticisms, does this remind you of the ways others treat you, or speak to you?
- Is there a link between how others treat you and how you treat yourself?
- Does being unkind to yourself get in the way of being kind to others?
- Do you find it easy to accept kindness, or compassion from others?
REFLECTION CIRCLE

Today we talked self-criticisms and self-compassion.

1. Did anything happen today that made you re-think the way you speak to yourself?
2. Did you learn anything about yourself kindness towards yourself, that you never thought of before?
3. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

HOMEWORK

Encourage clients to write a compassionate letter to themselves and practice relaxation techniques such as body scan and progressive muscle relaxation. Alternatively, you can challenge them to do a compassionate act.

KEY POINTS

- Self-acceptance & compassion is also about learning to work with strong emotions that arise and developing the capacity to ‘hold’ difficult experiences within our body and mind.
- When you feel compassion for others, you show kindness toward them, empathy, and a wish to help ease their pain. Being compassionate toward yourself is the same.
- Self-compassion creates a caring space within you that is free of judgment and criticism—a place that sees your hurt, your pain and insecurities, but it still allows you to treat yourself kindly and in a loving manner.
- Self-acceptance is accepting yourselves as you are (flaws, imperfections, strengths) – being true to ourselves.
Chapter 7: Unit 4

1. Self-Bullying
2. Self-Compassionate Flower
3. Mindfully caring
Most of you engage in Negative self-bullying talks and behaviours like...

- “I am such an Idiot! I am so emotional, no wonder people hate being around me.” “You are always getting it wrong” “I am such a loser” “I can be such a lazy cow.” “I am pathetic.”
Draw flowers, on each petal, write a compassionate, or kind things to yourself. See the example below.
List all the things you can do and all the ways you can be compassionate to yourself
Chapter Eight
Promoting Mindfulness
Mindfulness has been regarded as an approach for enhancing mental health and alleviating mental health difficulties among young people. The focus of mindfulness training is to increase one’s awareness of the present moment, enhance the non-judgmental observation of one’s surroundings, and decrease impulsive and automatic responding to events. Research on mindfulness training with diverse populations of young people has shown benefits for depression, anxiety, ADHD, among others.

The literature on mindfulness and young people is growing exponentially, and many clinicians are becoming more aware of the benefits of cultivating moment-to-moment awareness with their clients. In working with young people with FASD, I found the incorporation of mindfulness strategies to be very effective in helping a young person to ground him/herself.

Mindfulness starts when we recognize the tendency to be on automatic pilot and make a commitment to learning how best to step out of it to become aware of each moment. Practice in purposely moving attention around the body shows both how simple and difficult this can be.

Given that depression, impulsivity, anxiety and substance use are challenges faced by young people with FASD it is important that clinician work within a framework that manage these issues in a pragmatic way as well. When young people with FASD can be more mindful at times of low mood, they are less reactive and are thoughtful about how they feel, behave or think. Below is a graphical representation of how mindfulness can promote well-being.
What is mindfulness?

In general, Mindfulness is a meditation practice that begins with paying attention to breathing to focus on the here and now—not what might have been or what you are worried could be. The ultimate goal is to provide enough distance from disturbing thoughts and emotions to be able to observe them without immediately reacting to them, or judging them.
How do you explain mindfulness to young people with FASD?

There are several ways to broach the subject, how you decide to explain mindfulness to your client or group will depend on your therapeutic alliance with them, your knowledge and training in mindfulness approaches and your clients’ capacity. That concept is great—the idea of not identifying with the negative thoughts and feelings and having a little more space and freedom in the midst of it. When I am working with a young person with FASD or a group of young people I do not focus so much on defining mindfulness; I prefer not to define the word, but rather to invite the client to feel the experience first. For example, I may invite the client to observe what is in the room, if the client seems anxious, I may invite them to engage in some breathing. I get them to paying attention to their breath, the feeling of the expansion of the in-breath, the stillness between the in-breath and the out-breath as they pause for a few seconds. I invite them to rest in the space between the breaths. Then I explain that this peaceful place is always with us—when we are feeling sad, anxious, angry, happy, or frustrated. They can feel it in their bodies. Moreover, it becomes a felt experience of awareness. Sometimes I get them to learn to observe their thoughts and feelings by using a thought record sheet. As they engage in this practice, they begin to choose their behaviours. At a more pragmatic level, the idea should be about teaching young people with FASD stress reduction strategies, self-acceptance and ways to quiet their mind and regulate their emotions.

There are two skills in mindfulness, the ‘WHAT SKILLS’ and the ‘HOW SKILLS’.

**What skills includes:**

- **Observing** - attending to events, emotions, and other behaviour responses without necessarily trying to end them because they are painful or drag them out when they are pleasant. What we learn is to allow ourselves to experience with awareness, in the moment, whatever is happening, rather than leaving a situation or trying to end an emotion. One way you can try to observe is to listen to your favourite music or music you tend to dislike strongly. Detach yourself from all emotion that you might have to the lyrics or the musical style. Try just to observe the music itself, or the voice of the singer. You could also try to pick out a certain instrument such as a drum and concentrate and observe just the drum.

- **Describing** - Describing an experience that you dislike, like maybe cleaning the bathroom, and just notice everything about it without focusing on your feelings. This is a way to stay in the present and to be mindful of what is going on.

- **Participating** - Participation is about awareness. It is about being totally present when engaging in an activity. For example, when you are learning something new, you are often forced into participating with awareness.

**How skills include:**

- **Refrain from judgment** – making quick judgments about things and people is very easy, part of being mindful is to notice without rushing to conclusions/judgment. Mindful awareness allows you to collect all the information to make a judgment or decision. For example, a jury in a court case needs to see and hear all the relevant evidence. Not everything is the way it seems at first.
Stay focused - If we have a conversation with someone, and we find ourselves drifting into something that happened that morning, then pull our attention back to what's going on now, and later make ourselves a place to think about that worry from this morning.

Breathing – “Breathing in and out is crucial, as breathing is the link between our body and our mind. Sometimes our mind is thinking of one thing, and our body is doing another, and mind and body are not unified. By concentrating on our breathing, 'In and Out', we bring our body and our mind back together, and become whole again. Conscious breathing is an important bridge.

Reflection Questions

1. Do I have sufficient training and knowledge with regards to mindfulness?
2. How can I incorporate mindfulness in my sessions?
3. Am I mindful?
4. Do I provide my clients mindful ways to ground themselves?
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients explore and understand what it means to be mindful
- Help clients be more responsive as oppose to reactive
- Help clients identify ways to apply mindful practices in their daily living
- Help clients become more attentive about their body and mind
- Help client explore 'letting go'

Handouts

- How mindful are you?
- Three Minutes breathing record sheet
- The Labyrinth
- Posters and Cards
CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in the mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Let clients know that the intention of this session is to help them embody a focus on the present, slow down and create balance.

Engage – what to do

Show your clients pictures of young people playing ping pong, rock climbing, bowling, soccer, gymnastics and hacky sacs. Ask participants what is required to accomplish this task. You will likely generate responses such as:

- Concentration
- Focus
- Attention
- Awareness

Discussion questions

Let’s think about your values for a moment…

- What are you sitting on? Is it comfortable?
- Do you remember what you did this morning for your breakfast, and how did it taste?
- Can you name something you noticed on your way here?
- How hard or easy is it to keep your mind focused for 1 minute?
- Do you miss part of what people say because cannot stop thinking about other things?
- How would you describe your ability to focus or pay attention?
- Are you aware of an intent to do something before you do it?
- Do you feel restless when you have to wait?
Learning Activities

**Activity 1: How Mindful are you?**

Ask participants to take some time to fill out a mindfulness tool *(find a mindfulness tool you think is useful and appropriate to your client or groups’ need).* For group session—walk around to ensure those who require help gets it. Let them know that it is not required, but completing the questionnaire will help them gain some insights about how they interact, and how attentive or aware they are. Once they have completed the exercise, go over their scores and allow participants to talk about their experience, insights or new learning from doing the exercise.

**Activity 2: Two Minutes**

Ask participants to stand in a circle with chairs behind the knees, ask each person to close their eyes and stay silent. The task is to count silently to two minutes (120 seconds) and quietly sit down. The facilitator should time the minutes. Note after how many seconds the first person sits and the last person, and also, who was closest to the 120-second mark.

- When the last person has sat down, ask how easy/difficult it was to guess two minutes?
- What did they notice during the time?
- What could they feel?
- What could they hear?
- Did other people’s movements influence you?

**Activity 3: Attention**

Create displays, take a photo of them; bring in all the materials, divide participants in groups and ask them to recreate the display. The first group to complete it. Ask participants how difficult was the exercise? How were they able to focus? Etc. This is an excellent exercise to practice paying attention to things.

**Activity 4: FACTS**

Get participants to learn how to “describe” using “JUST THE FACTS.” Remind them to describe, “just what they know”, “only what they observe,” “add nothing, subtract nothing.” Put objects on the table (e.g., a pen, a shoe, a half-full glass with some juice, etc.). Instruct participants to describe each object one at a time using their descriptive skill. If participants feel you are “nit picking,” tell them to just “observe” this, use a “non-judgmental stance” and to get back to using “just the facts.” Talk about the fact about that we tend to assume things as they are and usually our assumptions are wrong. Get them to look at “what is” (reality) and respond from there.
Learning Activities

Activity 5: Mindful Eating

- Ask for volunteers. Do a blindfold food challenge [have at least five dishes and also exercise caution for allergies such as nuts and diary-keep it simple like fruits etc.]
- Once the volunteer has completed the task, ask them what they ate
- See if they can identify the ingredients in the item
- Ask what did you notice as you imagine each flavour?
- Did you smell anything?
- How about its texture?
- Ask for volunteers. Do a blindfold food challenge [have at least five dishes and also exercise caution for allergies such as nuts and diary-keep it simple like fruits etc.]
- Once the volunteer has completed the task, ask them what they ate
- See if they can identify the ingredients in the item.
- Ask what did you notice as you imagine each flavour?
- Did you smell anything?
- How about its texture?

Activity 5: Labyrinth

Invite your client to share their artistic representations of mindfulness using a labyrinth. If you have space outside this can be a group project.

INSIGHTS

Invite participants to reflect on the activity; ask:

- How hard or easy it was to keep your mind focused?
- Did you feel any emotions or body sensations?
- What did you learn about being mindful?
REFLECTION CIRCLE

Today we talked about mindfulness, what it is and how it can be useful

1. What stands out for you the most?
2. Do you think you will be able to use some of the mindfulness strategies we talked about?
3. Do you feel mindfulness strategies will be helpful for you?
4. Is there anything else you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present

HOMEWORK

- Three Minute Breath Space: Ask clients to practice three times a day at times that they have decided in advance. They can record each time they have done it.
- Challenge participants to a one-week gratitude challenge. Instruct them to write at least three things they are grateful for each day in their journal and observe how they feel.
- Challenge them to do mindful walking. Tell them the task is to pay attention to their body and environment.

KEY POINTS

- Mindfulness can help improve our concentration
- Mindfulness can help you develop values like tolerance and equanimity (calmness, cool headedness, self-confidence, composure)
- Mindfulness brings us closer to difficulties but without becoming caught up in our reactions to difficulties
- Mindfulness promotes self-resilience, self-compassion and self-acceptance
- Mindfulness helps to recognize patterns of the mind that contribute to immense sadness, anxiety and depression
Chapter 8: Unit 1

1. Three minutes breathing record sheet
2. Labyrinth?
3. Mindfulness Posters
Bring yourself into the present moment. Close your eyes. Then ask: "What is my experience right now—my thoughts, my feelings and my body sensations? Acknowledge thoughts. Turn towards any sense of discomfort or unpleasant feelings, acknowledging them without trying to change them. Scan your body quickly to pick up any sensations of tightness, recognizing the sensations, but, do not try to change them. Now, gently redirect full attention to breathing; at the count of three, inhale hold for two seconds then exhale. Continue breathing for 3 minutes.

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CHANGE

- Calm down
- Honour yourself
- Ask for help when you need it
- Notice your attitude
- Give generously
- Embrace change

GROW

- Get resources to help you grow
- Reflect on thinking and behaviour that need changing
- Open to new opportunities
- Work towards your growth
**LETGO**

- Let go of hurt, and resentment
- Exercise to help you relax
- Take steps to heal and forgive
- Give generously
- Open up to new beginnings

**ACT**

- Ask questions before acting out
- Create new thoughts
- Talk to someone you trust that can step in to help
CREATE

Communicate calmly
Release tension
Exhale and breathe deeply
Attend to your needs
Talk to someone
Explore your options

RAP

Reflect on the situation
Awake to possibilities
Practice mindfulness
HOPE

Honour yourself
Offer a lending hand
Practice gratitude and self-compassion
Expand your thinking

RESTORE

Reframe your thinking
Exercise to help you relax
Stay in the present moment
Take some deep breaths
Observe without judgment
Review your actions
Expand your thinking
COPE

Create new memories
Open to new beginning
Practice mindfulness
Embrace change

DARE

Delay gratification
Attend to your needs
Rethink your position
Evaluate where you are
PATH

Pay attention to your thinking
Allow yourself to think differently
Take time to say sorry
 Honour yourself

FOCUS

Focus your attention on the present moment
Open to new ways of doing
Challenge unhelpful thinking
Understand your emotions
Stop and take a deep breath
**STEP**

- Stop and think before acting
- Take steps to apologize
- Express your emotions appropriately
- Plan a relaxing activity

**CALM**

- Communicate what you are feeling & think assertively
- Accept the things you cannot change
- Let go of negative thought
- Monitor your emotions & choices
**BLOW**

- Breathe
- Let go of anger
- Observe your thinking without judgment
- Walk for 30 minutes

**RESET**

- Rethink your position
- Explore alternatives
- Stop and catch your thoughts
- Examine the other person’s point of view
- Take three deep breaths
Chapter Nine

Change
Clinicians Note

One of the most challenging questions from a psychological perspective is, ‘what is change?’ This has enormous practical significance for both clients and clinicians alike. As clinicians we cannot simply focus on the mechanical "how to change something", but we must first understand “what”, "with whom" and "why" we are trying to encourage and support a specific change. We also need to know about the individual and contextual factor that influences change. Our focus should not only aim to achieve change, but also to build the capacity of individuals with whom we work to enhance self-resilience and to sustain and actively maintain change. Before beginning to work to facilitate any behavioural change process with a young person with FASD, it is useful to understand what change is and what it is not.

What is Change?

Change can be considered in its quantitative aspects (“an event that occurs when something passes from one state or phase to another”) and qualitative aspects (“becoming different in essence; losing one's original nature”). This latter definition highlights the positive/negative contradiction that sometimes characterizes “change”: “becoming different” also means losing its “original nature”, and its related positive elements.

Change, in itself, isn’t “good”, “desirable” or “necessary” of its accord; in some cases, the original nature of something is “functionally better” and enables one to adapt and cope with the context in which the behaviour developed. The usefulness of change, or the opportunity for promoting “change” is thus a very relative concept, and it is related to the “systemic fit” between the “new behaviour and the old context”.

Behaviours can be defined as actions and mannerisms carried out by individuals or systems (e.g. communities, social groups) in relation to their environment.

Other approaches in psychology tend to conceptualize behaviour in a less mechanistic way, representing it as “a person’s pattern of actions finalized to reach an aim”.

Chapter 9

Change
To understand processes involved in change, it is important we also have an understanding of behaviour. Behaviour, like change, is a very complex process, which is interrelated with various other psychological and psychosocial processes. As clinicians having an understanding of the “causes” of behaviour, and the factors contributing to maintaining or changing behaviour (the determinants of behaviour) is vital.

The complex interaction of these determinants influences and shapes individual and social behaviours. Different behaviour can have a different function, from adapting to the environment, to coping, to expressing social and individual identity. It is important to recognize individual, social, values, emotions, meaning and perspectives. An understanding of theoretical models of behaviour change is also useful.

**Change is:**

- A pragmatic and organized effort to change what it is possible to change, and to improve what it is possible to improve.
- Change is an alteration, or adjustment to any component, or variable of one's behaviour, or life
- Change can be an opportunity or a threat
- The only certainty is continuing uncertainty
- Change works best when it is a collaborative, interactive process.
- Ability to make changes depend on internal and external resources
- People can be ‘good at change’… however, they can also be quite attached to the way things are
- A comprehensive effort, both to sustain good practices, as well as to build a “supportive environment” to enhance and modify critical practices

Helping clients change behaviour is an important role for clinicians. Change is usually useful in managing life challenges and addictions. The concepts of readiness and motivation are often use when working within addiction and mental health settings. It is important to understand your client’s readiness change, and assist your client to identify and recognize his/her barriers. The Readiness to Change Ruler and motivation to change are tool that can be used to promote discussion with your client.

**Remember:**

Change is complicated by multiple needs and multiple factors (e.g., family histories and current situation, concurrent disorders, available resources) each of which have many interacting variables. Therefore, this makes it even more important that you help your client build resilience.
It is important to remember that:

- Change can be a scary prospect for most people. I have found it very useful having some experience with motivational interviewing and narrative therapy when addressing the idea of change with young people with FASD.
- Keep in mind that your role is to facilitate a process not ‘fix’ the young person. Therefore, encourage him/her to believe in the possibility of change and to take self-responsibility for change (self-efficacy).
- By trying to persuade participants or a client, you can ironically, make it more likely that the participant or client will stay the same.
- The aim of a motivational approach is for young people with FASD to identify their reasons to change; we must be careful not to impose our reasons. It is the difference between ‘intrinsic’ motivation, which comes from within and ‘extrinsic’ motivation, which needs external rewards or threats. For example, developing the desire to stop drinking alcohol to focus on school will only be effective if the young person who is considering change, really wants to focus on school and do well.
- The aim of a narrative approach is to allow the young person to exercise some agency—have a voice, share his/her story and give his/her definition of the problem.
- Amrhein et al.’s (2003) psycholinguistic research indicated that the most effective self-motivating statements demonstrated high levels of a:
  - Need to change
  - Desire to change
  - Reasons to change
  - Ability to change
  - Commitment to change.
- When a young person believes in, is confident and willing to do something, their statement will likely take the form of “I want to change”; I can change”, “it is important for me to turn my life around”…
- Encourage, or boost self-belief. Client-centered therapy suggests that people are more likely to change
- If they feel good about themselves and are affirmed (Rogers 1951). To affirm someone is to work with them in a way that builds his or her self-belief and self-confidence. When a young person feels he/she is genuinely supported and encouraged, he/she feels valuable.
- Work with resistance
- Work with ambivalence, ambivalence can be a good thing as it creates an opportunity for a young person to explore the pros and cons of his/her substance use.
It is also important to know that the idea of “change” is particularly complex. When confronted with the possibility, many young people quite often ask these three questions:

1. Why should I change?
2. What is in it for me?
3. What do I do differently?

Behaviour change process can be divided into two aspects: initiating behaviour change and maintaining behaviour change. These two aspects are influenced by different psychological determinants.

**When a young person needs to make a change, it may be viewed as:**

- Opportunity
- Threat
- Major issue
- Irrelevance
- Something I have to make happen
- Something that others are imposing (trying to impose) on me
- Both something that’s imposed on me and something that I have to make happen

**Concepts or elements requiring consideration as you facilitate a process of change**

- Readiness
- Self-efficacy
- Determinant of behaviours
- Belief
- Awareness
- Attitude
- Motivation
- Resistance
- Engagement
- Unwillingness
- Ambivalence
- Lapse or Relapse
- Action

As clinicians it is important that you understand the various elements within the change process, in order to be able to identify where young people face particular obstacles or have certain reactions at different points in time. Real change cannot be imposed on young people with FASD, so this understanding will help you to support young people and find ways of moving forward.

**Helping young people think about change starts with**

- Communication about needs, strengths and abilities—*every behaviour is motivated by need.*
- Participation and involvement
- Exploring their vision for themselves
- Finding what resources, they have and what is available to them
Barriers to change

- It always takes longer than you think
- Exaggerated expectations
- Scepticism
- Impatience
- Denial that a problem exists
- Mistrust of service providers and system of care
- Unwillingness to make change
- Internal factors (e.g., shame, lack of confidence) present within the individual and his/her family and external factors present within the individual’s social contexts.

Why young people with FASD resist change?

- Belief that there is nothing to change or no problem to attend too
- Fear of losing something – A sense of loss and confusion
- Mistrust
- Fear of letting go of that which led to success in the past.
- People hold onto & value the past.
- High uncertainty, low stability, high emotional stress
- Perceived high levels of inconsistency.
- Perceive high level of stress
- Control becomes a major issue.
- Conflict increases
- Too complex
- Reminder of past failure
- Resistance to change can be a defense mechanism caused by frustration and anxiety
- Feeling inadequate with the requirement of change

No matter how positive, promising, or proactive the change is, expect a sense of loss. An individual may not be resisting the change as much as they are resisting a potential loss. In many cases, there is not a disagreement with the benefits of the new process, but rather a fear of the unknown future and about their ability to adapt to it. For example, fear that one will not be able to develop new skills and behaviors that are required. There are many reasons for resistance; it is important to understand it.

Transition

It is important to remember for every change we make; we go through a transition. The difference between individuals is the speed at which we go through that transition, affected by a variety of factors:

- past experience
- Personal preferred style
- The degree of involvement in recognising the problem and developing possible solutions
- The extent to which someone was pushed towards a change rather than moving towards it voluntarily.
**Summary overview of behaviour change models**

Knowledge of theoretical models and related theoretical debates can help us to identify pragmatic operational guidance to help facilitate a process of change for young people with FASD. While it is not important for you to spend time educating young people about these theories, it is important that you be aware of them and have sufficient knowledge so that you are better equip to work with young people. Understanding the different models of behaviour change will help to facilitate more meaningful discussions on behaviour change, several different “health behaviour” models explain the process of change. See below for a summary.

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>The bio psychosocial Model</strong></td>
<td>Focus on a detailed description and analysis of the factors involved in behaviour change. The biopsychosocial-spiritual model has been widely used, as it shows the simultaneous interaction of biological, psychological, social and spiritual variables in the determination of behaviours.</td>
</tr>
<tr>
<td><strong>The Transtheoretical Model</strong></td>
<td>Introduces the concept of different “stages”, or phases, of behaviour change, and the importance of adapting the interventions (timing and typologies) to the specific stage in which an individual is situated.</td>
</tr>
<tr>
<td><strong>The Theory of Reasoned Action or The Planned Behaviour Model</strong></td>
<td>Analyzes, from a rationalist point-of-view, the different variables that influence the personal “intention” to behave in a certain manner. It is important to understand what the behaviour means to the individual, as well as the effect that social norms and the perception of the ability to perform an action have on the actual intention to act.</td>
</tr>
<tr>
<td><strong>The Protection Motivation Theory</strong></td>
<td>Focuses on the equilibrium between “threat appraisal” and “coping appraisal”; it is necessary to stimulate a “coping” attitude, enhancing the perception of efficacy (in relation to both the proposed solutions as well as personal efficacy), increasing a person’s perceived control over threats.</td>
</tr>
<tr>
<td><strong>The Health Behaviour Model</strong></td>
<td>Focuses on the barriers and benefits of behaviour change; a behaviour change intervention needs to focus on both, and to work on people’s subjective perceptions, not only on objective data about different risks (the implementers’ perception).</td>
</tr>
</tbody>
</table>
Most young people with FASD want to make changes in one or more areas. When working with clients remember that FASD is not homogeneous, clients have their uniqueness. It is also important to believe that clients are capable and have a right to manage their lives and are capable of making changes. Thus, an empowerment attitude is relevant as it focuses on the capacities and strengths of clients.

Everyone makes changes in his or her way and in his or her own time, but the pattern can often be similar. For most young people at the beginning they may feel stuck, helpless or hopeless to mobilize their circumstances—many don't feel able to face the problem or are not ready to accept help. From hopeless, helpless or not being ready, they can sometimes move to seeking and accepting help. If they feel heard and respected, they will start believing in the possibilities that they can develop goals and work toward change. When I work with young people with FASD, I try to use simple approaches to explain change. See the diagrams below.
An example of a problem scenario.

**Past and current Behaviour**

- The past and Current State is how you did things (solve problems, cope) in the past and how you are coping or resolving problems at the present moment. Basically it is the collection of processes, resources, behaviours, coping tools that you are using. It may not be working great, but it is familiar and comfortable because you know what to expect.

**Transition**

- The Transition State is psychological, it is the process that people go through as they internalize and come to terms with change. It is often emotionally charged - with emotions ranging from despair to anxiety, to anger, to fear, to relief. The Transition State requires you to accept new perspectives and learn new ways of behaving and coping while still keeping up your day-to-day efforts. The Transition State can be challenging.

**Future**

- The Future State is where you are trying to get. It is often not fully defined, and can actually shift while we are trudging through the Transition State. The Future State is about “becoming” and “belonging”– its getting to your personal goals, and there is a chance that you may have lapses, or relapses along the way.

Alternatively, I use this diagram. Some clients find it very helpful to help them identify where they are.
Motivation & Readiness to Change

Motivation

Simply put, Motivation can also be defined as what causes a person to want to repeat or stop a behavior. Motivation initiates and drives the change process. Johnson, McClelland, and Austin (2000) noted three factors that are central to motivation: “the push of discomfort, the pull of hope that something can be done to relieve the problem or accomplish a task, and internal pressures and drives toward reaching a goal” (p. 133). Thus, not only must clients want to change, but they must also believe in their capacity for change. Change is stressful; every change brings with it a loss and it requires risk and sometimes tremendous drive to give up established patterns of behavior and thinking. Young people with FASD differ in the extent to which they have the skill or vigour to make changes. According to Shebib (1997), the willingness to engage in the work of counselling, the commitment to devote energy and resources to the change process, the capacity to sustain effort over time and in the face of obstacles and sufficient self-esteem to sustain the courage to change are essential elements of high motivation (p. 252). Clinicians can take these into consideration when helping clients and then design appropriate strategies to meet each client’s particular need. These four elements suggest two major motivational tasks for counsellors: engaging clients to commit to change and supporting and energizing clients as they deal with the stresses of obstacles to change.

Motivation to change behaviour may also be related to an individual’s locus of control (i.e., whether the young person feels that events in his/her life is within his/her own control—internal locus of control, or whether they are in the hand of others—external locus of control).

Further, Nicoli (1988) suggested that the concept of secondary gain is a useful way of understanding why some people resist change despite the obvious pain or losses involved in maintaining their current situation. Secondary gain refers to the benefits that people derive from their problems. These benefits may include “increased personal attention, disability compensation, and decreased responsibility, as well as more subtle gratifications, such as satisfying the need for self-punishment or the revengeful punishment of others who are forced to take responsibility” (p. 13). It is also useful to assess a client’s intrinsic and extrinsic motivation.

The Motivation Matrix breaks down motivation along two dimensions: Internal vs. external and positive vs. negative. The resulting four quadrants can each provide motivation, but will produce different experiences and outcomes.

- **Internal-positive**: Challenge, desire, passion, satisfaction, self-validation (likely outcome: successful change, fulfilment).
- **External-positive**: Recognition and appreciation from others, financial rewards, (likely outcome: some change, partial fulfillment, dependent on others for a continued change and good feelings).
- **Internal-negative**: Threat, fear of failure, inadequacy, and insecurity (likely outcome: some change, possible relapse).
- **External-negative**: Fear of loss of a relationship, insufficient respect from others, financial or social pressures, pressure from significant others, unstable life (likely outcome: some success, high risk of relapse). The ideal type of motivation is internal-positive because the motivation is coming from a place of strength and security.
Readiness

It is important to evaluate a young person's readiness to change for any proposed intervention (Zimmerman Olsen & Bosworth, 2000). When an individual is not ready to make a change, if you impose change you are likely to alienate the client. It is also important to ensure that your intervention matches your client’s readiness if intervention is not congruent to the client’s readiness the individual will be less likely to succeed. Also, if you try to rush a client through his/her goals and strategies for change he/she is more likely to put up resistance that will impede behavior change.

For example, if trying to get a young person to stop drinking, it is essential to know where the person is in his/her readiness to stop. A person who is not even thinking about quitting is not ready to receive information about specific things he/she can do. In this case, focusing your session on quitting sends the message that you are not listening. This may not only damage client alliance and rapport but can also make the young person even more resistant to quitting. A more appropriate approach with this person would be to try to get the person to think about quitting.

Two main factors that have been found to affect a person's readiness to change are "importance" and "self-efficacy". Importance is determined by what value a person places on making the change. Self-efficacy is a person's belief or confidence in their ability to succeed in making the change. Depending on the circumstance and resources (internal & external) available, young people with FASD may exhibit different levels of importance and self-efficacy (Rollnick, Mason & Butler, 1999). A young person with FASD may be convinced of the dangers of running away from home: living on the street or couch surfing, but have a low level of confidence based on previous experience at home or in foster care about things working out.

Anything that moves a young person with FASD along the continuum toward making a positive change should be viewed as a success. Two questions that I quite often put to my clients to help evaluate their readiness to change is: ‘Are you willing to think about changing your behaviour?’ and ‘how will you know it is time to make changes?’
**Capacity for Change**

One of the most overlooked factors when facilitating or initiating any change is the understanding of young person’s available capacity for change, or to implement change. The capacity for change refer to an individual coping and self-management, self-belief and confidence, positive thinking, problem solving skills, belief in their skills, as well as environmental factors that impacts the individual. The capability and capacity of young people with FASD to make behaviour changes and sustain these changes is reflective of their complex realities, including consideration for individual challenges and environmental problem faced by their families and how the problems interlock and the potential impact of factors such as availability of resources.

When life circumstances/stresses overload a young person it may reduce their capacity in a number of ways. For example, abuse and neglect may expose a young person to danger and may have negative impact on their sense of safety and security. Substance misuse and mental health challenges such a depression may engender apathy and helplessness and reduce their ability to cope. When a young person feels overloaded their confidence, competence, comfort and control are disrupted. When confidence, competence, comfort and control is disrupted stress levels go up and the capacity to implement change is reduced.

**Factors that impact a young person's capacity for change are:**

- Competencies skills
- Environment (e.g., family histories and functioning, employment, housing, community resources)
- Impact of risk and protective factors

**You can assist a young person with FASD in their change process by:**

- Understanding the problem and their need for change
- Understanding and respecting where they are and what they can give
- Understanding environmental factors impacting them
- Exploring their strengths and values
- Identifying the possible resistance to change
- Understanding readiness
- Create change paths
- Assess and build competencies to manage change
- Help build resilience
- Teach emotional regulating skills.
- Helping them develop goal and change and action plans
- Help them navigate resources
- Build meaningful linkages
- Teach problem solving skills
- Build self-efficacy skills
- Help them explore turning points in their life

**Important note:** some young people will experience events or circumstances which create a turning point in their lives and motivate them to make the changes needed to overcome adverse behavior patterns. As clinicians you need to recognize these potential turning points so that you can help a young person make the most of this window of opportunity.
References


Other References consulted


Reflection Questions

1. How do you empower clients and assist them to make changes?
2. What are the forces acting upon the young person’s life?
3. What are the pressures I should take into consideration as I become a change agent in helping to facilitate or stimulate a process for a young person?
4. How should I support that young person?
5. What does change mean to that young person?
6. Why is change important to the young person?
7. Are they ready for change?
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients explore their motivation to change
- Help clients understand change
- Help clients explore their readiness to change and importance of change
- Help clients explore why they resist change, even when change seems like a good idea
- Help clients explore their desire to change
- Help clients understand what motivates change
- Help clients understand the role of motivation in behaviour change

Handouts

- Readiness to Change Ruler
- How motivated am I?
- Things that get in way of change
**Learning Intention**

Let clients know that the intention of this session is to help them understand change and to explore their motivation and readiness to make changes in their life.

**Engage – what to do**

Engage participants in a discussion about areas in their life where they have made changes.

*Ask:*

- What was it like before you decided to change?
- Do you remember thinking about change and then deciding you would do it?
- Do you recall anyone talking to you about your behaviour?
- What was the first thing that you did?
- What changes, if any, are you thinking about right now?

**Discussion questions**

*Let’s think about your values for a moment…*

- Then invite them to think a bit more about change. Ask your client to think about some significant changes they have been through, and encourage them to describe their experience?
- When you think about change, what comes to mind?
- Think back about some changes you have experienced, were you ready for that change?
- How do you know when you are ready to commit to something?

**CHECK-IN**

*Group:* Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

*Individual:* conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

**QUIET MOMENT**

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.
Breaking it Down

Motivation

Motivation is a key factor in successful behavior change and has been shown to promote devotion to clients committing. Below I provide some useful ways you can explore motivation with your clients.

Exploring Motivation

- On a chalk board or flip chart paper write the word motivation in the middle
- Ask what is motivation? Encourage participants to go to the board to write any phrase or word they have to define motivation in any of the boxed. See below for an example of a motivation map.

Ask why is motivation important?

Responses may include: Motivation helps with:

- Patience in giving myself time for the changes to occur
- Persistence when old habits and patterns resist my efforts
- Determination in overcoming obstacles and setbacks

Lifestyle that supports the changes:

Likely responses could include:

- Having a goal
- Staying out of trouble
- Friends

What Hurts Motivation?

- In your experience, what sort of things take the ‘wind out of your sails’ when it comes to motivation?
- On the flip chart create a summary of what hurts motivation, using a node-link mapping format.
- Prompt and suggest other key ideas as needed.

Likely response:

- Negative criticism from love ones,
- No hope,
- No support, fear, shame, etc.
Think back to what motivations you:

What Motivates You?

On the flip chart create a summary of what motivates, based on your clients’ response using a node-link mapping format. Prompt and suggest other key ideas as needed. Summarize the group's ideas about things that motivate them.

- Those times in the past that you were actually motivated by something – what did other people notice about you that told them you were motivated?
- When you think about people you know who are motivated and get the thing done, what can you learn from them?
- Who motivates you the most when you are working on personal changes or goals?
- What do people say, or do that is helpful and useful to you?
- How do you help motivate other people you care about?

Assessing Readiness to change

A Readiness-to-Change Ruler can be used to assess a person's willingness or readiness to change, determine where they are on the continuum between "not prepared to change" and "already changing", and promote identification and discussion of perceived barriers to change (See readiness to change assessment tool below).
Learning Activities

Activity 1: Change Game

- Tell participants we are going to engage in a brief activity.
- Tell them every time you say the word swap they will need to switch sits with someone else in the room. [We will be doing this sometimes, but I cannot tell you how many times you will be required to swap].
- Allow them to sit for about a minute then say SWAP again, allow them to sit this time for two minutes.
- Say SWAP, this time, allow them to sit longer. [Do this for about five cycles, each time increasing the wait time]
- At the final swap enable them to stay where they are and begin to engage them in a discussion

Activity 2: Barriers to change:

Distribute handout—barriers to change. Ask participants, or client to work on what get in their way of change

Activity 3: Unknown

- Use a simple gift (e.g., stress ball, coffee card) wrap it in several sheets of paper, each sheet should contain an activity/or something that the participants should do (e.g., sing a verse from your favourite song, say something kind
- To the person on your right – simple to-do-task that will be fun) upon removing the layer till the gift is obtained.
- The last sheet should say give the gift to the person on your right [pay attention to reactions in the room]

Activity 3: Unknown

- Use a simple gift (e.g., stress ball, coffee card) wrap it in several sheets of paper, each sheet should contain an activity/or something that the participants should do (e.g., sing a verse from your favourite song, say something kind

INSIGHTS

- How did you feel during the game?
- How did it feel to be asked to change seats?
- Was the change uncomfortable?
- What are some of the things that make you resist change?
- How did it feel to be ask to make so many changes?
- Was there any point when you wanted to return to your original sit? If so, why didn’t you? Or if participants return to their original sit ask the following questions:
  - Why is it difficult to make changes?
  - What kind of support is necessary to maintain change?
REFLECTION CIRCLE

Today we talked about what motivates you to change; as you think about our discussion:

1. What stands out for you the most?
2. Do you think differently about your motivation to change?
3. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

HOMEWORK

Readiness to change - Distribute handout—readiness to change ruler. Ask participants to give some thoughts about their readiness to change.

Motivation to change - Distribute handout—how motivated are you? Ask the client to circle the number that best reflect their motivation to change.

KEY POINTS

- As you can see, motivation is made up of many things and it can be impacted by many things.
- Change is never easy, whether you're trying to change a behaviour, an attitude, or your current circumstances. The process is likely to be more "stop, start, stop, start" than the smooth transition you would like it to be, as there are many distractions competing for our attention.
- Sometimes what we want for ourselves is very different from our realities.
- During change, you are encouraged to do things differently, when we do things differently, you are forced out of your comfort zone.
Chapter 9

1. Readiness to Change Ruler
2. Motivation to Change?
3. Barriers to change.
Readiness means being prepared. It is the willingness to do something about your current situation or behaviour. Readiness is also about:

- Having the right conditions and resources in place to support the change process
- Having a clear vision and objectives for the intended change
- Having the motivation and attitudes to engage with the change and make it work

Think about the habit or behavior you are interested in changing. Using the readiness web below, circle the number that best fits with how you are feeling right now about your readiness to make changes where 0 = Low and 10 = High

| The behaviour or habit I would like to change is ___________________________. My readiness to change is… |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not Ready | Ready | Already Changing |

| How important is this change for you? This change is… |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not Important | Important | Very Important |

| How confident are you in making this change? I am… |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Not Confident | Confident | Very Confident |
Think about three habits or behaviours you are interested in changing. Use the rulers below to indicate how motivated you are to change these habits/behaviours below:

<table>
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**The behaviour or habit I would like to change is ___________________________.** My motivation to change is:

- Not Motivated
- Slightly Motivated
- Very Motivated
Take into consideration yourself and your current environment (home, school, friends, work, etc.), and identify some forces that could affect a habit or behavior change you are considering.

**Barriers to Change**

Diagram illustrating the layers of influence including self, family, friends, community, and external environment.
Chapter Ten
Understanding FASD
Clinicians Notes

For many young people with FASD the degree of awareness and information, they have about the disorder that impacts their life varies. For some, their support system has done an excellent job in teaching them about FASD, as well as how to advocate for themselves; for others their knowledge of FASD is limited, and they have very little awareness about the disorder that has and is currently impacting their life. Having limited knowledge about FASD, can have implication for a young person’s sense of being, belonging and becoming. I am always left contemplating where have we gone wrong when a client ask me what is this FASD thing that I have?

This module is to help clinician facilitate a process for young people with FASD to learn more about their disorder and to share their stories about how it impacts their life. Young people with FASD do not want to stick out from their peers, and they especially do not wish to be made fun of or denied access to things. If a young person with FASD knows and understand what FASD is, he/she will be more accepting of him/herself and will be more open to strategies to help him/her cope with challenges and will be better able to deal with it. Talking to a young person about FASD and allowing them space to explore their experience of having FASD is a critical first step towards increasing their awareness and perception of self with regard to FASD, as well as how they cope with FASD. Many young people with FASD have low self-esteem; this does not have to be the case. Talking to young people with FASD about FASD and helping them explore FASD and how it manifests in their everyday life and experiences is an excellent way to reinforce that FASD is not all of who they are. For many young people with FASD, there are lots of blind spots, and they make decisions based on inaccurate or partial information, which often can land them in trouble at school, home or with the law. Learning to live and thrive with FASD has a lot to do with having a good understanding of FASD and learning how to deal with the challenges it present. With that in mind, here are some things to keep in mind.

- Start the conversation in a very positive way. Emphasize that their brain works “differently.” When you talk to a young person with FASD, let them know that every person is different in many different ways, and we should celebrate these differences and that there is nothing they need to be ashamed off or embarrassed about.
Each young person is different, but there are some common themes based on the age of the young person. Your client may have many detailed questions. They may be interested in learning more about their diagnosis.

They are most likely to think about FASD regarding its effects on their daily activities, such as school, and relationships with friends and families.

Your client will likely hear messages about FASD from a variety of sources. Do your best to ask about any information your client is getting from other sources. Learn about your client’s specific fears so that you can discuss it together.

Encourage your client to ask questions. Answer questions honestly and be sensitive. This should be done in a very reassuring and constructive manner.

There are some suggestions on how you can help young people with FASD understand FASD Better. (Facilitate a discussion about what they know, what they would like to know as well as their personal histories and stories of having FASD.)

What is FASD? - A good way to understand what FASD is to establish what it is not.

There are various areas of the brain that control young person’s ability. These areas may be less active and develop for young people with FASD.

Try using a simple explanation like this:

- FASD is a group of disorders that makes it hard for a person to deal with the world around them.
- It is a group of neurological or brain-based problems that affect one or more ways that a person takes in, stores or uses information.
- The effects are different from person to person. They relate to:
  - Getting information into the brain (Input)
  - Making sense of this information (Organization)
  - Storing and retrieving information (Memory)
  - Getting information back out (Output)

What causes FASD?

- It is what happens when a woman consumes alcohol while pregnant.
- Emphasize that FASD is not caused by factors such as, cultural or language differences, socio-economic status or lack of motivation

How common is FASD?

- FASD is one of the most common forms of disability and within Canadian society, FASD is estimated to affect over three million Canadians (Stats Canada, 2006).
- FASD vary widely in form and intensity: No two people with FASD are the same.
What Do FASD Affect?

Many individuals with FASD have difficulties with (list some of the challenges):

- Academic functioning, daily life and social life. For example, FASD can interfere with reading comprehension and math.
- Planning, organizing, and time management
- Self-monitoring - may not be able to pay attention to how they are doing something
- Self-control & Attention - may have trouble inhibiting impulses
- Understanding body language, or understanding tones of voice
- Generalizing - They may have difficulty applying what they have learned in one setting to new situations
- Problem solving
- Slow processing speed – may need more time to process information - may take longer than most to make sense of what is being said or to organize their thoughts.
- Memory (is an important part of learning) - Working Memory refers to the ability to hold information in mind while reorganizing or manipulating it. This type of memory has a limited storage capacity: If overloaded, one usually loses track of the information in mind. We use this type of memory to multi-task, or to think about more than one thing at a time
- Sensory – may be sensitive to bright lights, certain clothing, tastes and texture in food and loud music.
- Individuals with FASD may not only have difficulties at school, but they also have difficulty at times coping with the world around them; they also can have a hard time communicating and express
- They may have a hard time anticipating consequences or being flexible and adapting to new situations sing their feelings
- They may likely experience difficulty regulating their emotions
- **Social skills:** young people with FASD often have a tough time making and keeping friends Being hyperactive or impulsive can make it hard for them to follow social rules, control emotions and say the appropriate thing.
- **Organization, planning and learning:** FASD affects the part of the brain that deals with executive functions. This is the ability to plan, organize and think ahead. For example, losing track of calculators, notebooks and assignment sheets can make it hard to complete assignments and homework. Losing track of his/her thought process can make it even harder. Your client may struggle with breaking down a school assignment or work activities.

Engage Participants in a discussion about the brain and FASD.

For this part, is critical that you have a good understanding of how FASD impacts the brain. In my experience this has been a fun discussion, you will get a lot of reference to things and the way they receive, process, store and give information or think about their brain. You may use different analogies such as a car, or a house to supplement the information they provide. I have used both examples with visual elements (pictures of the brain, a house, car) with groups and individual clients, both examples seem to resonate well with the clients I have worked with.
Begin by saying:

Our brains are amazing things. They allow us to think, to hear, to see, to smell, to solve problems, to create things, to decide what we want to do or have for a meal, and many other functions. Sometimes they can work slightly different and different disorder can impact how they work. With FASD the brain works differently. Below are some brain diagrams that may be useful to you.

Ask participants to imagine that their brain as a house, with an upstairs and downstairs.

- The downstairs is responsible for basic functions like: breathing and blinking, for reactions and impulses (like fight and flight) and strong emotions like anger and fear. [For example, when you instinctively flinch because a ball is thrown at you, your downstairs brain is at work].
- Your upstairs brain is entirely different; this is where more complex mental processes take place, like thinking, imagining, and planning. It is responsible for producing many of the characteristics we aspire to see such as control over emotions and body, self-understanding, sound decision and planning, and empathy.
- A person's brain works best when the upstairs and downstairs brain is united or joined with each other.

If you like cars or your group like cars, you can use cars to explain it as well.

- Tell them that the brain has different parts with different jobs.

Talking about experiences and being different

Sometimes I use the metaphor of taking a road trip and that there are many ways to get there. I ask them to imagine two people taking a road trip to the same destination but each taking a different route. We discuss what taking a road trip would require—the preparation, lengths of time each route may take, and the ability to navigate certain road signs and to manage the vehicle in such a way that they would arrive safely at their final destination. The metaphor of the road trip provides clients the opportunity to discuss:

- How taking a different route is ok
- The fact that one route may require more time than the other
- Differences in experiences, landscape etc.

Reflection Questions

1. Do I have sufficient training and knowledge about FASD?
2. Do I have a holistic understanding of the daily experiences my clients?
3. What problems are being experienced by clients and what is their view or attitude towards their experience?
4. Am I facilitating access to information and development of knowledge about FASD for my clients?
5. Am I aware of the stigma and discrimination discourses related to FASD?
6. What stigma or discriminatory statement has impacted my clients?
Discussions like these help clients identify the challenges of having FASD and how these challenges are manifested in school, at home and other areas of their life. They are able to focus on their individual and collective experiences—their feelings, thoughts and how those thoughts and feelings are related to their behaviours. Further, they are also able to appreciate that learn in different ways than others. They are, in one sense, a different traveler in the world. I also explain that sometimes they take the same road as others while learning and doing things and then, at other times, they will go another way, perhaps taking some detours, even though everyone is trying to get to the same place.

I often conclude by reinforcing that having FASD doesn't mean you can't be successful or have good outcomes; however, it does mean that you might have to find some ways to get there that will be a little different than the roads others take. You will need to learn to be a creative traveler and do some things differently, at times on your own and other times with the help of others to help yourself become successful. If you do, you will have more control over where you are going and how you will get there.
Resources Needed

• Name Tags
• Presentation slides
• Flipchart Paper
• Pens, Pencils, Markers
• Sticky Notes
• Laptop
• LCD Projector
• Yoga Mats or Towels

The Goal of the session is to:

• Help clients explore and gain increase knowledge of FASD - what it is and how much they know about it.
• Provide clients with an opportunity to discuss their own FASD diagnosis and express associated feelings
• Help clients explore how their brain work
• Help clients identify behaviours associated with FASD and the effect of these behaviours on school success and overall well-being
• Help clients distinguish between facts and myths about FASD
• Help clients embrace and work with their 'difference'

Handouts

• What I know about FASD
• What I would like to Know about FASD
• My experience of FASD
• My Brain
• Haiku
Learning Intention
Today we are going to talk about FASD—(what it is, facts and myths about FASD) and your experience of having FASD. The things we will discuss today will help you gain a better understanding of FASD and better self-knowledge about how FASD impact your life.

Engage – what to do

- Divide the group members into two groups—‘what I Know’ and ‘what I would like to know.’
- Distribute the appropriate handout to each group; allow some time to complete the task.
- Collect the sheet from the ‘what I would like to know group’, then ask the groups to swap [the ‘what I know’ group should now be sitting in the ‘what I would like to know’ section and vice-versa]. Again allow sufficient time. Once they have completed the task, collect the sheet from the group.

For individual clients—have a discussion on what they understand about FASD, be curious about their knowledge.

Discussion questions

Let’s think about your values for a moment…

- What do you know about FASD?
- What causes FASD?
- How common is FASD?
- What does FASD affect?
- Do you understand how your brain work?
- What is helpful?
- What are you good at doing?
- What is hard for you?
- What has your experience been like?
- How do people treat you?
- What would you like people to know about FASD or you in particular?
Learning Activities

Activity 1: Myths about FASD

What you will need: [Chairs in a circle, small pieces of paper, pens and large sheets of paper].

- Hand out 3 small pieces of paper to each group member and ask them to write on each one a statement they have heard about FASD (this need not be something they agree with; you can also probe by saying what have you heard about—what is FASD? What causes FASD? How common is FASD? What does FASD affect? Who gets FASD? Can you tell if someone has FASD by the way he or she look?).
- Collect the small pieces of paper and deal them out at random.
- Divide the group members into two roughly equal groups.
- Distribute a large sheet of paper to each group with headings 'AGREE', 'DISAGREE' and 'DON'T KNOW' on it. Ask group members to sort their small pieces of paper into each of these columns, reaching agreement on where each statement should be placed.
  - When they have done this, both groups should be asked to talk about their decisions to the main group as a whole.

Activity 2: My Experience

- Ask participants to take some time to discuss in groups what their experiences have been. They may discover some of their experiences are similar, and some are different.
- Ask them to write down their experiences---using the table; indicate which ones are similar to others in the group.

Activity 3: My Brain

- Distribute the handout ‘my brain’, ask participants to use this as a representation of their brain and illustrate what is happening for them. Tell them they can be as creative as they wish, there is no right or wrong way to illustrate your brain. [This should give you an idea about brain processes—you will likely receive a broad range of drawing.]
- They may also opt to do their drawing and not use the handout. Some of my clients have produced some incredible depictions of their brain.

Activity 4: Things we would like people to know

This can be a fun activity for clients. Provide a large poster paper and ask the group to brainstorm as many things they would like people to know about them. This can also be done with individual clients.
Learning Activities

Activity 5: HAIKU

ALTERNATIVELY, Get Participants to do HAIKU—Short poem that use sensory language to capture feelings, or images with regards to FASD. These can then be posted on a wall, almost like a collage. [They can also do both depending on time and interest].

Directions

- Have participants write a HAIKU expressing ideas, thoughts, and feelings about FADS. A haiku is a three-line poem with 17 syllables, as follows: first line—five syllables; second line—seven syllables; third line—five syllables.
- Create a collage of haikus on an FASD.

This is an example a client once wrote in a session.

If Only
I wish I never had
this FASD thing, whatever it is, then
I could choose for myself

INSIGHTS

- How did you feel about talking to someone else about your experiences?
- What was difficult?
- Were you surprise that you had things in common with others?
- How did you feel knowing that some others had similar experiences?
- Ask for volunteers to share their illustrations/drawings with the rest of the group.
- Is this your most consistent thought/feelings/emotion?
- Is the image always like this?
- Why do you think it is this way?
- What was your experience of doing this exercise?
- Could you identify with any of the challenges others spoke about?
REFLECTION CIRCLE

Today we talked about FASD and the brain. As you think about the things we did today,

1. Did anything happen today that made you re-think your thoughts and feelings about FASD?
2. Did you discover anything that surprised you about FASD?
3. What was helpful about today’s session?
4. Before this discussion what was your opinion about your behaviour? What were your views on your challenges?
5. Now that you have more information, how do you feel or think?
6. Think about how you behaved in the past, will the information help you think about your disability differently?
7. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present

HOMEWORK

Encourage participants to continue to practice mindful breathing at home

KEY POINTS

- Understanding your brain help reduce stress and frustration
- Practicing mindfulness techniques can help improve attention and impulse control and other functioning.
- Having FASD does not define who you are?
- FASD impacts the way you receive, process, store and give information
- Although individuals with FASD have some similar experience, everyone is unique and will likely have different experience.
Chapter 10

1. What I know about FASD

2. What I would like to know about FASD

3. My experience of FASD

4. My brain

5. HAIKU
Write a list of your experiences of having FASD (successes, challenges, frustrations etc.)
Chapter Eleven
Resilience Thinking
Resilience Thinking

As a clinician understanding resilience and its practical implementation will assist you in understanding, nurturing and empowering young people with FASD. In this module you will read about ways to enhance resilience in young people with FASD.

Young people with FASD face a range of challenges and experience a range of stressors including those in the areas of emotional, mental, education, relationships, legal, and overall wellbeing. Most young people with FASD live in families and households who can no longer cope with multiple and complex problems. As a result, they may not be having their physical, social and emotional needs met, and are often deprived of basic supports and services for prolonged periods of time. Many feel powerless and incompetent to do anything about the situation and some express a sense of hopelessness and helplessness. Further, young people with FASD are made more vulnerable and consequently less resilience by compounding risk factors. These risk factors are characteristic of contexts dominated by poverty, violence, abuse, low socio-economic status, mental illness, substance misuse, and intergenerational histories of: emotional dysregulation, trauma, substance use, school dropout, mental health issues, marginalization, among others. These risk factors are driving many young people with FASD into crisis month after month.

When working with young people with FASD, the focus is often too narrowly placed on their complex needs and problems. Such focus misses both the internal and external sources of resilience in the lives of these young people. In using MIRTS, clinicians are encouraged to shift their attention from merely engaging a young person with a problem orientation and risk focus, to a resilience thinking approach that also seeks to understand and develop the strengths and competencies.

Resilience thinking in practice is two-fold. Firstly, it offers a different way for clinicians to understand their own resources, training needs, collaborating with others and critically think about the systems of care they engage. Secondly, it is a way for clinicians to understand the abilities and resources that a young person with FASD brings. Clinician using a resilience approach embraces the inherent strength, competencies and complexities of these young people, and to seek to understand the components that must be enhanced to
help young people transform their lives in meaningful ways. Resilience thinking opens up an alternative to working with young people with FASD as individuals with agency and not merely individuals with deficits and problems to be solved.

With a resilience thinking mindset, clinicians can assist young people in understanding, negotiating and navigating resources, as well as engage and interact with young people with FASD in ways that invite a curious exploration of ‘what a young person with FASD can do and what can be’. 
Below is a graphical representation of resilience thinking approach.

- Clinicians
  - Being aware of their training needs and enhancing their knowledge and capacity to support young people with FASD
  - Having an understanding and knowledge of available resources
  - Collaborating with others to provide holistic care

- Resilience Thinking
  - Understanding contexts and level of appropriation (e.g., social, cultural, familial, FASD, trauma histories, resilience pathways and vulnerability pathways)

- Young people with FASD
  - Being responsive to needs and validity
  - Building capacity to self-regulate and manage change
  - Building on existing strengths and scaffolding new learning
  - Assisting clients to navigate and negotiate services and resources
  - Promoting a sense of agency and providing opportunities to thrive

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Conceptualizing Resilience?

Resilience mean different things to different people and there are many definitions of resilience. In everyday use, people think about resilience as the ability of an individual to bounce back from adversity. Using a Biopsychosocial-spiritual (BPSS) conceptualization, I propose a cross-cutting definition of resilience for FASD-informed care that expands on the previous definitions of Masten (2001) and Ungar (2011) with the varied components of resilience reflected in their definition, which I hope can serve as a foundation for ongoing work in the FASD field. In the context of FASD and substance use treatment, resilience is conceptualized as nurturing growth, working collaboratively and creatively to advance the skills of young people with FASD by building on their strengths and early learning, and scaffolding new learning. It is helping young people with FASD understand, negotiate and navigate resources. It is also about developing their coping resources, building their capacity to self-regulate and manage change, reinforcing & sustaining positive behaviours and relationships, validating their concerns and feelings, and providing opportunities for them to thrive and become contributors to society. Further, resilience also encompasses their personal resources, effective responding, and intentionality that protects them from life challenges and results in well-being. Young people with FASD with enhanced resilience capacities will demonstrate better social, emotional, behavioral, or health outcomes that reflect a healthy sense of being, belonging and becoming.

In essence, the approach to resilience presented here considers resilience to be about: emphasizing strengths, creating opportunities to thrive, learning, validating, connectivity, negotiating and navigating available resources, managing change, building a sense of agency and empowering them to try things. It is important to remember that young people with FASD may not display the same level of resilience in all circumstances. A young person may demonstrate more resilience capabilities in one situation and less in another. Building resilience in the context of this curriculum is based on research that highlights the importance of taking a multidimensional approach. In preparing to build resilience in the young people with FASD, it is important that clinicians make an effort to practice these interrelated concepts into the work you do.

1. **Alliance**—effective methods to building the resilience of young people with FASD include active and positive partnerships with them, their families, and community services (health & social). Young people with FASD who feel supported and encouraged to engage in the processes that impact their lives and who are connected to their change or therapeutic goals are less likely to resist engagement with service and are more liable to experience a positive outcome. Clinicians who take action at relational, organizational, and pedagogical levels ensure the inclusion and participation, as well as, the provision of safe and caring therapeutic environments for young people and their and families.

2. **Coaching**—all clinicians have a role in enhancing the capabilities of young people with FASD. The goal should be to use strategies that foster the skills of self-awareness, self-regulation/self-management, social awareness, and social management, which are the fundamental when building resilience. Young people with FASD, who participate in services that are appropriate to their needs will demonstration improved outcomes, show more positive social behaviour, and are less likely to engage in risky and disruptive behaviour, including alcohol and drugs use.

3. **Linkages and referrals**—as clinicians we play a fundamental role in the identification of the multiple and complex needs of the young people they work with. Our ability to link them and their families to seek help from the appropriate service providers are useful in helping them navigate services and resources.
4. **Scaffolding**—Clinicians are well-placed to notice young people with, emotional, social or wellbeing needs and to initiate efforts to provide suitable support. Young people with FASD experiencing social or emotional distress will benefit from the provision of safe, non-judgmental and supportive therapeutic environment that facilitate the development of new skills.

5. **Validating**—validating what young people with FASD say means taking the time to understand them, the nature and context of their experiences and the emotional reactions and feelings. The feeling that one has been heard and validated is a critical component in helping young people with FASD to develop resilience. Such validation will prompt your clients to seek solutions to negative feelings.
Resilience Indicators

- Healthy Relationships
- Stress Management
- Mindfulness and Self-Regulation
- Emotional and Social Management
- Ability to Solve Problems and make Good Decisions
- Daily Living Skills and Resources
- Sense of Being, Belonging & Becoming
- Change Management
- Access to Transportation, Food, Clothing and Shelter
- Access to Information
- Access to Health Care
- Connection to Culture
- Resourcefulness
- Engagement with school
- Communication Skills
- Safety
- Self-care knowledge and self-care
- Access to employment and vocational training
- Access to counselling and support services
- Healthy self-concept and worldview
- Meaning Making
- Regulation of emotion and arousal
Why is it important for clinicians to build resilience?

Resilience provides insights about a young person sense of being, belonging and becoming, on the one side; and on the other, being, belonging, and becoming tells us of the relationship between wellbeing and resilience. Inculcating resilience in young people is of vital importance. A resilience approach is always vital when working with young people, it is particularly important when working with young people with FASD as they are contending with the complexities that FASD bring, as well as, with the transition from being a child to an adolescent to a young adult and the challenges this bring: physical, psychological spiritual and social development (e.g. managing mood fluctuations, dealing with romantic relationships, developing an independent identity and school and work demands). The extent and complexity of difficulties experienced by young people with FASD can invite individual or family blame and negativity. Similarly, the term ‘risk’ is regularly used when discussing young people with FASD. However, it is important that deficits, problems and difficulties do not come to define these young people. A resilience-informed approach acknowledges the positive aspects of the young person and looks for exceptions to problem-saturated descriptions. A resilience approach looks for what young people with FASD do well, how they have tried to overcome their problems and explore their aspirations and hopes and build their capacities, as well as, build in supports that promote and sustain change.

Building the resilience capabilities of a young person with FASD is particularly relevant as a coping strategy in response to the challenges they face in that the need for them to rely on substance use as a coping mechanism will likely be reduced or removed. By providing support that explicitly foster the development of psychosocial skills (for examples, self-awareness, self-regulation, social awareness, social management and creative thinking, problem-solving); clinicians can help these young people establish a range of sustainable alternatives to substance use as a way of coping with life’s challenges. In this way, the agency of each young person is recognized and respected which maximizes the likelihood of engagement and minimizes resistance. Young people with FASD who are supported to enhance their self-resilience are better able to cope with challenges and mental health distresses, perform better at school, behave more positively, and have greater life opportunities (including employment and relationships). Thus, promoting the resilience capacity and well-being of young people with FASD should be a part of the core responsibilities of clinicians.

How can clinicians strengthen the resilience capacity of young people with FASD?

Individual as well as family resilience is something that can be developed over time. Young people with FASD can be supported to develop knowledge, skills and confidence to cope with challenges and changes. There are many ways that clinicians can promote resilience; below I articulate several categories that, if adequately addressed, will contribute to improved resilience and wellbeing. This is by no means an exhaustive list; it merely presents an example of what you can do to build resilience in young people with FASD. Work collaboratively with the young person to identify internal and external resources.
### Specific Domains that can be Targeted

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<th>Type of Resources</th>
<th>What might this involve as a clinician</th>
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| Help build a sense of self | 1. Help build self-efficacy  
2. Help build self-esteem/confidence  
3. Encourage a sense of agency  
4. Build motivation  
5. Encourage expectations for improvement and change  
6. Encourage self-empathy and acceptance  
7. Help them to recognize personal qualities and achievements  
8. Help them to identify their values and their strengths  
9. Utilize narrative practices to help young people with FASD tell stories about their lives in ways that make them stronger and more hopeful about the future. |

Resilience is strongly linked to an individual’s sense of self. Those who have positive self-regard are more likely to maintain personal well-being. It is important for young people with FASD to see themselves as powerful, valued and constructive contributors to their lives, their families and their communities. A young person’s sense of self-influences his/her capabilities across all areas of development.

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<thead>
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<th>Type of Resources</th>
<th>What might this involve as a clinician</th>
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| Sense of safety and stability | 1. Comfort them in every way you can  
2. Help them identify people and demonstrate protective behaviours that help keep themselves safe and healthy  
3. Assist them in recognizing actions that help them be healthy and safe  
4. Teach them to manage and resolve crisis situations and how to take responsibility for their safety.  
5. Build the capacity of parents, guardians and significant others to provide adequate support and protection  
6. Provide a space for them to explore their thoughts, feelings and behaviours without feeling judged, told off or shamed.  
7. Help them establish a routine to reduce frustration and increase organization. |

The capacity of a young person with FASD to be resilient also requires a degree of safety. Crisis situations often manifest when those responsible for their care (parents, extended family, foster parents) do not have the capacity to deal with stressors and/or provide adequate support and protection, as well as when the physical and emotional safety of young people is compromised or threatened. Masten (2001) points out that it is most often the young people who contend with the greatest adversities that do not have the protections offered by adequate resources and social ‘scaffolding’ capable of regulating their exposure to risk.
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<th>Type of Resources</th>
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<td>Teach emotional skills</td>
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<tr>
<td>– Self-awareness</td>
<td>1. Assist them in identifying their emotions and describe situations that may evoke these emotions</td>
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<tr>
<td>– Self-regulation</td>
<td>2. Equip them with the vocabulary for talking about their emotional and behavioral responses to situations</td>
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<td>3. Support them to recognize and understand their feelings and how to respond to these feelings in different and appropriate ways.</td>
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<td>4. Assist them to recognize and identify how their emotions influence the way they feel and act</td>
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<td>5. Help them to express their emotions</td>
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<tr>
<td>6. Constructively in interactions with others</td>
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<tr>
<td>7. Enable them to recognize they have some degree of power over the outcome of emotionally destabilizing events</td>
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<td>8. Provide and enhance cognitive emotion regulation strategies such as impulse control, attention control¹ and cognitive reappraisal² (for example, you could direct participants to think of 4 responses to a situation before deciding on a response, this way they can slow themselves down and pick the best option without being impulsive or reactive).</td>
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<tr>
<td>9. Build distress tolerance capacity</td>
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<tr>
<td>10. Enhance or teach self-discipline</td>
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<tr>
<td>11. Develop capacity to work independently and take initiative</td>
<td></td>
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<tr>
<td>12. Teach verbal mediation (self-talk) and inhibitory control (e.g., feeling charade or pictures to teach cognitive labeling of emotions—by deconstructing situations in this way, it makes it possible for the young person identify the opportunities to exercise control over the outcome of an event).</td>
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<tr>
<td>13. Provide training in how to handle stress and interpret cues</td>
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<tr>
<td>14. Provide exercises designed to enhance an attitude of commitment, control and challenge</td>
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<tr>
<td>15. Help them work through emotional barrier, e.g. shame, embarrassment,</td>
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<tr>
<td>16. Help them to develop reflective practice</td>
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<tr>
<td>17. Help them to identify, build and focus on personal strength and capacities</td>
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<tr>
<td>18. Help them put their thoughts, feelings and behavior in context to their situation and normalize their experiences in order to support them to make choices from a position of understanding themselves and likely consequences of their choices.</td>
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<tr>
<td>19. Encourage mindfulness (meditation, tai chi, yoga, kijong)</td>
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<td>20. Enhance their capacity to reflect and reframe</td>
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Helping young people with FASD to develop, and enhance the knowledge, attitudes and skills necessary to understand, manage and communicate about their feeling is critical for enhancing personal resilience.

If young people are empowered to sustain their emotional wellbeing, make positive choices and cope with challenging situations they will be in a better position to mitigate the ‘push’ factors towards substance use.

¹ Attention control consists of selectively attending towards or away from certain stimuli (either internal or external) in order to change their emotional impact (Ochsner & Gross, 2005).

² Cognitive reappraisal involves reframing a situation in order to change the emotional impact. In context of stress, this could involve changing one’s appraisal to another less-threatening or more positive interpretation of the event (Gross & Thompson, 2007).
<table>
<thead>
<tr>
<th>Type of Resources</th>
<th>What might this involve as a clinician</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Social skills</strong></td>
<td>Social skills involve the processes through which young people develop, extend and enhance the knowledge, attitudes and skills necessary to understand, manage and communicate about their emotions, feel and show empathy for others, establish and maintain positive relationships. Positive relationships are at the core of a young person’s social and emotional development</td>
</tr>
<tr>
<td><strong>– Social awareness</strong></td>
<td>1. Teach awareness for the feelings, needs and interests of others</td>
</tr>
<tr>
<td><strong>– Social management</strong></td>
<td>2. Teach appropriate ways to respond to the needs, feelings and interest of others</td>
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<tr>
<td></td>
<td>3. Help them to acknowledge that people hold many points of view</td>
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<td></td>
<td>4. Help them to Understand relationships</td>
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<td></td>
<td>5. Assist them in developing effective communicate strategies</td>
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<td>6. Encourage them to work collaboratively</td>
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<td></td>
<td>7. Help them to negotiate and resolve conflict effectively</td>
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<td></td>
<td>8. Help them in setting boundaries and respecting boundaries of others</td>
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<tr>
<td></td>
<td>9. Teach them assertiveness skills</td>
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<td></td>
<td>10. Help them to identify people and situations with, which they feel a sense of familiarity or belonging</td>
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<td>11. Help them to identify situations that feel safe or unsafe, and ways to approach new situations with confidence</td>
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<td></td>
<td>12. Help them identify positive ways to initiate discussion or communicate their needs, or concerns</td>
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<td></td>
<td>13. Help them to explore and identify options when making decisions to meet their needs and the needs of others</td>
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<td></td>
<td>14. Encourage them to listen to others’ ideas, and recognize that others may see things differently from them</td>
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<td></td>
<td>15. Assist them to identify ways to take responsibility for tasks at home and school</td>
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<tr>
<td>Type of Resources</td>
<td>What might this involve as a clinician</td>
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</tbody>
</table>
| **Help build healthy relationships** | 1. Help them build trust  
2. Encourage the development of healthy boundaries  
3. Encourage them to have positive, nurturing relationships and connections in their lives  
4. Help them to identify the strength and importance in relationships, and work on how to improve their relationships.  
5. Encourage cultural connection and participation  
6. Help them tap into good influences                                                                 |
|                                   | Resilience is also fostered through positive relationships. A sense of connectedness or belonging to the family, peer group and school is one of the most important protective factors for young people. When young people with FASD have good relationships in their life, and they belong to families, friends, and communities that accept them as they are, this helps them create a good sense of self and identity. Moreover, when they feel they are cared for by people at home, and their peers and feel connected, in general they are more likely to be motivated, show improved outcomes and self-efficacy. Social and cultural connectedness is also associated with a range of physical health and mental health outcomes. Young people with FASD with a higher level of connectedness are less likely to abuse substances. Continuity of relationships is also key to helping young people construct their identity and develop a strong sense of belonging.  
Friendships sustain healthy psychological development as they support young people in their emotional and social growth. Young people impacted by FASD, who have a strong circle of friends have a greater sense of well-being, better self-esteem and fewer social problems than individuals without friends.  
Clinicians can help by trying to encourage good relationships with friends, family and others. It is important that your clients have somewhere they feel that they belong (e.g., activities, school, relationships with animals) and that they encounter people who are good influences, who help them make a sense of where they come from and their place in the world. |
The table below provides examples of risk and protective factors that can likely impact a young person’s resilience.

<table>
<thead>
<tr>
<th>Area of Focus</th>
<th>Strength and Protective Factors</th>
<th>Risk Factors and areas for change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Resources</td>
<td>▪ Sense of humour ▪ Inner strength ▪ Optimism ▪ Self-control ▪ Thinking skills ▪ Confidence and self-esteem ▪ Participation and engagement ▪ Positive outlook ▪ Future oriented</td>
<td>▪ Consistent negative thought patterns ▪ Developmental delays ▪ Difficult temperament ▪ Defense Mechanisms (e.g., catastrophizing)</td>
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<td></td>
<td>▪ Emotional dysregulation ▪ Substance use ▪ Trauma &amp; Grief ▪ School drop out ▪ Mental illness ▪ Loss of culture ▪ Poverty, Crime and violence</td>
<td>▪ Diminished parenting capacity ▪ Disrupted parenting ▪ Harsh parenting ▪ Parental incarceration ▪ Family stress ▪ Long and extended history of family and or parental physical and mental health concerns posing cumulatively impacting the young person’s emotional and developmental outcome</td>
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<tr>
<td></td>
<td>▪ Warm attachment with grandparents, aunts, uncles and cousins ▪ Support from relatives</td>
<td>▪ Disunity and lack of connection</td>
</tr>
<tr>
<td>Family History</td>
<td>▪ Cultural continuity, assimilation and integration ▪ Family harmony ▪ Supportive parents ▪ Adaptive family functioning</td>
<td>▪ Physical concerns ▪ Co-occurring mental health and developmental disabilities</td>
</tr>
<tr>
<td></td>
<td>▪ Positive parent/child interactions, relationships, physical safety, adequate care, love, affection, opportunities for positive engagement in activities ▪ Parents making progress in addressing concerns.</td>
<td>▪ Skipping school ▪ No support at school ▪ No friends</td>
</tr>
<tr>
<td></td>
<td>▪ Support in place at school ▪ Attend school regularly</td>
<td>▪ History of abuse ▪ Little social network, or isolation</td>
</tr>
<tr>
<td>Relationships</td>
<td>▪ Positive and attached sibling relationships ▪ Supportive friends</td>
<td>▪ Lack of service, poor access to service ▪ Marginalization</td>
</tr>
<tr>
<td></td>
<td>▪ School, counselling, social services, mental health ▪ Inclusion &amp; Participation</td>
<td>▪ Financial difficulties ▪ Few informal community support and resources ▪ Discrimination ▪ Lack of opportunities for positive engagement and advancement</td>
</tr>
<tr>
<td>Support Services</td>
<td>▪ Community support services ▪ Access to care ▪ Employment opportunities</td>
<td>▪ Unsafe and unstable housing ▪ Homelessness</td>
</tr>
<tr>
<td>Social Factors</td>
<td>▪ ▪ ▪ ▪ ▪ ▪ ▪</td>
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</tr>
<tr>
<td>Housing</td>
<td>▪ Family has stable housing, well suited to nurturing growth and safety</td>
<td>▪</td>
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</tbody>
</table>

Note: It is critical that you do not assume culture is a risk factor – connection to culture and community is protective for young people. For example, culture and the maintenance of culture is central to healthy infant development and identity formation in Aboriginal communities.
References


Other References Consulted


Reflection Questions

1. Do I recognize growth in young people with FASD?
2. What are the strengths of the young person and what strengths can the young person build on?
3. How can I remain responsive to the needs of young people with FASD?
4. How can I provide a safe and supportive environment in which all Young people with FASD can maximize their potential?
5. How can I assist young people with FASD to develop their ability and skills to cope with challenge and stress?
6. How do I map protective resources and establish protective mechanisms to buffer the impact of multiple risks for young people with FASD?
7. Do I promote a sense of agency?
8. How are the problems being experienced by the young person related to each other?
   ○ For example, is a youth’s substance use linked to his/her current or past experience of abuse? Is the family’s lack of money and transport preventing the young person from accessing support?
9. What is the young person’s view or attitude towards his/her experience; does the young person normalize or minimize it?
10. What are the strengths of the family?
11. Who are the significant adults in the young person’s life?
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients explore what resilience is
- Help clients combine their knowledge of resilience with concept of wellbeing
- Help clients apply their knowledge and practice of resilience in their own life
- Help clients nurture personal growth

Handouts

- Resilience tree
- Belonging Web
CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to talk about resilience. This will help you understand resilience and why it is important. The questions and activities will help you discover themes, patterns, stories and connections in your life that can enhancing or hinder your capacity to be resilience.

Engage – what to do

On index card get each participant to provide three words they think best describe resilience and then place their ideas on the board, alternatively engage participants in speaking about their understanding of resilience and use their response to develop a resilience map.

Discussion questions

Let’s think about your values for a moment…

- What is resilience?
- Can you remember a time when you did something really well? How did you feel?
- How do you engage with others? Do you calmly tell other people that you disagree with them?
- Can you recall a time when you did something well, and another situation when you did not do that same thing as well as you would like?
- If something bad happen, how do you usually deal with it?
- How do you handle change?
Learning Activities

Activity 1: Self-Awareness & Emotional Regulation

- Ask clients to think about emotions—what do they know about them? What are they?
- Ask them to write four of the emotions they feel more consistently on posit note.
- Divided the board into two columns—negatives and positives
- Get them to place their posit under the column they think is appropriate
- Discuss why the emotions are under each heading
- Ask how that make them feel
- Explain to clients that keeping a check on their emotions assists in knowing how to respond to certain situations and how best to move forward and learn about how situations make us feel
- Get clients to work on a list of emotions using letters of the alphabets—A –Z, alternatively you can provide them a list of emotions and a worksheet of exercise to complete, or use a difficulty in emotion regulating scale
- Discuss strategies clients can use to help regulate their emotions.

*For example,*

Self-soothing is an aspect of self-regulation; its absence leads to dysregulation. Dysregulation is the inability to modulate emotional and behavioural responses, which can result in addictive behaviours such as alcohol and drug abuse.

Activity 2: Optimism

- Ask your clients to think of as many thoughts they have had (e.g., thoughts such as “I am going to do well on my math test today”, or “I am going to try my best, my best is all I can do”).
- Explain to your clients that they will be exploring the things that go on in people’s mind which are called “self-talk.”

Activity 3: Belonging Web

Distribute the handout belong web, ask client to complete it to reflect their relationships and connections
Learning Activities

Activity 4: Impulse Control

We all have impulses to do things and say things – these are not always in our best interest, nor helpful to others. To be resilient doesn’t mean to stop these impulses, but it does require you to stop acting on every impulse that does not serve you well. These skills of impulse control can be learned

- Use the 10-second rule
- Use the four finger response before

These techniques may help stop participants’ automatic thought reactions (defensiveness, disconnections, criticism, sarcasm) to the comments of others, as well as prepare them for sensitive way of interacting with others. Provide participants with some scenario and then get them to write their reaction to those scenarios, create scenarios that are applicable and that participants would have most likely experienced at some point or another.

For example:

- When someone says something that you perceive as hurtful, you are worried about, or anger you:
- Pause: do not hastily react or respond
- Take three deep breaths to calm yourself down, so you can think or count backwards from 10 or 20.
- As you pause, focus on your dominant hand, use four fingers to consider four options or 4 ways to understand the meaning of the thoughts, feelings or behavior you just experienced

Example 1: your mum raised her voice and also forcefully told you how disappointed she is

1. If you felt criticized, hurt, or attacked, identify the thoughts, ideas, feelings or interpretation that you have and let that represent one finger.
2. Pick another finger to represent another negative interpretation of the possible intentions of the statement
3. With another finger imagine a positive interpretation
4. Finally, with the fourth finger imagine another positive meaning.
5. You can now calmly ask the person if the meaning was one of the positive ones. If not, ask for clarification

Provide your clients with some example scenarios to work through

Activity 5: Resilience Tree

Provide client with a picture of a blank to tree that represents their resilience. They can also draw their own picture. They can use the roots, stems, branches and leaves creatively.
REFLECTION CIRCLE

Today we talked about resilience and how we can enhance your self-resilience.

1. What stands out for you the most?
2. What have you been doing to improve your self-resilience?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

HOMEWORK

Provide clients with the reframing using mindfulness and resilience handout. Ask them to work on it over the next few days.

KEY POINTS

Wellbeing and resilience are important in coping with mental health challenges.

Some signs of resilience are:

- Coping well with change
- Ability to self-manage
- Having a sense of belonging
- Confidence to approach new situations and approach new people
- Being hopeful
- Realistic optimism
- Positive self-talk
- Ability to set goals
HANDOUTS

Chapter 11

1. Resilience Tree
2. Belonging Web
Use the tree below as a representation of your internal and external resources. Use every part of the tree (roots, branches, leaves, stem) to represent aspects of your life. Alternatively, you can add fruits, and leaves or you could draw your own tree. Be creative.
Having a sense of belonging is important. Use this web to illustrate your sense of belonging.
Chapter Twelve
Emotions
We all experience emotions. Experiencing and expressing emotions are integral parts of life, yet for many people, emotions remain confusing and difficult to express constructively. Emotions are central to one’s ability to adapt to the challenges of daily life. They influence how we feel subjectively, how we deal with events and how we interact with others. Emotions also affect the relationships we have with others.

Young people with FASD often have more emotional problems than their counterparts without FASD. They often have more dysfunctional and socially inappropriate ways of expressing emotion and tend to struggle with understanding and interpreting emotions. From my clinical experience and observations many young people with FASD

- May also have trouble controlling their behaviour and emotions. Others may find their hyperactive or impulsive behaviour irritating.
- Maybe very aggressive.
- May react angrily or inappropriately when they are upset.
- May have trouble cooperating with friends

Young people with FASD are confronted with some tasks and stressors specific to their disability. The secondary disabilities that often accompanies FASD can represent a risk to the emotional health of these young people, including anxiety, and depression. The consensus from most studies is that most individuals with FASD have difficulty with regulating their emotions and are not able to adapt very well to stressors.

Efforts to define the critical features of emotion have proven valuable in our understanding of emotional experience, expressions and the development of emotion knowledge. However, little direct attention has been given to the way young people with FASD express, interpret or understand their emotions. Hence, there is a need for qualitative studies of self-reported emotional experiences of young people with FASD. Below I provide some insights from my experience and observations of working with young people with FASD about their emotional experiences, how they understand, express and interpret emotions. This is by no means a systematic account, but it is hoped that my experience and observations will provide some insights that will
help you better understand how young people with FASD talk about emotions and hopefully provide you with some insights about how to support a young person with FASD to develop his/her emotional skills.

In my experience of working with young people with FASD, discussions about emotions and their understanding of emotion during individual and group sessions can be broken into two categories: (1) the context of their emotional experience and multifaceted nature of their emotions.

The Context of their emotional experiences
In this category what I learned is that clients often spoke about and experienced challenges leading to what they believed to be and described as mostly negative or difficult emotions. The emotional experiences were expressed in many forms. Concerning FASD itself, many clients mentioned specific implications of FASD, some statements reflected emotions related to either possessing or lacking information or knowledge about FASD. Anger was described as a reaction to finding out about having FASD, but this emotion was sometimes mixed with a feeling of confusion. Emotions such as anger, frustration, shame and sadness were described, in relation to any trauma, or in care placement. When in care, feelings of compassion and empathy appeared to be evoked through their surmising about the mental state of their siblings. Many clients spoke about their frustrations and fear about not fitting in. Often clients described emotional distress about school and home life.

What is apparent is that there appear to be many sources for negative feelings, for young people with FASD. Some young people with FASD cope by bottling up how they feel because they are not able to express their emotions appropriately while others tend to voice their feelings (sometimes based largely on incorrect interpretations of events) often in negative ways. As an example, one participant of a group session described: “I just feel so mad sometimes and other times I do not know how to feel so I run away from home because it is easier than trying to explain how I feel”.

Multifaceted Emotions
Common among young people with FASD that I worked with were descriptions of how they experience wide-ranging emotions. For example, one youth often spoke about how her feelings for her mother were composed of (1) anger because of her drug use; (2) frustration because of being in foster care; (3) sadness when thinking about her condition; (4) embarrassment because all her friends knew she was in foster care and that it is because her mum has been using drugs and (5) fear because she is afraid to trust anyone. Although varied, there are many examples like this. It appeared that talking about one feeling they had about an event or what someone said or did seemed to remind these young people of another so that the variability in emotional experiences often appeared continuously during conversations. Similarly, descriptions of worries for the future were often noted. Positive experiences of enrichment resulting from their life or interactions with others also noted. Some spoke fondly about times when they felt happy or excited. These enriching experiences were related to activities they did with their families or friends, or to personal growth stemming from their experiences. As an example, one client stated: I become a little happy I have to visit my mum and I look forward to hanging out.
But why do they get stuck?

One of my biggest realizations from my experience of working with young people with FASD is that they deal with many of the same emotions that we all do; they get angry, sad, frustrated, nervous, happy anxious, but quite often they do not have the words to talk about how they feel. Instead, a vast majority of them struggle to understand the emotions they are experiencing, to interpret events and what others say and do in a positive way and to express their emotion in a healthy way. While many can express emotions, what I discovered is that quite often they got stuck speaking about and expressing only the basic emotions such as sadness, fear, anger, frustration, happiness, surprise, and disgust. The only other emotions mentioned frequently were: embarrassment, anxiety, shame, pride, boredom and guilt.

As clinicians, you cannot fully comprehend the experiences of young people with FASD without understanding the role of emotions in how our brains work. Many young people with FASD tend to get quickly flooded with frustration, anger, worry, boredom, discouragement, or other emotions that crowd out other important feelings and thoughts. For some, the main emotions that overwhelm them are anger and anxiety. And it can be the result of things happening—or not happening—in the brain.

The human brain has a mechanism that allows it to modulate the intensity of experienced anxiety, frustration, discouragement, and so on. If those mechanisms for regulating, for example, anxiety works as it should, it would allow cognitive space for a young person with FASD to think about how to deal more rationally and realistically with stressors. When I young person with FASD say 'I didn't think, I just reacted', it is a result of their emotional brain responding to a threat, and a function of how a brain impacted by alcohol works. Thus, understanding how our brain works and how FASD impacts the brain will help you better support young people with FASD.

Our emotional brain is known as the Limbic System, which is responsible for emotion and emotional behaviour. There is a group of structures in the Limbic System including the frontal lobe, hypothalamus, amygdala, and hippocampus. Below are some images of specific areas of the brain that play key roles in emotions. It is important that as clinicians you have a good grasp of how the brain work and how FASD impact the brain for you to be able to be more efficient in developing the emotional skills of young people with FASD.
The amygdala are essential to our ability to feel certain emotions and to perceive them in other people. This includes pleasure, anger or fear and the many changes that they cause in the body. For example, if you are being threatened by someone, your heart may be rare quit quickly, chances are that your amygdala are very active.
The prefrontal cortex is where emotions, problem solving, reasoning, impulse control, planning and other functions are managed. However, the prefrontal cortex gets information only when the amygdala is calm.

The prefrontal cortex also seems to be involved in the final phase of confronting a danger, where, after the initial automatic emotional reaction, we are forced to react and choose the course of action that can best get us out of danger. In individuals whose frontal cortex is damaged, planning and the slightest task is very difficult, if not impossible.
Helping a young person to analyze and understand how his/her emotion work will go a long way to helping him/her control his/her responses. Understanding emotion is a critical part of a young person’s overall development. Helping young people to develop awareness of emotional processes in themselves, and using words to identify emotional experiences can improve social awareness and self-control.

As clinicians, we need to teach young people with FASD to understand, interpret and express their emotions in appropriate ways. They are experiencing so many intense, but also exciting emotions. It can be overwhelming, and as such we need to ensure that we help them validate their emotions and understand their emotions rather than being afraid of it, or labeling it as right or wrong, negative or positive.
Feelings can be difficult to express for a variety of reasons. You can help a client develop positive ways to express his/her emotions by:

1. Helping them develop the comfort level and use of their words to explain their feelings in a way that expresses emotions constructively so people will react with understanding and support.
2. Teach them different ways we can deal with feelings. Talk about positive and not so positive ways to express feelings. Keep it simple, use visuals or pictures to help get your point across.
3. Use some of their experience to help bring context to their experience and situate their understanding in something that is real to them. For example, you could say yesterday you were angry because your mum would not let you go out with your friends. You were so mad that you slam your bedroom door. When you feel angry like this again, what can you do?
4. Alert them to pay attention to their body sensation. Each feeling has a particular way it impacts our body. For example, fear often starts in the belly; our shoulders usually get tense when we are angry. Teaching them to pay attention to their body sensation may also help in understanding what they are feeling.
5. Teach feeling words—we often only think of teaching common emotions like happy, sad, mad, etc., but there are many other feeling words that young people with FASD should learn to express feelings. I also find Plutchik’s wheel of emotions useful.

Reflection Questions

1. How do you support young people with FASD to become more aware of their emotions?
2. Think about how and why you might provide the information presented above differently for different individuals?
3. How do you support healthy emotional expression?
4. How do you support young people with FASD in expressing their feelings and showing their concerns to others?
5. How do you give opportunity and instructions to express emotions constructively?
6. How do you support your clients so they feel able to express their fears, explore their options for interpreting events and validate and accept their feelings?
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels
- Water
- Bucket, paper cups
- Lime, spoons
- Emotional dice (made from Paper)

The Goal of the session is to:

- Help clients understand and express emotions and feelings.
- Help clients explore their emotional experiences.
- Help clients learn to incorporate emotions into their life in healthy ways, including how to express them in ways that are conducive to building healthy relationships.
- Help clients identify, express, value and accept their emotions.
- Help clients increase awareness of emotions and identify times when they are felt.
- Help clients understand the role feelings play in maintaining a sense of wellness and strength.
- Help clients increase or decrease emotional energy in keeping with the situation
- Help clients learn mindful ways to work through emotions/feelings.

Handouts

- Emotional Meter
- Draw your Emotion(s)
- Emotion Iceberg
- Emotional Development
- Naming Emotions
- Emotional Monitoring Form
- My Emotional Health Journal
CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

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Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to talk about emotions—what it is, how you experience and express it. You may be coping by denying your feelings or shutting them down. You may also block them with your mind, with eating or not eating, with drugs, alcohol, or cigarettes, or other habits that can lead to difficulty. While at other times you may act on your emotions without thinking of the consequences, by saying and doing things that you later regret. The questions we will discuss, and the activities we will engage in will guide you towards thinking about healthy ways express your emotions.

Engage – what to do

It has been noted that language is closely related to our visual processing system. Expressions such as “blowing a fuse” “blowing off steam”, and “this is getting on my nerve” all reflect how our brains process language and emotions in a visual way. You can take advantage of this to begin a discussion on emotions. Start by drawing a picture that will represent different emotional states. It can be a glass, a bottle, an odometer, a traffic light, or even just a circle.

Discussion questions

Let’s think about your values for a moment…

- Do you often feel like your emotions are out of control?
- Do you blow up over minor incidents?
- Do you fly off the handle at people who do not necessarily deserve it?
- Do you feel numb even though something upsetting has happened?
- Do you find yourself wanting to cry over anything?
- When you are experiencing difficulty with a friend or family member how do you react?
- When you feel angry what does that look like?
Breaking it down

What is emotion?

Emotions are what you feel on the inside when things happen. Emotions are also known as feelings.

For example:

- **Depressed**: feeling sad, blue, discouraged, and unhappy
- **Embarrassed**: feeling worried about what others may think
- **Excited**: feeling happy and stimulated
- **Angry**: feeling mad with a person, act, or idea
- **Afraid**: feeling fear and worry
- **Ashamed**: feeling bad after doing wrong
- **Confident**: feeling able to do something
- **Confused**: feeling unable to think clear

Identifying Feelings

*Explain to clients that:*

- There are times when we are unable to name exactly what we feel, and that identifying our feelings may require us to take the time to focus on ourselves and our emotions, rather than someone's action.

*Let them know that:*

- The relationships between the events in their life and their feelings will be less clear if they have difficulty identifying what they are feeling.
- If they find it difficult to notice or name what they are feeling, it may require that they pay some attention to their body, the sensation they are experiencing and where in their body they are feeling their emotions, because most are experienced in the body. For example, anxiety may show up like a knot in their stomach or sweaty hands.
- Feelings are also connected to their behavior. If you are not sure how you feel, but you realize that you are acting in a way that sends a clear message to others, you may be able to **understand** what you are feeling from your behavior. For example, if you have an angry facial expression or tone of voice when you are talking with a sibling, it may be that you are angry or frustrated with your sibling without recognizing it.
- They may find it helpful to make a list of various feelings (e.g., sadness, fear, insecurity, shame, etc.) and spend some time reading the list to see if you are aware of having experienced some of these.

Accepting and Valuing Your Feelings

Talk to your clients about accepting and valuing their emotions. *Let them know that:*

- We all experience emotions, they are an important part of living and interacting. There are many sources of information we use to help motivate us, guide us and help us make sense of things. (e.g., our thoughts, our senses, our emotions, etc.).
There may be a strong relationship between the events in our life and our feelings—for example; you may likely feel sadness in response to the loss of a close friend, or feel happiness in response to achieving something, like winning a race.

Feelings may also be related to past events or even to our expectations of the future. For example, feeling anxious about an upcoming test. These feelings can be an important source of information as well. Sometimes we ignore our feelings by pretending that we are not bothered and other times we exaggerate our feeling by behaving inappropriately. Rather than ignore or exaggerate your feelings, the healthy way is to take your feelings as they are, accept them, think about them, and learn from them.

When you are feeling something consider asking yourself the following kinds of questions:

- What is this feeling?
- What is this feeling telling me about this situation?

### Three roles emotions play:

**Communication**

- Emotions are used to communicate what we are feeling. We communicate our emotions by our faces, our voice tone and volume, our posture, and our gestures. Often, other people can tell what we are feeling by observing our behaviour, body language or tone of voice, even when we are trying to hide it.

**Motivation**

- Emotions tell us to “ACT NOW!” and “STAY FOCUSED”. They give us motivation to change a situation. Strong emotions can help us overcome problems, or difficulties—in our mind and in the environment (e.g. when you lift a heavy rock off a friend due to fear of losing him/her, or someone expresses an opinion to a manager due to anger). I don’t understand how this 2nd example relates? ie how it overcomes a problem

**Validation**

- Emotions can be information about a situation. Think of a time that you had a “gut feeling/instinct” in a situation. Emotions can be SIGNALS or ALARMS.
First Reactions and Interpretations

Let clients know that:

- Often our feelings are related to our interpretations of what someone said or did as well as our interpretations of events, more than to the events themselves or what was said and done. We make interpretations or judgments of things that are said and done, and these interpretations play a fundamental role in our emotional responses. When you stop to think about it, you then realize that each event could produce a range of emotional responses; our interpretation of an event helps link a particular emotional response to that event.

- Similarly, when we first hear an idea, our first reaction is likely to be based on feelings/emotions. For example, if you are speaking to you parents about house chore you may likely react by saying things like:
  - This is very unfair
  - I do not like that I have to do all the dishes.

- First reactions can add liveliness to situations, or it can complicate a situation if the idea is being misunderstood or if you are too quick to put the idea in a ‘box’ when it does not fit in there. So it is important that we slow down and think about what is being said before we make assumptions or judgments.

Consider the following: Explore the cycle that often characterizes emotional experiences.

Adapted from Ellis, (1996)
An event triggers automatic thought, which leads to an emotional experience, which in turn prompts a response. The aftereffects of that reply then start the cycle anew. For example, if Tommy fails an exam, he might experience an automatic thought along the lines of "I am not smart enough." This idea will lead to intense feelings of shame and sadness. After worrying in this upsetting series of thoughts and emotions, Tommy may then attempt to change his mood through a behavior like not eating, or frequently crying. Tommy’s continual focus (ruminating) about the event may be followed by more intense feelings such as anxiety about exams or lying to his friends about his results.

- **Event**: something happens.
- **Interpretation**: how you understand what happened
- **Emotional experiences**: changes in the brain, face, body, sensations, and action urges — biological, involuntary, automatic, and autonomic reactions to your interpretation.
- **Emotional expressions**: body language, facial expressions, words and actions — YOU CAN CONTROL THIS: expressions are intentional because you do not have to act on your urges, and at this point, you can also use your physical experience to recognize and name the emotion.
- **After effects**: consequences of your actions — memories, thoughts, physical functioning, behavior, and secondary emotions, e.g., shame in response to expressing anger inappropriately.

**Explain further by providing an example like the one below;**

- Here, an event can be any experience in their life—for, e.g., taking part in the school track meet. Get them to consider the example of two friends running a race and achieving the same result, or outcome—third place, but interpreting their result in the race in dramatically different ways. One friend interpretation might be, “Wonderful! I got a medal, that was a tough competition, but my hard work paid off!” Now, imagine the other friend interpretation to be, “that sucks! I trained so hard, and I did not even win the race. I am so disappointed all that hard work gave me a mere third place”. The result or outcome was the same for both; the different interpretations led to the opposite emotional responses.

**Tell them that:**

- Their interpretations can be made so quickly and so automatically/robotically that they may not realize they are happening. When our emotional reaction is erratic or unfitting to the event, it is most likely due to our interpretation of that event, more than to the event itself.
- Specific types of interpretations, rather than specific types of situations, produce specific emotions.
- The same situation can be interpreted in many different ways, and thus, can provoke many different emotions.
- The ‘same’ event is likely to have different meanings in different relationships and thus, to result in different emotional experiences, as well as different types of emotional expression.
- Our emotions can be an important signal to us that we may need to re-examine our interpretation.

**Explore**

- Examples of self-defeating ways people think about and interpret the events of their lives
Here are some common examples of self-defeating ways people think about and interpret the events of their lives:

- All or nothing/black and white thinking—interpreting events in extremes, (e.g., depicting events as wonderful or terrible, with no recognition of the grey areas in between).
- Excessive Personalization—automatically concluding that another’s behavior or mood is in direct response to you (e.g., “my mother is in a bad mood. I do not know what I did.”).
- Overgeneralization—seeing an event as having more impact, in more areas of your life, than it truly does.
- Filtering—magnifying negative events in your life and discounting positive ones.
- Emotional reasoning/rationalization: concluding that what you feel must be the truth (e.g., if you feel stupid, you must be stupid), or dealing with emotional stressors by justifying an already taken unconscious emotional action.
- Reaction formation is dealing with emotional stressors by altering an uncomfortable feeling into its opposite. (Cramer, 2003; Northoff, Bermpohl, Schoeneich & Boeker, 2007)

Encourage your clients to:

- Learn to recognize any tendencies they may have to misrepresent events through interpretational styles like the ones mentioned above.
- Practice choosing and committing to more valid or healthy interpretations.

Expressing Emotions

Let your clients know that:

- We need to be open to our feelings. We need to validate them for what they are, and we need to respect them as natural responses to the process of living. For example, when we are feeling sad we need to allow ourselves to cry if we need too.
- Just as they have choices about how to interpret an event or what is being said, they also have options about how to express those feelings they are experiencing. Quite often we limit our expressive options to two things: either directly expressing them to someone else (e.g., in a personal confrontation), or “bottling up” the feelings and keeping them to ourselves. However, in reality, there are many ways to respond to your feelings and express yourself. It is important to remember that to some extent, you express a feeling any time your behaviour is influenced by that feeling, but the way you express that feeling, and the intensity of that expression can fluctuate.
  - It is critical to consider what your options are. For example, if a close friend did something that you are not comfortable with. You have several options here. For example, you can tell your friend how you feel. Also, you can make a special effort to understand where he/she is coming from and ensure you are kind and gentle in telling them what you think. These give you the opportunity to express your feelings to your friend. On the other hand, you can ‘swallow’ your feelings and pretend to be ok with what your friend said, or you can avoid the friend, or you can stay busy with other friends so you will not have to spend time with this friend. These choices may allow you to postpone or avoid painful feelings at the time, but they do not provide the opportunity for closure with your friend.
Some useful questions to help a client consider when deciding how to respond to his/her feelings:

- What interpretations or judgments am I making about this event or situation?
- Do I have more than one feelings that I need to pay attention to?
- Does the intensity of my feelings match the situation?
- What are my options for expressing my feelings?
- What are the consequences of each option for me?
- What are the consequences of each option for others?
- What result am I hoping for?
- What do I want to do?
- What will happen if I do nothing?

Reinforce that:

Learning to experience their feelings fully and expressing them in ways that are healthy is not a simple process. Below are some key components that can help.

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References:

2. *Psychosomatics, 76:141–153*
Learning Activities

Activity 1: Exploring Emotions

- Divide participants into two or three groups depending on the number of participants.
- This activity might be better done outside (if it is warm). You will need water, a bucket, and some paper cups.
- Instruct participants to walk 100m balancing the cup of water on their heads. Once at the end of the line, he/she will hand the cup to his/her teammate who will walk 100m [if the cup drops, the group member will have to start from the beginning again] until they have all completed the task.

The team with the most water at the end of the challenge wins.

For indoors

- Use a lime and spoon: get participants to walk 100m or 50m to his/her teammate once, at the end he/she will hand the spoon over to their teammate who will walk 100m or 50m. The first team to cross the line with fewer drops of the lime wins [co-facilitator will need to record. Also, you may wish to ask one member from a team to purposefully drop the lime or the cup of water—this will open up discussion about frustration, etc.]

Activity 2: Emotional Meter

- Your clients have many different experiences. They all feel differently about each experience. Below is a list of different scenarios that can elicit different emotions and intensity of emotion. By getting your clients to express feelings about these scenarios, you can help them talk about and view emotions in a more positive way. Use handout: emotional meter to complete this exercise.

Example of some situational statements (Please note: you can, along with your client develop statements that are more personal to their experiences.)

- When I argue with my parents, I feel…
- When my friends bully me, I feel…
- Talking in front of the class makes me feel…
- When I use drugs, I feel…
- Friends make me feel…
- When I am having a difficult time understanding what others are trying to say, I feel
Learning Activities

Activity 3: Drawing your emotions

Ask your client or participants to draw a visual representation of the emotions that he/she is experiencing more consistently. Use the handout: Draw your Emotion(s).

Activity 4: Emotion Iceberg

The purpose of the activity is to increase awareness of hidden emotions. Tell clients that we tend to express some emotions frequently and other emotions we tend to bottle them up or keep them inside. Ask them to use the handout: emotion iceberg to represent the emotions they express and those that they keep hidden.

Activity 5: Emotional Development

The purpose of the activity is to determine participant’s and need for emotional development. Use handout: Emotional Development Questionnaire for this exercise. Alternatively, depending on the client, I sometimes use a simplified emotional intelligence (EI) questionnaire. When using an EI questionnaire I work collaboratively with the client to complete the questions, and then review both areas they are good at and those that we could work on together.

Activity 5: Naming Emotions

The purpose of the activity is to help clients identify an array of emotion. Pass out supplies. Require participants to write one emotion in each box and do not write emotions more than once. Encourage them to walk around and talk to each other to see if there are emotions that others have on their list that they do not have. To make this more fun, you can also turn this into a bingo game once all the boxes on their handout has been filled. Cut out a list of emotions into small cards. Pull out one note card at a time and read emotion to the group. Require participants to mark emotion with small rocks, buttons, small Lego or any other items that can be used to identify the emotion if they have it written on their sheet of paper. The first participant to get five in a row must read each emotion and tell a time when he or she felt that emotion.

INSIGHTS

1. What was the purpose of this activity??
2. What did you learn about emotions?
3. What did you learn about yourself?
4. What did you learn about others?
5. Why do you feel it is important to understand emotions?
6. How did you feel during the activity?
7. What do you typically do with your feelings?
REFLECTION CIRCLE

Today we talked about emotions—what it is, and how we understand and express it.

1. Did anything happen today that made you re-think about the way you express your emotions and feelings?
2. What did you learn about emotions?
3. Did you learn anything about yourself through the discussions and exercises?
4. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

HOMEWORK

Encourage your clients to keep track of their emotion throughout the week and how they work through challenging emotions. Distribute the handout: Emotion Monitoring Form.

KEY POINTS

- Emotions are reactions we have to things that happen around us that make us feel a certain way.
- Our emotional state can make us feel good, or can make us feel awful.
- Emotions can create very strong feelings in us but these intense feelings usually last for only a short time.
- We all experience emotions. They are an important part of being human. At any given time, we can experience a range of emotions.
- Many of you may experience a lot of emotional highs and lows throughout the day. Some of you are uncomfortable with feelings—perhaps your feelings are locked-up inside and you are unable to express what you are feeling.
Chapter 12: Unit 1

1. Emotion Meter
2. Draw your Emotion(s)
3. Emotion Iceberg
4. Emotional Development
5. Naming Emotions
6. Emotion Monitoring Form
7. My Emotion Health Journal
Emotion rating moving towards the right are more positive.

Emotion rating moving towards the left are more intense, may be difficult to find words to express, or not expressed at all.
Create your emotional iceberg. Use this example as a guide to create your own iceberg. On the top of the iceberg write all the emotions you express consistently. At the bottom write the emotions that you keep hidden. You can create different levels if you wish.
This self-assessment questionnaire is designed to get you thinking about your emotional strengths and to determine your need for emotional development.

Direction: Place a checkmark in column to identify your answer

<table>
<thead>
<tr>
<th>Emotional Skills</th>
<th>Yes</th>
<th>Sometimes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I like who I am</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I understand my feelings and emotional</td>
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<td></td>
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<tr>
<td>3. I know that I am good at doing somethings</td>
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<td>4. I learn from my mistakes</td>
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<tr>
<td>5. I know different emotions</td>
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<tr>
<td>6. I can cope with my feelings</td>
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<tr>
<td>7. I know activities to do when feeling angry</td>
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<tr>
<td>8. I always know when I’m being unreasonable</td>
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<tr>
<td>9. I do not let stressful situations or people affect me</td>
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<tr>
<td>10. I can motivate myself to do an activity when I feel down</td>
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<tr>
<td>11. I often hide how I am feeling about things</td>
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<tr>
<td>12. I can tell if someone is unhappy with me</td>
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<tr>
<td>13. I know when I feel stress</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14. I can express how I feel on most occasions</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>15. I am always able to see from the point of view of others</td>
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<tr>
<td>16. I apologize when I interpret the ideas and behaviours of others wrongly</td>
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<td></td>
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<tr>
<td>17. I understand feelings and emotion</td>
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<td></td>
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<tr>
<td>18. I am open to pleasant and unpleasant feelings and emotions.</td>
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<tr>
<td>19. I can spot the clues and warning signs of emotions</td>
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<tr>
<td>20. I often ask questions to understand another person</td>
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</tbody>
</table>

Work with your counsellor to identify your strength. Then consider your results and identify one or two actions you can take immediately to strengthen your emotional skill and emotional wellbeing.

<table>
<thead>
<tr>
<th>Strength</th>
<th>Need attention</th>
<th>Priority</th>
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</thead>
<tbody>
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List all the emotions you can think of do not write any emotion twice.
<table>
<thead>
<tr>
<th>Emotion</th>
<th>Date &amp; Time</th>
<th>What was happening when I felt that emotion(s)?</th>
<th>Did I interpret the situation correctly?</th>
<th>How can I do better next time?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Happy</td>
<td></td>
<td></td>
<td>Yes  No</td>
<td></td>
</tr>
<tr>
<td>Angry</td>
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<td>Yes  No</td>
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<tr>
<td>Sad</td>
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<td>Yes  No</td>
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</tbody>
</table>

©2015, Mockett, V
I feel happy when...

Some things that make me feel sad are

Some things that I can do to help myself feel better when I am feeling sad:

Some things that make me feel frustrated are:

Some things that I can do to help myself feel better when I am feeling frustrated:

Some people who I can trust to talk to about my emotions are:

I want to talk to my counsellor about...

I want to talk to my family about...
Clinicians Note

Anger is a common human emotion that is experienced by everyone. No one group of people has exclusive rights to the experience of anger. In the most general sense, anger is a response to a situation that presents some threat. Often a feeling of being victimized, deceived, insulted, rejection, being treated unfairly or frustration accompanies anger. It is a feeling or emotion that range from mild irritation to intense fury and rage. However, the ways in which we express anger can have negative consequences, both for ourselves and others. Anger is an emotion that leads many people to destructive behaviours when it is not expressed in a healthy way; it can also result in aggressive, passive aggressive or passive communication patterns, and many people identify anger as a trigger for alcohol or drug use. Anger becomes a problem when it is felt too intensely, is felt too frequently, or is expressed inappropriately. Feeling anger too intensely or frequently places an extreme physical strain on the body.

Research, as well as anecdotal report, indicates that young people with FASD have difficulties with emotional regulation particularly anger control. Many individuals with FASD tend to have problems controlling anger and frustration, as well as having problems understanding the motives of others. They are prone to anger outbreaks, tantrums, yelling or becoming extremely upset. They often show cognitively distorted thinking and a limited capacity for coming up with several possible alternative solutions. They may misread or misinterpret what is being said or done, or unable to think about the consequences of their actions.

Moreover, many of the young people with FASD I worked with, self-reported being angry and cranky frequently. Some these young people have mild learning disabilities, and difficulty with impulse control and feel uncomfortable their challenges. They prefer to avoid situations where their deficits can be exposed, sometimes reacting with anger. For many young people with FASD, anger slowly builds on itself as they constantly think about things that make them angry. Sometimes the issue causing a young person to be angry can get overwhelming, and they may get stuck thinking about it over and over again.

Unfortunately, some individuals with FASD become angry and aggressive very quickly and find it hard to deal with. The speed and intensity of their anger vary. From my observations, when feeling angry, some young people with FASD do not appear to be able to pause and think of alternative strategies to resolve the situation. In some cases, the individual with FASD may not acknowledge they have trouble with anger, and
will blame others for provoking them. This can create enormous conflict within a family or relationship with friends.

**MY clinical experience and observation of anger expression in young people with FASD**

When exploring the issue of anger with clients with FASD, one theme that prevails is the influence of past experiences and hurt. The experiences, in particular, trauma and neglect experiences, that young people with FASD have early in life highlight their inability to cope and the anger that so many express. As a result, young people with FASD are less likely to express anger effectively and, instead, divert their anger or use indirect means of anger expression that may be less effective or engender adverse behave.

Another theme that seems to permeate the experience of anger in young people with FASD is that of powerlessness or lack of agency. Having worked in some remote communities and with a number of individuals with FASD who are in care; powerlessness for many of these young people was reflected in their internal subjective experience of having little or no control over the decisions that impact them (for example, where they live, if they get allowance, can they purchasing their own clothing etc.,) and what I call the external reality of having little or no access to appropriate support or resilience promoting resources. The lack of access to these valued resources limits one’s ability to make choices and create solutions, thus contributing to the experience of powerlessness. Although powerlessness and a lack of sense of control are prevalent themes in the experience of anger for most people in general, young people with FASD, in particular, have difficulty with emotional regulation, experience multiple comorbidities, are often challenged interpreting other people’s emotions or the emotion they are experiencing, and quite often fall through the cracks in services. As such are more likely to experience powerlessness, or disempowerment, disproportionately, compared to other young people without FASD. Additionally, from conversations with many young people with FASD many find themselves not only facing disempowering conditions and dependence, but often they also find themselves experiencing abusive and chaotic situations that make them more susceptible to the internal experience of distress, anxiety, depression, and anger.

Some common causes of anger in relation to FASD are:

- Feeling swamped by multiple tasks or sensory stimulation
- Other people’s treatment and behavior e.g. insensitive comments
- Having routines and order disrupted
- Misinterpreting situations, of the views of others
- Build-up of stress
- The environment (e.g., chaotic homes, too much stimulation, lack of structure, change of routine)
- The person’s physical state (e.g. pain, tiredness)
- The person’s mental state, (e.g. existing frustration, confusion, depression, PTSD)

The ability to control and resolve anger is helpful in the overall treatment plan for most young people with FASD. As clinicians, you can help young people with FASD work through their challenges with anger. From my experience of working with clients with FASD, it may take carefully phrased feedback and plenty of time for the person to gradually realize they have a problem with how they express their anger, but they can make changes that are demonstrative of enhancing emotional learning.
WHAT YOU CAN DO:
You can help young person with FASD work through anger by:

- Increasing awareness of emotional expression and how anger shows itself.
- Increasing awareness of realistic boundaries of control
- Helping them develop appropriate assertive communication and conflict resolution
- Helping them identify individual and environmental strengths and the functionality of such strengths in coping with challenges and overcoming obstacles
- Promoting better access to appropriate resources, expand opportunities, and promoting resilience.
- Helping them to identify the origin of their hurt and pain as well as major disappointments in their lives and the anger associated with the hurt they have experienced
- Promoting mindfulness
- Helping them develop cognitive regulation skills
- Helping them to identify the cues that occur in response to the anger-provoking event. These cues serve as warning signs
- Help them to explore the implication of unhealthy anger expression for themselves and others

MORE TIPS FOR HELPING YOUR ADOLESCENT:

- **Offer support**—Let your client know that you are there for him/her completely. Ask the client what he/she feels he/she needs right now.
- **Be gentle but persistent**—Do not give up if your client shuts you out at first. Talking about emotional health can be tough. Be respectful of his/her comfort level while expressing your concern and willingness to listen.
- **Actively listen without criticizing**—Do not criticize or pass judgment once your client begins to talk. The important thing is that your client is talking. Avoid offering advice that is not asked for.
- **Validate their feelings**—Do not try to talk them out of their feelings, even if their feelings or worries appear irrational to you. Simply acknowledge the pain and anger they are feeling. Remember that sometimes anger is just the secondary emotion—the tip of the iceberg.

**Reflection Questions**

1. How do you support young people with FASD to become more aware of their expressions of anger?
2. How do you support healthy emotional expression?
3. How do you support young people with FASD in working through feelings of anger?
Resources Needed

• Name Tags
• Presentation slides
• Flipchart Paper
• Pens, Pencils, Markers
• Sticky Notes
• Laptop
• LCD Projector
• Yoga Mats or Towels

The Goal of the session is to:

• Help clients recognize when they are angry and out of control.
• Help clients recognize when anger is building up
• Help clients understand that anger can be an emotional trigger that lead to substance use and relapse
• Help clients learn how to express feelings of anger in a healthy way
• Help clients identify strategies to address unhealthy expressions of anger

Handouts

• Events that Trigger Anger
• Anger Iceberg
• Identifying how anger affects you and others
• Mindfulness & Anger
• Anger Monitoring Form
CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT
Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to talk about anger—what it is, how you experience and express it. The questions we will discuss, and the activities we will engage in will guide you towards thinking about healthy ways express your anger.

Engage – what to do

Ask clients to discuss:

- Times when they have felt like they have been treated unfairly. How did they feel and how did they express that feeling?
- The physical and behavioural clues that let them know they are angry?
- Time when you feel like you were angry for a good reason
- A time when another person responded to their anger in an extremely helpful way?

Discussion questions

Let’s think about your values for a moment…

- When you feel angry what does that look like?
- Is it okay to act out anger and frustration by hurting others?
- Is it okay to feel angry?
- Are you able to realize immediately when you lose your temper?
- Do you always know when you are being unreasonable?
- How difficult is it for you to resist the impulse to act immediately?
- What are some situations that most quickly cause you to be angry?
- Where does anger come from?
Breaking it down

Where does anger come from—What triggers our anger?

- Anger is an emotional reaction to events or things which happen.

Below are some triggers which can make us angry:

<table>
<thead>
<tr>
<th>Trigger</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stress</td>
<td>Internal pressure, pull, or other forces that we feel</td>
</tr>
<tr>
<td>Frustration</td>
<td>A feeling is a dissatisfaction resulting from unfulfilled needs or unresolved problems</td>
</tr>
<tr>
<td>Disappointment</td>
<td>When some fail to meet your expectations or wishes, or the feeling that come from defeat after you have worked hard on something</td>
</tr>
<tr>
<td>Annoyances</td>
<td>These are things that “get on your nerves”</td>
</tr>
<tr>
<td>Irritations</td>
<td>Feeling annoyed by inconveniences, impatience or feeling like 'someone is a thorn in your flesh.'</td>
</tr>
<tr>
<td>Abuse &amp; Neglect</td>
<td>This can be verbal, sexual, or physical abuse. Moreover, failure of other to provide necessary care</td>
</tr>
<tr>
<td>Injustice or unfairness</td>
<td>These are situations where you have not been treated fairly</td>
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<tr>
<td>Resentments</td>
<td>Disappointment due to injustice or replaying a feeling and the event that lead to it-</td>
</tr>
<tr>
<td>Trauma</td>
<td>When something horrible happens to a person, they can experience anger</td>
</tr>
</tbody>
</table>

You may also get angry if you feel that someone else is being mistreated.

Understanding Anger

Let your client know that understanding anger is the first step in controlling it and making it work for them. You can explain anger using the diagram below.

- There may be a strong relationship between the events in our life and our feelings— for example; you may likely feel sadness in response to the loss of a close friend, or feel happiness in response to achieving something, like winning a race.

- Feelings may also be related to past events or even to our expectations of the future. For example, feeling anxious about an upcoming test. These feelings can be an important source of information as well. Sometimes we ignore our feelings by pretending that we are not bothered and other times we exaggerate our feeling by behaving inappropriately. Rather than ignore or exaggerate your feelings, the healthy way is to take your feelings as they are, accept them, think about them, and learn from them.

- When you are feeling something consider asking yourself the following kinds of questions:
  - What is this feeling?
  - What is this feeling telling me about this situation?
How does anger affect us?

Anger affects the body

Let your clients know that: Anger raises stress levels and that their bodies prepare for a stressful situation. This is known as a “fight or flight” reaction. If you find it necessary, you may go on to explain fight or flight in more details to your clients.

When you get angry you may notice some of the following effects on your body:
- Muscles tense up (jaw, fists, shoulders)
- Breathing gets faster
- Stomach feels in knots
- Sweating
- Unable to think clearly

Anger affects physiology

Let your clients know that: The physiological (somatic) signs of anger are often the signs that let you know that you are angry and upset.

Anger affects behaviour

Let your clients know that: Displays of angry behaviours are often the signs that others notice. Angry behaviours include aggression, irritability and sometimes shutting down. Angry behaviours are often what make anger a problem, resulting in trouble with family, friends, school or the law. The magnitude, extent and setting off of anger are related to angry behaviours.
Some angry behaviours are:
- Punching someone or something
- Slamming doors
- Hitting
- Shouting
- Throwing items
- Swearing
- Pace around

Anger affects thinking

Let your clients know that: It is not usually the situation itself that causes anger. Generally, it is the way that they interpret and think about a situation that causes them to get angry or not. Angry thoughts or judgments often make them feel worse, and the same thoughts are likely to happen again and again. It is important to reinforce that thoughts are not facts, and it can be helpful to assist them in expanding their thinking.
Angry thoughts include:
- She is being unfair
- He is so stupid
- I hate this place
- He is selfish
- They are not doing right by me

What makes anger worse?
Let your clients know that: Although there is usually a direct cause for our anger, there are often elements affecting whether or not we get angry.

Below are a few things you can explore to get a better sense of anger expressions of your clients.

<table>
<thead>
<tr>
<th>Relationships</th>
<th>The interactions which we engage in and the relationships we have with others can be a significant source of stress or can prompt for anger</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drugs &amp; Alcohol</td>
<td>Drugs &amp; alcohol lead to physical changes in our bodies similar to when we feel frightened or angry. The brain can misinterpret these sensations and go into defense mode because it believes there is a threat. Substances can also decrease our level of control over behaviour. You can ask them to think about a time when they were drunk or high and how they reacted, then ask if they would have acted that way when you are sober?</td>
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<tr>
<td>Mental health (e.g., depression, anxiety, trauma, grief &amp; loss)</td>
<td>Psychological difficulties can complicate anger.</td>
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<tr>
<td>Environment (e.g., living conditions, peers)</td>
<td>Living conditions, for example, overcrowding, homelessness, living in foster care, etc. can all increase stress, increasing the likelihood of getting angry</td>
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<tr>
<td>Poor self-care</td>
<td>For example, insufficient sleep leads to poorer coping and less ability to find solutions. Also, we are more likely to be irritable when tired. Poor nutrition can also lead to irritability as well</td>
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</table>
The Cost and Benefits of Anger

Work with your client to explore the good things and the not so good that happens as a result of their angry expressions. See the table below.

<table>
<thead>
<tr>
<th>Cost of Anger</th>
<th>Benefits of Anger</th>
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</thead>
<tbody>
<tr>
<td>Displaying our anger in certain ways can have downsides. Some of these are:</td>
<td>Let them know that while anger can cause us to do rather destructive and silly things. Sometimes where are some benefits that can arise.</td>
</tr>
<tr>
<td>▪ Relationship problems: loss of friends and challenging at home, and school</td>
<td>▪ Anger can motivate you do advocate for yourself in a meaningful way</td>
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<tr>
<td>▪ Health problems</td>
<td>▪ Shows that something is wrong, e.g. Noticing that someone has hurt us</td>
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<tr>
<td>▪ Problems with authorities: aggression and violence can lead to problems with</td>
<td>▪ Gets us going to do something</td>
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<td>police, probation, social services</td>
<td>▪ A way of expressing ourselves, e.g., Telling someone that they have upset us</td>
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How to Handle Anger

**Let them know that:** Even when there are triggers for anger we do not always get angry. Some things make it less likely that we will get angry or act on anger. Discuss some things or ways they can handle angry feelings differently to minimize costly effects.

**Some of these things are:**

- Controlled breathing
- Other mindful activities (e.g., yoga, body scans)
- *Relax your family*—find a quiet place, sit down, slow down, focus on things that make you calm, listen to music, be creative (arts).
- *Find support*—talk to someone you trust, friends, family, or professionals when things are overwhelming.
- *Write down your thoughts*—writing can help you understanding your emotion and gain perspective on your thinking, and behaviour. Journaling is therapeutic and creative.
- *Rest*—getting enough rest will help you feel better.
- *Get involved in activities*—becoming involve in spiritual activities, sports, groups like youth group etc. can help you feel better and increase your sense of hope, resilience and emotional-wellbeing.
- *Exercise*—exercise can improve your peace of mind, and mood as well as your energy.
- *Help other*—helping others can increase social network, improve your self-esteem and sense of purpose. It also helps you to demonstrate other emotions like empathy.
Learning Activities

Activity 1: Events that Triggers Anger

When you get angry, it is because you have encountered an event in your life that has triggered feelings of anger. Many times, particular events touch on sensitive/delicate areas. These sensitive areas or “red flags” usually refer to long-standing issues that can easily lead to anger. In addition to the circumstances that you are experiencing currently, you may also recall an event from your past that made you angry. Just thinking about these past events may make you angry now. Here are examples of events or issues that can trigger anger:

- A friend joking about a sensitive topic
- A friend is not paying back money owed to you
- Being wrongly accused
- Having to clean up your sibling’s mess

Use the handout: event that trigger anger to help you people become more aware of the things that provoke anger for them.

Activity 2: Anger Iceberg

The purpose of the activity is to increase awareness of other emotions that can lead to anger. Tell clients that we tend to express anger frequently and other emotions we tend to bottle them up or keep them inside. Ask them to use the handout: emotion iceberg. You may provide some example of some situational statements (Please note: you can, along with your client develop statements that are more personal to their experiences.)

- When I argue with my parents, I feel…
- When my friends hurt me, I feel…
- When I am being treated unfairly, I feel…
- When I use drugs, I feel…
- When I am not being listened too, I feel…

Activity 3: Identifying how Anger Affects you

Ask your clients to think about the times that they have gotten angry and how it has impacted their thinking, body and behavior. Get them to think about how it has impacted others as well. Get them to think about how it has impacted others as well. Distribute the handout: identifying how anger affects you and others.
Learning Activities

Activity 4: Mindfulness and Anger

For group settings, you can invite a yoga instructor to do some yoga or Pilates with the group. Be sure to participate. You can also use the quiet moments on the CD. For individual sessions, you can help lead the client through a guided meditation or body scan exercise if you have mindfulness training.

INSIGHTS

1. What was the purpose of this activity??
2. What did you learn about anger?
3. What did you learn about yourself?
4. Why do you feel it is important to understand anger?
5. How did you feel during the activity?
6. How do you express, or not express anger?
7. How do you keep your emotions in check?
Reflection circle

Today we talked about anger—what it is, and how we understand and express it.

1. Did anything happen today that made you re-think about the way you express anger?
2. What did you learn about anger?
3. Did you learn anything about yourself through the discussions and exercises?
4. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT
Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage your clients to keep track of their emotion throughout the week and how they work through challenging emotions. Distribute the handout: Anger Monitoring Form. Alternatively, you could encourage your clients to try mindful ways of working through anger by distributing the handout: mindfulness and anger.

Key points

- Emotions are reactions we have to things that happen around us that make us feel a certain way.
- Our emotional state can make us feel good, or can make us feel awful.
- Emotions can create very strong feelings in us such as anger
- We all experience anger.
- Anger is neither good nor bad, right nor wrong. Feelings just ARE.
- It is hard to make good decisions when we are feeling extremely angry.
- Anger is not Facts about you. When we experience anger it can sometimes be overwhelming. It is important to remember that your ‘feeling angry’ do not define who you are…you are not an ‘angry person’. Anger is a feeling that does not last forever.
Chapter 12: Unit 2

1. Events that triggers Anger
2. Anger Iceberg
3. Identifying how Anger affects you and others
4. Mindfulness and Anger
5. Anger Monitoring Form
Think about what sort of things cause you to feel angry and write them down. Think about: people, places, other emotions, etc.

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Create your anger iceberg. Use this example as a guide to create your iceberg. On the top of the iceberg write all the emotions you express consistently and those that you keep hidden. You can create different levels if you wish.
Think about the times that you get angry, how have anger affected you and others around you.

<table>
<thead>
<tr>
<th>How has anger affected your body?</th>
<th>How has anger affected your thinking?</th>
<th>How has anger affected your behaviour?</th>
<th>How has anger affected your family and friends?</th>
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</table>
Everyone experiences anger; it is a normal human emotion. However, the ways in which we express anger can have negative consequences, both for ourselves and others. Anger is an emotion that leads many people to relapse. This is more noticeable early in your change process. Often, anger slowly builds on itself as you constantly think about things that make you angry. Sometimes the issue causing you to be angry can get overwhelming as you may get stuck thinking about it over and over again. Often a sense of being victimized accompanies the anger. Anger can also lead to aggressive, passive aggressive or passive communication patterns, and many people identify anger as a trigger for alcohol or drug use.

<p>| 1. Talk to the person you are angry with. | 15. Shift your thinking – often, how we experience a situation has a lot to do with how we think and feel about it and less to do with the actual situation. |
| 2. Talk to a counsellor, a 12-Step sponsor, or another person who can give you guidance. | – Use REM-Recognize, Evaluate, Modify your thinking |
| 3. Talk about the anger in an outside support group meeting. | – Do not personalize |
| 4. Write about your feelings of anger. | 16. Ask yourself am I ‘REACTING’ or am I ‘RESPONDING’? |
| 5. Be aware of your body (e.g., tight muscles, clenched fists, etc.) | When people react, it seems to be defensive. We are often uncomfortable with what is being said or done, and we react. In our reactions, our emotions take a central role. On the flip side is respond. Responding is more thoughtful and guided less by emotion. |
| 6. Take a few deep breaths of relaxation. Stay calm. | 17. Mindfully Listen/ Actively Listen |
| 7. Remember that anger is a signal that something needs to change. | Raising attentiveness – when you maintain your inner calmness and strength, you can listen to what is being said more intently, and you are better able to watch the way in which it is being said. You are then more aware as you formulate your response. Mindful listening will enable you to respond more thoughtfully and, if needed, begin to direct the exchange in a direction of collaboration and resolution. |
| 8. Look for positives; don’t jump to conclusions. | |
| 9. Leave the situation if necessary (Take a “time-out”) | |
| 10. Can you laugh about it? | |
| 11. Ask someone you trust to mediate the situation | |
| 12. Practice letting go - forgiveness | |
| 13. Practice grounding strategies (counting backwards, using ice, imagery, etc.) to help you calm down | |
| 14. Use progressive muscle relaxation | |</p>
<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Situation, event, or people</th>
<th>What was happening when I felt that angry(s)?</th>
<th>Did I interpret the situation, or what was said correctly?</th>
<th>The cost of my anger – how did it impact you or others?</th>
<th>Things I did to calm myself down</th>
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Clinicians Note

The role of emotional management in young people with FASD is something that is not well studied, but most of us who are clinicians and researchers who deal with young people with FASD frequently encounter clients who have difficulty managing their emotions. For many young people with FASD, when they are experiencing an emotion, whether it is anxiety, or they are feeling angry about something, or their feelings are hurt, or they worried about their current living situation, that emotion is often experienced with high intensity. A young lady once told me, “it is like I go from ‘0 to 100’ in a flash. It is like the emotion just takes up all of the space inside me, it takes over, and it is hard for me to make sense of it, so I smoke pot to help me relax”. For many young people with FASD, it is difficult to put the emotion into perspective and to put it to the back of their minds and get on with what they have to do. Therefore, substance use becomes a way to cope with their emotions or a way to gain some control.

As clinicians working with young people with FASD, one factor that warrants particular attention is association between substance use and emotion dysregulation among young people with FASD. Emotional dysregulation is defined here as maladaptive ways of responding to emotions (regardless of their intensity/reactivity), including nonaccepting responses, difficulties controlling behaviours in the face of emotional distress, and deficits in the functional use of emotions as information (Gratz and Roemer 2004).

In general, the experience of young people with FASD can be classified as complex and given that substance use is associated with emotional dysregulation. It is critical that young people with FASD be supported to work through and understand their emotions. Helping your clients to understand the complexity, and giving them the skill to manage their emotions will improve their agency and makes them actors in their lives rather than victims.

It is important to acknowledge that there are also many young people with FASD who have experience trauma, neglect and out-of-home placement. These young people have had to learn to trust again, as well as take care of themselves. These experiences can be both difficult and frightening, and those who go through it may experience a broad range of emotions. Before engaging young people with FASD, it is useful to take into consideration their perspective and concerns.
How to help young people with FASD experience Emotions without Distress

I always want to find out what has been going on in the person's life over the last 3 to 6 months because this provides some sense of whether something has changed, in the support system or the challenges he or she is facing. In my experience, many young people with FASD have managed to get along reasonably well up until a certain point when something changes, for example, they have been moved to a new foster home. The vital point here is, assisting these young people to accept that they cannot stop uncomfortable emotions. From this point of acceptance, they can learn to change how emotions affect them. Three techniques that can help young people with FASD become better at riding through emotions without distress are:

1. Learning to observe their emotions in a nonjudgmental way
   Before a young person with FASD can change how he/she react to difficult emotions, he/she need to learn the practice of paying attention to his/her emotions as they change. To do this, you can ask your client to try to imagine him/herself as a third person who is observing objectively. Teach them not to get involved with their emotions, but just watch the emotions and not try to alter it in any way as they flow past. Over time, as they practice this detached watching, they will gain a better understanding of how their emotions come and go, build and regress in intensity and shift and evolve into other emotions. Reinforce the importance of not judging their feelings as either positive or negative. Remind them that they are only a curious outsider watching a stream of emotions flow slowly past.

2. Learning to label emotions for what they are
   Labeling is a practice that can help an individual maintain awareness of and separation from his/her feelings. For example, right now I am feeling anxious—“I can feel it in my body too because my heart rate is up.” Not only does labeling help an individual in his/her practice of mindfulness, but it also contributes to enhancing a feeling of separation between the individual and his/her emotions. When a young person with FASD label an emotion like anger, and he/she knows that although he/she is feeling anger at this moment, it is only a passing emotion, and he/she do not have to act on it or let it consume him/her. Through this feeling of separation, you can teach your clients to learn to interpret their emotions as informative messages rather than commands they must submit to.

3. Using mental imagery to remind them of the fleeting nature of emotion
   It is important to remind young people with FASD that emotions will pass in time, that they are not their emotions and that they do not have to act on emotion, but that they can use mental imagery to help them work through their feelings.

Reflection Questions

1) Do I understand the experiences of young people with FASD?
2) How do I broach the topic of substance use with my clients?
3) How do I support my clients to regulate their emotion without using substances?
4) How do you support you people with FASD who are not ready to stop using substances?
Examples of Mental Imagery:

- **Wave** – you can ask them to imagine emotion as an unstoppable ocean wave. Let them know they cannot fight against the ocean; another wave is always coming along behind, but if they let the wave go and just ride it out it will eventually crest and subside into nothingness.

- **Speeding Train** - You can also ask them to imagine their emotion, for example, anxiety, or guilt as an express train that passes every now and again. You cannot stop a speeding train, and you cannot change its course, so the best thing to do is just watch it past, eventually the train comes to a stop and then it begins to speed by again.
Resources Needed

• Name Tags
• Presentation slides
• Flipchart Paper
• Pens, Pencils, Markers
• Sticky Notes
• Laptop
• LCD Projector
• Yoga Mats or Towels

The Goal of the session is to:

• Help clients explore how unresolved feelings and emotions can result in use of drugs and/or alcohol
• Help clients to explore ways to work through emotions.

Handouts

• Emotional Mask
Session Guide

Chapter 12
Unit 3

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to talk about emotions and addictions. Your emotions play a big part in why some of you may be using alcohol and/or drugs. The use of alcohol and drugs is a way to mask some of the intense emotional states you may be experiencing. The questions we will discuss today will help you gain a better understanding of emotional states and how it can lead to unhealthy coping such as the use of alcohol and/or drug.

Engage – what to do

Present the following questions to start a discussion about what emotional states are likely to cause your client, or participants to feel the need to drink or use drugs

Discussion questions

Let’s think about your ability to fully and calmly accept and experience uncomfortable emotions and strong need to escape them for a moment…

- Think back to the last time you experience intense emotion. How did you handle it?
- What is the emotion you usually experience before using?
- Which emotions trigger cravings for you most often?
- Do you hide what you are feeling from your friends and family? What happens when you do?
- Do emotions like shame, anger or worry tip you back toward drinking or drugs?
Learning Activities

Activity 1: Emotional Mask

- I want you to think about the kind of masks you most often use. What kinds of images do you portray to hide what is going on inside of you?
- Now I would like you to draw a mask. Make a picture of the mask you show to the world. What does that image look like? What does it hide?
- Allow participants time to work on it and also to move around and hopefully share with each other. [Let them know that after they have completed their masks, they are welcome to discuss them with each other in small groups. However, be sure also to let them know that no one will be forced to share their mask, but you can encourage them to do so].

INSIGHTS

- How did you feel during the activity?
- What was it like to draw a mask?
- Which emotions do you mask by drinking alcohol or using drugs?
- When do you use this mask?
Reflection circle

Today we talked about emotions and how they can lead to using drugs and/or alcohol.

1. Did anything happen today that made you re-think your use of alcohol and/or drugs to mask your emotions?
2. Did you learn anything about yourself through the discussions and exercises?
3. Did you think this was helpful? How?
4. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT
Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

- Encourage participants to continue to monitor their emotions. You could even suggest, or challenge them to use a clear bottle as a symbolic way of keeping track of their emotional pile-up. Instruct them to write down any unexpressed feelings or emotions that they experience throughout the week and put it in the bottle. [This may help them to see when their bottle is getting filled and needs emptying before it overflows].
- Encourage participants to practice their muscle relaxation exercise.

Key points

- Our emotions experiences play a big part in why use alcohol or drugs
- Alcohol and drugs can be used to masked what we are feeling inside
- When you are able to experience emotions without feeling overwhelmed and without feeling as if you need to escape you will have less need to use drugs and or alcohol to numb your feelings.
- Emotions are normal and healthy, when you try to block emotions you end up missing the richness of human experience. You can truly appreciate what you have when you allow yourself to feel.
- No emotion is permanent. Emotions tend to come and go like, for example, the waves in the ocean, rising and falling in time. Sometimes it can feel like your shame, or frustration will last forever, but they won’t.
HANDOUTS

Chapter 12: Unit 3

1. Emotional Mask
Think about the kind of masks you most often use. What kinds of images do you portray to hide what is going on inside of you? Use this mask or draw your own draw a mask to show your *emotional mask*. 
We all experience emotions, and we all need to learn to regulate them. Emotional regulation skills are about learning to cope and express feelings appropriately. Acquiring the skills to persevere when things do not go well, or according to plan and expectation are significant parts of emotional and social learning.

**Emotional Regulation** is being able to respond to the ongoing demands of our experience with the range of emotions in a manner that is positive, productive and appropriately flexible to allow someone to be more ‘responsive’ rather than ‘reactive’. It includes being aware of and paying direct attention to the emotions you are experiencing without judgments, expressing emotions mindfully, understanding and labeling emotions, allowing emotions to occur without necessarily acting on them, and managing or modifying emotional reactions and interpretations. More generally, emotional regulation = behaviors, strategies, and skills whether automatic or effortful, that serve to lessen, improve, and/or prevent undesirable expressions of emotions.

Emotion dysregulation appears to be prevalent in young people with FASD. This stems from executive functioning difficulties at the neurological level. Specifically, the inability to inhibit responses causes difficulties with selective attention, problem solving, planning, hyperactivity and impulsivity inherent in FASD, as well as an impaired ability to inhibit strong emotional responses (Fryer, McGee et al., 2007; Greenbaum et al., 2009; Rasmussen, & Wyper, 2007; Schonfeld, Mattson, & Riley, 2005; Schonfeld et al., 2006). In children with FASD, deficits in self-regulation are evident throughout development, for example, as heightened reactivity and high levels of distractibility and hyperactivity and sensory processing (Kodituwakku, 2009; Mattson et al., 2010).

Researchers have also found that as children with FASD get older, they lag further behind their same-age peers in self-regulatory and social abilities (Thomas et al., 1998; Whaley, O’Connor, & Gunderson, 2001). Given that the self-regulation deficits in this population are pervasive and worsen with age, researchers have proposed that it may represent a core target of executive function for intervention (Kodituwakku, 2010).

From my observation of working with young people with FASD, they tend to exhibited various manifestations of emotion dysregulation, including behavioural dyscontrol in the presence of strong emotions.
and inflexibility or slow return to emotional baseline. It has been recognized by many in the field that young people with FASD have difficulty regulating their emotions. In particular, research has shown that individuals with FASD exhibit behavioural problems and can sometimes be impulsive. It should also be taken into account that cognitive operations necessary to imagine different scenarios are a complex task for young people with FASD.

From self-reported accounts, it would also appear that individuals who have experienced complex trauma can have added difficulties coping with their emotions as well. Learning how to manage and respond to external stimuli that are triggering is an important skill to develop in young people with FASD to help them reduce symptoms of, for example, stress, anxiety, anger and frustrations.

What does helping young people with FASD to regulate their emotion look like?

Enhanced emotion regulation is valuable to all areas of a young person’s life. Young people with FASD, who can regulate their emotions will be able to pay more attention, reduce impulsivity, and be more mindful of the feelings of others. They will be able to resolve conflicts with their peers and family better and show lower levels of physiological stress.

In my experience, however, young people with FASD most effectively learn to regulate their emotions when they are confident that their feelings will be heard. They expect that their feelings and concerns will be validated, appreciated and understood. Young people with FASD need repeated experiences of having their needs met by a responsive, intentional and caring clinicians to help them manage their emotions. When young people with FASD have these experiences, they are more likely to be mentally healthy and have good relationships with others. This contributes to their feelings of satisfaction, happiness, and overall well-being. Each disappointment and frustration will then feel less painful, and less "catastrophic," and they will be more open and flexible in seeking solutions to problems. Further, they are less likely to get repeatedly stuck in attitudes of blaming, argument and denial. Clinicians can extend the development of emotional skills by helping their clients to regulate their emotions. This involves gently guiding the learning of a young person with FASD through various steps to help them achieve something that they possibly may not be able to do on their own.
To help young people with FASD regulate their emotion:

- Help them to recognize or identify the feeling. (Name the feeling)
- Encourage them to talk about emotions/feelings. Make sure your clients understand all the different kinds of emotions they can feel.
- Assist them to acknowledge and validate their experiences
- Help them develop the skills to express their emotions in a constructive way rather than disguising, ignoring or letting them explode in a destructive manner.
- Reinforce that they can make choices about how to respond to the feeling.
- Explore the underlying feelings.
- Teach them to be able to recognize how others feel. ...
- Reinforce mindful practices
- Provide as much stability and consistency as possible
- Talk to them about feelings - Use a variety of feeling words Over time young people with FASD experience more differentiated emotions (e.g., excited, elation, frustrated, calm, agitated) from the basic emotions (happy, mad, angry sad, afraid)
- Acknowledge and validate their emotions even when you are not comfortable with them or think they are unreasonable
- Suggest music, movies, and games that can help them relax. (for example, there is a video game called “Caribbean Quest” designed for kids with FASD. The game aims to improve cognitive function and self-regulation and has shown promising results thus far)
- Provide them with confidence and optimism that maximizes their learning potentials
- Help them develop a sense of self
- Provide stress management, and time management strategies to help reduce overload
- Teach distress tolerance skills
- Teach self-distraction and grounding techniques
- Help them to reframe situations in a positive way
- Teach effective communication techniques

Helping young people with FASD regulate their emotions is important for development, resilience, sense of self, and nurturing their mental health and overall wellbeing.
See the image below for other useful ways to help enhance emotional regulation in young people with FASD.

Reflection Questions

1. Do you create a safe space for your clients to talk about their emotions?
2. Are you validating their emotions and concerns?
3. Have you reflected on the context they bring to a discussion?
4. How are you helping them to regulate their emotions?
References

Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD projector
- Yoga Mats or Towels
- Index Cards

The Goal of the session is to:

- Help clients develop awareness and acceptance of emotions.
- Help clients understand the role emotions play in maintaining balance.
- Help clients express emotions appropriately.
- Help clients increase coping with challenges and disappointment.
- Help clients develop mindful ways to work through uncomfortable emotions.
- Help clients develop distress tolerance skills.

Handouts

- Emotional Myths and Facts
- Emotional Jigsaw
- Situation, Feelings & Choice cards
- Emotions and Music
CHECK-IN
Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT
Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention
Today we are going to talk about how we balance or regulate our emotions. The questions we will discuss, and the activities we will engage in will guide you towards thinking about the way think about emotions, your experience of it and how you can actively manage your emotions in meaningful ways.

Engage – what to do
- What emotion do you regularly experience more strongly?
- What are your ASSUMPTIONS, BELIEFS, MYTHS, about difficult events?
- What are you telling yourself about this emotion?
- How are you coping with your feelings?
- Distribute handout: Emotional Facts and Myths
- Ask participants to pick the one they believe to be true for them.

Allow participants sufficient time. Encourage them to discuss their responses.

Discussion questions
Let’s think about how we work through emotions for a moment…
- Did your answer match how you genuinely feel about emotions?
- What was your reason for the choice you made?
Breaking it Down

How can you manage/regulate your emotions better so that you can discuss issues calmly and reasonably?

There are several steps in accepting and managing emotions or feelings:

- **Recognize or identify the feeling.** *Let your clients know that:*
  - Feelings just ARE. They are not right or wrong.
  - Some feelings are pleasant or comfortable; others are unpleasant or uncomfortable.
  - Be more aware of your feelings instead of fighting them.
  - Ignoring or denying unpleasant feelings does not make them disappear.
  - Emotions can be constructive and helpful; for instance, fear provides extra energy and alertness in frightening situations.
  - Your battery signal on your phone tells you how much battery life your phone has left and alerts you when your battery life is getting low to tell you how much battery life your phone has left.
  - Feelings can behave in the same way. They are like a gauge or indicator to let us know that something is or is not right.

- **Experience and express the emotions in a constructive way rather than disguising, ignoring or letting them explode in a destructive manner.** *Let your clients know that:*
  - It is not always appropriate to act on a feeling, but it is OK to express it.
  - The expression may include talking to a friend, writing in a journal, or even exercising to let off steam when you are angry or frustrated.

- **Make choices about how to respond to the feeling.** *Let your clients know that:*
  - There is a difference between expressing a feeling and acting on it.
  - For instance, you can feel so angry that you want to hurt someone.
  - It may be OK to express that anger to a friend, but it is not OK to act on that anger and hurt someone.
  - Look at what you might be able to change in your current circumstances to ease the uncomfortable emotions.

- **Explore the underlying feelings.** *Let your clients know that:*
  - We usually do not experience just one emotion at a time. They often occur together; for instance, we may feel hurt and disappointed or frustrated and angry at the same time.
  - Once the feeling has been recognized, it can then be explored and/or addressed. What is going on underneath the feeling? What is its origin?
  - There are often layers of feelings that may be compared to the layers of an onion. For instance, anger may be the first feeling to be identified, but under the anger may be hurt or fear.
  - Use these underlying feelings to understand yourself: what do these feelings tell you about yourselves?
Learning Activities

Activity 1: Regulating my Emotions

Distribute handout: Emotional Jig Saw. As the clients to think of ways to help them work through their feelings.

Activity 2: Building Emotional Regulating cards

Give each participant a stack of index cards
Ask them to use the index cards provided, to develop Emotional regulating card. Encourage them to develop a list of things that you can do to gain a sense of mastery over your emotions. Ask them to think of:

- When you are in a low mood
- When you feel mistreated
- When you feel unheard
- When things do not go your way

Activity 3: Situation, Feelings, and Choice Cards

Let your clients know that they have many different experiences and a wide range of response. Present the client with scenario cards and help them discuss response choices. This is a fun activity to discuss as a group in a circle.

Activity 4: Emotions and Music

Music can evoke different emotions in people. Provide clients with handout: Emotions & music to work on.

INSIGHTS

1. What was the purpose of this activity?
2. What did you learn about anger?
3. What did you learn about yourself?
4. Why do you feel it is important to balance your emotions?
5. How did you feel during the activity?
6. How do you keep your emotions in check?
**Reflection Circle**

Today we talked about emotional regulation.

1. Did anything happen today that made you re-think the how you manage your emotions?
2. Did you learn anything about yourself through the discussions and exercises?
3. Do you have any other questions or concerns you would like to discuss?

**CHECK-OUT**

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

**QUIET MOMENT: REFER TO CD**

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

**Homework**

- Distribute *handout: Emotional and music* ask them to come up with a list of music that could help them relax.
- Encourage participants practice muscle relaxation exercise.

**Key points**

- Understanding how we feel helps us deal with situations better.
- Alcohol and drugs can be used to masked what we are feeling inside.
- It is important to slow down and give some thought to what you are feeling.
- Mindfulness activities can help us balance our emotions.
- It is important to speak to someone we trust to help us make better sense of our emotions.
- Trying to understand another person’s point of view is helpful.
Handouts

Chapter 12: Unit 4

1. Emotional Myths & Facts
2. Emotional Jigsaw
3. Situation, Feelings & Choice cards
4. Emotions & Music
Please tick the statement you feel is true

<table>
<thead>
<tr>
<th>MYTHS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>There is a right way to feel in every situation</td>
<td>☑</td>
</tr>
<tr>
<td>Letting others know that I am feeling bad is a weakness. Uncomfortable feelings are bad and destructive.</td>
<td>☐</td>
</tr>
<tr>
<td>Being emotional means being out of control.</td>
<td>☑</td>
</tr>
<tr>
<td>All painful emotions are a result of a bad attitude.</td>
<td>☐</td>
</tr>
<tr>
<td>If others do not approve of how I am feeling, I obviously shouldn’t feel the way that I do.</td>
<td>☐</td>
</tr>
<tr>
<td>Uncomfortable feelings are bad and destructive</td>
<td>☑</td>
</tr>
<tr>
<td>Painful emotions are not important and should be ignored.</td>
<td>☐</td>
</tr>
</tbody>
</table>
Situation, Feeling & Choice Card

Someone called you a bad name

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?

Situation, Feeling & Choice Card

Your parents are getting a divorce

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?

Situation, Feeling & Choice Card

You are with friends and they are beginning to act silly

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?

Situation, Feeling & Choice Card

You just found out that you will be going to foster care

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?

Situation, Feeling & Choice Card

You just found out that you will be going to foster care

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?

Situation, Feeling & Choice Card

You are in foster care, you just begin to feel like you fit in, now you have to move again.

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?

Situation, Feeling & Choice Card

You are having a difficult time understanding your homework

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?

Situation, Feeling & Choice Card

Your best friend just broke her arm

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?

Situation, Feeling & Choice Card

The teacher did not select you for the field trip

Feelings & Choice
  • Feeling: What are your feelings?
  • Choice: What choice do you have in your response?
Situation, Feeling & Choice Card
You were caught smoking at school by your teacher.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
Your friends invite you to a party, you can't decide.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
Your mum is caught with drugs and has been arrested.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
You have been arrested for stealing someone’s money.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
You are turning 19 yrs old and will be leaving foster care in a few months.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
Your siblings are still in foster care.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
You just got a job.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
A friend offer to help you with your school work.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
Your friend offer you drugs & Alcohol.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?

Situation, Feeling & Choice Card
People are very nice to you.

Feelings & Choice
- Feeling: What are your feelings?
- Choice: What choice do you have in your response?
Develop a playlist of music you could use to help you balance your emotions

<table>
<thead>
<tr>
<th>Emotions</th>
<th>Music</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sad</td>
<td></td>
</tr>
<tr>
<td>Angry</td>
<td></td>
</tr>
<tr>
<td>Anxious</td>
<td></td>
</tr>
<tr>
<td>Depressed</td>
<td></td>
</tr>
<tr>
<td>Bored</td>
<td></td>
</tr>
<tr>
<td>Confused</td>
<td></td>
</tr>
<tr>
<td>Grieving</td>
<td></td>
</tr>
<tr>
<td>Embarrassed</td>
<td></td>
</tr>
<tr>
<td>Guilt</td>
<td></td>
</tr>
<tr>
<td>Shame</td>
<td></td>
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</tbody>
</table>
Chapter Thirteen

My Use
Clinicians Note

As has been previously documented the use of alcohol and drugs among young people with FASD is prevalent. Anecdotal reports from service providers and clinicians indicate that substance use coupled with mental health challenges common among the youth with FASD they worked with. Similarly, research (Clark et al., 2004, Streissguth et al., 1996, McLachlan, Wyper & Pooley, 2013) showed that young people with FASD struggle with addiction issues. Young people with FASD, like may experiment with alcohol and other substances, just like their peers without FASD. From practice experience, it would appear that some young people with FASD view alcohol and substance use as a means of peer acceptance, especially if they feel isolated in their peer group.

Like most young people, youth with FASD may also use alcohol and/or drugs as a coping mechanism to deal with feelings of sadness or hopelessness around issues related to their family context, school and their disability. Practice wisdom, observations and anecdotal reports indicate that not only do many of these young people are impacted by intergenerational histories of trauma and emotional dysregulation, but they also come from families impacted by intergenerational substance misuse. If a parent, caregiver, or another member of the household uses alcohol or other substances, the young is more likely to use him or herself. Self-reports from many of the young people with FASD I work with suggest that like FASD itself, their drinking and/or drug use occur on a spectrum. A large proportion of the young people I work with openly acknowledged using alcohol or other drugs. Although some identified as challenged by their misuse of drugs and or alcohol and felt that their substance misuse had created problems in their lives; many did not think that their substance use was a problem. This was also echoed in research by the Peled, Smith, & McCreary Centre Society (2014). In their reported they further noted that “some thought their drug use might be a problem but were not ready to stop using. While several others said they had never used substances, but their support workers later made it clear that the youth regularly used and had a serious addiction” (Peled, Smith, & McCreary Centre Society, 2014, p.21).
As a clinician, if you suspect your client may be misusing drugs and or alcohol it is important to talk to them before a problematic pattern of behavior or dependency is established. I have found motivational interviewing helpful in having conversations about substance use, and behavior change in general. Keep in mind that the young person must be ready to discuss these issues. Be mindful that young people with FASD, may not feel comfortable discussing substance use issues with parents or other caregivers present. Part of your general psychosocial screening and mental health screening could include a question such as: asking the young person if he or she has tried, or is using alcohol or other substances. It is essential that you reaffirming that your conversation will be kept confidential. Substance use may be a sign—or coping mechanism—of mental illness or experiencing trauma. You can use one of the tools identified in the assessment section of MIRTS.

You may also wish to have other dialogues with the youth to explore his/her relationship with alcohol and/or drugs and if it has impacted other relationships: social, school, and family. It is critical you work in a manner that respects your clients’ diversity and context. Be careful not to bombard the young person with too much information at once.

In my experience, knowledge alone does not lead to behaviour change. Most young people with FASD know, for example, that use of alcohol can have a negative impact on their health. However, that does not stop them from using it. Sometimes we talk to young people about their substance use without thinking about or understanding the functional role it plays in their life. Sometimes young people use drugs to gain access to some internal sense of control, and sometimes they use to mobilize the pain. Without actually exploring someone’s relationship with substances it is hard to make any lasting impact.

**Key points for clinicians about Engaging young people with FASD in discussion about substance use**

- Begin by stressing the importance of the adolescent and his or her health to you.
- Explain to the client that you are going to ask a series of questions about alcohol and substance use in the past year and that he/she should answer as best, he or she can remember. Review anything that may potentially have ‘double’ meaning, for example, explain what you mean by “nonprescription drugs,” as this could include pills like painkillers but also inhalants such as glue, and paint
- The information the client shares with you may remain confidential, but it might be important to include the family in the discussion as well if possible
- Be prepared to refer the youth for counseling to deal with depression, experiences of gender-based bullying, trauma, or other mental health issues that may lead to drinking and substance use.
- Have a list of possible referrals ready to share with the client
- If the youth is using a drug. If yes, which one(s)? Alcohol? How often?
- Ask whom he/she uses with. Where does the use happen?
- Ask why the youth uses. Was there a particular event that triggered use?
- Ask what you can do to help him or her not use alcohol or other drugs.
- Ask whom the youth feels he can trust and talk to besides you.
- Explore with the client, the potential negative consequences of alcohol and/or drug use
- Explore with the client, the negative impact they have experienced from of alcohol and/or drug use
- Remember you may need to have this conversation more than once.
- If the young person is willing and seeking further help, refer him/her for treatment as necessary for dependency. If this is not available, discuss treatment options within the family/caregiver and/or community context such as spiritual and peer support.

- Engage your client in a conversation about alcohol and/or substance use. Broach the subject in an open and caring manner that encourages the youth to share his/her experiences openly. Remember that talking about alcohol and substance use should be an on-going conversation that you have with your client to help him or her make healthy choices.

References


Reflection Questions

1. How can you prepare yourself for a session about substance use?
2. Are you sufficiently equipped to speak to the client about substance use?
3. How will you help the client?
4. Are you able to facilitate referrals and linkages?
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients understand and explore their relationship with alcohol & drugs
- Help clients explore the cost of their drug & alcohol use

Handouts

- The Cost of My Use
- The benefits versus the cost of using
Session Guide

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to explore your relationship with drugs and/or alcohol, as well as the cost of your drug and/or alcohol use. The questions we will discuss today will help you gain a better understanding of how your relationship with drugs and/or alcohol has evolved.

Engage – what to do

Ask them to close their eyes and imagine being in a relationship with a friend where they felt like you had very little say and control over what and how you guys spend your times together.

- Think about how the relationship was in the beginning. Would you say it started of kindly?
- Now reflect on your relationship with drug and/or alcohol; what is that relationship like?
- Do you feel you have a say?
- What does this relationship feel like?
- How did it start?
- When did it begin to overtake your life?

Discussion questions

Let’s think about how we work through emotions for a moment…

- Are there periods when the relationship with substance use is more intense?
- What does it feel like when it is less intense?
- Do you feel like you have more control?
- Invite participants to reflect on their life prior to habitually using drug and/or alcohol.
- Think about what is different now? Or what has changes (e.g., relationship with family, friends, work and even with yourself).
Breaking it Down

Exploring the cost of their substance use

1. **Control** — Problematic use can take away your power
   - They have to have drugs or alcohol all the time to feel ‘normal’ binge drink or use for a quick emotional fix.
   - Continue to use despite obvious problems
   - Consumed by thoughts of using.

2. **Self-management** — Problematic use could get in the way of being accountable and responsible.
   - Unable to manage emotion and feelings
   - Health
   - School
   - Role within family
   - Relationships with friends

3. **Values** — Even if your values are based on beliefs that are important. Excessive substance misuse can interfere with your values such as:
   - Personal integrity
   - Happiness
   - Trust & respect
   - Health
   - Dependability
   - Family connections

4. **Balance** — Problematic use can get in the way of things that are priorities for you, your boundaries and self-care
   - Helplessness
   - Hopelessness
   - Confidence

5. Family
6. Friends
7. School

Explore the benefits they derive from using alcohol and or drugs. Use the benefit vs. cost handout to help them explore this.
Learning Activities

Activity 1: SACS

Get participants to fill out the Substance and Choice Scale (SACS).
- Encourage participants to think about their responses to the questionnaire and then ask them to consider their attitude about drugs or alcohol use.

Activity 2: My Relationship with Alcohol & drugs

Now that we have discussed your relationship with drug and/or alcohol draw a diagram that you feel accurately represents this relationship.
- Encourage them to share their diagram with the group and have a discussion.
- Get them to reflect back to the reason they began to use, or the identified problem that alcohol is masking.

Activity 3: The Cost of My Use

Distribute the Cost of My Drug/Alcohol Use pie chart, as participants to imagine the pie as their life and begin to divide the pie base on what percentage they believe that their use of alcohol or drugs has cost them. [In my experience this has worked well as a reflective tool, having a visual image/representation of the impact of alcohol and/or drugs seem to get clients to begin to make some shifts in their use].

INSIGHTS

- What was it like working on this exercise?
- Was this difficult?
- Is using drugs and or alcohol a way to cope with your hurt and pain?
- What sorts of reasons or excuses do you give yourself for continuing to use?
- Do you find yourself wanting to hang on to your relationship with drugs and/or alcohol? Why/why not?
- Is there anything you would like to change?
- If you continue to use would that solve the problem?
- What are you worried about if you discontinue your relationship with drugs and/or alcohol?
- Now that you have had a chance to really take note of the cost of your use—the impact on your relationship and overall life balance, what commitments, or change are your considering.
Reflection Circle

Today we explored at your relationship with drug and /or alcohol, as well as the impact on your life and relationships. For some of you it may have been tough to come to terms with your use and for others, it may have been slightly easier. As you think about the things you did today,

1. What stands out for you the most?
2. What did you learn about yourself and your relationship with drugs and/or alcohol?
3. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

- Use handout: commitment to change over the course of the week to begin their change process
- Encourage clients to practice muscle relaxation exercises

Key points

- Alcohol and drugs can be used to masked feelings of hurt, pain, loneliness and isolation.
- Alcohol and drugs can give a sense of control
- It is important to find someone you trust who can listen and support you.
- Our relationship with alcohol and drugs and cost us friendships, cause problems at home, in school, on the job and sometimes with the law.
HANDOUTS

Chapter 13: Unit 1

1. The cost of my use

2. Benefits vs. Cost of doing drugs and/or alcohol
<table>
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<th>What do I enjoy about my use? What does it do for me?</th>
<th>What do I hate about my use? what does it do to me and my relationships?</th>
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<th>What do I think I will like about giving up my drug and/or alcohol use? <em>(what are the good things about quitting)</em></th>
<th>What do I think I will not like about giving up drinking or doing drugs? <em>(what are the bad things about quitting)</em></th>
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Clinicians Note

All of the issues that affect young people, such as access to education, employment, health care and social services, also affect youth with FASD, but in a far more complex way. Our attitudes and biases as clinicians can become a barrier that prevents young people with FASD from actively participating and making meaningful contributions to their treatment planning.

There is an increased need to support these individuals to develop ownership of their treatment planning and goal setting. Too often, young people with FASD are defined by what they lack rather than what they have. Their exclusion and invisibility serve to render them uniquely vulnerable, denying them respect for their dignity, their individuality, even their right to take part in decisions that affect them.

In my experience, many young people with FASD attend treatment planning meeting, integrated case management plan (ICM), and individualized educational planning (IEP) meetings without having their voice heard or being asked about their preference. Their perceptions on matters that affect them are scarcely sort. This happens most often with the young people with FASD, who are involved with multiple systems, are in foster care, have parents who have little to no service engagement or those who are felt to be in need of intensive support. For change to be effective and lasting, involving young people with FASD in developing their change and action plan is vital. When young people are active participants in processes that impact them they are more motivated to continue with the changes they have made. This promotes self-determination and agency of young people.

As clinicians, we have a responsibility to work responsively with young people with FASD build their capacity and sense of agency. While they may need support to help them achieve their goals, it is imperative that we recognize their strengths and abilities in developing their change and action plan. To better help a young person with FASD it is important to ensure that you have a good understanding of what goal setting, and SMART goals are. Also, keep in mind the contextual factors that impact a young person’s life.
You can support young person with FASD by (also, see the diagram below on how to help build ownership):

- Working with individuals to identify their strengths, needs, abilities and goals— involving family members, carers, advocates and others in their life that they request to have as a support team is helpful.
- Helping individuals to set themselves SMART goals and targets as part of their support plan.
- Working with individuals to identify the importance of the goal to them
- Working with individuals to explore their confidence level in making changes in their life
- Helping them identify and explore action steps that can be taken
- Helping them identify individuals who can help support them
- Working with individuals to help them implement their support plan, providing support as necessary.
- Establishing strong working relationships with others involved in supporting the individual.
- Ensuring individuals are provided with accurate and accessible information
- Encouraging and nurture active participation
- Building their autonomy and agency
- Build ownership for their change plan.

Reflection Questions

1. Are you attuned to your bias about the ability of a young person to meaningfully contribute to his/her treatment planning?
2. How can you prepare yourself for a session about goal setting and change plan?
3. Are you sufficiently comfortable and confident about the topic?
4. What resources can you utilize?
5. How can you promote autonomy and agency?
Building ownership for the change and action planning process

Build ownership

Help them to identify key internal & external resources

Help them explore and work on barriers to change

Mobilize and engage young people with FASD in discussion and treatment planning decisions as it relates to their substance use

Provide needed support
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients explore identify their strengths, needs, abilities and goals
- Help clients set goals
- Help clients explore the most important reasons they want to make changes
- Help clients think about their readiness confidence to make changes
- Help clients identify steps they can take to accomplish their goals
- Help clients identify others who can help with their goals
- Help clients identify barriers to accomplishing their goals
- Help clients identify how they will know when their plan is working

Handouts

- SNAG- Strength, Need, Abilities, Goals
- Individualize Action and Change Plan
CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: Conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we will explore your strengths, needs, abilities, and goals. Specifically, this should help you:

- Identify your strength
- Identify your needs
- Identify your abilities
- Develop effective goals
- Prepare to begin working on their individualized change and action plan

This should help you better prepare to work through changes you are considering.

Engage – what to do

Create some strength cards. You can type it up on the computer, or use poster and then cut them off. Create enough so that each person may be able to pick up three cards:

- Friendly
- Forgiving
- Generous
- Imaginative
- Kind
- Hardworking
- Loyal
- Funny
- Helpful
- Hopeful
- Adventurous
- Organized

Spread the card on the floor, ask participants to go around and collect three strength cards that best reflect them. If you have a small group, they can select more three cards.

Discussion questions

Let’s think about strength needs, abilities and goals (SNAG) use for a moment…

1. What are your strengths?
2. What are your needs?
3. What are your abilities?
4. What goals do you want to set to begin your change process?

Work closely with clients to complete their SNAG. Once they have identified their strengths, needs, abilities, and goals; you can assist them to use this information to complete their individualized change and action plan.
Learning Activities

Activity 1: Individualize Change Plan

- Distribute the individualize change plan.
- Ask participants to think about their needs, strengths, abilities, goals and values and supports as they develop their plan.
- Encourage them to ask questions and for suggestions or feedback.
- Remind them that most of the information they need is already in their binder.

INSIGHTS

- Are you happy with the plan you came up with?
- What was hard for you?
- What was easy about this?
- Remind participants that they can make changes at any time based on their needs and what is happening for them.
Reflection Circle

Today we worked on your change plan, reflect on the plan you created,

- What stands out for you the most?
- How or why is this important to you?
- How committed are you to this plan?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage them to practice muscle relaxation and other mindful practices.
Chapter 13: Unit 2

1. Strengths, needs, abilities & Goals (SNAG)
2. Individualized Change & Action Plan (long Version)
3. Individualized Change & Action Plan (short Version)
Please list your strengths, needs, abilities and goals.
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<th>Name:</th>
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<th>The changes I want to make (specific areas for improvement):</th>
<th>How important is it to me to make this changes? On a scale of (1-10), 1 being least important and 10 being most important.</th>
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<th>How confident am I that I can make these changes? On a scale of (1-10), 1 being least important and 10 being most important.</th>
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<th>My strengths are:</th>
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<tr>
<th>The steps/Action I plan to take in making these changes are:</th>
<th>People that can help or support me with these steps are:</th>
<th>Resources/skills/tools that might help me reach my goals are:</th>
<th>My target date is</th>
<th>I will know my plan is working when</th>
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<th>Somethings that could stop me from achieving my goals are:</th>
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<th>My self affirmation statement:</th>
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<th>I will reward myself for reaching my goal or part of my goals by:</th>
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# INDIVIDUALIZED CHANGE & ACTION PLAN (short version)

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**Strengths**

Things that can get in my way:

Strategies to accomplish my goals (things I can do)

**Progress towards goals**

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Chapter Fourteen
Trauma-Informed—Feeling Overwhelmed
Clinicians Note

Young people with FASD are among the most vulnerable young people, often having experienced multiple foster home placements and several different kinds of traumatic, or adverse experiences. Often many of these young people also experience trauma and are impacted intergenerational history of trauma. The stress that results from having traumatic experience(s) plays a critical role in mental health and behavioural problems and needs as well as their safety. Trauma, like FASD, impacts the way a young person functions, however, they often don’t recognize the significant effect of trauma in their lives; either they do not make the connection between their trauma history and their presenting problems, or they avoid the topic altogether.

Both FASD and trauma impact the ‘whole person’—brain, relationship, emotion, behaviour, learning and the body. Henry et al., 2007 noted that a combination of trauma and FASD significantly increase neurodevelopmental & neurobehavioral challenges. For many young people with FASD, the experience of trauma is complex, involving dysregulation of the mind and body, and disruption in a relationship with themselves and others. Essentially, the way we think, feel, learn, remember, and cope with others and the wider world is affected by traumatic experiences. In my experience, many young people with FASD, who have experienced traumatic stressors in primary relationships, at school and the community, are likely to have a problem with biological adaptations that impair their ability to delay gratification that make them prone extreme emotional reactions impulsive and disorganized thinking and sometimes poor coping styles.

As a clinician, it is important that we be aware of, and understand the complexities when trauma and FASD co-occur. Since trauma can overwhelm a young person’s capacity to function holistically—mentally, socially, psychologically and spiritually. Understanding, in this case, is much more than merely responding to emotions and behaviour, it is also about making sense of the meaning of young people’s behaviour, and interpreting it through a trauma-informed lens that asks, what has happened to this young person? How can I facilitate healing for this young person, rather than what is wrong with this young person?

Without understanding the effect of trauma on development and well-being, it will be impossible to provide appropriate service and support to young people with FASD. Bear in mind this is not training in neuroscience, but it is important to have a basic understanding of brain mechanisms. A brief understanding of the
brain will be helpful in understanding how we can help young people with FASD, who have experienced trauma. There are different types of trauma (psychological, physical, complex, chronic). The magnitude of the impact of trauma depends on whether an event is isolated or not. Neurodevelopment is affected by the nature of the trauma, as well as an individual characteristic and context.
It is important to remember that all experience changes the brain – good experiences like playing the guitar and bad experiences like living through abuse and neglect. This is so because the brain is designed to change in response to patterned, recurring stimulation. And the stimulation associated with fear and trauma changes the brain.

Over the past two decades scientist studying the brain have consistently noted how fear and trauma influence the brain. The experience of a traumatic event(s) by a young person with FASD impacts multiple areas of the brain, such brain areas includes the amygdala (involved in emotion management), the hippocampus (involved in memory and memory consolidation), the frontal lobe, particularly the region located furthest to the front, called the prefrontal cortex, (involved in sophisticated interpersonal thinking skills and the competence required for emotional well-being) and the corpus Callosum (the bridge between the left and right hemispheres of the brain involved in several functions such as maintaining the balance of arousal and attention). Changes in these areas create altered neural systems that influence future functioning.

Research indicates that trauma reduces the capacity of the thinking part of an individual’s brains, thus altering the way they react to challenges in their environment. As a result, young people with FASD who have had traumatic experiences appear to behave instinctively and sometimes inappropriately, without knowing why. They are also not able to easily influence their feelings when faced with perceived threat or increases in their experience of stress.

From observation and practice experience young people with FASD seem to live in a constant state of vigilance and heightened sense of alarm. As such, they seem to get easily triggered by seemingly minor issues. Their responses are often seen as ‘random’ or ‘over-reactions’ to situations. Many young people with FASD lack the flexibility necessary to respond differentially to varying situations and contexts. They have a limited range of coping strategies.
• Research indicates that exposure to trauma can have dramatic effect on the mind and body. Parts of the brain can become sensitized, causing a young person with FASD to be on high alert and to perceive threats all around, leaving him/her jumpy and anxious with shallow breathing, cold hands and feet and strong tension throughout the body.

• When we become exposed to a threat that we cannot control or escape, our natural instinct for survival—which includes the body activating a tremendous amount of energy to fight or flee—short circuits. These short circuits echoes through our bodies as well as our minds. This can result in shock, dissociation, and many other kinds of involuntary responses.

• In the face of a stressor, the brain tells the body to energise itself, releasing more oxygen and more energy in the form of glucose. It makes the body as efficient as possible at tackling stress by inhibiting any non-survival-related process, such as digestion. It also narrows the attentional focus of the brain so that it is able to more quickly analyse the best option to take in order to resolve the situation and bring the body back into equilibrium. In this sense, this first system of response promotes vigilance, arousal and alertness to environmental and relational threats.

• Cori (2007) suggested these physical signs results from the body becoming a “too-tight package.” The individual who has experienced trauma is “caught in a pattern of alarm and self-protection, with the lower brain stem still on alert. The individual, then, can live in perpetual anticipation of the next “attack” in part because of the body’s inability to complete the circuit and let go of the initial threat.
Trauma-based behaviour, plays an important adaptive role. It often makes sense in the context in which it first emerged. However, it can become counterproductive if it continues after the need for it has changed.

• The behaviour of a young person who has experienced trauma, according to the research is an insight into the responses of their brain-body system to stress and trauma. The behaviour we often witness as clinicians represents a complex interchange of the experiences of their past, their reactions to the present and the accumulative influence over time.

• Trauma-based behaviour can usually be identified as patterns or habits that are evident in the relationships and other context that young people are engaged in. It can be a reaction to memory triggered by events or interactions with others. It can be repetitive strategies used to manage their internal states, change or unpredictability in their environment. These behaviours is influenced by the negative self assessments and beliefs which young people with FASD believe to be true about themselves.

• As mentioned earlier, the amygdala acts like a switching system, sending incoming information from our environment to the cortex of our brain. Here the information is processed and made sense of, allowing us to address and process life events, for example, “Is this situation safe or dangerous?” The amygdala of individuals who have experienced trauma is often overly sensitive, resulting in hyper-vigilance. These individuals may appear aggressive, as they might be overly sensitive to perceived threats (words or gestures from families, teachers, friend, and service providers), or withdrawn due to fear of being close to others. Further, the feelings surrounding trauma can impair a young person’s judgment and effectively “freeze” him/her into harmful patterns of behaviour, including substance use, self-harming, and poor self-care in general. Without intervention aimed at supporting better connection and social skills, traumatised children and young people are likely to experience increasing levels of isolation.
Young people with FASD who have experienced trauma may have challenges with forming and maintaining relationships because of negatively affected brain areas. They may develop inappropriate ways to deal with people in their lives. For example, in my experience of working with young people with FASD, they appear to have difficulty expressing their emotional needs, live in constant fear of getting hurt and often remain distrustful of others.

Those who lack a secure attachment may become avoidant of establishing relationships, or overly dependent on others to meet their needs. In particular, it appears that young people with FASD exposed repeatedly to traumatic events lack the capacity to process experiences in a sophisticated way. Beliefs such as “I am not safe”, “I cannot trust anyone” are developed in the young person’s brain and he/she may act unconsciously in ways that confirm those core beliefs. They can become detached from their experiences and their relationships with others making it difficult for them to feel settled, safe, trust and engage meaningfully. Foster parents often experience the implications of disrupted connection with young people with FASD; as young people with FASD who have experienced high level of stress, abuse, neglect and rejection do not feel confident in their new environment and find it difficult to trust others to help them manage their internal states. Often young people with FASD can present as being unempathetic, having experiences with their needs met in inappropriate ways, they may not conceived of other people’s need.
• Through adopting trauma-informed approaches that are sensitive and predictable in their implementation, clinicians can open up a space for young people with FASD who have experienced trauma to learn. Effective responses are those which integrate a comprehensive understanding of the growing knowledge base about the neurobiology of trauma and stress and its implications young people.

• Trauma informed practice supports an emphasis on making the therapeutic space—its routines, its relationships and its activities in and around its clients—facilitative and flexible to the needs of all young people, but in particular those who are affected by the consequences of trauma and stress.

**Useful Strategies**

To effective assist an individual, it is helpful to adopt a trauma-informed approach. Trauma-informed practice begins by building or strengthening the relational base around young people with FASD, who have been impacted by trauma.

1. Develop a safe area and/or safe person the client can access if a situation is stressful, or threatening.
2. Give children an opportunity to have a sense of agency and control in their lives. Create structures within which children can make choices during their day.
3. Promote the strengths and interests of the of the young person.
4. Understand trauma and respond to trauma-based behaviour at its source rather than how it is expressed. Like emotions, behaviour contains multiple drivers, multiple explanations and multiple ways to respond to it.
5. Offer sensory toys to enable a young person to experience different feelings and then connect them to the words that can describe them. For example, link different textures to different feelings.
6. Use physical activity like walking to match the emotional state of a student at a particular time and join them in slowing them down to achieve a calmer baseline.
7. Utilize an identity web to explore the strength of the young person connections to his/her family, friends and people at school.
8. Teach mindfulness strategies such as meditation, body scan, deep breathing and yoga.
   a. Over the years, I have come to realize that when working with a client with FASD, who has also experienced high stress or trauma—talk therapy alone isn’t always the most effective course. Take, for example, a young woman who experienced years of childhood sexual abuse, she has periods of not being able to feel—feeling numb inside, and may resort to ‘cutting’ to gain some control and to feel ‘something’. Reorienting this client to her body—building her body sense and helping the client slow down the mind chatter can be the very key to unlocking the pain and building a path toward healing. When working with a young person with FASD, I often, with his/her permission introduce mindfulness before having fully established a treatment plan. Mindfulness can provide both the client and me with valuable information about what is unfolding inside. One of the first things I do is to teach the client to slow down and note the mental chatters and body sensations that typically occur with little awareness. It can be helpful to guide the client to become accustomed to feeling something in the body—feet on the ground, or a muscle contracting—in the present moment, choosing what to do about it in real time, and taking effective action. In this way, everything about the practice is optional, safe, and gentle, geared to helping clients to befriend their bodies. To fully heal from trauma, a connection must be made with oneself, including one’s body. A mindfulness approach moves beyond traditional talk therapies by bringing the body and the mind actively into the healing process. For example, body scan and muscle relaxation are concrete and can be done anywhere. This will allow young people to cultivate a more positive relationship to his/her body through gentle breath, mindfulness, and movement practices.

9. Inculcate resilience—build a young person’s capacity to manage strong emotions, and increase his/her confidence in what he/she can do or accomplish.

10. Support them in understanding the link between their behavior and its impact on others.

11. It is important to understand that young people with FASD often experience emotional invalidation—when their feelings and emotional states, such as anger or hurt, are not attributed to the harmful or abusive event. Validating a young person’s feelings is vital.

12. It is important to understand affect dysregulation and how clients modulate a dysregulated nervous system (for example self-harming and planning suicide). Research has indicated that many young people who have been traumatized tend not to have any baseline state of physical calm; in an attempt to calm themselves they will often rely on coping mechanisms that a self-destructive such as cutting or taking drugs. Teaching self-regulating skills will be helpful.

13. Focus on the possibilities for repair and empowerment.
14. It is also vital to understand that positive emotions such as safeness, joy and happiness are not necessarily experienced as pleasurable, but rather frightening. Exercise patience and be mindful not to overwhelm a young person.

15. Explore the range of emotions the client may be feeling or may have experience (anger, rage, shame, guilt, grief, anxiety, depression, fear, etc.).

16. Having insight and understanding of the nature, source and maintenance of emotions are important. Research suggests that some individuals struggle with competencies that facilitate the understanding and use of emotions. One approach to explore describing these difficulties is with the concept of ‘alexithymia’—it refers to a set of interconnected difficulties: of identifying and distinguishing between feelings and bodily sensation of emotional arousal; difficulty describing feelings (especially of other people). In my experience of working with young people with FASD, it would appear that many struggles to understand, process and verbally describe their feelings and emotions. Thus, teaching emotional and social cognitive skills will be useful. When young people with FASD have adequate pragmatic and social cognitive skills, they are better able to describe their emotions and feelings and better able to take the perspective of others.

17. Provide tactile activities to explore extents of experience. I find using a tactile board or sometime asking a client to blow a balloon to illustrate the intensity of what they are feeling and then releasing the amount of air from the balloon, he /she feels ready to let go helps. Alternatively, you can also use a blank sheet of paper to denote the experience and then ask the client to use the paper to illustrate the experience—some may fold it, crush it, or tear it into a shape. Be sure to validate their assessment of their experience.

18. Teach young people with FASD about the psychobiology of trauma, and help them identify their triggers and how trauma affects their body.

19. It is important to consider how the behavior displayed by a young person with FASD play a functional role—for example, it can act as a self-protective measure, survival function and comfort seeking. Always consider the internal stress levels experience by young people with FASD. Build strategies that promote safe and caring relationships, predictability and routine.

20. Use trauma-informed consequences, this will help a young person slowly shape his/her behavior by helping him/her to recognize the impact of his/her behaviors on him/herself and his/her network of friends and family.

Reflection Questions

1. What assumptions am I making about this young person’s behavior? Could there be another explanation?

2. What options do I have to respond to this behavior? How does the young person expect me to respond?

3. What is the purpose of enforcing the rules? Is it to discipline/teach the youth how to manage emotions, or to enforce the rules for the “rule’s sake?”

4. Is this youth intentionally pushing my buttons? Why would he/she want this type of attention from me? -- Keep in mind that for many youth negative attention is preferable to no attention at all.

5. How much of my response is because I feel personally hurt, offended, disrespected, helpless and frightened, or need to prove that I am in control?

6. Which option most closely fits my intent to maintain safety while building the young person’s capacity to manage intense emotions and learn more effective behavior? Which option is least disruptive to service delivery?
Reference consulted

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<th>Resources Needed</th>
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<tr>
<td>• Name Tags</td>
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<td>• Flipchart Paper</td>
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<td>• Pens, Pencils, Markers</td>
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<td>• Help clients identify their responses to trauma and stress</td>
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<td>• Help clients identify key variables that has been difficult</td>
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<td>• Help clients work on reframing their thought patterns</td>
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<td>• Help clients Develop strategies to mindfully cope with upsetting feelings</td>
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<td>• Relaxation</td>
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<td>• Journaling my feelings</td>
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**CHECK-IN**

**Group:** Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

**Individual:** Conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

**QUIET MOMENT**

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

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**Learning Intention**

Today we are going to talk about your feeling, beliefs and behaviours, as well as your ways of coping with unpleasant experiences. Traumatic events can cause people to feel frightened, upset, confused, and helpless.

**Engage – what to do**

Write these words on flipchart

- Loss of a loved one
- Car accident
- Natural disaster
- Violence
- Assault

Ask: what do these events have in common? Responses may include:

- Victim was unprepared for the event
- The event was unexpected
- The person experiences fear, helplessness, etc.

**Discussion questions**

Let’s think about why you are hurting for a moment…

- When we use the term trauma, what do we mean?
- Have you found yourself asking why did this happen to me?
- Are you experience intense and recurrent feelings of anger, anxiety or other emotions?
- Do you belief that no one is trustworthy?
- Are you having difficulty stopping yourself from thinking about the event?
- Are you hiding what you are feeling from friends and family members?
I am going to ask you a few questions, some of which you may find hard and some easy. There are no right or wrong answers. I do not require detail information, mainly yes, or no responses. If I need any more information I will let you know. If there are any questions you are not comfortable answering you a free to ask me to move on to the next question.

I ask about:

- Self-harming and suicidal ideations, attempts or plans
- Use of drugs and or alcohol as well as gambling and internet addiction.
- Any history of abuse and violence
- Any recent losses or separations (I typical refer to the past year or year and a half)
- Support network
- Any feelings of helplessness or hopelessness (be sure to ask them to describe what that looks like for them—hopelessness is different for everyone).
- I also ask about any family history of suicide or suicide attempts, violence, addictions and other stresses.

This way I am able to capture any potential trauma experiences, as well as any intergenerational histories of trauma without having to ask clients to fill out a form. If you use this approach, be mindful that some clients may provide great details, while other may not; acknowledge and validate where they are coming from.

Breaking it Down

For Individual client, use a trauma screening questionnaire, if the individual disclose history of trauma, or intergenerational history of trauma, don’t assume he/she wants to delve into it. Find out if it is something he/she wish to explore. Alternatively, see the box below for an example of how I implement trauma screening in my sessions.
Let's Talk—Hurting feelings

What are some of the emotion/feelings, or mental health issues you have, or are currently experiencing as a result of traumatic events?

Responses may include:
- Frustrated
- Anxious
- Fear
- Anger
- Feelings of being inadequate
- Shame & Guilt
- Feeling like I lost something or someone valuable
- Sadness
- Depress
- Stressed
- Confused

**IMPORTANT NOTES:**

- Remind participants we are only focusing on the feelings, the beliefs and the behaviour today and not the actual event, that during, or after the session if they are needing further help, or wanting to talk their counsellor would be happy to meet with them.
- In this discussion you want to create awareness in the participants that there are resources for them to talk about feelings, which may arise during the discussion. Help them understand that although feelings and memories may arise during the discussion, it is OK just to notice them and let them go. “Just let the experiences that arise pass by like a cloud.” It is certainly appropriate to acknowledge the feelings to the group today, but probing and discussing the memories in-depth can get in the way of learning about trauma. This is actually good practice for the participants to realize and manage the memories.
- Direct them to schedule individual sessions to discuss memories, or flashbacks if they are intrusive or reoccur frequently. The message should be of empowerment to participants (knowledge is power), not to create apprehension about their reaction.
- Exercise caution not to re-traumatize participants.
- Check in with participants to ensure that everyone is ok and not requiring further assistant.
Anxiety may develop due to the sudden, unexpected, terrifying nature of the trauma. This may lead children to anxiety, which can impinge on a young person’s ability to engage in tasks and to manage their responses to events, people or things. It can also impact their inability to tolerate uncertainty. A constant vigilance for the possibility of future threats and other anxiety-driven responses and actions can impact the life of a young person who has experienced trauma. All of these behaviors interfere with a young person’s ability to function and can lead to the development of comorbid anxiety disorder as well as other comorbidities.

About Anxiety—What is anxiety?
Anxiety is a common feeling usually described as “uneasiness”, “discomfort” or “fearfulness.” At one time or another, everyone experiences anxiety. Feeling of anxiety can be described in many different ways. Some feelings of anxiety may include:
- Stress
- Edginess
- Apprehension
- Worry
- Jumpiness
- Nervousness
- The shakes
- Fear
- Butterflies
- Uneasiness

While everyone experiences anxiety, some of us feel it more often, some more deeply, some less frequently, and some less intensely. Our bodies emit freeze, flight-or-flight response chemicals whether the threat we perceive is internal, external, real, or imagined.
- Have you been experiencing anxiety lately? How intense has it been?
- What are some physiological signs you are anxious?
- Do you react by physically fighting or physically running away from any of these threats?
- How do you react if you do not run away?
- Do you find it hard to concentrate and has a constant sense of uneasiness?
- How do you work through moments when you feel anxious?
Anger may result from the young person’s awareness that the event was unfair, that is, that he/she didn’t do anything to “deserve” the trauma. Anger can also result from feeling a sense of personal invasion or violation. Anger in traumatized young people may take the form of noncompliant behavior, unpredictable rages or tantrums, or physical aggression toward property or other people.

- Are you currently feeling angry, or have you experienced feelings of anger, frustration and irritability?
- How do you know when you are angry?
- What does anger look like for you?
- When does your anger become a problem?
- What are some of the payoff or consequences of how you express the anger you are feeling?
- How can feeling angry most of the time affect you?
- Has anger become a habit for you?
- Imagine your life as a bottle, how much of this is being overwhelmed by anger?

Key Points:
- In the most general sense, anger is a feeling or emotion that ranges from mild irritation to intense fury and rage.
- Quite often we use Anger to cover up deeper feelings such as fear, feeling weak or vulnerable, grief, sorrow and shame, and hurt that is associated with the experience of a traumatic event.
- Anger is also most often seen when we feel unheard, suppressed and belittled. Like an iceberg, we can see anger but have little idea what is below the surface.
- ‘Anger’ has a reputation as a ‘bad’ emotion, anger is a natural human emotion – and that in appropriate situations it can be valuable. When skillfully managed, it can motivate constructive action. Reinforce that anger does not define who they are (most people define themselves as, ‘I am an angry person’) let them know anger is an emotions and emotions are not permanent.
- Many people often confuse anger with aggression. Anger is not the same as aggression. Anger is a feeling that can lead to positive or destructive behaviour, whereas aggression is behavior that is intended to cause harm or injury to another person or damage to property.
- Anger becomes a problem when it is felt too intensely, is felt too frequently, is suppressed, is expressed inappropriately, or continues over too long a period of time. Feeling anger too intensely or frequently places extreme physical strain on the body. It becomes like a “pressure cooker” that builds up and explodes or that pop bottle in the experiment we did earlier. This may lead to the person becoming aggressive: abusing or attacking to let off steam.
- Anger can become a routine, familiar, and predictable response to a variety of situations. When anger is displayed frequently and aggressively, it can become a maladaptive habit. A habit, by definition, means performing behaviors automatically, over and over again, without thinking. The frequent and aggressive expression of anger can be viewed as a maladaptive habit because it results in negative consequences.
Box 3: Depression

Young people may experience depressive feelings after a trauma; this may arise in response to an abrupt loss of trust in other people and even themselves. Young people with FASD may experience both temporary and permanent losses. For example, a car accident resulting in loss of mobility for a short period of time is temporary, while sexual assault may have somewhat more permanently loss—i.e., loss of “virginity” and other personal violation. This can lead to self-blame, which in turn may lead to depressive symptoms that include guilt, shame, diminished self-esteem, feelings of worthlessness, and even suicidality. Negative self-concept—this can contribute to maladaptive choices in peers and relationships, as well as, self-destructive behaviors such as substance abuse, cutting, unsafe sexual practices, and suicide attempts, all of which are strongly associated with a history of child abuse or other traumas.

1. What is depression?
   - Feeling sad or low is a big part of life. When something goes wrong in your life, whether it’s an argument with a friend or parent, physical illness or other traumatic event, your mood might drop. If your mood is very low, you are experiencing intense feelings of discouragement and sadness or you have almost no interest in your life almost everyday, and this feeling goes on for weeks, you may be experiencing depression.

2. How do you know you may be depressed?

3. What are some other signs?

   Signs of depression are:
   - You feel sad, hopeless, or empty most of the time
   - You’re either so “sped up” or “slowed down” that others notice it.
   - You are tired, lacking in energy
   - Feeling numb or empty
   - You have less interest and pleasure in things than you used to
   - You eat too much or too little
   - You feel worthless or guilty
   - You have difficulty thinking or making decisions
   - You think a lot about death; you may want to HURT yourself.
   - Trouble concentrating
   - Unrealistic negative thoughts
   - Irritability
Let’s Talk—hurting beliefs

What are some of the hurting beliefs you have with regards to your experience? Responses may include:

- I am permanently damaged
- I am not good enough
- It is my fault
- Something is wrong with me, which is why people keep hurting me.
- My life is a shit hole so why bother
- I am never going to get past this
- I will never let this go…
- I hate myself
- People hate me
- I am an embarrassment to my family

Let’s talk—Hurting Behaviours

Each individual has his/her ways to “let the pressure out of the bottle”. What are those? (Include positive and destructive ways).

Example of responses may include:

- Drink alcohol
- Use drugs
- I do risky things like go on joy rides
- Sleep with multiple partners
- Lie to parents, friends and even myself to feel better
- I pretend everything is ok
- Cut myself
- Run away from home

Know your Triggers

Many times, specific events, things, places and people touch on sensitive areas. These sensitive areas or “red flags” usually refer to issues that can easily lead to intense emotions. The events that you experience may remind you of past hurts, or may result in flashbacks about your past experiences.

- What are the events, things, place or people that arouse, or provoke an intense emotion or feeling for you?
- What are some cues you can monitor? These cue serve as warning signs to let you know that you are becoming, for example, anxious, angry or irritable.
  - Physical cues [example, your body’s response—increased heart rate, excessive sweating, tightness in chest]
- Behavioural cues [example, what you do—raise your voice, clench your fists, bite your nails]
- Cognitive cues [example, what you think about in response to the event, person, or thing—thinking of revenge, negative self-talk]
- Emotional cues [example, feelings that occur—fear, hurt, anger]

What are some ways you can cope with the trauma you have experienced?
- Take a timeout (formal or informal)
- Talk to a friend (someone you trust)
- Exercise (take a walk, go to the gym, etc.)
- Use mindfulness strategies—for example, deep breathing and meditation
- Attend a trauma group
- Visualize your “safe place.”
- Listen to music.
- Listen to, watch, or read something funny.
- Write in a journal.
- Volunteer.
- Sing out loud.
- Dance to your favorite music.

What three activities you have done in the past week that could be considered useful in helping you cope better?
Learning Activities

Activity 1: Mix Feelings

Ask for three volunteers (caution the volunteers that they may get a little wet).

- Using the three small sprite/club soda bottles: 1 with the contents replaced with tap water.
- Hand the volunteers a bottle each, remembering which person is holding the bottle with tap water.
- Now ask everyone to think about the things that stress them out (for example, people not telling the truth, loneliness, etc.) and then share them with the group (be sure to allow everyone a chance to participate). Let the participants holding the bottles know you would like them to shake them while you are hearing about all of these stressful things.
- Once you have heard everyone’s list, Ask:
  - What is happening inside the bottle as our volunteers are shaking them? Example: When we get full of feelings, pressure begins to build up inside. We feel like a bottle about to burst.
  - Be sure to write the stressful things on a flip chart.

Ask person #1 (holding a real bottle of club or sprite) to open their bottle quickly. (Be clear about making sure that the other individuals holding bottles do not open their bottles until they are instructed.)
- What happens when we bottle things up? (Solicit responses such as those below)
  - We explode
  - Pressure gets released all at once
  - Things get messy
  - You have to clean up the mess

Ask person #2 (holding the bottle that holds tap water) to open their bottle quickly. What happened? (Solicit responses such as those below).
- Sometimes things get bottled up for so long that you go numb and feel like you do not have any feelings at all.
- Sometimes people end up feeling flat, emotionless.
- What is wrong with feeling numb?
- Can’t feel good things

Ask person #3 (holding a bottle of club soda or seltzer) to alternatively open and close their bottle slowly (they should have kept shaking it during the other discussions) to release the pressure.
- What happened?
  - Didn’t explode
  - Didn’t go flat
  - Let out pressure slowly
Learning Activities

**Activity 2: Guided Journal Writing**
Let them know we are going to engage in an activity and that to make this more personal and private you will be guiding through a journal exercise. *[You can either provide small journals or staple stacks of paper together]*. Let them know that there will be a box on the desk at the front and if anyone would like to share their journal with the facilitators they can leave it in the box. Emphasize its only if they feel comfortable and the need to share further, as well as talk to someone.

1. **FEELINGS**—Feelings are what we feel in your bodies and hearts. There are many different feelings that we have, and our feelings may change from moment to moment. Sometimes we even feel two or more feelings at the same time.
   - What are your most dominant emotions, or feelings as a result of your experience? *[Please write down as many feelings as you can think of in your journal]*
   - Next put a colour next to each feeling to describe it.

2. **EXPERIENCING FEELINGS IN YOUR BODY**—Remember the feelings and colours you listed. We are going to use those colours now to show where in your body you experience each feeling. You do not have to do all the feelings you listed.

3. **HOW STRONG OR INTENSE ARE YOUR FEELINGS?**
   - Sometimes we feel a feeling just a little bit, and other times we feel a feeling so strongly that we feel like we might BURST with that feeling. You can rate or measure your feelings, just like a thermometer measures temperature. The number tells how intense the feeling is.
   - What feelings are you having right now? How would you rate each of those feelings (on a scale of 1-10)?

4. **THOUGHT**
   - Sometimes we think about the bad things over and over (like a song you do not like that gets stuck in your head). We’ll call this a bad song because it can make us feel really bad!
   - Do you find yourself thinking and thinking about what happened?
   - Draw a picture to illustrate what it feels like in your head.

5. **BEHAVIOUR**
   When bad things happen, we can sometimes engage in behaviours to help numb our pain, or to help us forget. What are some of the behaviours you have engaged in?

6. **COPING WITH UPSETTING FEELINGS**
   - When we experience an upsetting feeling very strongly, we can DO THINGS to lessen the intensity of the feeling. For example, if your anger is at a 10 (very strong), you can do things to bring it down to a 1 or 2. What are some of these things you can do?
   - Tell participants we are now going to do this part collectively, but they will need to write the responses down
   - Now imagine I gave you a toolkit, what kind of thoughts, feelings and things that would help you cope better would be in there. [Invite them to brainstorm ways they could mindful cope, write their response on a flip chart as this will help them copy it onto their toolbox.
   - Once completed, use some deep breathing techniques to help ground participants. Remind them that they can speak if you during the break if they need to.
Reflection Circle

Today we talked about hurt feeling, hurt beliefs, hurt emotions,
1. What stands out for you the most?
2. Do you think differently about your ways of being, or how you approach things?
3. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT
Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present

Homework

- Encourage participants to reflect on what they have learned about mindfulness
- Ask them to use mindful strategies this week to help with their coping

Key points

This exercise reminds us that people are very much like these bottles and that we all need to figure out how to release the pressure that is inside of us. Refer participants to handout out on the body
1. Coping with unpleasant feelings and memories of trauma
2. Techniques to manage flashbacks
3. Coping with anxiety & depression
4. Mindfulness & anger
5. Relaxation
6. Journaling my feelings
7. Situational Matrix
For many of you, substance use is a coping strategy for dealing with unpleasant memories, and feelings. Many young people with FASD who have a history of substance misuse have experienced trauma in their lives. Examples of trauma are physical, sexual, and emotional abuse. Some of you have also experienced difficult separation from your families and home communities. It is likely that you may feel a range of negative, overwhelming feelings since you no longer use alcohol and/or drugs to cope. Experiencing flashbacks and nightmares is common. Flashbacks are recurrent, distressing memories of the traumatic event. A flashback may feel as if you are reliving the traumatic event.

This is a list of symptoms you may have experienced if you have been traumatized. Identify which of the following symptoms are triggers for you regarding relapse.

1. Hyperarousal
   - ☐ never feeling safe
   - ☐ easily started, react irritably to small things
   - ☐ a feeling of potential danger
   - ☐ sleep poorly (problems falling asleep)

2. Constriction (shutting down for self – protection)
   - ☐ feeling of numbness
   - ☐ not having feelings
   - ☐ dissociation – observing events from outside one’s body
   - ☐ suicidal
   - ☐ generalized fear (e.g., sleeping with a weapon or checking under the bed)
   - ☐ sleep problems

3. Intrusion
   - ☐ flashbacks- memory, reliving the event as if it were in the present
   - ☐ suicidal thoughts
   - ☐ traumatic nightmares – waking up feeling very frightened
     - body memories – feelings in your body that were with you at the time of the traumatic event (smells, tastes, sounds) may trigger memories.

Take a few moments and write down some signs that you experience when you feel overwhelmed. It is important to know your warning signs as a first step to managing these symptoms and feelings. Note physical signs (e.g., heart racing, confusion) or emotional signs (e.g., “I feel I am going crazy” or feeling intense anger).
Here is a list of strategies you can practice and use to cope with flashbacks, body memories, feelings of anxiety and cravings. You can use these strategies anywhere.

**Use grounding techniques**
- Count backwards from 100 in groups of 3, 4, or 7
- Use visualization and guided imagery to calm yourself down
- Hold ice cubes in both hands while keeping your focus on your breath
- Meditate

**Breathing**
- Holding your breath is a fear reaction.
- Become aware of your breathing.
- Tell yourself to breathe – repeat the word “breathe”.
- Breathe from your diaphragm, taking slow deep breaths.
- Breathe for a count of three, hold your breath for a count of three, and release your breath for a count of three. Repeat this pattern.

**Bring yourself back into your environment by using and becoming mindful of your senses (sight, hearing, smell, touch)**
- Mindful seeing: try not to close your eyes so you can be aware of your environment. If someone else is present, make eye contact.
- Mindful Hearing: Pay attention to hearing sounds around you (e.g. traffic, people’s voices)
- Mindful Smelling: Pay attention to smells (e.g. coffee, food, etc.)
- Mindful Touching: Hold onto the chair you are sitting on, feel the chair underneath you, and notice your feet on the ground. Repeat to yourself, “I am here in the room” (i.e. your home, your group therapy room).

**Create safety and a comfortable/nurturing environment**
- Carry things with you that bring you comfort (e.g., a stuffed animal, sobriety medallion).

**Use positive self-talk**
- For example, remind yourself of a good thing that you have done or that has happened to you

**Use music**
- For example, Raki, Ayurveda, yoga, nature sounds, or any other music you feel comfortable with

**Baths**
- Water can be very therapeutic and calming

**Use animals**
- Animals are very loving and can have calming effects. For example, dogs and horses are known to help people relax and reduce anxiety and stress.

**Use other mindfulness techniques such as Yoga, Tai Chi, Pilates and Qigong**
Most young people in substance use treatment report having trouble with anxiety from time to time. Anxiety can be particularly problematic for young people with FASD as they try to navigate through their environment. For some young people it easier to avoid some situations, while others may rely on alcohol or other drugs to reduce their anxiety to a tolerable level. Neither situation works well in the long run.

Using alcohol or other drugs to cope with anxiety can be a vicious cycle, in which a person comes to believe that he or she cannot function in a given situation without using substances. If you feel you cannot cope with your anxiety, seek help. The group facilitator should be able to direct you to the appropriate support person, or you could discuss your concerns with your substance use counsellor.

**There are some strategies to help you work through Anxiety**

1. Practice “thought stopping”. When you recognize some of the automatic thoughts appearing, shout “STOP!” and picture a large stop sign in your imagination.
   - What you think and what you tell yourself have a big influence on how you feel. Many people have responded to situations in the same way for so long that their thinking becomes almost automatic. These “automatic thoughts” are the negative messages people give themselves that contribute to feelings of anxiety. Becoming aware of your automatic thoughts, then challenging them, can help you break the cycle of anxiety-provoking thoughts and situation, and substance use.

2. Pay attention to the positive things that happen, and keep track of them. You may even want to write them down.

3. Challenge the automatic thought. Ask: Does it make sense? What is the evidence for this? Is there a more realistic way to interpret the situation?

4. Say something positive to yourself or reward yourself when you successfully cope with anxiety – producing situation without drinking or using drugs.

5. Re-label your negative feelings (e.g., stress, anxiety) – and the cravings that go along with them – as an important signal to take action.

6. Remember that some anxiety and stress is normal for everyone. Concentrate on reducing your anxiety to a manageable level, not eliminating it entirely.

7. Practice mindfulness techniques (muscle relaxation, breathing, meditation, yoga or Pilates)

8. Recognize your feelings before they become overwhelming. Practice self-awareness

9. Express emotions, do not suppress what you are feeling
Everyone experiences anger; it is a normal human emotion. However, the ways in which we express anger can have negative consequences, both for ourselves and others. Anger is an emotion that leads many people to relapse. This is more noticeable early in your change process. Often, anger slowly builds on itself as you constantly think about things that make you angry. Sometimes the issue causing you to be angry can get overwhelming as you may get stuck thinking about it over and over again. Often a sense of being victimized accompanies the anger. Anger can also lead to aggressive, passive aggressive or passive communication patterns, and many people identify anger as a trigger for alcohol or drug use.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Talk to the person you are angry with.</td>
</tr>
<tr>
<td>2.</td>
<td>Talk to a counsellor, a 12-Step sponsor, or another person who can give you guidance.</td>
</tr>
<tr>
<td>3.</td>
<td>Talk about the anger in an outside support group meeting.</td>
</tr>
<tr>
<td>4.</td>
<td>Write about your feelings of anger.</td>
</tr>
<tr>
<td>5.</td>
<td>Be aware of your body (e.g., tight muscles, clenched fists, etc.)</td>
</tr>
<tr>
<td>6.</td>
<td>Take a few deep breaths of relaxation. Stay calm.</td>
</tr>
<tr>
<td>7.</td>
<td>Remember that anger is a signal that something needs to change.</td>
</tr>
<tr>
<td>8.</td>
<td>Look for positives; don’t jump to conclusions.</td>
</tr>
<tr>
<td>9.</td>
<td>Leave the situation if necessary (Take a “time-out”)</td>
</tr>
<tr>
<td>10.</td>
<td>Can you laugh about it?</td>
</tr>
<tr>
<td>11.</td>
<td>Ask someone you trust to mediate the situation</td>
</tr>
<tr>
<td>12.</td>
<td>Practice letting go - forgiveness</td>
</tr>
<tr>
<td>13.</td>
<td>Practice grounding strategies (counting backwards, using ice, imagery, etc.) to help you calm down</td>
</tr>
<tr>
<td>14.</td>
<td>Use progressive muscle relaxation</td>
</tr>
<tr>
<td>15.</td>
<td>Shift your thinking – often, how we experience a situation has a lot to do with how we think and feel about it and less to do with the actual situation.</td>
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<tr>
<td></td>
<td>Use REM-Recognize, Evaluate, Modify your thinking</td>
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<tr>
<td></td>
<td>Do not personalize</td>
</tr>
<tr>
<td>16.</td>
<td>Ask yourself am I ‘REACTING’ or am I ‘RESPONDING’? When people react, it seems to be defensive. We are often uncomfortable with what is being said or done, and we react. In our reactions, our emotions take a central role. On the flip side is respond. Responding is more thoughtful and guided less by emotion.</td>
</tr>
<tr>
<td>17.</td>
<td>Mindfully Listen/ Actively Listen Raising attentiveness – when you maintain your inner calmness and strength, you can listen to what is being said more intently, and you are better able to watch the way in which it is being said. You are then more aware as you formulate your response. Mindful listening will enable you to respond more thoughtfully and, if needed, begin to direct the exchange in a direction of collaboration and resolution.</td>
</tr>
</tbody>
</table>
Breathing Exercise

You can practice relaxation exercises anywhere you are at any time. You will need to:

1. Find a place where you can relax.
2. Choose a relaxation exercise that you enjoy.
3. Get into a comfortable position and begin to practice.
4. Many people prefer to close their eyes during these relaxation exercises.
5. If this is not comfortable for you, you can fix your eyes on a spot on the floor or wall.
6. As you breathe in, let your abdomen expand outward, rather than raising your shoulders. This is a more relaxed and natural way to breathe and helps your lungs fill themselves more fully with fresh air, releasing more “old” air.
7. If during the breathing exercise you cannot stop thinking about your concerns and worries, come up with a word or a phrase that you find peaceful, such as “tranquility” or “I am relaxed.” Focus on this word or phrase as you breathe in and out. If other thoughts pop into your head, don’t get discouraged — just refocus and keep practicing!
MY FEELINGS JOURNAL
What are your most dominant emotions, or feelings as a result of your experience? [Please write down as many feelings as you can think of]. Next put a colour next to each feeling to describe it.
EXPERIENCING FEELINGS IN YOUR BODY— Use the feelings and colours you listed to show.
**HOW STRONG OR INTENSE ARE YOUR FEELINGS?** What feelings are you having right now? How would you rate each of those feelings (on a scale of 1-10)?

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Rank</th>
</tr>
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<td></td>
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</table>
THOUGHT:
Do you find yourself thinking and thinking about what happened? Draw a picture to illustrate what it feels like in your head.
**BEHAVIOUR:**

When bad things happen, we can sometime engage in behaviours to help numb our pain, or to help us forget. What are some of the behaviours you have engaged in?
COPING WITH UPSETTING FEELINGS: When we experience an upsetting feeling very strongly, we can DO THINGS to lessen the intensity of the feeling. For example, if your anger is at a 10 (very strong), you can do things to bring it down to a 1 or 2. What are some of these things you can do?
Use this sheet to help you understand your experience. Write the situation and then use the diagram below to explore how the event or situation has impacted you.

Situation:
____________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

Thoughts

Feelings

Behaviour

Physical symptoms
Chapter Fifteen
Relationship & Social Skills
Clinicians Note

Relationship and Social competence are central aspects of development in young people and contribute to well-being and self-confidence. They are also necessary for mental health and enhancing a young person's sense of being, belonging and becoming. In general, young people are often challenged in these two areas in one way or the other. For many, young people with FASD, these challenges are made more complicated because of the impact of FASD. Young people with FASD present both difficult dilemmas and unique opportunities for change, and growth in social and relational skills.

Social development represents a range of skills, including attention, problem-solving, and communication that can be built and layered to improve social competence. Many young people with FASD may find it hard to understand and cope with their relational and social context. They may have difficulty in solving social problems and in generating multiple solutions. They may also have difficulty with social cues of others, making and keeping friends, and often come from chaotic home environment and experience instability in their relationships making it difficult for them to trust others and feel confident in being. Issues of mistrust may impact their relationships with others. Additionally, ongoing use of substances can negatively affect the relationships between family members as well as with friends, employers, school and coworkers. Individuals with mental health disorders challenges, in addition to their substance use, may encounter even more struggles in the areas of communication, social functioning, and coping.

Young people with FASD who struggles with maintaining positive relations, feels unsafe in a relationship, and have difficulties with social skills such as problem-solving will struggle to reach their optimal potential without help and support. Young people with FASD can develop social competence through stable, caring
and responsive relationships with adults. It is essential that clinicians have an awareness of the relationship dynamics and social competence of young a person with FASD and how to support him/her in these areas and their importance for the development of positive dispositions towards lifelong learning.

**Communication**

Communication is an essential element of our daily lives and experiences. However, not everyone possesses the ability to communicate effectively, and for individuals with FASD this, particular skill may be especially challenging. They may be especially prone to communication and interpersonal skill deficits. Many of the young people I worked with reported their experience of communication as being somewhat being chaotic, and abusive. Additionally, some have been raised in an environment where the substance use of others hindered exposure to healthy communication styles. It is vital that we help young people with FASD with developing and maintaining this skill set. Effective communication coaching can enhance interpersonal relationship, boost confidence and improve well-being.

What we say, how we say it, and when it is said, can have a significant impact on how we relate, talk to, and socialize with others. Skills that are not developed can interfere with relationships and contribute to an individual's difficulty in managing and solving problems and setting, maintaining or respecting boundaries, resulting in unnecessary misunderstandings. All of these potential issues can be considered therapeutic challenges for a client and can create preventable frustration, isolation, and feelings of helplessness.

Therefore, it is important that clinicians assess the need of young people with FASD and appropriately introduce skills training as part of the client’s treatment plan. Young people FASD and co-occurring substance misuse who have struggled with building healthy relationships may benefit from skills development in the area of interpersonal communication, given that it is so integral to recover, change and well-being in general.

As clinicians engaging with young people in meaningful ways gives them opportunities to develop self-control. When we see young people with FASD as capable and competent, this will give them many opportunities to express their feelings and show concern for others. It is fundamental that young people with FASD learn effective communication. To enable this, clinicians should:

- Explore communication styles and teach assertiveness skills
- Reinforce the need to practice assertive communication
- Establish the value of listening and how to listen actively.
- Explore things that contribute to communication problems and discuss some ideas for overcoming those difficulties

**Problem Solving**

Confronting and effectively working through problems is a part of everyday life and problem-solving skills are the foundation of all areas of learning and development. The lives of young people are full of dilemmas and problems to solve. For young people with FASD, this may bring more than its fair share of challenges, from acting on their impulse to repeating the same problems over and over. A young person with FASD may rush into tackling a problem without thinking it through, and this may likely add a layer of complication to an
already fragile situation Logically, problem-solving strategies do not always come naturally to young people with FASD, but it can be taught.

It is important that the clinicians encourage their clients that they have the necessary skills to solve problems. A way of doing this is to ask clients what steps they have employed in the past to solve problems. A variety of techniques is beneficial when working with clients on problem-solving skills. Such techniques may include verbal instruction, written information, and skill rehearsal. A young person with FASD may find problem-solving a difficult exercise, which may require a lot of practice and simple, easy to follow information.

Learning to problem-solve will support young people with FASD to develop a range of positive learning dispositions including:
- Initiative
- Self-confidence
- Enhance self-Resilience

It is fundamental that young people with FASD develop effective to problem-solving skills. To enable this, clinicians should:

- Help client to develop their negotiation skill so that they can come to healthy compromises in the event they cannot agree on a solution
- Teach them how to respond, disagree, and differ
- Teach team how to agree
- Provide materials to support or promote problem-solving
- Encourage participation in sport and physical activities like this can be used to challenge your clients to solve problems
- Use reflection and discussions to assist clients to understand how to use their feeling of efficacy in other parts of their lives.
- Help them to organized, and break down tasks into step-by-step sequences, and relate parts to the whole
- Using open-ended questioning techniques to help stimulate creative problem-solving. For example:
  - What will you do to fix this?
  - Can you think of what you will need?
  - What will happen if...
  - How will you find out? …
- Using ‘Thinking’ Language—An effective pedagogical strategy to assist problem solving is to place emphasis on using ‘thinking language’. Draw their attention to the importance of thinking, for example, “Let’s Stop and Think”; “I am going to give you some time to think about this…”; and “I want you to think carefully and think back on…”
- Co-constructing with your clients—for example, explore multiple ways of explaining something or working out a problem
- **Ask metacognitive questions.** When the young person is talking to you about a challenging situation, for example, an upcoming meeting with their teacher to discuss challenges they are having at school, you might say, let’s talk about how you are feeling, let’s talk about what your struggles are? How can your teacher help you? What strategies will you use to tell her about your challenges? What study strategies worked best before in meeting such as these?
- Gather information from the client: Listen to his/her point of view, find out, without making judgments, about what might have happened
- Restate the problem. Repeat what the client have told you using their words and reframe their words if they are hurtful.
- Teach reframing techniques

**Decision Making**

It is very important that as clinicians we remain non-judgmental as we talk to young people about the decisions they make daily. Good decision making is an important life skill. You can use simple, carefully worded questions to keep the discussion emotionally neutral. The goal is to help youth with FASD develop good decision making skills. Here are some questions that you can use without judgment or criticism to help young people with FASD evaluate a decision they’ve made:

1. What do you think you could have done differently?
2. What do you wish you had done differently?
3. What did you need to consider that you didn't think about?
4. Are you pleased with how things turned out?

**Relationships**

Relationships are an essential part of the lives of young people with FASD and contribute largely to their overall development. Relationships can include people both inside and outside the family, for example, close family members, educators or caregivers. The most important aspect of any relationship for young people, especially a young person with FASD, is that it is a secure relationship. Stable relationships are those, which are responsive to all the needs of the young person. These needs can include their physical, emotional and developmental needs. With the help of secure relationships, young people with FASD can explore the world around them, and have a sense of belonging. Young people with FASD, like most individuals, bring their experiences of early relationships with them in life, and this can affect their long-term behavioural and emotional development, for example, how they react and adapt to new experiences, situations or people.

Being part of a healthy relationship enables children to develop a sense of who they are and a sense of being significant in the lives of others. The benefits for young people with FASD, who enjoy meaningful and healthy relationships are immense, including self-confidence, motivation, independence, good peer relationships, social skills and an understanding of emotions. Healthy relationships also develop a foundation for empathy (being able to understand how someone else is feeling), an openness to two-way interactions with peers such as taking turns and enhanced thinking and reasoning skills.

As clinicians engaging with young people in meaningful ways gives them opportunities to develop self-control. When we see young people with FASD as capable and competent, this will give them many opportunities to express their feelings and show concern for others. It is fundamental that young people with FASD build healthy relationships. To enable this, clinicians should:

- Help them to understand and build meaning in relationships
- Teach healthy boundaries
- Encourage ongoing self-reflection.
- Cultivate positive attitude

**Reflection Questions**

1. *What assumptions am I making about the way this young person communicates? Could there be another explanation?*
2. *Am I engaging in open-ended communication with my clients?*
3. *Am I tuned-in’ to my clients’ abilities, needs, interests and strengths?*
4. *How do I scaffold communication skills?*
5. *Do I provide appropriate scaffolding techniques?*
6. *How do I facilitate the development of active listening skills?*
7. *How do you help my clients to communicate effectively?*
8. *How can I help clients to nurture their relationships?*
9. *How do I help clients to build trust?*
Resources Needed

• Name Tags
• Presentation slides
• Flipchart Paper
• Pens, Pencils, Markers
• Sticky Notes
• Laptop
• LCD Projector
• Yoga Mats or Towels

The Goal of the session is to:

• Help clients develop effective communication skills
• Help clients solve problems effectively
• Help clients explore their decision making process
• Help clients work on building healthy relationships
• Help clients work on building trust in their relationship and confidence in being

Handouts

• Checklist for Mindful Listening
• Listener Instruction Cards
• Mindful Listening
• Tips for Effective Communication
• Problem Solving Steps
• Steps for making Good Decisions
• Building Healthy Relationships
• Positive Relationships
• Relationship Airplane
CHECK-IN

**Group:** Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

**Individual:** conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

### Learning Intention

Today we are going to talk about communication, mindful listening and things that can get in the way of communication. Listening and communicating can sometimes be a frustrating process. Communication is useful for developing healthy relationships, as well as how we express ourselves and respond to others communicate to us.

### Engage – what to do

Communication is an important part of our daily encounter. We communicate our needs, how we feel, what we want, what we dislike, etc. There are many ways to communicate with others—verbally, non-verbally, etc. Take some time to think about how you communicate with others. Would you consider the way you communicate effective, or positive?

### Discussion questions

Let’s think about your communication for a moment…

- What is communication?
- Why is communication important?
- How do you know someone is listening to you?
- How do you know you are listening to someone?
- Do you find it difficult to listen to others at times?
- What do you think mindful listening involves?
Breaking it Down

You can:
- Examine the role of communication in every aspect of your client’s life.
- Provide a range of activities that help your clients to practice effective communication in different settings and help them examine their interpersonal communication skills.
- Explain the importance of communicating their needs.
- Explore the barriers to effective listening.
- Explore how to improve listening skills.
- How they respond, disagree, agree, and differ
- Explore at the relationship between communication and behavior and how one influences the other.
- Explore communication styles (passive, passive-aggressive, aggressive, assertive)—use scenarios to help clients explore their consistent communication style.
- Explore ways communication gets blocked—barriers to good communication.
- When communication is blocked, what usually happens?

| AGGRESSIVE                        | ○ Shouting at people  |
|                                  | ○ Invading other’s space  |
|                                  | ○ Intimidating others  |
|                                  | ○ Making threats  |
|                                  | ○ Intense staring at people  |
|                                  | ○ Try to dominate others  |
|                                  | ○ Be demanding and overbearing  |
|                                  | ○ Use humiliation to control others  |
|                                  | ○ Not listen well  |
|                                  | ○ Use ‘you’ statements  |
| PASSIVE AGGRESSIVE               | ○ Trying to sabotage secretly a friend’s effort to get even  |
|                                  | ○ Muttering to self or a friend rather than confront the person or issue  |
|                                  | ○ Having difficulty acknowledging anger  |
|                                  | ○ Using sarcasm  |
|                                  | ○ Denying there is a problem  |
|                                  | ○ Indirect with feelings  |
| PASSIVE                          | ○ Allow others to deliberately or inadvertently infringe on their rights  |
|                                  | ○ Fail to express their feelings, needs, or opinions  |
|                                  | ○ Feels inferior to others  |
|                                  | ○ Avoid conflicts  |
|                                  | ○ Often feels hurt, anxious  |
| ASSERTIVE                        | ○ Stating needs and wants clearly, appropriately, and respectfully  |
|                                  | ○ Expressing feelings clearly, appropriately, and respectfully  |
|                                  | ○ Using “I” statements  |
|                                  | ○ Communicate respect for others  |
|                                  | ○ Listens well without interrupting  |
How can you build assertive communication skills?

**Example of response**

- Show respect for others
- Speak more gentle
- Listen better

How can we make assertive statements?

<table>
<thead>
<tr>
<th>Describe what is happening</th>
<th>I think…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[Just the facts (no judging or blaming)]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Express your feelings</th>
<th>I feel…</th>
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<tbody>
<tr>
<td></td>
<td>[Give your honest reaction without blaming or intimidating]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specify what you want</th>
<th>I would like it if you would…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[Be specific enough so that a person can do what you are asking]</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Consequences</th>
<th>I think we would both benefit because…</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>[State the payoff for you and the other person]</td>
</tr>
</tbody>
</table>

What is mindful listening?

**Responses may include:**

- Paying attention to the person speaking to you
- Validating the person’s concern
- Not interrupting while someone is speaking
- No criticisms or judgments
Mindful communication is:

- Sticking to the issue at hand
- Refrain from criticism
- Refrain from blaming
- Listening carefully, and try to see other point of view
- Managing our emotions & tone of Voice

Exploring communication barriers or blockers

Possible responses may include:
- Arguing
- Ignoring others
- Avoiding others
- Withdrawing from others
- Criticizing
- Threatening
- Stubbornness

Ask: When communication is blocked, what usually happens? Let clients generate ideas.
Learning Activities

Activity 1: Mindfulness Listening

- Divide the class into two groups [Drawers and Explainers], or you could do this with the entire group.
- One participant will be the “explainer” and will hold a picture in his/her hand and will give directions to the other participants, the “drawers”, about how to draw the picture as accurately as possible.
- The participants drawing the picture do not get to see it; only the person who is explaining it gets to look at the picture. [See handout: mindful listening for pictures]
- The “drawers” also have to turn their backs to the explainer, while drawing their pictures. That is, the explainer only gets to use his or her voice (with no body language or facial expressions) to explain what the picture looks like. The drawer may not ask the explainer any questions.
- Ask each group to pick one person to represent their group.
- Give the drawer a blank sheet of paper and pencil. Give the “explainer” the picture, set a time limit (e.g., you have 5 minutes) and tell the “explainer” to begin describing the picture to the “drawer.”
- When time is up, have the explainer and drawers reveal the pictures and have members compare how they did. Ask participants to say how easy or hard the task was for them.
- Select a different person to be the “explainer.” The facilitator says “This time the “explainer” and “drawers” will face each other. The “explainer” will use his or her voice, as well as facial expressions and gestures to describe the picture. The explainer also can answer your questions.” Give the “explainer” the second picture, set a time limit (e.g. you have 5 minutes) and tell the “explainer” to begin describing the picture to the “drawers.”
- When time is up, have the explainer and drawer show the group the picture and have members compare how they did. Ask “drawers”: “Was it any easier this time to draw the picture? If so, what made it easier?”

Alternatively, you could be the explainer and the entire class the drawer

- “I am going to describe the picture I am looking at, and I want all of you to draw it. I cannot tell you what it is you are drawing; I can only describe the shapes of the objects in the drawing and tell you where to place them on the page. Don’t worry if you get frustrated or don’t understand everything I say, just do the best you can. Most people find this hard to do.” [Allow 5 minutes]
- Provide a step by step description of the picture.
- “We are finished. Let’s compare what you drew with the picture I was describing.”
- After students compare their drawings with the picture, ask students to say how easy or hard the task was for them and what made it easy or hard.

See handout: mindful listening for pictures
Learning Activities

Activity 2: Listener

Invite clients to participate in an activity involving listening skills. Give the following directions:

- Pair off. One person will be the speaker; the other will be the listener.
- The speaker will talk about a problem that s/he has had recently (for example, some issue with his/her parent or a friend).
- The listener will be given a card with special instructions to follow.
- Divide participants into pairs and have them choose (or you assign) roles. Tell the speakers to think of a recent problem that they feel comfortable discussing (nothing too personal or intimate).
- Distribute the instruction cards to the listeners, asking them not to show them to the speakers until you say so. Ask the pairs to begin, explaining that you will stop them after three minutes.

INSIGHTS

- Speakers, how well did your partner listen? Did you feel you were being understood?
  - Why or why not? (Note: Focus the majority of the conversation on the people who felt they weren’t being listened to. Tell the people who had good listeners that you will come back to them in a few minutes.)
- Ask the listeners to share their instruction cards with their partners. [Read the instructions aloud and have a good laugh.]
- What does it feel like when you are talking about something meaningful and the other person isn’t giving you their attention or is being judgmental?
  - What was it like doing this activity?
  - Think about the ways that you behave and what you do when there is some conflict; do you express your opinions and if so, how? Or, do you withdraw or leave the situation?
  - Think about how you communicate your needs to other? Which of those styles do you use?
Reflection Circle

Today we talked about communication and mindful listening.

1. Did anything happen today that made you re-think how you listen to others, or communicate your needs, goals and ideas?
2. Did you learn anything about yourself through the discussions and activities?
3. Do you have any other questions or concerns you would like to discuss?

CHECK-OUT
Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage participants to practice the muscle relaxation exercise.

Key points

- Communication is when two or more people exchange messages using verbal and non-verbal language.
- Communication happens because people want to share information, ideas, thoughts, feelings, etc. and get another person’s feedback.
- Communication is key to every aspect of our lives and plays an important role in building and strengthening our relationships with others.
- We need to listen properly to what others are saying and not draw conclusions.
- The way a person communicates with another person will affect how the other person reacts.
- Aggressive communication will trigger an aggressive or defensive response.
- Assertive behaviour is important so we can negotiate for the things we want without being bullied or influenced by others.
Chapter 15: Unit 1

1. Mindful Listening
2. Listener Instruction Card
3. Checklist for Mindful Listening
4. Tips for Effective Communication
**Drawing Instructions**

1) Draw a circle and add two triangles on each side at the top.
2) Sketch a cross in the face. The horizontal line is where you will draw the eyes so remember not to put it too high or too low. Just below the center will do. Now draw the outline of the face and ears.
3) Draw two circles for the eyes and a T-like shape for the nose.
4) Complete the details. Draw another two triangles for the ears. To complete the eyes, draw a shape similar to the human eye but pointier on the sides. Draw two fairly thick lines for the bridge of the nose. For the mouth, draw lines similar to an inverted letter T.
### Drawing instructions

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Image</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Draw the circle, a pair of eyes, top and lower body</td>
<td><img src="image1.png" alt="Step 1" /></td>
</tr>
<tr>
<td>2</td>
<td>Add an upper and lower wing</td>
<td><img src="image2.png" alt="Step 2" /></td>
</tr>
<tr>
<td>3</td>
<td>Add patterns into the wings</td>
<td><img src="image3.png" alt="Step 3" /></td>
</tr>
<tr>
<td>4</td>
<td>Complete it with body detail. What does your drawing reveal?</td>
<td><img src="image4.png" alt="Step 4" /></td>
</tr>
</tbody>
</table>
CARD 1
Listen attentively to your partner for about a minute. Then begin to get distracted. Look at your watch or the clock, glance around, drop your pen—but don’t be obvious.

CARD 2
Pay attention to your partner, but disagree with everything that s/he says. Interrupt while s/he is talking and tell her/him what you think s/he should do, whether or not s/he asks for your advice. Point your finger and try to be aggressive.

CARD 3
Do your best to use active listening skills.
# MINDFUL LISTENING CHECKLIST

1. Tune into what the speaker has to say.
2. Give the speaker your full attention.
3. Make direct eye contact. (Be mindful of cultural differences in which direct eye contact might be uncomfortable or considered disrespectful.)
4. Don’t interrupt, judge or criticize the speaker.
5. Use non-verbal listening skills: Nod or shake your head; change your facial expression as appropriate (e.g., showing concern, excitement.)
6. Use brief verbal responses that indicate you are listening, such as “yes,” “I see,” “go on,” etc.
7. Ask questions to clarify what the person is saying and to encourage the person to say more. For example, “So, what happened that got you so upset?”
8. Try to figure out the feelings reflected by the speaker’s words. Ask a question to determine whether you are correct about how the speaker is feeling. For example, “Are you angry at your parents?”
9. Get feedback. Test how well you understand the speaker by telling him what you think s/he is saying.
10. Ask if there is anything you can do – that way you are not assuming the person wants advice; some people just need someone to listen to them vent.
11. Be aware of your experiences and biases and how it might impact your response.
12. When unclear about how you feel, ask for time to think about it.
Tips for Effective Communication

1. **Stay Focused:** Sometimes it is tempting to bring up past seemingly related conflicts when dealing with current ones. Unfortunately, this often clouds the issue and makes finding mutual understanding and a solution to the current issue less likely.

2. **Do Not Make Assumptions** about what the other person may or may not be thinking.

3. **Listen Carefully:** People often think they are listening, but are thinking about what they are going to say next when the other person stops talking.

4. **Try To See Their Point of View:** In a conflict, most of us just want to feel heard and understood. We talk a lot about our point of view to get the other person to see things our way.

5. **Respond to Criticism with Empathy:** When someone criticize you, it is easy to feel that he or she is wrong and get defensive. While criticism is hard to hear and often exaggerated by the other person’s emotions, it is important to listen to the other person’s pain and respond with empathy for their feelings.

6. **Own what’s yours:** Realize that personal responsibility is a strength, not a weakness. Effective communication involves admitting when you’re wrong. If you both share some responsibility in a conflict (which is usually the case), look for and admit to what’s yours.

7. **Look for Compromise:** instead of trying to ‘win’ the argument, look for solutions that meet everybody’s needs. Either through compromise or a new solution that gives you both what you want most, this focus is much more effective than one person getting what they want at the other’s expense.

8. **Take a Time-Out:** Sometimes tempers get heated, and it is just too difficult to continue a discussion without it becoming an argument or a fight. If you feel yourself starting to get too angry, or showing some destructive communication patterns, it is okay to take a break from the discussion until you both cool off. Sometimes good communication means knowing when to take a break.

9. **Think before you speak - and while you are speaking**
   a. What’s the message you are hoping to get across?
   b. Word choice, tone and body language shape your message.
   c. Being more conscious helps you to be a better listener, too.

10. **Cater to the Head and Heart:** Offer emotional values as well as practical reasons to influence desired behaviour.

11. **Make Your Message Simple, Clear and Direct:** Use ‘I’ messages to communicate what is going on for you.
Learning Intention

Today we will talk about effective ways of communicating and solving problems. The questions we will explore will help you to practice and think about communication in a way that supports healthy.

Engage – what to do

- We all experience difficulties in our daily interactions from time-to-time, it is important to find healthy ways to resolve conflict when it arises, as conflict can affect the mind and body, and therefore, our overall sense of wellness.
- Engage clients in a discussion about the way they solve problems.

Discussion questions

Let's think about how we work through problems for a moment…

- What are some responses to conflict?
- What elements are required to solve conflicts?
- What kinds of responses help to end a conflict between you and your parent or you and a friend?
- What types of response make a conflict get worse?
- What helps you come to an understanding of another person’s point of view?
- What are some things you have done in the past to work out a disagreement?
- When you have a problem what steps do you take to solve it?
Breaking it down

- Let clients know that the way they communicate will have an impact on their ability to resolve conflict
- Explore the barriers to effective listening

Assist client through the steps in problem-solving.

Define the problem—be clear about what the problem is.
Ask clients the following questions to help them gain a better understanding of the issue

- What is happening now?
- What is my behavior?
- What am I feeling?
- What do I want?
- What do I need?

Assert—Brainstorm possible solution

- Help clients brainstorm solutions and alternatives

Rate possible solution—Pros & Cons

- Help clients to explore the advantage and disadvantage of the solutions

Negotiate: Decide on a solution that is agreeable to both of you.

- Help client to develop their negotiation skill so that they can come to healthy compromises in the event they cannot agree on a solution.

Implement the plan

It is also important to use “I “statement and be non-judgmental.
e.g., I feel …, I am…
Alternatively, you could use the reflection model Rolfe *et al.* (2001) to help work through problems.

<table>
<thead>
<tr>
<th>What...</th>
<th>...is the situation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>...am I trying to do</td>
</tr>
<tr>
<td></td>
<td>...action I can take</td>
</tr>
<tr>
<td></td>
<td>...was the response of others</td>
</tr>
<tr>
<td></td>
<td>...were the consequences</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>So what...</th>
<th>...does this teach me?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>...was I thinking and feeling?</td>
</tr>
<tr>
<td></td>
<td>...other knowledge I can bring to the situation?</td>
</tr>
<tr>
<td></td>
<td>...is my new understanding of the situation?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What now...</th>
<th>...do I need to do to improve things?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>...broader issues need to be considered if this action is to be successful</td>
</tr>
<tr>
<td></td>
<td>...might I do differently in the future?</td>
</tr>
<tr>
<td></td>
<td>...might be the consequences of this action</td>
</tr>
</tbody>
</table>
Activity 1: Problem Solving

Use this example to explore how participants work through conflict. Let participants brainstorm ideas about how they would resolve the problem.

Sarah has a friend Susan; they have been friends since primary school. The two spend much time together. Sarah and Susan seem to get into a lot of trouble together—they drink and party. Recently, Sarah got in trouble for lying to her parents, and they have now insisted she see a drug and alcohol counselor. Sarah has been avoiding Susan; she knows if she gets into more trouble her parents will be extremely upset. Although she reluctantly went to the counselor, she is beginning to realize that even though she thought of Susan as her best friend, she was a drinking and party buddy. Susan is asking Sarah to hang out, Sarah is feeling pressured, they get into a huge argument on the phone as Susan is finding it difficult to understand why Sarah will not go out with her. Sarah is contemplating making some changes and is considering giving up drinking. She does not want to hurt Susan’s feelings or lose her childhood friend. What should she do?

INSIGHTS

- How can you change the way you feel and accept things that are beyond your control?
- How can being more aware/mindful help you solve problem?
- How do you become more aware of your thoughts, feelings and emotions as a difficulty arises?
Reflection Circle

Today we talked about ways to solve problems

- Did anything happen today that made you re-think the ways you solve problems?
- Did you learn anything about yourself through the discussions and exercises?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present

Homework

- Distribute problem-solving worksheet
- Encourage participants to practice muscle relaxation exercise.
HANDOUTS

Chapter 15: Unit 2

1. Problem-Solving Steps
Define the problem- (be clear about what the problem is)
Answer the following questions to help you gain a better understanding of the issue

<table>
<thead>
<tr>
<th>Question</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is happening now?</td>
<td></td>
</tr>
<tr>
<td>What is my behavior?</td>
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<tr>
<td>What do I want?</td>
<td></td>
</tr>
<tr>
<td>What do I need?</td>
<td></td>
</tr>
</tbody>
</table>

Assert—Brainstorm possible solutions

Rate possible solution—Pros & Cons

<table>
<thead>
<tr>
<th>Solution</th>
<th>PROS</th>
<th>CONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Solution 1:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solution 2:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solution 3:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Solution 4:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Negotiate: Decide on a solution that is agreeable to both of you.
Chapter 15
Unit 3

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT
Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we will talk about the process involve in making a decision. We will explore how you make decisions and important step to make decisions.

Engage – what to do

Think back to the moment you woke up today.

- What kinds of decisions have you made today? These can include what time they woke up, what to wear, what to eat for breakfast etc.

Discussion questions

When you are faced with making a decision…

- What is important in making a decision?
- What do you need to know to make a good decision?
- What other things influence your decisions?
- How do you make most of your decisions?
- How are decisions made in your families or your friendship circles?
- How do you determine if you have made a good decision?
Breaking it Down

Step to making good decisions are

We often do not sit down and think about the decisions that we make daily. However, when faced with big/difficult decisions, there are four important things to consider when making a decision.

Other important factors in decision-making are:

- What you have control over
- What you can change.
- Some things you have no control over
- Something you have very limited ability to change them.

You can ask clients to: Think about their life right now.

- What sorts of things do they have control over?
- What things can they choose?
- List things they have control over.

Note: there may be some variation within the group concerning what they can make decisions on and what is out of their control.
Ask clients to think back to decisions you have made, even the ones you had a huge influence or control over. Were you in a reactive or responsive mode?

- **Re-active**—is emotionally charged, your focus is mainly on the problem or concern. You do not think through the problem. You focus on the weaknesses of other people, and circumstances over which you have no control, or all the things that can go wrong. Your focus results in blaming and accusing attitudes, reactive language and increased feelings of victimization. The negative energy generated by this causes people sometimes to stay away or creates tensions in relationships.

- **Responsive**—work on things you can do something about. You try to make changes to things in your life that you have some control over. You are intentional and thoughtful in making your decision.
Learning Activities

Activity 1: Decision Treasure Game

You will need a brown paper bag, a tin/can with a Lid, and two shoeboxes of different size (make sure that you cannot see through the bag).

Put items in each bag: [fruits, gift card, other food items]

- Close the containers. No one should be able to see inside.
- Note: there is some flexibility in what you put in the bags, but be sure that you can make the connections to decision making and consequences.
- Place the four items on the table [put label 1-4] where everyone can see them.
- Ask for four volunteers to stand behind the table so that everyone can see them. Volunteers may not touch the bag, can or boxes.
- Direct the rest of the group to try to influence or convince each volunteer to choose a particular item. Give the audience a chance to attempt to influence the volunteers to pick a certain bag.
- Now I would like each one of you [talking to the volunteers] to select an item. Give each volunteer a chance to say what they would like.
- They are still not allowed to touch the item.

INSIGHTS

- Ask the volunteers: How did you pick their item?
- How do you become more aware of your feelings and the role it plays in your decision-making?
- What barriers do you face in learning how to make effective choices and decisions?
Reflection Circle

Today we talked about ways to decision making and the process involved in making good decisions

- Did anything happen today that made you re-think the how you make decisions?
- Did you learn anything about yourself through the discussions and exercises?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage participants to practice muscle relaxation exercise. Emphasize how calming down the system by relaxing the muscles and taking deep breaths can be useful.

Key points

- Becoming aware of what happens when you are angry, afraid, energized, or engaged is key to making that shift from responding to reacting when faced with difficult decisions.
- We must think of all the consequences of any choice, but especially any negative consequences there may be.
- People make wrong decisions sometimes. The important thing is to realize this and take steps to correct it.
- It is not always easy or possible to go through this thought process when making a decision. Sometimes we do not have time to think of the consequences but have to make a quick decision to ensure our or survival. It is therefore up to us to weigh this and do what is appropriate for the time and situation.
- Good decisions are not easy to
HANDBOOK

Chapter 15: Unit 3

1. Step for Making Good Decisions
### Steps for Making Good Decisions

<table>
<thead>
<tr>
<th>Identify the challenge or decision to be made</th>
</tr>
</thead>
<tbody>
<tr>
<td>Explore your options</td>
</tr>
<tr>
<td>Outline the consequences of each choice. What would or could happen as a result of each choice? It can be negative or positive.</td>
</tr>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
</tr>
<tr>
<td>Choose the option you think is best</td>
</tr>
</tbody>
</table>
Learning Intention

Today we will talk about trust and building trusting relationships. Trust is an important part of engaging in meaningful relationships. Through trusting relationships with family members, friends, teachers and mentors we learn more about our world and our place in it. Without trust relationships are not able to grow or evolve.

Engage – what to do

Think back to a time when you had your trusted broken.

- How did you feel?
- What did you do?

Discussion questions

- What is trust?
- What does it feel like to trust someone?
- What kind of behaviour creates trust and safety?
- What behaviours violate trust?
- How has substance use interfered with trust in your relationships?
- How do you feel when someone violates your trust?
- How do you build or rebuild trust in your relationships?

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.
Breaking it Down

What is trust?
Expand the discussion by reinforcing participants’ response. Trust is where you expose your vulnerabilities to people, but believing they will not take advantage of your openness, kindness or generosity.

Example of responses may include:
- Helps it grow
- So you can enjoy connection with someone
- Help you take someone at their word
- So you can open up and let someone help you
- If I do not trust myself how will I have the confidence to do things
- I can give help to others

What does it feel like to trust yourself?
When I trust myself
- I feel in control
- I feel confident
- I can relax better
- I believe in my abilities
- I try new things
- I am not afraid to ask for help
- I respect myself

What kind of behaviour creates trust and safety?
Example of responses may include:
- When someone tells me and shows that he or she accept me for who I am
- When someone is available to me in times of need
- When I am available for someone
- When someone does not try to manipulate me, or hurt me
- When people make and keep commitments
- When someone does not tell others about private things I share with them
- Being open
- Being honest
- Showing mutual respect
- When someone tells me that my behaviour was not appropriate, but he or she do it in a kind and gentle manner that is not criticizing
What behaviours violate trust and safety?

*Examples of responses include:*
- When some do, the opposite of what he/she says he/she will do
- Pretending to like someone
- Pretending to like something some give you, when you do not
- When someone judges me
- When someone is continually critical of what I do
- Being abused
- When someone covers up the truth
- Sharing private information
- Being forced to do something you do not want too

How has your substance use interfered with trust in your relationships?

*Examples of responses may include:*
- When I am using, I am not dependable
- When I am using, I do not always tell the truth
- When I use, I can be aggressive, and people do not like that
- I am very critical of others when I use
- I make mean jokes
- I take things without asking
- I steal to support my use
- I lie about where I am going to my parents

How do you feel when someone violates your trust?

*Examples of responses may include:*
- Sad
- Angry
- Detached from the individual
- Say hurtful things

How can you build or rebuild trust in your relationships?

*Examples of responses may include:*
- Apologize
- Make positive changes in my behaviour
Learning Activities

Activity 1: Blind Fold

- Ask participants to break into two groups, make one group the blindfolded group and the other the directing group.
- Design a small obstacle course either outside or in the room, nothing complicated.
- Instruct the directing group to provide instructions to the blindfolded teammate to assist him/her to complete the course.
- On one team ask the directing partner to give some wrong instructions at one point in the exercise, [preferable with about two steps to completion]
- On another team ask the blindfolded partner to demonstrate some hesitation in the beginning.

INSIGHTS

- What was the experience like?
- Was it scary to trust that your partner gives you correct information?
- What was your thought process when your partner gave wrong directions? Was it easy to trust the next set of instructions from him/her?
- What were you thinking when your blindfolded partner was reluctant to listen to you in the beginning?
- Ask participants to think about their own experiences in relationships they had with adults when they were a children. How long did it take for those relationships to form? How long, as a child, did it take them to trust and feel attached to the adult?
- How long, does it currently take you to trust someone?
- Why did you begin to trust that adult? Did the trust remain? Do you question your trust in this adult? If so, why?
- How about a friend? What happens when you stop trusting a friend? Or a friend or parent stops trusting you?
Reflection Circle

Today we talked about trust and how significant it is to have healthy relationships.

- Did anything happen today that made you re-think your ideas about trust?
- Did you learn anything about yourself through the discussions and exercises?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

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Homework

Encourage the clients to practice muscle relaxation exercise. Emphasize how calming down the system by relaxing the muscles and taking deep breaths can be useful.

Key points

- The key to creating effective relationships lies in the development of trust.
- Without establishing trust, you can never truly support, and believe the person with whom you interact.
- Establishing communication and developing a relationship can often be a difficult process.
- Learning to trust, especially if you have been let down before, requires time.
- We can make extra efforts to succeed or achieve our goals.
- Decisions don’t always have to be rushed, sometime it is best to delay making a decision to allow yourself time to consider all your options or to gain more information. Delaying also gives you time to be more thoughtful in your interactions.
Learning Intention

Relationships are a vital part of life, and we all desire and need connections and support. Having a connection with significant other is crucial when we embark on a change journey. Your relationship with substance misuse may have cost you some of those important relationships, but it also has allowed you to build some unhealthy ones as well. In this session, we will explore your relationships and ways to build and nourish healthy relationships.

Engage – what to do

Ask clients to think about the relationships they have at the moment…

- What is important about relationships? Why do we need relationships in our lives?
- How important are relationships in your life? [It might be helpful to think about how much time you spend with friends, family and other relationships. How we spend our time can be an indicator of what is most important to us.]

Discussion questions

- What are qualities of a healthy relationship?
- What are some strategies for building healthy relationships?
- What is personal space?

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.
Breaking it Down

It can be helpful to think of a relationship as a plane. See image below

- Point out that just as certain things keep a plane flying safely, there are certain things needed to keep a relationship afloat.
- Ask for an example of something that is necessary for a strong or healthy relationship (e.g. respect) and write it on the wing of the plane.
- Also, point out that certain things can ruin a relationship, just as stormy weather can cause a plane to crash. Ask for an example (e.g. dishonesty) and write it in the water clouds above the plane.
- Divide the participants into six groups and give each group a sheet of flipchart paper with one of the following headings written at the top:
  - Peer
  - Work
  - Romantic
Tell participants that each group will do the following:
- Draw a picture of a plane in the cloud.
- Identify at least five things that help make their particular relationship successful and write these on the wing of the plane.
- Identify at least five things that could damage or destroy the relationship and write these in the clouds.
- Hang the flipchart paper on the wall when they are finished.
- Spend about 20 minutes on this activity.
- When all the groups are finished, allow some time for them to move around and look at each other’s planes.

What are some strategies for building healthy relationships?

*Example of responses may include:*
- Set healthy boundaries
- Be mindful of others feelings
- Be respectful
- Be honest (with yourself and others)

Also, explore how one’s tendencies and preferences specifically influence one’s roles & relationships (when feeling well and not well)

**Boundaries in Relationship**

What is personal space?

*Example of response:*
- My bedroom
- My secret hideout when I need some alone time
- Please, I live with six people I do not have personal space
- The bathroom

*Probe by asking: how much space would you need to feel comfortable or safe? Provide scenarios, for example, riding the bus, or having a friend over for a sleep over.*

How do you feel when someone touch you, hugs you, or stand too close to you when you don’t want them to?

*Example responses:*
- I feel fearful
- I freeze
- I get nervous and panic
- I feel threatened
- I get defensive
Probe by asking: have you ever noticed that when you are out partying, using alcohol or drugs you let people get closer to you than you normally would? Some clients may answer yes. Ask—Do you have any idea why this is the case?

What kinds of signals (body language or nonverbal communication) tell others that a boundary has been crossed? Provide some scenarios and ask participants to tell you what kind of signal they would use.

- Someone standing too close to you at the grocery store
- Someone talking to you with a loud and intense tone
- Someone ask for a hug, and you do not want too
- Someone ask to borrow your iPod, and you do not want to
- Someone returned your book with lots of marks

Do you have people in your life that constantly violates your boundaries? If they answer yes

- Can they think of a time when someone in their life violated their boundary?
- Ask them if any boundary violation has affected their use of drug and/or alcohol?
- Do you violate the boundaries others set for themselves?

Invite participant to think of a time when they violated someone’s boundary. Ask them to consider how the person might have felt, and now looking back how they feel about it.

We have spent some time talking about physical and to some extent material boundaries. Now let’s talk about emotional boundaries.

**What do you think emotional boundary is? Encourage participants to provide feedback and suggestion.**

Then extend the discussion by stating:

- Emotional boundaries are crucial in helping us to enjoy a healthy relationship and avoid unhealthy or dysfunctional relationships.
- Emotional boundaries are like an imaginary line or force field that separates you and others.
- It allows you to identify your emotion and responsibility from others.
- Healthy boundaries prevent you uncalled-for advice, blaming or accepting blame.
- They protect you from feeling guilty for someone else’s negative feelings or problems and taking others’ comments personally.
- Healthy emotional boundaries require you knowing your feelings and your responsibilities to yourself and others.
BOUNDARY SELF ASSESSMENT

**ASSESSING MY BOUNDARIES**

<table>
<thead>
<tr>
<th>DO YOU SHOW SIGNS OF POOR BOUNDARIES?</th>
<th>ARE YOUR BOUNDARIES RIGID?</th>
</tr>
</thead>
<tbody>
<tr>
<td>I go against my values to please someone else</td>
<td>I feel that others are likely to hurt me — that I am all alone</td>
</tr>
<tr>
<td>I do not notice when someone else is showing poor boundaries</td>
<td>I expect others to do things my way, or go away</td>
</tr>
<tr>
<td>I take whatever I can for the sake of getting whatever I want</td>
<td>I do not ask for help</td>
</tr>
<tr>
<td>I let others tell me how I should think or feel</td>
<td>I do not offer help or support</td>
</tr>
<tr>
<td>I let others tell me what is important</td>
<td>I do not tell anyone how I feel</td>
</tr>
<tr>
<td>I expect other people to fill my needs without asking</td>
<td>I have a difficult time trusting others</td>
</tr>
<tr>
<td>I do things to hurt myself</td>
<td></td>
</tr>
</tbody>
</table>

**HOW DO I DEMONSTRATE HEALTHY BOUNDARIES**

- I have much self-respect
- I expect to give and take in a relationship
- I share responsibility and control
- I do not tolerate being abused
- I know what I need and want and express myself assertively
- I ask for help when I need it
- I do not push my values aside to avoid being rejected
- I am okay when others say no to me
Explore

- The people who make healing and a healthy choice hard for your clients?
  
  Tell participants that many of them may have people in their lives that are not very supportive of their change, or constantly violate their boundaries. Also, one of the costs of misusing drugs and/or alcohol is that sometimes you develop an unhealthy friendship.

  **Note:** [Be sure to probe in a manner that is none judging of the person as this can create defensiveness and you will be challenged to get participants to focus on the intended]

- How do people in their life help in their healing and personal growth?
  
  Sometimes people in our lives are very helpful and supportive. They even tell us things like, “I only want the best for you”, or “I just want you to be happy”. Let clients know that having people who are a positive influence is critical to maintaining change.

  **Example of response:**
  
  - My family and friends accept me for who I am
  - My friend—listens to me all the time and give me good advice
Learning Activities

Activity 1: Boundaries

- Divide the clients into two groups. Have each group line up facing each other. Give one group a sheet of paper with the instruction (keep walking closer to the person facing you while talking to them about anything, go as close to their face as possible)
- Ask participants, how did that make you feel? [This will transition into discussion about personal space.]

INSIGHTS

- What was the experience like?
- What do you notice about the positive things listed for each of the different relationships?
- What do you notice about the negative things mentioned for each of the relationships?
- Of these categories, are some relationships more important than others? If so, why?
- Which qualities do you think are the most difficult to find in relationships?
- Are those things reflected in any of your relationships?
- What is personal space?
- How do you feel when someone touches you, hugs you, or stand too close to you when you don’t want them to do so?
- What kinds of signals (body language or nonverbal communication) tell others that a boundary has been crossed?
- Do you have people in your life that constantly violates your boundaries?
- Do you violate the boundaries other set for themselves?
Reflection Circle

Today we talked about trust and how significant it is to have healthy relationships.

- Did anything happen today that made you re-think your behaviour in your relationship?
- How do you feel about the trust you have built?
- Did you learn anything about yourself through the discussions and exercises?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage participants to practice muscle relaxation exercise. Emphasize how calming down the system by relaxing the muscles and taking deep breaths can be useful.

Key points

- No two people are the same. We therefore need to compromise and understand each other’s differences for relationships to be successful.
- Many people practice negative behaviours in their relationships.
- Respect, trust and communication are important factors needed to building healthy relationships.
- We have to be honest with ourselves and those with whom we have a relationship. We should say when things are going right and when we are unhappy about something.
- We need to assess our relationships and decide whether they are good or bad for us.
- In general, healthy relationships are:
  - Kind
  - Respectful
  - Appreciative of your time and efforts
  - Supportive
  - Encouraging
  - Trusting
  - Compassionate
HANDOUTS

Chapter 15: Unit 5

1. Relationship Airplane
2. Building Healthy Relationships
3. Positive Relationship
Use this airplane to illustrate one of your relationships. Think of what makes it work, think of what creates tension in the relationship. Use all the features of the plane. Be creative.
BUILDING HEALTHY RELATIONSHIPS

Use this worksheet to help you navigate the process of building and evaluating your relationships. This will help you learn important information about yourself and your relationships.

1. What is important to me in my relationships with friends?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

2. What is important to me in my relationships with family?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

3. How has my alcohol and/or drug use changed these important relationships?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

4. What do I need to change in my relationships to help me sustain/maintain the changes I have made?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________

5. What steps do I need to take to change or improve my relationships?

__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
__________________________________________________________________________________
Think about the people who support you in your life, it could be a family member, friend, teacher, mentor, counsellor. Complete the sheet below.

<table>
<thead>
<tr>
<th>Positive Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
</tr>
<tr>
<td>Relationship:</td>
</tr>
<tr>
<td>Why I trust this person:</td>
</tr>
<tr>
<td>Ways this person helps me:</td>
</tr>
<tr>
<td>Values I admire in this person:</td>
</tr>
<tr>
<td>Ways I help this person:</td>
</tr>
</tbody>
</table>

| Name:                  |
| Relationship:          |
| Why I trust this person: |
| Ways this person helps me: |
| Values I admire in this person: |
| Ways I help this person: |

| Name:                  |
| Relationship:          |
| Why I trust this person: |
| Ways this person helps me: |
| Values I admire in this person: |
| Ways I help this person: |
Chapter Sixteen
Mindfulness-Integrated Change Management
Clinicians Note

For many individuals, sustain change can be a challenge. When a young person has decided to stop using drug and/or alcohol, there is usually a focus on preventing relapse. As a clinician, it is important that you help clients to sustain the changes they have made with regard to alcohol and drugs.

Clients know that they must remain committed to their change process. This knowledge may lead some to believe that their motivation for remaining abstinent must always be the same. However, what is important is what motivates clients to stay abstinent each day. As the clinician, it is important to remind clients that, although staying abstinent is a lifelong goal, they can achieve it day by day. It is important to let them know that their reasons for staying abstinent change over time and that change and growth is a part of life.

For many young people with FASD relapse can feel like a sudden occurrence—a surprising disruption of recovery. However, often it is the result of a gradual movement away from abstinence goals. Relapse rarely occurs without warning signs as such it is imperative you help the client explore all the barriers to sustaining change as well as all the supports to maintaining their change.
Strengthening their self-management by providing clients with methods for identifying problematic situations, analyzing those situations, and developing strategies to avoid, or cope more effectively with these circumstances and stress are useful ways to help a client. The overall goal here is to increase your client’s awareness and range of choices concerning his/her thinking, feeling and behavior, so as to enhance coping skills and self-management abilities, and to create a general sense of manageability to his/her life.

In recent years, mindfulness has been utilized in mental health, and addiction setting and the benefits of mindfulness have been suggested to help enhance well-being for many working through their change process. The ability to be mindful is an inherent capacity of all humans. Integrating mindful practices into therapy to help the client maintain change is a valuable tool. The influence of environmental factors can have either a positive or negative impact on the development of one’s capacity to act mindfully. Similarly, it is thought that the capacity for mindfulness can be enhanced through training, just like any other skill. Mindfulness is an adaptable process, with many different options. For example, you and your client may decide to focus on breathing or progressive muscle relaxation techniques, and this can be incorporated into many sessions in a row. Alternatively, you could recommend a mindfulness class such as yoga, Pilates or kijong. You may decide to open and close the therapy session with a mindfulness-based practice as a means of practicing self-awareness and emotional regulation. Be sure to follow best practice on how to incorporate mindfulness into your session. It is also important that you match mindfulness-based strategies to the goals of the client.

For example:

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Mindfulness strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Defensive, avoidance</td>
<td>Sun breath, practice self-compassion</td>
</tr>
<tr>
<td>Emotionally overwhelmed</td>
<td>Breathing through the edges (deep breathing), child's pose, muscle relaxation</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Ratio breath, deep breathing, neck roles</td>
</tr>
</tbody>
</table>

Adapted from personal conversation with Luci Djunaidi, 2016

Ways you can help a client maintain change are

- Teach mindfulness techniques
- Teach grounding techniques
- Teach emotional regulating strategies
- Help client to utilize sensory modalities
- Provide stress management strategies
- Promote sense of agency
- Promote self-efficacy
- Inculcate resilience
- Encourage the use of sensory modulation strategies
- Assist them in engaging in sensory modulation-related assessment, self-rating and self-reflection activities

Reflection Questions

1. How do I support your clients’ in sustaining change?
2. How do I support a client with mindfulness strategies?
3. How do I use sensory modifications to help clients?
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients develop effective communication skills
- Help clients solve problems effectively
- Help clients explore their decision making process
- Help clients work on building healthy relationships
- Help clients work on building trust in their relationship and confidence in being

Handouts

- Decision to Maintain Change
- Refusal Skills
- Substance Use Trigger profile
- Trigger Monitoring Form
- Positive Self-Talk Cards
- Practicing reframing
- Thoughts, Feelings & Behaviours
- Qualities of a good Friend
- Ways to Resist Negative Peer Pressure
- Eco-Map
- Bio-Flower
- Onion Model
- Grounding Toolbox
- Relaxation
- Stress Management Worksheet
- Individual Change Maintenance Plan
- Relapse Justification Checklist
- Working Through Relapse
Session Guide

Learning Intention

Today we will explore your decision and motivation for maintaining the changes you have made—i.e., achieving your goals. Your motivation is necessary as you continue your change journey. Evaluating your decision to change and monitoring your progress and outcome will enhance your confidence in sustaining change and increasing your self-resilience.

Engage – what to do

One of the first steps you made about your decision to change was your substance use. Now that you have had some time without using I would like to ask you to think about the good things and not-so-good things about changing versus not changing your drug and/or alcohol use.

Discussion questions

Let’s think about your motivation and confidence to maintain your change for a moment…

- How do you feel about your current motivation level?
- How motivated are you?
- How confident are you about your change?
- What has been the most difficult aspect of your change?
- What are you most proud off?
- Are you embracing opportunities to develop your skills?
- What activities do you undertake to continue to nurture your growth?

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.
**Breaking it Do**

A client’s motivation to sustain his/her change is important in preventing relapse. The motivation to Change Ruler is a quick assessment of a client’s level of motivation to sustain change. The rulers examine desire and motivation sustains change from the client’s perspective on a continuum between “low” and “high.” Once the client has identified where he or she is on the ruler, use the sample questions below to further discuss the client’s readiness to continue with his/her change.

- Why did you put your mark here?
- What are the benefits that you are experiencing from the change you have made?
- What are the barriers to changing?
- How can you overcome these obstacles?
- What people, places, or things do you still need to consult/go to, or what things do you still need to do to maintain your behavior?
- What has helped you to be successful in taking this step?
- What else will help?
- What is your next step?

Use motivational interviewing techniques. In motivational interviewing the client is considered to be the expert and is responsible for his or her healthy decision making, strengthening the client’s motivation to make healthy lifestyle choices. This collaborative process, which empowers the adolescent and encourages independent decision-making, identifies the adolescent’s values and motivation for positive change.
Learning Activities

Activity 1: Decision to Maintain Change Sheet

- Distribute handout decision to maintain change sheet. Clients should be given some time to complete the handout before the discussion begins.
- Go over the handout
- Have clients discuss their decision to change and what they have noticed about themselves.
- Ask participants what motivated them to change and what continues to motivate them?
- Encourage them to talk about why this change is important to them.

Have participants fill out the:

- The short version of the Drug Taking Confidence Questionnaire (DTCQ)
- Coping Skills Check List
- Some participants may have difficulty be sure to walk around the room engaging with the client and seeing who require assistance.

Have them discussed their responses to the Confidence and Coping List Questionnaire. Answer any questions that may arise and reassure participants it is okay to have varying responses as they are unique individuals with unique situations.
Reflection Circle

Today we talked about your decision and motivation to continue with the changes you have made.

- Did anything happen today that made you re-think your choices?
- Did you learn anything about yourself through the discussions and exercises?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage participants to practice muscle relaxation exercise

Key points

- Motivation is important to sustain mindfulness strategies.
- Change is sustainable when we continue to work at improving our skills.
- Use the analogy of having a plant and how in order for it to grow it need nutrients—water, sunlight etc. Let them know that maintaining change and nurturing their personal growth is similar to that.
1. Decision to Maintain Change Sheet
What are the reasons for maintaining your change?

What are the reasons for returning to your old habits and pattern of drug and/or alcohol use?
Learning Intention

Today we are going to talk about cravings and triggers, how you manage them and what can be done when you are experiencing them.

Engage – what to do

Let’s talk for a moment about cravings and triggers...

- **Tell them:** One of the things that most people worry about when they decide to make changes about their substance use is learning how to manage cravings and triggers.
- **Discuss occurrence:** Discuss occurrence of cravings with clients; review their experiences of craving and triggers by inviting them to discuss past or current experiences and how they have managed those occurrences.

Discussion questions

- How would you describe or define a trigger or a craving?
- What kind of cravings and urges do you experience or have experienced?
- Have you had a time in the past when you acted on your cravings & urges? How did you feel afterwards?
- Are there things, smells, people and places that have been a trigger for you?
- What are some ways, or things you have tried to cope with triggers and cravings?
- What has worked?
- Can you identify some common high-risk situations that have triggered you to use?

CHECK-IN

**Group:** Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

**Individual:** conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.
Breaking it Do

Explore with clients:

*Their experiences with cravings*—*explain* to clients, that most people have strong cravings to use drugs or drink alcohol when they first stop using. Sometimes the cravings can be overwhelming and hard to deal with. Ask them if this is something they have experienced.

Some important things you may want to convey to them about cravings are

- Learning to identify cravings is essential to managing them appropriately
- Cravings are common when abstaining from alcohol and or drugs
- Cravings have things, people, places, thinking patterns or behaviours that often trigger them.
- Identifying triggers can help in selecting appropriate coping strategies
- Everyone can learn to manage their cravings

*How they recognize, they are craving*—discuss what they experience when they have an urge. This may help them identify an urge early and respond before it gets overwhelming.

- Some examples to explore are:
  - Thoughts
  - Emotions
  - Behaviours
  - Physical sensations

*Work with them on identifying their triggers*

- People
- Places
- Events
- Things
- Smells
- Internal situations (emotions, thinking patterns, physical)
Learning Activities

Activity 1: Substance Use Trigger Profile

Distribute the Substance Use Trigger Profile, have your client or group participants work on it. This will help them gain a better sense of the things that increase cravings or trigger them to use.

Activity 2: 45 Ways to Manage Triggers

- Provide participants with poster paper, as a group ask them to brainstorm 45 ways to manage cravings and triggers. For individual clients, you could get them to write ten ways they can manage triggers and cravings in their journal.
- Encourage them to be creative in designing the poster. In my experience group participants have enjoyed the creative process.

INSIGHTS

- What did you discover about your trigger profile that was surprising?
- Was this exercise useful in helping you get a better sense of your triggers?
- What was your experience of working collectively on the poster?
- Did you find it easy to brainstorm ideas?
- Are there any ideas that one of your group members came up with that you have never tried, or considered? Would you consider trying it?
**Reflection Circle**

Today we talked about the cravings and triggers and how you manage.

- What stands out for you the most?
- How or why is this important to you?
- How does this information influence you to change your behaviour?
- Do you have any other questions or concerns you would like to discuss?

**CHECK-OUT**

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

**QUIET MOMENT: REFER TO CD**

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

**Homework**

Distribute the *hand: My trigger* form and ask clients to identify their triggers. You can also provide the *handout: situation monitoring form*.

**Key points**

- Triggers are your thoughts, feelings, things, people, smells, or places that make you want to drink and or use drugs, or engage in some other risky behaviours.
- Many triggers are common such as, hanging-out with friends who talk about use, or use whenever you are around them. *(In fact, today's discussion may have provoked an urge to drink or use drugs for some of you).*
- Some triggers can be personal—such as hearing a song and this can cause a flashback for someone who was sexually abused. Some triggers are avoidable and some are not.
- Cravings and urges can be strong and uncomfortable physical and emotional feelings to use, or drink. Having cravings and urges does not mean that they have done something wrong.
- Everyone have cravings and urges for things *(for example ice cream)*, but not everyone act on those cravings.
- Acting on cravings and urges to use drugs and drink will only bring temporary relief, *(if this was mentioned earlier acknowledge that as they have already mentioned).*
Chapter 16: Unit 2

1. Substance Use Trigger Profile
2. Trigger Monitoring Form
3. Refusal Skills
**INSTRUCTIONS:** Read each of the items below and then rate them according to how likely they are to cause you to use alcohol and/or drugs. If the majority of your response is in the likely and very likely scale, there is a strong potential for a slip or relapse. Take steps to increase your coping strategies.

<table>
<thead>
<tr>
<th>Social</th>
<th>Very Unlikely</th>
<th>Unlikely</th>
<th>Possibly</th>
<th>Likely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arguing or having conflict with someone</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Being with others when they are using</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Being encouraged to use by others</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Feeling like I am bore around others</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emotional</th>
<th>Very Unlikely</th>
<th>Unlikely</th>
<th>Possibly</th>
<th>Likely</th>
<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling bad, such as being anxious</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Feeling bored or having time on my hands.</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Feeling stressed</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
</tr>
<tr>
<td>Feeling good, or excited</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
<td>O</td>
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<th>Very Likely</th>
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<tr>
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<tr>
<td>Being at a location that I used in the past.</td>
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<tr>
<td>Running into my dealer</td>
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<th>Very Likely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Making excuses to myself about why I use.</td>
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<tr>
<td>Worrying about difficulties I am having.</td>
<td>O</td>
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<tr>
<td>Worrying about what others think of me</td>
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<tr>
<td>Thinking about how things should be</td>
<td>O</td>
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<td>O</td>
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<tr>
<td>Being hard on myself</td>
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© Mockett, V
By monitoring your triggers and cravings, you will develop awareness of the things that can likely cause you to begin to use drug and/or alcohol again. This will also be a good tool to help you explore and develop coping strategies.

<table>
<thead>
<tr>
<th>Date &amp; Time</th>
<th>Trigger</th>
<th>Intensity of Craving.</th>
<th>Did you use?</th>
<th>Coping strategies used.</th>
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## STRATEGIES FOR REFUSING DRUG AND/OR ALCOHOL

Although you may have stopped using alcohol and/or drugs, some of your closest friends may still be using. One of the highest risk situations you may experience is when a friend offers you a drink or urges you to use a drug. Just saying “no” requires some practice, and, in many cases, is not enough.

Try some of the following suggestions to help you cope with situations when you are being offered alcohol or other drugs.
- Tell the person to stop offering.
- Leave the situation.
- Don’t hesitate to say “no”.
- Look the person in the eye.
- Suggest an alternative – something else to do, or something else to drink or eat.
- Change the subject.
- Remind yourself of your goal.
- Think about the negative consequences of using and the benefits of not using.
- Don’t feel guilty about refusing.
- Feel good about yourself for not using.
- Step away and call someone your trust to support you (e.g., your mentor, sponsor, parents, friend, family member).

### PRACTICE EXERCISE:

In which situations do you anticipate being offered a drink or drug?

1. 

2. 

3. 

What will you think or say in those situations?

1. 

2. 

3.
Session Guide

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Your thought pattern may seem to have nothing to do with using in that the connection is not obvious. However, negative thinking loops or patterns can place you closer to a situation that may promote a lapse. Today we are going to talk about challenging thoughts you may be struggling with. This session will provide you with strategies or skills that may be helpful for you to work through and overcome challenging thoughts.

Engage – what to do

Write a list of thinking patterns (e.g., rationalization, blame shifting), and ask clients to identify which ones they do.
Say: now that you recognize them, let discuss some more how they help or get in your way.

Discussion questions

- How would you describe your thought process?
- What is your most consistent negative self-talk?
- What thought often get in your way of trying new things, or maintaining change you have made?
- Do you spend a lot of time thinking about negative things people say about you?
- What sorts of thinking can get you feeling down—sad, anxious etc.?
Breaking it Do

Demonstrate to participants the relationship between their thought, feelings and behavior.

- Ask the participants to think about a time when they may have decided to stop using, were successful for a while, but, later on, ended up having a relapse.
- Ask participants to provide you with examples, pay attention to the persistent thought process they recap. [I kept thinking no one cares so why bother, I will never be good enough, I am already a disappointment so one drink will not make a difference, I hate myself…etc.]
- Write their feedbacks on the flipchart
EVERYONE THINKS I AM STUPID
I AM HAVING A FEW DRINKS
MAYBE I WILL JUST HAVE A DRINK; IT WILL HELP ME FEEL BETTER
I FEEL REALLY SAD AND DEPRESSED
I HATE MYSELF

Some thinking patterns that can get in your way are:

**Jumping to Negative Conclusions**—drawing conclusions about what others are maybe thinking with very little evidence.

**would/Ought**—individuals with this pattern of thinking use ‘ought’ and ‘must’ when they think about a situation. This leads to inflexibility which may result in feelings of frustration and anger and can likely lead to a lapse as a way to calm down.

**Labelling**—using labels to describe oneself this can lead to unhelpful feelings. For example, “I am a failure so why bother”, may lead to a lapse in challenging situations.

**Personalizing**—blaming oneself for unpleasant things that happened may increase the pressure and expectation on oneself.

**Catastrophizing**—giving a lot of meaning to a situation. Convincing yourself that having something go wrong is unbearable. For example, my cravings are so bad it is impossible to be like that all day; I might as well have one drink.

**Black and White Thinking**—the idea that things are either all good or all bad. As such if something is seen as all bad it is more likely that you may have a lapse.
Ask participants to list some helpful strategies to maintain positive thought  

Some examples could include

- Running
- Listening to music
- Meditation
- Talking to someone
- Walking
- Deep breathing
- Self-affirming statements
- Thinking differently

THINKING DIFFERENTLY/CHANGING PERSPECTIVE

Let participants know that it is very easy to get stuck in a negative thought loop

As you get more embedded in negative thoughts, you begin to believe them, which causes a self-fulfilling prophecy [you may have to explain what a self-fulfilling prophecy is], which lead you to rely more and more on alcohol or drugs to help you feel better. This cycle—thoughts, feelings and behaviours—can be changed or stopped by making changes in one part of the cycle. You can change the way you think, or change how you do things—any change you make will have an impact on the whole cycle.

Changing your perspective is about seeing things from a different angle; it is like having a camera and taking pictures of the same landscape with several lenses and from different angles. Once spread out you will notice different features of the landscape. [Tell them our view of things, our life in general and how people in our life shape our understanding of who we are and how we feel and behave.]

- **Perception**: the way you regard something and your beliefs about what it is like.
- **Perspective**: a way of thinking about something which is influenced by the kind of person you are or by your experiences

**Explore**

- The feelings that client have when they are caught in negative thinking patterns, just after you did this
- The physical reactions/sensations
- The behavior that clients display

*For each feeling, get the client to define in one sentence what this feeling means to them and how this feeling relate to their behavior?*
Learning Activities

Activity 1: Thought, Feeling and Behaviour Record sheet

Provide clients with a thought, feeling and behaviour record sheet.

Activity 2: 45 Reframing Thinking

Right now, there are things you’re probably doing—the way you think, how you respond to those thoughts, and what you do—that are helping to keep this cycle wheel. List some ways you can reframe your thinking.
Reflection Circle

Today we talked about identifying and dealing with unhealthy thoughts. As you reflect on the things we talked about

- Did anything happen today that made you re-think your thought process?
- Did you learn anything about yourself through the discussions and exercises?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT
Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD
Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage client, or participants to practice muscle relaxation and deep breathing. See Appendix for deep breathing instructions.
HANDOUTS

Chapter 16: Unit 3

1. Thoughts, Feelings & Behaviours
2. Practicing Reframing
3. Positive Self-Talk Cards
<table>
<thead>
<tr>
<th>Situation</th>
<th>What are my Thoughts?</th>
<th>What am I Feelings?</th>
<th>What are my Behaviours?</th>
<th>How can I Mindfully Reframe?</th>
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</table>
| **EXPLORE WHAT’S STRESSING YOU** | **VIEW YOUR SITUATION WITH POSITIVE EYES.**  
**IF YOU COULD, WHAT PARTS OF YOUR SITUATION WOULD YOU MOST LIKE TO CHANGE?** |
| **FIND WHAT YOU CAN CHANGE** | **WITH POSITIVE REFRAMING, YOU MAY SEE POSSIBILITIES YOU WERE NOT AWARE OF BEFORE.**  
**NEGATIVE PERSPECTIVE:** “MY FRIEND HALEY HAS BEEN IGNORING ME ALL DAY. SHE IS PROBABLY UPSET WITH ME BECAUSE I DID NOT GO TO THE PARTY WITH HER.”  
**POSITIVE REFRAMING:** “I AM JUMPING TO CONCLUSIONS. IF HALEY IS IN A BAD MOOD, IT IS MOST LIKELY DUE TO SOMETHING THAT HAPPENED TO HER TODAY.” |
<p>| <strong>IDENTIFY BENEFITS</strong> | <strong>FIND THE BENEFITS IN THE SITUATION YOU FACE</strong> |</p>
<table>
<thead>
<tr>
<th>Positive Self-Talk Card</th>
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<tr>
<td>I will Practice Mindfulness</td>
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<td>I Can Do It</td>
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<tr>
<td>Positive Self-Talk Card</td>
<td>MIRTS</td>
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<tr>
<td>I Like Myself</td>
<td><img src="image3" alt="Image" /></td>
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<td>I'll try my best and that will be good enough</td>
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</tr>
<tr>
<td>Positive Self-Talk Card</td>
<td>MIRTS</td>
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<tr>
<td>I Will Replace fear with Curiosity.</td>
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<thead>
<tr>
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<tr>
<td>I have to Change Something, so that things can change.</td>
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<tr>
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<tbody>
<tr>
<td>It is important for me to let go so I can free myself.</td>
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<table>
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<tr>
<th>Positive Self-Talk Card</th>
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<td>I Am Unique</td>
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<tr>
<td>I will challenge myself to do something every day.</td>
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<td>Positive Self-Talk Card</td>
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<tr>
<td>------------------------</td>
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<td>I Will think of Reasons I can Instead of reasons I can't</td>
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<table>
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<thead>
<tr>
<th>Positive Self-Talk Card</th>
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<tr>
<td>I will challenge myself to do something every day.</td>
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Session Guide

Learning Intention

As young people, your friend is important to you. There is a great need to belong to a group, and this need is a natural part of adolescent development. Sometimes this creates a need to follow behaviour acceptable to the group of friends that you hang out with, which may not always be positive. Today we will talk about friends and the pressures we can sometimes feel to do things to fit in.

Engage – what to do

- You have recently succeeded in giving up smoking weed (cannabis). At a party one weekend, your good friend offers you a joint (marijuana/cannabis). S/he is very persistent and says, “Just this last time.” You know very well the high feeling you get from weed, and you do not experience any bad effects. In fact, it makes you feel cool and gives you the confidence to talk to people. However, you know that if you start again, it may take a while before you can give it up. What would you do?

Discussion questions

- What do you do when your friend pressure to do something you are not comfortable with?
- Do you use drug and/or alcohol to fit in?
- How to you deal with rejection from your friends when you do not give in to their pressure?
- How do you decide who are healthy friends?
- Is it difficult to stay away from your friends who use drug and/or alcohol now that you have decided not to use?

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.
Breaking it Do

Explore

- What friendship means.
- The importance of belonging to a group.
- What makes friends and friendships important.
- The benefits and disadvantages of belonging to a group.
- What are qualities of good/healthy friendship
- What negative peer pressure is?

1. Encourage the participants to share how they feel about having friends and different kinds of friendships.
2. Encourage clients to discuss the qualities that they seek in friendships
3. Encourage comparison between what they consider to be qualities of a great or healthy friend and some of their current friendship (young people, in general, will only continue to forge a friendship if adults in their life insist it is unhealthy, however, in my experience, when they can develop their reference point they can distinguish between good and negative friendship).
   You can use the following points to stimulate discussion:
   a. How similar are your friend’s qualities to the list of what you think of a healthy friend?
   b. Are the differences of any concern to you?
   c. How will you manage this friendship moving forward?
4. Encourage clients to brainstorm a list of ways they can resist pressure from their friends
Learning Activities

Activity 1: Influence of friends

- Put two sheets of flipchart paper on the wall. Write the heading ADVANTAGES (positive influence) on one sheet and DISADVANTAGES (negative influence) on the other. Place an assortment of markers next to the flipchart.
- Divide participants into two groups: ADVANTAGE and DISADVANTAGE. Invite a volunteer from each group to write one point under each heading.
- Ask participants to share stories of how they have been influenced positively or negatively or pressured by their friends and how they felt about the individual or group at that time.
- Encourage them to share how they handled peer pressure.
- Ask the group to get back into their groups of and come up with a list of ways to cope with the peer pressure.

INSIGHTS

- How difficult or easy was it to make these decisions?
- Which one do you think was the toughest decision to make?
- What were the “worst-case consequences” for each of the situations?
- Ask participants to talk about what makes friends and friendships important.
Reflection Circle

Today we talked about the pressure you may experience from your peers. As you think about the things, you did today

- Did anything happen today that made you re-think some of your friendships?
- Did you learn anything about yourself through the discussions and exercises?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT
Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage client, or participants to practice muscle relaxation and deep breathing

Key points

- Many young people get involved in drugs and alcohol, or are influenced to try drugs and alcohol, through their friends.
- Resisting peer pressure calls for a strong love of ourselves and a commitment to be true to ourselves and our values.
- Our decisions and choices affect us first, so it is important to make the right decisions for ourselves.
- It is healthy and normal to want to belong to a peer group.
- You must always be true to yourselves and your values and make decisions that are right for you.
- Mindful behaviour can help you handle peer pressure.
- As part of normal development, you become more dependent on your friends because you feel that they understand you better. This is fine, but it is important to know which friends are supportive of positive behaviour. They may not be bad people themselves, but they may have such an influence over you that they can convince you to do things which you do not want to do, or which are not promoting your health and well-being.
Chapter 16: Unit 4

1. Qualities of a good friend

2. Ways to resist negative peer pressure
### Qualities of a good friend

<table>
<thead>
<tr>
<th>Qualities of a good friend</th>
<th>My friend…</th>
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### Questions to consider:

1. Is the person supportive?
2. Are they emphatic to others?
3. Are they encouraging?
4. Are they respectful of your change?
5. Are they honest and trustworthy?
6. Do they respect your boundaries?
7. Do they pressure you to engage in risky behaviours?
Use the diagram below to think of ways you can be assertive and resist peer pressure.
CHECK-IN

**Group:** Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

**Individual:** conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

**QUIET MOMENT**
Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

---

**Learning Intention**
Using drugs and/or alcohol can often get in the way of your relationships. Currently, you may be isolated and disconnected from significant people in your life. However, healthy relationships are especially important to your sense of self-worth and personal growth. The decision to make changes can be a long, it is hard work, and it is important to have people around you who can help you along the way. You may have the most contact with people who are still using or who are not very supportive. It is a good idea to think about the people who can be supportive of your change. Today we are going to look at how you can build supportive networks.

---

**Engage – what to do**
- Distribute *handout: eco map*, ask participants to work on
- Tell them to think about the type of support you will need [e.g. emotional, practical, recreational, spiritual/moral, mentorship].

*By completing this exercise, you will be able to get a good idea of how the people in your life fit into your change plan.*
- Put the names of people on the chart according to how often you see them.
- *Circle* the names of people who are now or could be supportive.
- Put an *X* by the names of people who are not supportive or who might be harmful in some way.
- Try to move the unhelpful people away from the center

---

**Discussion questions**
- Do you have people in your life who can support your change?
- Are you able to trust them?
- To you feel supported at the moment?
- How did you feel working on this exercise?
- What did you notice about the people in your life?
- How did you recognize the healthy relationships?
- What are you looking for in a supportive relationship?
Learning Activities

Activity 1: The Role of Others
Encourage clients to think about what they need help with and the people in their support circle that can assist them with their goals.

Activity 2: Encouraging Statements
Ask clients to brainstorm supportive and encouraging phrases or word of advice they have received from their support network. Get them to develop a collage or some supportive cards.
**Reflection Circle**

Today we talked about your support network. As you think about the things you did today,

- Did anything happen today that made you re-think the people in your support network?
- Did you learn anything about yourself through the discussions and exercises?
- Do you have any other questions or concerns you would like to discuss?

**CHECK-OUT**

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

**QUIET MOMENT: REFER TO CD**

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

**Homework**

Encourage client, or participants to do some mindful walking, or take a yoga class.

**Key points**

- Having people who can support and cheer us on is important when abstaining from substance use
- A support person can act as a mentor or sometimes a sponsor
- A support person can help you through difficult moment
Chapter 16: Unit 5

1. Eco-map
Session Guide

Check-in

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

Quiet Moment
Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to talk about whom you are becoming now that you have had sometime abstaining from alcohol and/or drugs. This session will provide an opportunity for you to think about the growth you have made and communicate a better understanding of yourself and your well-being.

Engage – what to do

Becoming—self-representation

- Encourage your clients to draw self-portraits, write a poem, or any diagram they feel is a representation of whom they have become. Let them know you are not concerned with their artistic abilities, so draw anything that they feel is a representation of whom they have become or is becoming.

- Make the art materials available for all. Put on some background music to create a relaxed atmosphere. When they have completed, ask them to share with the rest of the group.

Discussion questions

- How have you grown since you made decided to stop using?
- What is the biggest change you have noticed about yourself?
- What has others notice about you?
- What are the different things that make you?
- How do you express the many sides of you?
- What sorts of things are you good at?
Breaking it Down

You can use The Grow Model to help your clients explore where they are and where they would like to be. The GROW model developed by John Whitmore(2003) provides a model of coaching that aims to unlock potential following a cycle that explores the Goals, Reality, Opportunities and Will to commit. The model does not always follow a monocyclic route, and you may find yourself moving between the different elements at various stages in series of coaching conversations. One of the key elements is the effective use of questions, such as those opposite.

<table>
<thead>
<tr>
<th>Goal</th>
<th>What do you want to achieve?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What would achieving this lead to long term?</td>
</tr>
<tr>
<td></td>
<td>When would you like to achieve this by?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reality</th>
<th>What is the current position?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What stops you from moving on?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Options</th>
<th>What could you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What else?</td>
</tr>
<tr>
<td></td>
<td>What else?</td>
</tr>
<tr>
<td></td>
<td>and what else?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Will</th>
<th>What will you do?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>What will be the first step?</td>
</tr>
</tbody>
</table>

Alternatively, you can also explore their motivation and whom they are becoming by using the Boyatzis’ Model of Intentional Change. If you use this model, take a step to make an adjustment to fit your client learning needs. I find this model more useful for individual sessions; however, with smaller groups it can also be helpful.
Boyatzis’ Model of Intentional Change provides a way for an individual to move explore long-lasting change in behaviour.

- First, for sustainable change you need a vision of where you want to be.
- What is the ideal self?
- Next, there needs to be some honest assessment. Where am I now? What is my real self?
- If the real and the ideal are the same, there is no incentive to change or develop. If they are too far apart, then some aspects need to be prioritized.
- The comparison of the real and ideal allows strengths and gaps to be identified. The learning agenda can then be formulated to give the opportunity to build on strengths. Boyatzis proposes that 80% of the focus should be on strengths and the ideal.
- There needs to be the opportunity to experiment, to practice and to review progress. How can I change my behaviours so that I change old habits into new habits?
- At the heart of the model is developing trusting relationships and support

Adapted from Boyatzis and Goleman, 2006.
Learning Activities

Activity 1: Onion Model

Use the onion model, as a representation of the deeper layers that participants can tap in themselves: behaviour is on the outside, and competencies, beliefs, identity, and mission are deeper and deeper on the inside. All these layers have their influence on the behaviour, but they do not always point into the same direction. Specific beliefs, in particular, can hamper the development (“I may want this, but whatever I do, it remains beyond my reach”). When all layers do come together, an experience of flow occurs. Then, those personal qualities emerge that come from the deeper inner sources of the acting. It is these that we call core qualities (e.g. goal-orientedness, courage, clarity of mind, commitment, strength).

The ‘onion’ model is useful because it demonstrates how things need to line up for you to feel happy and be the best you can be. It shows how each layer influences the others, and it is a way of understanding yourself and others and your interactions.

- Explain the onion model and levels using a popular figure as an example, and maybe even demonstrating with an onion as a visual aid.
- Ask clients to complete their ‘me’ chart, using the Handout—the ‘onion’ model.
- Review feedback. What have clients written in the different circles?
- Relate the words used during their sharing of information and giving feedback on the onion model.

Activity 2: Bio-flower

Distribute handout: bio-flower, allow your clients some time to be creative and fill in the blank petals.

INSIGHTS

- What have you discovered about yourself throughout this activity?
- Was the activity difficult?
- What did you like best about doing this activity?
Reflection Circle

Today we talked about who you are now that you have worked on so many aspects of your life. As you worked through the activities,

- Did anything happen today that made you re-think how you have been seeing or describing yourself?
- Did you learn anything new about yourself through the discussions and activities?
- Are you happy with whom you are becoming?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to

Homework

Encourage participants to practice muscle relaxation exercise. Emphasize how calming down the system by relaxing the muscles and taking deep breaths can be useful.

Key points

- Having people who can support and cheer us on is important when abstaining from substance use
- A support person can act as a mentor or sometimes a sponsor
- A support person can help you through difficult moment
1. Onion Model

2. Bio-Flower
ALL ABOUT ME

I AM

I WISH

I AM GOOD AT

I LOVE

I CAN

I WOULD LOVE TO BE
Session Guide

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to talk about how we manage stressful event, things and people in our life. The activities and things we will have a discussion today will we help you develop skill and strategies to cope and survive during a crisis. You will also be able to understand the relationship between stress, emotions, and addiction and learn mindfulness techniques to work with stress.

Engage – what to do

- Invite participants to think about those questions.
  - Do you feel like there are too many pressures and demands on you?
  - Are you having difficulty sleeping?
  - Are you worried about tests and schoolwork?
  - Are you worried about things at home?

Discussion questions

- What is stress?
- What sorts of thinking can get you feeling stress?
- How do you typically manage stress?
- How do you know when you are feeling stress?
- Where do you experience stress in your body?
Breaking it Down

Explore

What is stress?

- Stress is a feeling that is created when we react to particular events. Stress is a non-specific reaction your body has when you are facing challenges or circumstances that force you to act, change or adjust to your environment.
- The events that provoke stress are called stressors, and they cover a whole range of situations — everything from physical danger to making a class presentation.

What are the things or events that create high levels of stress for you? Examples of responses could include:
- School
- Family
- Health

When or how do you know that you are feeling stress? Of Examples of responses could include:
- Become irritable
- Tired
- Have a hard time staying focus

Where do you experience stress in your body? Examples of responses could include:
- Neck
- Lower back
- Shoulder
- Stomach
- Eyes
- Chest

Explore further,

- The concept of intensity
- How one’s tendencies and preferences change when feeling well versus not well (specific symptoms, emotions, thoughts, and behaviors experienced)
- Elements of different physical environments and how these elements increase stress, or enhance or impede the ability to self-organize (sensory room versus the general unit/milieu)
- The pros and cons of incorporating more healthful strategies into one’s lifestyle

What are some ways you can get through your stress? [Encourage them to brainstorm ideas. Have them write on the first handout you gave them the different strategies they can use]

Mindful ways to get through stressful situations without making them worse.
**Improve the movement**
- Get regular exercise
- Practice yoga and meditation regularly
- Breathing
- Progressive muscle relaxation
- Walking
- Relaxation (quiet your body)
- Swimming

**Sensory Modulations**
- Grounding activities
- Orienting/alerting activities
- Relaxation/calming activities
- Self-nurturing activities
- Self-soothing activities
- Distracting activities
- Mindfulness activities
- Strategies for identifying and coping with triggers
- Activities promoting increased connectedness (to others, nature, a higher power)
- Environmental modification
- Creation of a personalized sensory kit
- Journaling
- Sound & music therapy
- Weighted blanket
- Aromatherapy
- Taking a hot/shower or bath
- Pet therapy
- Beanbag tapping
- Art therapy

*Examples of themes for sensory kits/toolboxes:*
- Mindfulness kit
- Sobriety kit
- Grounding kit
- Relaxation kit
- Distress tolerance kit
- Self-soothing kit
- Calming Kit
- Sensory Kit
Self-soothe the five senses

- Vision – look at pictures of vacation spots etc.
- Hearing – listen to relaxing music
- Smell – go to flower shops or light scented candles,
- Taste – Sip a hot chocolate or chai tea
- Touch – take baths with oils, soft clothing, cuddle with a stuff animal or friend

Other

- Eat nutritiously and balanced meals
- Write all your stress in a bottle and let it float away
- Write all your stressors on pieces of paper, put them in a balloon, blow the balloon then go outside and set it loose.
- Imagine (better times, better things, success)
- Meaning (find one useful thing about the situation for you)
- Prayer (find some quiet place inside of you)
- One thing at a time (just this moment)
- Vacation (go someplace in your mind, or take a time out)
- Encouragement (tell yourself it will be OK)
Learning Activities

Activity 1: Social Readjustment Rating Scale
Get clients to fill the stress scale out and calculate their number of points
Note: This is a two-part activity using the Social Readjustment Scale (Holmes & Rahe, 1967). Before break, you should introduce the scale and have clients fill it out and have them calculate their number of points. They may need assistance with point calculation. Have them start their break whenever they have completed the scale, and give a specific time for them to return.

Activity 2: Substance-Induced Stress on the Social Readjustment
- After the break, have each client fill out another Stress Scale, leaving out all the stressors caused by substance abuse or any substance use at all.
- After recalculating their score, ask the discussion question, “how much of your stress may be eased by abstinence?”

Clinicians Note: It is usually very surprising for participants to realize that substance use is creating stress. They may have a strong belief that their drug of choice helps them manage their stress. The realization that they may reduce their stress by NOT using a substance is a significant cognitive shift. Encourage the participants to discuss this paradox. One of the greatest triggers for craving and relapse is high stress. They still need new tools to deal with the stress they may be experiencing

Activity 3: Grounding Kit/Toolbox
Provide clients with a shoebox and material to develop a grounding kit which they can use in time of stress to help them calm down.

INSIGHTS
- How much of your stress may be alleviated by abstinence?
- Do you think that stress could be a factor that can cause relapse?
- How important might stress management be in recovery?
- Can recovery itself create stress?
**Reflection Circle**

Today spent some time today looking at stress, and how you can tolerate and deal with stress more effectively.
- Did anything happen today that made you the way you handle stress?
- Did you learn anything new that you think will be useful?
- Do you have any other questions or concerns you would like to discuss?

**CHECK-OUT**

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

**QUIET MOMENT: REFER TO CD**

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

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**Homework**

Encourage client, or participants to practice muscle relaxation and deep breathing. See Appendix for deep breathing instructions.

**Key points**

- Distress tolerance/ stress management an ongoing process, and they can improve their ability to manage difficult situation
- Practice mindful techniques consistently will help in reducing frustration
HAN DOUTS

Chapter 16: Unit 7

1. Grounding Toolbox

2. Stress Management Worksheet

3. Relaxation
Find a beautiful box or an empty shoebox. Use it to great your grounding toolbox. Inside you can add things such as a teddy bear, beanbag, breathing instruction, etc. Add as many grounding tools as you want.
Breathing Exercise

You can practice relaxation exercises anywhere you are at any time. You will need to:

1. Find a place where you can relax.
2. Choose a relaxation exercise that you enjoy.
3. Get into a comfortable position and begin to practice.
4. Many people prefer to close their eyes during these relaxation exercises.
5. If this is not comfortable for you, you can fix your eyes on a spot on the floor or wall.
6. As you breathe in, let your abdomen expand outward, rather than raising your shoulders. This is a more relaxed and natural way to breathe, and helps your lungs fill themselves more fully with fresh air, releasing more “old” air.
7. If during the breathing exercise you cannot stop thinking about your concerns and worries, come up with a word or a phrase that you find peaceful, such as “tranquility” or “I am relaxed.” Focus on this word or phrase as you breathe in and out. If other thoughts pop into your head, don’t get discouraged — just refocus and keep practicing!
CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to talk about repairing relationships. One aspect of recovery or change is your acknowledgment that you have hurt the people close to you because of your substance use. It is important to rebuild the relationships that were broken as a result of your substance use to regain trust and move forward.

Engage – what to do

- Say: Friends and family members often get hurt as a result of the substance use habit of others.
- Ask: clients to think back to the people they have hurt and the friendship that no longer exist as a result of their alcohol and /or drug use. Who are the people who were most impacted by your use?

Discussion questions

- In what ways have you contributed hurt others because of your use?
- How important is it for you to repair these relationships?
Breaking it Down

Explore

- To whom they need to make amends
- Explore the client’s feeling and thinking
- How one’s tendencies and preferences specifically influence one’s roles & relationships (when using and not using)
- What they need to make amends for.
- The difference between apologizing and making amends.
- How they plan to handle a situation where someone is still angry and refuses to forgive them.
- Things resentments clients may need to let go off
- Things that they may have neglected to say or do that needs addressing
Learning Activities

Activity 1: Apology Letter/Card

Sometimes it is difficult to come up with the exact word to express regrets. Encourage clients to write a letter or design an apology card that they can give to people they wish to repair their relationship or simply apologize for hurting them.

INSIGHTS

- How did you feel after completing this exercise?
- What emotions came up strong for you?
- What are your feelings about letting go?
- Is it difficult for you to apologize when you have hurt someone?
Reflection Circle

Today we talked about repairing relationships and how significant it is to let go.

- Did anything happen today that made you re-think letting go?
- Did you learn anything about the value in making amends?
- Do you have any other questions or concerns you would like to discuss?

Check-out

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

Quiet Moment: Refer to CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Encourage participants to practice muscle relaxation exercise. Emphasize how calming down the system by relaxing the muscles and taking deep breaths can be useful.

Key points

- Apologizing is a sign of growth and strength, not weakness
- We quite often hurt the people we love, when this happens, we need to be aware of how our behaviour impact them and take steps to make thing right.
- Letting go of hurt and resentment is an important step in sustaining change, or maintaining abstinence.
1. Repairing Relationships
When you were using drug and/or alcohol, it is likely that your friends and family got hurt in the process, as a result of your habits and behaviours. People who misuse substance sometimes struggle to care for themselves or be kind to others. Most young people with whom misuse substances find it difficult to have open, honest relationships. Quite often things are said and done that destroy trust and damage relationships. When substance misuse stops, the trust does not return right away. To trust means to feel certain you can rely on someone. Trust can be lost in an instant, but it can be rebuilt only over time. Trust will return gradually as you give your friends and family reasons to trust again.

As part of your journey, you should think about whom you have hurt. You should also think about whether you need to do anything to repair the relationships that are most important to you. Admitting the hurt, you caused while you were using substances will probably help reduce problems in your relationships. Not everyone will be ready to forgive you, but an important part of this process is beginning to forgive yourself. Another aspect of repairing relationships involves your forgiving others for things that they did when you were using substances.

Use these questions to help you work on repairing your relationships

1. What are some of the past behaviors you might want to improve or change?
2. Are there things you neglected to do or say when you were using that should be addressed now?
3. Whom do you need to forgive?
4. What resentments do you need to let go of?
5. What can you do to help the process of reestablishing trust?
CHECK-IN

**Group:** Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

**Individual:** conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

**QUIET MOMENT**
Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to explore relapse, and justifications you may likely use when you begin to use alcohol and /or drugs again. The discussion today should help increase your awareness of the situations that can likely cause relapse and justifications that you use to sustain using.

Engage – what to do

- **Ask:** if your clients have experience a lapse or a relapse, how they felt and what are the things they told themselves to justify using.
- **Ask:** whether the clients had tried to stop using before and ended up relapsing. How did the relapses occur? Did they seem to come out of the blue?

Discussion questions

- What excuses do you tell yourself after you have a relapse?
- What situations, people, places can cause you to use again?
- What are your thoughts about relapse?
- Do you understand and know the warning signs of relapse?
- Describe the activities that you engaged in when you were using. Have these behaviors crept back into their lives?
Breaking it Down

Explore

- Their ideas about a slip (lapse) vs. a relapse
- understand what relapse is and how it develops
- What clients do after a slip (lapse), or a relapse
- Who they feel comfortable speaking to
- How many drinks or drug uses before they seek help again
- How they think about themselves after a relapse
- The things they tell themselves after a relapse
- Things they can do after a relapse or a slip
- how their work life or friendships affects their recovery, or change process
- possible solutions to problems that friends or work poses to their recovery
- compromises and changes clients have made to find time for recovery
- if there is any desire or need to attend treatment
- Emotional buildup—Emotional buildup may be a difficult concept for clients to grasp. So you may have to describe how emotions can build up and lead to relapse
- The concept of addictive thinking
- What relapse justification to which they feel especially vulnerable

Encourage your clients to develop a change maintenance plan / relapse prevention plan
Learning Activities

Activity 1: Change Maintenance Plan

Distribute the handout: individualized change maintenance plan. Assist the client in developing a plan to sustain the changes he/she has made.

INSIGHTS

- How do you feel now that you have developed a plan?
- Are you confident in your ability to stick to your plan?
- What are you concerned about?
**Reflection Circle**

Today we talked about relapse and the excuses you use when you begin to develop old pattern and habits of using again,

- Did anything happen today that made you re-think the excuses you tell yourself?
- Did you learn anything about relapse and how you can avoid it?
- Do you have any other questions or concerns you would like to discuss?

**CHECK-OUT**

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

**QUIET MOMENT: REFER TO CD**

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

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**Homework**

Encourage participants to practice muscle relaxation exercise and deep breathing. Emphasize how calming down the system by relaxing the muscles and taking deep breaths can be useful.

**Key points**

- Relapse can appear to come out of nowhere, when you have been managing well, it is important to be mindful about things that can lead to relapse.
- Being aware of the excuse that you are most vulnerable too is helpful to prevent relapse.
- It is important to be mindful of situation, thing, people and thinking and feelings that lead to relapse
  
  For change to be meaningful one need to:
  
  - *Have a sense of hope*—hope helps you see yourself as an agent for positive change in your life
  - *Have a sense of personal responsibility*—being proactive and using your power to move in the direction you want
  - *Be open to learning different strategies and exploring the self*—learning all you can about yourself will help with developing self-compassion and making good decisions, among other things
  - *Have healthy relationship*—developing and keeping strong support will strengthen your sense of being, belonging and becoming.
  - *Learn self-advocacy skills*—being able to speak to your needs and expressing yourself and needs clearly.
Chapter 16: Unit 9

1. Relapse Justification Checklist
2. Working through a Relapse
3. Individualized Change Maintenance Plan- (Ways to avoid relapse cycles)
Sometimes after a period of not using young people can struggle with their own thoughts about using vs. not using. Making excuses for using is called Relapse Justification. You may have decided to stop using, but it is important to consider that sometimes you may experience triggers and cravings. You may remember a time when you intended to go to a party and not use drug and/or alcohol, but you came up with a justification for using, and before you knew it, you had used again. Understanding and anticipating the common justifications you make will help you interrupt the process.

**Use the questions below to help you identify justifications you might be using.** Tick the ones that you have used or you are currently using to justify why you are using again.

<table>
<thead>
<tr>
<th><strong>Testing yourself</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am strong enough to be around it now</td>
<td>☐</td>
</tr>
<tr>
<td>I want to see whether I can say ‘No’ to drinking and using drugs</td>
<td>☐</td>
</tr>
<tr>
<td>I want to see if I can still be around my old friends when they are using or drinking</td>
<td>☐</td>
</tr>
<tr>
<td>I want to see how the high feels now that I have stopped using</td>
<td>☐</td>
</tr>
<tr>
<td>Other:</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Celebrating</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am feeling great; one time will not hurt</td>
<td>☐</td>
</tr>
<tr>
<td>I have been good for a while; I owe myself some good times</td>
<td>☐</td>
</tr>
<tr>
<td>This is such a special event; I have to celebrate</td>
<td>☐</td>
</tr>
<tr>
<td>Everyone is celebrating, no one will notice</td>
<td>☐</td>
</tr>
<tr>
<td>Other:</td>
<td>☐</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Emotions: (E.g., depression, anger, loneliness, boredom, sad)</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>I am already depressed; I do not think it will make a difference if I use</td>
<td>☐</td>
</tr>
<tr>
<td>I am mad right now; I need something to take the edge off</td>
<td>☐</td>
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<td>I am bored; if I use I will not feel so bored</td>
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<tr>
<td>If my parents think I have used, I might as well go ahead and use</td>
<td>☐</td>
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<tr>
<td>I need to forget why I am so sad, or what happened to me</td>
<td>☐</td>
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<tr>
<td>Other:</td>
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<thead>
<tr>
<th><strong>For a specific purpose</strong></th>
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<tr>
<td>I am out of energy; I will function better if I use</td>
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<tr>
<td>All my friends use, if I do I will keep my friend plus make new friends</td>
<td>☐</td>
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<tr>
<td>My friends say I am boring to be around</td>
<td>☐</td>
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<tr>
<td>I am gaining weight</td>
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<tr>
<td>Other:</td>
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© 2015, Mockett, V
Sometimes people have slips or relapse. If you find yourself in this position, use this table below to help you work through relapse.

<table>
<thead>
<tr>
<th>ACTION STEP I WILL TAKE</th>
<th>PLACES I CAN FIND HELP</th>
<th>PEOPLE THAT CAN HELP</th>
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</table>
### Individualized Change Maintenance Plan

<table>
<thead>
<tr>
<th>Substance use goals</th>
<th>Where am I now? <em>(think about your progress and milestone concerning your goals)</em></th>
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<tbody>
<tr>
<td>Goal 1.</td>
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<td>Goal 2.</td>
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<tr>
<td>Goal 3.</td>
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#### Reasons for the change

My strengths are:

#### Benefits of change
- 1.
- 2.
- 3.

#### Consequences of Relapse
- 1.
- 2.
- 3.

#### How can I continue with my progress

**My action steps**

**Who can help me?**

**What other resources do I need?**

#### How important is this change to you? *Circle a number below to indicate how important it is to you to maintain your change. 1 low importance, 10 very important*

<table>
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<th>1</th>
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<th>4</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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Chapter Seventeen

Transition Planning
Clinicians Note

Young people with FASD require extra support from individuals and organizations that provide social services when they are transitioning from, for example, mental health and addiction services, youth justice services, or care. As a clinician in the community, you have the opportunity to provide stability and to be of support throughout this vulnerable period in the young person's life. Work closely with other health and community care providers, the young person, and his or her family/caregiver to identify and respond to the unique needs of your client.

Effective transition planning begins early, is collaborative and promotes an environment that actively involves the young person in his or her care, which includes dialogue between you, the client, the family/caregiver, and other professionals involved in treatment planning. A young person's involvement varies depending on their age, maturity, skill sets, and ability; older youth may be more involved in exploring post treatment alternatives, job interests, monitoring their progress, or exploring postsecondary options. This can encourage healthy decision-making and raise the young person's level of awareness of his/her personal strengths and needs. Effective compensatory strategies help position a young person with FASD for successful transitions. Providing relevant information and establishing appropriate support systems for you're a client and his/her family/caregiver is an critical part of the transition process. Through providing young people with FASD with information, support that meet their individual needs and encouraging self-management of care, young people with FASD will be more empowered to take on increasing responsibility through the transition process.

You will play a fundamental role in connecting and referring the adolescent to community services. Always keep in mind available services in the community to which you can refer the young person and his or her family, including mental health support, health, legal services, relapse prevention support, education support, food assistance, homeless shelters, youth hubs, as well as support for social services. Keep in mind the benefits of extracurricular activities, which can help the young person with FASD develop new, or
maintaining existing healthy friendships. Having healthy relationships will the young person to develop a skill set for positive living and may decrease their sense of isolation.

Providing care that incorporates positive living strategies will build the capacity of young people with FASD to develop interpersonal skills, decision-making, and critical-thinking skills, and coping and self-management skills. Positive living strategies promote emotional, physical, and spiritual health and living responsibly, and are a topic that should be discussed and encouraged. Through the provision of information and education for positive living, you, the clinician, the support team and the family/caregiver can work together to help the young person to develop life skills to live a healthy life, and establish the foundation for a smooth transition.

Young people with FASD will benefit from supported opportunities to practice skills and strategies that will be important in a new learning situation; opportunities to become familiar with a new setting, the people, and the expectations of the change; and opportunities to practice responding appropriately to novel situations and forecasting consequences. To facilitate transition planning, it is critical that you have knowledge of what is required to make effective transitions. For example, you must understand the steps necessary for a young person with FASD in care to prepare for transition out of care: what services are required for the young person to access accommodations and supports? How much time is needed to get ready? What does the young person need to do to prepare?

Transition planning involves identifying the abilities and strategies that a young person with FASD will need for a future change early on and planning instruction to develop them. The young person’s readiness to make a transition is often part of the decision-making in transition planning. Adequate information regarding the young person’s strengths and needs facilitates appropriate choices for transitions.

The examples below provide valuable information about the needs of young people with FASD. The list is by no mean an exhaustive list; these are just some examples from my practice experience.

1. **Psychosocial development:** Assessment of psychosocial development is important as it provides information on the young person’s ability to take on increasing the responsibility for his or her health and well-being. It is important to assess the adolescent’s strengths support system at home and in the community.

2. **Mental health support:** young people with FASD may suffer from anxiety and depression or other mental health conditions. Monitoring them for emotional health issues that may arise and providing emotional health counseling and referrals is critical.

3. **Drugs and alcohol:** Providing support for relapse prevention or what I call, “change maintenance” after treatment program is vital. For young people with FASD, who have not been connected to addiction services, when drug and alcohol use is suspected, screen for use and provide counseling or a counseling referral.

4. **Sexual and reproductive health:** Discussing sexual and reproductive health with young people with FASD can help to prepare them for current and future sexual activity. Providing the young person with information surrounding contraception, pregnancy planning, and STIs, as well as access and referral to these services, are essential.
5. **Loss & Grief:** Many young people with FASD have suffered one or many losses and have may have post-traumatic experiences that are difficult to manage. Provide or refer for counseling services and encourage support group attendance.

6. **Positive Living:** Take opportunities to provide health education surrounding nutrition, exercise, the importance of mindfulness, creating and setting positive education and other goals, and other factors that contribute to a positive lifestyle for the young person.

7. **Transportation:** many young people are unable to access needed service due to transportation challenges. Provide bus passes/tickets or make arrangements for the young person to be taken to his/her appointment.

8. **Self-advocacy:** Self-advocacy involves taking action on one’s behalf and is related to success, for example, in school, and the workplace. In my experience, strong self-advocacy skills have been shown to facilitate smoother transitions for young people with FASD. Teach them an awareness of their strengths and abilities, communication, problem-solving, as well as other advocacy skills. A client’s ability to efficiently and constructively advocate on his/her behalf requires an understanding of his/her abilities and challenges, knowledge of what works for him/her and skills to communicate this knowledge to others.

---

**Reflection Questions**

1. How do I support your clients’ social learning?
2. Am I engaging in open-ended communication with your clients?
3. Am I tuned-in to your clients’ abilities, interests and strengths and respond by providing appropriate scaffolding techniques?
4. How do I helping my clients to communicate effectively or Problem-solve?
5. How do I Co-Construct?
6. How do I scaffold my clients’ learning and development?
Resources Needed

- Name Tags
- Presentation slides
- Flipchart Paper
- Pens, Pencils, Markers
- Sticky Notes
- Laptop
- LCD Projector
- Yoga Mats or Towels

The Goal of the session is to:

- Help clients develop effective communication skills
- Help clients solve problems effectively
- Help clients explore their decision making process
- Help clients work on building healthy relationships
- Help clients work on building trust in their relationship and confidence in being

Handouts

- Health & Social Resources
- Individualized Transition Plan
- My Support Network
- Transition Planning Checklist
- How do you Manage Money
- My Needs vs My Wants
- My Spending Plan
- Crisis & Safety Plan
- Independent Living Checklist
- Self-Care Assessment
- Self-Care Worksheet
Session Guide

Chapter 17
Unit 1

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

Individual: conduct a brief check-in to assess how your client is doing presently and how he/she have been doing. If this is a returning session ask the client if he/she have any questions about his/her last session, homework, or any other concerns the client wish to discuss.

QUIET MOMENT

Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we are going to work on developing your transition plan. Change is a process; it requires work to continue to sustain and maintain the improvements you have made towards your goals. We will explore the importance of being able to access help and support and being able to ask for it. This session will also provide you with an opportunity to re-evaluate your change plan and make any adjustments.

Engage – what to do

Getting from where I am, to where I would like to be.

Invite participants to think back over the sessions they had together then ask:

- What aspects stand out for you regarding the next steps that you may need to take?
- What do you need to feel safe, and supported?
- What can you do on your own, and what do you need help with?
- What concerns you most about your future?
- Are there any new things you would like to do?

Discussion questions

Let’s think about your transition plan for a moment for a moment…

- Ask your client to take a few minutes to consider his/her goals. Get him/her to and think about people and organizations they already have contact with and indicate which people, or organizations they would like to have contact with, or that can continue to provide support.
- Talk a little about the process of making contact, and ask if they need any support from their team with suggestions of either whom to contact, or how to make contact.
- Review the components of transition planning or an individualize transition plan with your client.
Breaking it Down

Help clients explore:

1. **Readiness for transition.** Use the transition planning checklist and self-management timeline
2. **Their support network.**
   Using drugs and/or alcohol can often get in the way of your relationships. Currently, you may be isolated and disconnected from significant people in your life, but healthy relationships are especially important to your sense of self-worth and personal growth. The decision to make changes can be long; it is hard work, and it is important to have people around you who can help you along the way. You may have the most contact with people who are still using or who are not very supportive. It is a good idea to think about the people who can be supportive of your change. Today we are going to look at how you can build supportive networks.
   - Engage clients in a discussion about the people in their lives.
     - Who are the people in your life?
     - Do you feel you have a good support network?
Learning Activities

Activity 1: My Support Network
Distribute handout, ask participants to work on it. Ask them to think about the type of support you will need [e.g. emotional, practical, recreational, spiritual/moral, mentorship].

- Emotional—someone you can talk about your feelings to, who will listen and will reinforce healthy coping strategies.
- Practical—someone whom you can ask for help with everyday tasks such as transportation to appointments.
- Recreational—someone you can have fun with, like going to a movie or for a walk.
- Spiritual/Moral—someone who will encourage you, and help you with mindfulness or other spiritual growth.
- Mentorship—someone who can provide guidance and instruction with your goals and plans.
- Think about what you need support with.
- By completing this exercise, you will be able to get a good idea of how everyone you . . . Everyone you know fits into your change plan. By identifying everyone, you will be able to see more clearly who might best help you in sustaining your change.
- Put the names of people on the chart according to how often you see them.
- Circle the names of people who are now, or could be, supportive.
- Put an X by the names of people who are not supportive or who might be harmful in some way.
- Try to move the unhelpful people away from the center.

Activity 2: Individualize Transition Plan
Group: Distribute the handout: individualized transition plan walk around and provides support to participants as they work on their goals and steps for moving forward.

Individual: For the individual session, work collaboratively with the client to establish his/her goals and the support and referral he/she will require.

Case conference/team meetings: For Integrated case management or case conference meetings, ensures that the young person’s voice is heard in the process. Ask the young person for his/her input on goals and other support needs he/she will require. Planning works best and young people are more confidence in transition plan when they have meaningful input in the process.

INSIGHTS

- How did you feel, working on this exercise?
- What did you notice about the people in your life?
- Do you feel you have supportive people in your family and friendship circle?
- What is the one thing you are looking for in a supportive relationship?
- How did you recognize an unhealthy relationship?
- Why are healthy relationships important?
- How do you feel about the plan you developed?
- Did you find it difficult?
Reflection Circle

Today we worked on your transition plan.

- Did anything happen today that made you think about your plans after you are done with treatment or counselling?
- How are you feeling about your goals moving forward?
- Do you feel you had sufficient input on the development of your plan?
- Are you feeling confident about the plan you have developed?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

- Encourage your clients to practice mindful strategies such as, walking and breathing.
- Challenge your clients to try something new.
Chapter 17: Unit 1

1. My support Network
2. Transition Planning Checklist
3. Health & Social Resources
4. Individualized Transition Plan
I can get emotional support from:

I can get practical support from:

I can be mentored by:

I can get recreational support from:

I can get moral support from:

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Transition is an important aspect of change. As you become increasingly independent, it is important to make sure that you continue to take good care of yourself and follow through on the tasks that keep you healthy and free from using alcohol and/or drugs. To have the smoothest transition possible, make sure that you can carry the tasks in the following checklist. Please tick the areas you need help with and discuss your needs with your counsellor, who can then help you develop a transition plan.

<table>
<thead>
<tr>
<th>I need help with:</th>
<th>What kind of help do you need?</th>
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<tbody>
<tr>
<td>Developing healthy relationships</td>
<td>□</td>
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<tr>
<td>Transportation</td>
<td>□</td>
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<tr>
<td>Medication reminders</td>
<td>□</td>
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<tr>
<td>Self-care</td>
<td>□</td>
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<tr>
<td>Assertiveness skills</td>
<td>□</td>
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<tr>
<td>Maintaining good health care</td>
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<tr>
<td>Nutrition</td>
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<td>Coping with emotions</td>
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<td>Problem solving</td>
<td>□</td>
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<tr>
<td>Grief &amp; loss</td>
<td>□</td>
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<td>Refusal skills</td>
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<td>Housing</td>
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Individualized Transition Plan  
*(Sustaining my current change and working towards where I want to be!)*

**Name:**

**Date:**

**My strengths are:**

<table>
<thead>
<tr>
<th>What do I need help with?</th>
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<tbody>
<tr>
<td>As you reflect on the changes you have made and your future. What do you need, want, or hope to happen to feel like you are achieving?</td>
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<thead>
<tr>
<th>I need help with:</th>
<th>My goals are:</th>
<th>Steps I will take are:</th>
<th>People that will help me</th>
<th>Places I can go for help are:</th>
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**How will you know when things are working out or improving?**

<table>
<thead>
<tr>
<th>Goals</th>
<th>Improvement indicators - I will know thinks are improving when…</th>
<th>My progress</th>
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CHECK-IN

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QUIET MOMENT
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Engage – what to do
Let's talk about how you manage your time for a moment… Engage clients in a discussion about the importance of managing their time and keeping things organized. Explore areas where time management and organization matters.

- Have you ever been in trouble for missing an appointment, or being late?
- Do you struggle to manage your time or have things organized?

Discussion questions
- How do you manage your time to ensure that you are not missing an appointment, or being late for appointments?
- Do you take medications daily? If so have you ever forgotten to take your medication?
- How does that make you feel?
- How did you manage that?
- Are you feeling like you do not have enough time to get things done while others in your life are interpreting this as you not caring or making an effort?
Breaking it Down

Explore what time management is

**What is Time Management?**
Time management” refers to the way that you organize and plan how long you spend on specific activities

**Benefits of having good time management:**
- Greater productivity and efficiency
- Less stress

**Greater opportunities to achieve important goals:**
- When we fail to manage our time effectively, we can have some undesirable consequences happen
  - Missed deadlines
  - Poor work quality
  - Higher stress levels

Provide clients with practical ideas and tips for managing their time in a manner that will reduce anxiety and stress, as well as promote productivity and engagement.

1. **Schedule Blocks of Time for Different Tasks:**
You might be juggling roles such as student, friend, and employee, etc. all at the same time. Try setting aside a block of time for each of these areas of your life and do only those tasks during that time. So, maybe you’ll have one hour every Wednesday that is exclusively dedicated to laundry or one two hour block every other day for doing schoolwork. The most important part of this technique is that it helps you stay focused on that one area exclusively and have down time later.

2. **Breaks – ESSENTIAL for Time Management Success**
Breaks are entirely necessary to avoid the burn-out that might come from busy schedules. Just as we should stick closely to our housework and schoolwork schedules, if we set aside time for a hobby or a break, we should stick to it! Self-care is important so making time for a yoga class, or a walk with a friend is useful

3. **Hard Copy technique**
Let them know that time management skills were just as important before the advent of computers, so there are many hard-copy techniques for keeping track of schedules.

**Planners & Calendars**
There are seemingly endless supplies of different planners and calendars out there to suit any time management needs. Many young people who use this method find it easier to use color-coding in their planners. By colour coding, you can make sure that your different schedules all fit together.
To-Do Lists and reminder posters
Doing a daily or weekly to-do list has been beneficial to some young people with FASD as it keeps them focus on the task requiring their attention. To-do-posters have also been designed by some young people with FASD to help them keep organized and on top of things they need to do daily at home.

Digital Techniques

If you live a more digital lifestyle, there are plenty of options for managing your time. Online systems have adopted many of the same techniques that we’ve already covered and combined them into easy-to-use programs. For example, Google Calendar, Trello, Any Do, Wunderlist, and Remember Me are some of the popular ones. However, there are many more options out there, so shop around until you find the app that fits your needs. Your various phones also have inbuilt calendar systems that you can also use to get your day organized. Great features of these are:

- Reminder alarm that allows you to set alarms to remind you of appointments and deadlines.
- Options for assigning all-day, weekly, bi-weekly or monthly reminders to a given task.
Learning Activities

Activity 1: Organization

You are parents going away for a business trip this weekend, leave a list of tasks (house chores, homework, self-care, etc.) for your child to get done while you are away. Let them know that you are aware they have some personal plans with their friends, but these need to be done as well.

Important Note: Be sure to walk around the room and be available to ask questions and concerns that participants may raise.

INSIGHTS

- What was the strongest emotion you felt doing this initially?
- What was the experience like?
- What was difficult?
- What was easy?
- Once you were able to organize and prioritize your tasks, how did that make you feel?
- Is the task list doable given the time frame?
Reflection Circle

Today we talked about time management and organizational skills. As you reflect on the things we talk about

- Did you learn anything you think may be useful in helping you better your organizational and time management skills?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present

Homework

Encourage participants to begin to practice mindful breathing at home

Key points

Time management is the process of organizing and planning the time you spend on activities and appointment.
Session Guide

Chapter 17
Unit 3

CHECK-IN

Group: Ask each group member to offer one word, thought or feeling that describe how he/she has been feeling today. The facilitators/counsellor may begin with “I feel … and go around the room.

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Engage clients in a short mindfulness practice. Let them know that establishing some balance and calmness in our mind and body is very helpful, as it increases our awareness and attention. Mention that learning a new skill can sometimes be intimidating; however, the goal here is not to be perfect, but rather, to develop new strategies to calm the body and mind. Reassure them that practice will help them develop a feeling of competence with the exercise as they continue to do them.

Learning Intention

Today we will work on money management and budgeting. Even if you do not have a regular income or live independently, the information will be helpful in getting you to think about practical money choices and their results. You will also work on planning how you want to use your allowances or money from your job. This session will also provide practice developing a spending plan.

Engage – what to do

Let your clients know that it is easy to overspend. Engage them in an activity that helps them think about the consequences of spending more money than they have available.

- Ask if they have ever spent all of their allowance money early in the week and did not have enough left for other expenses later in the week.
- Have each client write down a situation where this happened.
- Next, ask the clients to write about how they handled the situation.

Discussion questions

- What do you think about the way you spend the money you have? Is it ok to spend all your money?
- How important is it for you to save money?
- Why should you save?
- Are you saving for a particular reason?
- How would you describe your spending habits?
Breaking it Down

Young people with FASD are capable of managing small amounts of money. They can divide their money into several categories, including "spend," and "save." At the same time, they can spend their money and keep a record of what was spent. Allowances are the first step to understanding written spending plans or budgets. With guidance managing allowances, young people with FASD can become financially responsible.

You can help your client:

- Identify and prioritize some of their financial goals
- Identify the steps they can take and the resources they will need to achieve their goals
- Identify and examine their current spending behaviors and patterns
- Understand what it means to budget, and identify the reasons to maintain a budget
- Create a personal budget that supports their needs and financial goals

Explore the following:

What are your financial goals?

- Ask your clients what some of their goals are about money and how they would like to spend their money (e.g., allowance, money earn from working)

Where Does Your Money Come From?

- Have clients identify their current or potential (new job, parents) sources of income.
- Discuss their ideas and feelings about being financially dependent vs. financially independent.

Where Does Your Money Go?

- Discuss whether they keep a record of their spending? If so how?
- Ask clients what patterns they can see in their spending habits.
- Discuss topics such as impulse buying.
- How they decide what to purchase.
- Ask if they maintain a personal budget.
Budgeting

Ask:

- What do you think of when you hear the word “budget”?
- What are some reasons to budget?
- What are the benefits of a budget?

Banking

- Provide practice in comparing and evaluating various banking services, including checking and savings accounts, debit cards/ATM, and online banking.
- Help them to explore and provide explanation on the services offered by banks,
- List some of the factors to consider when shopping for bank services
- Explore the responsibilities of having a checking account
- Describe how to deposit a check
- Show them how to read and interpret their account statement
- Provide tips for responsibly using their ATM card, as well as how to keep their PIN secure.
Learning Activities

Activity 1: How are you with Money?
- Distribute Handout: how are you with money
- In the following exercise, evaluate your spending habits. Tick the item which best reflects the way you spend money.

Activity 2: My Need Vs. My Wants
- Distribute handout: my needs vs. my wants
- Use the chart to keep track of the things you spend your money on throughout a single week.
- How much money did you spend in the past week? What did you buy?
Directions:
- List what you spent money on in the past week (or month).
- Look at you spending log.
- Write down five things you spent money on.
- Then decide if each is a need or want. A practice sample is provided for you.
- Review your list

Activity 3: My Spending Plan
Distribute the handout: my spending plan
- Think about how well you manage your money now. What can you do to make improvements?
- Practice developing a spending plan for how you are going to use your money this week,
- Was this difficult?
- What was challenging?

INSIGHTS
- Do you think your friends or family would agree with your decisions?
- Are there times when your wants may become needs?
- After reviewing the above information, how would you describe your spending habits?
- Do you think you need to change some of your spending habits?
- If so, what might be some things you could do right away to improve the ways you spend your money?
- How could your social worker, foster parent, or staff help you?
Reflection Circle

Today we worked on your money management. Now that you have had some time to do some basic budgeting

- What do you think about how you have been managing money?
- Do you have any other questions or concerns you would like to discuss?

CHECK-OUT

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

QUIET MOMENT: REFER TO CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

Have clients set up a personal budget that supports their needs and financial goals. Ask students to try to stick to their budget for two weeks.

- After the two weeks have passed, discuss what it was like to keep to a budget. Was the budget realistic? Where did they overspend?
- In which areas did they spend less than what they planned?
- Were they able to make progress toward their financial goals?
- What would they change about their budget?
1. How do you manage money?
2. My Needs versus My Wants
3. My Spending Plan
<table>
<thead>
<tr>
<th>Do you usually</th>
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<tbody>
<tr>
<td>☐ Spend most of your money</td>
</tr>
<tr>
<td>☐ Buy things you like</td>
</tr>
<tr>
<td>☐ Save most of your money</td>
</tr>
<tr>
<td>☐ Buy things you need</td>
</tr>
<tr>
<td>☐ Budget your money so it will last</td>
</tr>
<tr>
<td>☐ Buy impulsively</td>
</tr>
<tr>
<td>☐ Spend most of your money as soon as you get it</td>
</tr>
<tr>
<td>☐ Plan your purchases</td>
</tr>
<tr>
<td>☐ Keep track of your money</td>
</tr>
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</table>

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List what you spent money on in the past week

<table>
<thead>
<tr>
<th>ITEM</th>
<th>COST</th>
<th>NEED?</th>
<th>WANT?</th>
</tr>
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<tbody>
<tr>
<td>Example 1: jacket to replace one that is torn</td>
<td>$40</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Example 2: CDs</td>
<td>$5</td>
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<tr>
<td>Total costs</td>
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</table>

1. Look at how much money you have spent on your needs and want column, how much money could you have saved this week?

2. Do you have a saving goal?
<table>
<thead>
<tr>
<th>MY INCOME</th>
<th>AMOUNT</th>
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<tbody>
<tr>
<td>Pay check</td>
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<tr>
<td>Allowance</td>
<td>$</td>
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<tr>
<td>Total Income</td>
<td>$</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>MY EXPENSES</th>
<th>AMOUNT</th>
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| TOTAL EXPENSES     | $      |
Learning Intention

Many of you are struggling with your current home environment or are transitioning out of care. In this session, various information aspect of independent living will be explored and discussed. This material discussed should help to create awareness of what is needed as you consider independent living as an option. This will help you understand the costs of living on your own, and provide practice in developing a budget that includes the cost of living, and to develop other positive living skills. Today we will discuss independent living skills and what is required to access help. We have invited someone to come in to talk to you about your options and the resources you can access.

Engage – what to do

Get your client to consider his/her decision to move.

Say: There are many reasons to move out—maybe it is your decision, maybe it is someone else’s, or maybe it is a necessity. No matter why you are thinking of living independently think about it calmly. Are you ready to live independently? What are your options?

Discussion questions

- Ask participants what preparation they have had to prepare them for independent living? Some examples could be cooking skills, job seeking, money budgeting, etc.
- Engage them in a sort of discussion about their responses.
Breaking it Down

As young people with FASD grow up, or phase out of care, a common goal is to live on their own or with roommates. However, the challenges of independent living are often quite different from their expectations. You can help prepare them to undertake this phase of their life by helping them take more positive steps. It is important to understand the divergence between young people with FASD. There will be a difference in motivation for independence between those who live in care versus those who do not live in care, male versus female as well as base on the level of maturity and life experiences. Not all young people with FASD will aspire to live independently, however, some will. In preparation for living on their own, young people with FASD should be reminded of some things such as, for example, the budgeting process—(budgeting strategies for both fixed and variable expenses. Variable costs change depending on the level of consumption, such as entertainment, and restaurants, and fixed expenses, are those that need to be paid every month, such as rent), rental agreement, furniture, setting up bank accounts, etc. As a clinician, you can encourage a young person with FASD to carefully consider where to live, how much to pay for rent, and whether to share an apartment with a roommate.

Many young people with FASD are not aware of the many essential elements of independent living. This should help young people with FASD understand the costs of living on their own, provide practice in positive living strategies.

Due to the nature of the information in this unit, and the likelihood of the questions, the knowledge, and expertise of an independent living worker may be better suited. It is recommended that a guardianship worker, social worker, or an independent living worker be invited as a guest presenter and resource person. This person will be able to supply you with copies of required materials. As a clinician, you will also play a fundamental role in connecting and referring the young person to community service.

Things to explore with the client

1. **Assess readiness for independent living**: Ask the adolescent how ready they feel if they were to start living independently today. Use the readiness checklist in the handout section; have the young person read each of the statements, and on a scale of 1 to 5, rate how ready they feel today to live independently. *Tell the client to tell you how he or she is honestly feeling (not what he/she thinks you want to hear).*

2. **Daily and Positive Living Skills**: For young people living with FASD, daily living skills includes keeping the mind, body, and spirit healthy while also being able to use life skills such as cooking, cleaning, etc. to maintain a home. Despite the young person’s increasing independence, he/she will continue to need support. You, as a clinician, play a significant role in the young person’s ability to live positively. Work together with the client and other support persons to discuss the client’s health, school attendance, work attendance, food hygiene, engagements, the client’s concerns, your concerns, and your thoughts on his or her readiness to take greater responsibility. *See handout for tips on positive living*

3. **Self-care**: Many young people with FASD tend to struggle with self-care. Encourage them to think about what they could do to take care of themselves better and how they can practice mindfulness daily. Utilize the handout on self-care assessment and self-care wheel. *See handout for an example of a personal hygiene poster I created for one client who struggled with personal hygiene.*
4. **Wants versus Necessity or needs**: Help the client to explore the difference between wanting something versus needing something. Refer to money management to explore want vs. needs. This is crucial as your client may end up spending their rent money on something less trivial. Break things down, for example, furniture, etc. After working on ‘necessity versus wants’ with a client for about three sessions. I received a called one day, she was at the furniture store and wanted to know if a futon was a ‘want or necessity’. We spoke about it some more, and she later decided that it could play a dual role of couch by day and her bed at night, so it was a valuable purchase. Although she had some questions, she was able to follow her list of things quite well and stayed on budget.

5. **Budgeting and Banking**: (see the unit on money management).

6. **Filling out required forms**: Your client will need assistance with acquiring and filling out required documents.

7. **Roommate problems**: issues such as paying bills on time, sharing housework equally, and lifestyle incompatibilities (such as a non-drug-user staying with a drug user) may result in hostilities and arguments.

8. **Safety & Crisis Management**: Crisis can occur as a result of an unpredictable event or as an unforeseeable consequence of some event. Planning is meant to help the client and his/her family prepare for times when life seems too hard to manage. Support conversations about what would help when there are challenges and the client feel overwhelmed. It will be helpful to reflect on the client’s strengths, external resources.

9. **Self-advocacy**: Many young people with FASD are marginalized and quite often others make decisions on their behalf without consulting with them. Self-advocacy, or speaking up for one’s self, is a vital skill, and as a young person with FASD prepare to transition to the adult. Learning how to self-advocacy will help them achieve outcomes that matter to them. You can help them develop self-advocacy skills by:
   - Working on goals that are important to them – this will help them feel competent and comfortable with themselves.
   - Helping them develop self-acceptance—to accept their weaknesses and build on their strengths.
   - Teaching them to use their resources effectively and how to successfully communicate their needs.
   - Helping them learn to communicate their needs, wants strengths and weaknesses—every young person with FASD is different. Make sure the young person is aware of his/her needs and the best way to communicate them.
   - Teaching them to reframe their thinking and feeling and ways to communicate positively.
   - Listening to the problem and issues, they are raising and asking them for input on possible accommodations or modifications that they may need.
   - Talking to the young person about possible solutions, discussing the positive and negative sides.
   - Getting them to talk about their ideas over with other people.
   - Encouraging them to ask questions for guidance, and then make up their minds after reviewing the information. They may have strong feelings, but they should try to be objective when making their decisions.
- Helping them learn to problem solve—use everyday situations to teach problem-solving. You can start with basics like doing house chores or negotiating for a monthly allowance.
- Having them learn about their disability and their rights.
- Building up their Self-Esteem—I have never worked with a young person with FASD, who did not have multiple strengths. Make the young person aware of these strengths and use their accomplishments to build up their self-esteem.
- Encouraging them to find a Mentor—talk to them about mentorship and the benefits of having a mentor.
- Helping them learn social cues.
- Letting them be involved in the creation of, or even lead their meetings—a meeting led by a young person can be one of the first steps on the way to self-advocacy. It is an excellent way to empower a young person to take responsibility for his/her life. Coach them through the process.
Learning Activities

Activity 1: Readiness for Independent Living
Provide the handout: independent living readiness checklist. Spend some time exploring their readiness for this phase of their life and the transition process.

Activity 1: Household Necessities vs. Wants
- Help client create a list of what they need. Alternatively, provide a list they can select from.

Activity 3: Guest speaker
Bring someone to speak with them about social service supports in place and what is required of them.

INSIGHTS
- Did you find the information provided useful?
- Do you have any questions you would like clarified?
- Are there any concerns?
Reflection Circle

Today we discussed independent living—what it looks like, as well as the process.

- What do you think about the information you received?
- Do you feel hopeful?
- Do you have any other questions or concerns you would like to discuss?

Check-out

Ask each client to offer one word, thought or feeling as a check-out. The clinician may begin with … and go around the room.

Quiet Moment: Refer to CD

Ending with quiet moment is a great way to help clients feel grounded. Encourage them to slow down. Congratulate them on having overcome all the challenges they faced to attend this session. Affirm their willingness to be present.

Homework

- Encourage participants to practice the muscle relaxation exercise.
- Distribute self-care planning sheet—ask participants to work on it throughout the week.
- Encourage the clients to do mindful breathing and walking.
1. Independent Living checklist
2. Self-care Assessment
3. Self-care Worksheet
4. Crisis & Safety Plan
<table>
<thead>
<tr>
<th></th>
<th>I AM GOOD AT</th>
<th>I NEED HELP WITH</th>
</tr>
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<tbody>
<tr>
<td>Healthcare</td>
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<td>Personal hygiene:</td>
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<td>School or work attendance</td>
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<tr>
<td>Nutrition and food hygiene:</td>
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<td>cooking</td>
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<tr>
<td>Household chores</td>
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<td>Getting to work on time</td>
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<td>Finding a job</td>
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<td>Self-care</td>
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<tr>
<td>Maintaining healthy relationship</td>
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<td>Paying rent on time</td>
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<td>Managing money</td>
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<td>Keeping and getting to appointments</td>
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<td>Sexual health</td>
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<td>Mental health</td>
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<td>Time management</td>
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<tr>
<td>Organizing</td>
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</table>
### MY CRISIS & SAFETY PLAN

**Step 1:** Warning are the signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________

**Step 2:** Coping strategies – Things I can do to take my mind off my problems without contacting another person (relaxation technique, physical activity):

1. __________________________________________________________________________
2. __________________________________________________________________________
3. __________________________________________________________________________

**Step 3:** My **strengths** I can use to help me work through crisis are:

**Step 4:** People whom I can ask for help:

1. Name: ____________________________ Phone: ____________________________
2. Name: ____________________________ Phone: ____________________________
3. Name: ____________________________ Phone: ____________________________

**Step 5:** Professionals or agencies I can contact during a crisis:

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MY SAFETY CARD

I will cope, calm and soothe myself
by: ________________________________
I will BREATHE
I will tell myself: __________________
I will call: _______________________
I will go: _________________________

MY SAFETY CARD

I will cope, calm and soothe myself
by: ________________________________
I will BREATHE
I will tell myself: __________________
I will call: _______________________
I will go: _________________________
Glossary of Terms

**Agency:** being able to make choices and decisions, to influence events and to have an impact on one's world.

**Anxiety:** a state of apprehension or fear of the unknown often resulting from the anticipation of a threatening event or situation, often to a degree that normal physical and psychological functioning is disrupted.

**Attachment:** The capacity to form and maintain a healthy emotional bond with another person or persons, which is a source of mutual comfort, safety, and caring.

**Attuned:** “Attunement includes the alignment of states of mind in moments of engagement, during which affect is communicated with facial expression, vocalizations, body gestures and eye contact” (Siegel, 1999).

**Being:** is about the significance of the here and now in the lives of young people with FASD. It is about the present and them knowing themselves, building and maintaining relationships with others.

**Belonging:** acknowledges the interdependence of young people with others and the basis of relationships in defining identities. Relationships are crucial to a sense of belonging. Belonging is central to being and becoming in that it shapes who young people with FASD are and who they can become.

**Becoming:** reflects the process of rapid and significant change that occurs in the life of a young person. It’s about them thinking about where they are and what they would like to do in the future and who they will evolve to be.

**Biological, psychological, social and spiritual factors:** are interlinked and are important with regard to promoting mental and physical health. There is a close relationship between the mind, body and spirit. They should not be seen as independent and separate, but as connected and interdependent: What affects the body often also affects the mind and vice versa.

**Capacity-building:** an approach focused on the enhancement of individual capacity.

**Change:** to become different. Behavior that is different from what it used to be.

**Clinician:** a person qualified in the clinical practice of psychology, psychiatry, addiction, mental health, or social work.

**Co-constructing** Learning takes place as young people with FASD interact with clinician and other young people as they work together in partnership. Co-construction promotes the collaborative nature of young people learning as it motivates them to enter into meaningful activities and discussions with the clinicians, or other adults, to explore shared meanings and build knowledge together through a range of learning opportunities and activities.

**Communicating:** is about young people with FASD sharing their experiences, thoughts, ideas and feelings with others with growing confidence and competence in a variety of ways and for a variety of purposes.

**Competency:** An ability, capacity, skill, or set of skills.

**Coping Mechanism:** is way we deal with or manage stress.

**Defense mechanisms:** defense mechanisms are ways that people learn to cope with disturbing thoughts and emotions.

**Dispositions:** enduring habits of mind and actions, and tendencies to respond in characteristic ways to situations, for example, maintaining an optimistic outlook, being willing to persevere, approaching new experiences with confidence.

**Distress Tolerance:** skills are used to help us cope during times of stress, and helps us tolerate short term or long term pain, or stressful situation.

**Emotional regulation** is a process that involves initiating, inhibiting, or moderating one's state or behavior in a given situation.

**Empathy:** the ability to accurately understand the experience and perspectives of others.

**Emotion:** a strong feeling deriving from one's circumstances, mood, or relations; or an affective state of consciousness in which anxiety, joy, sadness, anger, fear, hate, or the like, is experienced,
Empowering: is about helping young people with FASD gain a sense of inner confidence, courage, and strength to successfully overcome life challenges. The act of empowering young people with FASD is a process of guiding them to feel and believe in their capacity.

Engagement: the degree to which one bonds and builds rapport with another. Research supports this as the most important factor in developing relationships that influence positive growth and change.

Fear: is the name given to the emotion you feel when you perceive yourself to be in acute danger.

Flashback: an involuntary recurrence, often repeatedly, of a feeling, memory or experience from the past.

Grief: is a response to loss. It is a natural but painful process, intended to release the affected person from what has been lost.

Grounding: the use of strategies that soothe and distract the client who is experiencing intense or strong emotions, helping the client anchor in the present and in reality. Grounding techniques direct the mental focus outward to the external world, rather than inward toward the self.

Ground rules: set out what is acceptable and how to behave during sessions.

Holistic: the recognition that all aspects are interconnected and mutually dependent.

Hope: is defined here as ‘a positive, action-oriented expectation that a future goal or outcome is possible.’ A good way of understanding hope is as the opposite of hopelessness.

Identity: is about young people with FASD developing a positive sense of who they are, feeling that they are valued and respected as part of a family and community

Inclusion: being included, being accommodated without barriers and limitations. A philosophy and practice of being non-discriminatory.

Learning: a natural process of exploration that Young people engage in from birth as they expand their intellectual, physical, social, emotional and creative capacities.

Meaning-making: creating new meanings by connecting new experiences and learning to what we already know.

Outcome: a skill, knowledge or disposition that clinicians can actively promote in therapeutic settings, in collaboration with young people with FASD.

Mindfulness: is a state of active, open attention on the present. It is about observing one’s thoughts and feelings from a distance, without judging them as good or bad. Mindfulness means living in the moment and awakening to experience.

Motivation: the desire to do something, or the reason one has for acting or behaving in a particular way.

Pedagogy: professional practice, especially those aspects that involve building and nurturing relationships, therapeutic approaches, teaching and learning.

Practice wisdom: is ‘knowledge that has emerged and evolved primarily on the basis of practical experience’ (Mitchell 2011, 208). The focus of this is often on the ‘how’ or character of practice, and can be found expressed in a range of places, including qualitative studies of practice and practitioners, client consultations, service evaluations and other accounts of practice from a particular setting.

Problem solving: skills or steps use to find solutions to a problem.

Progressive muscle relaxation: is a technique focusing on shifting between tensing muscles and relaxing muscles to improve body awareness and control.

Protective Factors: the positive relationships, resources, activities and internal characteristics that enhance well-being and insulate individuals from harm.

Psychosocial: a person's psychological well-being, as well as housing, employment, family, and other social aspects of life circumstances.

Reflexivity: growing awareness of the ways that our experiences, interests and beliefs shape our understanding.

Relapse: a setback in a person's attempt to change or modify any particular behaviour

Relationships: The role and involvement of family and significant others is considered and supported in working with young people.

Resilience – the capacity of a young person to negotiate and navigate his/her resources as well as his/ability to cope with challenging life circumstances.
**Risk factors:** are characteristics statistically associated with an increase in health and well-being risks – for example, violence or substance abuse.

**Scaffold:** the clinicians’ decisions and actions that build on a young person’s existing knowledge and skills to enhance their learning and well-being.

**Self-efficacy:** is the belief in an individual in their ability to act in a way that improves their situation.

**Self-esteem:** is the value we place on ourselves. It is a personal perception of ourselves and how this makes us feel. It is the knowledge that we are lovable, capable.

**Self-Regulation:** developing and maintaining the ability to notice and control one’s feelings.

**Sensory modulation strategies:** techniques used to effectively regulate the degree to which one is influenced by various sensory inputs.

**Social Pedagogy:** is concerned with holistic well-being, learning and growth. The pedagogical approach rests on an image of a child as a complex social being with rich and extraordinary potential,

**Spiritual:** refers to a range of human experiences, and an exploration of being and knowing. Being spiritual means something different to everyone. For some, it’s about participating in organized religion: going to church, while for others it’s about finding balance and peace, having a sense of purpose and having faith and hope.

**Strengths:** inner characteristics, virtues and external relationships, activities and connections to resources that contribute to resilience and core competencies.

**Substance abuse:** The excessive use of a substance, especially alcohol or a drugs despite the negative consequences in their lives.

**Substance misuse:** refers to consumption of drug taking or alcohol which leads a young person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence.

**Substance use** is the consumption of psychoactive substances, especially alcohol or drugs.

**Sustainability:** the ability to maintain the positive benefits, growth, development and capacity of an individual’s initiative.

**Transitions:** the process or a period of changing from one state or condition to another.

**Trauma:** is one’s experience off and his/her emotional response to a terrible event like an accident, rape or natural disaster.

**Trauma-Informed Practice:** are informed about, and sensitive to, trauma-related issues present in survivors. Trauma-informed services are not specifically designed to treat symptoms or syndromes related to trauma. A trauma informed clinician understands the impact of trauma on a youth’s behavior, development, relationships, and survival strategies, and integrates that understanding into planning.

**Trigger:** is an event, situation, person or place that sets off a memory or flashback transporting the person back to the event of her/his original trauma. It is also something that sets off old patterns or recurrence of behaviours such as drug use.

**Wellbeing:** describes the positive state of being when an individual thrives. It includes happiness and satisfaction, effective social functioning and the dispositions of optimism, openness, curiosity and resilience.
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