Fetal alcohol syndrome and the role of the school counselor

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Abstract
Concern over the consumption of alcohol and pregnancy have existed since the beginning of time. Reaching as far back as the Biblical era, women have been warned about the potential dangers and lasting effects of mixing alcohol and pregnancy together (D'Entremont, 1990). Despite unpublished 19th and 20th century scientific observations clearly describing the effects of alcohol on newborn babies and developing children, it has not been until the last 20 years that these problems have been given official recognition and labeled by the health and medical professions as Fetal Alcohol Syndrome, or FAS. As recently as 1973, alcohol was still being recommended to pregnant women as “better than a sleeping pill...” (Ellis & Cusack, 1991, p. 9).
FETAL ALCOHOL SYNDROME
AND THE
ROLE OF THE SCHOOL COUNSELOR

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Concern over the consumption of alcohol and pregnancy have existed since the beginning of time. Reaching as far back as the Biblical era, women have been warned about the potential dangers and lasting effects of mixing alcohol and pregnancy together (D'Entremont, 1990). Despite unpublished 19th and 20th century scientific observations clearly describing the effects of alcohol on newborn babies and developing children, it has not been until the last 20 years that these problems have been given official recognition and labeled by the health and medical professions as Fetal Alcohol Syndrome, or FAS. As recently as 1973, alcohol was still being recommended to pregnant women as "better than a sleeping pill..." (Ellis & Cusack, 1991, p. 9).

Since 1973, over 3,000 papers have been published on the subject of FAS (Abel & Sokol, 1986). Both FAS and the lesser damage known as Fetal Alcohol Effects, or FAE, are now considered major public health problems in the United States. In fact, FAS is now regarded as one of the leading causes of mental retardation in children in the Western World (Abel & Sokol, 1986). Fetal Alcohol Syndrome ranks behind only Downe Syndrome and Spina Bifida in terms of occurrence, despite being the only entirely preventable birth defect. There are
also more FAS births per year than Cystic Fibrosis, Sickle Cell Anemia, and Hemophilia (Ellis & Cusack, 1991).

As the medical profession becomes increasingly familiar with this particular area of mental retardation, schools will begin to see increasing numbers of students with the FAS and FAE labels within the classrooms. Estimates of the prevalence of Fetal Alcohol Syndrome and Fetal Alcohol Effects are as high as one in every 700 to 800 births (D'Entremont, 1990). Attempts to determine the number of "normal" children suffering from alcohol related impairments might be as high as one in every 150 births (Lamanna, 1982). The role of the school counselor in working with FAS and FAE students will become increasingly more important as students who demonstrate borderline mental ability related to FAS may not qualify for special services. The school counselor will be looked to for help in understanding this special category of children, as well as assisting in setting up appropriate intervention programs.

The purpose of this paper is to provide information about Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE). Information included in this paper will be the definitions of both FAS and FAE
and the characteristics that define both these forms of mental retardation. The role of the school counselor will be reviewed and specific counseling techniques discussed.

Definition of Fetal Alcohol Syndrome

Fetal Alcohol Syndrome (FAS) and Fetal Alcohol Effects (FAE) are the conditions caused by the maternal use of alcohol during pregnancy that adversely affects the developing embryo and fetus. It can best be summed up in the statement: "A pregnant woman never drinks alone" (Ellis & Cusack, 1991, p. 9).

FAS is characterized by a cluster of congenital birth defects caused by heavy consumption of alcohol during pregnancy that include the following: prenatal and postnatal growth deficiencies; a particular pattern of facial malformations, including a small head circumference, flattened midface, sunken nasal bridge and a flattened and elongated philtrum (the groove between the nose and upper lip); central nervous system (CNS) dysfunction; and varying degrees of major organ malformation (Rice, 1992).

At least 30% of the infants born to alcoholic mothers display the most severe physical and mental forms of FAS, while another 40-45% show some physical and developmental deficits synonymous with FAE.
(Holzman, 1982). Differences in severity depend on how much and how long a pregnant woman had been drinking. Laboratory research using animals has provided evidence that fetal blood alcohol levels may exceed those of the mother. Therefore, potential damage to an unborn fetus arises from two interesting factors: blood alcohol concentration similar to and often greater than that of the mother, and longer exposure time to alcohol while in the mother's body. The equivalent of two alcoholic drinks by a pregnant woman may mean that a developing fetus needs twice as long as the pregnant mother to eliminate alcohol from the bloodstream (Gold & Sherry, 1984).

Fetal Alcohol Syndrome can be detected at birth only in the most severe cases, usually occurring exclusively in the offspring of truly alcoholic women, who throughout the duration of their pregnancy regularly consumed more than 100 grams of alcohol each day. This is the alcohol equivalent of approximately eight beers or slightly less than a pint of whiskey or a bit more than a bottle of wine per day. One recent British study has shown that as little as 100 grams of alcohol per week in the first trimester of pregnancy doubles the risk that the baby will be in less than the
tenth percentile for weight compared with nondrinking mothers (Dorris, 1989).

Babies who have some characteristics of FAS but not enough for a full diagnosis are termed Fetal Alcohol Effects or FAE. This term is not a medical diagnosis and specific differentiating criteria have not been clearly defined (Streissguth, 1986). FAE is also the term used to link decreased birth weight, growth abnormalities, and behavioral problems in babies and children, to mothers who drink as little as one to two alcoholic beverages per day during pregnancy (Little & Ervin, 1984; Rice, 1992). Incidence rates of FAE range three to ten times the incidence rate of the full blown syndrome (Rice, 1992).

Characteristics of the FAS Child

Though knowledge and information concerning FAS and FAE continue to increase with current research activities, there are few, if any, actual handbooks or materials available for caregivers and professionals covering the spectrum of life-long behavioral, educational, and social difficulties experienced by individuals diagnosed with FAS. The day to day, year to year difficulties encountered by parents of children with FAS is a struggle with structure, consistency, and patience (Rice, 1992). Realistic expectations on the
part of the child's primary caregivers, educational, and social service professionals are an important part of achieving success with an FAS child. Without realistic expectations, caregivers and professionals will be easily frustrated, overcome with feelings of guilt and failure in dealing with the intellectual and behavioral characteristics of FAS children (Streissguth & LaDue, 1985).

Intelligence Levels

The mean intelligence quotient (IQ) as measured by an individual intelligence scale for individuals with FAS falls between 65 and 80, although individuals with IQ's as low as 15 and as high as 105 have been positively diagnosed (Dorris, 1989). Many of these children have learning disabilities which become apparent around the third grade and will likely require specialized educational services. These deficits appear in the form of attention span difficulties, concentration deficits, perceptual deficits, and slow development in speech and language capabilities. In terms of achievement, FAS children typically can read and write, but with only minimal comprehension, giving the indication that they are brighter and more capable than they actually may be (Guinta & Streissguth, 1988).
Behavior Patterns

Many of the behavioral characteristics associated with FAS are characteristics of children with Attention Deficit Disorder with hyperactivity (ADHD). In his work, Garber (1990) noted that exposure to toxins such as lead, nicotine, or alcohol pass through the mother to the fetus during pregnancy and may account for some cases of ADHD. These behaviors include impulsivity, hyperactivity, poor attention span, lack of inhibition, overfriendliness, over-inquisitiveness, poor social judgement, poor sensitivity to social cues, and excessive demands for physical contact and affection (Streissguth, 1986). Other common characteristics cited included difficulty remaining on task, disturbed sleeping patterns, and patterns of unresponsiveness to verbal caution given by caregivers. This means that children with FAS are unlikely to heed warnings or be threatened by possible punishment, given their low levels of comprehensive understanding.

Streissguth and LaDue (1985) reported that even though bedtime is a consistent part of the daily schedule in the home of an FAS child, sleep does not come easily for these children and a lack of sleep or change in the amount of sleep is often noted as a primary cause of additional behavioral problems. In a
study of 22 families with FAS children (Rice, 1992), one set of parents reported the need for a lock on their FAS child's bedroom door because of extreme nocturnal wandering. One respondent noted, "He would get up in the middle of the night as a toddler and leave the house. He would head outside, no clothes, no coat in the winter. By age four it had changed to 6 a.m." (Rice, 1992, p. 7). Another parent in the same survey remarked:

When he was a child, he could not fall asleep at night. Going to bed meant to him going up and rolling for a half hour, hour, two hours, etc... I would hear him rolling in the middle of the night... (Rice, 1992, p. 7).

Despite the range in age and abilities, common behavior characteristics noted among adolescents diagnosed with FAS include poor communication skills, impulsivity, lack of social inhibitions, being overly tactile, poor judgement, and the inability to evaluate the consequences of behavior (Streissguth, 1986). One mother in the Rice study (1992) noted of her adolescent with FAE:

Consequences mean nothing to him. He always repeats the wrongdoing, no matter what the consequences are or how bad he hates them. It seems as if he truly forgets. When he gets in trouble for an incident and there is a consequence the next time he does the same thing he says "What did I do? I know I was in trouble the last time, but why again?" (Rice, 1992, p. 5).
FAS and the School Setting

For many counselors and educators, FAS and FAE are barely mentioned subjects in college preparation coursework. Little information exists on FAS, due primarily to the fact that there is little research available about curriculum and classroom issues for children with FAS and FAE.

For many guidance counselors and classroom teachers today, initiation into the arena of FAS and FAE comes with direct contact with a student afflicted with the disorder (Rice, 1992). Many counselors and teachers find themselves becoming indirect researchers on the topic with primary sources of information being parents, diagnosing agencies and professionals, as well as professional workshops offered on the subject.

Special Education

Caretakers of students with FAS mention the need for appropriate educational placement in special education classes (Guinta & Streissguth, 1988). Small classroom settings where individualized attention will help FAS students with distractible behaviors and short attention spans capitalize on their educational and intellectual potential is a clear cut necessity.
Vocational Education

Appropriate vocational and daily living skills training are also seen as a necessity if FAS children are eventually to move into independent living situations (Guinta & Streissguth, 1988). FAS students need to be taught basic life skills, including money management, safety skills, and effective interpersonal relations. Vocational training curriculum is recommended during the high school years, when FAS students are capable of learning and retaining these skills and adapting them to everyday life (Streissguth, LaDue, & Randels, 1988).

The Role of the School Counselor

This research review located few studies that dealt directly with the role of the school counselor in working with FAS and FAE children. With FAS being a new focus of study for health and education fields, most researchers are considered pioneers on the topic (Lamanna, 1982). School personnel are generally aware of the fetal alcohol problems, but there is minimal transfer of that awareness to the implications of these problems for child development and school programming.

Streissguth (1988) recommended the role of the school counselor being that of a liaison between the school and the student's home. Recommendations offered
include the school counselor helping to devise a behavior management program compatible for both home and school, as well as acting as a consultant to parents in the area of parenting skills and providing outside referral sources.

It has also been suggested that the school counselor work as a consultant between the medical team, social agencies, and the school for those students who do not qualify for specialized services. This idea is offered on the promise of meeting the needs of the student adequately, thus providing a better opportunity for academic and social development (Streissguth & Guinta, 1988). With the relative nonexistence of specialized programs for students that deal directly with FAS, potential level of achievement for these students remains largely a mystery.

Counseling Interventions

Frustrated with the lack of direct information dealing with specific interventions for school age children, many researchers have begun looking in other areas for suggestions and techniques to use when working with an FAS child (D'Entremont, 1990). Many of the interventions used by counselors and specialists to deal with the behavioral aspects of the ADHD child, including impulsivity, hyperactivity, and poor
judgment, will be highlighted here since they are applicable for FAS children. Ideas will also be offered on the role of preventative counseling with pregnant mothers.

**Impulsivity**

Studies have suggested that impulsivity is manageable through the process of teaching cognitive strategies, with the focus on teaching the FAS child what he/she should be saying to him/herself. This process is initially done verbally, and then gradually more quietly until the child is able to process the information internally (D'Entremont, 1990). The Picture Matching Test was cited as a model for cognitive verbalization. The following is an example of this process:

I have to remember to go slowly to get it right. Look carefully at this one, now look at these carefully. Is this one different? Yes, it has an extra leaf. Good, I can eliminate this one. Now, let's look at this one. I think it's the one, but let me first check the others. Good, I'm going slowly and carefully. O.K., I think it's the one... (D'Entremont, 1990, p. 12).

The objective of this type of activity is instructor modeling with student practice through verbalizing the strategies being used. The student is then reinforced and encouraged for using the strategies that were modeled, as well as for self-verbalization.
This particular type of cognitive strategy is reinforced through eight practice trials, after which the child's self-verbalizations are faded and the child is able to internally verbalize. Study results indicate this type of cognitive modeling and self-instruction alters the attentional strategies of impulsive children (D'Entremont, 1990).

Garber (1990) offered a multi-step model for working with FAS children with poor impulse control. First, impulsive behavior needs to be explained to the child, using specific examples of inappropriate behavior and resulting consequences. The next step is to prioritize a list of situations in which the child acted impulsively. The child is then taught a hesitation response to lengthen the reaction time between impulse and action. The next phase in the process is demonstrating to the child how to hesitate, having the child practice the hesitation response a number of times under direct supervision, and giving specific feedback on what he/she has done correctly. Each situation on the prioritized list is likely to require a different hesitation response, so each needs to be dealt with separately. It is important to note the point of working on only one situation at a time until mastery is achieved, and appropriate reinforcers
and feedback provided along with praise each time the child has used his/her hesitation response. Setbacks should require more rehearsal of the response, particularly in situations where a response has already been learned (Garber, 1990).

Judgment

Poor judgment is one of the most subtle, most difficult, but most telling symptoms of FAS and FAE. According to Dorris (1989), the condition of poor judgment has less to do with intelligence than with the ability of a person to evaluate the consequences of his or her own actions.

Like most aspects of FAS, little information exists on early intervention techniques. A study conducted by Shure and Spivak (1987) used an approach which enhances a child's ability to think through and solve problems. The study presents the idea that a child's ability to generate solutions to interpersonal problems and the ability to foresee consequences related to judgment and how well a child can verbalize the "best" way suggested, demanded, or agreed upon by an adult. The Shure and Spivack approach, Interpersonal Cognitive Problem Solving (ICPS), focused
on the generation and production of multiple ideas, not for having one correct idea. The overall goal of an ICPS approach is to increase the overall solution repertoire of poor problem solvers.

In another judgment study, Glenn and Nelson (1989) focused on judgment as a learned skill developed through practice. Judgment and behavior control depend upon a child's ability to focus attention, understand causal relationships, and predict future events. The focus in this study was on age in relation to an individuals' developmental level, using the strategies of Piaget and Kohlberg as a basis for comparison. Based on this study, it was recommended that parents, teachers, and counselors take steps to help FAS children improve on judgment skills, by giving them the opportunity to consider consequences of their actions, through dialogue activities and decision-making experiences.

Hyperactivity

Interventions involving hyperactive behaviors characteristic of FAS children should be planned with the knowledge of any prescribed medical intervention the student may be currently using. Koester (1981)
offered learning techniques and strategies in four areas of learning to enhance the overall classroom environment for FAS students: (a) environmental manipulations, (b) curriculum modification, (c) behavior management, (d) affective attitude considerations.

Environmental Manipulations

Koester (1981) suggested that counselors can assist in matching individual student needs to the most appropriate classroom environment. Once the student-classroom match is made, the counselor's role may be one of assisting classroom teachers in making adjustments to ensure student success. Established routines need to be understandable to the child, allowing for work limits that are enforced on a consistent basis with plenty of opportunity for movement.

Koester (1981) also offered the following suggestions in relation to the role of the school counselor. These ideas included providing physical fitness activities before the beginning of the school day, such as jogging, jump roping or shooting baskets, assisting teachers in the recognition of warning signs
preceding outbursts of uncontrollable behavior, and using non-punitive activities such as asking the child to run errands or having them spend time in the counseling office working on a structured activity.

**Curriculum Modifications**

Koester (1981) recommended adjusting the amount of work and the expectations relative to task completion. The counselor can help in creating and setting up activity-oriented learning centers, as well as concrete manipulative aids to enhance learning and keep the student on task. Short-term tasks and goals in relation to seat work should be devised to ensure a success which will build upon self-confidence and a sense of acceptance and achievement.

**Behavior Management**

Before creating a behavior management program, target behaviors must be established and baseline data collected. Behaviors should be charted throughout the process and a schedule of reinforcers and reinforcement procedures need to be decided and agreed upon. In his work, Koester (1981) noted the imperative nature of providing specific feedback to the child during
reinforcement about what the child is, or is not, doing. Compared to other children, children with FAS or FAE appear to need more positive or negative consequences to alter behaviors (Streissguth, 1986). Among the negative consequences that have worked effectively with ADHD children and can be adapted to FAS children include ignoring a behavior and attending to the children when the behavior changes, or using time-out when a behavior requires removal from the present situation.

Garber (1990) suggested that rewards should be fairly easy to earn. Reinforcement schedules need to be adjusted so rewards are not presented as often and can gradually to be phased out and replaced with natural consequences. To be most effective, children should be included in the process of setting up their behavior plan.

**Affective Attitude Considerations**

Although understanding the emotional needs of FAS children is one of the most important classroom and home management techniques, little information exists on this aspect of the syndrome. Patience, sensitivity, creativity, and acceptance on the part of the
significant adults are key components if FAS children are to be given the opportunity to be successful and build a self-confident personality (Koester, 1981). Counselors, educators, and parents, who treat FAS children as normally as possible and combine loving acceptance with firm limit setting, will find a higher success rate and personal satisfaction than will caretakers who set unrealistic expectations and unattainable goals.

In the study of FAS families conducted by Rice (1992), parents surveyed considered school success and emotional stability in their children dependent upon counselors and teachers who created calm, consistent, structured learning environments. Teachers and counselors who were able to adapt classrooms, provide continual encouragement, and who employed esteem-building activities achieved greater success with their children than educators who were considered rigid in their methods and unstructured in their approach.

Parents in the Rice survey (1992) also mentioned the need for support groups, respite programs, and educational opportunities, not only for themselves, but for extended family members to further their
understanding of the difficulties encountered in the course of raising a child with FAS.

**Preventative Counseling**

The emphasis in preventative counseling should be directed towards adolescent females before drinking becomes a problem. Rosett (1981) recommended that responsibility for counseling rests with the family physician or specially trained school counselors. The primary goal of this type of counseling is promoting abstinence or reduction in the use of alcohol. Counselors are advised to avoid direct criticism of drinking mothers as it increases and interferes with efforts to abstain from drinking (Rosett, 1981). The following points should be covered when counseling a female who is using alcohol during pregnancy: (a) information should be provided on the risks of drinking alcohol during pregnancy; (b) abstinence from alcohol should be encouraged; (c) information should be provided that shows decreasing alcohol use during the last trimester of pregnancy may prove beneficial if early interventions fail; and (d) alcohol intake during pregnancy must be noted in prenatal history taking and assessment (Elliot & Johnson, 1983).
Prevention begins with factual information about alcohol and its effects. It includes learning how to make decisions about personal goals, careers, and relationships. The focus should be on finding alternatives to alcohol consumption, such as exercise, support programs, education and/or job skill training (Elliot & Johnson, 1985).

Conclusion

There are relatively few forms of mental deficiency that can be diagnosed prior to birth, and the mental deficiency associated with Fetal Alcohol Syndrome is one of them (Elliot & Johnson, 1983). There is no cure for a child with FAS. The damage has already been done and a set of lifelong realities need to be dealt with. Above all else, the survival of the child as a human being needs to be addressed.

In this paper, facts and issues pertaining to FAS and the FAS children have been presented. Despite warnings about the potential danger of combining drinking and pregnancy which have been raised throughout history, the study of FAS is in an infancy stage. Much work remains to be done, not only in research, but in finding effective counseling
strategies for the children and in preventative counseling for prospective mothers.

Counselors need to be aware of the current trends in care and services available to the families of FAS children. They also must attend to the needs of the parents, as well as those of the entire family. Because the mother-child relationship is governed by the mother's feelings of self-esteem and acceptance, it is especially important to support her and encourage her to care for the child however possible (Elliot & Johnson, 1983). A mother with a healthy attitude toward self may be inclined to feel positively towards the child, raising it with love and acceptance, rather than guilt and remorse. In two-parent families, parents need to work together to deal with the sensitive emotional issues surrounding FAS, as well as the costs of specialized medical care. Acceptance of these realities come with education and a strong support system, (D'Entremont, 1990).

Counselors can help FAS children learn specific behaviors other children pick up naturally. They can help to adjust learning environments to fit the momentary needs of the FAS personality (Garber, 1990).
Flexibility, patience, and understanding on the part of the school counselor will work to enhance the self-concept and development of a child with FAS.
References


