Managing the Behavior of a Child With Fetal Alcohol Syndrome

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Much discussion has been focused lately on the behavioral characteristics of a child who has been prenatally exposed to alcohol and has been given the postnatal diagnosis of Fetal Alcohol Syndrome. At present, many researchers and clinicians are searching for a profile which will best describe the behavioral sequelae of FAS as well as methods to address the supposed behavioral excesses. Although the results of these searches do not yet provide a definitive behavioral profile, or “cluster” of behaviors that are descriptive of the syndrome, the day-to-day reality of raising a child with FAS has nonetheless led many to seek therapeutic interventions. Unfortunately, much of that search has resulted in a reliance on therapeutic interventions that lack empirical support rather than an attempt to validate or invalidate more traditional methods of managing behavior. As with any therapeutic intervention, whether medical or psychological, there is no such thing as a 100% success rate. Our failure to fully explore existing, traditional methods of behavioral management before moving on to supplement these techniques with less empirically validated methods, will further complicate the process of outlining the behavioral profile of Fetal Alcohol Syndrome.

What would constitute a reasonable and empirically supported approach to the management of a child with FAS? According to the researcher Larry Burd (1999), appropriate treatment of FAS should best be viewed as a combination of science and art. Dr. Burd’s therapeutic approach includes such variables as careful supervision of the child with FAS, behavior management using positive reinforcement techniques, training in anger management, clearly articulated and defined schedules, careful screening and
development of peer groups, parent involvement in support groups, respite care, and a team management approach from the professionals involved in the child’s care.

Judith Kleinfeld, a researcher with many years of experience working with children with Fetal Alcohol Syndrome, notes that therapeutic success with these children usually encompasses what she terms the “wisdom of practice.” In other words, those techniques that are rooted and based in a high level of knowledge about the development of young children in general will also serve to best inform those techniques that are designed and applied to children with disabilities such as FAS. As examples of the “wisdom of practice,” Dr. Kleinfeld lists such behavior management variables as the importance of establishing routines with children and helping them prepare for change, the use of pictorial reminders to cue behaviors, protection from overstimulation, help with recovering from stressful situations, self-selected plans of respite, and the importance of teaching these children how to use relaxation techniques (1993). Also, Kleinfeld emphasizes the issue of being aware enough of the child’s behavioral cues to allow for intervention before problems such as negative behavioral excesses occur.

Obviously, no “one size fits all” approach to the management of negative behaviors would be appropriate to address the complex nature of human behaviors. However, traditional behavior management techniques have yielded good success in children with other various forms of developmental disabilities. An empirical implementation and analysis of behavioral management techniques with children with the diagnosis of FAS is needed in order to truly document the validity or invalidity of this approach.
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