

FAS and Mental Health Services: A Therapist's Perspective
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Children with disabilities from prenatal alcohol exposure present a significant and inescapable challenge to the Mental Health community.

1. Significant, because when FAS/E is present it is a pervasive factor in all the behavior presentations of the affected client.
2. Inescapable, because failure to recognize and 'factor' FAS/E into any planned intervention is to diminish, if not eliminate, the chances of success. A lot of effort and resources will be wasted and client, family and treatment provider will all be closer to burn out.

So how do we, as treatment providers, effectively screen, diagnose and plan for individuals with FAS/E?

Screening & Diagnosis

This stage is difficult because FAS/E is not in the current American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders (DSM IV). But to try conventional, cognitively-based interventions alone, for any standard presenting diagnosis, is like trying to stop a client from sneezing, while ignoring pneumonia. Alcohol Induced Persisting Dementia is a diagnosis in the DSM IV which I believe accurately describes the phenomenon of FAS/E. But I have never seen it used in that manner. I have considered using it because the public's familiarity with dementia would give them a reference point as to the seriousness and impact of FAS/E.

So the lack of an FAS/E diagnosis in the DSM IV means mental health professionals have to rely on personal experience for screening. I have established a method which works for my clients and their families. I usually find myself alerted to the possibility of FAS/E if a client has a long standing history of developmental and/or behavioral problems that seem pervasive and elusive. When interventions that really should work, don't, I get a history on the mother's (and father's) alcohol consumption. I include the father because if the father drank a lot and the mother claims no alcohol consumption, that may be a clue that the mother is inaccurately reporting her drinking behavior. (Also we are still learning more about what the father's alcohol consumption means for the child.) By current standards, if there was no maternal alcohol consumption, it can't be FAS/E. If there was maternal consumption, and the behavioral symptoms are consistent with FAS/E, then I begin the process of getting the client evaluated at the University of Washington's FAS/E Diagnostic Clinic. If FAS/E is present, the client may be eligible for needed benefits and services through Social Security/SSI and/or the Washington State Division of Developmental Disabilities. Having a thorough and authoritative diagnostic workup, such as the ones given at the University, can be beneficial in substantiating the disabilities and proving eligibility.

FAS/E is not uncommon in clients receiving mental health care. My own experience over the past 4-5 years is that 2-4 out of 10 of my clients at any given time have a behavioral profile and history consistent with FAS/E. We, as mental health providers, need to be aware and informed about this disability.

In the area of case planning, I have found a diagnosis very important. By the time a child with FAS/E (diagnosed or not) comes to the attention of a mental health provider, the parents are usually exhausted and multi-stressed. This means the professional is presented with parents who typically look upset, angry, intolerant and who may have attempted, in desperation, some parenting techniques which can appear less than

admirable. This seems to be a real 'trigger' for a lot of mental health providers, which can cause a rush of support for the apparently poor, misunderstood child and a concurrent rush to judgment of the parents. Parents report this to be a common error that can have counterproductive results. Therapists alienate the parents and consequently hinder the chances of forming an effective team.

After eliminating or confirming an FAS/E diagnosis, the mental health professional should then look at the possibility of other co-existing conditions. There have been some DSM diagnoses which are commonly identified in children with FAS/E, according to the information gathered by FAS Family Resource Institute. These include: Oppositional Defiant Disorder, Conduct Disorder, Attachment Disorder, Attention Deficit Hyperactivity Disorder, Depression, Post Traumatic Stress Disorder, and Learning Disorders, among others. Once all the conditions are identified, the therapist can turn to the next stage.

Planning and Treatment

What has been shown to be of value with a person disabled by prenatal alcohol exposure?

- * Structure, consistency, realistic expectations, and more structure. It is helpful to think of the necessity for structure in terms of needing to provide an environmental exoskeleton for someone lacking an internal skeleton which will support them in the daily challenges they face.
- * Once appropriate structure is in place we are able to begin work on other areas of need, such as behaviors based in FAS/E and/or other co-existing conditions. One method of intervention is through medication. Various medications are being tried and found useful in helping to stabilize these individuals. A medication which shows promise, is Depakote in small doses (100 mg.) to reduce the incidence of violent acting out.
- * In all areas of endeavor with the client it is necessary to factor in their personal abilities, aspirations, and motivations as well as their limitations/disabilities relating to the presence of FAS/E.

In summary, when we fail to recognize a child or adult with FAS/E, we set the client and ourselves up for weeks, months or years of one frustrating treatment failure after another. Standard treatment modalities for these co-existing mental health diagnoses typically do not work with an individual with FAS/E. Here the analogy of a personal computer is useful. It is like trying one software correction after another in an attempt to address a problem which is inextricably tied to an underlying hardware malfunction.

Little glimpses of apparent success can keep a professional believing they are onto something. Then, when the inevitable relapse comes, the provider's only refuge is rationalizations that point the blame somewhere else. Here, again, it is easy to point the finger at the parents and accuse them of not providing enough love, consistency, support, patience, etc. We must objectively evaluate not only the parents' contribution to the situation, but our own accuracy in screening, diagnosing and planning. Ultimately, when we fail to appropriately assess and address the needs of the consumer, it is just one more bit of evidence to substantiate the doubts of those who are skeptical of mental health treatment in general.

However, when needs are properly recognized and diagnosed, treatment

plans can be developed to accurately address them not only for the individual with FAS/E, but also for the needs of the family or caregivers. Effective behavior management plans, family/parent support, case management, advocacy and medication management are a few of the

mental health services which can be provided. The key to success is the understanding that standard mental health diagnoses by themselves, do not define the problem nor do they point the way to effective service provision. When the underlying disability is recognized, it provides a stable point of reference for appropriate interventions. Under these circumstances, mental health services can be a very effective avenue to tackle the problems associated with FAS/E.

(Editor's note: When appropriate assessment and intervention don't occur, the child can lose hope and be overwhelmed by rage, as described in the following poem.)

My Rage Inside
by Mark Waller

The rage I have inside
I can no longer bear.
Is there someone out there that can lend me an ear?
I need someone there,
someone that will care
a friend to talk to
because this I need to share.
Sometimes in my life it seems that no one cares.
Living here is the deepest pit,
full of despair,
that engulfs my life.
Here, where I have no say so
just rules to follow.
This is not the life to live,
not the life for me.
On the outside is
where I'd like to be

at home with friends and family.
To most it is a given,
but to me it's a dream-
something in my life
I may never see.
It was something I had,
but then abused.
It leaves me in question,
my family confused
with all the stupid things
that left me and my friends amused.
It shortly burned up
like a dynamite fuse.
When I got older, it finally blew.
Now in jail
don't know what to do.
Juvenile life
is what I got.
Now I'm on the inside looking out.
That's what my rage is all about.

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