



2003

Occupational Therapy's Intervention for Fetal Alcohol Syndrome: Family Centered Therapy

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Occupational Therapy's Intervention for

Fetal Alcohol Syndrome:

Family Centered Therapy

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A Scholarly Project

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Master of Occupational Therapy

Grand Forks, North Dakota

May

2003

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Preface

The information in this manual is derived from a literature review that was conducted by an occupational therapy student from the University of North Dakota for her master degree requirements. The information came from a wide variety of authors who wrote about fetal alcohol syndrome (FAS) and/ or family-centered therapy in occupational therapy.

This manual was formed to give occupational therapy students and practitioners ideas that may help them when working with children who have FAS and their families. It provides the reader with helpful information that can enhance communication between therapist and parents. It also exists to encourage practitioners to provide services to the entire family rather than an individual with a disability. The manual does not discourage client-centered therapy, but rather provides information on how family centeredness can be included within that traditional practice.

When working with individuals who have FAS it is important to acknowledge the entire family system and how one individual's disability can affect the whole. The family is the most consistent and important context in a child's life as he or she develops. The family is the primary source for information about the child and a collaborative relationship with the family will ultimately benefit the child with FAS.

Chapter 1: Fetal Alcohol Syndrome

Fetal alcohol syndrome (FAS) has been in the literature since the late 1960's. Diagnostic criteria for FAS include a maternal history of alcohol use, along with growth retardation, typical facial characteristics and some degree of CNS abnormality. The diagnosis of FAS is usually made over time because developmental delay may go unrecognized until the child reaches two or three years of age. Also, because denial is the trademark of alcoholism, eliciting an accurate history or prenatal alcohol use from the mother may be difficult (Green, Diaz-Gonzalez de Ferris, Vasquez, Lau & Yusim, 2002). According to Warren and Foudin (2001), maternal drinking is frequently unknown. Parents who adopt alcohol-exposed children may not have access to a child's birth history and this may also cause an inaccurate diagnosis until the age of two or three.

Facial Features of children with full FAS phenotype include at least two of the following:

- ✓ A rounded, indistinct philtrum
- ✓ Thin upper lip
- ✓ Drooping of the lip (ptosis)
- ✓ Midface hypoplasia that manifests as a short upturned nose
- ✓ Flattened nasal bridge
- ✓ Small palpebral fissures
- ✓ Epicanthal folds

The facial features of FAS can be subtle and tend to fade as the child ages; this makes diagnosis more difficult in older children (Green, et al. 2002).

Other Features of FAS:

- ✓ Small jaw (micrognathia)
- ✓ Microcephaly
- ✓ Abnormal palmar creases
- ✓ May have limb anomalies
- ✓ May have cardiac defects

Children with FAS also experience a growth delay compared with “normal” children. This can occur prenatally, postnatally or both. The most common is growth retardation as a result of alcohol exposure during the third trimester. Infants with FAS are often born small for gestational age, but with a good nutrition program these children catch up in weight by school age. However, FAS children tend to remain below average for head size and of short stature through the adult years.

According to Green et al. (2002) prenatal exposure has a wide range of neurodevelopmental effects. Clinically, severe retardation is rare, but mild retardation is more common. FAS children on average have a lower IQ ranging from 50-70, but a “normal” IQ does not disqualify a child from having FAS.

Characteristics and Behaviors of FAS At Different

Stages of Development: (Green, et al. 2002)

Infants:

- ❖ Hyperexcitable
- ❖ Poor Sleeping-Waking Patterns
- ❖ Feeding Disorders Such as Dysfunctional Swallow
- ❖ Texture Aversion from Sensory Integration Disorder

Children:

- ❖ Coordination Disorders
- ❖ Hyperactive
- ❖ Poor Judgment
- ❖ Poor Impulse Control
- ❖ Delayed Gross Motor Development
- ❖ Sensory Hypersensitivity
- ❖ Low Frustration Tolerance

Adolescents:

- ❖ Poor Short-term Memory
- ❖ Short Attention Span
- ❖ Poor Judgment
- ❖ Overly Trusting
- ❖ Poor Social Skills
- ❖ No Understanding of Boundaries or Personal Space
- ❖ High Risk of Sexual Abuse
- ❖ Naïve about Social Expectations of Modesty and Sexual Appropriateness
- ❖ Increased Risk for Criminal Activity

Adults:

- ❖ Difficulty maintaining steady employment
- ❖ Difficulty Managing Money
- ❖ Loose the Ability to store New Memories (Mattson, Schoenfels, & Riley, 2001).
- ❖ May Require a Job Coach

- ❖ May Require Protective Living Arrangements Such as a Group Home
(Streissguth, et al. 1991)
- ❖ Difficulty with Independence in Housing and Income (Rotert & Svien, 1993).

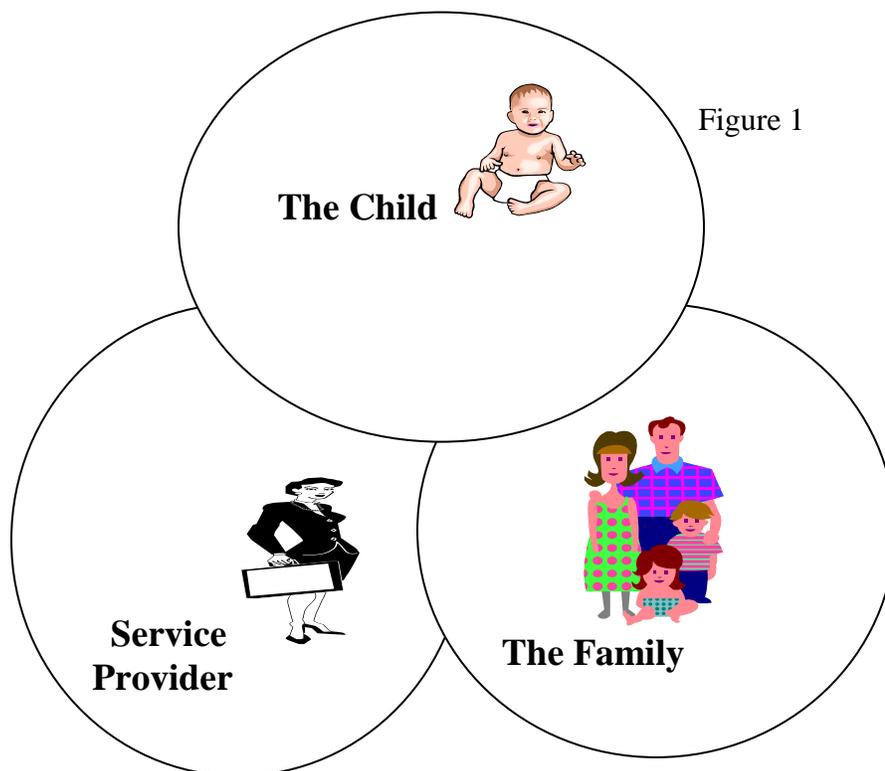


Chapter 2: Collaboration

What is collaboration?

Professionals and families have the mutual and shared right and responsibility to involve each other in the organization and structure of occupational therapy services (Dunn, 2000).

For every parent and family, there will be a preferred and optimal way to communicate. The professionals who practice family-centered care will take time to identify these strategies and implement them in the interest of supporting the family's development as informed advocates for their child. According to Hanft (1988), family centered therapy recognizes the individual resources and needs of three partners—the child, the family and the service provider in an interactive system. See Figure 1.



A. Community Based Practice settings

- ❖ According to Brown, Humphry & Taylor (1997) a young child's growth and development is nourished by his or her interactions with caregivers in their physical environments and family unit.
- ❖ Achieve competency in providing intervention and assessments within the family's natural environment known as home-based therapy.
- ❖ Therapist must coach and support key caregivers to incorporate therapeutic activities in a child's daily life (Hanft & Anzalone, 2001).
- ❖ Encourage use of wider community resources (Hanna & Rodger, 2002).

B. Involvement of Families with the Treatment Process

- ❖ Families know what they need from professionals in order to achieve success in promoting the health and well being of their child (Brown, et al. 1997). Professionals just need to ask!
- ❖ Families represent continuity in the lives of the child with FAS who may be receiving services from a multiple of agencies (Brown, et al. 1997). The family knows their child the best. Professionals working with family have the responsibility to view the parents as the expert on their child, their family, and their strengths, needs and values (Hanna & Rodger, 2002).
- ❖ Therapists need to ask for the family's assistance during the intervention process. This helps the therapist gain knowledge from the family members and helps educate the family on the techniques and procedures that are being used.

C. Model of Occupational Performance Framework

- ❖ This a useful framework to collaborate with parents to enable children's performance in their meaningful daily occupations (Hanna & Rodger, 2002). In this family centered approach, parents, the child and the therapist work together to define the nature of the occupational performance problem, the focus for intervention and the preferred outcomes of therapy for the child with FAS (Baum & Law, 1997).

D. Develop a Relationship with the Family Members

- ❖ Starts with an understanding of family systems, member's development and how the family copes with stress and change (Brown, et al. 1997).
- ❖ The family needs to be viewed as a primary team member in all aspects of occupational therapy services (Brown, et al. 1997).

- ❖ The therapist needs to give as much responsibility to the family as they are willing to assume. The occupational therapist provides services to the family unit rather than just the individual being served (Brown, et al. 1997).
- ❖ Open communication is imperative in developing a relationship. This may include providing interpreters, avoiding jargon, using positive non-verbal strategies, good eye contact and active listening (Dunn, 2000).
- ❖ According to Hanna and Rodger (2002), professionals need to have a positive attitude towards parents, be sensitive and responsive to parent concerns, provide information about resources and options for the family and treat parents as friends.

Family-Therapist Involvement Hierarchy

A seven-level hierarchy (See Table 1) was created to assist the development of family-therapist involvement. The first four levels were proposed by Doherty and Baird (1986) and the last three levels were proposed by Brown et al. (1997).

Table 1 Family-Therapist Hierarchy.

Family Role (Figure 2)	Interaction Focus	Occupational Therapist's (OT) Attitudes/Beliefs	Skills & Knowledge Area
1. No Family Involvement	Interactions are by accident	OT is focused on what is wrong with the client. Family involvement is not considered necessary	-No knowledge in working with families is needed -Good clinical skills
2. Family as Informant	Family interview is used to obtain information about the client's history.	OT understands the family has information that can be used.	-Interview skills -Understanding of human development, behavior and culture
3. Family as Therapist Assistant	Education and follow through on OT interventions and activities.	Decisions are best left up to therapist. Lack of follow-through can compromise OT services.	-Ability to teach family -Understanding of activity analysis -Communication skills needed
4. Family as Co-client	OT focuses on how well the family copes and adapts in order to stabilize the family.	Family's needs may lead to an adapted intervention plan. Empathy shown toward entire family.	-Empathetic interpersonal skill -Knowledge of coping strategies for families
5. Family as Consultant	Family input into goals. Family is not a team member, but a guest.	Families have insight into what will work best. Input of the family helps establish needs of client.	-Understanding family functions -Understanding how families accomplish tasks
6. Family as Team Collaborator	OT includes family in the evaluation, goals and	OT believes the family determines best practice.	-Family evaluation and skills -Collaborations

	interventions.		skills -Expressed respect for values of family
7. Family as Director of Service	Family decides if OT is needed. Family is team leader.	OT believes family is capable of screening, selecting and determining services.	-Consultation skills -Community resources/services -Family-centered care philosophy

Note: Adapted From “A model of the nature of family-therapist relationships: Implications for education, “ by Brown et al. 1997, The American Journal of Occupational Therapy, 51, p.599

It is important to know the levels of the family-therapist involvement hierarchy as a therapist in order to successfully interact with the family. In addition, it is important that the therapist knows his or her skills and abilities in order to communicate with the family on these seven levels.

Dilemmas with Family-Centered Therapy and Collaboration

Negative variables identified in parent-therapist collaboration have generally reflected actions considered unproductive by parents or service providers rather than negative attitudes towards partnerships (Hanna & Rodger, 2002)

Dilemmas that may occur with collaboration that will need to be addressed throughout the process of family-centered therapy include:

- ✓ Parents feeling their concerns were ignored by professionals
- ✓ Parents or professionals not following through with activities as agreed
- ✓ Professionals scheduling appointments without first checking with the family
- ✓ Professionals feeling that parents had difficulty honestly expressing needs or evaluating therapists’ suggestions
- ✓ Professional’s perceptions of parents belonging to a social class different from their own.

- ✓ Parents with multiple problems, as being more difficult to relate to and work with.
- ✓ Attitudes of professionals may adversely affect collaboration.
- ✓ The extent to which occupational therapist's truly believe that parents should have the final decision-making authority about goals to be addressed.

(Hanna & Rodger, 2002)



Chapter 3: Assessments

With the growing interest in family-centered therapy comes a need for assessment tools and procedures designed to provide therapists reliable information about family functioning and interactions. There are far more assessments available to assessing and evaluate the child with FAS compared to the family. According to Grove (2002), evaluation should not occur in isolation but be collaborative, including input from family. The following ideas and assessments can be implemented when including the family during the assessment process.

A. Gaining Background Information:

- ❖ Is important in order to obtain a general knowledge about the child and thier family to provide a comprehensive assessment.
- ❖ Retrieve available records, talk with family members, guardians and other caretakers
- ❖ Important questions to ask to gain information about the family
 - ✓ What are the needs of the primary caregivers ?
 - ✓ What agencies are involved already ?
 - ✓ What kind of educational programming or assistance is the family receiving ? (Rotert & Svien, 1993)

B. The Canadian Occupational Therapy Performance Measure (COPM)

The Canadian Occupational Therapy Performance Measure (COPM) (Law, et al. 1994) is being used in pediatric occupational therapy settings to identify the child's and parent's perspectives of occupational performance problems and to provide a framework for collaborative goal setting. The COPM involves a standardized interview to identify occupational performance areas of self-care, productivity and leisure, which are then used to establish goals for interventions (Law, et al. 1994).

Benefits of the COPM :

- ✓ Allows a collaborative framework for establishing needs and setting goals relevant to both the child and the family
- ✓ Allows changes in performance
- ✓ Interventions outcomes can be measured
- ✓ Grows with the client
- ✓ Assesses families satisfaction
- ✓ Allows families to be part of the assessment process

C. The Parent Interview

Another assessment, the Parent Interview (Cohn, Miller & Tickle-Degnen, 2000) can be conducted to gain knowledge about parents' priorities. The parent's priorities may depend on understanding what behavior, events, persons, or routines mean to those who participate in them. Meanings cannot be assumed. Occupational therapists need to understand the family's values, goals, and dreams for their child and themselves and to do this therapist's must listen intently to each family's story through a comprehensive interview. Occupational therapists should ask parents to describe their hopes for

treatment outcomes and how they will know if therapy is successful. Questions should also focus on a description of the family, what they enjoy doing together, in other words what are the family's occupations, and questions gaining insight into the family routines (See Table 2) (Cohn, et al. 2000). All of these open ended questions will allow the therapist to paint a clear picture of the families dynamics and help "best fit" families needs into the intervention process.

Table 2 The Parent Interview

1. Tell me about [child's name]. I especially want to hear about the kinds of things that you enjoy about [child's name], what his/her gifts and talents are, what his or her strong points are.
2. What has led you to seek occupational therapy services for [child's name] (If necessary: what have you noticed about [child's] development that concerns you)?
3. Tell me about [child's] abilities in: daily care activities, play, making and keeping friends, following directions, communicating, regulating his/her behavior, activity level, and following and staying asleep?
4. What do you notice about [child's] reaction to sounds, reaction to lights and other visual stimuli, reactions to be touched, reactions to smelling things, and reactions to moving in space?
5. Tell me about your pregnancy, delivery and [child's] early history.
6. Tell me about [child's] hospitalizations or medical problems.
7. Tell me about [child's] previous therapy or treatment.

8. Tell me a little about whom else is in your family. What things do you enjoy together?
 9. (If in school) What is school (preschool) like for [child's name] ? Is there anything that you would like to see changed about his or her school situation or the way she or he is at school?
 10. What kind of toys or outdoor equipment do you have that [child's name] enjoys ?
What does [child's name] do after school and on weekends?
 11. What are your expectations and/or hopes for therapy? (Or what is it about [child's name] that you are hoping will change?)
- (Cohn, et al. 2000)

Note. From 'Parental hopes for therapy outcomes: Children with sensory modulation disorders,' by Cohn, et al. 2000, The American Journal of Occupational Therapy, 54, p. 42. (permission pending)

D. Assessment of the Child's Home Environment: Physical and Social

It is important for the occupational therapists to assess the alcohol-exposed child's home environment. This can be done by using a standardized home evaluation that includes social aspects of the home. Asking each biological parents separately and privately about drug and alcohol use at each visit is important in gaining knowledge of the environment that the child is brought up in. The CAGE questionnaire (Ewing, 1984) is an effective tool for asking these sensitive questions (Table 3). This assessment consists of four questions that can determine if alcoholism exists. When this type of assessment is done it is important that the occupational therapist present a nonjudgmental attitude when there is a positive response to the CAGE questions and emphasize

confidentiality (Green et al., 2002). This assessment may lead to a referral to a drug and alcohol program within the community in order for the parent to seek out help.

Table 3 The Cage Questionnaire

1. Have you ever felt you ought to reduce your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to calm your nerves or get rid of a hangover?

(Ewing, 1984)

Note. From “Detecting alcoholism: The cage questionnaire,” by J.A. Ewing, 1984, JAMA, 252, p. 1907. (presented with permission of author).

E. Occupational Therapy Skilled Observation

In addition skilled observation may be used for an assessment by an occupational therapists. This is especially helpful in gaining knowledge in the social interaction between the mother and child bond. Barrera & Vella (1987) found that mothers of disabled children engage in more controlling behaviors than did mothers of nondisabled children. They used observations in detecting the mothers vocalizations, commands, questions, touch and praises given to the child and whether those behaviors of the mothers issued a smile, a vocal response, a negative response or no response from the child. These interactions can be observed and assessed by occupational therapists in order to give suggestions and recommendations to the families with an individual with FAS.

Limitations of Skilled Observation

- ✓ Time consuming
- ✓ Behaviors may not generalize to the “real environment”
- ✓ Accumulation of vast amounts of data
- ✓ Expensive to sift through data
(Epstein, Baldwin & Bishop, 1983).

F. The Occupational Self-Assessment (OSA)

The Occupational Self-Assessment (Baron, Kielhofner, Goldhammer & Wolenski, 1999) can be used with individuals who have FAS to assess an older student’s performance at school in order to measure occupational competence, values and the impact of the environment on performance (Baron, et al. 1999). It is in an interview format given to the individual. The OSA could also be given to the parents of that individual with FAS to gain an understanding of their interpretations of the individual with FAS performance while attending school.

G. The McMaster Family Assessment or FAD

The McMaster Family Assessment Device or FAD is a screening tool designed to evaluate families according to their family functioning (Epstein, et al. 1983). The FAD is based on the McMaster Model of Family Functioning. This model describes the organization of the family, the patterns among family members, which have been found to differentiate between health and unhealthy families. The FAD provides a detailed picture, because it contains seven different scales measuring Problem Solving, Communication, Roles, Affective Responsiveness, Affective Involvement, Behavioral Control and General Functioning (See Table 4). The FAD is a paper and pencil questionnaire that can be filled out by all family members over the age of twelve. Each family member rates his or her agreement or disagreement with how well an item

describes their family by selecting one of four choices: strongly agree, agree, disagree, and strongly disagree. The questionnaire takes approximately fifteen to twenty minutes to complete. Its goal is to collect information from the various dimensions of the family system as a whole and to collect this information directly from the family members (Epstein et al., 1983).

This assessment would be useful for the family with an individual with FAS within the adolescent years because the adolescent with FAS would be able to participate in rating their perceptions of their families. The family would be able to rate itself as far as how they function as a unit. This type of assessment would help an occupational therapist understand where the needs of the entire family lie and how he or she could help the family within the area of need. The therapist would gain all members perspectives, which would be beneficial to the intervention process.

Table 4 McMaster Family Assessment Device

Problem Solving
We usually act on our decisions regarding problems. After our family tries to solve a problem, we usually discuss whether it worked or not. We resolve most emotional upsets that come up. We confront problems involving feelings. We try to think of different ways to solve problems.
Communications
When someone is upset the others know why. You can't tell how a person is feeling from what they are saying. People come right out and say things instead of hinting at them. We are frank with each other. We don't talk to each other when we are angry. When we don't like what someone has done, we tell them.
Roles
When you ask someone to do something, you have to check that they did it. We make sure members meet their family responsibilities. Family tasks don't get spread around enough.

We have trouble meeting our bills.
There's little time to explore personal interests.
We discuss who is to do household jobs.
If people are asked to do something, they need reminding.
We are generally dissatisfied with the family duties assigned to us.

Affective Responsiveness

We are reluctant to show our affection for each other.
Some of us just don't respond emotionally.
We do not show our love for each other.
Tenderness takes second place to other things in our family.
We express tenderness.
We cry openly.

Affective Involvement

If someone is in trouble, the others become too involved.
You only get the interest of others when something is important to them.
We are too self-centered.
We get involved with each other only when something interests us.
We show interest in each other when we can get something out of it personally.
Our family shows interest in each other only when they get something out of it.
Even though we mean well, we intrude too much into each other's lives.

Behavior Control

We don't know what to do when an emergency comes up.
You can easily get away with breaking the rules.
We know what to do in an emergency.
We have no clear expectations about toilet habits.
We have rules about hitting people.
We don't hold to any rules or standards.
If the rules are broken, we don't know what to expect.
Anything goes in our family.
There are rules about dangerous situations.

(Table

4 continued)

General Functioning

Planning family activities is difficult because we misunderstand each other.
In times of crisis we can turn to each other for support.
We cannot talk to each other about the sadness we feel.
Individuals are accepted for what they are.
We can express feelings to each other.
There are lots of bad feelings in the family.
We feel accepted for what we are.
Making decisions is a problem for our family.
We are able to make decisions about how to solve problems.
We don't get along well together.
We confide in each other

Note. From “The mcmaster family assessment device,” by Epstein, et al. 1983, Journal of Marital and Family Therapy, 9, p. 173-174. (permission pending).

H. Occupational Profile

An Occupational Profile (Occupational therapy practice framework, 2002) can be obtained by an occupational therapist. Originally this occupational profile was intended to be collected on each client, however in family-centered care families are the clients in the treatment process. This occupational profile is intended to gain an understanding of the client’s, in this case the families, perspective and background on their values, experiences, patterns of living and needs. Six main questions are asked and the information is assembled in order to understand what is meaningful and important to the family (See Table 5). When seeking out this information, the families’ priorities and desired outcomes that will lead to successful occupational engagement are identified. Valuing and respecting the families input will lead to family involvement in the intervention process.

Information for the occupational profile is collected at the initial contact and over time throughout the intervention process with the family. The information gathered in the profile may be obtained both formally and informally and can be completed in one session or over a period of time when working with the families. It is intended that using the occupational profile will lead to a more individualized approach for each family in the assessment, intervention and intervention implementation stages (Occupational therapy practice framework, 2002).

Table 5 Occupational Profile

1. Who is the client/family (individual, caregiver, group, population)?
2. Why is the family seeking services, and what are the family's current concerns relative to engaging in occupations and in daily life activities?
3. What areas of occupation are successful, and what areas are causing problems or risks?
4. What context support engagement in desired occupations, and what contexts are inhibiting engagement for the family?
5. What is the family's occupational history (i.e., life experiences, values, interests previous patterns of engagement in occupations and in daily life activities, the meanings associated with them.
6. What are the family's priorities and desired targeted outcomes? (Occupational performance, Family satisfactions, Role competence, Adaptation, Health and wellness, Prevention and Quality of life.

Note. Adapted From "Occupatioanl therapy practice framework: Domain and process, 2002, American Journal of Occupatioanl Therapy, 56, p.616.



Chapter 4: Interventions

Family resources such as time and energy should be considered when developing an intervention program (Washington & Schwartz, 1996). Practitioners and families often bring different perspectives to the intervention process. Perspectives of both parties should be altered as they gain and consider new information brought about through a collaborative practice (Lawlor & Mattingly, 1998).

Below are some ideas that will help an occupational therapist develop effective intervention strategies when working with families.

A. Conduct Interventions that Coincide with Family Routines:

- ❖ In order to learn the family's routines interventions must take place in the natural environments of the family's homes and communities. This will allow the therapist to be more responsive to the individual family priorities (Jirikowic, et al. 2001).

Benefits for OT:

- ✓ Gives the therapist access to assess the home environment and the family's occupational behavior within the home setting
- ✓ The therapist can gain insight into the parents' skill at providing toys appropriate to their child's developmental level, their ability to tap into their child's play interests and skills and their values in relation to play.
- ✓ Home visits also provide the therapist with an opportunity to observe the organization of the non-human play environment and its effect on the child's ability to engage in their occupation

(Schaaf & Mulrooney, 1989).

Benefits for Parents:

- ✓ Hanna and Rodger (2002) suggest using alternative environments such as the parent's home to offer the chance for therapists to collaborate with the parents where they are likely to be more comfortable.
- ✓ Coinciding with family routines will allow the parents to open up more, share their ideas for intervention and their thoughts and feelings about the intervention process. (Hanna & Rodger, 2002).
- ✓ Having therapy in the child's home may also decrease the stress of the parent having to travel to the facility for interventions.

B. Involve Parents and Siblings:

- ❖ Interventions should focus on the entire family system. Siblings of FAS children often have feelings of abandonment due to all the attention being placed on the child with FAS. Children with FAS require an increased level of supervision. Siblings can have trouble adjusting to the way that the affected child's behavior becomes the focus of attention in the family (Green, et al. 2002).

Interventions that can be used to Involve Siblings and Parents:

- ✓ The "alphabet book" by Hanney and Kozłowska (2002)
 - Helps children deal with the emotional impact of a severe medical illness
 - The pages of the book are based on the child's name
 - The content includes artwork and the child's predicament whether they are the child with the traumatic experience or the sibling living in the household.
 - The book is then shared with the family and experiences are discussed.
 - Fosters a safe family context
 - Strengthens attachment relationships
 - Insures appropriate boundaries and structure
 - Enhances parenting capacity.
- ✓ Non-verbal Therapeutic Techniques:
 - Puppet play
 - Art
 - Drawing
 - Active metaphors
 - Story telling
 - Role playing
 - Sculpting
 - Unstructured play
 - Structured family art exercises
- ❖ Families can be involved in these interventions by helping them pick out materials, allowing them to express themselves freely in a supportive

environment at home, developing their self confidence and giving the parents knowledge and insight into how their child is feeling and thinking. A bonus to this intervention is that it also develops the child's fine motor skills, dexterity, coordination, and problem solving (Grove, 2002).

- ❖ Arts and crafts were among the earliest treatment approaches used in occupational therapy practice with persons with mental illness (Grove, 2002). Individuals with FAS have some of the same behavior characteristics of people with mental illnesses due to their low cognition level, lack of insight, poor short-term memory and poor judgment. Arts and crafts can serve as therapeutic mediums for working through interpersonal conflicts and children are proud to have a final product to share with their families.

C. Interventions must be Constant

- ❖ Interventions for the parents may include providing information about respite programs within the community and encouraging parents to be involved in parenting classes offered within the community.
- ❖ The intervention with the child with FAS should include interaction with the family, involving them whenever possible.

D. Education

- ❖ Educating the entire family on techniques and skills that can be used with a child with FAS gives the power back to the members of the family rather than the professional. This will allow the family members to be involved in the treatment process with hands on experience.

E. Correlate Skilled-Based Interventions with Stages of Development

- ❖ There are several skill-based interventions that the parents can learn and participate in with the individual with FAS to help gain skills they will need throughout their lifetime.

Infants and Children: (Hanft, 1988)

- ❖ Developing awareness of body parts through play activities at home
- ❖ Enhancing basic oral-motor functions for preparation of speech
- ❖ Correcting positioning at bedtime and nap times
- ❖ Providing age appropriate toys for the child and siblings to increase social interactions

Adolescents:

- ❖ Structure family leisure time to reduce opportunities for misconduct and encourage positive friendships (Green, et al. 2002)
- ❖ Talk to their children about sexual appropriateness and social environments they may encounter (Rotert & Svien, 1993)
- ❖ Help establish a positive routine and create boundaries (Rotert & Svien, 1993)

Adults: (Green, et al. 2002)

- ❖ Begin financial and guardianship planning
- ❖ Educate their son or daughter on social skills needed within the community
- ❖ Support individual in their semi-independent living arrangements
- ❖ Support finding work programs available through vocational rehabilitation

With any age of the intervention process, early identification of problems with supportive planning with parents, guardians, and caretakers along with other members of the team is imperative. The most effective intervention will be one that addresses the individual's and family's needs throughout life. The greatest challenge for an occupational therapist in working with these individuals is to successfully implement strategies that will facilitate appropriate behavior to succeed in the interventions of the "real world" (Rotert & Svien, 1993). Families and professionals need to remember that the intervention process is life-long and will be a continuous process of rewards and struggles throughout the individual with FAS's life.



Chapter 5: Summary and Conclusion

Every family has strengths that make it special. Recognizing, acknowledging and building on these strengths make a family stronger. Too often families and professionals focus on problems or concerns and neglect to acknowledge the strengths a family can call upon. As a result, families can feel unnecessarily overwhelmed. Families have so much to teach professionals and each other. As professionals we need to learn to listen better. Together families and professionals can find solutions that reflect and tap into these strengths. “Families are a powerful resource, one that should not be ignored but rather acknowledged, nurtured and called upon during the treatment process” (Darley, Porter, Werner & Eberly, 2002, p36).

Individuals with FAS need support from their families to learn skills needed for real life situations. Occupational therapists need to recognize that families can play a vital role in helping these individuals gain as much independence as possible by including them in all aspects of the treatment process. Incorporating a family-centered model of care into the practice of occupational therapy requires innovation, a redefinition of practice and creativity at multiple levels. This family centeredness will shape how individual practitioners perceive their role and the role of the family in evaluation and treatment of individuals with FAS (Lawlor & Mattingly, 1998).

Despite the enormity of challenges that face family-centered occupational therapy, practitioners and family members do develop effective partnerships. In the words of Lawlor & Mattingly (1998), “family-centered therapy happens.” They find

ways to work together, to attend to one another's needs and concerns, and to come to understand and appreciate differing point of view.

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