

# rffada FACT SHEET



Russell Family Fetal Alcohol Disorders Association

## SCREAMS

Adapted from SCREAMS - The Sweet Sound of Success © 2001-2006 Teresa Kellerman

From feedback received, Teresa Kellerman's model for intervention has been very successful and while not strictly related to ADHD can be utilised to reduce symptoms of hyperactivity, in particular by using an environment which reduces stimulation, and medication which helps to calm.

There are seven basic components and they form the acronym **SCREAMS**.

- **Structure:** a regular routine with simple rules and concrete, one-step instructions
- **Cues:** verbal, visual, or symbolic reminders can counter the memory deficits
- **Role models:** family, friends, TV shows, movies that show healthy behaviour and life styles
- **Environment:** minimised chaos, low sensory stimulation, modified to meet individual needs
- **Attitude:** understanding that behaviour problems are primarily due to brain dysfunction
- **Medication and Diet:** many individuals can improve their control over their behaviour with the right medications and a good diet
- **Supervision:** 24/7 monitoring may be needed for life due to poor judgment, impulse control

### Structure:

Most people who know about Fetal Alcohol Spectrum Disorders are aware of the need for structure, but sometimes this is confused with control. While providing structure as a foundation, we need to offer choices they can handle, remain flexible, and remember KISS - Keep It Simple Sweetie! There are three simple, concrete rules at the end of this article that every parent and child can discuss and memorise. The most important rule is the 'B' rule:

## Be Respectful!

### Cues:

Giving cues can be tricky, as we tend to give only verbal reminders. Parents might call it cueing; children might call it nagging. Children with FASD respond well to visual cues, to symbols and signs, to music and rhythm.

### Role models:

Children with FASD learn behaviour primarily by mimicking the behaviour of others. This makes healthy role models extremely important. A saying that is very relevant to children with FASD, "Children learn by example; unfortunately they can't tell a good example from a bad one."

We need to provide positive examples for dealing with frustration and anger, for appropriate social interactions, and for life styles that are healthy. Our kids need to be shown how to act in ways that will keep them out of trouble. Children with FASD may have a sensory disorder which means that if someone touches them or pats them, it feels like a slap or a punch. This can create problems for both parties so it is important for the child with FASD to learn to walk away from being shoved or hit.

### Environment:

Behaviour modification is not on the list, because it is not very effective when dealing with FASD behaviours. Children with FASD might understand consequences, but they usually are not able to learn from them. Time-out may not teach them to change their behaviour either, but quiet time can be useful when they are overwhelmed or over-stimulated as an opportunity to self-calm before re-joining a group. Behaviour modification implies changing the

child. What works better for children with FASD is to change the environment. Avoid noisy, crowded places; reduce the chaos; and prepare in advance some coping strategies for unavoidable situations that might be too stimulating. One overlooked factor in environment is diet - avoid all artificial additives [preservatives, colouring agents, aspartame, etc], which may heighten behaviour issues.

**Attitude:**

Understanding the nature of FASD as a neurological disability helps to minimise unrealistic expectations. Dr Calvin Sumner stated that the greatest obstacle that children with FASD must overcome is chronic frustration from unreasonable expectations of others. I believe this attitude of understanding by all who are in the individual's life could reduce the risk of depression and suicidal tendencies later on in life. The parents whose children experience the most success are those who have achieved an attitude of acceptance that their child may not fulfil their dream of 'normalcy'. Again, unrealistic expectations for full independence might set the teen up to fail. The teens and young adults who enjoy the most success are those who have acknowledged and accepted the limitations of their disability and the need for protective restrictions.

**Medication and Diet:**

The right combination of medications can normalise the balance of brain chemicals, and can give the individual more control over their behaviour, increase memory, and learning, and enable them to function more appropriately in social interactions. The individual can also function better with daily vitamin, extra B vitamins, Lecithin, and a diet that is free of artificial additives and preservatives.

**Supervision:** Close monitoring is difficult to enforce, especially as the child gets older and wants the same independence as it seems their peers are awarded. Unfortunately, the privileges offered an 18-year-old without FASD will not be the same as those offered to a person with the judgment, conscience, and impulse control of a 6-year-old. These privileges could result in hospital, living on the streets, ending up in jail or in the morgue. Sometimes being a good parent to a child with FASD looks like overprotection, refusal to let go, neuroses [on the part of the parent] especially when your teenager says he doesn't need the supports that you are trying to gain for him.

*Presented by the rffada as a community service*