

Treatment of Fetal Alcohol Spectrum Disorders



Addressing FASD in Treatment

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Introduction

Value of Addressing FASD

Although the evidence base for effective substance abuse/mental health interventions with individuals who have or may have an FASD is limited (Premji, Benzies, Serrett, & Hayden, 2006; Paley & O'Connor, 2009), research has demonstrated that this population can and does succeed in treatment when approaches are properly modified, and that these modifications can lead to improved caregiving attitudes and reduced stress on family/caregivers as well as providers (Bertrand, 2009).

For the counselor, building competence with FASD has the obvious value of enhancing professional skills, as the counselor can provide FASD-informed care. For the client, addressing FASD has the potential to enhance the treatment experience for both the individual with an FASD and those around him or her, increase retention, lead to improved outcomes, reduce the probability of relapse (thus helping to break the cycle of repeated treatment, incarceration, displacement), and increase engagement rates in aftercare services. Access to FASD-informed interventions and accommodations, like those discussed in this chapter, has the potential to create protective factors for the client that can reduce secondary disabilities (Streissguth et al., 2004) and has been shown to lead to better outcomes (Bertrand, 2009).

For the client, addressing FASD provides an additional route to possible treatment success. Individuals with an FASD are a largely hidden population, yet these individuals frequently need services for substance abuse, and, especially, mental health (Streissguth et al., 1996). For every client that did not return for appointments, seemed noncompliant or resistant with no clear explanation of why, or just didn't seem to 'get it,' a knowledge of FASD could be an extra clue that helps solve that puzzle and enable success for both the client and the program.

Be Willing...

To effectively serve individuals who have or may have an FASD, what is needed most is a counselor who is willing. For many individuals with an FASD, it is not that they *can't* do the things necessary to succeed in treatment. Rather, it's that no one is willing to develop the understanding needed to help them succeed. While individuals with an FASD do present unique challenges, a willing counselor can make the difference between treatment success and treatment 'failure.'

- **Be willing** to understand the brain-based disabilities that are characteristic of these disorders: With any diffuse brain damage, including the damage that can result from prenatal alcohol exposure, some of the effects are permanent, and one cannot assume or teach the usual decision-making and self-care capabilities.
- **Be willing** to observe physical and behavioral factors and consider possibilities beyond defiance, noncompliance, or other more commonly diagnosed symptoms.
- **Be willing** to meet the client where they are and enable their growth.
- **Be willing** to set aside the false view that, because an FASD is permanent, "nothing can be done." Individuals with an FASD can and do respond positively to treatment that is modified to meet their unique needs.
- **Be willing** to develop treatment plans for this population with the identification and addressing of secondary disabilities as a built-in expectation, as research has shown that individuals with an FASD exhibit a unique prevalence of co-occurring disorders (O'Connor et al., 2002; Astley, 2010; Pei, Denys, Hughes, & Rasmussen, 2011; Kodituwakku & Kodituwakku, 2011).
- **Be willing** to redefine success and consider multiple treatment options and make modifications (frequency, duration, cultural issues, client strengths, etc.) to maximize the client's opportunities for recovery.
- **Be willing** to stretch the schedule. Success with a client who has an FASD can take longer, but it is achievable. Interventions should aim to "...support the life path of an individual with disabilities in a positive direction over time" (Olson, Oti, Gelo, & Beck, 2009).

It is important to note that this TIP is not encouraging counselors to forego the primary treatment issue that brought the client to their setting in the first place, in favor of treating FASD. This chapter is only providing a process for identifying FASD as a possible barrier to successfully addressing the primary treatment issue, and making appropriate modifications to your treatment approach to maximize the potential for positive outcomes. Even if the cognitive or behavioral barriers that you identify through this process do not ultimately result in a diagnosis or positive assessment for an FASD, these are still functional impairments presenting barriers to treatment, and thus the process remains valuable.

Identifying the Need for FASD Assessment, Diagnosis, and Services: Suggested Steps

The step chart on the next page illustrates a six-stage process that counselors can implement with clients for whom there are indications of an FASD. These steps will form the outline for the remainder of this chapter.

1. The Starting Point: Observing Indicators

Identifying Barriers and Causes

If there are indications of an FASD in the form of maladaptive behaviors, Step 1 represents a critical intermediate process: Be willing to consider the *root cause* of the behavior rather than just responding to the behavior. The

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easiest way to think of Steps 1 and 2 is that Step 1 is the observation of a treatment barrier or group of barriers, Step 2 is the examination of a possible root cause (or causes).

So, in Step 1, you have a client who is not doing well in treatment, and you have exhausted your normal protocol of approaches for improving the efficacy of the treatment relationship. Since individuals with an FASD are at an increased risk of having substance use or mental health issues in the first place (Streissguth et al., 1996; Astley, 2010), what this step asks you to do is take a step back and consider whether the maladaptive behaviors that you are observing (e.g., frequently missed appointments) match the profile of an individual who may have an FASD (i.e., poor time management skills, memory problems).

When working with an individual who has an FASD, a counselor would be likely to observe problem indicators in the following functional domains:

- Planning/Temporal Skills
- Behavioral Regulation/Sensory Motor Integration

- Abstract Thinking/Judgment
- Memory/Learning/Information Processing
- Spatial Skills and Spatial Memory
- Social Skills and Adaptive Behavior
- Motor/Oral Motor Control

Problems in these domains will likely show up as deficits that interfere with treatment success, including:

- Inability to remember program rules or follow multiple instructions.
- Inability to remember and keep appointments, or to get lost on the way there.
- Inability to make appropriate decisions by themselves about treatment needs and goals.
- Inability to appropriately interpret social cues from treatment professionals or other clients.
- Inability to observe appropriate boundaries, either with staff or other clients.
- Inability to attend to (and not disrupt) group activities.

- Inability to process information readily or accurately.
- Inability to ‘act one’s age.’

When indicators occur in any these domains (and particularly when they occur across multiple domains), it is worthwhile to apply the FASD 4-Digit Code Caregiver Interview Checklist (Astley, 2004b) in Step 2 to determine if there is sufficient cause to 1) pursue evaluation for an FASD with this client, and 2) modify treatment to account for the client’s functioning in these areas.

2. Functional Observation and History/Interviewing

An Appropriate Approach to Observation and Interviewing

If you have decided to move on to a fuller examination of the possible presence of an FASD based on indicators observed in Step 1, it is important to approach the topic with care and sensitivity. For the client, discussion of a possible FASD can cause feelings of shame, or possibly even anger or disbelief, about being identified with a “brain disorder.” For the family of the individual, particularly for a birth mother, suggesting the possible presence of an FASD can lead to feelings of guilt or a feeling of being ‘blamed,’ and a perception that service systems are unhelpful or even a negative experience. It is critical for a counselor to take a no-fault, no-shame approach to the topic of FASD, continually reassuring the individual and the family that you are examining the possibility of an FASD only as a way to achieve the best possible treatment outcome.

The FASD 4-Digit Code Caregiver Interview Checklist

The FASD 4-Digit Code Caregiver Interview Checklist provided below is from the FASD 4-Digit Diagnostic Code (Astley, 2004b). The checklist is also reproduced in Appendix D, and can be considered for reproduction and

inclusion in your treatment file for clients where you believe a form of FASD may be present.

However, please note: **This checklist is not presented as a validated FASD screening instrument.** It is simply provided as a tool that can be used over time to note typical problem areas for someone who might have an FASD (i.e., building a profile of FASD), and provides information that you can combine with your clinical judgment to make a better-informed decision about whether to direct a client toward a more extensive FASD assessment or diagnosis.

It should also be noted that the behaviors identified on this checklist can indicate other disorders, as well. Individuals with an FASD are frequently misdiagnosed (Greenbaum et al., 2009). Given their symptoms, they may be described as meeting criteria for Attention Deficit/Hyperactivity Disorder (ADHD), Attention Deficit Disorder (ADD), Oppositional Defiant Disorder (ODD), adolescent depression, or bipolar disorder. It is possible for FASD to co-occur with any of these diagnoses, but it is also possible that a condition on the fetal alcohol spectrum may better describe the pattern of target symptoms than these other diagnostic terms. A differential and comprehensive diagnosis is essential, whether in-house or through referral, and the information gathered through this checklist can help to inform a diagnostic process.

In a profile of the first 1,400 patients to receive diagnostic evaluations for an FASD at the Washington State FAS Diagnostic & Prevention Network (FAS DPN), caregivers completing an interview with a professional based in part on this checklist demonstrated an impressive ability to differentiate the behavior profiles of children with FAS/pFAS, children with severe ARND (SE/AE), and

The FASD 4-Digit Code Caregiver Interview Checklist

Severity Score: Severity of Delay/Impairment (Displayed along left margin)

Circle: **0** = Unknown, Not Assessed, Too Young **1** = Within Normal Limits **2** = Mild to Moderate
3 = Significant

Severity	Caregiver Observations
0 1 2 3	Planning/Temporal Skills
0 1 2 3	Needs considerable help organizing daily tasks _____
0 1 2 3	Cannot organize time _____
0 1 2 3	Does not understand concept of time _____
0 1 2 3	Difficulty in carrying out multi-step tasks _____
0 1 2 3	Other _____
0 1 2 3	Behavioral Regulation/Sensory Motor Integration
0 1 2 3	Poor management of anger/tantrums _____
0 1 2 3	Mood swings _____
0 1 2 3	Impulsive _____
0 1 2 3	Compulsive _____
0 1 2 3	Perseverative _____
0 1 2 3	Inattentive _____
0 1 2 3	Inappropriately [high or low] activity level _____
0 1 2 3	Lying/stealing _____
0 1 2 3	Unusual [high or low] reactivity to [sound touch light] _____
0 1 2 3	Other _____
0 1 2 3	Abstract Thinking/Judgment
0 1 2 3	Poor judgment _____
0 1 2 3	Cannot be left alone _____
0 1 2 3	Concrete, unable to think abstractly _____
0 1 2 3	Other _____
0 1 2 3	Memory/Learning/Information Processing
0 1 2 3	Poor memory, inconsistent retrieval of learned information _____
0 1 2 3	Slow to learn new skills _____
0 1 2 3	Does not seem to learn from past experiences _____
0 1 2 3	Problems recognizing consequences of actions _____
0 1 2 3	Problems with information processing speed and accuracy _____
0 1 2 3	Other _____
0 1 2 3	Spatial Skills and Spatial Memory
0 1 2 3	Gets lost easily, has difficulty navigating from point A to point B _____
0 1 2 3	Other _____

Severity	Caregiver Observations
0 1 2 3	Social Skills and Adaptive Behavior
0 1 2 3	Behaves at a level notably younger than chronological age _____
0 1 2 3	Poor social/adaptive skills _____
0 1 2 3	Other _____
0 1 2 3	Motor/Oral Motor Control
0 1 2 3	Poor/delayed motor skills _____
0 1 2 3	Poor balance _____
0 1 2 3	Other _____

Source: Astley, S. J. (2004). *Diagnostic guide for Fetal Alcohol Spectrum Disorders: The 4-Digit Diagnostic Code*, Third Edition. Seattle, WA: University of Washington. Accessed June 1, 2012 at <http://depts.washington.edu/fasdnpn/pdfs/FASD-2004-Diag-Form-08-06-04.pdf>. Used with permission from the author.

children with moderate ARND (ND/AE) (Astley, 2010).

In addition, the box “Risk Assessment Questions” contains a group of questions developed at the FAS Community Resource Center in Tucson, Arizona. These questions can further assist providers seeking to determine whether an evaluation for an FASD is warranted.

3. Assessment (External or Through an In-House Assessment Team)

Assessment for the presence of an FASD is an interdisciplinary process best accomplished through a team approach. The sad reality is that the existing network of qualified assessment teams and facilities in the United States is insufficient to meet demand, and behavioral health experts have repeatedly observed the urgent need for an increase in FASD

Risk Assessment Questions	
Yes/No	Additional Areas of Consideration
	Client History
Y N	Are there alcohol problems in family of origin?
Y N	Was the client raised by someone other than the birth mother?
Y N	Has the client ever been in special education classes?
Y N	Has the client had different home placements?
Y N	Has the client ever been suspended from school?
Y N	Has the client ever been diagnosed as ADHD?
	How many jobs has the client had in past 2 years? _____
Y N	Can the client manage money effectively?
	Are the client’s friends older or younger (for an individual with an FASD, friends will tend to be younger due to lag between physical age and functional age)? _____

Adapted from: Kellerman, T. (2005). Recommended assessment tools for children and adults with confirmed or suspected FASD. Tucson, AZ: FAS Community Resource Center. Accessed June 5, 2012 at <http://come-over.to/FAS/AssessmentsFASD.htm>.

assessment, diagnosis, and treatment capacity (Institute of Health Economics, 2009; Interagency Coordinating Committee on FASD, 2011).

However, many substance abuse and mental health treatment settings may have an interdisciplinary staff team and/or sufficient referral relationships to attempt FASD assessment internally, creating an opportunity to help fill a gap in the behavioral health field. If this is the case with your agency, this section discusses some of the essential elements of FASD assessment, as well as available resources that can help your agency develop this staff capability. (The first interdisciplinary FASD diagnostic clinic [the Washington State FAS Diagnostic and Prevention Network (FAS DPN)] was established in Washington State in 1993 as part of a CDC-sponsored FASD prevention study [Clarren & Astley, 1997]. A comprehensive description of the interdisciplinary model used by the Washington State FAS DPN is presented by Clarren, Carmichael-Olson, Clarren, and Astley [2000]; see Appendix A: *Bibliography*). In addition, for sites that cannot provide FASD capacity internally, referral options do exist, and this section will provide information on accessing those resources.

In-House FASD Assessment: The Essential Elements

Effective in-house assessment for FASD is built on three core components: 1) building the right team, 2) accessing the right resources, and 3) gathering the right information.

Building the Right Team

FASD assessment, as will be explained below, involves gathering information and making evaluations in a variety of functional areas, and is an involved process that can overwhelm the client and his or her family. This necessitates a wide range of professional skill sets, not only to perform the various clinical and observational tasks, but also to help the client and family navigate the process smoothly. The box “In-House FASD Assessment: An Ideal Core Team” describes an ideal in-house FASD assessment team and its functions.

Part 2, Chapter 2 of this TIP outlines appropriate processes if these professionals need to be added and/or accessed through referral relationships.

Accessing the Right Resources

Appendix C, *Public and Professional Resources on FASD*, provides information and links for accessing FASD information and training from a variety of national and regional sources.

In-House FASD Assessment: An Ideal Core Team

Case Coordinator	<ul style="list-style-type: none"> • Reviews history and current stability • Assesses needs of individual and caregiver • Post-diagnosis, connects individual/family to positive supports • Is often a social worker, but in this case could be the role of the counselor
Psychologist ¹ and Speech Language Pathologist	<ul style="list-style-type: none"> • Assess basic and higher levels of brain function
Physical Therapist, Occupational Therapist, or Vocational Rehabilitation Counselor	<ul style="list-style-type: none"> • Assesses motor and sensory issues (including sensory-motor integration, and balance and gait issues)

Physician	<ul style="list-style-type: none"> • Assesses dysmorphism, neurological findings, and basic health determinants • Also contributes to behavioral health profile
Family Navigator	<ul style="list-style-type: none"> • Helps the family through the process • Ideally is an actual caregiver of someone with an FASD • Ideally is available to help the family connect with parent support and other needed resources

Based on TIP consensus panel recommendations and *Canadian Guidelines for Diagnosis* (Chudley, Conry, Cook, Look, Rosales, & LeBlanc, 2005).

¹ The psychologist should be trained to do neuropsychological testing.

Among these are two excellent resources for agencies seeking to develop FASD capabilities; the Washington State FAS DPN and the CDC's FASD Regional Training Centers (RTCs).

- One of the primary sites for FASD assessment and diagnosis in the United States is the Washington State FAS DPN, based at the University of Washington in Seattle. Established in 1993 through Washington State Senate Bill 5688 and support from the CDC, March of Dimes, Chavez Memorial Fund, and the Washington State Department of Social and Health Services, the Washington State FAS DPN provides FASD diagnostic services as well as training in FASD. Training resources include the FASD 4-Digit Diagnostic Code Online Course and a 2-day FASD Diagnostic Team training for interdisciplinary clinical teams (or individual clinical team members) seeking to establish FASD services in their community. Visit the FAS DPN's homepage (<http://depts.washington.edu/fasdpn/>) to find out more about their services.
- The CDC's RTCs develop, implement, and evaluate educational curricula regarding FASD prevention, identification, and care, and incorporate the curricula

into training programs at each grantee's university or college, into other schools throughout their regions, and into the credentialing requirements of professional boards. Visit the CDC's RTC homepage (http://www.cdc.gov/ncbddd/fasd/documents/flyerfasd_rtc.pdf) to find out about currently funded RTC sites and available services.

Gathering the Right Information

A useful tool that your team can use to gather and organize the necessary information to support a formal FASD diagnosis is the *New Patient Information Form*. This form was developed by the Washington State FAS DPN and is part of the *Diagnostic Guide for Fetal Alcohol Spectrum Disorders: The 4-Digit Diagnostic Code* (Astley, 2004b, Third Edition, pp. 103-114). If your agency decides to refer a client for an FASD diagnosis, this information will provide a necessary foundation for the diagnostic process. The *New Patient Information Form* can be downloaded for free from (<http://depts.washington.edu/fasdpn/htmls/diagnostic-forms.htm>).

In addition to basic information about the client and your agency, the *New Patient Information Form* provides a template for gathering information in the critical areas of Growth; Physical Appearance and Health; Neurological Issues; Attention Deficit and

Hyperactivity; Mental Health Issues; School Issues; Alcohol Exposure; Information About the Patient’s Biological Parents; Medical History of the Biological Family; Pregnancies of Birth Mother; Pregnancy, Labor, and Delivery of this Patient; List of Professionals Currently Involved in Patient’s Care; Placements (foster, adoptive, etc.); and What to Bring to the [diagnostic] Clinic.

To further ensure collection of appropriate information and build staff knowledge and capabilities related to FASD, it will be valuable for your team to become familiar with the basic guidelines of the most widely used diagnostic approaches to the various disorders in the spectrum. A comprehensive comparison of the current FASD diagnostic systems is presented in a chapter entitled “Diagnosing FASD” (Astley, 2011), and is reprinted in Appendix E, *Comparison of Current FASD Diagnostic Systems* with the author’s permission.

External: Assessment and Diagnosis

The reality for many programs will be that, for reasons of cost and/or lack of community resources, building an in-house FASD assessment team or diagnostic capability will be unrealistic. If this describes your agency, the FASD diagnosis and training sites discussed

under *Accessing the Right Resources*, above, should be accessed so that you can refer your client to an appropriate provider. Agencies can also use the **Resource Directory** (<http://www.nofas.org/resource-directory/>) provided by the National Organization on FAS (NOFAS) to help locate FASD-related services.

At the same time, referral for assessment and diagnosis should be paired with treatment modifications and accommodations that are discussed in the next section. This can be done with or without a formal diagnosis of a form of FASD. If you and your clinical team have identified symptoms indicating an FASD through Steps 1 and 2 of this chapter, the methods discussed in the next section can still help the treatment process.

Many providers will not have an existing relationship with the FASD assessment or diagnosis provider to whom they refer a client. In such cases, it is vital to actively assist the client through the transition and provide regular follow-up to ensure client satisfaction and full and open communication between agencies and with the client. (Also the client’s family, if they are involved in treatment.) The box “Overview of the Diagnostic Process (As Performed by the FAS DPN)” summarizes the phases of the diagnostic process as performed

Overview of the Diagnostic Process (As Performed by the FAS DPN)

A comprehensive description of the FAS DPN interdisciplinary FASD diagnostic process is presented by Clarren et al. (2000).

Phase	Description
Phase 1	<ul style="list-style-type: none"> • Clinical intake: Caregivers complete a comprehensive “New Patient Information Form” prior to the clinic visit to report current concerns and developmental, social and alcohol exposure history. Past medical, educational, psychological, social, and legal records are also obtained. • Record review: Psychologist reviews all available medical, developmental, clinical, educational, and other records, and presents a case summary to the FASD diagnostic team on the day of the diagnostic evaluation. Clients 18 and older are referred elsewhere for their neuropsychological evaluation.

Phase	Description
Phase 2	<ul style="list-style-type: none"> • Psychometric screening/evaluation: Diagnostic team members (occupational therapist, psychologist, speech–language pathologist) screen/assess the patient’s current neurobehavioral performance (e.g., language and communication, executive function, cognition, sensory–motor skills). • Physical examination: Physician examines diagnostic parameters of growth and facial dysmorphology (and general health, sleep problems, medications used, etc.). • Caregiver(s) interview: Physician and psychologist conduct a caregiver interview (up to 2 hours) using the 4-Digit Code Caregiver Interview checklist.
Phase 3	<ul style="list-style-type: none"> • Diagnosis and intervention recommendations: Diagnostic team reviews and synthesizes data, derives the 4-Digit Code, and generates intervention recommendations. • Diagnostic summary: Diagnostic team shares the diagnosis and intervention recommendations with caregiver(s) in a brief case conference. Adolescent and adult clients are included in the case conference. • Diagnostic summary report: Diagnosis, assessment results, and intervention recommendations are integrated into a comprehensive 6- to-8-page diagnostic summary report (http://depts.washington.edu/fasdpn/pdfs/4-digit-medsum-web-2006.pdf) and submitted to the patient’s medical record. • Follow-Up Debriefing: A private follow-up debriefing is conducted with the caregiver (and client, if old enough) to discuss the impact of the diagnosis and review specific recommendations.

Table originally appeared in Jirikowic, Gelo, & Astley (2010) with minor modifications.

by the Washington State FAS DPN. The phases of this process are likely to be similar in other interdisciplinary FASD diagnostic clinics.

When the Client Already Has a Diagnosis of an FASD

If a client has already been diagnosed with an FASD at the time of presentation to your setting, the guidelines in the next section should automatically be considered. In addition, as indicated in the table *Overview of the Diagnostic Process* in the previous section, the diagnosis report may also be a source of intervention and modification guidelines and should be thoroughly reviewed by the counselor with the client (and the family, if involved in the treatment process). A comprehensive summary of the types of intervention recommendations provided in relation to 120 youths following their FASD diagnostic evaluations

at the Washington State FAS DPN is provided by Jirikowic et al. (2010).

At the same time, further assessment by medical, mental, and allied health professionals may still be needed to determine the client’s current level of function in important areas, particularly if the diagnosis occurred years earlier. “Refreshing” the functional information will help the counselor tailor the treatment plan and counseling strategies to the client’s strengths, needs, and preferences. Forms of re-testing and assessment can include the following:

- Being familiar with any medications the client is taking and observing any behaviors or physical symptoms that might indicate the need to reevaluate medication use or dosage;
- Hearing and speech tests to identify any progress in communication or barriers

that may affect the client's treatment and ongoing recovery;

- Occupational therapy and physical therapy evaluations to assess the client's daily living skills and motor function, vocational skills, and preferences and possibilities;
- Determining current achievement levels in reading, spelling, and math; and
- Use of an appropriate, standardized interview or questionnaire to determine how the client compares to peers in receptive, expressive, and written communication; personal, domestic, and community daily living skills; and interpersonal relationships, play and leisure time, and coping skills.

4. Tailoring Treatment for Individuals with an FASD

Introduction

This section will discuss appropriate approaches to modifying treatment and/or making necessary accommodations for clients who exhibit indicators suggesting an FASD, or who show cognitive and behavioral barriers to treatment success, as identified in Steps 1 and 2 of this chapter.

This discussion is divided into two sections; 1) general principles for working with individuals who have or may have an FASD (regardless of age), and 2) specific considerations for adolescents who have or may have an FASD. The chapter then moves on to Step 5, *Working With the Family*, and Step 6, *Transition and Connection to Community Supports*.

As noted above, if the individual already has a diagnosis of an FASD, the diagnostic report may also include recommendations for appropriate interventions and modifications to treatment. The counselor should review this report thoroughly, if it is available.

General Principles for Working with Individuals Who Have or May Have an FASD

Safety Considerations

Safety is a primary health issue for individuals of all ages with an FASD (Jirikowic et al., 2010). Starting a treatment process without first addressing safety issues is futile and potentially dangerous: The clinician must first evaluate physical safety for the adolescent or adult with an FASD. This includes issues of violence, harm to self (such as self-mutilation) or others, victimization, adequate housing, and food. In typical adolescents and adults, psychiatric severity can be significantly reduced when co-occurring issues are treated together and mental health and substance abuse treatment are provided as an integrated program (Hser, Grella, Evans, & Huang, 2006).

For older individuals who have or may have an FASD, there are special safety considerations. This population has a number of risk factors for accidents and injury; poor decision-making, impulsivity, impaired motor coordination, working memory, attention, emotional and sensory regulation, and susceptibility to peer pressure. Even seemingly routine tasks like crossing the street safely may be impossible for those who are more severely affected. Other examples of possible safety and health concerns in adolescents and adults with an FASD are remembering medication schedules, decisions about legal and illegal substances, driving, and risk-taking situations in which poor social problem-solving (McGee, Fryer, Bjorquist, Mattson, & Riley, 2008), impulsivity, and peer pressure combine to compromise safety.

Vignette #9 in Part 1, Chapter 3 of this TIP elaborates the process of working with a caregiver to develop a personalized Safety Plan on behalf of an individual with an FASD. In addition, Appendix F, *Sample Crisis/Safety Plan*, contains a sample plan that has been

adapted from the work of the *Families Moving Forward Program* (<http://depts.washington.edu/fmffasd/>), and can be printed and used with a client and/or their family member(s)/caregiver(s).

Risk for Abuse

Children with physical, psychological, and sensory disabilities—including FASD—are known to be more vulnerable to violence and maltreatment, or to be at a greater risk of these forms of abuse (Olivan, 2005). This vulnerability is brought about by a variety of factors, including dependence on others for intimate and routine personal care, increased exposure to a larger number of caregivers and settings, inappropriate social skills, poor judgment, inability to seek help or report abuse, and lack of strategies to defend themselves against abuse. Murphy and Elias (2006) report figures from the National Center on Child Abuse and Neglect indicating that children with disabilities are sexually abused at a rate 2.2 higher than that for children without disabilities. The United States Department of Justice reports that 68 to 83 percent of women with developmental disabilities will be sexually assaulted in their lifetimes, and less than half of them will seek assistance from legal or treatment services (Pease & Frantz, 1994). In a study of 336 males and females in treatment for alcohol abuse or dependence, more than 56 percent had also experienced childhood sexual or physical abuse (Zlotnick et al., 2006).

In one long-term study, 80 percent of young adults who had experienced abuse as a child met diagnostic criteria for at least one psychiatric disorder at age 21. These individuals exhibited many problems, including depression, anxiety, eating disorders, and suicide attempts (Silverman, Reinherz, & Giaconia, 1996). Other psychological and emotional conditions associated with abuse and neglect include panic disorder, dissociative disorders, attention-deficit/hyperactivity disorder,

depression, anger, posttraumatic stress disorder, and reactive attachment disorder (Teicher, 2000; De Bellis & Thomas, 2003; Springer, Sheridan, Kuo, & Carnes, 2007).

Astley (2010) has documented a high prevalence of abuse, neglect, and multiple home placements among 1,400 patients identified with an FASD—70 percent were in foster/adoptive care and had experienced, on average, three home placements. In fact, in a separate study, Astley and colleagues (2002) identified a prevalence rate of FAS in foster care that was 10-times higher—1/100—than in the general population—1/1000. Children in foster care face a risk of maltreatment, which can affect their physical health and lead to attachment disorders, compromised brain functioning, inadequate social skills, and mental health difficulties (Harden, 2004). Another study among young women with FASD found that they had poor quality of life scores and high levels of mental disorders and behavioral problems relative to standardization samples and other at-risk populations (Grant et al., 2005).

Risk for Suicide

In addition, individuals with an FASD are at significant risk of suicide at all ages studied (Huggins et al., 2008). A person with an FASD may not appear to plan or execute a suicide attempt effectively; this is not indicative of the seriousness of the intent.

High Risk of Repeated Involvement with the Legal System

People with an FASD can have specific types of brain damage that may increase engagement in criminal activity (Kodituwakku et al., 1995; Page, 2001; Mattson, Schoenfeld, & Riley, 2001; Page, 2002; Moore & Green, 2004; Clark et al., 2004; Schonfeld, Mattson, & Riley, 2005; Schonfeld, Paley, Frankel, O'Connor, 2006; Brown, Gudjonsson, & Connor, 2011). These can include:

Suicide Intervention/Prevention for Individuals with an FASD

- Standard suicide assessment protocols need to be modified to accommodate neuropsychological deficits and communication impairments:
 - Instead of “How does the future look to you?” ask “What are you going to do tomorrow? Next week?” (Difficulties with abstract thought.)
 - The seriousness of the suicidal behavior does not necessarily equal the level of intent to die (lack of understanding of consequences).
- Obtain family/collateral input.
- Be careful about words used regarding other suicides or deaths.
- Intervene to reduce risk:
 - Address basic needs and increase stability.
 - Treat depression.
 - Teach distraction techniques.
 - Remove lethal means.
 - Increase social support.
- Do not use suicide contracts (impulsivity issues).
- Monitor risk closely.
- Reinforce and build reasons for living.
 - Be literal.
- Strengthen advocate-client relationship.

Source: Huggins, J. E., Grant, T., O'Malley, K., & Streissguth, A. (2008). Suicide attempts among adults with Fetal Alcohol Spectrum Disorders: Clinical considerations. *Mental Health Aspects of Developmental Disabilities*, 11(2), 33-42.

- Lack of impulse control and trouble understanding the future consequences of current behavior;
- Trouble understanding what constitutes criminal behavior (for example, a youth with an FASD may not see any problem with driving a car he knows was stolen if he wasn't the one who stole it);
- Difficulty planning, connecting cause and effect, empathizing (particularly if the experience is not explained in a very concrete way), taking responsibility, delaying gratification, and making good judgments;
- Tendency toward explosive episodes, often triggered by sensory overload, slower rates of processing the information around them, and/or feeling “stupid;”
- Vulnerability to peer pressure and influence (e.g., may commit a crime to please friends), and high levels of suggestibility; and
- Lower level of moral maturity (due in part to social information processing deficits).

The number of people in the criminal justice system with an FASD has not specifically been determined. Data are limited, and populations vary by state. In addition, few systems conduct any screening or can provide diagnosis. Streissguth and colleagues (2004) conducted an evaluation of 415 clinical patients with FASD at the University of Washington. Trouble with the law (including arrest, conviction, or otherwise) was reported in 14 percent of children and 60 percent of adolescents and adults with an FASD. In addition, Fast, Conry,

& Looock (1999) evaluated all youth referred to a forensic psychiatric assessment for FASD in Burnaby, British Columbia, Canada. Of 287 youths assessed, 67 (or 23 percent) were found to have an alcohol exposure-related diagnosis. Although this result should not be generalized to the entire prison population, it does reveal a possible disproportionate representation of individuals with an FASD in the juvenile justice system.

It is important for counseling professionals to consider a client's criminal history and any factors that place the client at risk for further criminal involvement. Because persons with an FASD have problems learning from experience, they may repeat crimes and cycle through the legal system multiple times.

Clinicians may encounter individuals with an FASD who are participating in court-ordered treatment. Such individuals need help navigating the legal system. The clinician can consult with the client's attorney and assist in educating him or her about FASD. In addition, the clinician can assist in finding resources to help the client understand any legal proceedings and requirements. The National Legal Aid & Defender Association (<http://www.nlada100years.org/>) or the American Bar Association (www.americanbar.org) may be able to identify resources at the local level.

Vulnerability of Individuals with an FASD

Individuals with an FASD are vulnerable not only to criminal activity but also to victimization (Freunscht & Feldman, 2011). Their poor judgment may lead them to associate with people who victimize them physically, emotionally, and financially. Their impulsivity may lead them into dangerous situations. Women with an FASD may get involved with negative associations for food, shelter, attention, or drugs (Page, 2003). In addition, their impaired sense of boundaries can lead to sexual victimization. Because of their unpredictable

behavior, they may need 24-hour supervision (Streissguth, 1997).

Even with compensatory strategies, the person with an FASD may be less able to use judgment, consider consequences, or understand abstract situations (Kodituwakku, 2007; Astley, 2010; Freunscht & Feldman, 2011). Impulsivity is an ongoing issue. Social isolation and loneliness may drive the person to seek out any type of friendship and lead to victimization. A discussion or pursuit of safeguards for the person may be necessary:

- Recognize that victimization may occur, and keep vigilant for situations that may arise in the person's life.
- Role-play personal safety and specific scenarios that people face (e.g., who is a stranger vs. who is a friend) to allow the individual to practice taught skills and perhaps allow them to pursue safe activities (De Vos, 2003). Consider videotaping the client doing it right in the role-play, so he or she can watch it over and over, reinforcing the lesson. Watching the video also helps move the information from short-term memory to long-term memory. (In many cases, though certainly not all, long-term memory has been observed to function better than short-term memory for individuals with an FASD).
- Establish written routines and structured time charts, and have these where they are easily seen throughout the day.
- Provide a buddy system and supervision to help decrease opportunities for victimization.
- Consider a guardianship of funds to protect the individual. A trustee can ensure that the necessities of life are covered, including rent, food, clothing, and finding an advocate. The clinician may want to

include such provisions in the aftercare plan.

- Help the client find a healthy, structured environment in aftercare to help them avoid criminal activity.

Family Safety and Support

For all families caring for an individual with an FASD, or when parents themselves have an FASD, establishing family safety and support is vital. A crisis/safety plan should always be put in place (see Appendix F for an example *Crisis/Safety Plan* form). To stay safe and well-supported, it is important to help the client (and caregivers) identify available services, determine which ones are effective for them or their children, and understand how to work productively with service providers (Streissguth, 1997). (See Appendix G for a *Services and Supports Checklist* that can be reviewed with clients as a worksheet.)

For birth families in recovery, the counselor can help families cope with FASD during the recovery process. This is best done by building a protective environment for clients and their children. This may include helping them obtain safe, stable housing, assisting with daily living skills (such as bill paying and food shopping), and overseeing home situations. It is also important to establish a network of community service providers who will be available for aftercare to promote ongoing recovery and avoid relapse (Millon, Millon, & Davis, 1993).

For more information about this topic, see Step 6, *Transition and Connection to Community Supports*).

Modifying a Treatment Plan

Factors to Consider

When modifying a treatment plan for an individual who has or may have an FASD, the following should be considered:

- **Help the client adjust to a structured program or environment and develop trust in the staff.** Individuals with an FASD tend to be trusting (Freunsch & Feldman, 2011) and need a great deal of structure, but may have trouble adapting to changes in routine and to new people.
- **Share the rules early and often.** Put instructions in writing and remind the client often. Keep the rules simple and avoid punitive measures that most individuals with an FASD will not process. If a rule is broken, remind the client of the situation and help to strategize ways they can better follow the rule in the future.
- **Take a holistic approach,** focusing on all aspects of the client's life, not just the substance abuse or mental health issues. Include basic living and social skills, such as how to dress, groom, practice good hygiene, present a positive attitude, and practice good manners. Help the client develop appropriate goals within the context of his or her interests and abilities.
- **Provide opportunities to role-play or otherwise practice appropriate social behaviors,** such as helping others. Areas of focus may include impulse control skills, dealing with difficult situations such as being teased, and problem-solving.
- In an inpatient setting, **allow time** for the client to be stabilized and acquire the basic skills to cooperate with others before discussing his or her substance abuse or mental health issues. In an outpatient setting, it may help to develop a rapport with the client and establish trust and communication before addressing the primary treatment issue.
- **Assume the presence of co-occurring issues.** It is likely that a high percentage of people with an FASD have at least one co-occurring mental disorder (O'Connor

et al., 2002; Streissguth et al., 2004; Clark et al., 2004; Astley, 2010). In a study of 1,400 patients with FASD, Astley (2010) documented that 75 percent had one or more co-occurring disorders, with the most prevalent being ADHD (54 percent). In a study of 80 birth mothers of children with FAS, 96 percent had from one to nine mental disorders in addition to alcoholism (Astley et al., 2000b); the most common was phobia (76 percent). Forty-four percent of the women had mental disorders diagnosed by the age of 8 years.

- When possible, **include the family or caregivers in activities**, such as parent education about FASD and substance abuse and/or mental health, strategies for providing care for an individual with an FASD and a substance abuse or mental health problem (e.g., avoiding power

struggles), and building the client's self-esteem. Help family and caregivers practice positive communication skills such as active listening, use of literal language, and avoiding "don't" (i.e., focusing on what *needs* to be done rather than what *should not* be done).

- **Include the client in treatment planning/modification**, and build family/caregiver meetings into the plan as well, with a clear purpose and agenda. Recognize that some family members may also have an FASD, and work with them accordingly.
- **Incorporate multiple approaches to learning**, such as auditory, visual, and tactile approaches. Avoid written exercises and instead focus on hands-on practice, role-playing, and using audio- or video-recording for playback/reinforcement of learning. Use multisensory strategies,

The Navigator

A person who has impaired vision is given a seeing eye dog. A person with impaired hearing is given an interpreter or a hearing aid. These external devices are necessary for the person with physical impairments to be able to function to maximum potential in life.

The person with an FASD has a physical impairment in the area of the brain, particularly the forebrain or frontal lobes, which regulate the executive functions. A navigator refers to the presence of another responsible person (parent, teacher, job coach, sibling) who can mentor, assist, guide, supervise, and/or support the affected person to maximize success (which may need to be redefined as the avoidance of addiction, arrest, unwanted pregnancy, homelessness, or accidental death).

Because some individuals with an FASD may appear to be bright and normal, the disability that is brain damage may only be apparent in test results, or in actions that place the person at serious risk. It is the risk of danger to the person and to others that makes a navigator such a useful and important concept. A navigator can seem like a form of enabling or an encouragement of co-dependency. More accurately, however, a navigator is an appropriate form of advocacy to ensure that the individual receives whatever assistive devices are needed for him or her to participate in life in as normal a capacity as reasonably possible.

For many individuals with an FASD, the navigator can be someone with whom they "check in" on a regular basis, or vice versa. For others, the navigator will play a more constant advocacy role, and may share the role with others. (See Vignette #9 for an example of a father playing the role of a navigator, and sharing the role with a coach and one of his son's relatives.)

such as drawing, painting, or music, to assist the client in expressing feelings. These strategies take advantage of skills that many individuals with an FASD have. They can also help the client share difficult feelings that may be hard to talk about, such as fear and anger.

- **Consider sensory issues** around lighting, equipment sounds, and unfamiliar sensations and smells. Individuals with an FASD can be very sensitive to these environmental factors.
- **Arrange aftercare**, and encourage family/caregivers to participate in a support group to continue to learn parenting skills and to be encouraged in the recovery process (see Step 6, *Transition and Connection to Community Supports*).

Counseling Strategies

Due to the cognitive, social, and emotional deficits seen in FASD, counseling clients with these conditions requires adaptability and flexibility. Research data, clinical observation, and caregiver reports all suggest that it is crucial to tailor treatment approaches. Traditional approaches may not prove optimally effective, and more effort may be needed to convey basic concepts and promote a positive therapeutic relationship and environment. The following are recommendations designed to help providers:

- Set appropriate boundaries;
- Be aware of the client's strengths;
- Understand the impact of any abuse the client has experienced;
- Help the client cope with loss;
- Address any negative self-perception associated with an FASD;
- Focus on self-esteem and personal issues;
- Address resistance, denial, and acceptance;
- Weigh individual vs. group counseling;
- Consider a mentor approach; and

- Assess comprehension on an ongoing basis.

Boundaries

Establishing a trusting and honest relationship while maintaining boundaries is important with any client. Because persons with an FASD often lack social skills and have social communication problems (Kodituwakku, 2007; Greenbaum et al., 2009; Greenspan, 2009; Olson & Montague, 2011), they may breach boundaries by making inappropriate comments, asking inappropriate questions, or touching the counselor inappropriately. To set boundaries, it may help to have the client walk through the rules and expectations and demonstrate expected behavior. Frequent role-playing can help the client learn to apply concepts and figure out how to respond to various situations.

Persons with an FASD frequently experience difficulty with memory (Rasmussen, 2005; Riggins et al., 2012). Added to this, they may be able to repeat rules but not truly understand them or be able to operationalize them. Thus, it is important to review rules regularly. It is much more effective to limit the number of rules, review them repeatedly, and role-play different situations in which the person will need to recall the rules. Repetition is key.

Strengths

Many people focus on the deficits in persons with an FASD, but they also have many strengths. Some of these can be used in the treatment setting as part of counseling. Family may be a strength area: Parents report their children with FASD were engaged with their families and willing to receive—and even seek—help (Olson et al., 2009), as well as demonstrating a willingness to provide assistance with ordinary tasks (Jirikowic et al., 2008). Based on extensive clinical experience, Malbin (1993) identifies a number of other strength areas. For example, some people with

an FASD are quite creative. They can express themselves through art and music, which may prove more effective than traditional talk therapy. Other approaches may involve storytelling and writing. These techniques can also be used for practical matters, such as developing a poster with treatment goals. In addition, visual aids can assist by drawing on areas of relative strength, so drawn or pictured goals may aid recall better than a written or spoken list of instructions.

History of Abuse

Given the risk of abuse among persons with an FASD and among individuals with substance abuse and/or mental health issues, it is likely that a client with a combination of these will have some personal abuse history (Astley et al., 2000b). The counselor working with persons with an FASD needs to be sensitive to the possibility of childhood abuse and other forms of victimization, and their impact on the counselor–client relationship. A common theme that counselors need to be attentive to is *powerlessness*, a theme often reflected in the following types of client communications and behaviors:

- Clients undervaluing their own competencies.
- Clients viewing others' needs and goals as more important than their own.
- Clients' inability to obtain nurturance and support for themselves.
- Clients' feelings of depression, anger, and frustration about their lives.
- Clients' low expectations for their own success.

Loss and Grieving

All individuals with an FASD have experienced losses in their lives. The fact that they are not like their peers is a loss of the ability to be like everyone else. Some have lost the hopes and dreams of what they wanted to be. Others lose their family or a secure future.

Some lose the opportunity for meaningful peer relationships and friendships. These losses can affect people in many ways and need to be addressed. The counselor can help to address these areas of loss through a number of strategies:

- Use active listening strategies, such as repeating what the person has said;
- Be honest;
- Raise awareness of experiences of separation and loss;
- Acknowledge and validate losses experienced;
- Acknowledge the client's feelings about loss;
- Avoid "good parent/bad parent" issues;
- Encourage communication; and
- Refer for further treatment (e.g., mental health) when necessary.

Self-Perception

Self-perception is a major issue with FASD. Despite the advent of the disease model, many people still view alcohol problems as a sign of moral weakness or a character flaw. This negative stereotype can be particularly severe in relation to pregnant women who drink, making the topic difficult to discuss (Salmon, 2008). Added to this, the negative judgment toward the mother may also be visited on the child. A counselor needs to be aware of this, and approach the issue carefully and sensitively if he or she suspects a client has an FASD.

Given their cognitive, social, and emotional deficits, persons with an FASD may think they are powerless to change. It is important to work through this issue with the client. They need to understand that they are not responsible for their disability and that they deserve respect. They also need to know that change is possible.

Self-Esteem and Personal Issues

The combination of abuse, loss, grief, and negative stereotypes can lead to self-esteem issues in any individual. Self-esteem is regularly an issue for individuals with an FASD (Olson, O'Connor, & Fitzgerald, 2001). Those who also have substance abuse or mental health problems face a double-edged sword: Their self-esteem can be damaged by their experience with an FASD and by their substance abuse or mental health issue. The clinician can use several strategies to help address self-esteem and personal issues:

- **Use person-first language.** An FASD may be part of who a person is, but it is not the person's entire identity. Someone can have an FASD, but nobody is an FASD.
- **Do not isolate the person.** Sending persons with an FASD out of the room to think about what they have done or responding to issues in a group session by simply ejecting them will often increase their sense of isolation and does not help them learn appropriate behaviors.
- **Do not blame people for what they cannot do.** Demanding that people repeatedly try to do things they cannot do is a lesson in frustration. It is important to have patience and understand individual limitations. People with an FASD may need something repeated several times because they have trouble remembering, not because they refuse to pay attention.
- **Set the person up to succeed.** Measures of success need to be different for different people. It is important to identify what would be a measure of success for the individual with an FASD and reinforce successes in concrete terms (e.g., "You did a great job of being on time for our session today. Thank you.") Training in social skills, anger management skills, and relaxation skills can help. In order for

skills-building programs to be most successful for the person with an FASD, they need to be repeated periodically.

Resistance, Denial, and Acceptance

Individuals who have or may have an FASD may deny that they have a disability. Although some are relieved to know the cause of their difficulties, others may struggle to confront or accept their situation. The counselor needs to take time to help the person cope with the lack of understanding that often surrounds FASD. Women with an FASD, for instance, may fear becoming like their mothers and having a child with an FASD. An individual with an FASD may have difficulty with forgiveness of the birth mother, or may feel that it is inevitable that they will pass on FASD to their children. Counselors should reassure clients that they are not responsible for their disability, help them resolve their feelings about the birth mother, and educate them about the science of their condition (i.e., that it is not inevitable that they would pass on the condition). This process may take awhile, and the person may drift back and forth from accepting the disability to denying it. Exploring the reasons for the denial and understanding the client's fears can help.

Individual Counseling vs. Group Sessions

Individuals with an FASD may struggle to function in a group setting. Studies have shown increased levels of sensory sensitivities in this group, at least for children (Jirikowic et al., 2008). Clinical observations suggest individuals with an FASD can become overwhelmed by sensory input from large groups, noise, small spaces that cause crowding and touching of others, and visual distractions. Given the executive function deficits that are common in this clinical population, individuals with an FASD may not be able to process everything in the discussion and become lost. They may also 'talk too much,' and/or not be

able to effectively convey their feelings and ideas in group discussions.

Individual counseling may be needed to avoid some of the issues that arise in clients with an FASD who lack social skills and find group settings confusing or overwhelming. Talk therapy can be modified to incorporate role-playing, practice dialogues, play therapy, art therapy, and other methods that can draw on the strengths seen in individuals with an FASD. Printed material may be helpful, but should be written in simple language with a clear, non-distracting page layout.

If group work is necessary, the counselor can assist the client who has or may have an FASD by making some accommodations:

- Explain group expectations concretely and repeat these ideas often.
- If a person monopolizes conversation or interrupts, use a talking stick as a concrete visual reminder of who should be speaking. Hand the stick to the person whose turn it is to speak and pass the stick to others as appropriate.
- Give the person time to work through material concretely within the group time so he or she can ask questions or you can check understanding of material. The client may need extra time to process information. Listen for key themes to emerge slowly through the person's talk and behaviors.
- Allow the client to get up and walk around if he or she gets restless.
- Use concrete representations, such as marking the floor, to show the concept of boundaries.
- Make adaptations for the whole group to avoid singling out the client.

Use of a Mentor

Programs that work with individuals with an FASD have found that mentoring can be

effective, as it provides a consistent, stable, one-to-one relationship and allows for the development of a personal bond with a trained individual who has knowledge and experience working with those who have an FASD (Malbin, 1993; Schmucker, 1997; Grant et al., 2004; Denys, Rasmussen, & Henneveld, 2011). A mentor can:

- Assist with the development of concrete and consistent rules and goals that will guide behaviors in specific situations;
- Improve comprehension in discussions with others (e.g., providers or other clients); and
- Assist with the development of personal scenarios for the adult to work out responses and practice through role-play.

Ongoing Assessment for Comprehension of Information

Extensive clinical observations reveal that individuals with an FASD may appear to understand when they do not. Parents often say their family member with an FASD "just doesn't get it." This means that individuals with an FASD may repeat information without actually understanding the content, and so will be unlikely to follow through. Because of this, it is important to provide consistency and re-check the retention of information often:

- Ask the client to summarize what you have said.
- Review written material, such as rules, at each session.
- Do not assume that the client is familiar with a concept or can apply it simply because you have reviewed it multiple times; have discussions that explore their understanding beyond simply being able to repeat the concept.

Clinical wisdom holds that the only consistent thing about FASD is that those who are affected behave inconsistently. This means, for example, that a client may demonstrate

that they know something on Monday, but have trouble recalling that same information on Tuesday. The clinician can benefit by following the rule to: REPEAT, REPEAT, REPEAT.

Sexual Abstinence, Contraception, and Pregnancy

Adolescents and adults with an FASD should be well informed and consulted about decisions regarding abstinence, contraception, and pregnancy. There are many ways to support pregnancy, delivery, and parenting by an individual with an FASD. The client may have questions about whether or not the FASD can be passed on to any offspring; caregivers must clarify that only prenatal exposure to alcohol can cause an FASD. If the client has children, the parenting skills taught to the client should account for the possible presence of an FASD in both parent and child; the skills learned must be appropriate to each of them and work for each of them.

Clinical experience reveals that women with an FASD can be vulnerable to exploitation and unintended pregnancy (Grant et al., 2004; Merrick, Merrick, Morad, & Kandel, 2006). It can be difficult for them to use contraception effectively due to memory lapses, problems following instructions, or difficulty negotiating contraceptive use with a partner. Counselors can help clients evaluate their family planning needs and assist in obtaining reliable, long-term birth control methods.

Although it may be unusual in a treatment setting, very practical and basic assistance may be important for a woman with an FASD. The counselor may need to accompany the client to a doctor's appointment to help her understand her options and choose the best one. One study found improved use of contraception among young women with an FASD by implementing a community intervention model of targeted education and collaboration

with key service providers, and by using paraprofessional advocate case managers as facilitators (Grant et al., 2004).

Clinical consensus based on evaluation of common behavioral characteristics of FASD suggests that the causal relationship between HIV/STDs/viral hepatitis and substance use disorders may be heightened among those who also have an FASD. Care plans for individuals with an FASD entering substance abuse treatment should include communicable disease assessment.

Medication Assessment

In some cases, medication options may be appropriate to treat some of the functional or mental health components of FASD (Coe, Sidders, Riley, Waltermire, & Hagerman, 2001). The counselor may want to refer the client for an assessment to determine whether he or she can follow a regimen of taking a pill every day or getting a shot every few months. It is also important to consider the possible physical impact, since persons with an FASD may have health problems and be prone to side effects. Medications for individuals with an FASD may not work at rates similar to other populations and/or may require different dosages to work (O'Malley & Hagerman, 1999). Including a mentor or supportive family member in the discussion may help the individual with an FASD to be more comfortable asking questions and better understand what is being said.

Job Coaching

In a study of 90 adults with a diagnosed form of FASD, most had some work experience but the average duration was only 9 months (Streissguth et al., 1996). Some of the general barriers to successful work for people with disabilities are external; discrimination by employers, co-workers, and family, transportation issues, completing applications and job testing, social skills, and the lack of support

at interviews. Other barriers are internal, and need to be addressed early on in the vocational process; self-esteem and self-worth, fear of success, self-sabotage, and having a realistic view of strengths and career goals. All of these internal factors affect career choice, self-presentation at the interview and the job, and ultimate vocational success (Fabian, Ethridge, & Beveridge, 2009; Leon & Matthews, 2010). These issues should be addressed through counseling and skills-building prior to standard vocational tasks.

A job coach or vocational rehabilitation counselor may need to remain involved with an individual with an FASD beyond the time when he or she seems to “know” the job, and be understanding if the individual has days or situations in which he or she can’t remember what to do or gets overwhelmed. Individuals with an FASD may do well enough on a job that a coach or counselor decides they “get it” and stops providing support, when in fact it was the support that enabled success.

Vocational Rehabilitation

Vocational Rehabilitation should be viewed as an interdisciplinary team process. It may be up to a parent or caregiver to coordinate information. The team may include a physician for medical and health issues, an occupational/physical therapist, a psychologist for counseling to address some of the above issues, teachers, case managers, and job placement agencies (Gobelet, Luthi, Al-Khodairy, & Chamberlain, 2007). Some adults and families will choose sheltered workshops because of concerns about safety, transportation, long-term placement, work hours, maintaining disability benefits, social environment, and work skills issues (Migliore, Grossi, Mank, & Rogan, 2008). At the same time, the majority of adults with an intellectual disability prefer integrated employment over sheltered workshops, regardless of disability severity (Migliore, Grossi, Mank, & Rogan, 2007).

Special Considerations for Adolescents Who Have or May Have an FASD

It is important to remember that adolescents are quite different from adults, and adolescents with an FASD differ from teens that develop in typical fashion. Adolescents with an FASD may function at social and emotional levels well below their chronological age, with an uneven cognitive and physical profile (some skills less impaired than others). The treatment process must incorporate the nuances of the adolescent’s experience. In modifying treatment plans for adolescents with an FASD, it is important to consider cognitive, emotional, and social limitations, as well as risk factors that led to their substance abuse or mental health issue. Many youth with an FASD have grown up in less-than-ideal environments, facing parental substance abuse, economic deprivation, abuse, and multiple foster care placements. These situations can increase their risks for substance abuse and mental disorders.

A summary of clinical and empirical evidence shows that adolescents will commonly exhibit learning and behavior challenges, especially in adaptive function (getting along from day to day), and in remaining organized and regulated (Streissguth et al., 2004; Spohr, Willms, & Steinhausen, 2007). They often learn information slowly (especially what is said to them), tend to forget things they have recently learned, and make the same mistakes over and over. They can often have trouble shifting attention from one task to another. Like those with ADHD, they may be impulsive and find it hard to inhibit responses, and may be restless or even obviously hyperactive. In general, they may have trouble regulating their behavior. Even though adolescents with FASD may be talkative, they have social communication problems (such as leaving out important details or explaining things in a vague way). Adolescents with FASD tend to show poor judgment, are suggestible (and therefore easily

Treatment Tips From the Field

In addition to the guidance provided in this chapter, providers in British Columbia provided the following anecdotal suggestions for effective programming for individuals who have or may have an FASD.

Treatment Planning	<ul style="list-style-type: none"> • If medication is used, simplify medication schedules and provide support. • Avoid using students as therapists. <ul style="list-style-type: none"> • May reinforce loss issues related to childhood/youth. • May not be skilled with FASD. • Reassess concepts of dependency and enabling. • Use reminders. <ul style="list-style-type: none"> • Use texting to provide reminders and stay connected. • Find something that the person likes to do and does well (that is safe and legal) and arrange to have the person do that regardless of behavior. • Create “chill-out” spaces in each setting. • Be creative about finding ways for the individual to succeed. <ul style="list-style-type: none"> • Establish achievable, short-term goals. • Reconsider zero-tolerance policies. • Be consistent in appointment days and times. <ul style="list-style-type: none"> • Consider shorter, more frequent meetings or sessions. • Arrange for someone to get the person to appointments for at least 6 months. • Have the meetings on the same days each week. • Discuss each meeting with the person. • Use open meeting times, if necessary.
Assisting Navigation and Success	<ul style="list-style-type: none"> • Have pictures of the counselors on their office doors. • Identify possible buddies (e.g., family, friends, church or other organizations) to ensure the client gets to appointments, etc. • Identify persons who are appropriate supports for the client, as well as persons who are not helpful. • Program important numbers and reminders into their cell phone for them.
Language	<ul style="list-style-type: none"> • Do not use metaphors or similes. • Do not use idiomatic expressions and proverbs. <ul style="list-style-type: none"> • “A day late and a dollar short.” • “People in glass houses shouldn’t throw stones.” • Don’t use sarcasm, and be careful about joking with the person.

Source: Rutman, D. (2011). *Substance using women with FASD and FASD prevention: Service providers’ perspectives on promising approaches in substance use treatment and care for women with FASD*. Victoria, British Columbia: University of Victoria.

influenced by others), and show immature social skills. Because of this, they may be too friendly with people they do not know well, too trusting, and have difficulty recognizing dangerous situations.

Treatment Plan Modification

It is generally believed that traditional forms of therapy, such as “talk therapy,” are not the most effective choice when working with adolescents with an FASD. Their cognitive

Adolescent Development Issues in FASD

The following table outlines some of the more common developmental delays and deficits experienced by individuals with an FASD through the adolescent years (ages 12–21), and useful treatment approaches. This table is based on an expert clinical consensus.

	Normal Development	FASD	Intervention
Age Range: 12-21	Ability to evaluate own behavior in relationship to the future	Lack of connection between thoughts, feelings, and actions	Repeated skills training with role-playing and videotaping; videotaping of person's behavior
	Understanding consequences of behavior		
	Importance of peer group	Difficulty resisting negative peer influences	Connect person with pro-social peers, mentors, and coaches
	Development of intimate relationships	Difficulty with accurately interpreting social cues (e.g., words, actions, nonverbal cues)	Social skills training; repeated discussions of sexuality and intimacy as appropriate

deficits prevent them from developing insight or applying lessons to their real lives. However, with creativity and flexibility, a treatment plan can be developed that includes techniques counselors are familiar with and comfortable with, adapted to fit the needs of the client (Baxter, 2000).

Addressing Peer Influences

Clinical observations indicate that adolescents with FASD are socially immature, and research documents that adults with FASD are more suggestible (Brown et al., 2011). Developmental literature makes clear that peer influences are important in the adolescent stage, and that deviant peer influences can lead to antisocial behavior. The counselor should address issues such as peer pressure in treatment to set the stage for less risky behavior outside treatment. Linking an adolescent with an FASD with a mentor is a sound treatment strategy.

Ongoing Assessment for Comprehension of Information

As with adults, it is important to check often to make sure the adolescent client understands what has been said. Ask the client to summarize what you have said. Review written material, such as rules, at each session. *Repeat, repeat, repeat*, even if the client says, "You've told me this a hundred times."

For adolescents, applying concepts can be difficult. Cognitive deficits, the frustration of having an FASD, and typical teen rebellion can make communication especially hard. Role-playing different situations, providing opportunities to share and process feelings, and giving the client time to process information is important. It also may help to use alternative methods of expression, such as drawing, to assist the client in sharing his or her understanding.

Educational Support (IDEA and FAPE)

The Individuals With Disabilities Education Act (IDEA) entitles every young person to a *free and appropriate public education* (FAPE) in the least restrictive environment. If the client is eligible, this can continue until age 21. If you have a client who has or may have an FASD and is in school, it is important to consult with the school regarding any provisions in that client's individualized education plan (IEP), either those identified by the school that should be carried over to treatment or vice versa. In a study of 120 children undergoing FASD diagnosis at a Washington State FAS DPN clinic, Jirikowic and colleagues (2010) found that over 90 percent did require intervention recommendations associated with their educational plan.

In the outpatient setting and during aftercare, it is a good idea for the psychologist to consult with the school counselor or case manager (if the client has one) regarding educational needs. Areas such as social skills may be addressed in the IEP, and are important to address during treatment and as part of aftercare. It also helps to be aware of any academic issues that may affect the client's treatment, such as stress about academic performance or difficulties with classmates.

Parents may not be aware of the laws regarding education of children with disabilities and may feel overwhelmed. They may be having problems dealing with their child's school and wonder what to do. The counselor can help by informing the client and family about IDEA and FAPE requirements and helping outline possible interventions to suggest to the school.

The U.S. Department of Education provides an online overview (<http://www2.ed.gov/about/offices/list/ocr/docs/edlite-FAPE504.html>) of the stipulations of FAPE and who qualifies for educational support under its terms.

In addition, vignette #10 in Part 1, Chapter 3 of this TIP discusses some of the key aspects of developing an IEP for an individual who has an FASD.

Psychosexual Development

Early and ongoing social experiences play a key role in psychosexual development. Adolescent tasks include having and maintaining intimate relationships, managing complex emotions and social situations, and developing independent thinking. The adolescent with an FASD may not achieve these milestones all at the same time, at the usual age range, or at all. Many adolescents with disabilities are delayed or prevented from achieving these goals by social isolation or a variety of functional limitations. Social skills may be broken down into manageable tasks, just as in every other area of instruction. This includes the basics first, such as mastering appropriate greetings, eye contact, body language, personal space, self-advocacy skills, and telephone and computer skills. A foundation in some or all of these basic skills will allow for the development of more complex skills. Mentors and peers may be very effective in this regard.

Vocational Coaching

Young adults with a disability need advocacy and support with a variety of new agencies and support services throughout the transition and adult years. A life skills curriculum should include how to use the internet to search for employment and employment enhancement services, awareness of issues associated with safe work environments, interviewing strategies, appropriate use of medication, managing finances, dealing with workplace routines and expectations, being cautious about at-risk situations, and knowing when to ask for help (Winn & Hay, 2009). Role-playing each of these skills with the client will be beneficial.

Counselor Self-Assessment

Working with clients with an FASD can raise issues for you, the counselor. You might feel resentment about being “stuck” with such challenging clients, or harbor negative attitudes toward women who drink while pregnant. The client with an FASD can trigger feelings of guilt and shame in a counselor who drank while pregnant or has a child with an FASD.

Understanding how to cope with clients with an FASD can help the counseling professional serve such clients more effectively. Olson and colleagues (2009) have underlined the importance of the need to **Reframe**, **Accommodate**, and **Have Hope** for caregivers raising those with FASD. These same strategies can help counselors, and are combined with the recommendations of Malbin (1993) and Schmucker (1997) to create the following recommendations for counselors providing FASD-related services.

REFRAME

Reframe your perception of the person’s behavior. He or she is not trying to make you mad or cause trouble. He or she has brain damage and may have a history of abuse or other family dysfunction. You need to explore behaviors, stay patient, and tolerate ambiguity.

- Understand that FASD involves permanent brain changes.
- The client is not refusing to do things. He or she can’t do them or does not understand what you are asking him or her to do.
- Clients often are not lying purposely. They are trying to fill in gaps in memory with their own information.
- Perseverating behaviors are an attempt to control or make sense of their own world.
- Transition and change are very difficult for the person with an FASD. Acting out when things change may be a reaction to fear of transitions or difficulty processing change.

ACCOMMODATE

- **Expect to repeat things many times in many ways.** Clients with an FASD may ask the same question every time you see them. Remember that these clients have cognitive deficits. They are not asking just to test your patience. Be patient and avoid looking bored going over the same information multiple times.
- **Use a written journal or goal sheets** to remind people how far they’ve come and where they are headed. Due to their memory difficulties, clients with an FASD will not always remember what supports or programs have been developed with them or their goals. Keep a positive attitude and focus on what the person has accomplished, rather than on goals yet to be met.
- **Realize that there is no set approach;** what works one time may not work the next. As part of the dysfunction of FASD, the client may experience things differently day to day or even hour to hour, and variability is the norm. Keep an open mind and be flexible. Avoid statements such as “But it worked last time.”

HAVE HOPE

- **Be good to yourself.** Even with a realistic plan and an established routine, nothing is perfect. Things change and setbacks occur. By expecting bumps in the road of a person’s journey through life, we can learn to not take these dips personally. By offering the person with an FASD nonjudgmental and informed support, we offer hope.
- **Know yourself, and take the time to reflect on your comfort level in dealing with issues surrounding FASD.** Gain knowledge if needed. Gain comfort in tackling the subject by role-playing with colleagues. Know your limits and get outside help or referrals as required. Plan to connect to appropriate community resources.

Thinking Ahead and Planning for the Future

It is important to think ahead and plan for the future with adolescents and young adults with FASD. If they are able to build an independent life, counselors can help the client learn how to self-advocate and self-monitor, and should communicate these skills to the client's caregivers, as well. It is important to think ahead about education on topics such as (1) safe sex; (2) communicating clearly with partners about consensual activity; (3) use of cigarettes and alcohol; (4) use of illicit substances, such as marijuana and drugs; (5) the consequences of criminal activity; and (6) ideas of what to safely do when the individual goes through times of feeling irritable and negative (calming strategies).

5. Working with the Family

Introduction

Multiple studies have spoken to the value of involving the family in the treatment of an individual who has or may have an FASD, if possible (Schmucker, 1997; Grant, Ernst, Streissguth, & Porter, 1997; Olson et al., 2009; Olson, Rudo-Stern, & Gendler, 2011). Involving the family in planning, choosing, and shaping services for the client has become a key intervention concept in the field of developmental disabilities, as greater family involvement has been linked to better outcomes (Neely-Barnes, Graff, Marcenko, & Weber, 2008). Family-centered care is also strongly advocated for individuals with co-occurring mental health issues and a developmental disability like an FASD (McGinty, Worthington, & Dennison, 2008).

As with many clients in substance abuse and mental health settings, it is advisable to take a broad view of family. Many individuals with an FASD will have resided with foster parents and/or in kinship care (foster and adoptive scenarios being the most common), and care scenarios may extend well beyond the more

typical ages of independence, like 18 or 21. Ultimately, who the client chooses to see as family or as the important caregiver in their life should be incorporated into the process, if possible.

As the table on the next page makes clear, involving the family can be as much about meeting their needs as the client's. The most frequently unmet family needs can be met with emotional support and, later in the counseling relationship, offering opportunities to "look forward" to the future and discuss both hopes and worries. Other frequently unmet needs can be met by helping caregivers find methods for self-care and respite. FASD education and appropriate intervention will meet other common needs, but may be less important (at the start) than support and direct assistance to help understand and meet caregivers' own needs.

Approaching the Family

It is imperative to obtain permission to approach family on the topic of an FASD. If the birth mother is still involved in the individual's care and is not aware of the possibility of an FASD, it is vitally important not to make her feel shamed or judged. The counselor should be prepared to address feelings of guilt. The family may also experience many of the feelings of anger, grief, and loss that the client experiences. All members of the family should be made to feel as comfortable as possible expressing these feelings.

If the family agrees to be involved, there are a number of ways that the counselor can support both them and the client. It is vital to use "reframing" to help the family better understand the client's behaviors as being at least partly caused by brain-based disabilities (Olson et al., 2009). A positive view of the affected individual, of the relationship between the caregiver and the individual, and of the caregiver process has been associated with

Top Unmet Needs for Caregivers Raising Children who have FASD and Behavior Problems

Percentage Indicating Need is Unmet	Type of Family Need
69.2%	Discuss feelings about my child with someone who has gone through the same experience.
61.7%	Have help in preparing for the worst.
60.8%	Have enough resources for myself or the family.
58.8%	Have help in remaining hopeful about my child's future.
58.0%	Get a break from my problems and responsibilities.
55.8%	Be reassured that it is usual to have negative feelings about changes in my child's behavior.
52.9%	Have complete information on my child's thinking problems.
51.0%	Be shown what to do when my child is upset or acting strange.
48.1%	Be told why my child acts in ways that are different, difficult or strange.
47.1%	Have different professionals agree on the best way to help my child.
47.1%	Pay attention to my own needs.

'Important' is defined as parent report that a need was 'important' or 'very important' (where there were two other levels indicating less importance). 'Unmet' was defined as parent report that a need was met 'not at all' or 'a little' (where there were two other levels indicating that a need was met more completely). Items shown here were the most frequently endorsed items; the remaining items (of 20) received far less frequent endorsements.

Source: Olson, H. C., Oti, R., Gelo, J., & Beck, S. (2009). "Family Matters:" Fetal Alcohol Spectrum Disorders and the family. *Developmental Disabilities Research Reviews*, 15, 235-249.

more positive outcomes for the individual and family (Blacher & Baker, 2007). The counselor can then help the family reach out to extended family and friends to help them reframe the situation. Reframing can help everyone more positively understand the client's behavior, and appropriately adjust the home and school environments. Treatment approaches that stress problem-focused management and stress reduction may be a useful addition to parent training (Olson et al., 2009). Other suggestions include:

- As with the client, review the diagnostic report thoroughly with the family (if it is available). Chapter 3 of Part 1, *Clinical Vignettes*, contains a vignette illustrating this process.
- Help the family arrange for respite care or a community support worker: Caregivers may feel stressed or burned out by the responsibilities of caring for someone with an FASD.
- Assist family in coming up with ways to educate extended family and friends about FASD to help them understand the client's behaviors and adjust the home environment accordingly.
- Connect family and friends with support groups or other community resources (see Step 6).
- Help find long-term mentors for clients. Family members or friends who have become exhausted or burned out dealing with an FASD may be willing to help

after a mentor has stepped in for awhile and the client has made progress.

- Encourage parents and caregivers to maximize independence, even if they are used to “helping” or completing tasks for the client.
- Help the family access needed services and supports (see Appendix G, *Services and Supports Checklist*, for a list that can be used as a worksheet).

The *Families Moving Forward Program* intervention is a scientifically-validated behavioral consultation program tailored for families raising preschool and school-aged individuals with FASD or confirmed prenatal alcohol exposure. The intervention includes methods and materials that appropriately trained counselors can use when working with families of a client who has an FASD, even if the client is older (<http://depts.washington.edu/fmffasd>). See Appendix F, *Sample Crisis/Safety Plan*, and Appendix G, *Services and Supports Checklist*, for materials that have been adapted from the *Families Moving Forward Program* for this TIP.

If the client had an existing diagnosis of an FASD before presenting in your setting, involving the family is still valuable. Caregivers are probably already well-versed in FASD and the difficulties of obtaining effective services, and can be as much of a resource of information for the counselor as the counselor is for the family.

6. Transition and Connection to Community Supports

Transitional Services

Part of the counselor’s role is to prepare for discharge of the client. This involves working to establish a network of community resources and providers of service who will continue to provide support and advocacy when your role

is complete. Providing these supports with education about FASD and the client’s unique patterns of behavior is an important part of successful transitioning. See Appendix G, *Services and Supports Checklist*, for a worksheet that can be used to quickly identify linkages the counselor and client may want to explore.

Network of Providers

Counselors need to be familiar with available resources in the community, such as psychiatrists, social workers, developmental disability providers, and physicians. Counselors can include referrals to these resources in the transition plan and work with case managers at their facility as appropriate. For clients who are still in school, it is also important to consider the transition to school, and to work with school administrators and/or the school counselor to determine how best to address the client’s ongoing needs within the school setting.

It may also be necessary to consult an advocate or legal representative if the client has had any legal problems. Adolescents with an FASD can get pulled into illegal activity or manipulated into relapses.

Mentorship

Locating a long-term mentor within the person’s sphere of relationships can be another way to support the transition process. Providing tips and strategies for things that have worked well with the client during treatment can enable the mentor to provide support in the future (Schmucker, 1997). There are also organized programs that can help to identify mentors, though these resources are scarce and differ by community.

If the family is involved in treatment and the client had an existing diagnosis of an FASD before treatment, it is likely that they will have developed relationships with a variety of providers and can thus potentially be a useful

resource for information on services available in the community. There are a number of things that should happen during transition planning that a parent or caregiver could help to facilitate, such as introduction to the relevant service providers and transfer of information to those agencies.

Assessment of Living Skills/Planning for Safety

Even if taught as part of treatment, basic functional living and social skills will need to be re-assessed before transition to help the client function more effectively and safely in the community. The provider should work with the client to:

- Assess ability to handle money, pay bills and rent, buy groceries, etc. The clinician can consider a representative payee, if necessary.
- Anticipate housing needs: Will the client live alone? With caregivers? With others in structured housing or a group setting? An individual with an FASD is likely to need dedicated, long-term caregiver support in any setting, but this is particularly vital if they will be living alone. Assistance is likely to be needed with negotiating public transportation, handling interpersonal relationships, grocery shopping, and structuring leisure time (Streissguth et al., 1996).
- Identify job desires and possibilities, as well as what is needed for job success.
- Review appropriate social interaction.
- Review processes for checking whenever the client is unsure of a situation or response, or is in trouble.
- Ensure that learned skills are practiced in the new environment.
- Continue supports at least until the client adjusts to the new environment.

If a mentor, family member, or other caregiver is identified for the client, Vignette #9 in Part 1, Chapter 3 of this TIP walks through the process of working with that person or persons to develop a personalized Safety Plan on behalf of an individual with an FASD.

Connection to Community Supports

Both the client and the client's family and caregivers (if involved) can benefit from connection to support systems in their community. As with referral for assessment or diagnosis, it is vital that the counselor actively assist the client through transition to other providers and follow up regularly to ensure client satisfaction and full and open communication between agencies and with the client (and the client's family, if they are involved in the treatment process).

Appendix C, *Public and Professional Resources on FASD*, provides links to a number of support organizations for individuals with an FASD, including NOFAS (www.nofas.org), the Birth Mothers Network (also known as the Circle of Hope; visit the NOFAS Web site and the FAS Community Resource Center (<http://www.come-over.to/FASCRC/>)).

NOFAS can be a particularly valuable resource, as it houses not only the Birth Mothers Network but also an extensive affiliate network whose members provide a broad range of FASD-related services to individuals and their families. In addition, NOFAS's "Living With FASD" page (<http://www.nofas.org/living/>) contains links to financial assistance programs such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), and Medicaid, as well as family and mother support programs such as Women, Infants and Children (WIC).

An emerging community resource for individuals with an FASD is the Self-Advocates with FASD in Action (SAFA) Network. Members

include individuals with an FASD and their support persons. The SAFA Network provides speakers and training on living with an FASD, and also peer support for other individuals and families coping with these disorders. The SAFA Network can be contacted through SAMHSA's FASD Center for Excellence (www.fasdcenter.samhsa.gov, or toll-free at 1-866-STOP-FAS).

Job Support

Your local One-Stop Center (www.careeronestop.org) may provide links to your state Department of Labor and Workforce Development, the local division for vocational rehabilitation services, and/or specific state initiatives for development of customized employment for people with disabilities. For individuals with an FASD, customized employment should include a protocol that addresses their special needs.

Self-Help Participation

The person with an FASD will need support to participate successfully in a 12-Step program. Many areas of the country have "Double Trouble" meetings; these are 12-Step self-help groups designed to meet the special needs of people with addiction and mental health issues (Vogel, Knight, Lauded, & Maura, 1998). Double Trouble meetings may be more flexible about impulsive behaviors than routine meetings. The counselor should be cautious about referring a client who has or may have an FASD into a self-help group, due to issues of victimization as well as the possibility that the individual's special needs will not be met.

Another significant resource for people with an FASD and co-occurring issues is the recovery movement in the mental health field. Recovery centers (also known as "drop-in" centers) offer a variety of supports, groups, and meetings in some areas.

Clinical Vignettes

IN THIS CHAPTER

- Introduction
- The Culturally Competent Counselor
- Areas of Clinical Focus
- Clinical Vignettes

Introduction

This chapter presents vignettes of counseling/intervention sessions between various service professionals and either 1) women of childbearing age where FASD prevention is warranted, and/or 2) individuals who have or may have an FASD or their family members. The vignettes are intended to provide real-world examples and overviews of approaches best suited (and not suited to) FASD prevention and intervention.

The Culturally Competent Counselor

This TIP, like all others in the TIP series, recognizes the importance of delivering culturally competent care. Cultural competency, as defined by HHS, is...

“A set of values, behaviors, attitudes, and practices within a system, organization, program, or among individuals that enables people to work effectively across cultures. It refers to the ability to honor and respect the beliefs, language, interpersonal styles, and behaviors of individuals and families receiving services, as well as staff who are providing such services. Cultural competence is a dynamic, ongoing, developmental process that requires a long-term commitment and is achieved over time” (U.S. Department of Health and Human Services, 2003, p. 12).

A critical element of this definition is the connection between attitude and behavior, as shown in the table on the next page.

Areas of Clinical Focus

In this chapter, you are invited to consider different methods and approaches to practicing prevention of an AEP and/or interventions and modifications for individuals who have or may have an FASD. The ten scenarios are common situations for behavioral health professionals and focus on:

Attitude	Behavior
Respect	<ul style="list-style-type: none"> • Acknowledging and validating the client's opinions and worldview • Approaching the client as a partner in treatment • Communicating with clients in their primary language, either directly or through an interpreter • Respecting the client's self-determination
Acceptance	<ul style="list-style-type: none"> • Maintaining a nonjudgmental attitude toward the client • Considering what is important to the client
Sensitivity	<ul style="list-style-type: none"> • Understanding the client's experiences of racism, stereotyping, racial profiling, and discrimination • Understanding the life circumstances, daily realities, and financial constraints of the client
Commitment to Equity	<ul style="list-style-type: none"> • Intervening on behalf of clients when a problem stems from racism or bias • Actively involving oneself with minority individuals outside the counseling setting to foster a perspective that is more than academic or work-related
Openness	<ul style="list-style-type: none"> • Recognizing the value of indigenous helping practices and intrinsic help giving networks in minority communities • Building ongoing collaborative alliances with indigenous caregivers • Seeking consultation with traditional healers and religious and spiritual leaders and practitioners in treatment of culturally different clients, when appropriate
Humility	<ul style="list-style-type: none"> • Acknowledging the limits of one's competencies and expertise and a willingness to refer clients to a more appropriate counselor when necessary • Seeking consultation and pursuing further training or education, or a combination of these • Constantly seeking to understand oneself as being influenced by ethnicity and culture and actively seeking a nonracist identity • Being sensitive to the power differentials between the client and the counselor
Flexibility	<ul style="list-style-type: none"> • Using a variety of verbal and nonverbal responses, approaches, or styles to suit the cultural context of the client • Using cultural, socioeconomic, and political contextual factors in conducting evaluations and providing interventions

This table originally appeared in TIP 48, *Managing Depressive Symptoms in Substance Abuse Clients During Early Recovery* (SMA 08-4353). The authors of this TIP gratefully acknowledge the authors of TIP 48.

1. Intervention with a woman of childbearing age who has depression, is consuming alcohol, and may become pregnant (AEP Prevention)
2. Examining alcohol history with a woman of childbearing age in substance abuse treatment for a drug other than alcohol (AEP Prevention)
3. Intervention with a woman who is pregnant (AEP Prevention)
4. Intervention with a woman who is pregnant and consuming alcohol, and who is exhibiting certain triggers for alcohol consumption, including her partner (AEP Prevention)
5. Interviewing a client for the possible presence of an FASD (FASD Intervention)

6. Interviewing a birth mother about a son who may have an FASD and is having trouble in school (FASD Intervention)
7. Reviewing an FASD diagnostic report with the family (FASD Intervention)
8. Making modifications to treatment for an individual with an FASD (FASD Intervention)
9. Working with an adoptive parent to create a safety plan for an adult male with an FASD who is seeking living independence (FASD Intervention)
10. Working with a birth mother to develop strategies for communicating with a school about an Individualized Education Plan for her daughter, who has an FASD (FASD Intervention)

Organization of the Vignettes

To better organize the learning experience, each vignette contains an **Overview** of the general learning intent of the vignette, **Background** on the client and the setting, **Learning Objectives**, and **Master Clinician Notes** from an “experienced counselor or supervisor” about the strategies used, possible alternative techniques, timing of interventions, and areas for improvement. The Master Clinician is meant to represent the combined experience and expertise of the TIP’s consensus panel members, providing insights into each case and suggesting possible approaches. It should be kept in mind, however, that some techniques suggested in these vignettes may not be appropriate for use by all clinicians, depending on that professional’s level of training, certification, and licensure. It is the responsibility of the counselor to determine what services he or she can legally/ethically provide.

1. INTERVENTION WITH A WOMAN OF CHILDBEARING

AGE WHO HAS DEPRESSION, IS CONSUMING ALCOHOL, AND MAY BECOME PREGNANT (AEP PREVENTION)

Overview: This vignette illustrates how and why a counselor would address prevention of an AEP with a young woman who is being seen for depression.

Background: This vignette takes place in a college counseling center where Serena, 20, is receiving outpatient services for the depression that she’s been feeling for about 4 months. In her intake interview, Serena has indicated that she consumes alcohol, is not pregnant, and is sexually active. She has had two prior sessions with the counselor, during which they have discussed Serena’s general background, family interactions, social supports, and her outlook on school.

In today’s session, they have been discussing her boyfriend, Rob. A therapeutic relationship has begun to form between Serena and the counselor, and the counselor would now like to explore Serena’s alcohol use and whether it is a possible contributing factor in her depression. While doing this, the counselor will identify an opportunity to deliver an informal selective intervention to prevent a possible AEP.

Learning Objectives:

1. To illustrate that clients often have multiple issues that need to be addressed besides their primary reason for seeking counseling.
2. To demonstrate a selective intervention (“FLO”) for preventing an alcohol-exposed unplanned pregnancy.
3. To recognize that prevention of an AEP can be accomplished by eliminating alcohol use during pregnancy or preventing a pregnancy during alcohol use; often the most effective route is to prevent the pregnancy.

Vignette Start

The session is already in progress. Serena has been discussing how she and her boyfriend Rob tend to fight a lot, but she continues to spend time with him because they have fun at parties.

COUNSELOR: So, how long have you and Rob been together?

SERENA: About 7 months.

COUNSELOR: And you've said that the two of you are sexually active.

SERENA: Yeah, I usually sleep over on the weekend, after the parties.

COUNSELOR: Do these fights occur at any particular time?

SERENA: Not really. When we're stressed, mostly, over school or work or whatever. Then I feel more depressed cuz we're fighting, and he gets upset because I'm depressed. It's like a circle. That's why we go to the parties, to unwind and forget about stuff.

COUNSELOR: And then you tend to end up spending the night with him.

SERENA: Usually.

COUNSELOR: Are you using any protection, or birth control?

SERENA: No.

COUNSELOR: And during these parties, are you drinking?

SERENA: Sure.

COUNSELOR: About how many drinks do you have?

SERENA: I don't really know. My cup's never empty, it just gets refilled at the keg.

COUNSELOR: Are there other times when you drink alcohol?

SERENA: No, it's really just at the parties.

Master Clinician Note: Serena is presenting high-risk behavior by combining alcohol use and unprotected sex. The counselor seeks to identify the link between alcohol, unprotected sex, and pregnancy.

COUNSELOR: I know you're not expecting this, but if you were to find out right now that you were pregnant, how would that change things for you?

SERENA: Oh lord, that would *totally* turn my life upside down. And Rob's. God, he'd freak.

COUNSELOR: So, you do not want to get pregnant.

SERENA: No, I definitely do not wanna get pregnant.

Master Clinician Note: Serena has made it clear that she does not want to become pregnant, so the counselor shifts to addressing the gap between Serena's behaviors (being sexually active but not practicing safe sex) and her stated desire (to not get pregnant).

COUNSELOR: I understand, and I'm concerned about your health and what you want for your future. So, if you plan to keep attending these parties and being sexually active, then maybe we can talk about contraception. Did you know that half of all pregnancies in the U.S. are unplanned?

SERENA: Wow. No, I didn't know that.

COUNSELOR: It's true. It's possible that you could get pregnant, and the drinking could impact the health of that baby. Let's talk about how we can avoid those things.

SERENA: Okay.

The counselor gives Serena a pamphlet that describes effective contraception.

COUNSELOR: Would you be willing to read this? It's short, but it has good information. Perhaps we can go over it when we meet next week.

SERENA: Okay. I thought I was here to talk about depression, though.

COUNSELOR: Yes, absolutely, our first goal is to help you stop feeling depressed. And as you've said, you definitely don't want to have a baby, so I think it's important for us to discuss ways to avoid getting pregnant, so that that's not something that adds to your worries.

SERENA: Oh, okay. I see what you mean.

COUNSELOR: So next week I can answer any questions you have about that material, and then we can talk about some positive goals you want to lay out, like feeling less depressed, or fighting with Rob less, or not getting pregnant. Does that sound okay?

SERENA: Yeah, thanks.

Master Clinician Note: This vignette does not "solve" the issue of Serena's depression. However, as part of examining the possible causes, Serena has talked about a pattern of regular at-risk drinking, combined with unprotected sex. Because of this, the counselor—who by now has established a good rapport with Serena—has taken the opportunity to carefully include a selective intervention for preventing an AEP.

In an informal way, the counselor has used the steps of the "FLO" intervention discussed in Part 1, Chapter 1 of this TIP. During intake and again at this visit, Serena has indicated that she consumes alcohol and is sexually active. The counselor provides **F**eedback on these responses (by discussing the possibility of an AEP), then **L**istens as Serena indicates that she does not want to become pregnant. The counselor thus shifts the focus of medical advice to the **O**ption of contraception and provides Serena with educational material.

At the same time, the counselor has not lost sight of depression as Serena's primary treatment issue. In this session, the counselor has laid the groundwork for continuing to discuss Serena's at-risk drinking and her problematic relationship with Rob as possible components of the depression, but in the context of positive goals that Serena can aim for (i.e., finding ways to feel less depressed, fight with Rob less, and avoid an unwanted pregnancy).

2. EXAMINING THE ALCOHOL HISTORY WITH A WOMAN OF CHILDBEARING AGE IN SUBSTANCE ABUSE TREATMENT FOR A DRUG OTHER THAN ALCOHOL (AEP PREVENTION)

Overview: This vignette illustrates the value of asking about alcohol use in a female substance abuse treatment client of childbearing age, even though her primary drug is not alcohol.

Background: Chloe is being seen at an outpatient treatment center for methamphetamine abuse. The counselor has the health history that was provided during intake. It indicates that Chloe reports as non-pregnant, but is 28 (of childbearing age) and is sexually active.

The counselor wants to explore whether Chloe is using other substances, as well as screening for a possible mental health problem. Given that the client is sexually active, there is a risk of an unplanned pregnancy, therefore the counselor begins with alcohol.

Learning Objectives:

1. To emphasize the importance of probing for alcohol use even if it is not the primary drug.
2. To recognize that quantity of use is subjective. The use of a visual helps the client understand what a one-drink equivalent is.
3. To recognize that if a mental health issue presents itself, it will need to be addressed concurrently.

Vignette Start

COUNSELOR: Hi, Chloe.

CHLOE: Hey.

COUNSELOR: Please have a seat. I have some questions that I would like to ask you, Chloe. You're in treatment for methamphetamines, correct?

CHLOE: Yes.

COUNSELOR: If it is okay with you, I would like to ask you first about your use of some other drugs. I would like to start with alcohol. Do you know how much alcohol you drink?

CHLOE: You mean, altogether? I don't know.

COUNSELOR: Okay, in an average week, how much alcohol would you say you drink?

CHLOE: Well, usually I just drink enough to wash down my pills.

COUNSELOR: What pills are those?

CHLOE: The, whatayacallit, desoxyn.

COUNSELOR: And what do you wash these pills down with? What kind of alcohol?

CHLOE: Usually vodka. With some orange juice in it.

COUNSELOR: And do you do this every time you take the pills?

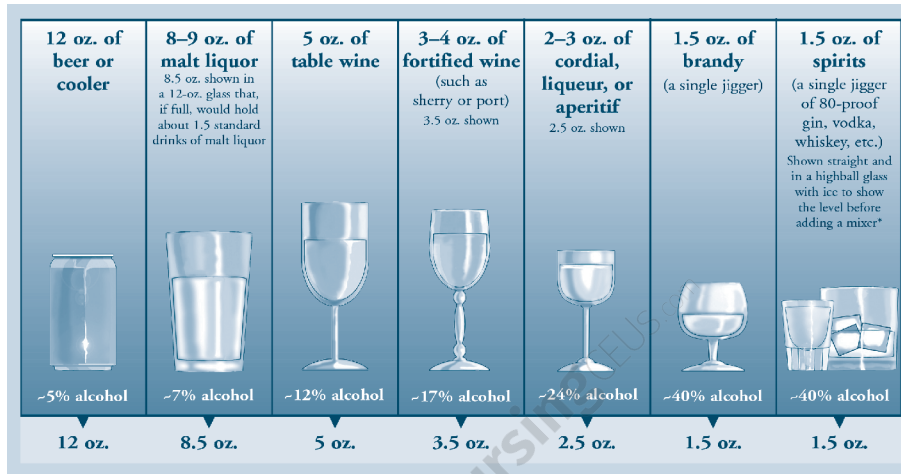
CHLOE: Not every time, but most times.

COUNSELOR: Okay. And how much vodka do you drink to wash down the pills?

CHLOE: One drink.

COUNSELOR: Here, let me show you something real quick. This is a picture of different glasses that people tend to use for drinking alcohol. Which one do you use?

Master Clinician Note: The counselor uses the visual below to help Chloe more concretely understand her level of consumption. However, this visual does not reflect every available drinking size or container, so any discussion of a standard drink should incorporate the client's personal experience (i.e., "If you don't see your glass on here, what do you use?").



CHLOE: None of them. Well (*Chloe indicates the 8.5 ounce drinking glass*), that looks like what I use, but it's not all vodka.

COUNSELOR: How much do you fill with vodka, and how much orange juice?

CHLOE: About half and half.

COUNSELOR: All the way to the top?

CHLOE: Yeah, but with ice in it.

COUNSELOR: Okay, so that's going to be about three to four ounces of vodka, and an ounce and a half of hard liquor is equal to one drink. So, it looks like you're having the equivalent of two to three drinks every time you wash down the pills.

CHLOE: Hmm. I didn't know that.

COUNSELOR: Is there any other time when you use alcohol?

CHLOE: I may have some when I'm feeling bad. It takes the edge off.

COUNSELOR: Can you tell me more about how you feel when you "need to take the edge off?"

CHLOE: I just feel very upset, worried. Sometimes sad.

COUNSELOR: That must be hard for you. About how often do you feel worried and/or sad?

Master Clinician Note: The counselor expresses empathy for the client and how sad/worried she is feeling. This expression of empathy assists in establishing more of a caring relationship, so that further questions around alcohol use can be explored in a helpful manner. The counselor also explores more with the client about how she is feeling when she talks about “taking the edge off” to see what might be the result of her drug use and to see if she needs a mental health evaluation. A mental health evaluation might explore whether medication is indicated that could assist Chloe in reducing her alcohol use.

CHLOE (*laughs*): A lot.

COUNSELOR: It must be difficult to feel so sad and worried a lot. Can I ask you a few more questions about this?

CHLOE: Okay.

COUNSELOR: Did you feel very sad or worried this week?

CHLOE: Yeah.

COUNSELOR: So, when you felt this way this week, did you need to use alcohol to feel better? Or, as you said, to take the edge off?

CHLOE: (*shrugs*) Yeah, I had three or four drinks.

Master Clinician Note: The counselor does not assume that the client is deliberately underestimating, but keeps in mind that clients may minimize when self-reporting alcohol use (Taylor et al., 2009).

COUNSELOR: Did you also feel like this *last* week?

CHLOE: Probably.

COUNSELOR: How about last month? Did you need to use alcohol to try to feel better then also? That would have been August.

CHLOE: I’m sure I did.

COUNSELOR: So Chloe, you would say that you’re feeling sad and worried, and using alcohol to help you feel better, has been going on for quite a while, is that right?

CHLOE: Yeah, most of this year.

Master Clinician Note: Given the frequency of poly-drug use among clients in substance abuse treatment, this counselor did not assume that methamphetamine was the only substance that Chloe was using. Through some simple probing, the counselor has identified that not only has Chloe been drinking, she has been doing so at a high-risk rate. At a future time when dealing more specifically with the amount Chloe is drinking, the counselor might show her a chart with drinking frequencies to help Chloe see what level of drinking is defined as heavy and/or problematic for women.

Chloe has also talked about a pattern of self-medication. The reason or trigger for this may be depression; Chloe has said only that she drinks when she is “feeling like s&@*.” This will require further exploration. For now, the counselor knows that a potential co-occurring mental health issue, a co-occurring substance abuse issue, and prevention of a possible AEP should all be factored into the treatment plan.

3. INTERVENTION WITH A WOMAN WHO IS PREGNANT (AEP PREVENTION)

Overview: This vignette illustrates that screening for alcohol use should be done at every visit with women who are—or are at an indicated likelihood for becoming—pregnant. Alcohol-exposed pregnancies occur in all demographics, regardless of socio-economic status, age, ethnicity, or marital status.

Background: April, 27, works full-time. She recently found out she is pregnant with her first child. She and her husband have relocated

to a new city, and she is being seen at a private OBGYN office for the first time.

Learning Objectives:

1. To recognize that asking about alcohol use during the first visit only is not enough; screening should occur at every visit.
2. To identify that a woman could begin drinking during the pregnancy if she is experiencing a relapse.
3. To highlight there is no known safe amount of alcohol use during pregnancy.

Vignette Start

1st Office Visit

PRACTITIONER: Hello, I'm Dr. Johnson. I see on the chart that you are pregnant. Congratulations!

APRIL: Thank you.

PRACTITIONER: I have a number of questions that I need to ask you before the exam.

Practitioner inquires about health history and eating habits, recommending an increase in fruit consumption.

PRACTITIONER: A few other quick questions. How much do you smoke per day?

APRIL: I don't smoke.

PRACTITIONER: That's good! How much coffee and water do you drink?

APRIL: I have a cup of coffee in the morning, that's about it. I try to drink water all the time. I don't know how much I have per day. Probably a few glasses worth.

PRACTITIONER: Okay, how often do you drink alcohol?

Master Clinician Note: The practitioner has included alcohol as part of a general health exploration rather than asking the question by itself, which can make some clients nervous. Still, April looks a little concerned.

APRIL: I don't drink any alcohol.

PRACTITIONER: Okay, that's good to hear. Not to worry, that's just a general question that I will be asking during all of our visits. There's no safe time, amount, or kind of alcohol to drink during pregnancy, so we recommend women not drink during their pregnancy.

2nd Office Visit: *We pick up the conversation after the practitioner has again gone over the general health questions about smoking and level of intake of water and coffee.*

APRIL: I'm actually trying to drink more water now, and less coffee. I carry a water bottle around with me all the time.

PRACTITIONER: Okay, that's good. How much alcohol have you had?

APRIL: None, really.

PRACTITIONER: Have you had *any* alcohol?

APRIL: One glass. We were having dinner with some friends.

Master Clinician Note: This interaction demonstrates the value of re-screening in relation to alcohol. April stated in the first visit that she does not drink. However, during this second visit, she has revealed that she does drink on occasion. It will be important for the practitioner to repeat the benefits of abstinence during pregnancy and probe for level of alcohol use, while remaining supportive and nonjudgmental.

PRACTITIONER: I see. Well, as we discussed at your last visit, no alcohol use during the pregnancy is the best policy. We just want to take the best possible care of your baby. About what size was that glass, would you say?

Master Clinician Note: The practitioner can use a visual aid, as in the previous vignette, to help April understand how much really equals one drink. The practitioner has also repeated the importance of abstinence during the pregnancy, and tied the guideline specifically to the health of April's baby.

3rd Office Visit: *At this visit, April again indicates alcohol consumption, this time "a couple of drinks" at a dinner party. The practitioner explores further.*

PRACTITIONER: How many drinks did you have?

APRIL: Well, my friend handed me a glass of cabernet when I arrived, because she said I would love it. I reminded her that I was pregnant, but she said a couple wouldn't hurt and that she had a few when she was pregnant and her kids were fine.

PRACTITIONER: So, you drank the cabernet. Did you have any others?

APRIL: Well, then I had some with dinner, too. I felt like I had been really good during the pregnancy, so I just decided to have a few drinks this one night.

PRACTITIONER: So, you ended up having a few drinks that night.

APRIL: Yes, but just that one time. And it was only wine.

PRACTITIONER: I know that the temptation to have some drinks at a party or a celebration can be great, but there are a couple things to keep in mind. One is that science has shown that alcohol can harm the baby. We don't know yet how much alcohol consumption is too much, so it's very important to avoid all alcohol during the pregnancy.

The practitioner pauses for the client to process what has been said.

APRIL: Okay.

PRACTITIONER: Also, it's important to understand that *any* type of alcohol you drink can hurt the baby, not just certain kinds. Wine, hard liquor, beer...any beverage with alcohol in it. So it's important to avoid all of them during the pregnancy.

APRIL: Gotcha.

Master Clinician Note: Given that April has continued to drink even after her first couple of visits, the practitioner takes the educational process a step further this time, clearly noting that science has established a risk and that there is no "acceptable" form or amount of alcohol. A counselor or practitioner may also want to discuss the possibility of equipping April with some tools to help her abstain during the pregnancy (e.g., relaxation techniques, recreation, avoiding trigger situations such as parties). The need to continue to monitor April's alcohol consumption should be clearly noted in the medical record.

4. INTERVENTION WITH A WOMAN WHO IS PREGNANT AND CONSUMING ALCOHOL, AND WHO IS EXHIBITING CERTAIN TRIGGERS FOR ALCOHOL CONSUMPTION, INCLUDING HER PARTNER (AEP PREVENTION)

Overview: This vignette illustrates a method for obtaining the alcohol history of a pregnant woman.

Background: Isabel, 30, has been referred to an outpatient mental health treatment center for feelings of depression. She is Hispanic, married, and pregnant (in her third trimester), and has one other child. The counselor and

client have completed the intake process and Isabel has participated in the development of her comprehensive treatment plan. This is their third meeting. The counselor and Isabel agreed at the end of their last session that this would be about potential health risks with the pregnancy.

Learning Objectives:

1. To learn how to use a practical visual tool (a calendar) to more accurately and effectively identify client drinking patterns and possible triggers for alcohol consumption.
2. To identify verbal cues that can indicate that a topic is becoming uncomfortable for a client, and apply effective techniques when a client becomes upset.

Vignette Start

COUNSELOR: Hi, Isabel. How are you?

ISABEL: Fine, how you doing?

COUNSELOR: I'm fine, thanks. When we met last, we finished working on your treatment plan. You have had a little bit of time to think about the plan now. Do you have any thoughts or concerns about what we developed?

ISABEL: No, not really.

COUNSELOR: How are you doing with the pregnancy?

ISABEL: Pretty good. Things are going pretty well.

COUNSELOR: Great. Now, at the end of your last visit here, we said we would spend part of today's session talking about alcohol use during pregnancy. You indicated during your intake that you drink socially, so let's talk about that a little more. Knowing about when and how much you drink will help us to see if there is any need to be concerned about any health issues for you or the baby. Is that okay with you?

ISABEL: *[Sounding a little concerned.]* What do you mean "concerned about health issues?" I am not an alcoholic.

Master Clinician Note: The counselor wants to reassure Isabel that she has not formed a negative opinion of her. The counselor now also needs to be aware that Isabel may try to minimize the frequency and amount of alcohol consumed so that she is not viewed as an alcoholic.

COUNSELOR: *[Calmly and reassuringly.]* I am sorry, Isabel. I wasn't trying to say that you have an alcohol problem. Nothing you have told me during our previous sessions would lead me to believe that you are an alcoholic or have a drinking problem. You said you only drink socially, correct?

ISABEL: Yes. I don't drink every day or even every weekend.

COUNSELOR: Good. That's just what I thought. I know, just from the short time we have been seeing each other, that you would never do anything to hurt your child. But, would you agree that drinking socially for one person might be different than drinking socially for another?

ISABEL: Of course.

COUNSELOR: Alcohol can have an influence on individuals who are anxious, depressed, and even on women who are pregnant, and possibly their unborn child. That influence can depend on the frequency and amount of alcohol consumed. So knowing the social situations and how much you drink at those occasions will help us determine if you need to make any changes between now and when the baby is born. If it is okay with you, let's see if we can identify those situations.

ISABEL: Okay, I'll give it a try.

COUNSELOR: Thanks. That's great. So first let me ask you this: Normally, when you aren't pregnant, how often would you say you drink alcohol?

ISABEL: Well, most of the time I'm not normally a drinker.

COUNSELOR: Okay, that's good. When you *do* drink, about how much do you have?

ISABEL: I can't really say. It depends.

Master Clinician Note: The counselor wants to get an accurate picture of Isabel's drinking during pregnancy, so she brings out a calendar. The visual is helpful as it allows both client and counselor to put their eye contact elsewhere, which can contribute to the ease of discussion. The counselor explains that it also helps to trigger memory by looking at dates.

COUNSELOR: Okay, so let's start by figuring out when you first found out that you were pregnant.

ISABEL: I went to Dr. Murphy's office and they did a pregnancy test. I had not had my period. I can look at the calendar, but I am pretty sure it was sometime in May.

COUNSELOR: Do you think it was the beginning of May or the middle?

ISABEL: It was the middle, and then I went home and told Marco.

COUNSELOR: Ok, so you found out you were pregnant in the middle of May. *[Counselor marks the calendar.]* When did Dr. Murphy tell you your due date would be?

ISABEL: Around December 22.

COUNSELOR: Great, so we know you're in your third trimester now. *[The counselor circles the third trimester with a colored pencil, then circles the other trimesters with different colors.]* It looks like you probably got pregnant somewhere around the beginning of April. *[The counselor also marks this on calendar.]* Did your alcohol drinking change after you found out you were pregnant in mid-May?

ISABEL: Yes, I pretty much quit drinking after that. But right before, around the beginning of May *[points to calendar]*, Marco had just gotten a job and we went out with some friends. We went to party that one time, and I drank a little, but I don't think that would harm the baby. It wasn't a lot.

COUNSELOR: You're doing great. Do you remember what you were drinking?

ISABEL: I had one rum and Coke. Mostly Coke, with a little rum.

COUNSELOR: Was that all?

ISABEL: I had one wine cooler which I sipped for the rest of night. That wasn't too much, was it?

Master Clinician Note: The counselor senses that Isabel is getting a little anxious about this line of questioning and tries to be reassuring and non-judgmental.

COUNSELOR: Two drinks in one night don't sound like a lot to me. I'm only asking because I want to help you do the best for the baby between now and the time you deliver. So let's see: It seems like you are saying that you mostly drink on special occasions. Is that right?

ISABEL: Yes, those are the times I usually drink, and sometimes when Marco has friends over to watch a game I might have a beer or two.

COUNSELOR: Okay. Can you remember any other occasions when you might have been drinking during your pregnancy?

ISABEL: I drank a little on my birthday in July.

COUNSELOR: Did you go out for your birthday?

ISABEL: No. Marco surprised me when I got home. He made me dinner with flowers and wine and everything.

COUNSELOR: He sounds very thoughtful.

ISABEL: *[Smiling, shrugs a little.]* He can be.

COUNSELOR: So, do you remember how much wine you had that night?

ISABEL: I had maybe two or three glasses. I have read that drinking a little wine would not hurt the baby. I try to be aware not to do anything that would hurt my baby. I drank a little with my first child and he is healthy.

COUNSELOR: I know that, Isabel. No mother would do anything on purpose to hurt her baby. I know how hard you're working to take care of yourself during the pregnancy, and that's really important. Did Marco drink with you on your birthday?

ISABEL: Marco drinks all the time. He drinks beer every day. I'm sure that I'm okay, because you know I'm not like Marco. I don't come home and have a six pack.

COUNSELOR: Okay. So, you drank these two times before you got pregnant. And right about here is when you would have found out you were pregnant. *[The counselor points to circled first trimester on calendar.]* Are there any other days in these months that you can think of, or any events?

ISABEL: *[Pauses, squirms a little in her chair.]* Well, there was one time Marco and I had an argument about the amount of time he spends with his friends. He goes out on Friday nights and drinks with his friends, doesn't come home sometimes until the next morning. He went out and I had some of my girlfriends over and I wound up getting drunk. I was so bad I was throwing up. I was embarrassed. I had to go to the bedroom and they had a bucket and they were saying "Isabel, are you okay?" But that's the only time I can think of.

COUNSELOR: And what were you drinking then?

ISABEL: We were drinking rum and Coke.

COUNSELOR: Okay, do you know how many drinks you had?

ISABEL: We were drinking and playing cards. I must have had three or four, at least.

COUNSELOR: How many drinks does it take to make you feel high?

ISABEL: It depends. A couple glasses of wine, or one rum and Coke, if it is strong.

Master Clinician Note: The counselor is gradually asking more detailed questions about Isabel's alcohol use. Although Isabel claims not to be a drinker, a pattern of usage is emerging through the use of the calendar. Isabel is bringing up Marco often, so the counselor takes this cue and probes further about her husband.

COUNSELOR: It sounds like whenever you drink it has something to do with Marco. Are there times that you drink by yourself?

ISABEL: No.

COUNSELOR: Okay, so tell me about drinking with Marco.

ISABEL: *[Sighs.]* It's just mostly because we're with friends and I like to do what everyone else is doing. I want to be social. I don't drink every day with him. He'll come home with a six pack and drink beer while he is watching TV or sports. He loves baseball and basketball.

COUNSELOR: So he drinks when he comes home from work. Does he want you to drink with him?

ISABEL: He'll offer me a beer now and then, ya know, but that's his thing. That's what men do. I have too many other things going on. I really drink just a little. I really don't think that I am doing anything that is going to hurt the baby. I don't want to fight with Marco about his drinking or his friends. I have to come here to deal with my other problems.

COUNSELOR: Is Marco excited about the baby?

ISABEL: *[Relaxing a little at the change in subject.]* Oh yeah. Very. I'm excited, too. We're looking forward to this.

COUNSELOR: How do you think it's going to be with his drinking after the baby is born?

ISABEL: I don't know. I doubt he will change.

COUNSELOR: Are you worried about that?

ISABEL: No, he's a good guy. *[She sniffles and wipes her nose.]* He really is. I know you probably think he's an alcoholic or something. That's not how it is. We're not like that. *[She starts crying.]* I love this baby. So does he. We're trying to take care of it. *[Her crying continues, and she gets an anxious expression on her face.]*

Master Clinician Note: Isabel is becoming anxious, and is shifting the topic away from alcohol. This is a signal, or cue, to the counselor that the client is uncomfortable. The counselor needs to acknowledge what Isabel is feeling and be careful about how much further she probes on this issue during this visit.

COUNSELOR: I know you have a lot on your plate and I think you are handling it quite well. You did quite a bit in today's session, and you did very well. I would like to end this session and talk a little about our next session. Would that be alright with you?

ISABEL: Sure.

COUNSELOR: I heard you say you had read something that drinking small amounts of alcohol was okay for a pregnant woman. Is that correct?

ISABEL: Yes, I read it on poster, I don't remember where.

COUNSELOR: I would like to give you something to read. It's short. It's about what can happen when babies are exposed to alcohol before being born. I would like you to read it so we can discuss it in our next session. Is that okay with you?

ISABEL: Sure. The more I know, the more I can protect the baby, right?

COUNSELOR: Absolutely.

Master Clinician Note: The mental health counselor is in a difficult position. Her use of the calendar helped to reveal a pattern of alcohol use by Isabel and her husband that exceeds what Isabel first admitted and is unsafe for the baby. It also helped to establish some of Isabel's triggers for drinking alcohol, which include her husband and being angry.

At the same time, discussing alcohol use and how it can hurt a baby can be an emotional topic for the mother. She is working hard to take care of her baby, and the topic of alcohol may have gone further than she is comfortable with. At the same time, it has been useful, as Isabel seems to be reaching a point where she has begun to question her use of alcohol during pregnancy.

This is a learning moment for the counselor. She can see the value of exploring alcohol use with her pregnant patients, but she also knows that, in the future, she can pay closer attention to verbal cues that indicate a client's discomfort; in Isabel's case, the changing of the topic and the repeated assertions that she doesn't think she has hurt her baby. The counselor should continue the session long enough to bring closure to the topic of alcohol use, while supporting the positive things that Isabel has done to take care of her baby. The door should be left open to come back to the topic of alcohol in future sessions.

If Isabel continues to show a pattern of alcohol use during the pregnancy, the counselor can help her identify other ways to deal with her anger besides drinking (stress management), and help her identify or find support systems in her life other than her husband if he is not being supportive of her abstinence during pregnancy (e.g., a pregnancy peer support group). If a mental health counselor does not feel comfortable addressing these issues, referral to a qualified substance abuse treatment counselor is advisable.

5. INTERVIEWING A CLIENT FOR THE POSSIBLE PRESENCE OF AN FASD (FASD INTERVENTION)

Overview: This vignette illustrates the clues the health care worker is receiving that suggest an impairment and possible FASD. A client with an FASD, with brain damage, will not receive the information from the worker the same way someone without FASD will receive it. The client may not have a diagnosis and may not immediately present as someone with a disability. There are a number of questions the worker could ask to determine whether they need to operate in a different kind of therapeutic environment with the client. The main goal of this vignette is for the health care worker to consider the *possibility* of an FASD, not to diagnose an FASD, which can only be done by qualified professionals. A woman who has an FASD is at high risk for having a child with an FASD.

Background: Marta is a single woman, 19, who recently had a baby, and is being seen at a Healthy Start center by a health care worker. This is the first time they are meeting. The health care worker's colleague asked her to meet with Marta as she knew that the health care worker was knowledgeable about FASD and was known as the office "FASD champion." The colleague has begun to suspect that Marta may need an evaluation for FASD, as she has repeatedly missed appointments or been late, gotten lost on the way to the center, failed to follow instructions, spoken at inappropriate times, and has repeated foster placement and criminal justice involvement in her case history. The only information in the history about Marta's biological mother is that she is dead. The colleague wants the health care worker to conduct an informal interview to assess the possibility of an FASD.

Learning Objectives:

1. To learn how to identify behavioral and verbal cues in conversation with a client that may indicate that the client has an FASD.
2. To learn how to apply knowledge of FASD and its related behavioral problems, in order to reassess clients with troublesome behaviors or concerns for factors other than knowing noncompliance.

Vignette Start

HEALTH CARE WORKER: Hi Marta, how are you?

MARTA: Good.

HEALTH CARE WORKER: Your regular counselor has asked me to meet with you today for a few minutes to ask you a few questions, if that's okay. *[Marta nods in agreement.]* Okay, so tell me how you got here today.

MARTA: *[Shrugs.]* I took the #10 bus, then I got off and walked.

HEALTH CARE WORKER: Where did you get off the bus?

MARTA: Madison Avenue.

HEALTH CARE WORKER: Did you know you could have taken the bus to Washington Street instead of Madison Avenue? Then you would have been six blocks closer.

MARTA: *[Shaking her head.]* I didn't know that.

HEALTH CARE WORKER: Do you want me to write that down for you?

MARTA: Okay.

HEALTH CARE WORKER: *[Writes down the information.]* Here, you can keep this in your purse. *[Hands Marta the piece of paper.]*

Master Clinician Note: Individuals with an FASD sometimes exhibit poor working memory. The health care worker is not assuming that Marta has an FASD at this point. However, if she does, it is unlikely that she will remember the information about the bus route, so the health care worker writes it down.

HEALTH CARE WORKER: Did you pay for your bus ride with cash or a bus card?

MARTA: Today I paid with cash, but I don't always have it.

HEALTH CARE WORKER: When are the times when you don't have money?

MARTA: Sometimes friends borrow it, or other people.

HEALTH CARE WORKER: What other people?

MARTA: Well, like last time, a man on the corner asked me for money, so I gave it to him. Then I didn't have any for the bus.

Master Clinician Note: Marta has exhibited a double “red flag” for an individual with an FASD; poor money management skills, and a lack of understanding of consequence (i.e., giving away the money without understanding that she then wouldn’t be able to pay for the bus).

HEALTH CARE WORKER: Marta, I’d like to ask you a little more about some of the questions that you were asked when you first came here.

MARTA: Okay, go ahead.

HEALTH CARE WORKER: You told us that your mother is not alive. How old was she when she died?

MARTA: Twenty-five, I think.

HEALTH CARE WORKER: How old were you when she died?

MARTA: Four.

HEALTH CARE WORKER: I’m very sorry to hear that you’ve lost your mother.

MARTA: *[Very matter-of-factly.]* I didn’t lose her. She died.

Master Clinician Note: Marta is exhibiting very literal interpretation of language, which is common among individuals with an FASD.

HEALTH CARE WORKER: You’re right, that’s what I should have said. That was probably a hard time for you. *[Marta nods.]* Did you know much about her?

MARTA: *[Shakes her head and shrugs.]* Not really.

HEALTH CARE WORKER: Do you know if she ever had any kind of problem with alcohol?

MARTA: Like, being an alcoholic?

HEALTH CARE WORKER: Yes.

MARTA: *[Shrugs.]* I heard she drank, yeah.

HEALTH CARE WORKER: Do you know if she drank alcohol while she was pregnant with you?

MARTA: I don’t know. *[Pauses for a moment.]* That’s a weird question. Why are you asking that?

HEALTH CARE WORKER: Did the question make you uncomfortable? Sometimes when women drink during pregnancy their kids end up having extra challenges. Do you know what I mean when I say challenges?

MARTA: Sure.

HEALTH CARE WORKER: Can you give me an example?

MARTA: *[Shrugs.]* I don’t know.

Master Clinician Note: Marta has stated that she understands when really she doesn’t. Any young person might do this, but it is especially common for individuals with an FASD. Checking for cognition is important with clients that have or may have an FASD.

HEALTH CARE WORKER: Needing extra help in school is an example of a challenge.

MARTA: Right, okay.

HEALTH CARE WORKER: Is it okay to ask a few more questions?

MARTA: Yeah.

HEALTH CARE WORKER: Thanks. This will only take a couple more minutes, I promise. How about you? Do you drink alcohol at all?

Master Clinician Note: Because this is an interview to see if there is reason to believe that Marta has an FASD, the counselor is probing to see if perhaps Marta's baby was also exposed to alcohol before birth.

MARTA: No, I don't like the taste of it.

HEALTH CARE WORKER: Me neither. So, you didn't have any alcohol while you were pregnant?

MARTA: No, my foster mom and dad told me not to drink or smoke while I was pregnant.

HEALTH CARE WORKER: That was very good advice. Tell me, where did you live when you were growing up?

MARTA: First with my aunt, then lots of places. I was in foster care.

Master Clinician Note: It is not unusual for individuals with an FASD to no longer be in the care of their parents, and to have been placed multiple times in foster care.

HEALTH CARE WORKER: Did you like school when you were growing up?

MARTA: *[Looking down.]* Umm... I guess it was okay.

HEALTH CARE WORKER: What classes did you like?

MARTA: I liked art. And I liked Ms. Norton.

HEALTH CARE WORKER: Who was Ms. Norton?

MARTA: Ms. Norton was in the resource room.

Master Clinician Note: Time spent in the "resource room," while not a clear-cut clue, is certainly a strong indicator that the child was identified in school as having special needs. This is often the case with children who have an FASD. The counselor could further explore by asking a follow-up question like "Did you ever have extra help with your school work?" or "Did you ever have special classes or tutoring in school?"

HEALTH CARE WORKER: How many students were in the class with you?

MARTA: Five, including Eddie.

HEALTH CARE WORKER: Who's Eddie?

MARTA: *[Laughing a little to herself as she remembers.]* Eddie is the kid that I used to get in trouble with all the time. He was always coming up with ideas.

HEALTH CARE WORKER: What do you mean when you say Eddie “came up with ideas?” Can you give me an example?

MARTA: Well, like, one time we were walking home from school, and he saw a bike in someone’s yard that he really wanted. So he told me to go get it for him. I did, but the man who lived there caught me and called the cops.

HEALTH CARE WORKER: Did you realize that taking the bike could get you into trouble?

MARTA: I had a feeling. I wasn’t sure, but I wanted Eddie to keep liking me.

Master Clinician Note: Involvement in “trouble” or crime as an unintentional secondary participant is an FASD “red flag,” particularly when the motivation is social (i.e., to make friends).

Master Clinician Note: Marta’s case/vignette is oversimplified. In a matter of minutes, she has exhibited a handful of behavioral clues that suggest that she may have a disability. Not all individuals who may have an FASD will be this easy to ‘spot.’ This conversation is provided simply as a way to learn how such “red flags” might come up in conversation with a client. By identifying these red flags, which are particularly common in individuals with an FASD, the health care worker will be able to manage the case in a way that better suits the needs of the client, and can make a better-informed decision regarding the need for a more complete FASD diagnostic evaluation. Additional probing questions that could be asked include the following:

- How much alcohol did your mom drink when she was pregnant?
- Think about when you were a child. How did you do in school?
- Do you ever have trouble keeping appointments? How do you do with telling time?

Refer to Part 1, Chapter 2 for guidance on referring a client for a formal FASD diagnostic evaluation, and for strategies and treatment modifications that will improve treatment success with an individual who may have an FASD.

6. INTERVIEWING A BIRTH MOTHER ABOUT A SON WHO MAY HAVE AN FASD AND IS HAVING TROUBLE IN SCHOOL (FASD INTERVENTION)

Overview: Counseling professionals in mental health or substance abuse treatment may avoid talking to a female client or family member about their alcohol use during pregnancy, either to avoid communicating any shame or judgment to that individual, or out of a lack of knowledge about FASD. This case illustrates

a scenario where such a discussion may prove fruitful, and the sensitivity required when starting the discussion.

Background: The vignette begins with a community mental health professional talking to Dixie Wagner, 35, about the behavior of Dixie’s 7-year-old biological son, Jarrod. (Jarrod is not present at this session.) Jarrod is in trouble again for hitting another child, and this is causing distress for the mother that the mental health professional wants to address, which leads into a discussion of FASD.

Learning Objectives:

1. Cite methods to help the caregiver clarify the child's issues and discover why the child is having problems.
2. Specify skills needed to follow the caregiver's lead in asking probing questions.
3. Explore the negative perceptions surrounding prenatal alcohol exposure, and examine how lack of knowledge or fear of shaming may interfere with asking the right questions.

Vignette Start


MENTAL HEALTH PROFESSIONAL: Dixie, we talked briefly on the phone about Jarrod's school issues. It sounds to me like you are concerned for him. Today I'd like to hear more about your concerns, and then we can work from there. How does that sound?

DIXIE: Yes, that's fine. You're right, I'm very concerned about him.

MENTAL HEALTH PROFESSIONAL: Is it okay that we talk about the kinds of behaviors that led to Jarrod hitting a fellow student? Was the student a friend of Jarrod's?

DIXIE: That is exactly what's so disturbing about this situation; it was someone I thought was a good friend, a kid named Garrett. Jarrod looks up to Garrett and talks about him all the time. I was excited that he wanted to be friends with Garrett. I was very surprised to get a call from the principal.

MENTAL HEALTH PROFESSIONAL: You're right. Friends are so important for all children this age. Has Jarrod been having problems with his peers?

DIXIE:  [Sighs]. He's always had a hard time getting along with kids his own age. He starts off happy and friendly. He wants everyone to like him. Sometimes I think his enthusiasm might be too much for some kids. Sometimes he says such crazy things. I don't know if he thinks the kids will laugh at what he says or if he is really being serious. Slowly I can see the kids moving away from him. It breaks my heart. He ends up playing by himself. He really wants everyone to like him. He'll talk to anyone! We always say Jarrod has never met a stranger he didn't like. I worry a little that he'll listen to the wrong person when he gets older. Most of the time he's just so sweet and loveable.

MENTAL HEALTH PROFESSIONAL: Okay, so what I'm hearing is that Jarrod has been having problems making and keeping friends his own age, although he really wants to have a friend. Is that right? [Dixie nods.] How about in the school setting? How do you think he is doing in class and with his school work?

DIXIE: Well, he's been labeled a "talker" in class, and we've gotten plenty of notes from the teacher because Jarrod likes to chat with his neighbors and that annoys them sometimes, and the teacher. He has a lot of energy, and sometimes loses focus on his work. He can get frustrated, and may have a hissy fit

at school when he doesn't want to do his work. He likes to do a good job. Sometimes he just won't finish his work. So the teacher will send it home for us to do with him. Every night we sit down and spend a lot of time on homework, but that usually ends up in Jarrod fighting and yelling at us.

MENTAL HEALTH PROFESSIONAL: So, Jarrod generally has a hard time focusing and sitting still. These hissy fits, as you call them, how many of these will he have in a typical school day? Can you tell me a little more about that? Are you noticing any consistent struggles?

DIXIE: I guess he's had several since starting school this year. The hissy fits are like toddler temper tantrums. I can't believe he is still having tantrums. We never really know why he has them, especially at school. I know he leaves every day happy to be going to school, but when he gets home he's tired and cranky, and very angry. He doesn't know where his homework is in his backpack. This leads to raised voices, either me or my husband. The teacher always tells us Jarrod was given the homework, so he must be deliberately misplacing it. If we do find the homework assignment, Jarrod will sit and work really hard for awhile, but then he starts to whine and cry that he is tired and doesn't remember what the teacher told him that day. My husband and I review his spelling words with him every day. He sits and really tries hard to remember them. But he never passes the test on Friday. We spend lots of time with him on his homework. It's like we have to re-teach him everything he learned from the day. Many times it ends in a hissy fit. It's not like we don't help him. We've done this with him since he was in first grade.

MENTAL HEALTH PROFESSIONAL: Jarrod sounds like he is facing some challenges with his school work. Are there other times or activities when he struggles?

DIXIE: Well, when he gets off the bus in the afternoon, he is out of control. He runs around, bumping into furniture and screaming. Sometimes he will knock down the dog. I am sure he doesn't mean to hurt the dog, though, because he really loves it. The teacher says he has trouble standing in line for lunch, and pushes the other students next to him. She also says he has a hard time on the playground for recess. He prefers to stay inside with her. And about 2pm every day, Jarrod gets very sleepy.

MENTAL HEALTH PROFESSIONAL: I see. Is he getting enough sleep?

DIXIE: We start the bedtime routine about 7:30, right after dinner. The kids will take showers, brush their teeth, and then we'll read a book together. We struggle to get Jarrod to brush his teeth. He hates taking a shower, but once the water is in the tub, he loves taking a bath. Everyone gets a chance to pick a book when it's their turn. Jarrod always picks a picture book

about Kermit the frog. But when it is time to go to bed, Jarrod is wide awake, talking or playing his video games. We've had to put him in his own room so my other children can go to sleep. Jarrod is up before my husband, usually before 5am, because he's never needed much sleep.

MENTAL HEALTH PROFESSIONAL: So what I am hearing is that you and your husband have set up a nighttime routine for all the children, but Jarrod has a hard time with the routine. It sounds like Jarrod is only getting a few hours of sleep at night. This may be a reason why Jarrod is having problems in school, since he is tired, but I would like to hear more from you. What else is worrying you?

DIXIE: This isn't school-related, but that boy can't keep his room clean! I run a tight ship, and an unmade bed is not welcome. He can never find anything. I raise my voice, and still no results. My other kids listen to me. I have no idea why Jarrod disobeys me all the time.

MENTAL HEALTH PROFESSIONAL: Can you describe a typical room-cleaning episode?

DIXIE: I'll say "Did you clean your room?" and he says "Yes" and then I'll go and check and nothing is put away. There are clothes on the floor. Dirty and clean clothes will be in his dresser drawers. The bed is unmade. He'll leave wet bath towels on the floor. And there he sits playing a video game. Nothing is done and he still says "Yup, it's clean!" He just doesn't listen. Sometimes I punish him. That doesn't work, either.

MENTAL HEALTH PROFESSIONAL: That can't be easy, and I can see where that could be frustrating for you and your husband. Do you think it's a case of Jarrod not having the organizational skills needed to keep his room clean, or that he doesn't understand what you're asking him to do?

DIXIE: I think he understands, he's just resisting. I know he can do it, but usually not until I stand over him and make him do it, one thing at a time. It's exhausting.

MENTAL HEALTH PROFESSIONAL: Well, That sounds like a lot of kids Jarrod's age. But what I'm getting at is when you break down the specific tasks for Jarrod—one thing at a time, like you say—he does what he's told and does it correctly. Is that right?

DIXIE: Yes, we have found that there isn't a better kid when you work with him one-on-one.

MENTAL HEALTH PROFESSIONAL: You're providing me with a lot of needed detail. Thank you. Knowing his behaviors out of school really does help me understand how we might be able to help him *in* school. I'd also like to follow up on something you mentioned earlier,

about Jarrod's friends. How is he with kids his own age, besides Garrett?

DIXIE:

Besides the kindergarten twins who live next door, Jarrod has no one to play with. We tried to get him into soccer, but he ran after the soccer ball no matter what side had it and the kids made fun of him. We tried cub scouts with my husband helping out as den leader, but Jarrod would be very bouncy and talkative, grabbing the other kids' project, sometimes breaking them. The kids would be polite, but eventually started to shun him. Eventually he would go off by himself and play with a toy.

MENTAL HEALTH PROFESSIONAL:

This must be hard for you and your husband.

DIXIE:

We were told last year that Jarrod was immature for his age, but the teacher said boys tend to mature later than girls. The teacher wanted to wait and see if Jarrod matured over the year before we did any official school testing.

MENTAL HEALTH PROFESSIONAL:

So, let's recap what we have talked about. Jarrod tries to be social and verbal, is trusting, and wants to be a good friend. He also has trouble cleaning his room, staying on task, and doing his school work, but when he does sit down for homework, he can be very diligent in getting his work done. Then there may be some sensory issues, like brushing his teeth or taking a shower, and the bus tends to be a problem. Of course, we cannot forget the fight with Garrett. Out of all these things, I don't see a child with an aggressive nature. What I am concerned about, though, is that Jarrod might be facing some difficulties that will lead him to get into another fight.

DIXIE:



This isn't making sense to me.

MENTAL HEALTH PROFESSIONAL:

Well, I don't have a real clear picture yet. However, one of things that could be at work is that Jarrod could have some cognitive issues that are creating differences in the way he processes information. These deficits can occur for a whole range of reasons. Sometimes children are born with them, and as they grow, their brains are different from most kids.

DIXIE:

You mean like ADHD? We've had people suggest ADHD before.

MENTAL HEALTH PROFESSIONAL:

ADHD may be one issue, but other things could be at work, too. Is it okay that we talk about before Jarrod was born? This is something that I've asked some of my clients before, and it may be helpful here, as well. I'd like to ask about Jarrod's birth, and when you were pregnant with him. It will help us understand Jarrod's environmental background. Were there any complications during your pregnancy with Jarrod?

DIXIE: No, everything was fine. In fact it was a pretty easy pregnancy. I didn't have much morning sickness.

MENTAL HEALTH PROFESSIONAL: Would you say that you planned your pregnancy with Jarrod?

DIXIE: No, not really. He's our third, and we weren't really planning on a third.

MENTAL HEALTH PROFESSIONAL: Now, many pregnancies are unplanned. About half in this country, in fact. Were you pregnant for awhile before you knew?

DIXIE: Yeah, I found out kind of late. *[Starts to become defensive.]* But I had a good doctor, and good prenatal care.

MENTAL HEALTH PROFESSIONAL: What did your doctor tell you about the use of alcohol during your pregnancy?

DIXIE: My husband and I are social drinkers, but we always have been. I don't smoke. I drank during my other pregnancies. My doctor even told me to do it sometimes, because I get really stressed out and it's how I used to relax. I really think you're way off here.

MENTAL HEALTH PROFESSIONAL: Your doctor told you that the occasional drink was okay? That it would relax you?

DIXIE: Yes, he did, and why would he say that if it wasn't true? He's a pediatrician, for god's sake. Where is this going? Are you saying I did something wrong to hurt Jarrod?

MENTAL HEALTH PROFESSIONAL: No I do not think you would do anything to hurt Jarrod. Some doctors still give that advice, even though the evidence now suggests that alcohol can harm a fetus. It won't necessarily harm every fetus, but it can hurt some. I recognize that this is hard to talk about. I only want to explore the possibility. We both have the same goal, to help Jarrod. He has exhibited a pattern of behavior that makes an FASD something worth examining, even if it's just to rule it out. Do you know about FASD?

DIXIE: *[Sits forward in her chair, holding up her hands in a defensive manner.]* So, wait. What you're saying is that I drank alcohol and hurt Jarrod while I was pregnant. Is that it?

MENTAL HEALTH PROFESSIONAL: Only experts can determine whether a person has an FASD. Changes in the brain due to alcohol can only be identified by certain professionals, but what I do suggest is that we start to look at why Jarrod might be experiencing some of the problems that you and his teacher have identified. I am seeing a pattern of behavior that may suggest an FASD. We all want the best for Jarrod, and knowing what is happening in his head may help all of us meet his needs.

DIXIE: *[Leans back, crossing her arms, more relaxed but still wary.]*
What is this stuff, FASD?

MENTAL HEALTH PROFESSIONAL: It stands for Fetal Alcohol Spectrum Disorders. See, alcohol is an environmental factor that can affect a developing fetus. I mentioned alcohol because some women are unaware of the effects that alcohol can have on an unborn baby. Scientists refer to the effects of alcohol on the fetus as FASD.

DIXIE: I've never heard of it. Are you saying you think Jarrod has that? *[Sits forward in her chair; tears well up in her eyes.]*
What you're saying is that I drank alcohol and changed Jarrod's brain while I was pregnant. Is that it? This is my fault?

MENTAL HEALTH PROFESSIONAL: I'm not leaping to that conclusion. If Jarrod does have an FASD, there is no blame here. I just think it's worthwhile to discuss the possibility, because it may help your son, which is what we both want.

DIXIE: *[Sits back in her chair and slumps a little.]* Yeah, I wanna help him. I want nothing more. My husband and I have done everything we can. *[She sniffles some more and shakes her head, considering; the counselor offers a box of tissues.]*
This has been so hard. It's been going on so long. We've seen so many doctors, and heard so many diagnoses, and no one's ever right. Nothing works. But no one's said anything like this before. And when you sit there and tell me that this might all be because I had some drinks while I was pregnant... *[She sniffles some more.]*

Master Clinician Note: It's important at this point for the mental health professional to respond to the fact that the client is feeling blamed and becoming agitated.

MENTAL HEALTH PROFESSIONAL: Then I have to apologize to you. If that's what you're feeling, then I'm to blame, not you. I haven't done my job properly. It's incredibly important to me that you understand that my only goal is to work with you to identify a potential root cause for the problems that Jarrod having, because it's clear that his situation is causing you distress. That's all I want to do. There are many cases of FASD. Jarrod would not be the first or the only one. No mother on earth does anything to intentionally hurt her baby. I know you certainly didn't. I have a child of my own. I know the feeling of being a mother, and it's very, very clear to me how much you love your son.

DIXIE: I just... I don't even know what to say. I feel like you're pointing a finger at me. *[She is angry, beginning to cry.]*
You're in *mental* health. No offense, but what do you know about *medicine*? Or about my son? About how much I love him? Or about what we've been through? I can't even understand that you're sitting there saying I did this to him.

I mean, I hear your “no blame” crap, but I’m feelin’ real blamed right about now!

MENTAL HEALTH PROFESSIONAL: Well, like I said, I do apologize if that is how you feel. Maybe we just need to rule out FASD. If it happened, you were going on the advice of your doctor. Would it be alright if we focused on what you want to do next for Jarrod?

DIXIE: *[Waving her hand to stop the counselor.]* What’s it called again?

MENTAL HEALTH PROFESSIONAL: Fetal Alcohol Spectrum Disorders. FASD. I can give you a pamphlet that talks about the basics of it.

Master Clinician Note: It is advisable to provide FASD information that does not include pictures, particularly of children with prominent facial dysmorphism (e.g., thin upper lip, smooth philtrum). These facial characteristics are present in only a small percentage of children who have an FASD, and if the client’s child does not resemble the children in the pictures, this may enable the client’s desire to believe that their child can’t possibly have an FASD.

DIXIE: *[Taking the pamphlet.]* So I should read this?

MENTAL HEALTH PROFESSIONAL: Yes, it would be good if you and your husband both read it and discussed whether you think it describes Jarrod’s situation.

DIXIE: I still say you’re wrong. But, what if it does? What happens then?

MENTAL HEALTH PROFESSIONAL: To start, I think you could begin the process for the school to start testing Jarrod for a learning disability. There are several tests that could help them understand the best way to teach Jarrod so that he doesn’t get so frustrated. There are a few pieces of the testing that you will have to complete, like his developmental history, when he walked and talked, things like that. I think you should also look at doing another test for ADHD. In the meantime, we can set up another appointment to talk about FASD, possibly with your husband, as well. And if the two of you are okay with it, I can help you access a more complete evaluation.

DIXIE: Where does that happen?

MENTAL HEALTH PROFESSIONAL: It may be best to complete the assessment with a developmental pediatrician at the local hospital. I am sure that doctor will want to see the test results from school. If you like, there is a support group for families called the Circle of Hope. I could give you the phone number or e-mail address for them if you need someone else to talk to who has been through this. How would that be?

Master Clinician Note: Although the mental health professional makes repeated attempts to assure Dixie that she does not need to feel blame about the possibility that Jarrod has an FASD, Dixie has still become upset. This is a very natural response, and counselors should be prepared for birth mothers to feel as though they are being 'blamed' for their child's condition when FASD is discussed. However, many pregnancies are unplanned, some doctors do still recommend a glass of wine as a way for a pregnant woman to relax, and many women do not realize until well into their first trimester that they are pregnant. The mental health professional utilizes these realities as a way to reassure Dixie and disconnect her from a sense of guilt and consistently reiterates their shared goal, to find the best way to help Jarrod. She also effectively coordinates care by putting Dixie in touch with additional testing and offering a support group number.

7. REVIEWING AN FASD DIAGNOSTIC REPORT WITH THE FAMILY (FASD INTERVENTION)

Overview: The purpose of this vignette is to provide counselors with guidance on how to review a diagnostic report (or Medical Summary Report) with family members of a child who has been just diagnosed with FAS.

Background: The client, Jenine, is the caregiver of her grandson, Brice. Jenine is meeting with a counselor from the Indian Health Service to review Brice's Medical Summary Report for the first time. In a prior session, Jenine confided that she felt overwhelmed.

Knowing how detailed a Medical Summary Report can be, the counselor suggested that Jenine bring trusted family members and elders to this session. Together they arranged for Jenine's sister, aunt, and an elder to attend.

Learning Objectives:

1. To recognize that clients will need support after an FASD-related diagnosis.
2. To identify how to help the client prioritize the child's and the caregiver's needs.
3. To recognize that the client will need to be educated to understand that the child's behavior problems are due to damage to brain caused by prenatal alcohol exposure.

Vignette Start

COUNSELOR: Welcome, everyone. It is so good for Brice that you could be here. I am very happy to try to answer all of your questions today. We'll go through the basics, so that we can work on what is best for Brice. Does that sound good?

JENINE: Yes.

AUNT: Yes.

ELDER: Yes.

Master Clinician Note: The counselor is listening to everyone in order to validate the feelings and concerns of all individuals attending the session.

COUNSELOR: As I mentioned when you arrived, I am so glad that each of you are here today to support Jenine through this diagnostic process. Together, we can come up with a plan and move forward from there. The plan will build on Brice's strengths, as well as the diagnosis. We'll get started today, but it will take more meetings and community support to understand this diagnosis. A lot of detailed information can be overwhelming, but again, together, we will work through this process.

JENINE: Okay.

COUNSELOR: Before we review the report, let's talk about FAS. What kinds of things have you learned about FAS?

JENINE: I have been reading a lot on the internet.

Master Clinician Note: It is advisable for the counselor to caution the client and all attending the session that the quality and reliability of online information about all forms of FASD varies. She should provide the client with a reading list of up-to-date sources, but advise them to put it down when they need a break to avoid feeling overwhelmed.

COUNSELOR: Okay, I like the internet as a source of information because there can be some helpful sites. At the same time, not all internet information is up-to-date. Here is a list of three Web sites that I recommend. They are updated all the time. They're really the best place to start. The first site publishes some basic facts and I'd like to review that with you all for a few minutes.

Master Clinician Note: The counselor can now review the report with Jenine and her support persons. The counselor can use the review to assess the knowledge level of the client and her sister and elder, in order to determine how much education and support will be needed throughout the process. It is also advisable to inquire about other family members (grandparents, brothers, sisters, aunts and uncles, extended family) to assess how they will feel about the child's disability and to gain insight into cultural differences.

A sample Medical Summary Report can be viewed at the Web site of the Washington State FAS Diagnostic & Prevention Network (FAS DPN): <http://depts.washington.edu/fasdpn/pdfs/4-digit-medsum-web-2006.pdf>.

After completing the review, the counselor should focus on Brice's priority problem area, as well as the most significant need(s) of the caregiver.

COUNSELOR: Okay, now that we've worked our way through the report, we need to focus on the number one area where Brice is having problems. Is that in school or at home?

JENINE: Both, but I can handle home. School is getting out of control. I hope that this diagnosis gets him the help he needs.

COUNSELOR: Well, I know that a diagnosis is not always the pathway to services that we expect. But what I did see in the report was a clear description of Brice's speech and language difficulties, so I think that we can get him the speech therapy services that will help in school.

JENINE: That would be wonderful. Brice stutters, and really has a hard time coming up with the right word on the spot.

COUNSELOR: Okay, then let's make the top priority for Brice to get services and therapy for speech. Does that sound like the best place to start?

JENINE: Yes, let's do that.

AUNT: I will help.

ELDER: We will help, too.

COUNSELOR: Now let's discuss a top priority for you, Jenine. I want to check in with your stress level. If you are stressed, then it will be hard to be truly supportive for Brice. And it is my experience that parents and caregivers of children who have special needs do deal with burn-out.

JENINE: Yeah, that sounds like me.

COUNSELOR: Then since that's the case, let's use a couple of sessions to make a plan. If we have any medical questions, I can consult with a pediatrician to try to get those answered for you. Next, we'll get the speech therapy going for Brice.

JENINE: Okay. How am I going to pay for all of this? All of these services?

COUNSELOR: I know some of that is being paid through your insurance company. I'm more or less the case manager for Brice, so anything not covered, we'll work together to address how those things will get paid for.

JENINE: Okay. Now, what's going to happen in school now, with this diagnosis?

Master Clinician Note: Even though answers to these questions cannot all be provided immediately, the counselor assures the client that they will work together to establish plans to address them.

COUNSELOR: I think that it will be a process, and that will be the focus of our time next week. We'll want to think about how you can best approach the school to get Brice's special needs met. We'll also discuss how to talk to your family and friends as well as his teachers about FAS.

JENINE: Okay.

COUNSELOR: One thing we can definitely do today is make a list of Brice's strengths. It's very important that our plan for helping him focuses not just on his diagnosis but also on his positive abilities. Can you all help me with that?

JENINE: Sure. He has a lot of wonderful qualities, he really does.

COUNSELOR: I know he does. We're going to build on those. So, let's recap. Our first priority is to get the process started on Brice's speech therapy. We also need a plan to help you, Jenine, when you're feeling burned out. We want to talk about payment for services. And we want to address what this diagnosis means in terms of special needs at school. Does that sound right?

JENINE: Yes.

AUNT: Yes.

ELDER: Yes, it does.

COUNSELOR: Good. I'm writing all this down, and I'll give everyone a copy. And we'll set up a time for our next meeting. Let's pick a time that works for everyone.

Master Clinician Note: A diagnosis of any form of FASD can be overwhelming for a family. Although this vignette lacks specifics, the overarching theme of importance is that the counselor is positive, is willing to work with the family to make a plan to address any areas of concern, and is available to help them through the process. For families and caregivers of an individual with an FASD, having this navigational assistance can be tremendously helpful and relieve much of the stress that can go along with caring for such an individual. In addition to addressing the areas identified by the family as priorities, it will be important in future sessions for the counselor to:

- Consistently point out the child's positive attributes;
- Recommend a specific support group for the family, if available;
- Emphasize the need for respite care; and
- Ask the client about ways to involve the child in an area of interest, like music or sports or art. This can provide a 'break' for both the child and the caregiver.

8. MAKING MODIFICATIONS TO TREATMENT FOR AN INDIVIDUAL WITH AN FASD (FASD INTERVENTION)

Overview: The purpose of this vignette is to demonstrate how to modify treatment plans for a client with an FASD.

Background: The client, Yvonne, is an adolescent female with a history of truancy and fighting. She has been mandated to counseling for anger management, and has missed her last two appointments. When the counselor phoned her about the missed appointment, Yvonne's mother suggested that Yvonne may not be taking her medication, and hinted that Yvonne may be depressed.

Learning Objectives:

1. To adjust expectations regarding age-appropriate behavior, since individuals with an FASD may be adult-aged by calendar years, but are much younger developmentally and cognitively.
2. To demonstrate the value of collateral information and how to ask an individual for consent.
3. To demonstrate the importance of seeking involvement from parents and caregivers.
4. To identify how concrete thinking plays a role in comprehension for clients with an FASD.
5. To cite the value of time spent developing rapport and establishing trust.

Vignette Start

COUNSELOR: Hi, Yvonne. We've missed a couple sessions, so I haven't talked to you in awhile. How has everything been going? [*Yvonne does not respond.*] Are you taking your medicine?

YVONNE: Yep.

COUNSELOR: I understand that you are not coming home at night. I'm concerned that on those nights you're not able to take your medicine.

YVONNE: I take my medicine! Can I go?

COUNSELOR: Well, we have more time today, so let's keep talking. You know, I need a break. Do you?

YVONNE: Yes, I want to leave.

COUNSELOR: Well, I don't want you to leave yet, but we can go for a walk. Would you like to walk around the courtyard, or go to the cafeteria?

YVONNE: Outside. I want to walk in the courtyard.

COUNSELOR: Yeah, let's do that. It'll get us out of this stuffy office.

They exit to the courtyard.

Master Clinician Note: Yvonne is clearly confrontational. The counselor is navigating around the resistance by not repeating questions and insisting on answers, and changing the physical environment to one that Yvonne chooses. The counselor then begins a rapport-building process by holding off on treatment talk in favor of getting to know Yvonne personally.

COUNSELOR: So, tell me a little bit about things that you like to do. We've only seen each other one time, and that was a few weeks ago. I'd like to know more about the kinds of hobbies and things you like to do.

YVONNE: I love being outside. I love being with animals. My pets are the best.

COUNSELOR: Mine, too. I have three dogs, all Dalmatians. What kinds of pets do you have?

YVONNE: We have a dog named Scooter, he's a chocolate lab, and we have a cat, Cory. I don't know what kind of cat he is. My brother also has a little lizard, but I think it's pretty gross.

This continues for several minutes. At an appropriate time, the counselor begins to shift the conversation back to treatment issues.

COUNSELOR: Let's talk a little about your treatment plan, what is working and not working for you.

YVONNE: Okay.

COUNSELOR: Sometimes clients do not like to take medication, or they don't remember to take their pills. Do you ever forget to take your medication?

YVONNE: Sometimes.

COUNSELOR: Okay. Well, that's not surprising. Taking medication is hard to remember for a lot of people. Sometimes there are bad side effects, or sometimes it's just a bother.

YVONNE: Yeah, it's annoying.

COUNSELOR: What annoys you about your medication?

YVONNE: I don't know.

Master Clinician Note: The counselor should not leave it at "I don't know," but probe further. With a client who has an FASD, the probes should be very specific.

COUNSELOR: Does the medication make you feel bad?

YVONNE: No, not really.

COUNSELOR: Is it hard to remember to take it?

YVONNE: Yeah. I have a lot of stuff to do, ya know.

COUNSELOR: Yeah, I know what you mean. Ya know, I take a vitamin each day with my lunch. That way, whenever I eat lunch, I know to take the vitamin. They go together. Since I go home for lunch, I keep my vitamins at home on the counter, next to the 'frig. I also put a reminder in my phone so that at noon, my phone says "Take vitamin." I think we could work out a system like that for you, something easy that reminds you to take your medication that won't be annoying.

YVONNE: Okay.

COUNSELOR: Let's start by writing this down.

The counselor works with Yvonne to develop a few simple, concrete steps to help her remember to take her medication. Once back in the office, the steps are written down and then reviewed with Yvonne to make sure she comprehends them.

COUNSELOR: Does that look okay?

YVONNE: Yeah.

COUNSELOR: When did we say you should start using that plan?

YVONNE: Right away.

COUNSELOR: That's right.

Master Clinician Note: The counselor does not merely ask "Does that look okay?" but also asks a follow-up question to make sure Yvonne understands. Since this is a client that has been noncompliant with medication, the counselor also schedules another session at an early date to reinforce the new plan, rather than waiting a week or longer.

COUNSELOR: Okay, let's try this treatment plan for the next few days. I'd like to see you in three days so that we can see how it worked.

YVONNE: Okay.

COUNSELOR: I'll write all this down for you. Also, I'd like to ask that your mom help you with taking the medication. Would it be okay if I talked to your mom after today's session? The three of us could spend a few minutes discussing how she can help you remember to take your medication.

YVONNE: Yeah, that'd be okay.

COUNSELOR: I know she's picking you up today, so let's also ask if she can drop you off for your next appointment.

YVONNE: Okay.

COUNSELOR: *[Reinforcement of rapport-building].* Will you bring me a picture of Scooter and Cory? I'd like to see what they look like.

YVONNE: Sure. I'd like to see your Dalmatians.

COUNSELOR: I'll bring a picture, too. Let's program a reminder into our phones for our next appointment, with a special note to bring pictures.

Master Clinician Note: The counselor has employed a number of steps to build rapport, avoid confrontation, and simplify processes for a client that has an FASD:

- Although clinicians are trained to ask open-ended questions, this counselor made the questions quite specific. For example, when the question "How has everything been going?" got no response (it's a fairly abstract question to someone with an FASD), the counselor avoided confrontation and switched to something specific: "Have you been taking your medication?"
- The counselor never used the word "why." A person with an FASD will most likely struggle with understanding or communicating their motivations.
- The counselor limited choices to avoid overload; for example, instead of "What would you like to do?" the counselor offered a specific choice: "Would you like to walk around the courtyard, or go to the cafeteria?" This simplified the choice for Yvonne, and also changed the environment to one she likes, allowing her to share a little more easily.
- The counselor broke down the medication plan into small chunks, wrote them down, and reviewed the steps one at a time with Yvonne. If Yvonne had not seemed to be grasping the plan, the counselor could have considered reviewing it several more times, or even role-playing to solidify each step.
- The counselor scheduled a quick-turnaround follow-up visit so as not to lose valuable time if the plan isn't working, and is bringing the mother into the process as reinforcement.
- Lastly, the counselor built rapport and found a common ground around something that Yvonne really enjoys, her pets.

9. WORKING WITH AN ADOPTIVE PARENT TO CREATE A SAFETY PLAN FOR AN ADULT MALE WITH AN FASD WHO IS SEEKING LIVING INDEPENDENCE (FASD INTERVENTION)

Overview: The purpose of this vignette is to demonstrate how counselors can help develop a safety plan for clients with an FASD. This vignette focuses on creating a safety plan with a caregiver, as many individuals with FASD have someone in their life who provides advocacy and support. If there is no such person in the life of the client with FASD, an important treatment goal will be to identify persons who can fill that role.

Background: In this vignette, Mike's son, Desmond, is 21 years old, and has been

diagnosed with an FASD. Mike adopted Desmond when he was five years old. Since Desmond turned 16, and Mike's wife left him (partly due to the difficulties of parenting Desmond), Mike has been Desmond's sole caregiver. Lately, Mike has become increasingly distressed about his son and life in general, and has sought counseling from a mental health provider.

We are picking up this session after Mike has mentioned that Desmond is excitedly preparing to live on his own, with the move-in date just a month away. Mike is sure his son can't handle all the responsibilities of independent living. He has tried to talk to Desmond about this, his son doesn't seem to listen or agree. Mike is realizing that there is a lot he has not talked about with his son.

The counselor took time to gather a good deal of background information. Mike is here on his own in this visit, but the counselor has met Desmond. Desmond has intellectual abilities in what is called the borderline range (just below average). Like many individuals with an FASD, he acts like someone who is younger. In the first session, when the counselor asked Mike to estimate Desmond's "acts-like" (i.e., functional) age, Mike said that Desmond still acts like someone who might be in 10th grade. As the counselor has gotten to know Desmond, this estimate seems accurate. The counselor has also carefully reviewed Desmond's Medical Summary Report (from age 11) and his latest school testing (age 20, when he graduated from high school). She now better understands his unique learning profile.

Master Clinician Note: Clinical wisdom in the field of FASD, and now some scientifically validated treatments, hold that knowing the unique cognitive/learning and behavioral profile of the affected individual is crucial to understanding the reasons for their actions. This helps to reframe caregiver understanding in light of the individual's brain-based disability.

Mike also told the counselor that Desmond was diagnosed with ADHD at age 8, which

helped with an accommodations plan at school and a medication regimen. When Mike tried to transfer responsibility for taking the medication to Desmond 3 years ago, he couldn't remember to take it on his own. When Mike and Desmond's doctor realized Desmond showed no decline in function off the medications, they decided to stop the regimen. Without a clear benefit, and because Desmond could be pressured to give away his stimulants to peers, stopping the medication seemed wise.

Learning Objectives:

1. To show how to identify and validate caregiver concerns, and how to integrate common issues for individuals with FASD in safety planning.
2. To show that safety for a client with an FASD requires a plan that decreases risk, increases protective factors, and focuses on comprehensive life skills planning.
3. To illustrate how to assist caregivers as they proactively develop strategies to ensure their child's safety.
4. To demonstrate that individuals with FASD need a plan that is practical, useful, developmentally appropriate, uses concrete language and visual aids, uses role-play, and takes into account their unique cognitive/learning and behavioral profile.

Vignette Start

[The dialogue starts with the counselor meeting with Mike in an individual counseling session. The counselor requested that Mike come in on his own for this session, but expects to meet with Mike and Desmond together in at least some future visits.]

COUNSELOR: What are your greatest concerns about Desmond living on his own?

MIKE: Well, I've always been there for him, and I'm really concerned that he could get into trouble out there in the real world. He has a lot of good points, and I know Desmond's tough. We got through it when his mom left a few years back. I know he turned 21 and he's *feeling* independent, but I know that he can't be totally independent. There's too much stuff I help him with, all the time. But I do need some time of my own. Some days...well...there are those days that

I'm zapped—done. The truth is: I'm at my wit's end. I work my butt off. Besides that, I don't take vacations from being a parent. I've sacrificed. Don't get me wrong, I love him, but there are days.... Well, you know. I'm sorry, my head's somewhere else today.

COUNSELOR: I know how much stress parents of a young person with an FASD can be under, and how much strength it takes to parent a child with a disability, especially alone. Take all the time you need to explain what's on your mind. Sounds like there are many sides to this situation.

Master Clinician Note: Mike's thoughts are somewhat discursive due to stress, and perhaps due to grief about the challenges of his son's upcoming life transition. Creating safety protection for Desmond is an important way to help Mike, but the counselor should remain aware that Mike also has his own needs. Research shows that caregivers have many unmet family needs, often focusing on dealing with the emotional aspects of caregiving. The counselor is allowing Mike to express all sides of the situation. This includes negative feelings, but the counselor is also listening for signs of positive "expressed emotion," deemed to be a protective factor. The counselor is also thinking about how to promote caregiver self-care.

[Mike expresses his concerns for several more minutes. The counselor listens and normalizes, validates and reflects Mike's emotions and thoughts, and also makes clarifying summary comments. Providing Mike with time to express his emotions and thoughts and to have his perspective heard allows the counselor to move ahead with more skills-based techniques. These include problem-solving, identifying social supports, identifying and clarifying treatment goals, and cognitive restructuring.]

COUNSELOR: Okay, thank you. I think I have a sense of your concerns, both for Desmond and for your own situation.

MIKE: Yeah. I mean, this is one tough gig.

COUNSELOR: It is, and feeling "burned out" is natural. At the same time, if Desmond is going to be on his own to some degree, as he moves into his life as a young adult, that means a huge transition for both of you.

MIKE: That's an understatement.

COUNSELOR: The good news is that I can provide you with some strategies to help you cope, in the short-term and the long-term. The key here is that the definition of independence and safety is different for a person with an FASD or other developmental disabilities. I think it's important that we start by identifying one or more advocates or "champions" for Desmond. These can be professionals or family members; people who are willing to help him—and help you—manage various parts of his life. So, who can act as an advocate for Desmond? Who are his supports?

MIKE: I can be an advocate, first and foremost. And so can my aunt. Desmond gets along with her really well and sometimes she has him help at her law office doing filing, that kind of stuff. Also, she is one of the few people he'll talk to when he gets upset or angry, and she's good at calming him down. He also helps out with the middle school football team, so Coach Gray looks out for him, but they don't see each other much in the off-season. But...I think he would still be willing to help Des out. Yeah, I think they can help when I can't. And maybe Des can reconnect with his mom.

COUNSELOR: It sounds like Desmond has a number of advocates and supports, but that he may need help with both identifying *when* he needs help and, then, *how* to best communicate to get that help. I am so impressed and pleased that Desmond is involved with your aunt and Coach Gray. That gives Desmond's days and weeks more structure and meaning and more opportunities to connect socially. Everyone likes to feel useful! I bet there are more folks who can act as support persons or advocates. We'll try to figure out all those folks in our next session, and what each support person can do. To help move us along, here is the first page of a worksheet to do at home, to make a list of people you think of, their contact info, and what kinds of things they can help with.

[Shows Mike the first part of the Crisis/Safety Plan Worksheet.]

Think about family friends, any providers that work with Desmond, people who know him in his circles, like other people that help with the football team or friends from the community, kids from his high school youth group, church, anything like that. If possible, it is especially important to find someone in their 20's—more Desmond's age, who has good problem-solving skills, to be a kind of "mentor." Can you bring that back next time?

MIKE: *[Nods, takes the first part of the Crisis/Safety Plan Worksheet.]* I'll try to get it done. I don't know about that mentor idea; can't think of anyone right away. But it does help to write things down. If I don't have time for the worksheet... well, you know.

COUNSELOR: Sounds good. This may be a chance to ask your aunt and Coach Gray for ideas, too, as there may be someone that Desmond already knows that could be a good mentor. In terms of the worksheet, I will leave that to you.

Master Clinician Note: Clinical wisdom, and now some new interventions for caregivers of adolescents and young adults with FASD, such as the *Partners for Success Program* (information available through the CDC-funded FASD Regional Training Centers), hold that mentors can be very useful in intervention. Mentors can be community college students, aides who work in developmental disabilities services, younger relatives or family friends, or students studying to work in social services. A mentor is someone who can act as a very competent peer or a caregiver closer in age to the affected individual. They can build an ongoing and positive relationship, be available for check-ins to provide input and guidance on solving problems with peer relationships and lifestyle problems, and work toward helping the affected individual become more self-aware. They may also be able to connect the individual to pro-social and competent peers, and help find appropriate, positive recreational activities for leisure time.

COUNSELOR: Okay, let me ask you: Have you worked much with developmental disability services to help Desmond with life skills, how to live as independently?

MIKE: No, hardly at all. Desmond doesn't qualify for those kinds of services because of his FASD, and his ADHD diagnosis doesn't help, either. He doesn't have really low scores on his IQ test. And, you know, even though he struggles sometimes, he really tries to be friendly and sociable, and he talks a good game. Sometimes I think his good points actually keep him from getting all the help he needs.

COUNSELOR: It must be hard that others don't always see that he struggles with a lot of things. At that same time, it's good to know that he has so many strengths. Alright then, I think you and I will need to work together to identify the most

important things to think about as Desmond becomes as independent as he can safely be.

MIKE: I think my biggest concern is that others will take advantage of Des. Especially if he has a place of his own and people want to stay with him. He tends to do things like steal to be someone's friend, or fall in with wrong crowds, then it's always him that gets caught. I'm not going to be there to prevent that if he's on his own. I mean, Des is willing to accept help, and that's good, but he may not always realize he needs to ask, especially when he gets worked up.

COUNSELOR: I hear you. That sounds like a really big worry for you, so let's talk about some way to provide safety and structure for Des as he moves into having this new freedom. This will be a safety plan, basically. We'll have to find what works and doesn't work for him, and this will be an ongoing process. We can come up with an initial plan, then when he gets into his own place, we can meet together with Des a few times to modify the plan. We'll kind of be testing it out. Adjusting a plan is always a good idea.

MIKE: I've done a lot on my own, talking with Des about what is an appropriate situation and what's not. Appropriate money use. Appropriate touching. This has been all from me. No doctor or therapist helped me out. I should write a book on it. At least I got through to him about drinking, because he just tells people he's allergic, and so far, so good. But now...well, that's another worry.

Master Clinician Note: For parents of individuals with developmental disabilities, it is very helpful to be proactive. At the same time, "looking forward" is an emotional process. The clinician will have to judge how far ahead the caregiver really wants (and needs) to plan. The clinician also needs to use reflective listening and summary statements to help the caregiver process their own emotional reactions as they do future planning. Beyond this, the clinician can help caregivers plan ahead in a practical way. Because Desmond is a young adult (though functionally an adolescent), and is starting to build an independent life, the clinician can coach Mike on how to help Desmond self-advocate and self-monitor.

One important direction is to coach Mike in creating concrete, behavioral "benchmarks" for his son, so Desmond can show daily or weekly progress and also show his father that he is ready for this life transition. This could include practicing things such as buying groceries as if he were already living on his own, and/or troubleshooting, such as thinking out loud about what to do in real-life situations—e.g., if he gets sick, the toilet starts overflowing, etc. If Desmond resists doing this (which would not be unlikely given his functional age), the counselor can work with father and son to integrate rewards for Desmond after he shows certain behaviors or masters specified tasks. An age-appropriate reward for someone functioning at an adolescent level could be more 'space,' i.e., increased time between check-ins from his father after Desmond demonstrates mastery.

Mike has educated his son carefully about drinking, which is good, but he should think about other areas he needs to talk about with Desmond, as well, including 1) safe sex; 2) communicating clearly with partners about consensual activity; 3) use of cigarettes; 4) use of illicit substances, such as marijuana and other drugs; 5) the consequences of criminal activity; and 6) ideas on what to safely do when Desmond has times of feeling irritable and negative (calming strategies).

COUNSELOR: I'm glad you already laid the groundwork! For now, let's write down some of the ideas you already figured out. We'll make cards. Two kinds, actually. First,

when Des comes in we can make an identity card that says “I have an FASD” for Desmond to give to caregivers, police, co-workers, etc. Then we can make Safety Cards that he can use as reminders in his new routine. The Safety Cards can be one thing to talk to Desmond about when he comes with you to see me. We will also plan to talk about specific behavior benchmarks or things you want to see him doing before he moves out. We can talk to Des about how having him do this will let you be more comfortable giving him space and independence. *[The counselor and Mike work together to identify areas of safety concern for Desmond.]*

Master Clinician Note: Choice and level of language used on Safety Cards will differ depending on the intellectual level of the individual with an FASD. Areas of safety concern may include:

- Household reminders (buying groceries, paying bills, cleaning the apartment, taking out the trash, maintaining personal cleanliness, etc.)
- Useful phone numbers (advocates, police, hospital, primary providers, etc.)
- Transportation (routes, times, and costs)
- Work and school schedules
- Personal and household safety reminders (turning off appliances, locking doors and windows, etc.)
- High-risk behavior warnings (e.g., unsafe sex, alcohol or drug use, getting really irritable and upset)

There are programs for caregivers raising affected youth that have other useful ideas for ways to plan ahead (e.g., the *Families Moving Forward Program* and *Partners for Success Program*).

COUNSELOR: What else could help you with keeping Desmond safe?

MIKE: Well, I think, as long as he applies these things we’re writing down for him and I check in on him regularly, things may go okay. For awhile, anyway. Then I just need to get organized with my aunt and Coach, so they’re helping to keep an eye on him. Like I said, he’s pretty good about accepting help and listening to us when we give him advice. That’s one of the most important things I taught him—*accepting* help. But he really has trouble *asking* for help, or watching for signals that he’s getting into trouble.

Master Clinician Note: Research on FASD and, more generally, on developmental disabilities has uncovered important protective factors. Many of these are well-known, such as positive family and peer relationships, appropriate social services and freedom from substance abuse by the individual, peers, or family members. Other protective factors may be less obvious but are no less important. For the caregiver, these include decreased stress and depression, a sense of parenting efficacy, positive expressed emotion and a viewpoint on the affected individual, and adequate caregiver support and self-care. For the affected individual, these include a willingness to ask for (and value) help from others, positive, time-filling extracurricular activities, adequate and refreshing sleep, connections to pro-social and competent peers, a positive self-perception, a sense of meaningfulness through activities such as a job, talents that others recognize and value, spirituality, and more.

COUNSELOR: Will Des be working?

MIKE: He’s going to continue as an assistant with the football team as a volunteer. And he can keep helping my aunt. When he gets done with his training, we think he’ll be able to do inventory and stocking at the grocery store.

- COUNSELOR: Okay. Let's start figuring out how all this is going to work. So, I think it may make sense for you to manage Des's budget, at first anyway, by doing his shopping and grocery list-making until new routines are established.
- MIKE: Yeah, I expected that. I'm gonna be checking in on him every day for as long as I need to, then less often if I'm sure he's doing okay. I made sure the apartment isn't far away, even though we have to pay a bit more. He isn't showing a real interest or understanding of all the little things required to live on your own; budgeting, or don't buy all your groceries at the gas station just because that's where you get gas, stuff like that. He can use my car if he asks permission, and tells me where he's going and when he'll be back. Mostly, he's going to be taking the bus. I can't imagine him knowing how to take care of his own car, even though he's a pretty good driver.
- COUNSELOR: Clearly, you've already thought a lot of things through! Okay, so, why don't you bring Des next time? That will give me a chance to see if I think he needs the support of his own mental health counselor. With his ADHD, and times he gets irritated, that might be a good idea down the road. He has lots of supports, but we should think about this angle, too.
- MIKE: That sounds like a plan. I appreciate your help, Doc. I feel like the load is a little lighter.
- COUNSELOR: I'm glad. Remember—if you bring that worksheet back next time we can move forward more quickly with our plan.

Master Clinician Note: This session shows what it is like to work with the caregiver of someone with FASD. A possible future session could include Desmond's aunt and the coach, to create advocacy or "look-out" tasks they could all divide up to help Desmond stay organized while Desmond first starts living on his own. In sessions that include Desmond, the clinician will need to change pace and style. Specific ideas that would help Desmond, and can be used with most other affected individuals:

- Work with the affected individual to identify his or her goals, including how to generate an effective goal, "mini-steps" to achieve the goal, and needed supports.
- Discuss warning signs that they need help.
- Discuss and practice through role-play how to ask for help.
- Create a written Crisis/Safety Plan.

This vignette would play out differently depending on the culture and ethnicity of the caregiver and youth. Research shows there are different expectations for independence and type of family relationships in different cultures. This interacts with the impact of developmental disabilities. In some cultures, for instance, adult children are not expected to move out of the family home, though they will still increasingly assume more leadership and adult responsibilities within the family. In cultures where the extended family tends to be closer, affected individuals may have more resources and support from relatives, or a greater likelihood of available peer models to serve as caregivers or mentors. Research also shows that some protective factors may differ by culture: Attachment to and identification with the values of one's culture of origin is a protective factor for immigrant youth. Yet this can also be a risk: Data suggest that these youths may also be at higher risk for marginalization and discrimination. Recommending involvement in culturally relevant and pro-social leisure time activities can be a productive way for an individual with an FASD to learn about their own culture.

10. WORKING WITH A BIRTH MOTHER TO DEVELOP STRATEGIES FOR COMMUNICATING WITH A SCHOOL ABOUT AN INDIVIDUALIZED EDUCATION PLAN FOR HER DAUGHTER WHO HAS AN FASD (FASD INTERVENTION)

Overview: This vignette illustrates how a social worker can make useful suggestions for a parent or caregiver's first meeting with educators at the beginning of a new school year.

Background: The start of the school year is 2 weeks away. Denise is a birth mother who is meeting with a social worker to get some advice on how to educate the school staff

about working with her daughter, Elise, who is 11. Elise has recently been identified as having an FASD, although she has been tested as having a "normal" IQ and is in a mainstream learning setting. This social worker was part of the diagnostic team that assessed Elise for FASD, but this is her first time helping with Elise's school issues. Denise is hoping to develop learning strategies that she can discuss with the school staff in an Individualized Education Plan (IEP) meeting.

Learning Objectives:

1. To describe typical challenges that children with an FASD may face in the classroom.
2. To demonstrate how collaboration and creativity can lead to accommodations that result in improved outcomes for a child with an FASD.

Vignette Start

- DENISE: Now that we're gearing up for a new school year, with a new teacher who is also new to the school, I need some tips on talking to her. I want to avoid last year's fiasco with the parent aide who complained that Elise was disrespectful and "the worst."
- SOCIAL WORKER: This will be 6th grade for Elise this year, correct?
- DENISE: Correct.
- SOCIAL WORKER: And what happened last year?
- DENISE: The parent aide was a nightmare from the get-go. I had heard it all before: "Your kid won't listen" or "Your kid isn't motivated" or "Your kid *never* does her homework." I knew this aide was gonna be a problem, but I couldn't be in the classroom because I was working full-time. Poor Elise got in trouble day after day for the same stuff; homework not completed, late to class, missing class, getting in fights. Honestly, I think the parent aide did not get any insight into FASD from the teacher at all.
- SOCIAL WORKER: That's unfortunate, but not uncommon, as you know. Educators will sometimes relate differently to a birth mother than they do to adoptive or foster parents. We've talked about those issues before, and it is something that may come up again.

Master Clinician Note: Whether intentional or not, the birth mother of a child with an FASD can be perceived negatively by others, including educators, for having “caused” her child’s disorder. The social worker is gently preparing Denise for this possibility and reinforcing the positive nature of how she advocates for her child.

DENISE: I know. I’ve been there.

SOCIAL WORKER: Well, it’s important to remember that you’re a fantastic mom, dealing with issues that not many people would have the courage to handle. You’re open and willing to learn, to educate yourself about what will work best for Elise, and she is successful because of all the love and support you give her.

DENISE: Thank you, I appreciate that. When I set up the meeting, do you think you can attend with me?

Master Clinician Note: If the social worker cannot attend an IEP meeting with the client, they should still encourage them to have a support person with them, if at all possible; someone else who is familiar with the caregiving situation.

SOCIAL WORKER: I won’t be able to attend with you, unfortunately, but I absolutely suggest that you bring someone with you to all meetings. I recall that your sister-in-law has helped out a lot. Is she available, or a good friend?

DENISE: My sister-in-law is the best, yeah. She’d be a great support. She knows the questions to ask.

SOCIAL WORKER: Great. We’ll come up with the suggestions and strategies, and you and Elise and your sister-in-law can talk and jot down any additional key issues that you think of. Definitely include Elise. It’s her education, after all. Will she be part of the meeting with the school?

DENISE: We weren’t planning to include her in the actual meeting, no. She wasn’t in it last year. We do talk to her about the issues, though.

SOCIAL WORKER: Well, she’s at an age now where it might be worthwhile to consider including her. She’s in middle school now, and at this age it might be beneficial to her to see how caring people are planning her supports. Plus, it teaches her to self-advocate, and she can offer specific information and suggestions about problems she’s having, or environmental issue that are bothering her; lighting, noise, etc.

DENISE: Okay, we’ll talk to her about joining us.

SOCIAL WORKER: Great. And you’re meeting with her teacher only? Are there any volunteers in the class this year?

DENISE: I’m not sure.

SOCIAL WORKER: You might wanna ask. If there are volunteers, it would be great if they can attend, as well.

DENISE: Okay.

- SOCIAL WORKER:** And be sure to allow enough time in the meeting to discuss concrete solutions. Accommodations can take a lot of time to work out. It shouldn't be left to the end of the session.
- DENISE:** I'll try to address them right up front. What suggestions do you have?
- SOCIAL WORKER:** I have a couple suggestions for the meeting itself, and then some examples of free, simple accommodations that can improve Elise's school experience. These go beyond the stuff on a standard IEP form. You did a plan last year, correct?
- DENISE:** Yes, we did.
- SOCIAL WORKER:** And she'll be in the same school?
- DENISE:** Yes.
- SOCIAL WORKER:** Okay, good. So there's already a record with the school of an accommodation history.
- DENISE:** Right. And it really is just frustrating to have to do this every year. I'm always surprised that one teacher can be great and the next is like a blank slate.
- SOCIAL WORKER:** I find that, as well. Many families have to start over every year with the school, transferring information, as school personnel changes each September. At the same time, the child is growing and changing, too. Elise is growing older, and what worked for her last year might need to be revised this year. Also, the accommodations in last year's plan might not have been implemented, at least not fully. Elise can speak to that if she's in the meeting. So, let's go through a few simple things that I've found have worked for other clients and their children.

Master Clinician Note: Denise is clearly frustrated with the educational process, and this is understandable. At the same time, the social worker is tempering this frustration and laying the groundwork for a more successful IEP meeting by helping Denise remember the reasons why annual meetings are worthwhile even if difficult. For the meeting itself, the counselor makes the following suggestions:

- To spotlight the child's aptitudes and hobbies, bring pictures of the child enjoying these activities and/or examples of things they've done or created (e.g., artwork, crafts).
- Parent should be encouraged to "catch more flies with honey than with vinegar." The parent's frustration with the system as a whole should not be targeted at the individuals on the other side of the table.
- Parent should approach the meeting with a mindset of using statements such as "My child needs..." rather than "I want my child to..." The federal law is for educators to meet the child's needs, not the parent's wishes.

DENISE: I like those ideas, thanks. What accommodations were you thinking of?

Master Clinician Note:

- Example 1: Federal law limits schools in terms of sanctioning children who act out as a result of a disabling condition, such as an FASD. If the child is acting out, a Behavioral Modification Plan should be considered instead.

SOCIAL WORKER: This first example is really important because I see so many kids with FASD who get into trouble when they're revved up. As a parent, you probably see this often with Elise, and you know her triggers, but educators won't. I worked with a middle-school-aged child, a boy, and his caregiver. The boy was acting out, hitting the bus driver. The school threatened to get the police involved, and the boy was kicked off the bus. I suggested that he be given time at end of each day to relax. It turned out that one of his favorite places was the library, because he could listen to music, so he ended up being able to use last period to go there and sit with headphones on, and we arranged with the librarian to keep an eye on him and monitor the time for him. We called it his "chill zone." After that, he was always cool for the bus ride home.

DENISE: I like that. Elise gets antsy very easily, especially with headphones on, but she'll sit still to read and draw. The library might work.

Master Clinician Note:

- Example 2: Watch for cases when bad behavior is a result of modeling other children with behavioral issues.

SOCIAL WORKER: Another student I worked with, a girl, was getting out of control during the day. She sat in the front row of her classroom, but the teachers and classroom volunteers still reported that even on a good day she was fidgety, and on bad ones she was practically climbing the walls. I explained that sitting in the front row typically helps children focus, but a child with an FASD can also get distracted by kids nearby. In the girl's class, the rest of the kids in the front row were working on behavioral issues, including ADHD. In this case, the girl was modeling the behavior of these classmates in an effort to make friends. I suggested we move the girl next to a model student who could maybe be her buddy or mentor, and that worked well.

DENISE: That could prove useful, as well. Elise does tend to model other children's behavior.

Master Clinician Note:

- Example 3: Work with the educational staff to think "outside the box" when it comes to accommodations.

SOCIAL WORKER: Educators are generally working from a menu of options when it comes to accommodations; such-and-such is suggested based on what the child's condition is. Now, this menu is fairly long, as you know, but it's still an Individualized Education Plan. It should still be geared to Elise's specific needs. Don't be afraid to suggest ideas that you've found work for her, even if they aren't "on the form." Think about what you've done with her in other environments, like at church or in other social activities.

DENISE: Okay. Thanks for your suggestions.

SOCIAL WORKER: You're welcome. Please call me after the meeting and let me know how it goes.

DENISE: I will, thank you.

Refer to Part 1, Chapter 2 for additional guidance on educational accommodations for individuals with an FASD who are still in school.

Part 2: Administrator's Guide to Implementing FASD Prevention and Intervention

Introduction

This Treatment Improvement Protocol (TIP) is designed to assist not only substance abuse treatment and mental health counselors in providing FASD-informed services, but also the clinical supervisors and administrators who support the work of these professionals. The need for a TIP that addresses FASD prevention and intervention for these settings is clear:

- Individuals with an FASD experience higher rates of substance abuse and mental health issues than the general population (Streissguth et al., 1996; Streissguth & O'Malley, 2000; Astley, 2010). In addition, individuals with an FASD exhibit higher rates of life problems commonly encountered in substance abuse and mental health treatment populations, including higher risk of suicide (Huggins et al., 2008), exposure to multiple traumas throughout the lifespan (Henry, Sloane, & Black-Pond, 2007; Greenbaum et al., 2009), homelessness (Fryer, McGee, Matt, Riley, & Mattson, 2007), and increased interaction with the criminal justice system (Streissguth et al., 1996).
- According to the 2009 *National Survey on Drug Use and Health* (NSDUH), 17.1 percent of women age 18 or over in the U.S. received mental health treatment or counseling in 2009, compared to

only 9.2 of men in the same age group (Center for Behavioral Health Statistics and Quality [CBHSQ], 2010), while the *Treatment Episode Data Set* (TEDS) indicates that 33.0 percent of admissions to substance abuse treatment facilities in 2011 were female, more than half of whom (50.5 percent) indicated alcohol as a primary, secondary, or tertiary substance of abuse (CBHSQ, 2013). In addition, an in-depth study of 80 birth mothers of children with FAS revealed that 97 percent had from 1 to 9 mental disorders, and the subset that successfully achieved abstinence was significantly more likely to have received treatment for their mental disorders than the subset who did not achieve abstinence (Astley et al., 2000b).

Thus, these settings are 1) likely to see a high prevalence of individuals with an FASD (and/or their parents/caregivers), and 2) provide an ideal environment for conducting interventions with women of childbearing age to prevent additional incidences of FASD.

The methods and techniques presented in this TIP are appropriate for clients in all stages of recovery and treatment. However, this TIP is not meant to create a 'one-stop shop' for FASD-informed services. An FASD is not a simple category that can be addressed with a simple, categorical response; the disorders in this spectrum cannot be cured, and clients

with an FASD need specialized treatment from a variety of healthcare professionals to function at their maximum potential. At the same time, when treating a substance abuse or mental health issue with a client, the counselors' role is to:

1. Be able to recognize when a client is exhibiting a co-occurring issue (such as an FASD) that can impede treatment success;
2. Address how the physical, cognitive, and behavioral manifestations of that issue interact with treatment; and
3. Develop a collaborative treatment relationship with the other healthcare and social service professionals who do—or potentially can—provide assistance to the client to maximize that person's potential for success, both in and outside treatment.

Like any other co-occurring issue in treatment—trauma, homelessness, etc.—addressing FASD is a fundamental step toward helping the *whole* person and ensuring that he or she does not encounter treatment barriers.

Note: This Implementation Guide follows two tracks; FASD prevention, and FASD intervention. This is because this TIP promotes 1) the screening of all women of childbearing age (whether pregnant or not) in all behavioral health settings for alcohol consumption, to help prevent future incidences of FASD [FASD prevention], and 2) the development of staff skills in recognizing individuals who have or may have an FASD, to be able to more effectively tailor treatment to their needs [FASD intervention]. In Part 1 of this TIP, these topics are treated separately. In the Implementation Guide, they are discussed together, since they each represent organizational change and the core processes involved in making such changes within a program overlap significantly.



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