



Foster parent perceptions of placement needs for children with a fetal alcohol spectrum disorder

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Received 21 July 2004; received in revised form 10 October 2004; accepted 16 October 2004
Available online 8 December 2004

Abstract

A random sample of 63 foster parents from a central Canadian province was asked “What do you need for a successful placement for a child who has a fetal alcohol spectrum disorder?”. The responses to this question were edited for clarity and sorted into piles of like statements by foster parents. Two types of statistical analysis were applied to the sorting of the statements to describe the relationship between statements and their groupings. The major concepts were identified according to the contents of the cluster, and a map was constructed to provide a graphic representation of the conceptualization process. Foster parents described the need for social support, material support, a structured home environment, professionals, other foster parents, understanding of fetal alcohol spectrum disorders, the right kind of personality, and organization skills. Discrepancies between the existing literature and study results were described, and suggestions for future research were made. © 2004 Elsevier Ltd. All rights reserved.

Keywords: Foster parents; Fetal alcohol spectrum disorders; Placement success; Concept map; Canada

1. Introduction

Jones and colleagues coined the term ‘fetal alcohol syndrome’ in 1973 (Jones & Smith, 1973; Jones, Smith, Ulleland, & Streissguth, 1973). Since that time, considerable research has been conducted on the range of neurodevelopmental effects resulting from prenatal

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alcohol exposure. However, relatively little research has been conducted on the family issues experienced by children who have been affected, in particular, foster parents.

Fetal alcohol effects have been described in different ways. Classic features include dysmorphic facial characteristics, central nervous system problems, and developmental delays. However, the diagnosis of Fetal Alcohol Syndrome identifies only a relatively small proportion of children affected by alcohol exposure before birth (Alcohol Research and Health, 2000). The *American Academy of Pediatrics* (2000) published criteria for different conditions resulting from prenatal alcohol exposure. *Streissguth and O'Malley* (2000) distinguished four types of fetal alcohol disorders, including FAS with or without confirmed prenatal alcohol exposure, partial FAS (pFAS), Alcohol-Related Birth Defects (ARBD), and Alcohol-Related Neurodevelopmental Disorder (ARND). The term Fetal Alcohol Effect (FAE) has been used to describe birth defects associated with prenatal alcohol exposure that did not include facial or other physical abnormalities.

Most recently, the term Fetal Alcohol Spectrum Disorder (FASD) has been used to encompass a broader range of fetal alcohol effects. In April 2004, a FASD Terminology Summit which included representatives from the Centers for Disease Control, National Institutes of Health, Substance Abuse, and Mental Health Services Administration, as well as Health Canada, reached a consensus statement which defined FASD as an umbrella term that includes a range of effects resulting from prenatal exposure to alcohol including physical, mental, behavioral, and learning disabilities with lifelong implications. (*Warren et al., 2004*). Incidence rates for disorders in the FASD spectrum vary according to geographic location, diagnostic criteria employed, and sample characteristics. Across North America, incidence rates for disorders in the fetal alcohol spectrum approach 10 per 1000 births (*Health Canada, 2004; May & Gossage, 2001*).

There is no safe amount of alcohol to drink during pregnancy. However, its impact depends on the amount, timing, and duration of use as well as other maternal characteristics and environmental factors (*Larkby & Day, 1997*). For example, when alcohol use patterns are controlled, women who live in poverty are far more likely to have a child diagnosed with FAS (*Bingol et al., 1987*). Maternal poverty is also strongly associated with child welfare involvement (*Culhane, Webb, Grim, Metraux, & Culhane, 2003*). Substance abuse is identified in case documents of the majority of families who are reported to authorities for investigation (*Barth, 2001*) and is reportedly high among birth mothers of children who come into care (*Besinger, Garland, Litrownik, & Landsverk, 1999*). These children are likely to receive a medical diagnosis associated with prenatal exposure to alcohol (*Ernst, Grant, & Streissguth, 1999*).

Children who enter out-of-home placements are most likely to be placed in a foster home (*Ali, 2002*), and this is no different for children affected by alcohol (*Aronson & Hagberg, 1998; Autti-Ramo, 2000; Streissguth et al., 1991*). *Astley, Stachowiak, Clarren, and Clausen* (2002) conclude that foster children are a high-risk population for FAS based on their finding of 10–15× the prevalence of the general population. It has been estimated that about 1/3 of children with FAS are raised by a birth parent (*National Organization on Fetal Alcohol Syndrome, 2002*). The authors of this study found in a random sample of licensed foster homes that 63% had fostered a child with an FAS diagnosis.

Once in foster care, alcohol-affected children are more often subjected to multiple placements (*Habbick, Nanson, Snyder, Casey, & Schulman, 1996*). Placement breakdown

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