

***“Most approaches to changing behaviours
do not recognize brain dysfunction”***

FASD and Standard Interventions: Poor Fits?

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Until recently, there have been few studies exploring the effectiveness of interventions for children, adolescents and adults with FASD. FASCETS, a private non-profit organization, developed and successfully tested a model in a three-year FASD interventional study. This model provides a structure for linking research findings of FASD as a brain-based disorder with behavioral symptoms. Recognizing FASD as a physical disability redefines the meaning of behaviors, redefines the nature of the problem, and clearly redefines the approach and focus for interventions. One place to start exploring the idea that brain dysfunction equals behavioral symptoms is to articulate the assumptions on which many techniques are based and to clarify their compatibility with neurobehavioral characteristics of those with FASD. This helps explain how good techniques simply may not be a good fit.

FASD Standard Interventions: Potential poor fits

Most parenting and professional approaches to changing behaviours do not recognize brain dysfunction and associated primary and secondary behavioural characteristics. Instead, interventions often target presenting behaviours. These techniques are usually based on learning theory and include behaviour modification to eliminate or change behavioural symptoms.

In work with people with FASD, we are by definition working with people who have a degree of organic brain changes that affect learning and other behaviours. This brief look at learning theory, the unexamined assumptions about cognitive abilities that are required in order for behavioural techniques to work, clarifies how these assumptions are often incompatible with the needs and neurobehavioral characteristics of people with the disability of FASD.

The following looks at common parenting interventions that rely on behaviour modification to achieve desired results. Consider the underlying assumptions about brain function and cognitive abilities that are inherent in the behavioural paradigm.

Example: Consequencing behaviours

Fred at age ten fails to follow through on a simple set of instructions: Pick up your room, take out the garbage, and set the table for dinner. Since this is the tenth time this same set of requests has been made and “ignored”, his parents impose a consequence for failure to comply: “Go to your room and think about your behaviour.” Goal: For the unpleasantness of the consequence to result in changed behaviour now and forever in the future, including other occasions which may be similar in nature though not identical.

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Unspoken expectations:

1. That the person being consequence is functioning at an “age-appropriate” level, has intact short term auditory memory, is able to hear and understand the consequence, link the consequence with a behavior which may have occurred some time in the past and in some other context –outside, with others – or, in other words, is able to:

*Expectations need to be based on developmental level
not chronological age*

2. Associate the consequence with the behaviour;
3. Integrate the meaning of the consequence with future behaviours;
4. Predict different outcomes based on anticipated future different behaviours, and;
5. Retrieve this information in yet other different circumstances at some other time.
6. Further, it is expected that the person will recall other consequences of past behaviours, perceive that there are various choices available, and anticipate potential negative consequences that could be imposed on current events. Next, memory retrieval and predictions are expected to be automatically integrated, the memory of punishment significant enough to deter some behaviours, serving as the impetus to choose what others would expect to be appropriate behaviours.

Fundamentally, this approach is not bad. It may work for children of all ages who have the inherent ability to retrieve information at will, link behaviours with auditory input, compare and contrast information, anticipate consequences, develop abstract reasoning, predict, evaluate similarities and differences and generalize.

Research on FASD has found the learning and behavioural differences between people with FASD and others to be characterized by gaps in cognition in just these mechanisms:

1. May be functioning at a much younger developmental age (dysmaturity); the 7 year-old may be more like a competent 3 year old; the 16 year old may be more like an 8 year old. In order to be appropriate and effective, expectations need to be based on developmental level rather than chronological age.
2. Difficulty linking from one modality into appropriate behavior, e.g. hearing into behavior (may ‘talk the talk but not walk the walk’), thinking into speaking, seeing into writing
3. Difficulty retrieving previously stored information,
4. Difficulty making associations,
5. Difficulty comparing and contrasting,
6. Difficulty forming generalizations,
7. Difficulty with abstractions—predicting future behaviours and outcomes requires the ability to abstract and generalize
8. Difficulty seeing similarities and differences.

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9. Besides. By the time Fred reached his room to “reflect on his Behaviour”, he may well have completely forgotten what just happened and why he was sent to his room because of his short-term auditory memory problems.

“It is essential that recognition of organic challenges be integrated into our interventions”

The above are just a few of the common gaps which would directly and specifically compromise the efficacy and appropriateness of learning theory-based interventions. Whether time out, lecturing, grounding, or incarceration, the underlying principle is the same. Examining any technique for underlying assumptions, as in the example above, simply helps clarify whether the technique is a good fit for the person with this neurocognitive disorder.

The point is not that the technique or approach is bad; it’s just that it is essential if our goals to support all children are to be met that recognition of organic challenges be consciously integrated into our interventions.

No one would tell a paraplegic to do a high jump, that they could do it if they just tried harder. Asking people with FASD to do mental gymnastics of the kind which are inherent in a learning theory/behavioural approach is tantamount to asking the paraplegic to jump. We change environments to support people with other physical conditions. Organic brain differences are another kind of physical condition; environments need to change.

The goal is to provide support and prevent deterioration, neither limiting people nor enabling inappropriate behaviours. Improvements occur when appropriate, realistic, and effective approaches are used in working with people with FASD.

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BCAEA Newsletter Summer 2005*