On the Fetal Alcohol Spectrum Disorder (FASD) Child and Education (Stacey Burnard, 2001)

This notion conjures up a number of questions and concerns…What are the limits, the constraints? Is an FASD child educable given inabilities to retain information and generalize concepts across settings? For what vocational opportunities are we preparing the child? When is integration with other children appropriate?

These are all pressing concerns that require a shift in our paradigms of understanding regarding models of learning, educational theories and the role of the classroom teacher. As Twain aptly stated we cannot let education get in the way of learning. Educators are no longer simply conduits of prescribed curriculum but must respond to the emotional needs of students given the significant role they play in the lives of these children today.

The diagnosis of an FASD child is useful for a number of reasons. It provides us with the knowledge of the course and progression of the disorder, as well as provides vital epidemiological information that can assist with long term planning including housing and healthcare. Equally important, an accurate diagnosis permits us, as adult, parents and educators to understand the motivation behind the FASD child's cognitions, emotions and behaviours. In doing so, a diagnosis of FASD assists us in adjusting our perspective from that of one of blame to one of support and understanding. An FASD child cannot be held accountable for actions that may not have been understood, intended and most certainly for consequences that could not have been forseen.

By understanding the limitations of the FASD child we can embrace the potential and gifts that these children bring and offer the necessary guidance for each to reach his/her potential.

When devising classroom-based educational interventions two objectives must be accomplished: the development of a structured learning environment and as well as a behavioural management system.

In devising such systems it is enlightening to draw parallels with the ADHD child. In fact, in a substantial number of cases, the FASD child also possesses ADHD traits. As such, the strategies outlined in my article a few months back apply equally in this case as well. The significant difference lies in the commonly evidenced cognitive deficits associated with the FASD child that do not usually exist with the ADHD child.

Accordingly, with both student "types" there exists a need to structure and schedule activities, provide clear rules and consequences, and shorten task activities. However, in the case of the FASD child adults cannot employ cognitive rationale strategies in order to effect change, but rather must rely solely upon behaviourally management techniques. Unlike the ADHD child, the FASD child doesn't comprehend the consequences of his/her actions nor is s/he able to generalize teachings from one setting to the next. Consistency in action simply does not exist and attempting to ask "why" is an exercise in futility.

To reiterate, to a large extent, as obviously there are many exceptions, a hallmark intervention strategy is based on traditional learning theory. The old 'stimulus-response' model is effective regardless of whether we are developing a system of behavioural management or of learning for the FASD child. In other words, the home or classroom environment must be set up or structured to the extent of containing a series of stimulus and responses with a consequent reward system. Facilitative conditions are critical and must be in place to encourage learning.

Given the correlation of FASD with high risk behaviours and with the inability to respond appropriately to unsupervised activities, it is imperative that choices be limited and predetermined for the FASD child. Similarly, a period of appropriate behaviour is no guarantee for future success. With most FASD children rather than providing problem solving opportunities, adults need to build parameters that thwart any possible opportunities for risk and institute behavioural management schemes based on stimulus and response models.

To assist in developing these conditions, a visual schedule of planned activities is used for each day to reduce unpredictability. Routines exists for every aspect of the student's day with blocks of 15-20 minute segments, and opportunities for breaks. Folder systems are developed with limited choice activities. Students have their own space/desk in the classroom where a limited number of distractions are possible, as well as a personalize behaviour system or plan that contains permissible and unacceptable behaviours. A well developed and practiced time-out component is also integral to success.

In terms of a behavioural management system here again, conditions are set to reduce the amount of stress placed upon the FASD child. An understanding of valued rewards and adequate supervision must be made available. Positive behavioural supportive management techniques, as espoused by EBS theory, which emphasize a "valuing" of the child, is paramount. Similar to all children and people alike, FASD need to know that they are cared for and truly "liked." Where possible, ignoring

negative behaviours while reinforcing positive behaviours are cornerstones. Choosing the most pressing aberrant behaviour and establishing a baseline and introducing reinforcements when the child exhibits the appropriate behaviour is recommended. Every opportunity is made available to promote successes.

The level of curriculum instruction and degree of integration are directly related to intellectual development and amount of behavioural regulation exhibited by the child. Most FASD children have cognitive deficits that require a modification of curriculum that focuses on functional skill development and community-based practical work experiences. FASD children with High Borderline to Low Average IQs may have educational gaps due to dysfunctional behaviours or ADHD-type symptoms and as such would benefit from integration into some of academic subjects but still require literacy and numeracy development in learning assistance, alternate, or resource blocks. Regardless of cognitive functioning, most FASD children require additional support in the area of social skill development. The focus of which would build upon friendship skills and emphasize communication skills, as well as the reduction of inappropriate behaviours through anger management training and appropriate labelling of emotions. Opportunities for role modelling of these skills is essential to complementing the individualized instruction. Accordingly, planned peer interactions and community group activities are crucial to the refinement of these skills.

Given the cognitive and behavioural limitations of most FASD children, educators and parents need to provide encouragement based on effort and work habits. It is equally important to reinforce appropriate behaviours and manage disruptive behaviour through positive supports, clear consequences, limited discussion and options, carefully laid out schedules. Planned peer group development and involvement in appropriate social activities are necessary for modeling, learning and participation to take place. Once again, planning with appropriate stimulus and responses systems are crucial.