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STRUCTURING SUCCESS FOR FASD TEENAGERS IN NORTHERN SASKATCHEWAN

BY

MARIE MIHALICZ

A Final Project submitted to the

Campus Alberta Applied Psychology: Counselling Initiative

in partial fulfillment of the requirements for the degree of

MASTER OF COUNSELLING

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DEDICATION

This project is dedicated to the young people in Northern Saskatchewan that have taught me patience, strength and hope. You have been my driving force throughout my efforts in this program and for this final project.

CAMPUS ALBERTA APPLIED PSYCHOLOGY:

COUNSELLING INITIATIVE

SUPERVISOR SIGNATURE PAGE

Faculty of Graduate Studies and Research

The undersigned certifies that she or he has read and recommends to the Faculty of Graduate Studies and Research for acceptance, a final project entitled **Structuring Success for FASD Teenagers in Northern Saskatchewan** submitted by **Marie Mihalicz** in partial fulfillment of the requirements for the degree of Master of Counselling.

Dr. Paul Jerry

Project Supervisor

____June 20, 2005__

Date

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COUNSELLING INITIATIVE

SECOND READER SIGNATURE PAGE

Faculty of Graduate Studies and Research

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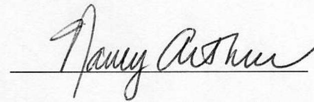
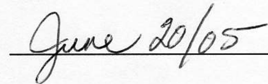


Dr. Nancy Arthur

Second Reader



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ABSTRACT

Northern Saskatchewan communities have limited services and resources in regards to counselling practice in rural areas. Rural communities consisting of towns with less that 2,500 persons offer diverse challenges for mental health professionals and, compared to urban centres, suffer more socio-economic pressures and poverty. The combination of poor federal funding for mental health services in rural districts, with the tendency of providers to stay in urban centers where they were trained, contribute to a lack of mental health services in rural areas. This project is twofold: The first objective is to provide a working holistic model which is based on a review of all the present services and resources available in Northern Saskatchewan that address the needs of Adolescents with Fetal Alcohol Spectrum Disorders. Secondly, following the recommendations of the review, and the holistic model, a Hands-on-Tool Kit is developed for those directly involved with the FASD teenager - the parents, caregivers, teachers, and counsellors. Adolescents need to be reached with health related interventions and health-promoting programs that are based on a holistic understanding of their development in emotional, physical, social and spiritual needs in order to ensure healthier lifestyles both during adolescence and throughout adulthood.

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CHAPTER 1

INTRODUCTION

Research has shown increasing numbers of teenagers are being diagnosed with Fetal Alcohol Spectrum Disorder (FASD), and one could speculate that many more teens have passed/failed through the educational system without being diagnosed (Alberta Children's Services, 2004). Teenagers diagnosed with FASD present a very complex picture because of their developmental life stage: typical adolescent behavior can mask the more serious developmental difficulties (Harpur, 2001). This project will review some of the present services for Adolescents at Risk in Northern Saskatchewan. A holistic model is designed for improved service delivery and role clarification for all who participate in the treatment plan of the at-risk adolescent. A toolkit is provided that outlines and discusses successful learning strategies, interventions and programs that provide direction for caregivers of FASD children. The interventions and strategies identified here attempt to provide a base that promotes awareness and knowledge and skills for the parents, caregivers, teachers and counsellors.

FASD, Fetal Alcohol Syndrome (FAS), Alcohol-Related Birth Defects (ARBD), Fetal Alcohol Effects (FAE), and Alcohol-Related Neurological Disorders (ARND) are the most commonly used terms to refer to the various forms of impact, resulting from exposure to prenatal alcohol (Alberta Children Services, 2004).

Saskatchewan has been a leader in research and program development in the area of FAS. The first diagnosed case of FAS in Canada was made at the Royal University Hospital in Saskatoon in 1975 (Fetal Alcohol Syndrome, 1997). Since then it has both developed and delivered prevention awareness throughout the province, country and

world (Fetal Alcohol Syndrome, 1997). In 1996, the Saskatchewan Minister of Health provided funding for a new province-wide initiative on FAS.

The main focus of much of the lay literature distributed to the public focuses on prevention. In many of the brochures found in hospitals, clinics and programs that educate the public about FAS/FAE, most of the focus is on prevention. Topics include reproductive health, and the effects of alcohol on the fetus and newborn babies. This is all very valuable information and is a crucial part of program initiatives. One significant gap in the applied literature is in regard to the longer term care of these FAS/FAE children who are growing into adolescents and adults Long-term consequences result in manifestations that involve physical, cognitive, emotional, legal social and occupational difficulties across the lifespan.

While program development has improved in recent years, the accessibility of information for parents and families could improve, especially in more remote communities. This project aims at creating an understanding of services available in Northern Saskatchewan through developing a culturally sensitive, holistic model which clarifies the roles of participants in the recovery process and providing an accessible, easy-to use manual for parents, caregivers, educators, and counsellors of adolescents with FAS/FAE.

What is Fetal Alcohol Spectrum Disorder?

Fetal Alcohol Syndrome (FAS) is a pattern of growth deficiencies, cranial malformations and central nervous system dysfunction that can occur in babies whose mothers consume alcohol during pregnancy (Olesen & Williams, 2003). There are a number of criteria, which relate to FAS. When a child has experienced prenatal alcohol

exposure but does not fulfil all of these criteria for FAS, the individual is given a diagnosis of Fetal Alcohol Effects (FAE) or Alcohol-Related Neurodevelopmental Disorder (ARND) (Harpur, 2001). The current conception of this disorder is that it falls on a continuum, and Fetal Alcohol Spectrum disorders (FASD) has been suggested in order to include all people who are affected by prenatal alcohol exposure (Streissguth & O'Malley, 2000). The all-inclusive term FASD is used for the purposes of this project. One common assessment tool for diagnosis is the Seattle Model (Canadian Paediatric Society, 2002). The following chart outlines how diagnosis is made:

Code	Growth	Face	Brain	Alcohol
4	Significant	Severe	Definite	High
3	Moderate	Moderate	Probable	Some
2	Mild	Mild	2b Possible	Unknown
			2a Possible	
1	None	Absent	Unlikely	No risk

Table 1: Seattle Model

"The term FAS applies to children who have all "4"s or combinations of at least two "4"s and no more than two "3"s on the four scales. Other scores are converted to words in combinations of the descriptive terms: sentinel physical findings; static encephalopathy or neurobehavioral disorder; and alcohol exposed, alcohol unexposed, and alcohol exposure unknown. A full explanation of this approach and its diagnostic terms as well as a method for judging the importance of these co-morbidities, are available in the *Diagnostic Guide for Fetal Alcohol Syndrome and Related Conditions* (Astley & Clarren, 1997). The fetal alcohol diagnosis must be considered in the context of other prenatal and postnatal factors that contribute to the unique findings for each individual. (Clarren, et al., 2000). *The Canadian / Alberta Model (in development*) substitutes the term FASD for FAS-related

diagnosis and uses it to describe any of the light-grey shaded area on the grid. (Glenrose Hospital, 2003)

Imagine an unassembled puzzle and one way you will know if you have all the pieces is to put it together. A child with Central Nervous System Processing Issues is much like a puzzle. A particular way to begin is to sort out the similar pieces and work on one small section at a time (Kulp, 2002). Assessment of FASD adults seems to show that they are essentially missing pieces of the cognitive puzzle (P. Jerry, personal communication, March 22, 2005).

An individual with FASD is likely to show intellectual deficits and learning disabilities, hyperactivity, attention or memory deficits, inability to manage anger and difficulties with problem solving as a result of damage to this function (Health Canada, 2002). Implications include early school drop out, alcohol and drug abuse problems, problems securing and maintaining employment, homelessness, trouble with the law and mental health problems (Health Canada, 2002). This lack of control leads to immense levels of stress for caregivers of FASD adolescents. Protective factors include abstinence, early identification and diagnosis, direct involvement with special services and supportive environments (Health Canada, 2002).

The current understanding of FASD is that there is a wide spectrum of difficulties that are attributed to in utero alcohol exposure and the severity of physical, behavioral, social and emotional disturbances may be mild to severe, (Olesen & Williams, 2003). The wide spectrum is caused by the variation in the pattern of drinking that the mother engages in. This includes frequency, amount consumed, time of gestation at which the mother drinks, and the physiological components of mother and baby. The result is that

there is damage to the brain as part of the central nervous system (CNS) (Olesen & Williams, 2003).

Individuals with FASD may or may not have some obvious physical and/or CNS dysfunction. There are cognitive and behavioral difficulties, but their IQ is either low, or average to borderline (P. Jerry, personal communication, March 22, 2005). This brings several issues into the diagnosis of teenagers and adults when there are attempts to identify the nature of their disabilities. This includes determining whether a certain issue is a result of FASD or if the behavior is simply a result of the individual's personality (Olesen & Williams, 2003).

The focus of my project was brought about through my teaching experiences in the middle years. So many at risk adolescents are falling through the cracks of the system, and the problems that parents and communities face are accumulating. The need for intervention for the adolescent, family, teachers and community is crucial now. During the stage of adolescence, and contributing factors of FASD, we see escalating behaviors that result in the involvement of the justice system. This leads to increase costs. The estimated lifetime, extra health care, education, and social services costs associated with the care of an individual diagnosed with FASD are $1.4 million dollars U.S (Health Canada, 2002). FASD judgement about sexual activity brings issues related to selection of partners, use of protection and teen pregnancy. The consequences include young FASD mothers raising FASD children. This project aims at providing practical interventions for everyone to help prevent significant systemic consequences. It attempts to inject the system at a crucial point with support and reinforcement through a traditional, holistic concept.

Review of Available Services

Chapter 2 presents a literature review that outlines services available in Northern Saskatchewan that are available for Adolescents diagnosed with FASD. The development of the holistic (Keewatin) theory provides insight into the worldview of First Nations and ties an eclectic approach into addressing the whole person. Keewatin is a Cree word meaning “North” and is an ideal concept that reminds counsellors of the need for using holistic approaches to these individuals. The model and toolkit present specific, hands-on interventions and strategies for caregivers and professionals who need resources at their fingertips.

Because of the geographical challenges in Northern Saskatchewan, families and professionals gaining access to resources takes extra time and money. Many parents and professionals are overwhelmed with efforts to balance demands at work and home. Most mental health service models are based on urban centers and it is very important for professionals to learn how to modify their approach in order to maximize their efficacy in rural settings (Chapman, 2001). There are several specific characteristics of rural settings which provide unique challenges in areas of service provisions, including (a) lack of available resources, (b) geographical, knowledge and financial barriers, and (c) attitudinal and values factors (Chapman, 2001). Service is markedly lower in rural areas and this is true, especially for ethnic minorities for who culturally based mental health resources are sparse (Chapman, 2001). The extra amount of energy and amount of travel involved in accessing specialized resources and materials is an added stress factor. Providing services to populations in much bigger physical rural areas is expensive, time-intensive for a single mental health worker. This is complicated with the fact that many rural residents

may be under-informed about mental health services and that this may contribute t o the reluctance of seeking services (Chapman, 2001). In addition, service providers in rural areas, such as psychologists, requires the need to be generalists, and to assume numerous roles for which they have not received specific training (Chapman, 2001). They may overstep their boundaries in order to meet the services of their clients and this leads to ethical dilemmas of competency. If the professional refuses to provide service in a rural area, the client receives no help at all.

Project Purpose

This project attempts to alleviate this stress and provide for some, a starting point, and to others, a supplement to resources. It is hoped that through the use of the literature review, model and toolkit a new spark will be ignited in developing both understanding and integrated efforts in northern communities that meet the holistic needs of families with teens who are diagnosed with FASD.

With the fact that there may be complications and diagnostic issues in mind, the literature review and Tool Kit are all inclusive and may be utilized for work with adolescents at risk. This is in efforts to address the needs of families who do not have specific diagnoses for their child, but may find the products of this project useful.

CHAPTER 2

LITERATURE REVIEW

"If I have come to the end of my rope, I have lived in this turmoil for a long time. Let me be patient a little longer while I weigh the alternatives"

(One Day At A Time in Al-Anon, 1985).

Introduction

Adolescence is a time of rediscovery, newfound independence, and exploration. It is a time of great change and challenge. Throughout this process lie experiences that shape and define each individual's behaviour. Contemplating life's meaning and finding a place to belong in society can be a very confusing time for adolescents. "All adolescents face physical, cognitive, and emotional changes during this period of their lives. Understanding the general nature of some of these changes can be very helpful to those who work with young clients" (Broderick & Blewitt, 2003 p 340). In addition to various factors, contemporary fads relay and promote happiness in material things such as drugs, alcohol and sex leading them to stray from culture, values and healthy behaviours. As these young people negotiate adolescence, they develop behavioural patterns that will affect them for the rest of their lives. Adults who are responsible for adolescents need to be committed to providing authoritative practices for the long haul. The last thing adolescent's need, despite their protests, is parents, teachers or counsellors who disengage from them or grant them too much power (Broderick & Blewitt, 2003).

Traditionally, adolescence was a time of optimum health. However, adolescents are often inclined to engage in behaviours that impact health status in a negative way (Spear

& Kulbok, 2001). Therefore it is very important for health professionals to reach adolescents with effective health-promoting programs.

Adolescents living at risk in northern communities face immense challenges when seeking intervention for developing healthier behaviours and developing promising futures/careers. This section describes the main factors that influence at risk behaviours, examines the effectiveness of interventions, and reasons for limited effectiveness of treatment approaches and implications for developmental models for designing and implementing innovative intervention programs.

Key issues affecting healthy child development

The primary factors related to health behaviour include gender, family structure, socio-economic status, ethnicity, knowledge and attitudes. Increased knowledge of factors that impact adolescent health behaviours is essential so that health professionals can be more responsive to developmental and lifestyle factors that influence the health of youth within communities (Spear & Kulbok, 2001).

Changing Family Structures

Demographic information helps us to gain a perspective of the at risk dynamics in small, rural communities. In examining one community profile, Statistics Canada (2003) provides this opportunity for gaining understanding. In a northern Saskatchewan village with a population of 800, 60% of its citizens are between the ages of 12 and 20. There are 215 families, of which 90 are lone parent families. Seventy of these families are female lone parents and 20 are male lone parent families. The median family income of lone parent families is $16, 960 compared to the provincial median of $24,787 (Statistics

Canada, 2003). Of this targeted population, as high as 70% are experimenting, using or abusing drugs and alcohol (Canadian Community Health Status Survey, 2000/1).

Increasing numbers of children and adolescents are being raised in single parent homes. Occurrences of delinquency and adolescent fatherhood are linked to the family and social environmental factors (Unruh, Bullis, & Yovanoff, 2003). Crime and violence rates are rising due to addiction in rural communities. Child and adolescent males who are raised without a father lack the full experience of masculinity, and the responsibility for this may be projected onto women and may provide a perceived rationale for violence against women, children, or others who may come to symbolize what the wounded masculine is missing (Rybak, Chapin & Moser, 2000).

Family dysfunction and lack of father figures has long-term effects on children. An area that has rarely been examined is the relationship between fathers and daughters. This important relationship can often be the cornerstone for future long-term relationships in all aspects of life. "Left unexamined, the relationship between a daughter and a father will impact her sense of entitlement, power, and authority in her personal life as well as in society" (Murdock, 1994 p. 5).

Although many daughters in single parent families are successful, lack of father figures can contribute to daughters seeking attention from boys in early adolescence, experimenting with sex and leading to teenage pregnancy and single parenting. With increasing numbers of single parents and blended families, where children are living with their mother, but not their biological father, and the high-risk environment is steadily growing. “The emotional process of separation and divorce has significant social, psychological and economical consequences for children and parents, especially for

women who most often assume the role of home parent" (Health Canada, 1999 p87) Community services are challenged to provide thorough and consistent support for these individuals. Findings from a four-province Atlantic Drug Use Survey found that 26% percent of Grade 9 students, 37% of Grade 10 students and 58% of Grade 12 students had intercourse during the previous year. Among these sexually active students, 40% had more than one sexual partner, and 50% had unplanned intercourse on at least one occasion while under the influence of alcohol or another drug (Health Canada, 1998).

Implications for designing successful programs for children and adolescents raised in single-parent families mean that professionals must take the responsibility of guiding youth in the quest for wholeness as the sorting begins in their individuation process. Individuation is the lifelong process in which a person increasingly becomes whole. This involves the individual in his or her psychological and spiritual journey (Rybak, Chapin & Moser, 2000).

Socio-economic Status

The socio-economic environment refers to the living and working conditions in both the economic and social realms. Key influences on the health in the economic dimension of this environment include income and income distribution. The major determinants in the social environment include education, literacy, employment and working conditions, levels of social support, violence in the home and community (Health Canada, 1999).

Low-income levels due to unemployment have detrimental effects on self-esteem, identity and confidence. When families are struggling in poverty, children and adolescents are directly affected. Regardless of income, some parents have trade skills

that are passed on to their children and are effective in gaining an economic advantage. Examples of northern skills include hunting, commercial fishing, logging, and trapping.

Parental influence has a greater impact on the career choices of Native students than on those of White students, and many First Nations students do not expect to realize their occupational goals (McCormick & Amundson, 1997).

The primary advantage of viewing the unemployment experience in terms of identity negotiation is that the focus for both counsellor and client becomes one of process and change. There is always the possibility of renegotiation and the forward direction is one of seeking greater personal control within the negotiation process. As such, the concept of identity negotiation serves as a useful construct around which action plans and counselling interventions can be organized (Amundson, 1994).

However, when parents do not pass any skills to their children and are struggling with poverty and addiction, dysfunctional patterns develop and lead to higher at risk environments for children and adolescents.

Knowledge

Learning Disabilities

A growing number of families with youth are struggling with the effects of Fetal Alcohol Syndrome (FAS). FAS can be 100 per cent preventable, yet it is a problem that spans all social, economic and racial boundaries. It is a permanent condition that can have devastating effects on an individual and their family. One of the main characteristics of FAS is central nervous system damage. Effects include intellectual impairment, developmental delay, behaviour disorders, short attention span, hyperactivity, and poor muscle tone and co-ordination (McCormick, 2003).

Even if the above characteristics are absent, prenatal exposure to alcohol can cause an "invisible disability" that manifests behaviourally, known as fetal alcohol effects (FAE) or alcohol-related neurological disorder (ARND). Many children have the brain damage without the physical signs of full FAS, and may have an IQ that is considered "normal" (McCormick, 2003).

Many FAS/FAE children drop out of school, experience mental health problems or find them marginalized. Some researchers estimate that more than half of the prison population is affected by prenatal exposure to alcohol (McCormick, 2003).

Adolescents who are successful in maintaining healthy lifestyles move on to seek education and training outside of the community, eventually returning and contributing to the local workforce. Some examples include teachers, justice and social workers, counsellors, contractors, miners, mechanics and truck drivers. Success comes to the determined, not necessarily to the educated. Traditionally, many teenagers, who were trained by their parents in trades, such as logging, fishing and mining are successful today because of early training in job skills. With a grade eight education and high motivation to work, many adolescents grew into adults with successful trades and businesses. These people are a source of inspiration to students in high school and having role models visit the school to plant these seeds of inspiration is an important task.

Ethnicity

Northern Saskatchewan communities are rich with the Métis, Cree and Dene cultures. Most families comprise of mixed races. Udry, Li and Hendrickson-Smith (2003) demonstrate how mixed race adolescents show a higher risk when compared with single-race adolescents on general health questions, school experience, smoking and drinking,

and other risk variables. The most common explanation for the high risk status is the struggle with identity formation, leading to lack of self esteem, social isolation, and problems of family dynamics in mixed race households. This is not to imply that children and adolescents of mixed race are vulnerable to unhealthy lifestyles. However, with a combination of factors such as family dysfunction, mixed race does become an issue in the formation of healthy identity and growth.

Addiction/Substance Use

One of the most disturbing facts about addiction in some Aboriginal communities is the alarming rate of substance abuse among young children. Studies show that the age of onset for use of tobacco products, alcohol, solvents and cannabis is substantially younger than for children in the population as a whole. Aboriginal children are also entering treatment centres at younger ages (Health Canada, 1999). In a 1993 report 67% of participating Friendship centres reported that children were consuming alcohol and sniffing solvents during school hours, after school, on the streets, and in their homes (Health Canada, 1999).

These escalations of experiences with the justice system sexual activity, alcohol and drug use combine to reinforce the need in priorities for action. Intervention strategies that are culturally relevant, consistent and meet the needs for the individual, parent, family and community are crucial today. Efforts to educate individuals and build personal skills that support healthy lifestyle decisions are nowhere more important than with youth (Health Canada, 1999).

Overview of Effective Treatment Approaches

Many programs are in place in Northern Saskatchewan that address the needs of at risk youth. However there are limitations that influence the success and effectiveness of these programs. This section identifies programs and their limitations in attempts to formulate concepts. They will aid in the development of specific research questions that are necessary for creation of new and revised editions of programs in place.

Parent Management Training Programs

To address parental needs and develop family support this program teaches parents how to develop and implement very structured management programs in the home. The program focuses on three areas:

- improving parent-child communication
- changing antecedents to behaviour that promote development of positive pro-social behaviour
- improve parent's ability to monitor and supervise their children
- teach parents more effective strategies for discipline in the home (Frick, 2001).

Key limitations for this treatment approach are the large number of parents who do not complete the parenting programs and the lack of effectiveness for the dysfunctional families (Frick, 2001).

Adolescent Recovery Centers (ARC)

Adolescents with chronic addictive behaviours receive treatment in adolescent recovery centers that are located in urban centers. Successful treatment involves a boot-camp attitude, use of peer counsellors who have recovered from their own addictions, and insistence that parents and siblings commit to the program and appear for counselling

alongside the addicted teenagers (Ko, 2001). These centres provide rehabilitation, education and prevention services to persons who are affected by substance use. Rehabilitation services include inpatient, detoxification, outpatient and field services for adults and youth (Health Canada, 1999).

The most successful treatment centres are those that involve the entire family in the process of intervention and recovery. The reason ARC works so well is because the whole family is counselled, so that when the child returns home, he or she cannot manipulate the family into old behaviours that will enable relapse (McLean, 1998). There are services specific to cultural treatment intervention and the majority of Métis Addictions Council of Saskatchewan (MACSI) services clients are of Indian or Métis ancestry. However, services are available to all members of the population. MACSI programs are a vital component of alcohol and drug recovery services in Saskatchewan (Government of Saskatchewan, 2003).

Key limitations with this treatment are expensive fees for intervention services, location of the centres and the lack of preparation for re-integration into home communities. Treatment is successful in adolescent centers but maintaining sobriety in isolated, at risk environments and returning to dysfunctional homes is too much to bear for children and adolescents. As the young offender commented, his two greatest needs are finding a job and having proper, responsible supervision. Although many adolescents can be helped by current treatment programs, further research is needed to establish what kind of treatment, and at what intensity and duration, is necessary to reduce alcohol consumption and prevent relapse in patients currently unresponsive to treatment (Buckstein, 1994).

Working with Strengths

Young people living in at risk environments have developed two distinct types of strengths. The first is knowledge of their environment. They know where to find resources and learn who to trust and adapt quickly to new situations. The second strength is the development of internal motivators for self- improvement. There is a sense of freedom, responsibility for others, recognition of good feelings associated with healthy behaviours and definite goals for the future (Rew & Horner, 2003). When professionals are developing programs for these at risk children and adolescents, it is crucial to the program's success to involve youth in the planning and implementation of these programs.

Community Services

Most rural communities have services such as mental health workers, addictions counsellors, nurses, recreation facilities, youth centers and justice workers. Psychologists and other counsellors today have newer therapies available that also are significantly more effective than a decade ago. An example of this is Motivational Interviewing (MI). The definition of MI is a directive, client-centered counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence (Miller & Rollnick, 1995). The evidence is compelling for the effectiveness of such therapies as cognitive behavioural therapy for anxiety and depression, assertive community treatment approaches and assisted-employment programs. There are behavioural programs for parents and children with ADHD and disruptive disorders and multi-systemic community-based programs for youth with antisocial behavioural problems and substance abuse (Conway, 2003).

Mental health services are delivered in community based programs by non-physician practitioners. This has its benefits in keeping families and individuals together and in their cultural surroundings. In Saskatchewan, services are available to children and youth with serious and persistent mental health disorders. Services are also available for those with less severe mental health and behavioural challenges and those who are at risk of developing mental health and behavioural problems. A number of community-based organizations also receive support from health districts to provide services for children and youth. However not all health districts have access to specialized services.

Limitations in Community Based Programs

Community services provide "nine to five" interventions. They do not provide supervision after hours and are not attached to job markets. There is often a lack of career awareness of Native youth and criticism of the culturally encapsulated counselling techniques used by mainstream counsellors who work with First Nations and Métis youth. Career development models are based on generalizations of "middle-class and white male populations" Career counselling strategies need to focus on increasing counsellors' sensitivity, enhancing First Nations students' self-concepts, decreasing stereotypes and gender differences, emphasizing First Nations role models, and facilitating work opportunities (McCormick & Amundson, 1997).

Other limitations are in the process of diagnosis; testing and referral to long term care facilities. Community based programs are sometimes over exemplified and the needs of families with mental illness are underestimated. In small communities traditional family care sometimes clashes with the actual needs of at risk families. When

resources run thin, and cannot meet the demands families with special needs, agencies need to have steps in place that guarantee safe environments for all members.

Residency Services

Social service agencies have provided group homes for at risk youth but these services are being phased out. Due to a decrease in government funding, group home treatment in Northern Saskatchewan has been dissolved and finances transferred into other forms of youth services in community based programs. Two such homes have been discontinued in Northern Saskatchewan in the last five years. The only facilities in Saskatchewan that provide long-term residential services for adolescents are the Hopeview Recovery Home in North Battleford and the Recovery Manor in the Regina Health District. There are no short-term residence facilities for at risk youth in Northern Saskatchewan.

Adolescents, as well as their families, teachers, counsellors and communities need to be reached with health related interventions and health-promoting programs that are based on a holistic understanding of their development in emotional, physical, social and spiritual needs in order to ensure healthier lifestyles both during adolescence and throughout adulthood (Spear & Kulbok, 2001).

School Based Programs

Safe Schools

Over the past ten years the Northern Lights School Division 113 has designed and implemented a Safe Schools program that sets out guidelines that principals can adapt to meet the needs of each school's situation. Each school forms a committee that consults with the community and local board, to develop their own policies. The school division

supports local efforts by encouraging integrated services consultants available to help. The Safe Schools handbook covers topics such as conflict resolution, violence intervention, bullying and child abuse. The program promotes the teaching of non-violent values and behaviours. It also targets adults in the community as role models. It has a provision fro tracking at-risk children that are both victims and aggressors and helps them modify unhealthy behaviours (Safe Schools, 2004).

Limitations of this program are its restriction to the children who attend school on a regular basis and exclusion of parents and guardians unwilling to change their dysfunctional lifestyles. Intervention may be taking place in the schools but is not reaching the homes of the children. Safety is promoted in the school but not necessarily in the home.

Integration of Business Programs

Addressing academic needs of at risk youth and providing them with skills that will prepare them for the workforce has been an ongoing concern. Many adolescents are dropping out of school because of learning disabilities and have no trade skills. A lot of students, who are not academically inclined, are very talented in fields such as mechanics, carpentry and contracting.

One particular school in Northern Saskatchewan has recently offered, initially through the Buffalo Narrows Economic Development Corporation, a unique entrepreneur class. The federal Northern Development Agreement committee contributed $38, 500 to the program. The money was used to purchase a computerized routing machine, computer programs and specialized training. A company was created and named Eagle Manufacturing Company, which the students are shareholders. It has various divisions

that include the Arts Division for conceptualization, the Information Technology Division for design with Computer Assisted Drawing and Industrial Arts Division for manufacturing products (Scissons, 2004).

Limitations include lack of specialized personnel to administer the program and drop out rates in the class itself. Students became frustrated with the lengthy amount of time being spent on ironing out problems with equipment. However, it is a positive step toward developing career-oriented programs for adolescents in school.

Outdoor Education Programs/Camps

School divisions have implemented outdoor education programs/camps in efforts to reach out to at risk students. Lessons in Life skills, cultural history, traditional healing and survival are interwoven into physically active programs. (Saskatchewan Physical Education, 1998). Students benefit from the experiences and encouragement to live healthy lifestyles. For example, at Valley View School in Beauval, SK, students are provided with opportunities to go on canoe trips and trapping camps. They are accompanied by elders who share traditional stories that involve healing methods, hunting and trapping skills and use of medicinal plants. The students are taught the interconnectedness and how their efforts can achieve balance.

The Need for Integrated Service Delivery

Both health and social service delivery have important influences on healthy child development. Restructuring and cost reductions in these sectors over the last ten years has limited services further. In recent years there has been renewed emphasis on finding ways to connect the contributions of various sectors (e.g. health, education, justice, social

services, recreation and housing) in the pursuit of healthy child development (Health Canada, 1999).

There is a growing interest in alternative approaches to treatment. Many programs have begun to incorporate a variety of family or behavioural treatments, health services, vocational and educational services, and recreational activities in addition to 12-step principles. Other initiatives treat alcohol-abusing youth as part of a comprehensive system of services for hard-to-reach, multiproblem adolescents, as well as their families (Henggeler 1991). In these programs, case managers and multidisciplinary teams from different social service agencies and treatment programs coordinate services and care. Also, increasing emphasis is placed on providing help to the adolescents in their own community and in as "normal" a setting as possible (Buckstein, 1994). For example, in northern Saskatchewan, the Keewatin-Yathe Health District provides mental health and addictions professionals that work together with the Northern Lights School Division, to provide services for the youth in the community. This saves time, money and stress for everyone involved.

Summary

This review has analyzed various programs and services available for at risk youth in many rural communities. Parenting programs offer guidance, support, skills and structure for parents who are willing to dedicate time to address the needs in the home. However, many parents, in dysfunctional homes, do not complete the program or even attempt to participate. Some parents complete training but are unable to control their child's behaviour and need outside support. Adolescent recovery centres in urban locations provide valuable treatment but when clients return to their communities it is

difficult to maintain healthy lifestyles. Community services and government agencies construct intervention planning but do not provide the necessary continuous supervision or physical structure that is needed.

Conclusion

This literature review was useful in identifying and listing components that will be helpful to the rural counsellor. It is a necessary step towards developing new and improved services in rural communities. Many programs provide support but sometimes fall short of emergent needs. Specific services are required to ease transitions from treatment to mainstream society or vice versa. A bridge is needed in programming that is able to carry at risk youth through difficult transitions, specifically youth at risk in their own homes. Those without this emergent, consistent support fall through the cracks of the system and are at greater vulnerability to drug and alcohol abuse, violence and death. Common themes projected through the literature of this review are:

- integration and cooperation of various agencies in modification of existing programs to meet unique needs of rural communities. Teens who are diagnosed with FASD need integrated support (Harpur, 2001). Kleinfeld and Wescott (1993) suggest that integration and coordination of the family, schools, and other community services can be beneficial in working with the child (Streissguth, 1996).
- the role of career development in successful intervention programs (Amundson, 1995)
- need for continuous and consistent intervention and treatment Further study is needed to address the persistence of cognitive and emotional problems throughout

the life span of people with FAS, particularly for adults with FAS/ARND, as many of the infants that were first diagnosed in the early 1970's are now adults (Streissguth, 1995). For example, difficulties in memory functioning that have been observed in people with FAS/FAE and show that they may often forget their obligations at school or work, possibly resulting in disruptions of education or termination of employment. They also may forget medical appointments and may not receive timely medical care. Because of this problem, people with FAS/FAE often require someone else to remind them of appointments (Streissguth, 1995).

- family counselling services: it is imperative that interventions include the whole family. Parents of children with FAS/FAE must be helped to understand that the behavioural and cognitive problems that arise are not something that the child is consciously choosing to do (Streissguth, 1996)

Further research is needed to integrate service providers and revise existing programs through the development of active models and programs.

The remainder of this final project will focus on presenting such a model that addresses needs of at risk youth in rural communities in efforts to develop consistency in delivery of specific programs that provide them with successful transitions into adulthood and the workforce. Investigating successful treatment models and adapting them to rural community needs will aid in the development and design of a bridging an active service for youth.

CHAPTER 3

PROCEDURES

Step One: Personal Reflection

The steps taken in this project began with the development of the Keewatin theory. This involved intense reflection and research with both personal and professional experiences. My personal experience, having been born and raised Northern Saskatchewan and immersed in the Cree and Metis culture and traditions, has given a unique insight into this lifestyle. With ethnic roots in French and Hungarian ancestry, I have also been raised with insights into European culture. With the development of my understanding in the Western theories and how these correlated with concepts in Native spirituality I was able to form a base or medium to work with in the counselling profession. The key values I derived from these roots were taking pride in one's identity while celebrating the strengths and unique opportunities that all cultures have to offer.

Step Two: Service Review

The second step involved doing a review of services in Northern Saskatchewan that help to address the needs related to the secondary disabilities of FASD. The cooperation of professionals in the Health district, school division and medical facilities helped provide the information in the literature review. Each year resources have emerged so that more is available now than five years ago when the issue of public education about FAS reached its peak. What remains a missing link is an integrated collection of these resources for the rural/remote counsellor and a theory to integrate and inform the application of these interventions.

Step Three: Researching Successful Interventions for FASD

Additional research in areas specific to Adolescents diagnosed with FASD involved gathering medical information, attending FAS workshops, consulting with FAS education counsellors in the Health District office and reading materials written by parents with direct experience. The Internet provided helpful information in gathering and confirming medical facts related to issues of FASD. Health, wellness and career education in the school division provided crucial resources.

Step Four: Developing a Model and a Theory

With the plans for providing a resource unique to rural, Northern Saskatchewan, the combination of the previous efforts provided the foundations for the development of a holistic model. After research of services available it became clear that it was necessary to base the treatment for this particular adolescent population with a culturally relevant model. Using the basic teachings of the Medicine wheel (Saskatchewan Learning, 2002) and combining this with interventions in the CAAP courses (CAAP 615) the model began to take shape. Locating written resources of traditional teachings on the Medicine wheel was a challenge during this research, as most teachings are passed on orally. It is my hope that more people continue the process of writing these teachings down from the elders.

Step Five: Developing a Toolkit

With my background in teaching and counselling adolescents in the Northern Lights School Division and work with Keewatin Yathe Regional Health Authority, I had access to resource materials that provided the base for the Toolkit. The intervention and assessment materials from classes in CAAP also provided ideas for the counsellor section.

I did further research with the FAS/FAE Community Education worker to select Parent information for the toolkit. This involved attending workshops on FASD and selecting parenting materials relevant to this project. I was fortunate to have the opportunity to attend a workshop by Dr. Mavis Olesen. She has first hand knowledge about raising an adolescent diagnosed with FASD and has written a book on this topic. Similar to her goals, the purpose of creating the toolkit is to provide a starting point for persons working with adolescents diagnosed with FASD, particularly in locations where resources are scarce Copies of the toolkit will be made available to the parents, teachers and counsellors in our school division and health district.

CHAPTER 4

SYNTHESIS

Fresh Perspectives and Unique Solutions: Development of the Keewatin Model

In Northwest Saskatchewan residential schools have had devastating long-term effects on aboriginal people and their communities. These schools broke the connection between children and their parents and culture (Quinlan & Reed, 1999). Many of the children were unable to reconnect to their family and culture after this enforced isolation and anti-aboriginal instruction. This resulted in a rejection of their past. In 1996, the Report of the Royal Commission on Aboriginal peoples identified residential schools as a major facto in the high rates of substance abuse, suicide and family problems among Aboriginal peoples (Quinlan & Reed, 1999). However, many survivors have begun the healing process and these efforts have provided unique opportunities.

The Keewatin-Yathe Health District has recently developed their service delivery by integrating First Nations' perspectives and beliefs with medical theories and interventions. This injection of traditional knowledge has been spurred on by the residential school survivors, which has been focused on finding community-based answers within a Native based ethos. The main thrust has been to work with clients through integration of local services. Culturally based therapies have gained acceptance with government agencies and this has helped encourage First Nations people to share their ideas openly. Society is also much more accepting than it has been in the past. Undercurrents can be seen in the educational system with the insertion of Indian and Metis content into the curriculum, and more noticeably in the political arena, where aboriginal issues are dealt with at the highest political level.

In order to promote knowledge, awareness and skills that develop competency that addresses the holistic needs of these youth, it is recommended that this holistic model be incorporated into the programs for parents, teachers and counsellors**.**

A Rural FASD program would need to incorporate the following needs:

- Residency options for Short- term care in the community that act as lifeline monitors for at risk youth
- Linking treatment to labour market attachment programs
- Training for staff that provide residency services out of their home
- Intervention that incorporates special needs education, prevention, peer counselling, parental and family involvement
- Education programs that provide a general shift that academics is not the only answer for everyone, given the sophistication of today's trades
- Active channels for referral and placement in long-term care facilities, specifically for special needs children and adolescents

I have included my personal (Keewatin) theory in this section in attempt to promote understanding of the development of the holistic model in this project.

For many Aboriginal people there is a common belief that everything in creation follows a cycle of change. The seasons follow this cycle, as do animals and plants, which have cycles of migration and birth. Human life also has a cycle. It involves birth, maturity, death and entrance into the spirit world. The circle is a central symbol that represents the connection of all things. Despite the changing world, it is believed that all humans must live in harmony with the natural order. Each culture has its own way to keep in touch with the spirit world; through songs, dance and ceremonies. Aboriginal

people consider the effects of their actions seven generations into the future (Quinlan & Reed, 1999).

The Traditional Indian Code of Ethics (Saskatchewan Learning, 2002) provides insight into the development of Aboriginal values and worldview:

- Give thanks to the Creator each morning upon rising and each evening before sleeping.
- Seek the courage and strength to be a better person.
- Showing respect is a basic law of life.
- Respect the wisdom of people in council. Once you give an idea it no longer belongs to you; it belongs to everybody.
- Be truthful at all times.
- Always treat your guests with honour and consideration. Give your best food and comforts to your guests.
- The hurt of one is the hurt of all. The honour of one is the honour of all.
- Receive strangers and outsiders kindly.
- All races are children of the Creator and must be respected.
- To serve others, to be of some use to family, community, or nation is one of the main purposes for which people are created. True happiness comes to those who dedicate their lives to the service of others.

- Observe moderation and balance in all things.
- Know those things that lead to your well-being and those things that lead to your destruction.
- Listen to and follow the guidance given to your heart. Expect guidance to come in many forms: in prayer; in dreams; in solitude; and, in the words and actions of Elders and friends. *(*Saskatchewan Learning, 2002).

It is essential for counsellors to communicate with clients in a meaningful way. In order to achieve this level of communication with First Nations clients, counsellors need to develop an understanding about the worldview of aboriginal people. This process involves issues related to power in the counselling relationship. When working with racial identity counsellors must consider their own identity development. Counsellors racial identity impacts the counselling process such as the ability to build rapport, develop a working alliance, and to be culturally empathetic (MacDougall & Arthur, 2001).

Keewatin theory explains how humans are born with the ability to make meaning from experiences. In many Aboriginal ceremonies, there are ceremonies for naming children at various stages of their development. The importance and centrality of children was reflected in the public celebration of events in a child's life, such as a child's first steps, a girl's first menstrual cycle, or a boy's search for his spiritual helper at puberty (Devine, 2004). Each of these ceremonies celebrates the child’s accomplishments and develops a sense of meaning and purpose in the community. In the traditional teachings it is recognized that, at the time of adolescence, there is a deep need for a sense of belonging and independence (Reynolds, 2005). It is a time to teach values of generosity

and how to master certain skills. At the ages of twelve through eighteen adolescents are taught about their strengths and gifts of storytelling and use of silence (Reynolds, 2005). The use of metaphors in counselling practice is encouraged in situations where clients have difficulty expressing themselves. Metaphors are a more indirect way of exploring values and meaning, and encourage more active involvement and participation by clients and counsellors (Amundson, 1997). This could prove to be useful in constructing a preferred future with a client, particularly for someone who has difficulty envisioning future directions, or for those that have a more cyclical worldview and less linear perspective. The use of the medicine wheel and its quadruple concepts incorporate metaphors in the form of symbolism. This is especially effective with adolescents, particularly those with special needs (Reynolds, 2005). It allows the client to visualize where they are and the direction they need to work towards. We see examples of this use of metaphors and symbolism in the teachings of interconnected consciousness.

Individuals grow towards wholeness when both conscious and unconscious parts of the mind work in harmony. Aboriginal teachings include four dimensions of interconnected consciousness: hearing, seeing, smelling and tasting. It is taught that hearing is represented by fire, seeing with water, tasting with mother earth and smelling with the air (Reynolds, 2005).

Within the teachings we learn, for example, how children hear things and thus learn from their surroundings. This fire is built and continues to burn and influence their lifestyle in later years. If a child from an early age learns negative ways, such as ineffective communication skills, this affects how this person interacts in later life.

However, if the child learns positive ways, such as problem solving, these skills are used in later life (Reynolds, 2005).

Seeing is connected to water. Our tears represent are a form of cleansing and we are also reminded that our bodies are 80% water (Reynolds, 2005). We are connected to nature because our bodies are made from it (Reynolds, 2005).

Smelling and air are connected and teach us the interconnectedness and interdependence. We are one big family with our "relations". We do not do anything by ourselves; together we form a circle (Graveline, 1998). When the trees exhale, I inhale, when I exhale, the trees inhale. We live in a world of interconnected circles; these circles extend out into the universe, they constitute our identity, our kinship with others and our relations (Graveline, 1998).

Tasting is directly related to mother earth because whatever sustains us comes from the earth. This teaches us to respect what we take from our surroundings and to ensure that our environment is sustained for future generations (Reynolds, 2005).

Wholeness is achieved by continuous reflection, and becoming aware of the inner patterns, how they are formed and making adjustments in areas of dysfunction. We work through the four dimensions physically, spiritually, emotionally and mentally, always returning to the centre, which is the Creator. There is a natural movement towards balance and self- healing in this process.

Keewatin theory is humanistic and views the personality as holistic. Holism suggests that humans are self regulating, growth-oriented and that persons and their symptoms cannot be understood when they are separated from their environment (Yontef & Jacobs, 2000).

Keewatin theory emphasizes the significance of a person's environment and the formation of social context. This ties into the Aboriginal communal approach and strong influence of community on decision- making. The family constellation is the child's primary social environment. It is here that the child searches for significance and finds a psychological position (Mosak, 2000). The relationships formed in these early years influence the core ordering processes or meaning making nucleus of the child's personality.

As the one matures and reaches adulthood the various experiences form one's personal realities and identities. Personal meaning is directly related to relationships with others and the environment. One cannot be studied outside of the social or environmental context. Who we become from infancy onward depends on the social relations we have with others and the patterns of meaning and communication in which we participate (Vance, 1993). It is through our environment and relationships with others that we learn to develop the four aspects of our being. Keewatin theory believes that all humans have the innate ability to sense imbalance when one, two, three or even all of these aspects may be underdeveloped, ignored or neglected. When the state we are in becomes blurred and confused our perception is distorted. This is when intervention is necessary to help reflect and identify areas that need healing. This process works towards being whole again. Keewatin theory is a system of healing and self-healing based on learning and perceiving.

There is significance in the interpretation of dreams, and the role of early childhood experiences in the formation of personality. They help the individual in the quest for meaning. Dreams reveal the underlying pattern of how the individual relates to

the world (Douglas, 2000). They provide clues and warnings for each individual when they are in a state of imbalance.

Keewatin theory believes in the reality of evil and that humans can confront it by becoming conscious of it. It offers a way of looking at all of life and can extend into whatever embraces and transcends human life and experience (Hinksman, 2001). It recognizes the dialogical nature of people – we are who we are in a continuous process of interaction. That process is who we are and who others are also. The personal relationship with Self is the primary determinant of the quality of life and resilience of each individual (Vance, 1993). This concept of connectedness is central to Keewatin theory.

A self-organizing process drives the development of each individual. Through personal meaning, derived from relationships and the environment, and the ability to apply the process of restructuring, people are able to learn how to self-heal.

In Keewatin theory health is mainly a matter of being whole and this is achieved when a balance is struck in the four aspects of the person. Attaining and maintaining balance in the physical, mental, emotional and spiritual dimensions is the aim of Keewatin therapy. All things and all people are dependent on and share in the growth and work of everything and everyone else. Beings thrive when this interconnectedness between the individual and the community and between the community and nature is realized (Graveline, 1999).

The needs are met in each dimension through the individual's ability to recognize and priorize their shifts. In some cases a change in one category brings about recognition for change in another. For example, if one is feeling very upset and needs to work on

anger management they will work on their emotional state. They may discover a physical factor such as stress or diet that is influencing their emotions. A willingness to develop each category as the awareness arises is crucial to becoming healthy.

As outlined earlier in the Code of Ethics, it is through moment-by-moment experiencing one is allowed to organize behaviour and learns to be reflective, considerate, respectful, compassionate, loving and caring. These are all aspects of well-adjusted functioning.

Balancing emotional, spiritual, physical and mental aspects is central to healthy functioning. In the process of developing balance one is joined to his relationship with the current realities. When one learns to confront dysfunctional aspects of the self one can reclaim important parts of the personality to consciousness. These are essential tasks for the mature personality (Douglas, 2000). Social experiences as well as personal experiences are combined in the development of a healthy personality. A healthy person is aware that the self is not a rigid set of characteristics or traits. It is, rather, a system of meanings that are under continuous revision. It is an internal process that constitutes meaning, purpose, intention and order. We are able to interact with both our internal and external processes (Vance, 1993). One has a conscious awareness of all contact in the four domains.

Keewatin is a Cree work which means 'North". The purpose of this section is to define and refine my personal theoretical position. With my major influence being the Northern Cree lifestyle, I find the name "Keewatin Theory" appropriate for representing my perspective.

Keewatin theory is an eclectic approach that reflects aspects of Gestalt theory and Constructivist philosophy but integrates Jungian and Adlerian themes as well. It is consistent with the worldview of First Nations peoples. It is a holistic approach that addresses healing in all four aspects of the person. These are the emotional, physical, spiritual and mental dimensions. According to Keewatin theory, every individual has the opportunity to explore and develop these aspects of self. Keewatin theory agrees with the concept of "internalized culture" and considers each session a "cross cultural experience" (Ho, 1995). Each individual learns to gain knowledge of how one's self is structured, strategies to own thoughts, feelings and behaviors and develop insights through the experience of Keewatin therapy.

Basic Concepts

Holism

Counselling should be based on holism as a quadruple entity. It strives for balance in the physical, emotional, spiritual and mental aspects of the individual. The First Nations peoples use this concept in their medicine wheels to promote harmony, balance and good health (McCormick & Amundson, 1997). Holism and harmony are dependent on one's responsible actions and thinking and the quality of relationships with others. It is influenced by the quality of one's engagement beyond one's own ego. Engagement with such phenomena as nature, society, compassion for others, and God are examples of these influences (Vinson & Griffin, 1999). The meaning an individual connects with experiences and relationships gauges one's awareness of self and others.

The concept of holism is related to systemic theories. A change in one part of the system influences changes in other parts. For example, if an individual is struggling with

anger as a result from stress at work, one goal could be to exercise regularly in efforts to relieve tension. Another would be to help identify stress buttons at work and how to prevent stressful situations rather than react to them (Sarafino, 2002).

Physical

The physical component deals with all energy that influences an individual's physical person. It includes behavior, bodily functions and the individual's physical and social environment. For example, early on in life, the family constitutes the primary social environment for each individual. Keewatin theory recognizes the significance of this social environment and its impact on the child's psychological development. This includes the child's position in the family constellation (Mosak, 2000).

One's physical domain is influenced by thoughts, emotions and beliefs. By keeping the physical body healthy through diet and exercise people can avoid illness. It recognizes the Greek philosophy that "a healthy mind is a healthy body".

Spiritual

The concepts of interconnectedness with one's surroundings and belief in a higher power other than self are the core of this component. There are two major emphases in the spiritual dimension that counsellors must address with their clients. The first is that spirituality is a major component of one's identity and extent to which a client defines one's self. The second is that in the majority of clients there is a reliance on a higher power. This may be represented informally or formally through prayer and meditation (Gerber, 2001). Clinicians and other health care systems should not deprive their patients of the spiritual support and comfort on which their hope, health and well being may hinge (Larimore, Parker, & Crowthner, 2002).

Spiritual beliefs are significant for clients. Many topics may have spiritual meanings such as suicide, extramarital sex, homosexuality, self-image, self worth, grief/death, disrespect for parents, etc. Counsellors need to find clarification of the meaning and experience of the client's spiritual context to understand what drives their thoughts and behaviors. An individual's values and beliefs are maintained in the spiritual dimension. Values can both constrain or facilitate efforts to reach goals towards balance (Vinson & Griffin, 1999).

Mental

Mental functioning includes the *Conscious* and *Unconscious*, *Dreams*, and *Memory*, and all cognitive functioning (Corsini & Wedding, 2000). The mental context is influenced early in one's meaningful experience, and is based on relationships in the immediate environment. The construction of ego identity in early adolescence and beyond incorporates many of the components of self concept developed earlier, such as social, academic and physical self concept (Broderick & Blewitt, 2003). The concepts that include the development of ego, dialogue with Self, and creation of personal constructs occur mainly in the mental dimension of the person. In the stages of identity development during adolescence, members of marginalized groups confront negative stereotypes and discriminatory practices of others. Some adolescents immerse themselves in their racial or cultural groups or actively reject the dominant culture during this period (Broderick & Blewitt, 2003). To gain a more mature perspective and higher stage of identity formation, these individuals affirm their identity as a member of the group by achieving two things: (1) having the ability to reconcile the differences that exist between the ethnic minority group and the dominant group and (2) coming to terms with the lower

status of the individual's group within the larger society (Broderick & Blewitt, 2003). It is very important to consider the place of their own race/culture/ethnicity in this self - definition. It is crucial in developing the ability to think about our thinking and how this process influences our self-concept. Attention to self-talk is also important in identifying one's perspective of self within one's own culture and how this fits in the dominant society. Keewatin theory recognizes the reciprocal influences of each dimension, particularly the mental and emotional domains.

Much of therapy is focussed on this dimension but also acknowledges the influences of the other three dimensions. "Psychotherapists, above all, should live by the old American Indian adage, "Respect your brother's dreams."" (Faraday, 1980).

Emotional

Feelings, intuition, attitudes are a major component of this dimension. They are closely linked to physical, mental and spiritual dimensions. What do emotions have to do with healing? When emotions such as anger, fear, unworthiness are not dealt with in a healthy way they contribute to weakening our thoughts, beliefs and even physical sicknesses. Emotions act as a foundation on which we build our lives. They can inspire or limit us. Fear, anger, confusion, happiness and joy are all part of our whole person and must be acknowledged and addressed in holistic counselling. The western world sometimes loses touch with the basic concept of holistic healing, especially in this dimension (Muran, 2005).

Balance

All the elements of life and living are considered to be interdependent. Well-being flows from harmony among all elements of personal and collective life

(McCormick & Amundson, 1997). This reinforces the concept of interconnectedness and the belief that one part cannot be the center but must learn to work in harmony with all of the other parts. The First Nations' concept of the Medicine Wheel represents this balance that exists between all things (McCormick, 1996). An understanding of the significance of the circle is the first step toward understanding the Medicine Wheel concept. The Medicine Wheel circle is unique and sacred to many indigenous peoples in North and South America. The concept of the circle is reflected across the many diverse tribal cultures that collectively are referred to as indigenous peoples. Many tribal cultures, especially the plains tribes, use concepts of the circle through their teachings of the Medicine Wheel. The circle is the heart of their value system, philosophy, and religion. Many traditional tribal cultures teach that all living elements are connected and each is affected as much as any part of the circle is affected. What is put in the Medicine Wheel Circle is circulated among the people. It is important that people are careful about what is put in the Medicine Wheel, as it will go around. The circle is eternal. The Medicine Wheel circle is a vital part of Northern and Southern Plains culture, as well as of other tribal cultures throughout North and South America. It is important to understand that not all tribes believe in the concept of the Medicine Wheel. However, for the purpose of brevity in explaining the Medicine Wheel, a brief and general description is presented from a Comanche and Kiowa perspective.

First and foremost, the symbol of the circle provides the foundation of spirituality, family structure, gatherings of people, meetings, songs and dances. The circle surrounds the entire thought process of traditional indigenous peoples. This symbol is still used by many indigenous peoples in North and South America. There are many different ways to

express this concept: the four grandfathers, the four winds, the four cardinal directions, and many other relationships that can be expressed in sets of four (Saskatchewan Learning, 2002).

The Medicine Wheel teaches us that we have four aspects to our nature: the physical, the mental, the emotional, and the spiritual. Each of these aspects must be equally developed in a healthy, well-balanced individual through the development and with the use of volition. All elements are contained within the Medicine Wheel, and all elements are equal within it. The Medicine Wheel is symbolic of the total universe. For people who recognize this holistic unity, the natural forces of the universe inspire wholeness of being. An indigenous worldview holistically interrelates all components of life. (Saskatchewan Learning, 2002).

Inside-Out vs. Outside-In

The first place to start is with "self." Therefore, the inside-out approach means to start first with self. This means to start with the most inside part of self; with one's paradigms, character, and motives (Saskatchewan Learning, 2002). One is encouraged to look at his own life first, rather than looking at other people's lives when examining the whole picture. The inside-out approach suggests that if we want to develop trust we must learn to control our own lives and subordinate our short term desires to higher purposes and principles (Saskatchewan Learning, 2002). .

The Medicine Wheel teaches us that the four symbolic races are all part of the human family. All are brothers and sisters living on the same Mother Earth: white, black, yellow, and red. The Medicine Wheel teaches us that the four elements, each so

distinctive and powerful, are all part of the physical world. All must be respected equally for their gifts of life: fire, water, air and earth. The Medicine Wheel teaches us the cycles of human development from our birth toward our unity with the wholeness of creation: wholeness, growth, nourishment, and protection. The Medicine Wheel teaches us symbolic meanings of life: virtue, power, competence, and significance. Finally, the Medicine Wheel teaches us that in this global universe, "all things are connected and related." (Saskatchewan Learning, 2002).

Alongside the teachings of the medicine wheel there are twelve principles of Indian philosophy, which help guide our holistic development.

- Wholeness. (Holistic thinking). All things are interrelated. Everything in the universe is part of a single whole. Everything is connected in some way to everything else. It is only possible to understand something if we understand how it is connected to everything else.

- Change. Everything is in a state of constant change. One season falls upon the other. People are born, live, and die. All things change. There are two kinds of change: the coming together of things, and the coming apart of things. Both kinds of change are necessary and are always connected to each other.

- Change occurs in cycles or patterns. They are not random or accidental. If we cannot see how a particular change is connected it usually means that our standpoint is affecting our perception.

- The physical world is real. The spiritual world is real. They are two aspects of one reality. There are separate laws, which govern each. Breaking of a spiritual

principle will affect the physical world and vice versa. A balanced life is one that honours both.

- People are physical and spiritual beings.
- People can acquire new gifts, but they must struggle to do so. The process of developing new personal qualities may be called "true learning". There are four dimensions of "true learning".
- A person learns in a whole and balanced manner when the mental, spiritual, physical and emotional dimensions are involved in the process.
- The spiritual dimension of human development has four related capacities:
    1. the capacity to have and respond to dreams, visions, ideals, spiritual teaching, goals, and theories;
    2. the capacity to accept these as a reflection of our unknown or unrealized potential;
    3. the capacity to express these using symbols in speech, art, or mathematics;
    4. the capacity to use this symbolic expression towards action directed at making the possible a reality.
- People must actively participate in the development of their own potential.
- People must decide to develop their own potential. The path will always be there for those who decide to travel it.

- Any person who sets out on a journey of self-development will be aided. Guides, teachers, and protectors will assist the traveller. The only source of failure is a person's own failure to follow the teachings.

- The only source of failure on a journey will be the traveller's own failure to follow the teachings of the Sacred Tree (Saskatchewan Learning, 2002).

The Twelve Principles can be applied to all cultures, including those where a power difference may be apparent. These power differences may only be different positions within a whole, as we all sit in the circle of the Medicine Wheel. In other words, power differences are really just individuals coming from different places on the wheel.

We are crossing cultures even within the same cultural group when considering factors such as sex, age, and socio-economic status. Every encounter can be experienced as a cross- cultural one (Ho, 1995). Another point to consider is historically counsellor training has been based on theories developed by white, middle-class males**.** These theories carry bias, racism and they limit the cultural perception of counsellors**.** Some professionals presume that they are free of racism. This presumption shows that the counsellors seriously underestimate the "impact of their own socialization (Pederson, 1995). This type of covert or unintentional racism, in most cases, emerges from "well-meaning, right thinking, good hearted caring professionals" (Pederson, 1995). When a counsellor has the opportunity to develop self-awareness of the concept of culture he or she becomes more sensitive and appreciates the diversity other cultures have to offer.

Native American philosophies of child management represent what is perhaps the most effective system of positive discipline ever developed. These approaches emerged from cultures where the central purpose of life was the education and empowerment of children. Modern child development research is only now reaching the point where this holistic approach can be understood, validated and replicated. Fostering self-esteem is a primary goal in socializing normal children as well as in specialized work with children and adolescents at risk. Without a sense of self worth, a young person from any cultural or family background is vulnerable to a host of social, psychological and learning problems. In his definitive work on self concept in childhood, Stanley Coopersmith observed four basic components of self esteem are significance, competence, power and virtue: 1. Significance is found in the acceptance, attention and affection of others. To lack significance is to be rejected, ignored and not to belong; 2.Competence develops as one masters the environment. Success brings innate satisfaction and a sense of efficacy while chronic failure stifles motivation. 3. Power is shown in the ability to control one's own behavior and gain the respect of others. Those lacking in power feel helpless and without influence; 4. Virtue is worthiness judged by values of one's culture and of significant others. Without feelings of worthiness, life is not spiritually fulfilling. (Saskatchewan Learning, 2002)

Traditional Native educational practices addressed each of these four bases of self esteem: (1) significance was nurtured in a cultural milieu that celebrated the universal need for belonging, (2) competence was insured by guaranteed opportunities for mastery, (3) power was fostered by encouraging the expression of independence, and (4) virtue was reflected in the pre-eminent value of generosity (Saskatchewan Learning, 2002).

The number four has sacred meaning to Native people who see the person as standing in a circle surrounded by the four directions. Belonging, mastery, independence and generosity are the central values. We believe the philosophy embodied in this circle is not only a cultural belonging of Native peoples, but also a cultural birthright for all the world's children (Saskatchewan Learning, 2002).

Self-organization

Keewatin theory states that our self-perception and organization is best taught through our ability to see ourselves in relation to others: family, community, those behind and those yet to come (Graveline, 1998). In the development of this worldview, each individual becomes aware of the personal accountability for the welfare of others in our communal responsibilities. We are expected to develop and maintain this personal awareness of intergenerational responsibility and proper conduct throughout our life cycle (Graveline, 1998). Focus is placed on clarifying an understanding of this awareness process. This includes exploring all four dimensions of the person and identifying areas of strength as well as weakness.

People gain a sense of empowerment as they gain a greater access to themselves, clarifying confusing processes, and unblocking the flow of energy into each domain. The use of traditional healing methods incorporate this concept of positive and negative energy. Everything must begin in the East direction, which symbolizes new beginnings and works towards the West and always goes back to the center after every fourth rotation (Reynolds, 2005). Movement in the sacred circle teaches one the importance of maintaining life balance.

Traditional elders need to be involved in this healing process. Their advice and guidance ensure that this balance is achieved and that teachings are sincere. They may also lead ceremonies such as the purification in the sweat lodge, fasting, and/or the use of traditional medicines (Reynolds, 2005).

The Nature of Problems or Non-adaptive Functioning

When there is imbalance in one dimension this has reciprocal effects on the entire health of a person. People's environment, particularly during childhood, reaffirms these tendencies to be disturbed in later life experiences. During youth one's experiences and learned responses to these experiences develop patterns that can be both productive and self-destructive. These patterns create a mold that shapes our personality. Parents and cultures teach children different standards and values, which sometimes have self-defeating behaviors and negative consequences.

Dysfunction occurs when the self-destructive patterns are repeated, and/or the system remains static. Clients cannot trust their own self- regulation because of repeated use of a solution from an earlier time. It erodes their ability to respond with awareness. Problems often reflect failed efforts to develop healthy patterns and recognize dysfunctional behavior. There are disequilibria in the development of the emotional, mental, physical and spiritual dimensions.

One may begin living in the past, worry about the future, or hold on to illusions that resemble what they might have been if they took a different course in life. This diminishes emotional and conscious awareness and interrupts with the immediacy of experience, which is key to healthy living and growing. As a result of these inadequacies, one is not in full contact or aware of present relationships with others and the

environment. The patient is unable to form clear meaning with moment-by-moment experiencing because of the barriers in contact. One's self-regulatory abilities cannot lead them beyond the repetitive patterns that were developed originally in difficult circumstances. One is inadequate in crisis situations and cannot handle relationships with others. The client is in need of guidance for personal growth because of the breakdown in the self-regulating process.

The Nature of Change, Growth, or Corrective Action

A person is inclined towards growth and will develop as fully as conditions allow. Awareness is the key. One experiences empowerment through the development of awareness in each of the four dimensions.

Change occurs when one aims for self-knowledge, acceptance, and is willing to face challenges that help to develop inadequate characteristics of Self. True growth starts with conscious awareness of what is happening in one's current existence. This includes how one is affected and how they affect others (Yontef & Jacobs, 2000).

"Change is viewed as a process of reconstruction" (Vinson & Griffin, 1999, p.2).

Keewatin theory holds that knowledge and meaning are based on constructs that are formed by each person's perception of relationships with others and the environment. These personal constructs filter as well as influence perceptions. Different individuals will create and develop different ways of responding to reality based on their unique personal constructs. One must learn to interpret and predict to find meaning from events. When one's present constructs are unable to handle conflict situations, reconstruction is necessary. This reconstruction brings competence and growth towards being whole again.

In the growth process one begins to reframe the dysfunctional constructs and derive new meaning with the newly developed ones. The Keewatin therapist observes the process, directs the patient to observe his or her own thoughts and explores alternative ways of thinking. This approach places a high respect on values and respects the client's experiences and beliefs (Yontef & Jacobs, 2000).

Keewatin therapy believes that awareness and human relationships are inseparable. Awareness develops in early childhood through relationships with others that continue throughout life. People regulate relationships by how they experience them and define themselves by how they experience themselves in relations with others. The only Self that exists is the self in relation to others.

The Counselling Experience

Definition of Counselling

Counselling helps clients to explore and re-examine personal constructs. Flexible viable beliefs and actions are co-created through the interaction with the counsellor. The general goals are to develop an awareness and growth towards greater consciousness by bringing about spiritual, physical, emotional and mental balance. Another goal is to facilitate client self-construction of new meanings. This is done in a safe, caring, unbiased environment and strong, cooperative working relationship (Vance, 1993).

Counselling is meeting the client halfway, respecting worldview regardless of culture, and entering into a genuine, honest, trusting relationship. It is the dialogue process that introduces the client to constructs that are new to the client's system (Vance, 1993). Counselling is viewed as a collaborative process in which each individual

deserves the respect and the right to have equal power in the working relationship (Sands, 1998).

Counselling outcomes

How success is defined

When one reaches equilibrium or balance in the four dimensions success is achieved. A sense of wholeness is achieved and contact with others and the environment is aligned. One becomes clear about one's needs, wishes, goals and values and makes significant progress towards them in the counselling process. Knowledge and meaning are based on personal meaning that is formed in life experiences. When an individual has gained the awareness and understanding and gains a sense of balance in each of the four dimensions of the wheel they have been successful (Vinson & Griffin, 1999). The client has moved forward and achieved the goals that were set early on in the counselling process.

How success is evaluated

When a client finds the courage to seek help they have an expectation that some kind of an event will occur. These events are called rituals or interventions. There is a common element that all healing processes control these events. The client's acceptance of these rituals, or methods of intervention, as relevant and healing is an important factor in predicting their success (Daya, 2001).

A cooperative relationship offers a continuous, consistent source of feedback throughout therapy. Other sources of evaluative data are available through informal methods. Informal assessment procedures have a major role to play in examining both outcome and process factors in the counselling process. These include developing clear

goals at the beginning of therapy and simply monitoring progress in achieving these goals. Client learning is recorded on Goal Attainment Scales, learning outcomes are clarified by examining counselling activities, and checklists can be used to document both counselling process and outcome (Hiebert, 1996). Other suggestions for evaluation are teaching clients to self- monitor progress through skills such as thought listing, cognitive mapping, and mind mapping. Keewatin therapy includes the four dimensions, which involves the client starting with a circle labelled physical, mental, spiritual and emotional. Patterns may develop that provide identification of areas that need a healing focus.

Client checklists, homework logs and self-monitoring grids can be useful ways to monitor progress in the intervention plan. Having clients record this information encourages them to take their work seriously and motivates them to engage in the intervention plan to a greater degree (Hiebert, 1996).

Counselling process

Counsellor-client relationship

In Keewatin therapy the counsellor and client develop a very close working relationship. It is based on trust and honesty. It is through this relationship that meaning is co-created and developed to meet the needs of the client. Both counsellor and client honour differences in worldviews, value equality, recognize the influence of the social context on life and are prepared to enhance the conditions that promote growth and change.

Keewatin therapy involves a therapeutic dialogic relationship. It has a highly developed method that allows the counsellor and client experience each other in the

therapeutic relationship. It assumes that reality is formed in this relationship (Yontef & Jacobs, 2000).

This relationship requires the use of three principles. First, the counsellor practices empathy and inclusion, which involves putting him or herself in to the experience of the client. The counsellor imagines the existence of the other, experiences the sensation as if it was part of his or her own body and at the same time, maintains a sense of self. It is through this imagining of the client's experience that the counsellor confirms the potential of the client. Second, the counsellor uses discreet disclosure to show authenticity and genuiness. The counsellor is careful not to overload the client with inappropriate information. Third, the counsellor shows tremendous commitment to the dialogue in the relationship. The counsellor makes use of strategies such as Narrative therapy and allows the client to tell their story. The counsellor plays a variety of roles to meet the different needs of each client and each moment of counselling. One of the main roles is that of facilitator. This involves being direct at times and indirect at others. Sometimes the counsellor assumes a "not-knowing" position by listening, and asking questions that enable the client to clarify or redirect the conversation. During therapy the counsellor shows an appreciation of client's worldviews, personal histories, and cultural origins to gain respect and trust in the working alliance (Vance, 1993).

Counsellors work to activate client resources and facilitate the movement through each of the dimensions in the holistic model in order to achieve a sense of balance. Counsellors guide clients in their struggles to understand themselves and find meaning. Counsellors help clients create healthier personal constructs and problem solving skills (Vance, 1993).

The healing potential of therapy rests firmly upon the ability of the therapist and client together to do three things. First, they need to understand the world and relationships, as they exist. Second, they need to have a vision of how things might be other than they are. Third, they have to have an understanding of how these gaps may be bridged between the present situation and desired alternatives (Hinksman, 2001).

Counsellors need to prepare themselves for all situations that may arise in therapy. They need to continually enhance their competence by developing knowledge, skills and values. This requires the role of student and demands a sense of humility and reflectiveness.

Counsellors must also be open to feedback from, not only clients, but from their communities. This requires being open to a communal versus individual approach (McCormick & Amundson, 1997). This allows the counsellor to provide the client with support, not only in the therapeutic relationship, but develop a network of support in the community as well. This type of support building involves an active relationship and active methods in which counsellors act as strong advocates in the community.

In a more directive approach, counsellors take on the role of educator and teacher. They teach the client new skills for problem solving, self-reflection that promotes healthy awareness. Patients are shown how they tend to block their own awareness and functioning and are taught the necessary tools for independent, self- restructuring to enhance meaningful experiences in life. In addition to providing this support, counsellors help clients create healthier personal constructs that promote the process of lifelong learning (Vinson & Griffin, 1999).

Necessary and sufficient conditions for change

Counsellor competency

From a Keewatin counsellor's point of view the ability to counsel assumes four basic competencies. If we envision a braid made up of four strands and that each strand is woven into three threads; values, knowledge and skills, we can begin to understand the framework involved in becoming culturally competent counsellors (Sue & Arrendondo, 1992). The first, and primary strand is Awareness. The counsellor needs to reflect on his/her own identity through self- awareness exercises. The second strand is Understanding. The counsellor seeks empathizes and understands the diverse worldviews of their clients. The third strand is Intervention. The counsellor evaluates actions, approaches, techniques, strategies and models that can be adapted to meet the diverse needs of our clients. The fourth strand is Organization of the big picture: Counsellors reflect and assess organizational and systemic dynamics of the counselling profession and bring forth ethical implications of their practices (Sue & Arrendondo, 1992).

Climate

The therapeutic setting, climate or atmosphere is crucial for successful therapy. The counsellor is responsible for setting this climate through expressions of genuine empathy. Clients need to feel safe before disclosing their personal, vulnerable issues. The counsellor promotes this feeling of security by showing interest in providing meaningful dialogue. This is done by asking questions, listening, observing summarizing and paraphrasing in natural progression.

Power

Counsellors must be aware of the different levels, forms and impacts of power. The process of developing empowerment involves this recognition and exemplifies the cultural context in which it is so deeply embedded. Counsellors need understand and know about the cyclical nature of power, acculturative stress and the different dynamics of power that are within minority and ethnic development (Ramsey, 1997). Counsellors should be able to define the power that exists within the client's cultural context. The aim is to empower the client and reduce the power of the problem over them. This process requires the intertwining of self-determination and empowerment. Assertiveness training must be culturally sensitive as it may have different meaning across cultures. Emphasis must be put on power to produce positive change rather than power to dominate (Russo & Vaz, 2001). Keewatin therapy is also humanistic in that its central focus is to place personal power back into the hands of the client (Hill, 1996).

The use of the Keewatin model encourages the application of the Twelve Principles of Indian Philosophy to all cultures, including those where power differences may be evident. The model teaches equality and demonstrates how power differences may only be different positions within the whole. Counsellors are encouraged to use racial identity models that promote valuing the individual and the environment (MacDougall & Arthur, 2001)

Choice/Volition

People have the choice of changing their dysfunctional behaviors and need to be shown how to do so. After the counsellor gains an understanding of the client's

worldview a plan is co-created with the client. This process of goal setting, choosing specific forms and methods of therapy to suit the needs of the client, provides a sense of empowerment and direction. There is a significant, shared feeling of momentum towards positive change when clients choose to participate in a cooperative manner. The expression, "what you put into it is what you get out of it" sums this concept up nicely.

Client motivation

When faced with a truly receptive counsellor a client is able to trust and share their story in a healthy and safe manner. Therefore counsellors need to ensure that there is focus on creating a comfortable, safe climate early on in therapy. Clients also need to be actively involved in planning therapy sessions. Empowering clients by promoting responsibility and self- help frameworks is crucial in creating motivation. A sense of vision is necessary for the client to move forward in a positive way.

Influencing Client Change

Counsellors are encouraged to use a common factors approach in Keewatin therapy to produce and influence change, especially with culturally different clients. Frank emphasized the importance of considering factors that are universal, relevant, and common to all psychological and spiritual healing encounters (Daya, 2001). The therapeutic relationship, a shared worldview between client and counsellor, client expectations for successful outcome and interventions that are co-created and planned are the most relevant to the multicultural counselling technique of therapy (Daya, 2001).

Mainstream counselling tends to focus on thinking, feeling or behavior but leaves out the spiritual and physical. This is an important factor in Keewatin therapy. Each of

the dimensions must be examined to achieve balance. The conventional medical world is on the brink of recognizing the link between energy or spiritual dysfunction and illness. It is inevitable that it will someday cross the divide that exists between body and spirit (Myss, 1996). This is where the medicine wheel approach comes in. The belief that our spiritual dimension has direct influence on our physical, emotional and mental dimensions is addressed in counselling. For example, if one is spiritually confused it affects our physical dimensions in the form of stress, a common issue brought forward is one related to identity (Reynolds, 2005). We are more familiar with the physical and mental dimensions, but need to be in touch, on a more continual basis with our spiritual and emotional selves and how these are interconnected (Reynolds, 2005).

The interconnection and interdependence of one dimension teaches choice, and self- discipline in the use of volition. The interwoven strands of significance, power, virtue and competence keep the focus on the healing process in each of the four dimensions. Keewatin theory encourages counsellors to expand on backgrounds of western theories based on this simple, traditional model.

Individual Therapy

Awareness and self-organization are the main tools for striking a balance in each of the four dimensions. Client contact is explored by sharing personal stories and the therapist introduces the client to strategies that involve developing the concept of self-regulation. By getting in touch with the here and now, moment to moment client and counsellor work, through conscious awareness, to identify patterns or constructs that are dysfunctional. This process includes exploration of the conscious and unconscious,

dreams, experiences and relationships. Through the processes of meaning making, reality construction or reconstruction, and interpersonal negotiation self-organization is achieved. The counsellor collaborates and guides the client in activities such as reconstruing, reframing, revising, and reinterpreting the perspectives of the client in each of the four dimensions (Vinson & Griffin, 1999).

The Keewatin therapist believes that individuals create their own circumstances as a result of deliberate actions and decisions they make. Patterns are formed and are the roots of meaning for the individual. This personal meaning must be explored to identify the roots of problems the individual is experiencing. Once these patterns are identified the counsellor can assist in the process of self-organization bringing new, altered meaning into the client's life. Through the expansion of reflection, critical thinking and self-knowledge, clients feel empowered and confident.

After exploring the physical dimension lifestyle, clients are assisted in shifting from external to internal processes. It is here that counsellors, as well as clients, gain access into emotional, spiritual, mental systems of the client. Changes in thinking, acting, feeling and believing begin with changes in these internal processes of the client. The counsellor's challenge is to help promote this type of awareness.

From the beginning, the client and counsellor work cooperatively to identify and clarify the needs of the client. Therapy begins at a pace that is comfortable for the client. Some may want to begin sharing directly about their problems while others may begin with their life stories. The therapist helps the client become aware of feelings, and needs that are emerging out of the stories. This is done by paraphrasing and offering reflective statements or questions and by suggesting goals for developing awareness.

Focusing

Through the process of storytelling, a client may fail to connect feelings with events. The therapist might ask to go back over the story and focus on recognizing and verbalizing the feelings associated with specific stages of the story. This is repeated until the client can revisit the experience without the negative emotions associated with the experience. During this time the therapist also makes an assessment of the strengths and weaknesses of the patient, including all four dimensions in the process (Yontef & Jacobs, 2000). The therapist and patient then review the assessment and make plans for the direction of treatment. The patient is part of this planning process. They set goals and choose appropriate strategies and methods that meet the needs of the client.

Dialogic Relationship

The therapist is able to put himself or herself into the experience of the patient and, at the same time, maintain a sense of self. Self-disclosure is provided by the therapist, when necessary, to maintain genuine authenticity with the client. The therapist remains open throughout therapy and is committed to the dialogue. This means that the therapist is open to change as well as the patient (Yontef & Jacobs, 2000).

Group Therapy

Clients are taught to identify strengths and weaknesses in each of the four domains and choose appropriate strategies to reach a balance. In group therapy clients work at designing their own medicine wheels and sharing strategies that are useful to them. Elders and family members are encouraged to participate in the sessions.

Brief Therapy

Individuals with specific problems that are easily identified by both client and therapist are involved in Brief therapy. This type of therapy is used to improve the client's condition in just a few sessions. The client may only need to focus on one of the dimensions to achieve balance. A self-help form is filled out, identifying the strengths as well as the weaknesses in each of the four dimensions. A plan is drawn, goals are set and homework assignments are made.

Role Play

The client is asked to experiment with putting their feelings and thoughts into action. This strategy is used to reinforce actions and behaviors that need modification. The client has the opportunity to practice in therapy before applying the skills in real life situations. It is used to increase awareness of feelings.

Creative expression is also encouraged in Keewatin therapy, especially with children. It is helpful where there is difficulty expressing feelings or thoughts in words. This includes journal writing, meditation, play therapy, art and movement.

Modeling

During specific points of therapy the therapist may need to model specific actions or behaviors to help clarify meaning for the client. Involving elders in sessions with clients also provides mentorship and modeling.

Use of Dreams, Imagery

Visualizing the experience sometimes helps to promote awareness more effectively than acting it out. There are many possible images that can be drawn from dreams, guided fantasy and imagery. In traditional teachings dreams are taken very

seriously and one is encouraged to investigate the meaning of dreams. Traditional elders have interpreted dreams for individuals, but often encourage one to make this personal discovery, as it is directly related to the events occurring in one's personal life (Reynolds, 2005)

Homework

During therapy clients are given homework that involves strategies to develop balance. These assignments are based on specific client needs. Examples could be journal entries based on reactions of a partner, mending differences by apologizing or asking for forgiveness and watching an educational video on communication skills. These assignments provide a sense of independence and place responsibility on the patient for progress in therapy. Patients provide feedback in follow up sessions on the outcome of their assignments and continue on with further goals or adapt existing goals that may not have been successful.

Traditional healing

Clients are given the opportunity to participate in traditional healing. Sweat lodges provide purification and spiritual, mental, physical and emotional healing while Vision Quests provide opportunities for direction and reflection. The discovery of a personal spirit guide is very important for developing identity, especially for adolescents, as this is a confusing time (Reynolds, 2005). More simple practices include smudging with sweetgrass or sage to cleanse one's mind and may be done whenever one feels necessary.

Communal Approach

As well as providing an individual approach in counselling, Keewatin therapy encourages the use of the communal approach. Family and community members are encouraged to participate in defining their roles to help the client reach goals in therapy. This support is significant for clients from minority groups who live in small, rural communities.

Throughout Keewatin therapy each of these general principles of therapy are adapted to meet the diverse needs for each client.

Conclusion

Values and meaning are often ignored in mainstream counselling or, if they are included, they are only viewed in terms of beliefs. Values are very significant in Keewatin theory because they are a collective source of meaning (McCormick & Amundson, 1997). The spiritual, developmental and environmental contexts have been explained throughout the process of Keewatin therapy in the above sections.

Who is most likely to benefit from this approach and why

Keewatin therapy is more of a process theory and can be used effectively with any patient that the therapist understands and feels comfortable with. The therapist is not limited to a set amount of techniques but is trained to be flexible with the goal of meeting the needs of each client. Principles must always be adapted in each situation. Therapy will fail if the client is forced to conform to the systems that do not offer this flexibility. The concept of interdependence and balance is open to any individual from any culture. This universal characteristic of Keewatin therapy provides access for anyone wishing to try it.

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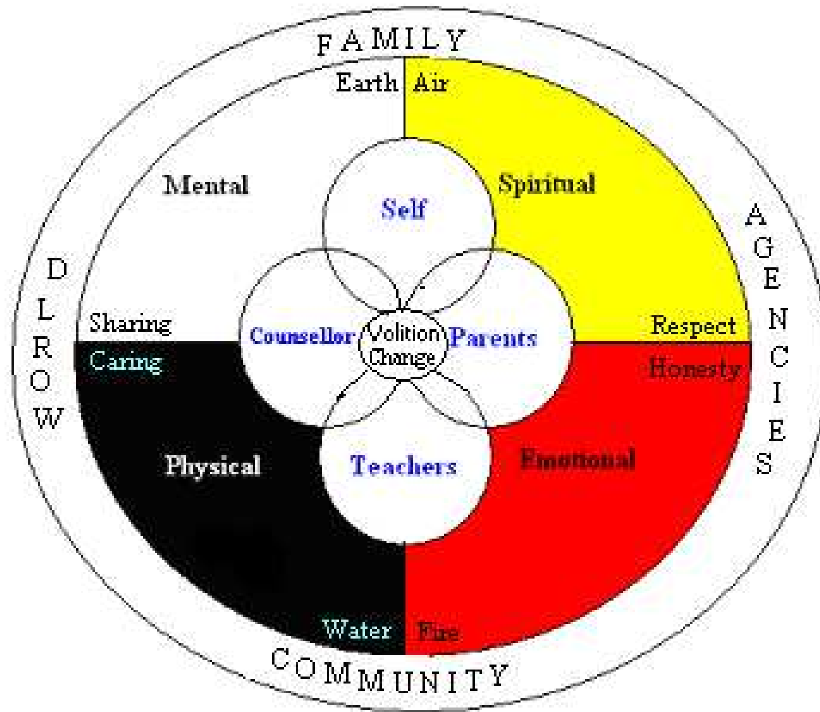
APPENDIX A

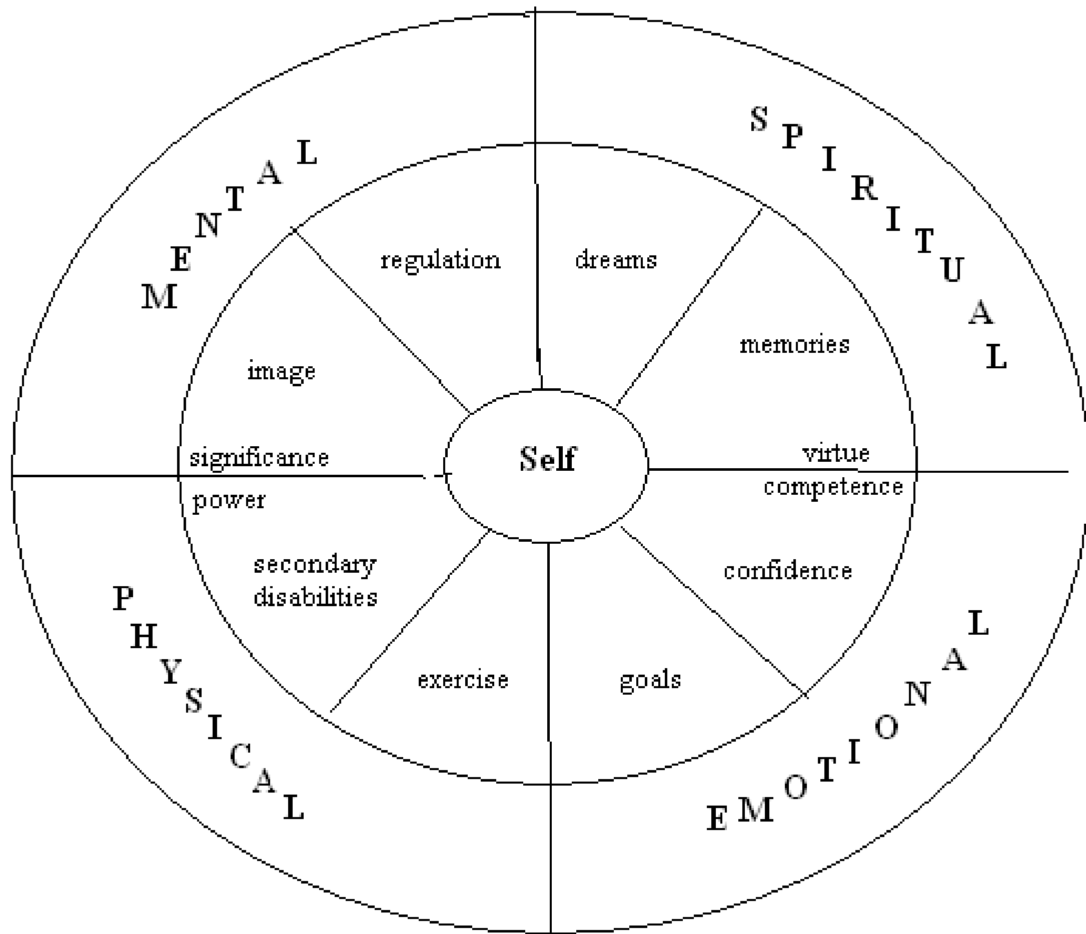
Keewatin Model Figures

Figure 1. The Keewatin Model.



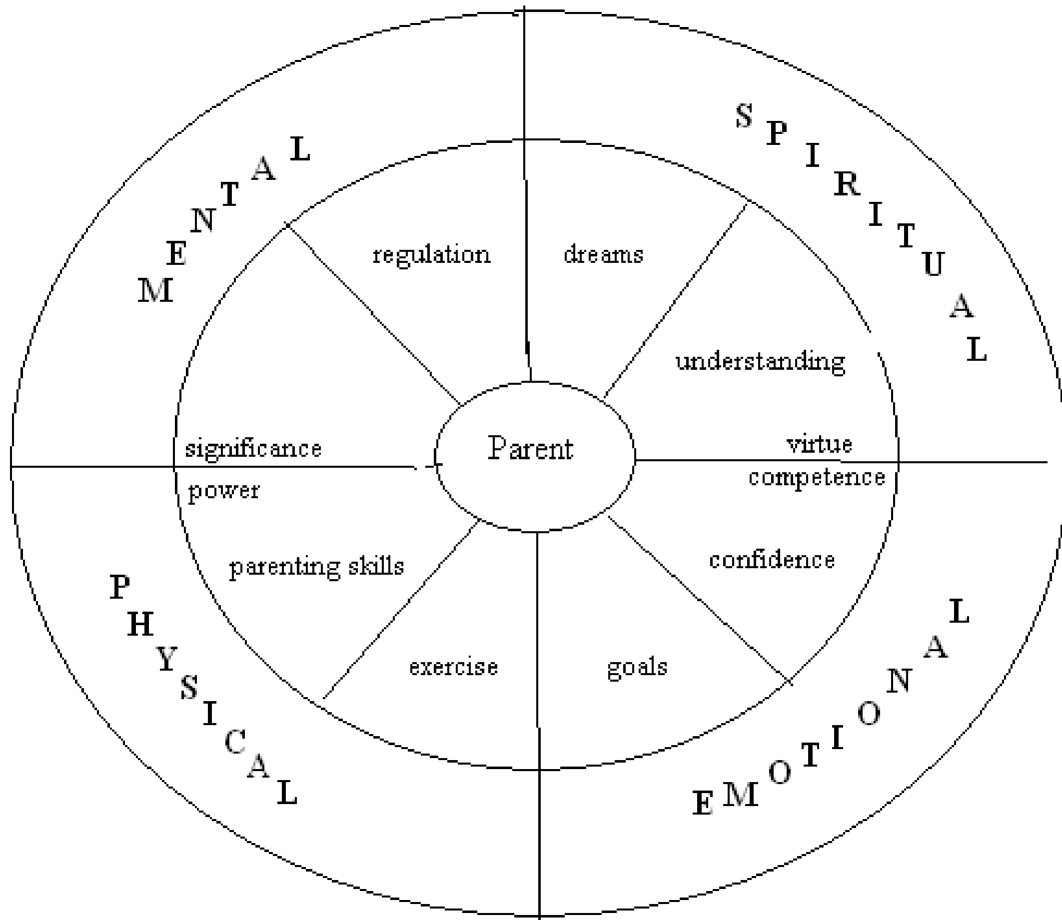
The Keewatin model integrates the holistic approach of First Nations with an eclectic mix of Western theories. All dimensions are interconnected so thoughts actions and behaviors in one dimension have reciprocal influences in the others. Sets of four are used to represent each dimension. Examples are the four directions, four colors of the human race, four dimensions, and, in this case, include four people involved in the healing process.

Figure 2. The Self in the Keewatin Model.



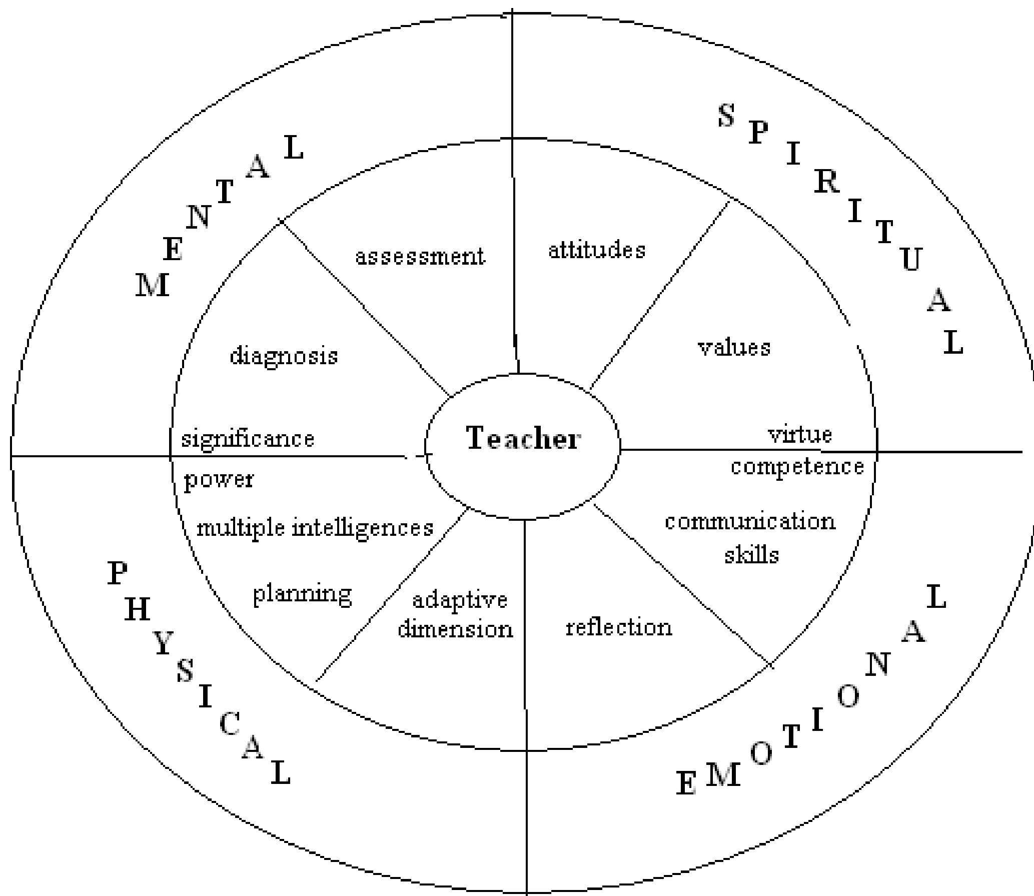
In the definition of one's identity each of the dimensions are explored in efforts to find answers to "Who am I?" This is a fundamental question, especially for adolescents. Keewatin theory adopts the First Nations belief that one has certain rights, responsibilities and obligations. The importance lies in the discovery and expression of these rights.

Figure 3. The Parent in the Keewatin Model.



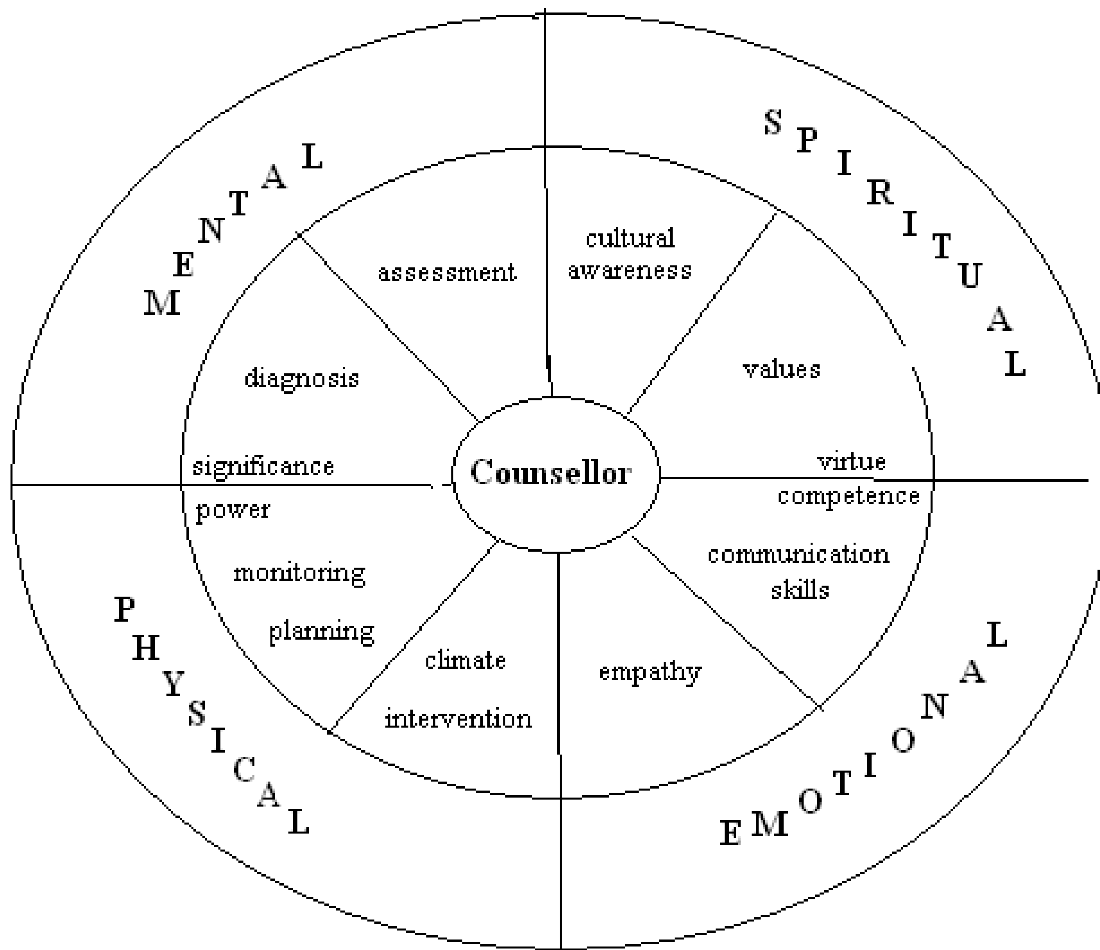
Parents/guardians are actively involved in the process of counselling adolescents with FASD. Developing understanding and skills for working effectively with their teenager are crucial in reaching goals in counselling. The needs of the teen as well as the parent(s) are recognized and addressed.

Figure 4. The Teacher in the Keewatin Model.



Teachers of adolescents with FASD need to receive professional development in diagnosis, assessment and evaluation. Ongoing assessment is necessary to ensure that students receive consistent support in the school setting. Providing a safe learning environment and using specific teaching strategies to meet the individual needs of FASD students is key. Support from administration and resource room teachers is helpful in successful program delivery for student lifelong learning.

Figure 5. The Counsellor in the Keewatin Model.



Counsellors are encouraged to incorporate the four dimensions into the counselling process. Understanding the interconnectedness of each dimension and providing an approach which includes cultural sensitivity and awareness is key. Professional development in knowledge, skills and awareness in terms of First Nations beliefs and the needs of each FASD adolescent, will provide the counsellor with tools for successful intervention.

APPENDIX B

A Toolkit for Parents, Teachers and Counsellors

Of

Adolescents with Fetal Alcohol Spectrum Disorder

By

Marie Mihalicz

TOOLKIT

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General Information

Children diagnosed with FASD exhibit a very complex array of emotional, social, behavioral and cognitive problems, which is not a fault of their own (Harpur, 2001). When the mother drinks during pregnancy, the alcohol acts as a teratogen, and the developing fetal neurons are altered which in turn causes behavioural changes in the child (Sampson, et al., 1997).

Teenagers diagnosed with FASD grow into adults with FASD. There is no cure and the damage is irreversible. Therefore, it is crucial for parents, teachers and counsellors to be knowledgeable about various strategies for clients with this chronic illness.

In FAS and FAE, the primary birth defect involves central nervous system (CNS) damage that occurs while the baby is still developing in the womb (Streissguth & O'Malley, 1997). When this prenatal brain damage is not recognized and behavioral problems from it are not understood, the growing child is at risk of developing additional "secondary disabilities" that can be very crippling (Streissguth & O'Malley, 1997). Understanding that there are secondary disabilities and recognizing the linkages between the secondary and primary disabilities are important first steps in effective treatment. A critical key in this process is finding information about prenatal alcohol exposure and possible maternal alcohol abuse at the intake interview for any mental health assessment or treatment (Streissguth & O'Malley, 1997).

One of the first steps caregivers need to take is to educate teenage clients about their condition in order to promote understanding and acceptance of their disorder. Effective systems of social support are also important for teenage clients and their

families (Sarafino, 2002). It is during these years that families are faced with the recognition that their child is not following a regular pattern of development and this has many adverse affects. Teens diagnosed with FASD need integrated support. Everyone in the teen's life has the potential to play an important role in the development of compensatory strategies (Harpur, 2001).

Table 2: Secondary disabilities associated with FASD

A – Problem B - % of all cases of FASD

A	B
Mental health problems	90
Dependent living	80
Employment problems	80
Disruptive school experience	60
Trouble with law	60
Confinement	50
Inappropriate sexual behaviour	50
Alcohol or drug problems	30

Diagnosis

There must be an understanding that there is often a dual diagnosis in FASD patients and the combinations of mental health problems with developmental disabilities can be quite complex. The fact that there are so many complex issues and combinations

provides a tremendous challenge for parents, counsellors and teachers to identify the specific problems.

Teenagers diagnosed with FASD may experience stress from both academic and personal difficulties born from secondary disabilities. Many of these teenagers know they have difficulties in learning and become very anxious when new learning is to take place (Harpur, 2001). What can be most challenging is the fact that most teens diagnosed with FASD experience problems learning from past behavior; they lack planning and display logic that is faulty; they are impulsive and disorganized; and they have storage/retrieval memory problems (Harpur, 2001).

Behavior

Teenagers diagnosed with FASD often experience problems learning from their past behaviors. Their performance is very inconsistent. They appear normal and may speak about things as though they understand, but when asked to explain concepts, they will fail. Malbin (1999) stated that an 18-year-old diagnosed with FASD would respond socially and emotionally at the level of a seven year old (although this would vary with the severity of the disorder). When caregivers provide choices or consequences as part of behavior therapy/modification, it is important to keep this in mind. Behavioral therapy is recommended to help develop social skills. This includes modelling positive behavior and involves four conditions: a) attention, b) retention, c) motor reproduction and d) motivation (Boeree, 1997).

Self-control therapy is helpful to develop self-regulation to improve negative habits. Strategies recommended are behavioral charts, environmental planning and self-contracts (Boeree, 1997).

When introducing new skills to develop self-control, the skills must be broken down into small steps, using examples that are familiar to the teenager. It is also important to have the teen explain what is learned and incorporate awareness of emotions, feelings or reactions to certain challenges (Streissguth, 1997).

Physical Environment

Teens with attention problems often need minor adjustments in their physical environment. Caregivers should include decreased audio and visual distractions and use clear, concise, and concrete directions (Streissguth & O'Malley, 1997). Focussing on memory tasks with the use of repetition is key in strengthening abilities for encoding (Harpur, 2001). A daily planner is recommended to record information for key concepts, to set priorities, schedule tasks and manage emotions. Parents are encouraged to set up a system for entering information into the planner. This helps the development of time management, organization and life planning (Harpur, 2001).

FASD teenagers have tremendous difficulty coping with change. They need to have a structured, predictable routine and have the opportunity to practice coping skills for adapting to transitions in order f to develop independent lifestyles (Harpur, 2001).

Caregivers need to be aware of the difference between structure and control. These teenagers will not respond well to an environment that is over-controlling. It is very important to be educated about the development of this type healthy environment.

Social Issues

Teenagers are especially sensitive about issues affecting body image and social acceptance. Teenagers diagnosed with FASD present an even more complex picture because of this developmental life stage and their typical adolescent behavior can mask

more serious developmental difficulties (Harpur, 2001). Psychosocial interventions for people with chronic conditions such as FASD include a variety of adjustment problems (Sarafino, 2002).

Career Issues

Although teens diagnosed with FASD are not socially mature, they are maturing physically. They are reaching an age where planning for either independent or semi-independent living is necessary. Career counselling for job placement, modelling communication skills and work plans can be very helpful. An aide to help the teen learn about finances such as time and money management, and budgeting is essential in their preparations for future independence (Harpur, 2001). Skill training for job interviews and constructing resumes is also recommended.

Spiritual Factors

Another dimension that is used in coping and stress management involves spirituality. Research indicates a strong spiritual belief system correlates well with health and well being in general (Cormier & Nurius, 2003). Spiritual beliefs and activities such as prayer, meditation, participation in services, rituals or traditions, are examples of spirituality as a coping mechanism. Counsellors must be careful how the term spirituality is interpreted and ensure that focus remains on the development of positive values. Persons with chronic conditions such as FASD need to maintain a positive outlook which means infusing ordinary events with meaning, stimulating positive reframing and goal-directed problem-focused coping; all of which are important stress management ingredients (Cormier & Nurius, 2003).

Research and Education

Continued research and education is vital in providing ongoing and successful diagnosis and treatment for FASD patients. Parents and families with children diagnosed FASD need to be given current, ongoing information.

Olesen and Williams (2003) found the following:

Streissguth (1996) discusses eight protective factors, which have been identified through recent research, that help reduce the likelihood of secondary disabilities. They are:

1. For over seventy-two percent of life, children should live in a stable and nurturing home.
2. Be diagnosed before the age of six.
3. Never have experienced violence against oneself.
4. Stay in each living situation for an average of 2.8 years.
5. From ages eight through twelve experience a good quality home.
6. Has applied and been eligible for Department of Developmental Disabilities services.
7. Has a diagnosis of FAS rather than FAE.

Has had basic needs met for at least thirteen percent of their life.

Olesen and Williams (2003) suggest that public policy makers address these factors by providing more funding to support families with FASD children.

When children who are diagnosed with FASD reach school age it is crucial for parents to support teachers by providing good quality homes. Provincial departments in education need to provide detailed, specific training and resources for educators (Olesen & Williams, 2003).

Health

Health agencies are responsible for educating parents about FASD, facilitating diagnosis and following up with appropriate decisions for treatment. "To be successful with treatments and programs related to the home the best practices of programming, implementation and delivery need to be considered" (Health Canada, 1996). Primary prevention includes informing the public about prevention of FASD. Health personnel need to supply brochures and educate mothers-to be about the dangers of drinking during pregnancy. Secondary prevention provides screening for people at risk, early intervention programs and services for women. Tertiary prevention aims at lessening the impact of cognitive, social and behavioral of FAS/FAE. All prevention needs to be family centred, comprehensive and culturally sensitive (Olesen & Williams, 2003). Drug and alcohol education is important and referral for treatment may be necessary (Harpur, 2001).

Justice

"In Canada, twenty-five to fifty percent of the prison population have been affected by FASD brain damage" (Olesen & Williams, 2003 p.252). The number of people with FASD is not decreasing. This means that, like the health, education and

social services systems, the legal system will be facing an increase of issues in the coming years. Family and criminal courts need to be aware of the effects of FASD. Judges and legal system professionals need to be educated about FASD in order to give meaningful sentences. Sentencing circles have been set up in some First Nations Communities to provide programs that offer a "wrap around" approach that addresses awareness, education, identification, diagnosis, response and prevention. This type of restorative justice is very useful for people with FASD as it provides meaningful, concrete solutions. The wrap around project is a comprehensive system that addresses the special needs of people with FASD. Education, health, social services and justice agencies work together to provide ongoing, successful services that support transitional stages in the lives of FASD families. (FYI - Diane Fast has produced some good information about FASD and the justice system – she literally wrote the book on it)

Community Programs

According to John Conway (2003), a devoted policy and advocate worker in Saskatchewan mental health, none of the information about funding is new to our decision makers in governments in the past twenty years. He reports that less than five percent of the budget goes into mental health care and it has decreased each year because of higher costs in acute care.

He suggests the development of community programs in schools, churches, workplaces and the criminal justice system that help with early diagnosis. Health professionals are needed to design and implement programs that will support others who provide the services (Conway, 2003).

Conclusion

Ideally, intervention programs to help individuals with chronic health problems involve interdisciplinary teams of professionals such as doctors, counsellors, and social workers who work in an integrated manner towards overall goals of rehabilitation (Sarafino, 2002). Although there is no cure for FASD, it is important for counsellors to focus on the present situations affecting clients and work towards every day solutions. These children will experience greater success with early, consistent intervention. The advocacy of prevention and early diagnosis is crucial. Parental support is also very important. Society tends to judge others harshly in regards to FAS, and many parents are reluctant to seek help as a result. If proper supports through education, health and other agencies, parents are more likely to respond to the help that services have to offer.

Each teenager has individual strengths and weaknesses that need to be observed, recorded and addressed. Many teenagers diagnosed with FASD display exceptional abilities in specific areas and it is important to capitalize on these strengths in the development of weaker areas (Harpur, 2001). The work that counsellors do with these specific clients need to be repeated and reinforced by parents, educators and other support workers. New concepts for treatment need to be explored and practiced in the community.

Of utmost importance is cooperation and collaboration of agencies involved with the teen and family. This is a major challenge for some communities. Services tend to overlap in certain areas and in working with recent information, such as FASD, much tends to be overlooked and ignored.

Communities depend on the collaboration of external agencies to access intervention services. For example, physical and mental health professionals, social services, addictions, community living and education services all provide elements of program delivery. In some cases all efforts of agencies have been made to help families with FASD, but with more sever cases, the community can only handle so much. Government agencies sometimes depend too much on the community services and referrals for specialized care, such as community living placements, are painfully slow. A liaison is needed to clarify the roles and services of various agencies in the work with FASD programming and intervention. Development of a comprehensive model that outlines protocol and integration of intervention strategies linked with community services would provide meaningful, organized direction for these agencies. It would also quicken services for families in rural communities who need specialized services that are only available in urban centers.

All caregivers need to provide consistent, individual attention that offers a structured, caring environment for teenagers diagnosed with which fosters hope for a successful and meaningful future.

Parents

Understanding your FASD child

You have probably been very concerned about your son or daughter for some time. Now you may know or suspect that his or her school difficulties and behavioral problems are related to FASD. You may have heard about other terms such as Attention Deficit Hyperactive Disorder (ADHD) and possibly to Learning Disabilities (LD). Your main questions at this point may be “What can I do to help?”, “What will the future bring?”, and “What do I do now?”.

This Toolkit is designed to help you better understand your teenager and help you to be aware of resources that are available for you. It is very important to note that each person with FASD is different and that treatment has to be designed on an individual basis. This kit is a guide that provides you with information. You are encouraged to work with other professionals to help in planning the necessary help your son or daughter needs.

Parents of teens with Fetal Alcohol Spectrum Disorders (FASD) sometimes feel like they are living with an explosive bundle of emotions that may go off at any moment. Sometimes it is hard to predict their behavior, and even more difficult to understand it. Some describe the teen years as a return to the “terrible twos” and for parents of teens diagnosed with FASD, the challenges are even greater (Streissguth, 1997).

This is where the development of knowledge and strategies come in. It is critical to understand the neurological aspects of FASD in order to implement effective strategies.

Because of the nature of FASD and the brain damage caused by prenatal exposure to alcohol, many affected individuals have such difficulty controlling their impulses and have such poor judgment, that most will require close supervision or at least frequent monitoring well past their teen years. Having come to a reasonable understanding of the behaviors observed in teens diagnosed with FASD, parents must then come to terms with the possibility of facing a period of never-ending adolescence. The "terrible teens" could last into the "terrible twenties." That prospect would strike terror in the heart of any parent. However parents of teens diagnosed with FASD have discovered that sometime before the age of 30 these young adult children seem to mellow out emotionally and socially. Their cognitive abilities may not improve with age, but their emotional behavior and social skills appear to finally become tolerable and this allows them to engage in social and employment relationships with limited success. Their ultimate success will be fragile and will depend on continued guidance and close monitoring that might require a one-on-one mentor or job coach acting as an "external brain" in social situations. An "external brain" is a concept coined first by FASD expert Sterling Clarren and later made popular by FASD speaker Susan Doctor (Kellerman, 2004).

Because of the many types of possible learning and or emotional problems your child or adolescent may be facing, it is best that a team of professionals pinpoint the cause. This may take place in a doctor's office or clinic, educational facility, or mental health clinic. Your child's doctor may participate directly, request the evaluations, or receive results from the team, and help you to understand what was discovered in testing procedures.

To understand your teenager, you have to examine difficulties from every viewpoint to identify how they affect every aspect of life. This is not limited to school. It involves your child's relationships with peers and family. Through the use of this Toolkit you will become more knowledgeable so that you will be able to better understand your teenager and be able to develop successful experiences for him/her.

You are encouraged to explore the activities provided for the teachers and counsellors. This will help to develop your understanding of holistic approaches and plan to help your child using a holistic Wellness model that addresses all his/her needs.

Problems Specific to Adolescents with FAS/FAE

Adolescents with FAS/FAE:

Jan Lutke is a foster and adoptive parent of eight children with FAS/FAE. She lists these common difficulties for adolescents:

- Are very easily influenced, subject to peer manipulation and exploitation
- Are subject to sexual exploitation, both as victim and victimizer
- Lack reciprocal friendships which often leads them to be accepted socially by teens at risk, which leads them to further victimization and manipulation
- Have grandiose expectations. Talk about these aspirations may be very convincing to adults: such as buying a car, going to university or living independently
- Have weak social skills which cause difficulties in their acceptance as adults
- Are often depressed
- Have a lack of compliance in following the rules of society, school or home. This can lead to further frustration on the part of teachers, parents and other caregivers. It often leads to being expelled from school, facing shoplifting charges, etc.
- Experience frequent outbursts of anger, insistence in “borrowing” others possessions and have an apparent selfish behavior. For example, coming home when they want, turning up music loudly. This can make things very difficult for the family.

- Have their lack of comprehension skills overlooked because of their ability to talk so well "Asking a child with FAS/FAE to repeat back instructions does not ensure compliance or understanding" (Jan Lutke, 1993).

Support systems

Setting up an integrated support system ensures that you will have professional help at your fingertips. If you are new to a northern SK community, be sure to take the time to ask about resource person in your community who can help to provide the holistic support you need- for the long haul. A list is provided here as an example:

- Health District Services: Clinic staff, doctors, nurses, mental health, addictions, FAS/FAE education workers, social services

- School division services: teachers, administrators, division office staff, school counsellors, resource room teachers, student support staff, sports coaches

- Community Access Programs: parenting classes, meetings

- Spiritual leaders: pastors, elders

Learning Disabilities

Learning Disabilities (LD) and Attention Deficit Hyperactivity Disorder (ADHD) are disabilities that impact on all aspects of life. For most children with LD, the disabilities will last a lifetime, whereas up to 50 percent of ADHD children will be so afflicted.

With the right help, most LD children overcome or learn to compensate for the problems. They will progress in school and strive toward reaching their potential. There will be many programs available to them throughout school and after. But without the necessary help, they will fall behind and become increasingly unavailable for learning.

With the appropriate help, ADHD teens can function without hyperactivity, distractibility, or impulsivity. They can develop confidence and a feeling of control and success. Without help, your teen will continue to struggle and your family will be less successful.

Your role is extremely important. You must be informed. You must be an advocate, that is, active in seeking the recognition and help your child needs. You must use your knowledge to maximize growth for your son or daughter and for your family. It is not an easy task, however, no one else is better equipped or more motivated than you. It is a job that must be done!

It is best to plan only one year at a time. If you try to do too much, you may over-predict your child's progress and frustrate your child, or under-predict and fail to

challenge him or her. With your help, your son or daughter will learn to succeed with skills for coping with disabilities and will be a happy, healthy person.

FAST Track

A program named FAST Track has been successful in helping families with children who have conduct disorders. It is a community-based program that is designed to promote competence in the family, child, and school in a coordinated and integrated network (Frick, 2001). One of the most important components of this program is the Parent Management Training. Parents of teenagers diagnosed with FASD would benefit from this type of program, as this would be an opportunity to learn new strategies such as problem solving skills, anger management and they would have the support of school teachers and counsellors to encourage them.

Teacher

Teachers are encouraged to work closely with parents and counsellors in order to provide consistent support for students diagnosed with FASD. This section includes various strategies for teachers. You are also welcome and encouraged to use other resources in the parent and counsellor sections of this kit, depending on the needs of your students and the relevance of the information provided. The following units have been adapted from the Lion's Quest, Skills for Adolescence program.

Unit One: Building Self Confidence and Communication Skills

Objectives of this unit are

- Lesson 1: To identify factors that strengthen self-confidence
- Lesson 2: To practice listening and responding effectively
- Lesson 3: To identify ways to act responsibly
- Lesson 4: To understand the importance of respecting yourself and others
- Lesson 5: To learn and practice steps for making positive decisions

Lesson 1: Strengthening Self Confidence.

1. Brainstorming: Help students identify the characteristics of a self-confident person. Record ideas on the blackboard or flipchart. Some examples include: the person is comfortable in most situations, is assertive but not rude, is fun to be around, not afraid to make mistakes or take risks, etc.
2. Clarify the concept of self-confidence for the students in discussing how people are never confident all of the time.
3. Using the Medicine Wheel and Twelve Principles of Indian Philosophy approach discuss how each dimension affects the other and how improving areas of each dimension helps our self confidence.
4. Discuss the difference between bragging, being rude and the role of respect in self-confidence.

Lesson 2: Effective Listening and Responding Skills.

1. Role-play NON-effective listening skills using volunteers from the class. Have the class observe your behaviors as you respond to the conversation of the students in the role-play. As the student is talking look away, write things down, doing things that are distracting, interrupting, always agreeing or giving advice in order to avoid the topic.
2. Students practice effective listening skills that include eye contact, posture, giving full attention to the speaker, ask questions and/or comment on their points. Point out to students that they are not only listening to the words of the speaker, but also understanding the meaning behind them.
3. Students complete a journal at the end of class evaluating the skills they learned about listening and responding effectively.
4.

Lesson 3: Identifying Responsible ways to Behave.

1. Have students write five things in their journals, which describe responsible actions. Share ideas with the class.
2. Ask students to write who taught or guides these actions. Share with class.
3. Make a chart on the board with two headings: Responsible Actions and Actions that Lack Responsibility. Be sure to point out that the behaviors and actions are irresponsible, not the people and that everyone can learn to act responsibly.
4. Discuss the outcomes of both responsible and irresponsible actions and behaviors.

5. Group work: Students create situations where someone acts irresponsibly. They will then decide what the consequences would be for everyone involved. They will provide a responsible action and the consequences for each situation.
6. Groups may share results with the whole class or pair up with other groups.

Lesson 4: Respecting Yourself and Others.

1. Brainstorm the importance of respectful behavior: treating yourself and others with respect. Have students contribute to examples of actions that involve demonstrating respect to self and others.
2. Discuss the relationship between respect and self-confidence.
3. Activity: "Warm Fuzzies". Have students tape papers on each other's backs. Students walk around the room and take turns writing positive, respectful statements about each other on the papers using specific words that are unique to each of their peers.
4. Students read and share their warm fuzzies. They enter reactions to this activity in their journals. Be sure to have them connect the activity to their feelings of self-confidence.

Lesson 5: Making Positive Responsible Decisions.

1. Brainstorm with the class how people learn to make good decisions. Discuss how people learn by practice, experience and help from adults with good skills.
2. Lead the discussion into how families, communities and cultures within those communities contribute to the development of decision-making. Examples may

include: curfew times, homework times, cultural ceremonies, and recreational sports.

3. Identify behaviors that reflect poor decision making such as stealing, lying, disobeying parents, destruction of property, etc).

Review steps of decision making such as

   a. Evaluating options
   b. Think about the possible consequences
   c. Eliminate the negative consequences
   d. List steps to take for positive consequences to occur

4. If students are unsure have them ask themselves the following questions:
   a. Is this against the rules of my family, school, laws or my religion?
   b. Will it harm others or me?
   c. Is it wrong?
5. Activity: Have students react to situations that require decision-making skills. As a group have them discuss the decision to be made and options they need to review in order to make the right decision.
6. Journal entries help students reflect and summarize their learning experience in the lesson.

Unit Two: Goals for Healthy Living

Unit Objectives:

- Ability to plan for the future
- Develop understanding that reaching goals involves commitment, self-discipline and a sense of purpose in life
- Identify positive role models
- Dealing with challenges/barriers towards goals

Lesson 1: Planning for the Future.

1. Define purpose, goals and goal setting.
2. Have students list goals they have.
3. Discuss the difference between short and long-term goals.
4. Have students categorize their first list of goals under short and long- term headings.
5. Students draw a timeline and place their goals on the timelines. They will write when they expect to reach their long-term goals.
6. Students share their goals in groups or with the class.
7. Students summarize their learning by discussing the differences between short and long term goals and the time periods they represent.

Lesson 2: Identifying Characteristics of Positive Role Models.

1. Define "role model". (A person you admire and want to be like). Ask students for examples of positive role models. Invite students to share examples with the class.

2. Using the list of role models on the board, have the students identify characteristics that are similar among these people (caring, honest, respectful, etc).
3. Activity: Students discuss their role models with a partner. They list the characteristics of the role model and reasons why they chose this person.
4. Journal entry at the end of session includes a summary of what the student learned about role models and their importance in setting goals.

Lesson 3: Dealing with Challenges.

1. 1.Students state purpose and goals. Then list the steps they will take to reach each goal.
2. Students consider the possible barriers they will face in attempts to reach each goal. Beside each corresponding goal they will list ways to deal with these barriers.
3. Students will build a support system by listing people that will help them reach their goals. These support people will sign the action plans to promote accountability.
4. 4.Students will create action plans that include their goals, challenges, timelines for reaching these goals and check in dates for support people.
5. 5.Plan a celebration on the end date of the action plan and what the celebration will be.

Unit 3. Improving Relationships with Peers

Unit Objectives:

- Lesson 1: Strengthen healthy and mutually respectful friendships
- Lesson 2: Learn ways to resist peer pressure
- Lesson 3: Identify responses to intimidating and bullying behaviors
- Lesson 4: Learn strategies to deal with conflict in peer relationships

Lesson 1: Strengthen healthy and mutually respectful friendships.

1. Discuss the differences between friends and acquaintances.
2. Students list the qualities of a good friend.
3. Students create a symbol that represents friendship and make a logo with it.
4. Discuss the meaning of cliques. Point out that cliques tend to exclude others more than include them. Explore reasons why people create cliques.
5. Name behaviors that lead to including others in groups or cliques. Then name behaviors that lead to excluding behaviors.
6. Have students discuss the feelings associated with both sets of behaviors.
7. Student's role- play being inclusive in an example of meeting a new kid at school. They create positive behaviors that will include the new kid in their activities.
8. Journal entries: What could you and your friends do to be more inclusive?

Lesson 2: Peer Pressure.

1. 1.Define peer pressure and list examples on the board with student input.
2. Categorize examples on board under headings negative and positive pressure.
3. Discuss the definition of assertiveness and how to develop this quality.

4. Present information : When confronted by peers with something you are unsure of:
    i. Ask questions about the activity
    ii. Determine whether the activity is right or wrong according to rules in your family, school and community.
    iii. If the pressure you are experiencing results in "yes" to above you must answer "NO". If the person or people do not accept your answer LEAVE. Follow the healthy decision making skills when practicing dealings with peer pressure.

5. Have students role play in partners or groups how to respond in different situations that involve peer pressure and the various responses they can choose from. Many teens do not know how to say no. This is their opportunity to practice statements such as:
6. "I'm busy, maybe later".
7. "I have to go home to finish my chores".
8. "No thanks, I'm not interested".
9. Students summarize their learning in a journal entry.

Lesson 3: Dealing with Bullies.

1. Define intimidation and bullying. Discuss the possible motivations behind bullying and intimidation.
2. Identify different ways people respond to bullying.

3. Explain that bullying is a form of intimidation.
4. Discuss examples of verbal and physical threats. These may include: using words to threaten someone, force someone to do or not do something, tease, dare someone, degrade someone; actions that include stealing or destroying property, pushing or hurting someone, intentionally bumping someone, swarming a person with a group.
5. It is important at this point to point out that most people have been bullied and that it is NOT THEIR FAULT. Intimidation and bullying are NEVER acceptable.
6. Students identify emotions that are felt by
7. People who bully others
8. People who are bullied by others
9. People who see someone being bullied
10. Students practice strategies for dealing with intimidating situations in groups. If students suggest negative ways of handling intimidation, such as forming gangs or increasing violence, be sure to devote more time in class that involves discussion of the seriousness involved.
11. Remind and encourage students to report threatening behavior to a teacher or counsellor and to talk about it with their parents.
12. Closure questions could include:
13. What have you learned about the reasons for bullying?
14. How can you stop teasing when it is no longer friendly?
15. How can inclusive behaviors reduce intimidation and bullying?

16. Students enter their experiences of bullying in their journals and how they can avoid these situations in the future.

Lesson 4: Handling Conflict

1. Examine and discuss the reasons why conflict is a normal part of friendships.
2. Use problem-solving steps to deal with conflict situations.
    a. Define the problem
    b. List all possible solutions
    c. List the consequences of all solutions.
    d. Choose the best solution
    e. Act on the choice
    f. Reflect on the outcome.

3. Activity: Have student's role-play various situations that involve conflict and provide practice in working through the problem-solving steps.
4. Journal entry: A time that I was involved in a conflict. How these problem-solving steps could have provided a different outcome.

Unit 4. Making Healthy Choices

Unit Objectives:

- Lesson 1: to select, plan and act out a drug prevention project in the school or community
- Throughout the project learn to serve as role models for younger students by taking action against drug use
- In the time frame of this unit learn to recognize the internal and external pressures that influence the use of tobacco, alcohol and other drugs and how to develop positive supports for non-use

Lesson 1: Selection and Planning of a Prevention Project.

1. Invite RCMP, public health nurse, mental health and addictions workers into the classroom for a presentation on the different types of drugs, their effects on individuals abusing them, how this influences family and the community as a whole.
2. Discuss reasons and situations, which promote the use of drugs and confusion surrounding its effects on behaviors.
3. List the problems that drugs can cause and the help that is available for individuals and their families.
4. TEACHING TIP: Encourage students to respect others by keeping any disclosures confidential and to meet with you privately to discuss any other concerns they may have . If a student approaches you about a family substance abuse problem assure them that

a. They are not alone and that many other students face the same problem. Refer them to a professional for help.
b. The substance abuse of a family member is not your fault and you did not cause it.
c. Addictive behavior is a medical problem that needs professional help.

5. Prepare a survey for the school to determine areas of need in your school and/or community.
6. Have students involve the panel members in their selection of questions for the survey.
7. Tally the results of the survey and decide the topic of the Projects students are willing to act on.
8. Project ideas include:
    a. Providing an in-depth report of issues related to drug use in your community. This could involve another survey. Publish it in your community or school newsletter.
    b. Write a poem, song or skit to perform for younger students and peers.
    c. Prepare an advertisement that can be aired on the local radio station, which promotes drug fee lifestyles.
    d. Create a video for peers demonstrating the skills that prevent drug abuse.
    e. Research ideas that include a Brochure for healthy, drug-free activities that are available in your community.

Unit 5. Sexual Wellness Program

Sexual Wellness Programs

"A myriad of other influences from social class and ethnicity to religious background, geographic setting (urban versus rural), popular culture (as portrayed in movies, teen magazines, music and internet sites), and the quality of sex education in schools, play a part in when and whether adolescents become sexually active" (Crump, et. al. in Broderick & Blewitt, 2003).

The resource for sexual health education promotes the Saskatchewan curriculum aim in health education: *to enable students to apply health knowledge in daily life in order to increase health-enhancing behaviors and decrease health-risking behaviors (NLSD 113, 2004).*

The Northern Lights School Division #113 in partnership with Mamaweetan –Churchill Health District has recently approved a Sexual Wellness program to be taught in schools from grades 4 through 10 in its division. Other northern health regions such as the Keewatin Yathe Regional Health Authority and Athabasca Health Region will make use of this resource. A Teacher's Guide complete with lesson plans and activities provides you with all the resources necessary. Be sure to provide parents with an overview of the program and begin your program I with an information session for all parents of children enrolled in this program. There are activities that involve work at home with parents, so please be sure to inform parents of this during the information sessions. This entire resource is available from the Division office.

Unit 6. Strengthening Family Relationships

Unit Objectives:

- Understanding the different types of families and to celebrate and appreciate the culture of our families
- To explore ways that the family helps to contribute to the healthy development of its members
- To strengthen the bonds between young people and their families by fostering positive interaction and demonstrating appreciation

Lesson 1: Different types of families.

1. Discuss and define the different types of families that exist today:
    - § Nuclear family
    - § Extended family
    - § Blended family
    - § Single parent family
2. Discuss the ways that families help to meet the need of its members. Examples include providing a loving environment, shelter, food, support, culture, guidance, etc.
3. Have students make a family tree/mural that represents their own family.
4. Students discuss in groups and in a journal reflection how the skills that they have learned in class that involve decision making, strengthening relationships and conflict resolution can help them contribute to their family relationships at home.

Unit 7. Working with Multiple Intelligences

Multiple Intelligences

Dr. Howard Gardner, professor of education at Harvard University, developed the theory of multiple intelligences in 1983. It suggests that the traditional notion of intelligence, based on I.Q. testing, is far too limited. Instead, Dr. Gardner proposes eight different intelligences to account for a broader range of human potential in children and adults. These intelligences are:

Linguistic intelligence: word smart

Logical-mathematical: number/reasoning smart

Spatial intelligence: picture smart

Body-Kinesthetic intelligence: body smart

Musical intelligence: music smart

Interpersonal intelligence: people smart

Intrapersonal intelligence: self-smart

Naturalistic intelligence: nature smart

Dr. Gardner states that our schools and culture focus most of their attention on linguistic and logical-mathematical intelligence. We seem to put more value on the highly articulate or logical people of our culture. However, Dr. Gardner says that we should also place equal attention on individuals who show gifts in the other intelligences: the artists, architects, musicians, naturalists, designers, dancers, therapists, entrepreneurs, and others who enrich the world in which we live. Unfortunately, many children who have these

gifts don’t receive much reinforcement for them in school. Many of these kids, in fact, end up being labelled "learning disabled," "ADD (attention deficit disorder)," or simply underachievers, when their unique ways of thinking and learning aren’t addressed by a heavily linguistic or logical-mathematical classroom.

The theory of multiple intelligences proposes a major transformation in the way our schools are run. It suggests that teachers be trained to present their lessons in a wide variety of ways using music, cooperative learning, art activities, role play, multimedia, field trips, inner reflection, and much more.

School Achievement, Behavior and Attendance: Questionnaire:

School is an adolescent's "job" For some youth school is a place where they thrive, while all other aspects of their lives are falling apart. For others failure in school contributes to their feelings of hopelessness and despair. Some youth turn to alcohol and drugs and these influence school behavior and achievement.

Questionnaire:

Describe your attendance at school.

What do you think about your teachers?

What do you like about school?

Who are your friends at school?

What effect does taking drugs/alcohol have on someone's school life?

Does your family speak the same language as people at school?

Do you understand what the teacher says and other kids' conversations?

How important is education to your family?

Extra-curricular Activities

Do you participate in any sports or clubs organized by the school?

If yes, what do you like about this activity?

If no, what keeps you from participating?

Close Relationships

Who are your friends?

How close are your friends?

Have your friends changed in the last while?

How do you feel about your friends?

Are there friends in your life that you can count on?

What things do you and your friends do together?

Do you belong to any groups or clubs?

Do you go to any self-help groups?

Are you in a romantic/sexual relationship?

If so, how do you feel about the person you are involved with?

Do you have friends that use drugs or alcohol?

If so, what effect has this had on your relationship?

Counsellor

Power in the Therapeutic Alliance

When working with racial identity counsellors must consider their own identity development. Counsellors' racial identity impacts the counselling process such as the ability to build rapport, develop a working alliance, and to be culturally empathetic (MacDougall & Arthur, 2001). It is very important for counsellors to focus on cultural variable early on in counselling. A counsellor's non-judgemental stance may encourage clients to bring up race related issues. It is best to attend to racial issues while eliciting client information. Clients reveal themselves more fully when the context of their environment is acknowledged (MacDougall & Arthur, 2001).

A counsellor needs to become aware of one's own cultural heritage and how this relates to one's perceptions of others. This enables the counsellor to recognize any personal limitations may be forming unconscious barriers. By developing this sense of self the counsellor feels more secure and comfortable when addressing different cultural issues with clients. Our effectiveness with clients depends on our awareness of our culture within (Arthur and Stewart, 2001).

It is extremely important for counsellors to acknowledge their own biases and stereotypes in preparation for accepting the cultures of others. "We don't all need to agree but we need to be clear about our disagreements" (Sandu, 1995). To become a culturally skilled counsellor one must be actively and continually question our personal assumptions about human behavior, values, biases preconceived notions and personal limitations. They begin to understand their own worldviews, the fact that they are a product of their own

cultural conditioning and how this affects their work with ethnic and racial minorities (Sue and Arredondo, 1992).

Community Advocacy

Career Guidance and Life Roles

Many teenagers work part time and older youth who drop out of school may be working full time. They may experience some frustration or failure at work.

Where do you get your spending money?

What kinds of jobs have you had in the past?

How have these jobs worked out?

Have you ever had troubles with an employer?

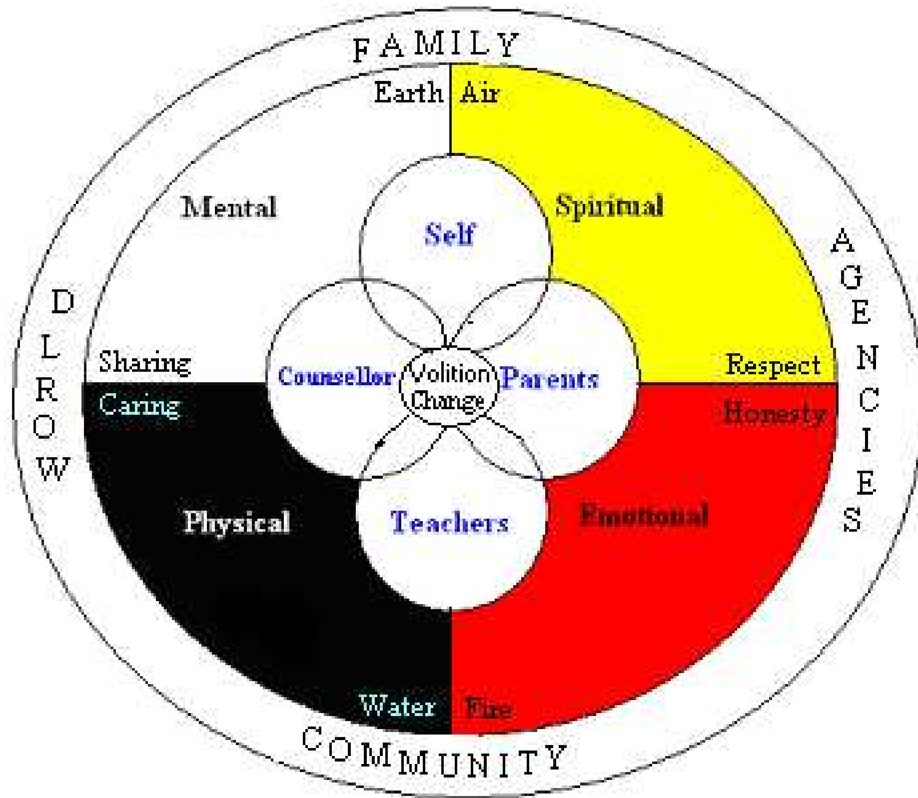
If so, what kind of troubles?

Are you working now? If so, what is your job?

Part-time, full time?

If you are using drugs/alcohol, how has this affected your job?

Keewatin Model



The Four Directions and Corresponding Colors (Saskatchewan Learning, 2002)

East

Yellow: It is said by our elders that this is the path of life, the path of the great warrior, the sun. Yellow represents the Eastern Direction. The direction of the rising sun is thought of as a Grandfather personifying the winds and natural phenomena of that direction. It symbolizes all that is new in the creation, like newborn creatures, including humans. Like the rising sun, a new day is brought to light. So it is with all things. Knowledge is brought to consciousness and like the circling of the sun, the seasons change. The East is the time of change. It is the spring, the time of change from blackness to beauty. It is the sun breaking over the horizon.

South

Red symbolizes earth and fire Represented on the flag with the red background, is a continuation of our circle of life is the direction of maturing life, like young men and women. It is the time of year we call summer, the time we call mid-day, the time of day the eagle soars. South is the direction of full understanding.

West

Black the direction of the setting sun is the time of gradual change as from daylight to darkness, from life to death. It is evening, the change of life. The West is the time of full maturity. It is a time of insight.

North

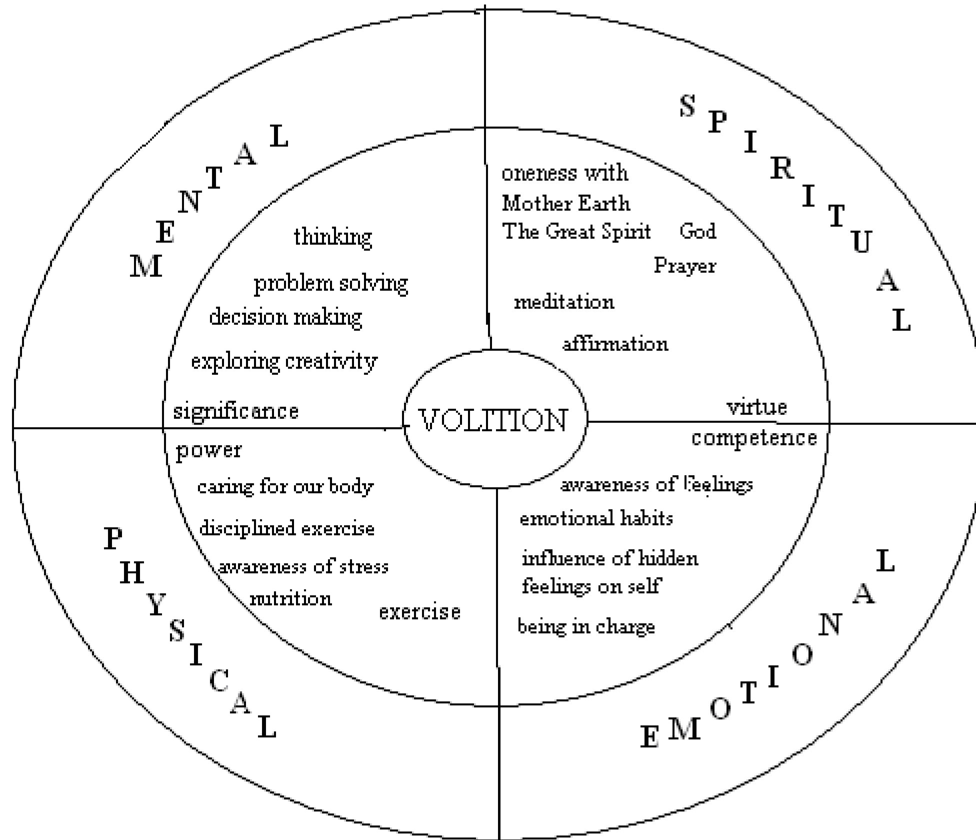
White This is the time of our elders, our old people. It is a time of wisdom. It represents the night, and a time called winter. North is representative as those things that are positive, a time of snow and purity (Saskatchewan Learning, 2002).

Summary

From wherever we stand upon our Earth Mother we have companionship of these four directions. We are cared for by our Earth Mother with her blessings of food, clothing, shelter, and medicine. We give thanks to our Earth Mother, the direction below us.

The directions above recognize the daytime and nighttime skies of our creation. This is where we look to acknowledge the Great Spirit, The Creator. The Creator gives us everything we know. Therefore our greatest acknowledgement is to the Creator of all the universe (Saskatchewan Learning, 2002).

My Medicine Wheel



In each of the four parts of your medicine wheel write your areas of strengths in each dimension as well as weaknesses. Then write words or actions that describe what you can do to look after that part of you. This is your personal plan and will be used to set goals to help you.

These four aspects must be developed equally so that a person will be healthy and well balanced. This is done through the use of one's will or volition.

It is your own will or volition that determines whether you will be happy today. No one else decides that for you. If you are emotionally upset, then it is only you and your volition /will to do something about it.

When you have resolved anything negative in your life and put things back into perspective –then your own Medicine Wheel with the four aspects are in balance.

Example: Emotional: If negative feelings persist because an apology is in order, and you have been putting it off because sometimes this is very difficult to do, you need to be brave, make an apology and set things right. Put yourself in order, in harmony in your own medicine wheel.

Counsellor Self-awareness Preparation

Who Am I as a Person?

How do I assess my developmental history up to this point in my life? What were the high and low points?

When did I realize I was an Adult? How did I handle this realization?

What are my five best qualities?

What five areas of my life do I need to improve?

If someone asked me what my philosophy of life were, what would I answer?

Is my glass of water half full or half empty? Why?

What mood do I find myself in most of the time?

What do I think about people in general?

What role do my religion, culture, ethnic values, gender and sexual orientation play in my view of life?

How do I respond to those who are different than me? How open am I on multiculturalism?

Who are my heroes?

Who is the most creative person I know? Why? How can I nurture creativity in my life?

What is maturity?

What are my personal goals and objectives?

How do I cope with life's challenges and personal stress?

Am I past, present or future oriented?

Where do I lie on the continuum of cooperation versus competition?

Who and what influenced my life?

What would my best friend say about me?

What is the biggest criticism that people have of me?

What three adjectives best describe me?

Am I open to my own potential needs for counselling?

How do I ground and center myself? What do I do for my self- care?

Do I rely on my intuition? Why or why not? How do I rely on it?

Do I take time to play? How do I play?

Where are my spiritual beliefs? How do they influence me as a person?

Do I possess all the necessary attributes to be effective in my present career?

How do I balance meeting my own needs and meeting the needs of others?

Who am I as a Professional?

What are my reasons for becoming a student/parent/teacher/counsellor?

Do I feel my emotional issues will be addressed and resolved by being a parent/teacher/counsellor?

What is my need to be a student/parent/teacher/counsellor??

What makes me think that I will be an effective student/parent/teacher/counsellor??

How do I handle my own issues when they emerge?

What do I expect from parents/children /students/ clients?

What do I expect from my profession or career?

What do I anticipate getting from peers/colleagues?

What are my professional strengths and weaknesses?

What are my professional goals and objectives?

What would my fellow students/peers say about me?

What type of people do I wish to work with? Why?

With whom will I not work? With what issues? Why?

Do I know when and where to get help/refer?

How would I handle stress and burnout?

How do I handle praise and criticism?

Do I fully attend to my parents/children /students/ clients? How so?

Self Esteem

Most often teenagers diagnosed with FASD receive very little positive feedback. Their self-esteem is often quite low because of constant failures and inability to keep up with their peers (Harpur, 2001). Counsellors can help with interventions that boost self-esteem such as positive self-talk, providing small, incremental steps that guarantee successful experiences for the teen. This is an opportunity for the counsellor to tap into the four components of significance, competence, power, and virtue to aid in the development of the adolescent's self esteem (Saskatchewan Learning, 2002). Providing consistent encouragement and praise also goes a long way. The University of Washington study showed that over 90 percent of the patients had mental health problems and that it would be wise for counsellors to attempt to examine areas of stress in the patient's environment early on in therapy.

Given that self-esteem is not a fixed state, numerous methods have been developed to enhance this form of self-appraisal. Bruning, Schraw, & Roning (1999), suggest several methods to use in teaching. Suggestions include: increasing awareness of the self-efficacy concept and the impact it has on behavior and learning (psycho educational approach); using expert and inexpert modeling (to establish behavioral goals

and provide examples of models like themselves); emphasizing self-efficacy in specific domains; providing feedback on accomplishments as well as failures, including ways to improve; establishing small, incremental goals to emphasize small successes; and encouraging self-regulation (includes setting goals, self-observation, self-evaluation, and self-reaction), which enables the learner to recognize successes and work toward increasing achievement. Jacob (2002) also suggests a number of interventions that can be used in counselling to increase client self-efficacy. For example, she suggests assigning small goals and recognizing attainment and mastery, teaching clients to recognize and combat distorted thinking patterns which lead to negative self-efficacy, and working with clients to develop effective coping methods for dealing with failure.

According to social learning theory, "self-efficacy is an internal determinant, or causal mechanism, that regulates overt behavior" (Morgan, 2002). As revealed in this section, self-efficacy is a complicated cognitive structure, influenced by a number of personal and social factors that play a key role in the development of healthy attitudes towards self.

Insight therapy is suggested for clients with chronic health conditions. It is designed to help people gain an understanding of the roots of their problems. It is a useful approach in helping clients deal with their anxieties, self-concepts and relationships (Sarafino, 2002).

Family therapy

In many cases, professionals will need to be willing to dig down to discover whether there is an alcohol problem in the past or present, or both. Whether professionals

have the time, training or systems to allow for this is questionable, and even if they did, one wonders if the system could cope with what might be uncovered (McCormick, 2003).

Anger Management

Anger is a normal, human emotion. It is intense. Everyone gets angry and has a right to his/her anger. The trick is managing your anger effectively so that it will mobilize you in positive, not negative directions.

The first step in anger management is to get to know your anger by recognizing its symptoms. Try these exercises:

Do You?

Physical	Emotional	Behavioural
Grit your teeth	feel like running away	cry/yell/scream
Get a headache	get depressed	use substances
Get sweaty palms	feel guilty	get sarcastic
Get dizzy	feel resentment	lose sense of humour
Get red-faced	become anxious	become abusive
Get a stomach-ache	feel like lashing out	withdraw

Does your Anger…?

Last too long	Y / N
Become too intense	Y / N
Lead to aggression	Y / N
Impair relationships	Y / N
Interfere with major roles	Y / N
Creep out in mysterious ways	Y / N
Contribute to physical problems	Y / N
Come too frequently	Y / N
Flare up too frequently	Y / N

Anger Inventory

1- no annoyance 2-little irritated 3-upset 4-quite angry 5-very angry

The higher your score, the more likely you need to address issues of anger.

Table 3: Anger Inventory

You've overheard people joking about you or your family	1 2 3 4 5
You're not being treated with respect or consideration	1 2 3 4 5
You're singled out for corrections while the actions of others go unnoticed	1 2 3 4 5
You're hounded by a salesperson from the moment you walk into a store.	1 2 3 4 5
You're trying to discuss something important with someone who isn't giving you a chance to express your thoughts or feelings	1 2 3 4 5
Someone offers continual, unsolicited advice	1 2 3 4 5
You're in a discussion with someone who persists in arguing about a topic he/she knows very little about	1 2 3 4 5
You've had a busy day and the person you live with greets you with complaints about what you haven't finished	1 2 3 4 5
Someone is given special consideration because of his/her popularity, good looks, financial position or family status	1 2 3 4 5
Someone comments on you being overweight or underweight	1 2 3 4 5
Total	

Additional situations that spark your anger.

Anger Styles

Stuffing

Do you avoid direct confrontation?

Stuffers can deny anger: they may not admit to themselves or to others that they are angry

Stuffers may not be aware that they have the right to be angry.

Some reasons we stuff are:

Fear of hurting or offending someone

Fear of being disliked or rejected

Fear of losing control

Feeling I is inappropriate to be angry

Feeling unable to cope with such a strong, intense emotion

Fear of damaging/losing a relationship

It's a learned behavior (but it can be unlearned)

Trying to use a different style that the one I was raised with

Consequences/Problems:

Anger comes out-regardless

Impairs relationships

Compromises physical and mental health

Escalating Anger

Do you escalate to Rage?

Do you try to control but lose control?

Escalators blame and shame the “provoker”.

Escalating often leads to abusive situations.

Some reasons we escalate are:

Feeling I have no other choice

To demonstrated an image of strength/power

To avoid expressing underlying emotions

Fear of getting close to someone

It’s a learned behavior

Lack of communication skills

Consequences/Problems:

Desired results may be short-term

Possible physical destruction

Impairs relationships

Compromises physical and mental health

Legal ramifications

Managing Anger

Do you manage your anger? Do you allow anger to mobilize you in positive directions? Open, honest and direct expression is the most effective way of managing anger. Easier said than done, eh? When expressing anger directly, keep these important skills in mind:

Remind yourself that anger is a normal, human emotion- it's okay to feel angry!

1. Before open, honest and direct expression, evaluate the following: the trigger event, Is this a good time for the listener?
2. Set a specific time limit for anger discussion
3. Remember your body language: firm voice, moderate tone, direct eye contact, maintain personal "space"
4. Don't attack or blame the person
5. Focus on the specific behavior that triggered your anger
6. Avoid black or white thinking (You never..) Instead say, "I'd prefer that, then I would feel…"
7. Use "I" statements: "I feel angry when…" " I feel angry that…"
8. Avoid statements or actions that you will regret later
9. Don't drag old issues now
10. Check for possible compromises
11. After open, honest and direct expression, close the discussion and then move on
12. When it's over pat yourself on the back for your assertiveness!
13. Say to you "I will be better off in the long run!"

14. Now say to yourself "By managing my anger I took an important step in improving my sense of well being".

Additional effective/emotional management techniques are:

- Trying physical outlets: exercise, housework, crafts
- Problem solving and coming up with action plans
- Involving an objective third party
- Use the empty chair exercise: Pretend you are sitting across from the person you're angry with and say what's on your mind
- Write a letter to the person you're angry with. You could describe your anger right now, at the time of anger event or both. You can destroy it/you can save it/you can mail it at a later date.
- Use relaxation techniques such as guided imagery, self help tapes or music
- Use positive self talk
- Work towards anger resolution through acceptance by learning to live with the fact that certain people and situations, past, present and future will not change.
- Make realistic expectations: What is one frustrating anger situation? Can it really change as you would like it to in the near future?

If not, realize the powerlessness over the situation

Give yourself a time limit to be angry and then let it go

Constantly remind yourself that you cannot afford to stay angry

Recognize the need for forgiveness

Focus on the present

Counselling: Sample Action Plan

Name: ______________________

Name of support person(s) ________________________

Date action plan begins: ___________________________

"Check-in" dates with support person(s): ______________

Date action plan ends: ____________________________

Topic/Issue

(list issue here)

Challenge

My challenge is to ….

Goals

My goal is to….

Action

I will approach the principal and vice principal on (date).

I will research the issues as they have been dealt with in other schools on (date).

I will meet with … on (date).

I will observe…

Once I have reached these goals ….

_________________ ________________________ _______________________

Teacher Support Person Student

Time Management

Everyone wastes time. It's part of being human. Sometimes wasted time can be constructive because it helps you to relax or reduce tension. However, other wasted time can become very frustrating. This is especially true when you are spending time doing something less important than you might otherwise be doing (Haynes, 1994).

There are two common time wasters: Self-generated and Environmental. The next few pages will concentrate on ways for you to recognize and manage your time wasters.

Self Generated	Environmental
Disorganization	Visitors
Procrastination	Telephone calls
Inability to say no	Junk mail
Gossip	Waiting for someone
Unnecessary perfectionism	Unproductive visits
	Crises

Provide lessons to deal with each of the common time wasters in the above table (Haynes, 1994):

For example, to deal with procrastination

a. Set a deadline
b. Set up a reward system
c. Arrange for follow up
d. Do it first.
e. Break jobs into small pieces

f. Do it now

Five Tips for Effective time Management

1. List and prioritize weekly objectives.
2. Make a daily "to do" list and priorize it.
3. Devote primary attention to the first items on your list.
4. Handle each piece of paper only once.
5. Continually ask, "What is the best use of my time right now?" and do it!

(Haynes, 1994)

Finances: Money Management

Objectives:

List the steps involved in drawing up a budget

Suggest some ways to stick to a budget

Budgeting

To be successful in managing your money you must accept responsibility. You need to set your own goals and make a plan that will help you meet them. This process is called "planned spending". The actual plan that you use to manage your money is called a budget. To practiced planned spending you need to know how to and maintain a budget.

Setting Goals

The first step in preparing your budget is to make a list of all your goals. Include all the things you would like to do and purchase. If your list is very long, underline the items that are most important to you. Copy your underlined items onto another piece of paper.

Estimating Expenses and Income

Now look at the second list. Cross out anything on the list that is not essential. NEEDS BEFORE WANTS. After you have budgeted for your needs, you can plan to spend for your wants. Group your needs under headings such as food, housing, education and clothing. Use these headings as in the example below to create a record of your spending (Haynes, 1994).

Table 4: Expense Record

Date	Food	Housing	Education	Clothing	Transportation	Medical	Recreation
1/6						10.00	3.00
1/7	5.00				5.00		
1/8	12.00			8.00			
1/9	3.00						
1/10	5.00						
1/11	5.00						
1/12					10.00		3.00
Total	30.00			8.00	15.00	10.00	6.00

An expense record gives you a clear picture of exactly where your money is going. Keep a log of your spending for two weeks to track your current spending habits. Then use the exercise above to make the necessary adjustments (Kimbrell & Vineyard, 1992).

APPENDIX A

Twelve Principles of Indian Philosophy

There are twelve principles of Indian philosophy

- Wholeness. (Holistic thinking). All things are interrelated. Everything in the universe is part of a single whole. Everything is connected in some way to everything else. It is only possible to understand something if we understand how it is connected to everything else.

- Change. Everything is in a state of constant change. One season falls upon the other. People are born, live, and die. All things change. There are two kinds of change: the coming together of things, and the coming apart of things. Both kinds of change are necessary and are always connected to each other.

- Change occurs in cycles or patterns. They are not random or accidental. If we cannot see how a particular change is connected it usually means that our standpoint is affecting our perception.

- The physical world is real. The spiritual world is real. They are two aspects of one reality. There are separate laws that govern each. Breaking of a spiritual principle will affect the physical world and vice versa. A balanced life is one that honours both.

- People are physical and spiritual beings.

- People can acquire new gifts, but they must struggle to do so. The process of developing new personal qualities may be called "true learning". There are four dimensions of "true learning".

- A person learns in a whole and balanced manner when the mental, spiritual, physical and emotional dimensions are involved in the process.

- The spiritual dimension of human development has four related capacities:

    1. the capacity to have and respond to dreams, visions, ideals, spiritual teaching, goals, and theories;

    2. the capacity to accept these as a reflection of our unknown or unrealized potential;

    3. the capacity to express these using symbols in speech, art, or mathematics;

    4. the capacity to use this symbolic expression towards action directed at making the possible a reality.

- People must actively participate in the development of their own potential.

- People must decide to develop their own potential. The path will always be there for those who decide to travel it.

- Any person who sets out on a journey of self-development will be aided. Guides, teachers, and protectors will assist the traveller. The only source of failure is a person's own failure to follow the teachings.

- The only source of failure on a journey will be the traveller's own failure to follow the teachings of the Sacred Tree (Saskatchewan Learning, 2002).

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