If you are pregnant, don't drink.
If you drink, don't get pregnant.

Many people may be unfamiliar with the terms "fetal alcohol spectrum disorders" (FASD) and "fetal alcohol syndrome" (FAS). FASD is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. The term FASD is not intended for use as a clinical diagnosis.

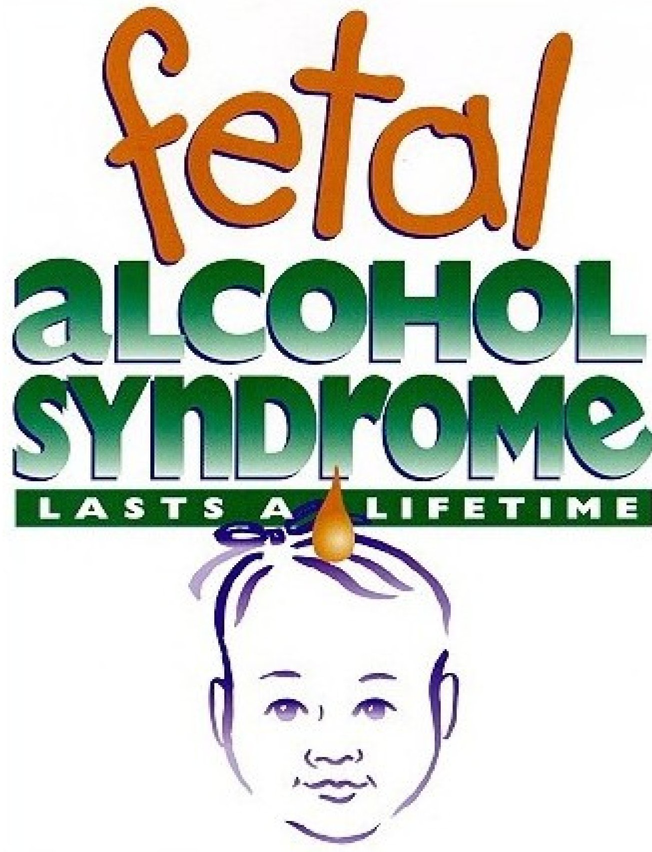
Prevention experts are hoping to increase awareness of these serious health risks that can result when a woman drinks alcohol while pregnant.

The many terms and disorders often grouped under the category of FASD include:

- **Fetal Alcohol Syndrome (FAS):** a pattern of neurological, behavior, and cognitive deficits that can interfere with growth, learning, and socialization. FAS include a characteristic pattern of facial abnormalities; growth deficiencies, such as low birth weight; brain damage, such as small skull at birth, structural defects and neurological signs; and maternal alcohol use during pregnancy. Partial FAS describes persons with confirmed alcohol exposure, facial anomalies, and one other group of symptoms.
- **Fetal Alcohol Effects (FAE):** describes people with prenatal alcohol exposure who do not have all the symptoms of FAS. Many have growth deficiencies, behavioral problems, cognitive deficits, and other symptoms but do not have the facial features of FAS.
- **Alcohol-Related Neurodevelopmental Disorder:** various neurological abnormalities that are associated with maternal alcohol consumption during pregnancy, such as problems with communications skills, memory, learning ability, visual and spatial skills, intelligence, and motor skills.
- **Alcohol-related birth defects (ARBD):** defects in the skeletal and major organ systems associated with maternal alcohol consumption during pregnancy. These may include abnormalities of the heart, eyes, and ears, holes in the heart, underdeveloped kidneys, and fused bones.

http://pathwayscourses.samhsa.gov/ev/ev_3_pg8.htm 11-30-06

A Pregnant Pause



- According to the U.S. Department of Health and Human Services in 1996 approximately 5.5% of all pregnant women used an illicit drug during their pregnancy.

- Educators need to better understand that learning and behavioral problems from prenatal alcohol exposure the caused by impairment of the executive function of the brain.

"A Pregnant Pause," picture and title provided on an educational web page maintained by a public service organization dedicated to FAS education and prevention

This program ended June 30, 2005. http://w3.ouhsc.edu/fas/

Fetal Alcohol Spectrum:
Teacher Training Would Help Identify Students with FASD

More fetal alcohol syndrome training for teachers likely would help schools recognize when FAS is factor in inappropriate student behavior and help reduce the legal costs schools now face when trying to have such a student face consequences for the behavior, says a lawyer who defends those students.

Schools do not know about FAS and there is a link between some students' behavior and FAS, says Susan Ball, a lawyer for FAS children who spoke at the Training & Advocacy Support Center conference in Washington. There really is no in-service training on FAS for teachers, so when teachers see these kids they think the parents have not raised the child right and this is a bad kid Ball tells *SAF*. The child develops a reputation as a bad kid and is always in trouble, she says.

Just as there is training for teachers to deal with autistic children, there needs to be a specific curriculum for FAS children because they need to be taught in a very specific way, says Ball. At a minimum it would cut the costs associated with a legal problems that are sometimes part of a school's effort to deal with an FAS child who has committed a violation of the school's code of conduct, says Ball. FAS mainly affects the brain, so depending on when the mother was drinking, the alcohol could have affected different parts of the child's brain controlling judgment or behavior.

Looking at MRIs of the brains of FAS children shows there are big black spots-holes in the brain, says Ball. Kids with F AS have no control over those sections because of the brain damage. Some of the areas affected are executive functions and impulses, the areas that help people understand that actions have consequences, she says.

In addition, some F AS children are unable to learn from experience. An FAS child caught with a knife in school may understand at the time that taking a knife to school was a bad thing to do, but three months later that child may not understand it is still a bad thing to do, Ball says.

Such acts are certainly violations of the school's code of conduct, and there are consequences. But a special provision in the Individuals with Disabilities Education Act affecting special education students-which FAS students are-says if the student violates a provision of the code, before a consequence can be imposed there has to be a "manifestation review," Ball says. That means looking at the student's disability and seeing if the conduct was related. If it is related to the condition, the consequences are not imposed. If it is not related to the disability, the FAS child is treated like any other student, she says.

Ball has defended two FAS students who took knives to their schools, and in at least one case she managed to negotiate an agreement between the student's adopted family and the school that did not cost anything and kept the student from having to go to a new school. The agreement required the mother to search the student before she left the house; for the student to turn out her coat pockets before boarding the school bus; for the mother to sign a daily log certifying that the student was searched; and for a female member of the school staff to search the student upon arrival.

The agreement did not cost anything; it made the other students safe and provided peace of mind to all the parents, Ball says. But such agreements will likely be worked out based on each individual situation, she says. It will depend in part how a school feels about a particular kid, she says. That is why Ball urges the Education dept. or the Centers for Disease Control & Prevention – the agency that provides most funding for FAS programs – to fund FAS training for educators, she says.

INFO: Ball, 248/473-2990

June 23, 2004 **SUBSTANCE ABUSE FUNDING NEWS**

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Who has to change? Trying their hardest, doing their best!

What it is like to live with Fetal Alcohol Spectrum Disorder

by
Nathan E. Ory, M.A.

This information applies to any individual who is functionally dependent on others in some specific areas, and who does not learn from correction, or who does not 'get' why people are distressed with their behavior.

Parents, teachers and support persons of individuals with fetal alcohol spectrum Disorder (FASD) are sometimes faced with episodes of extreme behavior. The first instinct we all follow is to use 'common sense' methods for controlling the disruptive behavior of any child. In many ways, children with FASD think and learn in a different manner than "normal' children. When a child with FASD acts out in some excessive or violent manner those of us who support them need to ask ourselves several questions.

Whose problem is this? Who has to accommodate? Who has to learn something new to be able to solve these problems?

When we are raising our children, our role as parents is to have our own cultural standards for behavior, and to teach our children how to conform and to share in those cultural expectations. Things like "Do unto others as you would have them do unto you", "Don't interrupt while someone is speaking", or "It's polite to share..." we are all familiar with them. They are those slogans on the poster about" Everything I need to know in life I learned in kindergarten."

The child is expected to accommodate and to learn. We set the standard. We model correct social behavior. We remind and caution about the "rules". We often make it fun to follow the social rules by offering positive consequences (rewards) for cooperation ("Whoever can use the quietest voice gets an extra book", "Whoever is the most polite gets to go on the computer first, etc.) When necessary we control a child who will not accommodate by removing them from social opportunity. If they are just too tired to get along, we may put them down for a nap or have them sit out a turn until they are calmed down and ready to cooperate. Often this is all that is required. These are the methods that we use to elicit voluntary cooperation and to socialize our children to grow up to become responsible, caring adults.

Some children still don't get the polite message that the world has boundaries and external expectations. We may use negative consequences (punishments) to teach them that they do not have the right to be omnipotent, to always have their own way, or to bully others. We may use consequences such as sending them to their room. We may briefly take away privileges (bed time, television), or even "ground" them from certain activity. When needed to maintain order and control, these are ways we educate our kids that their freedoms are related to their level of personal responsibility. Until they show a level of responsibility someone else will maintain control in their world.

In Western culture, using these methods, children learn that there are boundaries. We teach children that they are expected to act in a socially responsible manner, be accountable and responsible for their actions, and that they must accommodate some of their own behavior to be able to fit into the social norm.

And this works just fine for the greatest majority of our children. If we did not follow these cultural traditions our children would grow up “spoiled”, expecting everything to be their way, whenever they want, and not become caring about the rights of others.

Here is the dilemma. For a person with FASD, their mind often does not perceive the other point of view. They can sometimes see the meaning of what is being explained to them through a social story. Even then, it is bringing the information to them, in story form, so that it can become their point of view. They process, as through blinders, only what is concrete, and immediately apparent, in the immediate moment.

Many children with FASD are not able to learn from correction. They may not have a long enough attention span to connect what they did just before with the correction that was offered. If they are reminded about what is expected ahead of time they may be self-controlled and know exactly what to do. But if they are brought into a problematic situation without re-educating them about the expectation each time, they may be unaware of what is expected and unable to self-monitor their own behavior.

Such children do not generalize a “lesson” learned from past experience. If you admonish them about their behavior they may not know what to do to self-correct because they can’t make the connection. All they “process” when they hear “no”, “don’t” and “stop” is “you don’t like me”, or “I’m bad”.

Children growing up with these types of differences in their thinking and learning processes often become very emotionally fragile. They don’t ‘get it’ about why people are distressed with them. They experience that others are distressed with them and often mirror or reflect back the very emotion that is being shown towards them. For these children, it is very important to really like them when you are speaking to them. They work more off the emotions of those around them than the words and actions of those who are guiding them. Being emotionally angry towards them always further escalates their behavior.

For some children, each time they have an experience is like the very first time, no matter how many times they have been through it before. These children may always have to be coached and reminded. When they become frustrated or confused they often become very anxious.

Most such children ‘‘telegraph" their anxiety by first becoming slightly agitated. Such behavior must be interpreted by their parents/teachers/caregivers as communicative. The message is ‘come rescue me before I go out of control’. If the early signs of anxiety are not responded to the child will often escalate to a point of self-injury or aggression until someone else intervenes to assist them to calm themselves down.

The only point of view they have is their own, immediate perspective. They don’t know what to do to “correct” their own behavior until an understanding caregiver reminds them that now is the moment when they have to remember to apply a social rule. (“What do you do with your hands?” “Use your soft voice”). Criticising or challenging these children does not assist learning, is counter-productive and always makes things worse.

So here is the crux. Imagine an individual with FASD who can do exactly what you expect, perfectly well, each time you organize the situation and remind them of expectations. Yet each time you fail to put this much effort into anticipating what could possibly go wrong and trying to remedy every possible failure and reaction ahead of time they become agitated, aggressive, self-injurious, withdrawn, etc.

With such a child, no matter how much you use negative consequences, this only makes the child more reactive. No matter how much you use positive consequences, they still remain dependent on you to structure and remind them about what to do. Such a child may never become independently able to be responsible for their own actions.

So back to the original question: Who has to change? Whose problem is this? Who has to accommodate? Who has to learn something new to be able to solve these problems?

This is not a child that is "spoiled" by the parent or caregiver who is accommodating to their special needs. Living with their FASD frame of mind they need someone else to make the connections for them and to keep their world orderly and structured. The child may not be able to achieve our cultural expectation for eventual independent functioning, but the child is clearly showing that they are willing and able to follow expectations when someone is present to assist them to navigate through their life.

Most of these reactive kids are very emotionally fragile. When they have a smile on their face they can be happy, cooperate, focus and work within their familiar repertoire. When they are distressed, confused, frustrated or anxious they tend to lose their ability to function and become very reactive.
Another big dilemma is "outsiders" who don't see how much effort it takes to keep these kids "glued together" so that they can function at all. "Outsiders" see the accommodations made to protect these kids from "suffering consequences" of their actions. For kids who are unable to learn from their mistakes, accommodation must be made to protect them from negative consequences, which lead to self-injurious and anxious, regressed behavior.

"Outsiders" may unknowingly blame caregivers for "spoiling" the child. They may give generalized "advice" that "the child has to learn", and "the world isn't always going to protect them." Or, 'No one is going to do that for them when they get to high school.' But when children are capable when they are properly supported, yet unable to learn from negative experience, the world may have to always offer them protection.

These are not bad kids. Often they are working heroically to overcome their learning disabilities and to participate in the world wherever they are able.

Permission granted to MCFARES to reproduce this article by Nathan Ory is a psychologist with the Island Mental Health Support Team on March 12, 2007.
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How Alcohol Exposure Affects Behavior

The **number one cause** of preventable birth defects

"FAS represents the largest environmental cause of behavioral teratogenesis yet discovered and, perhaps, the largest single environmental cause that will ever be discovered." Riley, E. P., and Vorhees, C. V. (1986). *Handbook of Behavioral Teratology*. Plenum Press, New York, NY

How Alcohol Exposure Affects Behavior

Articles and resources to help Teachers and Parents better understand FAS behavior.

Arrested Social Development http://www.come-over.to/FAS/SocialArrest.htm	**FAS and Moral Character** http://www.come-over.to/FAS/morality.htm
Behavior Mod for FAS/E http://come-over.to/FAS/behaviormod.htm	**FAS and Stealing** http://come-over.to/FAS/stealing.htm
Cause and Defect http://come-over.to/FAS/causedefect.htm	**FAS Issues at All Ages** http://www.come-over.to/FAS/ladue.htm
Disrespect and Manipulation http://www.come-over.to/FAS/DisrespectManipulation.htm	**How to Explain Behaviors to Others** http://www.come-over.to/FAS/explain.htm
Liar! Liar! *FAS and Confabulation* http://come-over.to/FAS/LiarLiar.htm	**Motivation** http://come-over.to/FAS/motivation.htm
FAS/E and Conscience Development http://www.come-over.to/FAS/conscience.htm	**Neurobehaviour in Adolescents and Adults** http://come-over.to/FAS/Neurobehavior.htm
FAS and Impulse Control http://www.come-over.to/FAS/ImpulseControl.htm	**Suspended** http://www.come-over.to/FAS/Suspended.htm
FAS and Inappropriate Sexual Behavior http://www.come-over.to/FAS/InappropriateSexualBehavior.htm	**Vineland Adaptive Behavior Scales** http://www.come-over.to/FAS/VinelandRationale.htm
	Won't Or Can't? http://www.come-over.to/FAS/cantwont.htm

http://come-over.to/FASCRC/#behavior

February 2007

Arrested Social Development

(Teresa Kellerman's response to a parent's question)

Dr. Edward Riley in San Diego has done some interesting studies on comparing the social developmental level to the IQs of several children with FAS/E.

One quote from the full report echoes what parents of adults have been trying to say for a long time, in the face of teachers, professionals and family members who expect the person with FAS to act their age, when indeed they CAN'T: "Children with FAS appear to plateau in social abilities at about the 4- to 6-year-old level, which suggests arrested development. This interpretation is further supported by Streissguth et al, who found that adolescents and adults with FAS had social abilities age-appropriate for a 6-year-old child, and by Steinhausen et al, who showed that children with the social abilities of FAS did not improve with age."
Teresa

<u>CRIME TIMES</u> Vol. 5, No. 1, 1999 Page 7 Arrested social development seen in FAS
Individuals with fetal alcohol syndrome (FAS) often are retarded, but a new study indicates that they also suffer from social deficits "beyond what can be explained by low IQ scores"-a finding which may help explain why FAS is a risk factor for behavioral problems and criminality.

S. E. Thomas et al. compared 15 children with FAS to two control groups, one matched for verbal IQ and another with normal or high IQ scores. The researchers say, "the children with FAS were most impaired on [tests assessing] interpersonal relationship skills." Furthermore, they say, social deficits were more pronounced in older children with FAS, "indicat[ing] that there may be arrested, and not simply delayed, development of social abilities in children with FAS." "Comparison of social abilities of children with fetal alcohol syndrome to those of children with similar IQ scores and normal controls."
S. E. Thomas, S. J. Kelly, S. N. Mattson, and E. P. Riley, Alcohol Clin Exp Research, Vol. 22, No. 2, April 1998, pp. 528-533.
Address: S. E. Thomas, Institute of Psychiatry, Medical University of South Carolina, Charleston, SC 29425.

<u>ALCOHOLISM Clinical and Experimental Research</u> April 1998, Vol. 22, No. 2
Comparison of Social Abilities of Children with Fetal Alcohol Syndrome to Those of Children with Similar IQ Scores and Normal Controls
by Suzanne E. Thomas, Sandra J. Kelly, Sarah N. Mattson, and Edward P. Riley

Abstract:
Children diagnosed with fetal alcohol syndrome (FAS) were assessed with items from the social skills domain of the Vineland Adaptive Behavior Scales (VABS) via interviews with their caregivers. Their scores were compared with scores from children in two control groups. The control groups included children matched for IQ to the FAS group (specifically on verbal IQ, henceforth, the VIQ group) and children with IQ scores in the average to above-average range (normal control group). Forty-five children (age range, 5 years 7 months to 12 years 11 months) were assessed (n/group = 15). All groups differed with regard to social ability, as measured by the VABS (NC > VIQ > FAS), even when the effects of socioeconomic status were held constant. The three sub domains of the VABS social scale (interpersonal relationship skills, use of play and leisure time, and coping skills) were assessed, and results showed that the children with FAS were most impaired on the sub domain that assessed interpersonal relationship skills. An additional measure was constructed by obtaining an age-equivalent score for the VABS social scale and calculating a difference score by subtracting the child's chronological age from his/her age-equivalent score. There was a significant correlation between chronological age and difference scores for children in the FAS group but not for children in the two control groups. Specifically, in older children with FAS, there was an increased discrepancy between their ages and their age-equivalent scores, a discrepancy that was not present in children in the control groups. These results suggest that social deficits in children with FAS are beyond what can be explained by low IQ scores.

A copy of the full report can be obtained from:
Edward P. Riley, Professor, Department of Psychology
San Diego State University
6363 Alvarado Court, Suite 209, San Diego, CA 92120-4913

http://www.come-over.to/FAS/SocialArrest.htm

Behavior Mod - Does it Work for FAS/E?

by Teresa Kellerman, Eva Carner, and Russ N.

Sometimes it might work, BUT only to a limited degree, not the way it works with regular kids, not with the expected results, and ONLY if many other components are also in place. These include changing our OWN behavior and changing or controlling the environment for the child (home, school, public), as well as using role playing with them and good role modeling for real life examples to SHOW them what we expect in terms of healthy behavior. They don't learn from punishments but they do learn from mimicking behaviors of people around them.

I do not include "Behavior Mod" among my strategies that work for FAS/E. There are other techniques that are more effective, such as Deb Evensen's Eight Magic Keys http://www.fasalaska.com/8keys.html and Katharine Kersey's Guidelines for Discipline http://www.come-over.to/fasstar/Kersey.htm.

Rationale for why "Behavior Mod" does not work: Mod = modify, change. The child's ability to change his/her behavior is very limited due to the nature of the FAS/E behavior problems (organic brain damage http://www.come-over.to/FAS/FASbrain.htm). The term "behavior mod" is considered politically incorrect nowadays anyway, and many prefer to use the term "behavior management."

We want to help our kids learn socially appropriate behavior so they will be more accepted and treated with respect, but we have to be careful about trying to change them. I would like to work on helping others (and myself) to accept our kids as they are. But sometimes it is hard to accept nose-picking-bugger-eating behavior. Teresa Kellerman

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"The greatest obstacle that our kids must overcome is the chronic frustration due to unrealistic expectations." - Dr. Calvin Sumner, in a conversation with Teresa Kellerman.

Conventional Behavior Modification techniques do not work consistently. They may appear to work because severe punishment or highly motivating rewards may temporarily increase or decrease the target behavior, but it is only an illusion. It will bring no permanent change or lasting security. What does work is having realistic expectations and providing the appropriate environment. As Diane Malbin has a few catchy phrases that explain what to do when a person with FAS/E doesn't succeed: **"Modify the environment, not the child."** and **"Try differently, not harder".**

Now when I discipline Rick I make the consequences natural, I TRY to speak to him as I want him to speak to others (Role Modeling), we practice appropriate behavior (Role Modeling again) and we modify the environment as needed, (all the S-C-R-E-A-M-S).

My son is 23 now and a lot of the behavioral and emotional work we struggle with is because we are trying to undo years of failures from "behavior mod.", "trying harder", not providing appropriate supervision ("external brain") and having "unrealistic expectations". Avoid strife and depression, as they become teens and adults by educating your children and yourself. Eva Carner We use several of the ideas, but the one that has proven most effective is 5 minutes.

If Geoff (age 6) is mouthing-off, giving attitude to us, or deliberately disobeying us, we simply say "5 minutes" -- meaning Geoff goes to bed 5 minutes early. Some days Geoff goes to bed at his normal bedtime (and will get some kind of treat because of it) -- other days, well, he's gone to bed before his 3yr old brother. It's proved to be a decent method for Geoff and it saves us from getting too upset. We keep a chart so we all know -- it helps Geoff.

The other thing we do is when we discipline for breaking rules, we let them know the rule that was broken -- we will sometimes have them tell us the rule and how it was broken to (hopefully) bring in cause-and-effect. After we tell them the rule has been broken and what the consequence is we also tell them that we have rules in our house for 3 reasons:

1) we love them 2) we want to protect them 3) we want them to grow up to be a good person

Russ N

http://come-over.to/FAS/behaviormod.htm

Cause and Defect

2001 Teresa Kellerman

Making a "choice" implies thinking ahead:

Thought or Impulse	➡	Weigh the Risks	➡	Action or Consequence

When the child with FAS/E weighs the risk and takes an action anyway, in spite of the high risk of a negative consequence, that child is showing poor judgment. This is a process of "executive function" of the frontal lobe, which does not function properly in persons with FAS/E. The "choice" may be a poor one, but may be one that they cannot make well on their own.

Sometimes the child does not weigh the risks and just acts without thinking. This is acting on impulse, and most individuals with FAS/E have been known to have poor control of their impulses.

Thought or Impulse	➡	Action or Consequence

Again, this is a matter of dysfunction of the frontal lobes and possibly the corpus callosum as well. Sometimes the child can think things through and make a good decision, and sometimes the child cannot. Sometimes the child will be able to control impulses, sometimes not. It is the inconsistency of this ability to use good judgment and control impulse that is baffling. It misleads us into having higher expectations for behavior than the child can handle. It allows us to give these children more freedom than is safe for them. This sets them up for failure, because you can't predict when they will be functional and when they will be in FAS mode.

I talk with John when he has made a poor choice. I may even apply a consequence. But I spend more time talking about good choices we can make and the positive consequences. We do some role-playing, and I seek out healthy role models for him. But I don't expect him to always learn from the consequences. I know that sometimes his brain is going to be working and sometimes it won't. The tricky part is, I don't know ahead of time if he will be able to make a good judgment or control his impulses, so I have to be vigilant and provide the degree of supervision I think he needs to avoid serious trouble. I have to remember that I can only hold John accountable according to his ability to function, which I can judge by looking at his behavior in the recent past and by remembering how he scored on functional adaptive behavior assessments like the Vineland.

John's poor judgment and lack of impulse control are really not a matter of choice at all, but a matter of defective thinking caused by brain damage. That's the reality of FAS/E that I have to accept.

http://come-over.to/FAS/causedefect.htm

Disrespect and Manipulation

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Q: It is so amazing that these kids have such similar behaviors. It seems they are so good at knowing what pushes our buttons. Isn't that abstract? It puts me over the edge sometimes when he calls me a f---ing B*!@%. I wonder where they get it when we certainly don't model behavior like this. I still can't figure it out.

A: Where DO our kids get these behaviors when we certainly don't role model them? I had to think about this for a while, because it has really bugged me over the years. I'm such an analyst, I have to find answers, I'm so compulsive about it. I don't like to think that I am what the first four letters of the word analyze spell, but maybe I am, when it comes to understanding and helping others understand our kids' behavior.

First of all, I think the disrespect is mostly a matter of impulse control. In our house, RESPECT is the number one rule, the only rule that matters, the rule from which all the other rules flow. We don't call each other names, we don't hit, we TRY not to yell and if we do we try to apologize and make things right as soon as possible. Our kids don't have the "brakes" to stop the impulse to say how they feel. Sometimes they can control it, but most of the time they can't. Or maybe most of the time they do control it, and we just don't know how many times they are able to keep their mouth shut when they really want to scream an obscenity at us. The times they can't control it are the only times we are aware of it.

Their gift of being able to "tell it like it is" can be a curse when they are being honest with their negative feelings, but that is the gift we treasure most when they are feeling appreciative and loving toward us. No problem with wrapping their arms around us and saying, "I love you." That does not apply to the kids with Reactive Attachment Disorder, RAD, I'm only talking about classic FASD with frontal lobe damage that interferes with inhibitions.

The other thing I was thinking about was how manipulative our kids seem sometimes, which makes them look smarter than they really are. I heard a speaker once who asked everyone who had been manipulative in the past 48 hours to raise their hands. I and a few other brave persons raised our hands. He said everyone should raise their hands because everyone gets manipulative sometimes. I had to agree, this is normal human behavior, necessary too! Think about it - We manipulate people and situations in order to get what we want or what we need. It is a matter of survival really. Manipulation is only wrong when we are underhanded and dishonest about it or when others might be hurt by it. But most of the time, manipulation is healthy and helpful. When our kids try to be subtle about it but they aren't, we can see right through them. We all have powers of manipulation or persuasion might be a kinder way to phrase it.

PS: A note to the professional attempting to help children affected by prenatal exposure to alcohol, on behalf of all the parents who are unfairly judged based on their children's behaviors:

Children with FASD are vulnerable, naive, immature, and prone to getting into trouble with their poor communication skills, lack of impulse control, underdeveloped conscience, and poor judgment.

Children with FASD tend to exaggerate to make a situation look better or worse than it actually is. They tend to tell a person what they think that person wants to hear. They will embellish a story if it gets the attention of the listener. They are sometimes accused of lying, but they are more often just filling in the blank spaces, or touching up an otherwise real account, but they can at times make up stories just to see someone's reaction.

Attachment disorders are common among children with FASD, and manipulative behavior is common in children with attachment disorders. Professionals in the field of attachment disorders often refer to the affected children as "masters of manipulation."

Disrespect and Manipulation (continued)

Please, if a child with FASD relates something to you that sounds unreasonable or unfair, check with the parent to determine how much is true and how much is the child's attempt to manipulate a reaction from you. This is a common trait among children with FASD. In spite of the fact that most of the time they are telling at least partly the truth, keep in mind that it may not be entirely true. Keep in mind also that if you are hearing tall tales about the children's home life, the parents may be hearing tall tales about the teachers or therapists.

Unfortunately, many parents of children with FASD have been falsely accused of physical or sexual abuse of their children. By the time the truth is revealed, jobs are lost and reputations are ruined, and many families are devastated and broken, beyond healing, all because of false stories related by children and wrongly interpreted as true.

I invite you to get to know the family better so that you can be assured that they are not abusive or dysfunctional. Most parents of children with FASD are judged as being overly strict or overprotective, but it is the close supervision and seemingly unreasonable restrictions that keep these kids safe. They are at high risk of being lured into unhealthy or dangerous situations. Most parents are trying to apply the kind of parenting style that is recommended by FAS experts to prevent serious secondary problems.

Your taking the time to learn about FASD behaviors is appreciated. Hopefully you can understand the rationale behind parenting techniques that you might question. You are encouraged to take some time to read the articles at this website: www.fasstar.com/fas

Updated February 14, 2003

Abbreviated for this document on February 14, 2007.

http://www.come-over.to/FAS/DisrespectManipulation.htm

FAS and Confabulation

(Teresa Kellerman's reply to a parent's question)

Some notes about why our kids with alcohol effects might lie. I really dislike the implication that our kids are "Liars." They really are just confabulators, meaning they make up answers as they go along. And this is "normal" for kids with Fetal Alcohol Syndrome (FAS) or Fetal Alcohol Effects (FAE), collectively referred to as Fetal Alcohol Spectrum Disorders (FASD).

Making up stories and telling tall tales is a normal part of being a typical 4-5 year old. Scientific research done by Dr. Edward Riley shows that many kids with FASD have an arrested social development that stops at about the level of a 4 to 6 year old. Is it reasonable for us to expect them to develop the social and moral conscience of an adult, or even that which we would expect of a typical 8-, 10-, or 12-year-old (whatever chronological age we might be dealing with)?

Everybody lies. That's right, every person reading this has lied at one time or another. People lie for various reasons, sometimes to avoid punishment or embarrassment, to cover up a mistake or wrongdoing, to avoid getting found out. Well, with the lack of impulse control and poor judgment imposed unwillingly on our kids by their disability, they are more likely to do things that they might get into trouble for, and they are more likely to get caught. It seems unfair that they be punished for behavior that is sometimes beyond their control. (But of course we still need to hold them accountable, within reason, keeping in mind their emotional level of development, which might be about half their chronological age.)

Typical lying in typical children is addressed in an article published by the American Academy of Child and Adolescent Psychiatry here: Children and lying (Fact Sheet)

Sometimes we are looking at a normal psychological process that is in line with our child's developmental status mentally and cognitively. Sometimes it is beyond what is considered normal. The psychological term for pathological lying is "pseudologia fantastica ."

In an article published by the American Psychiatric Press on Pathological Lying, Dr. Charles Ford writes: "Brain dysfunction underlies pseudologia fantastica about one-third of the time. For some pseudologues this may take the form of dyslexia or other learning disabilities. Frequently, in those who do have cerebral dysfunction, verbal skills are disproportionately greater than other brain functions, and verbal IQ is higher than performance IQ (King and Ford 1988). It has been suggested that a contributing factor in the production of pseudologia fantastica is that there is a lack of "quality control" for the person's verbal productions (Ford et al. 1988). The more logical and critical portions of the brain (frontal lobes and nondominant hemispheres) fail to monitor verbal output adequately. In the extreme case, this leads to confabulation."

Even though our children's ability to control the lying might be impaired, rather than excuse the behavior, we need to deal with it in an effective manner. One parent's method of confronting her son in a situation where she could anticipate his making up an answer to avoid getting into trouble is commendable. She anticipated the temptation to lie to cover up a "no-no." What she did by giving him time to think about how to answer her request for an explanation was to follow exactly what the experts have been telling us, to help our kids stop before they speak or act and think about what they really want to say or do. One of my favorite new sites is the one from Deb Evensen in Alaska. Her intervention strategies include this sequence:

> Stop Action!
> Observe.
> Listen carefully to find out where he/she is stuck.
> Ask: What is hard? What would help?

This strategy not only helps in minimizing the lying, but also helps with other impulsive behaviors.

http://come-over.to/FAS/LiarLiar.htm

FAS/E and Conscience Development

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Normal conscience development is part a neurological program that progresses by levels to maturity as a child grows into adulthood.

Toddler level: Do what makes Mommy happy. Motivated by desire to please Mommy (or Daddy or Grandma) and to get affection. At this age they have a hard time understanding just what is right and what is wrong, but they begin to get it in concrete simple ways.

School age level: Do the "right" thing to avoid punishment. Desire to be a "good girl" or "good boy." With poor impulse control, this might more frequently translate to: Do "whatever" I need to do to avoid punishment, even if it means lying to cover my cute little butt. They know what is right, but they still can't always make the right decision, poor judgment being affected by neural dysfunction in the frontal lobes.

Adulthood: Do the right thing because it's the right thing to do, because it feels right. Altruism is more obvious in the late teen and early adult years, making a commitment to a program, or adopting a cause. Kids with FAS/ARND usually never make it to this level. They usually stay stuck in the "avoid consequences whatever way possible" mode.

It is my humble opinion (and that of several professionals) that conscience development with our kids who are FAS or FAE is connected to the ability to link cause and effect. They have the knowledge in their heads, they know what is right and wrong, they know it is upsetting to us when they repeatedly fail to "do the right thing," and sometimes it might appear to some people that they don't care But when you talk to them heart-to-heart, it is very clear that they do care, just at a very immature level.

When John has broken rules at school or displayed less than appropriate behavior and was confronted with his actions, he can seem flippant and uncaring, and might even say, "Who cares!" or "So what!" It has been reported to me that he has shown no remorse for wrong-doing. But I know John, and when he is mentally in a space where he can be honest about his actions and feelings, he is quite remorseful and expresses concern about how his actions affect himself and how they affect others, especially family who love him.

Some parents say, "My child has no conscience." Of course our kids have a conscience! It is just the conscience of a 6 or 7-year-old. Remember, moral development is a neurological process, a program that unfolds progressively in "normal" kids and is only fractionally complete at age 6, and this is where a lot of our kids stop developing emotionally and functionally, even if they continue to learn facts as they grow older, even if they have IQs in the normal range.

John as reached chronological adulthood, but is still maturing emotionally, and although sometimes he is capable of thinking like a 12-year-old, many times he is stuck at that 6-year-old level. I have to remember this when he acts as though he doesn't care or covers up what he has done wrong or denies responsibility or expresses other immature thoughts and ideas and feelings.

One mother reported that after the confession of stealing, her son thinks the solution is to give him a larger allowance so he won't have to steal. Makes sense to me! :-) Kid sense, anyway. You have to give him credit for trying.

http://www.come-over.to/FAS/conscience.htm

FAS and Impulse Control
(Teresa Kellerman's reply to a parent's question)

"Why can't they control their impulses? That is the part I don't understand. If they can understand, why can't they control it? I don't understand."

Fact: John understands the rules
Fact: John understands the consequences.
Fact: John goes ahead and does it anyway (AGAIN).
Fact: John can later relate the exact rules and consequences.
Fact: Mom emits a long sigh.
Fact: John still cannot control his behaviors most of the time.
Why?

Remember hearing about how the prenatal exposure to alcohol affects the corpus callosum? That's the membrane between the left-brain and the right brain that passes information between the two hemispheres of the brain. The corpus callosum of kids with FAS/FAE is damaged, and in some cases it is absent.

The left brain is the one that handles facts, rules, order, thoughts, language and logic. The right brain is the one that handles music, feelings, intuition, creativity, and impulses. Is it beginning to become clear yet?

The "do's and don'ts" are sitting there in the left brain, but when that impulse hits the right brain, a child with FAS acts first, and processes the information later, information that is there but cannot be accessed in time to prevent disaster.
This is very similar to what happens when a "normal" person drinks alcohol. After a few drinks, alcohol shuts down the left brain, which kind of falls asleep and no longer functions the way it should. So the person is now acting on the right brain only, feeling, acting on impulse, disregarding consequences.

A person with FAS is kind of like an inebriated person. You all know how a person who has had one too many might try to drive home, even if he knows he shouldn't, or a person might say things impulsively that she wouldn't dare say when she's sober. A man and woman are more likely to have unprotected sex when they have been drinking.

You all know what I'm talking about. I have heard this behavior described for FAS and alcoholics as "F--k it" syndrome, because a person does something anyway, even when they know it is likely to cause trouble.

Impulse control has NOTHING to do with knowing the rules or understanding the consequences when rules are broken. Impulse control is a neurological function of the frontal lobe, which is damaged by prenatal exposure to alcohol. The frontal lobe, when it functions properly, controls inhibitions and judgment.

When the frontal lobe has connections that are not wired properly or when it has holes in it, well, it just is not going to function well. It is NOT a matter of will power. Giving John cues and reminders helps him to control his impulses because it interrupts the process between impulse and action long enough for the information to get where it needs to go.

Medication seems to sober John up... really! And when his meds wear off, its just like watching him get drunk. He turns into Mr. Silly, immature, center of attention, pain in the butt. I have explained this to John enough times that I actually think he understands the concept pretty well. As a matter of fact, when John does something really stupid, I never ask him "Why did you do that?" because he just might explain it to me.

http://www.come-over.to/FAS/ImpulseControl.htm

FAS and Inappropriate Sexual Behavior

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Dr. Ann Streissguth has published a report on secondary disabilities (Final Report from Research for Centers for Disease Control and Prevention, 1996) based on studies of 415 individuals with diagnosed Fetal Alcohol Spectrum Disorders (FASD) from age 6 to 51. This research shows that about half of the individuals with FASD reported having been in trouble with the law or had repeated problems with inappropriate sexual behaviors.

Almost all of the parents who have spoken to me personally have confided that their child with FASD had exhibited inappropriate sexual behaviors, but they were reluctant to discuss this with helping professionals because they were unsure about the consequences of this being known or did not want it to be written into their child's official record.

When we understand that our children grow up with normal hormone surges (that begin well before puberty) and that they are stunted with the social development of a kindergartener even as they become of legal adult age, and that their frontal lobes are damaged in a way that interferes with their judgment and impulse control, it is easy to see how sexual behaviors can be a problem. When you add their vulnerability and naiveté to the palette, you get a picture of how high the risk is of becoming a victim, a perpetrator, or both.

It is the peculiar combination of normal sexual development and stunted social development that inspired an author to write the article "Boy in a Man's Body." At this writing, John is one of the few adults with FASD that I know who has not been in trouble with the law. But he has come close, too close for my comfort, and so there are few that I trust to provide supervision for John.

The problem seems to be that our children appear to be knowledgeable and wise, and often they are. But that brings with it the assumption that they should be accountable for their behavior, that they can control their impulses and make good decision, which we all know they cannot, at least not often, and not consistently.

There are those who have attempted to teach John to be appropriate. (As if I haven't tried all these years.) But it's not a matter of learning. John knows what is right and wrong, and he knows the consequences and understands many aspects of the law regarding sexual assault. But he still cannot control his impulses and he still makes decisions that get him into trouble. This is a matter of neurological dysfunction.

It's not a matter of intelligence either. There seem to be serious problems whether the person has a low IQ or is of normal intelligence. According to Streissguth's study, children and adults of all ages along the spectrum of FASD report a history of the following sexual behaviors (starting with the most prevalent):

- Sexual advances
- Sexual touching
- Promiscuity
- Exposure
- Compulsions
- Voyeurism
- Masturbation in public
- Incest
- Obscene phone call

Those with an IQ under 70 tend to get into trouble for inappropriate sexual touching and for masturbating in public. We all know that means they touch or rub themselves through their clothes without even thinking, in spite of our repeated reminders that this is not okay behavior in public. And of course, the sexual touching is not always intentional or understood as being wrong at the moment.

According to Streissguth, the females in her study who had sexual behavior problems were more likely to have been victims of sexual abuse. The males in her study with sexual behavior problems were more likely to get into trouble with the law. Among both males and females, those who had been victims of violence were four times as likely to exhibit inappropriate sexual behavior as those who had not experienced violence. John has never experienced or witnessed violence, nor had he ever been neglected or abused as a child, emotionally, sexually, or any other way. Still, at age 10, if he were in a room with other children who had been abused, neglected, or bounced from home to home, you would not be able to pick him out, as his behavior looked just as if he had been sexually abused and had never been taught proper manners. I'm afraid at age 24, there are times he still gives this impression.

Once John got in trouble for inappropriate touching while on a school playground. He was about 15 at the time, but emotionally at the level of a 5 year old. It's a long story, which I will tell sometime soon. The repercussions from this incident had a lasting impression on John, and invoked such fear into my heart for John's future, that I resolved to do everything in my power to keep John out of prison. So far I have succeeded. But only with close monitoring by either myself, his brother, his job coach, or his mentor. I can only hope that this success will continue after John enters a community home placement, which looms in the not-too-distant future as I prepare to apply for residential services for John.

In the meantime, I will continue to monitor John closely, especially in social situations, trying not to feel guilty about depriving him of a "normal life of independence" and trying not to buckle under the pressure professionals impose in the name of self-determination for me to just "let go." If I gave John the freedom that some disability experts think I should, it would only be a matter of time before he became another statistic in the criminal justice system. We could certainly let our child-adults fly from the nest, if it weren't for their Broken Beaks and Wobbly Wings".

http://www.come-over.to/FAS/InappropriateSexualBehavior.htm

FAS and Moral Character

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Let's talk about morality as it relates to FAS disorders. Moral character is one thing, and the ability to develop that is another. Conscience is related to morality in that we learn what is right and wrong from our parents, our spiritual leaders, our culture, and our laws. But the other part of that is the willingness and/or ability to act wisely with the knowledge of right and wrong.

If a person has a healthy brain and has been raised in a healthy environment, and chooses to go against their conscience, then that person is to be held accountable for his/her behavior.

If a person has been raised with abuse and/or neglect, or has had poor role models to learn from, it is harder to hold that person responsible.

If the person was exposed prenatally to alcohol before birth (whether there is evidence of full FAS or not), then that person is at risk of having a neurologically stunted social development, resulting in what looks like immoral behavior. In reality, this is a faulty program of the brain, whereby the person does not have consistent control over behaving in a morally correct manner.

Studies about morality will lead a student to learn about the different stages of moral development that a healthy individual goes through in life. Imagine that an adult has never had the capacity, physiologically, to grow beyond the childhood stage of conscience development? That is what we see with FAS, FAE and cases of alcohol exposure without any diagnosis.

Here are some other articles that explore conscience and morality and how they are affected by FAS disorders?

http://www.come-over.to/FAS/SocialArrest.htm
http://www.come-over.to/FAS/Citizen/part1_5.htm
http://www.come-over.to/FAS/cantwont.htm
http://www.come-over.to/FAS/responsibility.htm
http://www.come-over.to/FAS/PrisonersFAS.htm
http://www.faslink.org/fasmain.htm
http://207.158.228.221/define.txt
http://www.fasworld.com/facts.ihtml
http://www.conductdisorders.com/index.cfm?fuseaction=article231
http://come-over.to/FAS/dorris.htm

http://www.come-over.to/FAS/morality.htm

FAS and Stealing

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Stealing and lying and inability to learn from consequences are common in kids with FAS disorders. These are all part of the neurological dysfunction that is a result of damage from alcohol exposure, especially to the frontal lobes, which control the "executive functions."

Someone explained the stealing issue this way: Our kids may have a very immature conscience and a little-kid perception of ownership: "If it is just sitting there, it doesn't BELONG to anybody, and is free for the taking." They might slip into this mode of thinking even when they have mouthed the values and rules to you previously. They don't always connect the object with the owner of the object.

Some kids with FAS disorders are compulsive about stealing. Yes, this is brain dysfunction, and while it is wise to apply consequences and hold them accountable, we need to be reasonable about our expectations.

My daughter has a problem with stealing, it is neurological, she really can't control it, so I make sure that everyone understands it is THEIR responsibility to keep money (and food in her case) out of her reach and/or eyesight. When she lived at home, this meant I had my purse in my bedroom, and an alarm on her bedroom door so I would know if she got up at night, and there is always close supervision at all times. She is never left in the house alone. She had this problem when she was 10 and she still has this problem at age 26. It's not a matter of "trust," because she doesn't have the CAPABILITY to control the impulse to take what she thinks she needs. She is a sweet girl who would never intentionally hurt anyone, but she needs to be protected from her own disability. I make sure everyone knows about her problems so that we can all work together to protect her from harm (getting arrested, getting someone angry, getting punishment that won't "teach" her anything for something she really couldn't help in the first place).

I have to work with my embarrassment, but I explain to people that this is part of the disorder, she can't help it, I can't change it, so let's work together to help her. Let's do what we can to provide an environment where she won't be set up to fail. Success is spelled SCREAMS - note that the last S stands for Supervision. She needs an external brain, that would be you, the teacher, the respite sitter, whoever is available to think for her when she can't make good decisions for herself. Key word: CAN'T - not able to. Brain damage. Physical disability. Frontal lobes don't work consistently or efficiently. We have to remind everyone of that, so she is not blamed for behavior that is beyond her control. What is within my control is providing the supervision she needs.

http://come-over.to/FAS/StealingSolution.htmn **NEW!**
http://come-over.to/FAS/lying.htm
http://www.come-over.to/FAS/ImpulseControl.htm
http://www.come-over.to/FAS/conscience.htm
http://come-over.to/FAS/causedefect.htm
http://www.come-over.to/FAS/screams.htm

FAS Issues At All Ages

PSYCHOSOCIAL NEEDS ASSOCIATED WITH FAS & FAE
Prepared by Robin LaDue, Ph.D.
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General Issues

- Early and adequate identification and diagnosis
- Safe, stable and structured home or residential placement
- Unrealistic expectations of persons with FAS/E due to the outward appearance and verbal, gregarious manner
- Appropriate academics, vocational and living skills training programs

	Problems and Concerns	**Recommendations**
Infancy & Early childhood: Ages 0-5 Years	• Poor habituation • Sleep disturbances; poor sleep/wake cycle • Poor sucking responses • Failure to thrive • Delays in walking and talking • Delayed toilet training • Difficulty following directions • Temper tantrums and disobedience • Distractibility	• Early identification • Intervention with birth and/or foster parents • Education of parents regarding physical and psychosocial needs of as infant or child with FAS/E • Careful monitoring of physical development and health • Safe, stable and structured home • Assignment of a case manager for coordination of services and support to parents • Placement of the child in preschool • Respite care for caretakers
Latency Period: Age 6-11 YEARS	• Easily influenced and difficulty predicting and/or understanding consequences • Give an appearance of capability without actual abilities • Difficulty separating fact from fiction • Temper tantrums, lying stealing, disobedience and defiance of authority • Delayed physical and cognitive development • Poor comprehension of social rules and expectations	• Safe, stable and structured home or residential placement • Careful and continued monitoring of health issues and existing problems • Appropriate education and daily living skills placement • Help caretakers establish realistic expectations and goals • Caretakers establish realistic expectations and goals • Caretaker support group • Psychological, educational and adaptive evaluations on a regular basis • Use of clear, concrete and immediate consequences for behavior • Respite care for caretakers • Case manager role expands to include liaison between parents, school, health care providers and social service agents
Adolescence: Ages 12-17 Years	• Lying, stealing and passivity in responding to requests • Faulty logic • Egocentric; has difficulty comprehending and/or responding appropriately to other people's feelings, needs, and desires	• Education of caretakers and patients regarding sexual development, birth control options and protection from sexually transmitted diseases • Planning and implementation of adult residential and vocational training and placement • Appropriate and mental health interventions as needed • Respite care for caretakers

FAS Issues At All Ages (Continued)		
	Problems and Concerns	**Recommendations**
Adolescence: Ages 12-17 Years	• Low motivation • Low self-esteem • Academic ceiling, which is usually around grade 4 for reading and grade 3 for spelling and arithmetic	• Caretakers support group • Safe, stable and structured home or other residential placement • Shifting of focus from academic skills to daily living and vocational skills • Careful monitoring of social activities and structuring of leisure time • Working towards increased independence by teaching to make healthy choices (taught at the child's level)
Adulthood: Ages 18+ Years	• Residential placement • Economic support and protection • Job training and placement • Depression and suicidal ideation • Pregnancy or fathering of a child • Social and sexual exploitation, or inappropriate behavior • Increased expectations of the patient by other people • Increased dissatisfaction towards the patient by others • Withdrawal and isolation • Unpredictable behavior	• Guardianship for funds • Specialized residential and/or subsidized living • Specialized vocational and job placements • Medical coupons • Acceptance of the patient's "world" • Acknowledgement of the patient's skills limitations • Patient advocates to ensure the above occurs

http://www.come-over.to/FAS/ladue.htm

How to Discipline Your Child

by Katharine C. Kersey

LEARNING HOW TO BE GOOD PARENTS AND TEACHERS

Children come into this world helpless and unable to thrive without us. Our job is to love and nurture them and to teach them how to live. Discipline means, "to teach and train". We need to be good disciplinarians, to acquire skills that will accomplish the goal we set for ourselves - that of helping the child learn to control and set standards for himself.

There are several ways we can "make" children behave. One is by using force. Another is by using fear. Still another is by punishment. Unfortunately, these three methods imply that the caregiver is superior and should overpower the child. Rather than leading to a child with inner control, they make the child angry, resentful, fearful and dependent upon force.

There is another way to discipline children. Though it may not appear to get the immediate results we might like, it is safer, more natural and humanistic. It is based on the assumption that children are by nature good, fair, and honest and ultimately capable of responding to that which is good, fair and honest within us. This method is to treat the child with respect. It is treating the child as if he is as important a human being as you are. It is treating him with the same respect with which you wish for him to treat others, you, and himself.

HOW CAN WE TREAT OUR CHILDREN WITH RESPECT?

Discipline Techniques that Often Backfire

-Embarrassing -Repeating commands
-Humiliating
-Pleading, begging
-Spanking (physical punishment)
-Ordering
-Taking away favored things
-Nagging
-Punishing psychologically
-Labeling
-Engaging in power struggles
-Arguing
-Rewarding misbehavior
-Threatening
-Giving in to undue commands
-Being vague
-Allowing child to manipulate adult
-Fussing
-Saying what you don't mean
-Being inconsistent
-Expecting child to read your mind
-Losing your cool
-Making child feel guilty
-Allowing dangerous, destructive, embarrassing behavior to continue

Discipline Techniques that Work

-Following through with what you say
-Modeling appropriate behavior
-Clearly stating expectations before child has engaged in undesirable act
-Rewarding positive behavior and ignoring negative behavior (except when dangerous, destructive, or embarrassing)
-Providing when/then statements; "When you have...then you may."
-Providing if/then statements; "If you have...then you may."
-Removing child from the situation
-Being consistent
-Being firm yet kind/fair
-Giving a child a choice only when you intend to accept that choice
-Making the child feel worthwhile, liked and successful
-Providing consequence for misbehavior immediately after undesirable act is performed
-Abuse it/lose it
-Redirecting misbehavior
-Shaping non-existent behaviors

How to Stop Misbehavior in the Classroom

When children break the rules and their misbehavior cannot be ignored, it is important that the teacher have a system that is understood by everyone. This system should handle the misbehavior in the least reinforcing way possible. Ideally a private place should be created in a classroom where a child can be alone, to think and pull himself together. Such as:

YELLOW CARD: Warning. Return when ready.
GREEN CARD: Return when given permission.
BLUE CARD: Write about behavior and develop a plan to improve it.
RED CARD: Remove from room.

What to do in the Grocery Store to Help a Child Behave

-Give child a responsibility (Match coupons with the labels)
-Ignore inappropriate behavior unless it is dangerous, destructive or embarrassing to you or a bother to others
-Remove child to a private place to discuss misbehavior
-Praise another child's appropriate behavior
-Play a game with the child (Let's count all the tennis shoes we see on people's feet)
-Discuss rules before entering store
-Bring a nutritious snack for child to eat during the shopping

-Bring a storybook for child to look at
-Select a secret word or signal, which you can both use to get the immediate attention of the other
-Don't let the child out of your sight
-Reinforce appropriate behavior
-Bring a favorite toy, blanket, etc... to help make him feel secure
-Don't bring children who are tired or hungry to the store
-Role play at home how to act at the grocery store
-Sing songs with him
-Give child something of yours to play with -- keys, pocket book, etc.
-Tell child you will have to leave him at home next time -- then do it
-Stop unacceptable behavior as soon as it occurs
-Don't ever buy the child a treat from the store where he threw a fit
-Wear comfortable shoes and clothes to the grocery store (both parent and child)
-As your child is able, let him comparative shop for you
-Discuss pictures on the grocery items
-Take an older child to help you
-Let child know it is a privilege to go shopping with you

How to Build Your Child's Self-Esteem

-Show children that you like them by smiling at them, hugging them and speaking to them in a positive way.
-Read out loud together as a family.
-Use positive reinforcement to encourage responsible behavior.
-Help them to learn responsibility by requiring them to complete tasks.
-Set aside a time each day to spend with each child individually.
-Help children to develop organizational skills by providing space for toys, books, schoolwork, etc.
-Help them to discover their own special gifts by letting them develop an interest in activities such as sports, music, dance, drama, etc.
-Encourage their independence.
-Get to know their teachers.
-Do not embarrass children by yelling at them in public.
-Allow your child to express his feelings.
-Listen to your child and look him in the eyes when he is talking to you.
-Do not set your expectations so high that the chance of failure prevents your child from trying.
-Encourage your child to be proud of his name, his ideas and his work.
-Give your child recognition for the effort he makes, even though it may not come up to your expectations.
-Answer your child's questions openly, honestly and immediately, if possible.
-Take your child with you on trips to run errands and involve him in decision-making.
-Build a file of mementos of things in which your child participated.
-Point out and appreciate unique qualities in your child that make him special.
-Do not compare one child to another.

Positive Ways to Encourage Children's Growth

-Show children you like them.
-Provide a model for intellectual curiosity.
-Reward responsible behavior and tasks you ask them to complete.
-Require your child to complete certain tasks starting at an early age.
-Set aside time each day to give your child your undivided attention.
-Encourage organization at an early age.
-Help your child discover his natural gifts.
-Work with your child's teacher.
-Encourage your child's growing independence and autonomy (ability to become self-reliant).

Six Step Problem Solving Technique

1. State the problem.
2. Brainstorm the alternatives.
3. Select one possible solution.
4. Implement a solution.
5. Reassess the plan.
6. Start over, if unsuccessful.

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To get more information about Dr. Kersey's books, you may call this toll free number: 1-800-451-7771 or call 1-703-709-0006.
Dr. Kersey's first book, _The Art of Sensitive Parenting_ has been developed into a comprehensive audio program. You may call this toll free number: 1-800-227-0600.

http://www.come-over.to/fasstar/Kersey.htm

How to Explain FAS Behaviors

Q: How do I explain the behavior problems my child has to other children?

A: I would explain FAS to the other children rather like I would explain it to my child, with frank honesty, and without judgment or blame.

I recall the positive experience I had explaining FAS to the neighborhood children when John was younger, and later with his high school peers. My discussion with both John and with other children boils down to three simple statements: Everyone has problems and limitations; John's problem is FAS; John has some really great talents and gifts as well. This is how my little talk might go:

State fact #1: Everyone has problems and/or disabilities. One person has diabetes, another has high blood pressure, another has depression. These are not visible to others but they cause distress and difficulties for the individual who has one of them. One person might have spina bifida, another might have cerebral palsy, another might have parkinson's disease. These are more noticeable to others. One person might have cancer, another might have Bipolar disorder, another might have ADHD. Some problems are more serious than others. One person might be hard of hearing, another person might be deaf. One person might need glasses to read, another person might be blind. Some problems are more obvious than others. But EVERYBODY has some sort of problem, whether we are aware of it or not. What kind of problems do YOU have?

State fact #2: You notice that Johnny has a lot of inappropriate (rude, loud, annoying) behaviors. Do you ever wonder why he has more of these behaviors than other kids? Johnny has Fetal Alcohol Syndrome (effects, whatever). This happened before he was even born. When his birth mother was pregnant with him, she drank alcohol and the alcohol went into Johnny and damaged little parts of his brain. She didn't mean to do this, she didn't know this was harmful. So parts of Johnny's brain don't always work right. And this affects Johnny's behavior. Because Johnny's brain doesn't always work right, he can't always control what he says or what he does. He might do things without thinking about the consequences. He might make decisions without being able to guess right about the results. He might forget the rules or what you just told him, and needs lots of reminders. He might act really immature like a little kid. He might be rude or silly. Sometimes he can control his behavior and sometimes he can't. It is very frustrating for us when he cannot control his behavior. But it is very frustrating for Johnny too. Because he really wants to have friends and he wants to make others happy, but sometimes he does things that make other angry, and he gets in trouble, even when he is trying to be good. There are things that help Johnny have control, like the right medications, and a quiet house, and foods that don't have additives. Sometimes things that happen around him will make it hard for him to keep control, like teasing, or yelling, or fighting, or changes in plans, or too much music, or too many people in the room. Maybe there are things that we can do to make things easier for Johnny. Maybe we can be role models for Johnny with respectful, mature behavior. What do you think?

State fact #3: Even though Johnny has this disability called FAS, he also has some really cool talents. Did you know that Johnny is really good at music (art, mechanics, whatever)? I'll bet if you asked him, he might play a song (draw a picture, build a lego set) for you. Johnny is really friendly most of the time. And he forgives easily, and doesn't hold a grudge. He really likes playing with you, and wants to be friends. What can we do to be a good friend to Johnny?

How this conversation goes depends on the age person you are talking about, or if there are mental health issues (RAD or Bipolar might require a different dialogue). You would adjust it to the age level of the other kids. And of course, you would have this conversation with the affected person as well. Separately first, then maybe all discuss it together.

The key, I think, is adequate information presented in a non-judgmental way, with an emphasis on the neurological origins of the behaviors. You might consider using the FAS and the Brain brochure or the Aint' Misbehavin' brochure. Acceptance will make life easier for everyone. Maybe this article on the AAA's of FAS will be helpful as well. --Teresa Kellerman

http://www.come-over.to/FAS/explain.htm

Motivation

(Advice from parent/professional Daniel Dubovsky, MSW, LSW)

Q: I have an adolescent with FAE who has some serious behavior problems. Adderall and Prozac was a real help for the attention deficits and impulse control. When he started raging at age 10, the doctor put him on risperdal and depakote, and that has lessened the outbursts a great deal. But he doesn't seem to respond well to behavior management techniques, like reward systems, which are not effective at all. He likes getting prizes at school, but he seems to forget things he needs to do to earn the prizes, like getting papers signed. He just doesn't seem motivated. Please help! --a tired mother

A: I think that behavior modification systems can work if we change the way we view and use them. When something doesn't work, we need to stop saying that the individual is just not motivated enough or we haven't found the right motivator and begin to ask "what are we not doing to make sure that this individual succeeds." What does your son need to get the fabulous prizes and how can the school and others make sure he gets them? Expecting him to remember everything and get things from home to school regularly may be just setting him up to fail. How can we ensure that things get back and forth?

We can use a reward system as long as we are dedicated to making sure they receive the reward. That might entail seeing them do something "right" or trying to do something "right" and giving them a certain number of points. It might mean helping them get dressed in the morning and when they are finally dressed after much prompting and support, giving them their points or reward. It also means that the reward often has to be much better connected time-wise than it usually is. If you get your stars in school for the next 2 weeks, you can go on the class trip will usually not work. The sense of time (which is an abstract concept) is just not there. The only way something like that should be used is if the teacher will guarantee that s/he will make sure the child has the stars needed for the trip.

For my son, his motivation was always to fail so no matter what motivator was found, if it was something he really wanted, he would make sure he didn't get it. That had to do with his view of himself as a "bad kid" and his early experiences in life. It's not on a conscious level for him so talking with him about it doesn't do much. However, he really wants to be liked and helpful and if someone asks for his help and then after he helps tell him he earned points, he feels good. I call that catching kids at succeeding and I think we need to do that more - not make too big a deal about it, but make sure that we help them succeed. After all, if they could do it on their own, they wouldn't have many of the problems that they do have. --Dan

http://come-over.to/FAS/motivation.htm

Neuro-behavior In Adolescents and Adults

FAS/E is not about having a different looking face – which disappears with age, making diagnosis as an adolescent or adult very difficult, or about being somewhat shorter than normal. It is about having *deceptively significant brain damage*, even in the absence of mental handicap, with enormous implications for function in all adult domains. Its impact on the ability to parent cannot be overstated.

People with FAS/E have many neurobehavioral problems, which inter-relate to produce profound problems with accurately processing information and relating to the world around them. Those with the greatest impact on adult functioning are as follow:

Problems with cause and effect relationships and impulse control

Cause and effect can best be defined as prediction. It is somewhat like having your own crystal ball through which one can accurately foresee the future – both in terms of immediate mid-term, and long-term events. Without the neurological ability to do this, events remain disconnected from one another, and the affected person has great difficulty learning from experience or grasping consequences. They are often unable to understand that their behavior has an effect on another person and will be bewildered by, or even hostile to our reaction to what they have or have not done. They are frequently described as having no conscience or showing no remorse – which is really a *reflection* of the problem, and not the problem itself. Cause and effect is also intimately connected to the ability to control impulses. For people with normal cause and effect reasoning and impulse control, the two are seen as a three-part intermingled thought process: action, *reflection,* consequence, or impulse, *reflection*, action/lack of action. For those people with FAS/E the middle step, reflection, is faulty, works only sporadically, or is missing altogether. Reflection, something we do in a split second, is a very complicated function comprised of many inter-related thought processes, any one of which, if faulty, will radically alter the way one perceives relationships. Good cause and effect reasoning is also essential to motivation to do just about anything. This is particularly a problem in terms of motivating the individual to long-term changes, a primary reason why both rewards and sanctions, when used, must be immediate and why affected persons seem unable to delay gratification or work towards long-term goals. If you do not have good cause and effect reasoning, you "just don't get it".

Problems with the ability to generalize information

The ability to take information learned in one situation and use it to solve problems in another similar situation – the ability to generalize – is the essential thinking or problem solving process without which even marginal functions in an adult society is difficult to impossible to achieve. In FAS/E, this thinking process seems to lack movable parts; everything is seen as unprecedented, never having occurred before, and to which no previously acquired social and/or behavioral learning applies. People who are able to generalize see things as sets of shifting possibilities, depending on what has gone on before. People affected by FAS/E do not see those "possibilities", only what is here and now. They are not flexible thinkers. Decision-making is also governed by the ability to generalize. We use general rules of thumb – solution strategies – which we derive and remember from personal experience, and which worked before, to make decisions in new situations. These past experiences guide our thinking and provide a basis for making those choices. For the person with FAS/E, choice making and problem solving are very difficult undertakings because they lack the ability to re-organize – in other words, generalize – this information and perceive new relationships among the pieces of a problem. In FAS/E, the first solution to a problem is usually seen as the only solution to a problem, even when it clearly does not work. People who cannot generalize then, are unable to develop an understanding about something new they come across based on similarities to, or differences from, something with which they are already familiar: i.e.: if a rifle is dangerous, then a handgun is too; if leaving your child unattended causes him to be apprehended, then arranging for his care will prevent that happening. It has been said that the Golden Rule of FAS/E is "Thou shall not transfer".

Problems with understanding concepts and abstract thought

A concept, or idea is a mental {one that is held in the mind and not seen} *category* of things, events, occurrences, people, traditions, and society rules grouped together on the basis of commonalities. They are *general* ideas – the generalization dilemma again. They describe, in a nutshell, the sum total of society's past knowledge, and experience in an area of learning and provide guidelines and parameters for acceptable function. Grasping concepts and how they relate to the individual, allows that individual to understand and deal effectively with the world {i.e.: time, money, numbers} and to predict how he needs to interact with future

events {i.e.: honesty, integrity, responsibility, values}. If you cannot form ideas – concepts – and *maintain* and *apply* that learning, then you are forced to deal with every unfamiliar event or situation as entirely new – and again, previous learning does not apply.

Abstracts, very closely allied to concepts, can be defined as "a thought apart from any particular object or real thing not concrete, but somehow related to it". In other words, a lump of sugar is concrete, the idea of sweetness is abstract; a moving car is concrete, the idea of danger associated with it is abstract; cash money is concrete, the idea of value related to it is abstract.

Abstracts and concepts work together to help us deal with life. For the person with FAS/E, who is unable – not unwilling – to conceptualize and abstract even the most basic human interactions with any success, life is spent walking on quicksand. Social rules are a quagmire and human language is full of words of great abstraction. Consider the words "if", "when", "maybe", perhaps", "then", "soon", "sometimes", "later", "either", "or", "should", "could", "would", "but", etc. What happens to the person who simply cannot process or make sense of what is meant by such abstractions?

To deal effectively with life and to function successfully, you must be able to conceptualize and abstract at a fairly sophisticated level of accomplishment. Persons with FAS/E are unable – not unwilling – to do this. They cannot begin to understand why they keep running afoul of our expectations for their performance, never mind predict how they should behave in the future or how we might react to that behavior.

Problems with preservative behavior
Preservation is commonly described and thought of as some form of repetitive behavior – i.e. tapping toes, drumming fingers, knocking, pacing, etc. In persons with FAS/E, and particularly in adults, it manifests as a particularly rigid way of looking at things, a refusal to let go of an idea {rigid tenacity which can border on fanaticism}; and/or a certain way of feeling or interpreting a feeling and refusal to consider any other explanation. It can also be seen as a narrow interest in something, which excludes all others. Adults who persevere "lock in" to their behavior and are unable – not unwilling – to sort it out or make sense of it. Trying to "talk sense", "rationalize" or otherwise intervene, especially using languages, makes the situation worse. They are unable to "let go" no matter what the negative consequence and are unable to see other possibilities. Adults who perseverate usually have great difficulty in seeing similarities and differences in behaviors and situations, along with problems in sorting and classifying sub-sets of those behaviors. Again, the first choice is seen as the only choice.

Problems with the ability to conceptualize, internalize, and structure time
Time is an abstract concept; it is something which governs events, and the passage of which happens even in the absence of clocks and watches. People with FAS/E are largely unaware of time. It has little meaning for them and is not a valid method for negotiating a day, week, month, or year. Our culture works on time; it controls, to a very large extent, everything we do. The person with FAS/E who does not grasp the concepts involved, even if able to "tell time", is still unable to internally structure "time" in a way which would allow for its use. The implications for independent function are not to be underestimated. Adults with FAS/E {not to mention children as well} do not keep appointments. They do not follow through on instructions. They do not remember when a mealtime is; never mind when they – or the child – last ate. They do not show up for work on time, and do not come back from lunch on time. They seem oblivious to the days of the week and seasons of the year – all sequential cycles of time. They do not know whose birthday comes first, even when they know the actual dates for family members. They do not grasp that 7:55 and 8:00 are the same thing for all intents and purposes and are unable to organize their lives according to a time construct without years of specific teaching. They "tell time" using a digital watch {which has absolutely nothing to do with actual "telling time"} but are unable to generalize that skill {because it is not concept based} to an analog watch. If they finally master an analog watch with numbers, they will not be able to switch to an analog watch without numbers or only the l2, 3, 6 and 9 indicated. Again, generalization to a very slightly different situation. Add to this the fact they have no "sense" of time passing, are often truly unable to differentiate between 15 minutes and two hours, perceive "early" and "late" very differently than we do and are unaware of how long it takes to accomplish a whole range of tasks and you begin to understand that the expectations for this group of people must be substantially altered. A major mistake made by all systems, which deal with adults with FAS/E, is to assume that because they can tell you the time using a digital watch {and since most of us use the same watches} they actually know what time is and how it works. Consider these: How can 60 minutes be *one* hour if 30 days is *one* month when 30 is a smaller number than 60, but a month is longer than a day? How can there be 24 hours in *one* day when there are seven days in *one* week? How about

a.m. and p.m.? How can 7 o'clock occur *twice* in *one* day? How can the second 7 o'clock be at night when it is still light outside? How is the person with FAS/E supposed to hold all of this in his/her head, at the same time, all of the time?

Problems with short-term memory
Memory is defined as the mental ability to store information for later use, and the capacity to retain and recall that past experience as required. A functional memory is essential for the use of critical thinking skills in all of the following areas relative to successful functioning, particularly as it applies to parenting: understanding truth, comparative judgments, making choices, following through motivation, responsibility, delaying gratification, and problem anticipation, recognition and solution. Problems with the correct storage, integration, or retrieval of information from memory will have a negative impact on one's ability to adequately and accurately address a situation requiring a response from the individual. Adults with FAS/E {and children too} have what is known as "flow- through phenomena" – information may be learned, stored, and retained for a while, only to disappear without warning, and reappear just as suddenly, all with no predictable pattern – hours, days or weeks later. What can be said with certainty is that this unpredictable pattern happens just often enough to convince those who do not understand, this is deliberate "behavior", under the control of the person with FAS/E. The reality is very different, and no one is ever more frustrated than the person with FAS/E, who must constantly deal with the reactions of others to this behavior. Difficulties with sequencing – the ability to follow something in the order in which it is presented – also indicates a problem with short term memory, and means that information, when stored, is being done so in a random, haphazard fashion, in no predictable order. This has serious implications for being able to "tell the truth" and for being able to understand and make sense of something, which has happened, information which one is given, or something one is asked or told to do. It does not mean the adult with FAS/E is a "liar" in the commonly accepted sense of the word. He/she is, however, unable to recall and/or make sense of past events in the logical, rational, sequential order we call "truth". Confabulation occurs when interpretation of what has been incorrectly stored to begin with runs headlong into a distorted perception of the environment and one's relationship to it. *Even when* information has been successfully stored and accessed, the individual with FAS/E must be able to interpret what he needs to do with that information, which, once again, requires the use of generalization skills linked to cause and effect reasoning, in addition to accessing a time construct, to make a logical, rational, and sensible inference about *what* should be done, and *when* it needs to be done.

Problems in all areas of processing information, particularly auditory
FAS/E is a serious information processing deficit which covers all four domains involved in processing information obtained from the senses, most particularly auditory information. Information is neurologically processed using input {recording information from the senses}, memory {storage for use}, integration {interpretation} and output {appropriate use of the first three}. While adults with FAS/E have significant processing deficits, they are nonetheless highly verbal, and often very articulate individuals, who give the appearance of being much more functional than they actually are, based on their use of spoken language. As a rule, we judge people on just exactly this – language use. With FAS/E, nothing could be more misleading or farther from the truth. Information processing deficits of the type universally found in FAS/E, mean that the individual does not – because he cannot – do well in any of the aforementioned areas of neurobehavioural function which are absolutely inseparable from acceptable social, emotional and behavioral functioning in adult society, no matter how verbal he/she is. *The adult with FAS/E has the appearance of capability without actual, underlying ability*.

Processing deficits with FAS/E mean that one cannot use language as a primary means of effective communication with the individual. Consequently, any language and cognition based treatment, intervention or parenting program will fail. Belief that the adult {or child, for that matter} with FAS/E – or one who remains undiagnosed and/or unsuspected – is cognitively aware and comprehending of conditions and circumstances and able to make changes based on his/her statements to that fact, will cause one to make critical errors in case planning, case management and case dispensation. This is equally true for social service delivery and the judicial system.

In FAS/E, the brain link between what is asked or required of an individual by a person, place, situation, etc. {information going in} and the action he/she needs to take {activity going out} is defective. Input and output do not equate. The behavior of persons with FAS is not non-compliant behavior; it is *non-competent*.

The behaviors and functions associated with FAS/E and pre-natal exposure to alcohol are not developmental delays. They do not go away over time, but merely change how they manifest themselves. In fact, these

problems become more obvious with increasing age and our demands that all people become self-directed, self-motivated, self-controlled and self-"remembered". Any attempt at treatment or intervention for child or adult is unlikely to succeed if we do not keep this information at the forefront of case management. Our lack of tolerance for behavior which falls outside the norm is understandable; our lack of knowledge, training and understanding of what causes this behavior and how one might more effectively deal with it, is not.

The problems as discussed above also impact significantly on children with FAS/E. The primary difference is that adults do not expect children to "think" on the same level as adults; they expect children to "grow out of" what they see as "stages" and believe that if given enough exposure to the "right" things – whatever they are – children will somehow, through osmosis, metamorphosis into functioning people. When that does not happen, however, they typically impose more and more stringent sanction for behavior, which is no longer developmentally acceptable.

Children with FAS/E are very difficult to parent under the best of circumstances. They do not process or make sense of their environments any more than adults do. They may also be very hyperactive and have problems paying attention to just about anything. They are highly suggestible, impulse drive, and repeat behaviors, which have had negative outcomes over and over. Many are, or quickly become, oppositional and defiant and are highly intolerant of any kind of verbal restriction. Problems with eating and sleeping are common, and many have other significant medical problems as well. Children with FAS/E have trouble with attachment and bonding – even in the absence of abuse, neglect and multiple caregiving – due to their problems with cause and effect. Attachment is a primary cause and effect relationship and this may be the first place this problem shows up. Multiple care giving can be disastrous for these children.

Their problems with social, behavioral and academic school learning are usually significant, even in the absence of mental handicap. Most of them function, by IQ measurement, too high to qualify for more than minimal service in school. Their problems in the school can be overwhelming and frequently blow back on the parent or caregiver. The average child or teen with FAS/E is very verbal and talks a lot, and is subsequently thought to be brighter and more functional than he/she actually is, leading to the belief that what one sees is "behavior" and not organicity. They appear to be the product of "poor parenting". It is very easy for systems to fall into the trap of blaming the parent, and while poor parenting and unhealthy environments definitely make things worse, they do not cause the problems to start with.

Children and teens with FAS/E are very tactile and have many problems with inappropriate touching, even in the absence of abuse. They are ready targets for those who would take advantage of them, and frequently the subjects of sexual abuse themselves. A significant proportion of these children will go on to become abusers of other children. Treatment for this group of individuals has not been effective and this lack is cause for very serious concern for their futures.

They are very much at risk for physical abuse in the community at large and in dysfunctional homes due to the chronicity of their various behaviors. They frequently have a very high pain tolerance, and would not necessarily respond to physical abuse as would another child. Injuries and illness, which go untreated for longer than would be expected are common in this group of children, even in stable homes, due to this tolerance for discomfort and pain.

Children with FAS/E require early resolution of placement issues, and good, skilled case planning to meet their long-term needs. Multiple placements *must* be avoided. They must have, as an absolute minimum, stable, consistent, care giving, with a caregiver able to learn the specific skills, which are required to maximize functional potential in this group of children. To reach any kind of sustained function within individual parameters of ability, they *must have:*

- Constant, total supervision
- Highly structured, significantly altered physical environments
- Different communications techniques
- Mediated learning
- Labor intensive, time consuming interventions

Regardless of age or IQ
Individuals with FAS/E are not candidates for independent living as adults without extensive, intensive, comprehensive, and continuing supports in place. This is as true for the affected individual with the IQ of 90 as for the individual with an IQ of 68.

http://come-over.to/FAS/Neurobehavior.htm

Suspended!

Letter from a concerned teacher with reply by Teresa Kellerman

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Q: I have a 14-year-old student with FAS and ADD. He has been suspended twice in the past 3 months for petty theft at school (from teachers). There seems to be a recent escalation in unacceptable behaviors. His mom and I are trying to get the school district to move him to another program with lower student teacher ratios. This is an adoptive parent, a great gal, but she has an "in your face" demeanor that I'm pretty sure is not the way to deal with the recent problems. Can you recommend a procedure or "scripted speech" that works with these kids in these situations? I've talked with him calmly, have bribed him with payoffs for good behaviors, and recently put a Band-Aid on his shoulder to remind him to think before acting. I told him about Pinocchio and Jiminy Cricket acting as the puppet's conscience. School staff DO NOT GET IT!!!!! I am this boy's resource teacher and have known him for 5 years. He is on Adderall - when do they reevaluate the ADD meds? I have encouraged mom to access the NOFAS site. Any other suggestions? Thanks.

A: It sounds like this boy is right on track (for FAS development). I can't tell you how many other kids his age with FAS disorders are going through exactly the same behaviors, with consequences that just don't work. Some kids are into lifting cool things like cell phones and CD players or money from the teacher's desk or other students. Some are into inappropriate sexual behavior. Both are very common at this age, and neither is easy to deal with. Most FAS experts will tell you that suspension is not an appropriate or effective means of dealing with FAS behaviors. Self-talk with learned scripts might work, but only sporadically, as memory deficits, poor impulse control and poor judgment will interfere.

It looks like you have three challenges: the boy's behavior, the mom's behavior, and the school's behavior. The easiest way to change the boy's behavior is to change the environment and the behavior of those who are attempting to help/educate him. He can't always remember and he can't always control his impulses because of permanent brain damage, which manifests itself inconsistently and in unpredictable ways. (Some days he can do fine, and other days he just blows it.) A Band-Aid on the shoulder might work as a reminder for a non-disabled student, but it is probably pretty useless for a child with FAS. What he needs is that smaller classroom and more attentive staff who can provide the supervision he needs. Our kids almost always fail in the larger classroom that has more sensory stimulation than they can handle and usually not enough supervision to keep them out of trouble. Here is a list of my SCREAMS model of intervention strategies for FAS: http://www.come-over.to/FAS/ScreamsArticle.htm

I know lots of adoptive moms who have that "in your face" attitude. I keep trying to tell them that they will more easily get what the child needs if they are reasonable and calm, but to tell you the truth, I have to fight to control my own attitude sometimes, because it is so frustrating to have to deal with teachers and "helping" professionals who just don't get it. I would try to be more understanding of the chronic frustration this mom has had to go through all these years, having to deal with one professional after another who not only doesn't get it, but probably blames the boy's behavior on poor parenting (which is seldom the case with adoptive homes). Once she realizes that you are her ally, she will probably soften up a little when it comes to advocating for her boy. I hope that this mom appreciates your efforts to really understand this boy. Not many teachers are willing to search out info on the Internet and to ask questions the way you are.

There are a few things that this boy needs in his IEP:

1) A communication book that is not the responsibility of the boy but the responsibility of the school staff and mom to write in everyday, one thing positive and whatever issues each needs to be informed about. There is an attitude today that we need to hold kids accountable for their own behavior, and I agree, when the ability to control is there. This boy does not have the ability to control his behavior or to be responsible for notebooks, backpacks, communication logs, homework, notes, etc. His having what he needs when he needs it should be the responsibility of teachers and parents, and we can praise him when he does remember, but we can't expect him to have the same ability to be responsible as another student without disabilities. His level of ability for responsibility is about that of a kindergartener. Praise for his successes should be written in the communication book and read to him each day to encourage him. Heaven knows, he makes enough mistakes about which he is reminded constantly. The communication log can be used for relating both the positive and the negative, and even that can be put into more positive terms.

2) A one-on-one aide would be ideal, but I know this is difficult to get. But at the very least, this boy needs close supervision AT ALL TIMES, including on the bus, on the playground, in the cafeteria, before, during, and after classes. I insist that these particular situations be written into the IEP. That someone makes sure that a responsible person (not another student) is monitoring the boy at any given time. The boy has mental disabilities that prevent him from controlling his behavior and his impulses. This is not an excuse, it is an explanation, a statement of fact. His conscience does not always work. It is as if he were riding downhill on a bike with no brakes. We have to be there to be sure he doesn't crash. He can't STOP on his own. He needs 24/7 the same way a boy with MS needs a wheelchair, or a child with impaired vision needs Braille or a child who is hearing impaired needs a signer.

3) The staff who work with the boy need to be educated about FAS disorders and the nature of his behavior issues. Reading a brochure might help, but it will be difficult to relate second-hand all they need to know. They need to be trained with a workshop, or they need to attend a conference, in order to apply methods that will help him learn and to prepare him for transition when he is done with school. There are brochures on my website that you can download and share if you want: http://come-over.to/FAS/brochures/

If there is only one brochure that is shared with the teachers, the best one is FAS and the Brain. This explains that the behaviors are neurological in origin, not psychological, and therefore we need to approach the behavior management from a different perspective than we would for problems that are psychological in origin. We can help this boy learn what the rules are, what is right and wrong, what the consequences are. He can learn all that. But we cannot teach him to control his impulses. Rewards and consequences work, but not very well, not all the time, and when they don't work, it is more a matter of his brain not working efficiently that day, not a matter of choice on his part. If you ask him if he wants to get into trouble, he will say no. If you ask him if he wants to get good grades and rewards, he will tell you yes. He doesn't mess up on purpose. Even when he may appear to be manipulative, it is more a matter of poor judgment, which also is beyond his control, a matter of neurological dysfunction of the frontal lobes.

Another thing that is absolutely necessary is proper evaluation using the right assessment tools. I don't know which IQ test has been administered, but the best one to use for FAS is the Woodcock-Johnson, because it has so many sub tests with scores in each area that will indicate where he excels and where he has deficits, especially in the different areas of information processing and memory. The other basic test that is a MUST for kids with FAS is the Vineland Adaptive Behavior Scales. It seems that kids with FAS score about 20 or more points lower on the Vineland than they do on the IQ test, indicating that he functions in real life at a lower developmental level socially and emotionally than would be indicated by his academic achievement. This is important in that we need to adjust our expectations for him to control himself and his ability to function at his level of development, which socially and emotionally usually is stunted at the 5 or 6 year old level. Read the rationale for using the Vineland, which was written by a mother of a boy very much like your student: http://www.come-over.to/FAS/VinelandRationale.htm

About medications- He has a chemical imbalance in his brain that is permanent. He needs his Adderall the same way a child with diabetes needs insulin. If the child has ADHD caused by alcohol exposure (permanent brain damage), the child may need to be on meds for this the rest of his life. Adderall seems to be the most effective for kids with FAS and FAE. Most teens with FAS do well on this combination of Adderall and an SSRI like Paxil or Zoloft or Prozac. The SSRI is not for depression but it helps with the emotional outbursts and tends to help somewhat with the impulse control as well. I understand you may not legally be able to make suggestions about meds, but you can relay information about meds. There is an entire section on my web page about which meds work for FAS: http://www.come-over.to/FAS/meds.htm

You might want to purchase a very inexpensive book (about $7.50) from the FAS Book Store called "Fetal Alcohol Syndrome, Fetal Alcohol Effects, Strategies for Professionals." This is easy to read and easy to understand, great for parents and teachers alike: http://come-over.to/FAS/store/books.htm If the Mom has Internet access, I hope she has found my web site, as well as online support, like Faslink, an online support group mail list, or Olderfas, a mail list for parents of teens and young adults. Online support links are here: http://www.come-over.to/FAS/fasonline.htm

I love your analogy of Pinocchio and Jiminy Cricket! This boy is very fortunate to have you for a teacher.

http://www.come-over.to/FAS/Suspended.htm

Is it that the child *won't*? or Is it that the child *can't*?
by Diane Malbin

Beliefs dictate behaviors. The belief that many primary learning and behavioral characteristics, which may reflect the underlying neuropathology associated with FAS/FAE are the result of willful, volitional or intentional behaviors often leads to punishment of these symptoms. Inadvertently, this may in turn result in the development of an array of secondary defensive behaviors. The chronic lack of a good 'fit' between the needs of those with FAS/FAE and their environments may lead to tertiary characteristics of school failure, mental health problems, running away, or trouble with the law. These are all believed to be preventable. The key to prevention is linking the idea of brain dysfunction with presenting behaviors, reframing perceptions, and moving from punishment to support. The shift is from seeing a child as one who "won't" do something to one who possibly "can't".

Primary Characteristics: Neuropathology	**Standard Interpretation: May Lead to Punishment**	**Secondary Defenses or Characteristics**
Memory problems	Could remember if they he/she tried	Fear, self protection
Inconsistent performance	Not trying on "off" days	Anxiety
Forgetful	Willful	Frustration
Poor short term (auditory) memory	Not listening, paying attention	Anger, avoidance
Remembers some things, not others	Seen as lazy	Confusion, depression
"Gaps": Talks the talk, doesn't Walk the walk: disconnections	Willfully disobedient	More defensiveness
Can't link words with feelings	Seen as uncaring	Shut down, confusion
Forgets words, ideas	Doesn't try, could do it	FRUSTRATION!!!!
Decodes, doesn't comprehend	Manipulative	Inferiority, fear, masking
Difficulty forming associations	Does it 'on purpose'	Internalizes negatives
Doesn't see similarities differences	"Should" know better!	Isolated, fearful
May not generalize or apply rules in new settings	"Trying to make me mad"	Masks mistakes, lies
Difficulty with abstractions: money, math, time	Has to know times tables!	Avoids homework
Poor planning, sequencing initiating, following through	Punished for not doing tasks	Feels blindsided, may not understand
Difficulty understanding danger	Psychopathology	May shut down
Impulsive, suggestible	Daredevil, sociopath	Behaves accordingly
Can't see consequences	No conscience, punished	Blames others
Fatigue	Passive resistive	Irritability to rage
Long response time	Trying to be controlling	Gives up or acts out
Acts young for age	Too dependent, irresponsible	Overwhelmed
Socially "inappropriate"	Poor values, insensitive	Gravitates to "comfort" friends
Perseverative	Controlling, wants own way	Rigid, resistive
Oversensitive	Hypochondriac	Discomfort, distress, whiny
No response, flat affect	Doesn't care	Lacks language to communicate clearly

Diane Malbin's website FASCETS http://www.fascets.org/

http://www.come-over.to/FAS/cantwont.htm