Promoting Success with FASD-Affected Students

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Abstract

The purpose of this article is to provide educators with information to support the increasing number of Fetal Alcohol Spectrum Disorder (FASD) affected students in mainstream classrooms. Educating FASD-affected children requires a thorough understanding of identifiable and non-identifiable characteristics, common behavioural and social traits, and effective teaching strategies. This knowledge will help educators and families to support the diverse needs of affected children and promote success both inside and outside of the classroom.

For students with Fetal Alcohol Spectrum Disorder (FASD), school can be an unforgiving place. Because most students with FASD attend regular schools, determining suitable programming and using appropriate teaching strategies can be challenging for even the most experienced teacher (Blackburn, Carpenter, & Egerton, 2010). Teachers need to develop a thorough understanding of FASD, and of the trademark characteristics and other labels that fall within the FASD “umbrella” (Blackburn & Whitehurst, 2010, p. 123). Students who have been diagnosed with FASD exhibit numerous characteristics that often mirror other behavioural or attention-related disorders (Blackburn et al., 2010). This deception can hinder appropriate planning for FASD-affected students. Developing learner profiles and individualized learning pathways for FASD-affected students requires a team approach and family support (Mitten, 2013; Symons, 2008). However, local services and resources for families, including children in adoptive or foster care, can be limited or non-existent, depending on the geographic location (Fuchs, Burnside, Marchenski, & Mudry, 2010). The enduring nature of FASD, and the social stigma associated with it, compel educators to understand the lifelong implications, along with developing suitable programming and parental support, in order to promote a positive learning experience for affected students.

Due to the prevalence of FASD, the sheer complexity of the disorder, and the poor prognosis for students whom it affects, FASD remains a topic for concern in today’s classrooms. The effect of alcohol on infants born to mothers who drank while pregnant was first noted in 1968 by Lemoine in France and then named fetal alcohol syndrome (FAS) by Jones and Smith in 1973 (Blackburn et al., 2010). FASD is completely preventable and continues to be the most common cause of intellectual disabilities in the Western world, affecting 1-6 in 1,000 live births (Blackburn & Whitehurst, 2010, p. 124; Fuchs et al., 2010, p. 233). In Manitoba First Nations communities, the estimated FASD occurrences are as high as 55-101 per 1,000 live births (Fuchs et al., 2010, p. 234). These frightening statistics must alert educators to recognize a need for further understanding of the problem, especially in consideration of the stigma attached to FASD.

Because FASD is the title given to a range of effects and characteristics, it is important for educators to note the subtle differences and appropriate labels. Four labels describe prenatal exposure to alcohol: “fetal alcohol syndrome (FAS), alcohol-related neurodevelopmental disorder (ARND), alcohol related birth defects (ARBD), and partial fetal alcohol syndrome (PFAS)” (Blackburn & Whitehurst, 2010, p. 123). Children with FASD have both intellectual and physical disabilities, all of which are presented on a broad spectrum (Winzer, 2002). Physical and intellectual damage depends on several factors, including the quantity of alcohol and timing of consumption by the mother, and the mother’s present health and medical condition (Whitehurst, 2011). By understanding the subtle differences between the FASD labels, educators can correctly identify other common characteristics.

FASD-affected children are often born with noticeable characteristics. Obvious growth deficiencies, facial and physical anomalies, and central nervous problems are all associated
features of FASD (Blackburn et al., 2010). Facial anomalies are the distinctive characteristics of FAS, which typically identify the syndrome at birth when confirmed maternal alcohol consumption is not present. These facial characteristics can dissipate as a child ages, making a diagnosis in grown children much more difficult (Blackburn et al., 2010). While some children may have observable features of FASD, others may not. For educators, the hidden impairments become difficult to detect and differentiate from other learning or behavioural disorders.

Many children with FASD display only behavioural and neurobehavioural problems. Due to central nervous system damage, children with FASD exhibit difficulties in language, behavioural, and social domains (Mitten, 2013; Olswang, Svensson, & Astley, 2010). These behavioural problems, often compounded with other mental health issues, can result in a life-long struggle both academically and socially. Caring for and educating these children require an “informed approach that relies on reflective practice and adaptive teaching techniques” (Blackburn & Whitehurst, 2010, p. 122). Because these underlying issues are not as obvious as facial or physical anomalies, educators must attune to their students’ unspoken needs and the effects of the hidden impairments.

Language delays, including both receptive and expressive language, can be another identifiable characteristic of a student with FASD. More specifically, children with FASD exhibit “general communication delays, speech impediments, and problems with word comprehension” (Blackburn & Whitehurst, 2010, p. 124). Teachers must be prepared to use “clear, concrete, simple language backed up with visual cues” (Blackburn & Whitehurst, 2010, p. 127), in order to ensure that FASD-affected students understand directions and content in the classroom. Symons (2008) recommended avoiding figurative language and multistep instructions, and using visual aids to support learning experiences. FASD individuals are typically hands-on or visual learners (Mitten, 2013), and they benefit from differentiated instruction strategies (including assessments) for core academic subjects (Symons, 2008). Educators must be adaptive in their teaching practices in order to ensure student success.

Recognizing the difference between a symptom of FASD and a general behavioural disorder can pose many challenges inside the classroom. FASD-affected children do not understand or follow general theories of learning. For example, they do not typically apply rules and understand the consequences of their actions (Blackburn et al., 2010). Olswang et al. (2010) noted an increased level of assertive, unpredictable, impulsive, and aggressive behaviour in FASD-affected children. Educators must be prepared to handle extreme behaviour by developing specialized learning pathways that align with the students’ personality strengths and talents (Symons, 2008). More importantly, these risk-taking students will require additional supervision (Mitten, 2013), along with structure and routine (Blackburn et al., 2010). Unfortunately, impulsivity does not dissipate over time, often continuing into adulthood (Blackburn et al., 2010). Through the use of clear, concise, and immediate consequences, FASD-affected students will develop a greater sense of self-regulation, which may lead to better self-management as adults.

Children with FASD often experience disconnected or troubled social interactions. Olswang et al. (2010) observed that “difficulty with peer interactions is a recurring theme” (p. 1689), creating obvious challenges inside the classroom for both the teachers and FASD-affected students. Because these children do not understand the reciprocal effects of a relationship and lack language proficiency, preserving friendships and other social interactions can be extremely challenging (Blackburn et al., 2010). Unfortunately, FASD-affected children have noticeable difficulties engaging in pro-social behaviours such as “sharing, turn taking, and co-operative play” (Blackburn & Whitehurst, 2010, p. 126). Educators should be aware that these children often do not understand social cues or body language like other children (Olswang et al, 2010). As children age, these social gaps become more noticeable and aspects of their social interactions are viewed as immature (British Columbia Ministry of Education, 1996). Blackburn et al. (2010) recommended “repeated neuropsychological assessment” throughout a child’s life, in order to determine suitable plans and goals (p. 143). These social implications can lead to an
unfortunate and troubled school experience. Teenagers and adults with FASD have tendencies to engage in poor social relationships and are at an increased risk of developing “addictive behaviours (alcohol and drug related), inappropriate sexual behaviours, problems with the law, and mental health issues” (Blackburn et al., 2010, p. 142). To ensure that these students are prepared for adulthood and independent living, educators must provide positive social interactions, develop age-appropriate social skills, and promote healthy lifestyle choices.

When educators develop individualized plans for FASD-affected students, their parents or caregivers are an essential component to consider. There has been little research conducted on the impact that FASD has on families, but Whitehurst (2010) reminded professionals, “The news that a child has, or is at risk from, a developmental disability is often amongst the most frightening and confusing pieces of information that parents will ever receive” (p. 40). Parents often share common experiences around the diagnosis and the challenges of FASD; however, noticeable differences are commonly found in professional support and other services (Whitehurst, 2010). Educators should be sensitive and considerate of FASD-related stigma, and recognize the worthy insights that can be attained from the families or care providers.

Many children with FASD have been removed from their homes due to factors related to poverty-stricken environments and being placed in foster care. About 11% of Manitoba children in care are affected by FASD (Fuchs et al., 2010, p. 243). Family histories of mental illness, poverty, and drug or alcohol abuse are typically present in FASD-affected children, complicating their diverse profile. Dumaret, Cousin, and Titran (2010) noted a decrease of 18 IQ points in each generation affected by FASD, combined with other factors such as genetics, access to care, and poor nutrition (p. 1319). Similarly to educators, many caregivers are ill-prepared for the complex needs of their children.

Educators have a responsibility to advocate for appropriate services and provide FASD-related information to parents, foster parents, and other providers (Fuchs et al., 2010). Appropriate planning encompasses a long-term commitment to FASD-affected children over time, while preserving any cultural implications. Maintaining a strong sense of identity and “a sense of belonging” can be critical for children, especially those from Aboriginal cultures (Public Health Agency of Canada, 2013, para. 5). While focusing on long-term planning, transitions into adulthood and independence must accurately reflect their level of intellectual functioning (Fuchs et al.). Destigmatization is an important aspect of moving adults with FASD forward. Promoting FASD-affected students’ success throughout school and into adulthood will require a multifaceted approach from both an educational and familial standpoint.

Despite the myriad of challenges that confront children with FASD, including the stigma that their mothers face, teachers, families and other involved professionals must determine how to equip these children for academic, social, and personal success. Through deliberate research to acquire foundational knowledge about FASD, educators will develop a thorough understanding of FASD and, ultimately, better support for affected students and their families. Because each child presents his/her own unique set of challenges, involved educators must personalize learning pathways for meaningful education. Developing a relationship with families or caregivers may link educators to background and hereditary insight, which results in accurate, personalized programming. Well-informed educators will meet the needs of these complex children and their families through in-depth planning and advocacy for appropriate services for families and involved caregivers.

References


**About the Author**

Amy Schiltroth is currently working on her graduate diploma in special education at Brandon University while she teaches grade 3 at Goulter School in Virden, Manitoba. After completing her B.Ed. at Brandon University in 2005, Amy moved back to her hometown of Pipestone, Manitoba. She enjoys living and working in rural Manitoba.