# Transcript: Alcohol is STILL a Drug

Presenter: Lisa Rahm
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ANN SCHENSKY: Good morning, everybody, and welcome. We're going to get started in just a minute or so. I just want to give our speaker enough time to get started. So we're going to do our intros really quickly.

Again, good morning and welcome to Alcohol is Still a Drug-- An Exploratory Series. This is session six of our series. And Lisa Rahm is our presenter today. It is brought to you by the Great Lakes ATTC, PTTC, MHTTC, and SAMHSA. The Great Lakes ATTC, MHTTC, and PTTC are funded by SAMHSA under the following cooperative agreements.

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Just some housekeeping details. If you are having technical issues, please individually message Kristina Spannbauer in the chat section, and she'll be happy to help you. Also, if you have questions for the speaker, please put them in the Q&A pod at the bottom of the screen. And if we have time, the presenter will address them at the end of the session, or she will address them in writing, and they will be posted on the website with the recording.

We will be using automated transcriptions for today's webinar. Certificates of attendance will be sent to all who attended. They can take up to two weeks, and you'll get a link in your email. And this presentation will be recorded and posted on our websites, and it will take about two weeks. If you'd like to see what else we're doing, please follow us on social media.

And again, we are excited that our presenter today is Lisa Rahm. Lisa is the special initiatives manager for Prevention First. She has 28 years experience in education and human services fields, with the last 21 at Prevention First. In her current position, she has developed, implemented, and evaluated special initiatives, such as the Fetal Alcohol Spectrum Disorders Screening and Brief Intervention Project, Statewide FASD Project, as well as overseas conferences, meeting planning, and special events. She holds a Bachelor's of Science in Organizational Leadership from Greenville College and a certification as a Certified Meeting Professional. So I'm going to turn it over to you, Lisa.

LISA RAHM: Good morning. Is my screen showing? That's always my biggest fear with these, that I don't have it showing.

ANN SCHENSKY: Yes, it is.

LISA RAHM: Awesome.

ANN SCHENSKY: You are good to go.

LISA RAHM: Great. Good, good, good. Well, good morning, everyone. I really appreciate you taking time out of your busy schedules to sit in on this training webinar around FASD 101. I'm going to jump right in. It's a lot of information to cover. And if you have questions, if you'll, as they said, put them in the chat box, and then I'll respond to those in writing after the fact because it's a lot of information.

First stop, fetal alcohol spectrum disorders is what we'll be talking about today. And that term, FASD, is merely-- it's an umbrella term. And it indicates that there are a variety of effects of prenatal alcohol exposure. It's important to remember that FASD is not a diagnosis.

There are various fetal alcohol spectrum disorders, terminologies, and names for them. The disorders, the spectrum disorders, they are permanent conditions. Specific symptoms of those conditions may be treatable or manageable. The definition notes possible lifelong implications depending on the specific nature of the disorder and the individual affected.

FASD is one of the newer terms introduced to this field. And there's not universal agreement on how or when to use it. An example is Canada uses the single term, "fetal alcohol spectrum disorder," and the United States uses the plural, "disorders." However, both view FASD as a descriptive term, and as I said earlier, not a diagnostic term.

There is no consensus in the United States on the terms for the diagnostic descriptions of the effects of prenatal alcohol exposure other than FAS. Some people use FAS. Some use FAS and FAE. Some use FAS and ARND. They're all just different diagnostic terminologies underneath that umbrella of fetal alcohol spectrum disorders.

Just some really basic facts around FASD. And to me, this is the most important one, that FASD is 100% preventable. It is one of the major reasons to focus on prevention. Fetal alcohol spectrum disorders are some of the few totally preventable birth defects.

FAS is the leading known cause of preventable mental disabilities. It is more common-- and I find this amazing-- it's more common than Down syndrome or any other known cause of mental disabilities. Most individuals that are affected by prenatal alcohol exposure do not have any mental disabilities, and we'll talk about that a little bit later.

And I think the other really important thing is that women do not set out to harm their children in utero. That's not why pregnant women are drinking.

Some state legislators are considering passing laws or have passed laws that allow incarceration of women who drink or are using drugs during their pregnancy. Those measures don't really do much to help the women without providing the appropriate treatment. And also, it discourages women from talking about their alcohol use. That's especially true if they have the fear of losing custody of their children.

The cause of FASD is plain and simple. It's a woman drinking alcohol during her pregnancy. The direct effects of that alcohol in the developing fetus cause the difficulties seen in FASD. Alcohol is-- it's a teratogen. And a teratogen is a substance that might interfere with the normal development of the fetus. And there are a lot of teratogens in the world, including substance of abuse, lead, certain medications, and toxins. However, of all of those substances that women might use during pregnancy, alcohol has the most serious, long-lasting effects. It is also the most common teratogen used by women during pregnancy.

And this is a quote that I found really interesting. It's from 1996, but it's from the IOM Report to Congress. And it says, "Of all the substances of abuse that include cocaine, heroin, and marijuana, alcohol produces by far the most serious neurobehavioral effects in the fetus." That's pretty astounding when you think about how common alcohol use is in this country.

Any alcohol consumed by a pregnant woman can be harmful to that fetus regardless of the form it takes. It doesn't matter if you drink wine, beer, light beer, hard liquor. Any of it is potentially harmful to that fetus. So-called nonalcoholic beer has small amounts of alcohol in it, even though it says it's zero alcohol or no alcohol. It is best for that pregnant woman to find other beverages to drink while she's pregnant.

In February, 2004, the NIAAA defined binge drinking as a pattern of drinking alcohol that brings blood alcohol concentration to 0.08% or above. For the typical adult, this pattern correlates to consuming five or more drinks for a male, four or more drinks for a female, in about two hours. And it's known that binge drinking is clearly dangerous for the drinker and for society.

And the studies out there, one from 2001, has found that binge drinking may be more harmful to the fetus than ongoing drinking at lower levels, lower quantities of alcohol. When that mother consumes alcohol, the baby's blood alcohol level reaches as high or higher than the mother's. Consuming large amounts of alcohol in a short period of time-- when we're talking about two hours-- could be particularly damaging to that developing fetus.

There is no proven safe amount of alcohol use during pregnancy. Although there is no data to show that a drink a day causes FAS, there is no proof that a drink a day or any given amount of alcohol will have no effect on a specific developing fetus. Every person absorbs and metabolizes alcohol differently. There is no current research on the identification-- I'm sorry. There is current research on identification of some genes that may increase or decrease the

degree of effect of a given amount of alcohol on that fetus. But what we do know is the only definitely safe amount of alcohol to use during pregnancy is none.

The number of people with an FASD. Unfortunately, their accurate incident rates, FASD, are unavailable. There are a lot of different reasons for that. With the various types of FASD, they're not regularly diagnosed. Few physicians feel comfortable diagnosing the specific types of disorders. And there's no general agreement being reached on how to diagnose specific disorders.

However, there have been a number of incidence studies that have been conducted. And from those, it's been estimated that 40,000 babies are born with an FASD, making those disorders more common than new diagnosis of autism spectrum disorder, which-- that's pretty amazing.

In a recent school study, it suggests that cases of FASD among live births in the US, previously reported as approximately nine per 1,000, and that was in a 1997 study, could, in reality, be closer to 50 per 1,000, which, that, to me, is-- with how difficult it is for women, pregnant women in this country to talk about their alcohol use, it more than likely is even higher than the 50 in 1,000.

There is financial cost to FASD. The cost of raising a child with an FASD is pretty significant. For a child with identified FAS, incurred health costs were nine times higher than for children without an FASD. It's been estimated that the lifetime cost for a person with FAS to be at least $2 million. And the overall annual cost of FASD to the US health care system is to be more than $6 billion. That just blows my mind. The extremely high costs really, really amplify why prevention efforts are so, so important.

With FASD and all the different actual diagnostics underneath that umbrella of FASD, there are some primary disabilities that do show up. And those primary disabilities are the characteristics or behaviors that reflect differences in the brain's structure and function, such as mental disabilities, attention deficits, and sensory integration issues.

There are also secondary disabilities. And those are the disabilities that the individual is not born with. And they develop over time because of that poor fit between the person and their environment.

In a study by Ann Streissguth et al., they identified a number of primary disabilities in persons with an FASD. For example, in the study, persons with FAS had an average IQ of 79. Persons with FAE, another one of those diagnostic terms underneath that umbrella, they had an average IQ of 90 while the average IQ in people without neurological disorders or brain damage is 100. So you see that primary disabilities, they really do show up in the people that have been affected in utero by alcohol use.

Now, we do have to make sure we look at the strengths of an individual with an FASD. It's always important for us to really, when we're working with people with an FASD, to really not only take stock of what their disabilities are, but also what their abilities are. This is not by any means an exhaustive list of typical strengths of people with an FASD, but they are some of the more common ones. They tend to be cheerful and friendly, likeable, helpful, determined, verbal, hardworking. And they really come at life with the attitude that every day is a new day. And for the most part, people with an FASD are not malicious, and they do not act with premeditation.

They tend to have sensory integration issues. And that just refers to the way that the body responds to external stimuli to the senses, like sight, hearing, smell, touch, and taste. Persons with an FASD may have those-- they may be sensitive to sensory integration, sensory issues. And that makes them either over- or understimulated.

They may refuse certain foods because the texture of the foods is uncomfortable for them. They have issues with wearing certain clothing because of how it feels to them. Conversely, they may end up hurting themselves at times because they don't feel pain, such as when touching a hot stove or dress inappropriately for the weather because they don't feel cold. If they have a sensory integration issue, they can, at times, be clumsy because they have issues with being able to sense where their body is in relation to the space that they're in.

Information processing tends to be an issue with people with an FASD. And that just refers to the way that the brain stores, organizes, recalls, and uses information. They may appear to be oppositional by-- you give them instructions with multiple tasks involved in that.
For example, they're told to go to your room, put away your dirty clothes in the hamper, fold the clean clothes, put them away, and make your bed. The child doesn't follow through on all those instructions, not because they're being oppositional, but because he or she can't remember what to do. It's far too many instructions and tasks for them to process at one time.

They have a tendency to have trouble determining what to do in a given situation. They're not able to generalize from one situation to the next. An example would be if we've instructed them to don't talk to strangers. Well, when they go into their classroom, and they have a substitute teacher that day, and they don't talk to that substitute teacher because they've been instructed that that person is a stranger. Don't talk to them. So again, not being able to really generalize across all different situations.

And they have a tendency to not ask questions. People with an FASD know that there is something different about them. And they hesitate to do anything that'll draw attention to that because they do want to fit in. They do want to be like everyone else, like all of us do. And so asking questions is not something that people with an FASD generally do.

There's difficulties around information processing. They say they understand when they do not. They may want to let on that they've had-- they may not-- I'm sorry-- want to let on that they've had difficulty with what's being told to them. So they'll act like they understand, nod their head, when in actuality, they really don't.

Their verbal receptive language skills are more impaired than their expressive skills. They love to talk, but it doesn't necessarily mean that what's being said to them is being processed correctly. They can misinterpret others' words or actions and body movements. And again, as I said earlier, that individuals with an FASD typically have difficulty following multiple directions at one time. So it's really important that you give one task at a time.

More difficulties. Boy, we've got a lot of difficulties here. I'm just going to go through these really quickly. There are issues around executive functioning, such as their planning and problem solving and being able to cope with the tasks and demands of just daily life. They repeatedly break rules because they may know and understand that rule today. Tomorrow, they may not understand it, or they may have even totally forgotten it.

They don't learn from their mistakes. They don't respond well to the point or level systems that we typically we use in schools with children that have disabilities. The concept of time-- it just doesn't register, typically, with people with an FASD. The concept of money is totally foreign to them. And they have to be real careful that they don't get essentially ripped off with their money. They don't understand change and how to give that back or how to receive that.

And then peer pressure. People with an FASD tend to be very naive and gullible. And they believe what others tell them, and often do what others tell them to do. They want to have friends. And they'll often do whatever they need to do in order to make sure they have friends.

There are difficulties with self-esteem and personal issues. They're very uneven. It's not unusual for an individual with an FASD to do well one day and do poorly the next day, or to remember something from one day and not to the next, which can be very frustrating for the people who work with them.

Hygiene can tend to be a problem at times. They have difficulty maintaining good hygiene. They may not know-- they don't recognize when they're wearing dirty or stained clothes. They may take a shower or a bath and put the same clothes on they had on. Again, just that lack of awareness. And again, this isn't everyone with an FASD. These are just some general difficulties that people with an FASD can experience.

I said very early on, at the very beginning, that it's important really to note that FASD is not a diagnosis. There's no code for it in the DSM, that Diagnostic Statistical Manual of Mental Disorders. I think we're on DSM-5, maybe. I don't know if we've gone to six yet. It is not a diagnosis. Depending on your

community, you might have to go to a developmental pediatrician. There may be an FASD clinic, a genetics clinic, or some other specialist.

To prepare for that assessment, it'll help if the guardian or parent brings that child's history, their medical history, behavior, school records, any written reports with them. And bring a photo of that child, really making sure that you've got information on the history of prenatal alcohol exposure if you know that, the child's growth patterns, physical characteristics, and any signs of central nervous system damage or behavior problems.

Some of the possible signs of an FASD that may suggest that there's a need for an FASD assessment could be sleeping, breathing, or feeding problems, small head or facial or dental irregularities, heart defects or other organ dysfunctions, deformities of the joints, limbs, and fingers, slow physical growth before or after birth. That's a real key one for an FASD. It's just that overall physical growth. It could have hearing and vision problems, mental disabilities, or delayed development. Behavior problems are another real common sign. And then the big one is actual maternal alcohol use if you know that that's happened.

This picture is just, again, a general, overall picture of some of the facial features that can exhibit themselves if there is an actual diagnosis of fetal alcohol syndrome. Changes in the physical features are consistent with an overall flattening of the mid portion of the face around the nose, the upper mouth area.

And as a result, the face exhibits things such as-- and this picture doesn't have that. I don't know why this one doesn't it. The epicanthal fold, which are in the inside corners of the eyes. They have extra folds of skin coming down around that inner angle of the eye. There's a shorter palpebral fissure-- fissures, which are the real small eye openings. There's a flattened, elongated philtrum, that little groove that runs-- that crease running from the bottom of the nose to the top of the lip. It's either very flattened, or it could be even nonexistent. There's a smaller mouth that has a higher arched palate, or the roof of the mouth. There tend to be small teeth with poor enamel coating and low-set ears. These facial features are a result of the drinking early on in pregnancy.

It's really interesting when you're going through the diagnosis process for an FASD. Based on facial features, other things that professionals are looking for, you are to be able to pinpoint, at what point in the pregnancy did that mother drink alcohol?

This picture is an actual photo of a baby whose mother drank alcohol while pregnant-- Teresa Kellerman, who was generous enough to allow us to use this photo. You can note that there are smaller eye openings. There is that smooth philtrum, that crease underneath the nose. It's almost nonexistent in this photo. And a very, very thin upper lip for this baby. When we talk to

mothers, women who are pregnant-- and I don't know if some of you ladies who are on the webinar have had your doctors tell you that it's OK to have an occasional drink while you're pregnant.

Well, recent research with frequent drinkers, the majority of women reported drinking larger-than-standard drinks. Daily drinkers were consuming drinks that were anywhere from three to six times the standard drink, with the majority of drinkers underestimating the number of fluid ounces they consumed by about 30%. We hear that women are told by their doctors at times that it's OK to have an occasional drink. But there are several real major concerns with those statements. First off, what does "occasional" mean? What does that look like?

For me, it may mean once a week. For someone else, it may mean once in the morning and once in the afternoon. Occasional. There's just no concrete definition of what "occasional" is.

Second, what is it? What is a drink? What constitutes a standard drink? That was an activity for another one. But this chart, which is put out by NIAAA, is just a great chart for us to visualize what actually is a standard drink.

And as you can see, for a beer, it's a 12-ounce serving. For malt liquor, it's an eight to nine. The table wine, it's 5 ounces. It's not those giant goblets of wine that you get when you're out at a restaurant. 3 to 4 ounces of fortified wine, like port or sherry. The cordial or liqueurs is 2 to 3 ounces. And brandy is just a jigger, which is 1 and 1/2 ounces. And then for other spirits, like vodka, whiskey, gin, all of those are 1 and 1/2 ounces as well. That is what a standard drink actually is.

The risk factors for an FAS, Fetal Alcohol Syndrome. FAS is only the tip of the iceberg in terms of outcomes. There's only a minority, about 10% to 40% of children of chronic alcohol women, who are diagnosed with an FAS.

What makes some of the individuals more susceptible than others? What are the risk factors associated with prenatal alcohol exposure? It's all the things such as the dose of the alcohol, the pattern of exposure. Are they binge drinking? And like we talked about earlier, are they a chronic, ongoing, daily drinker?

The developmental timing of the exposure. Where in the development of that fetus was the alcohol ingested? Genetic variations. We talked about that they're looking at maybe being able to identify some of the genes that contribute to this.

Maternal characteristics, and then, as well as the interaction with other substances of abuse that that mother may be using. The brain undergoes a very prolonged developmental course throughout the gestation within their mother. Fetal and maternal genetic factors and the nutritional factors, just how

the interaction with other drugs-- it all influences the effects of that prenatal alcohol exposure.

It's important to realize that some fetal alcohol effects might even occur before a woman realizes she is even pregnant. In the US, over 50% of pregnancies are unplanned. Women, they're usually typically around eight weeks pregnant before they even know they're pregnant. And they could have been drinking and binge drinking during that eight-week time period.

PRESENTER: Lisa, I hate to interrupt you. We have a couple minutes left.

LISA RAHM: All right, thank you. It's really important that we all talk about alcohol use. We talk about it with children at an early age, even as early as elementary school, of course, in developmentally appropriate terms for them. The message is, say no to alcohol for you and your baby. That's very important for women.

And prevention starts with asking. We need to ask about alcohol use among women at all medical appointments, appointments in all the various systems that mom could be involved in, and asking in a nonjudgmental manner. Using effective screening tools is really critical. And ask about possible prenatal exposure. And ask it in the same vein that we ask questions about general health questions. Do you wear a seat belt? Do you take vitamins? Do you smoke? It's just important to ask.

And who needs to know this information? Everyone. It doesn't matter if you're a woman of childbearing age, if you're a teenager, if you're a man. You need to know this information for your partner if they become pregnant. And it's just, again, like I said, it's very critical for everyone to know the damage of drinking alcohol while pregnant.

These are some resources that are out there that we put together for you. Please feel free to go to any of these websites. There's a lot of information out there. These are the ones that we feel are very factual, very on target with the information that they have. And there's my contact information. I'm happy to try to respond to any questions that you may have. Feel free to email, call, whatever works for you.

[ALARM BEEPING]

And that's it. Ding, ding.

PRESENTER: Thank you so much, Lisa, for this wonderful presentation. We have a few questions that were in the Q&A. So as Ann mentioned earlier, we will email those to Lisa. And we will post her responses to the questions along with the slides and the recording on the Great Lakes ATTC, MHTTC, and PTTC product page for this series. So thank you once again. We hope to see you next month using the same link. And thank you again, Lisa. Have a great day, everyone.

LISA RAHM: Thank you.