Many children with learning disabilities and/or AD/HD remain isolated, teased and confused about how to interact successfully with their peers. Often, they may try to fit in, fail and not know why. Not all children have social difficulties for the same reasons. For some children, environmental factors, past failures, anxiety or depression may play a role. However, recent research suggests that certain children may have social competence problems because they have difficulty accurately perceiving and integrating the nonverbal cues in social interactions, such as facial expression and voice intonation.

Children with NVLD and other autistic spectrum disorders have difficulty perceiving and integrating information that is presented nonverbally, such as visual-spatial stimuli or nonverbal aspects of language (Rourke, 1989; Semrud-Clikeman & Hynd, 1990). Children with NVLD, for example, may not be able to interpret a very subtle look of fear or integrate a happy expression with an angry tone of voice. Children with AD/HD may also find it difficult to integrate or interpret social stimuli, but for different reasons. Due to behavioral disinhibition, children with AD/HD may not inhibit their responses long enough to fully process and accurately interpret the perceptual information. As a result, children with AD/HD may be likely to respond to general environmental cues and establish an overall mindset, which may or may not be appropriate to the situation (Barkley, 1998). For example, they may over-interpret the actions of others as joking or as hostile.

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Learning How to Get Along

Learning How to Get Along

The group discusses when emotions match or don’t match words, when mismatches may occur and which part is “more important” for interpretation.

When mismatches may occur, the group breaks down a complex interaction into smaller steps to help them understand it, so they can develop greater social competence and achieve a step toward social success. By the end of the intervention, the children’s social difficulties are by no means solved, however, the children will hopefully carry with them some new tools to face the social world.

The intervention, which has run twice for 8–10 week sessions, continues to undergo development and revision. The program is being expanded to 16 sessions (two sessions per week for eight weeks) to help generalize skills and increase group cohesion. A parent component is being developed to increase communication and support among parents. This spring, the intervention will undergo its first clinical trial as part of a study to measure its effects. Children will participate in a test before and after the intervention, which measures their social perception, while parents will be interviewed before and after to note any changes in social competence. It is hoped that the program will eventually expand and be used in the educational setting.

By the end of the intervention, the children’s social difficulties are by no means solved, however, the children will hopefully carry with them some new tools to face the social world:

- A more accurate perception of others’ emotions and behaviors,
- Awareness that they can break down a social interaction into smaller steps to help them understand it,
- A greater awareness about their role in social interactions,
- The realization that they can indeed connect with others

In doing so, the hope is that they will begin to develop greater social competence and achieve a step toward social success.

Laura Guli, M.A., is a doctoral student at the University of Texas at Austin in the Department of Educational Psychology. Margaret Semrud-Clikeman, Ph.D., is an Associate Professor at the University of Texas at Austin in the Department of Educational Psychology.

**References**


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**Sentence Content**

This task practices perception of emotion through voice tone and facial expression, and also helps a child to integrate the different sensory experiences. The group discusses when emotions match or don’t match words, when mismatches may occur and which part is “more important” for interpretation.

Improvisational role-plays are enacted more frequently towards the end of the program to integrate all of the processes in more natural interaction. For example, three children may be asked to pretend that they are playing ball on the playground and that one child drops the ball. They then decide what happens next. Participants break down a complex interaction into sequential parts, discuss the emotions present, act out possible responses, take different roles and experience another’s point of view. The improvisations are videotaped and used to help the children view their behavior more objectively.

Above all, the activities are fun and allow the intervention to be intrinsically motivating. Many children with poor social competence find fewer and fewer opportunities to succeed socially as time passes, which weakens their confidence. It is our hope that the intervention will allow children to take risks and experience the spontaneous enjoyment of social interaction in a safe and therapeutic setting. Group leaders (doctoral students) jump in and do activities with the children, modeling risk taking and participation.

Although it is too early to determine if the intervention has made a lasting change, it has received positive feedback from both parents and children. During group, the children enjoyed each other and experienced some social successes. One parent commented that his child felt comfortable knowing he wouldn’t be picked on or teased as he was elsewhere. Several children commented on what they had learned from the activities and the improvisations in particular from watching themselves on videotape. For example, one of the children was made aware of his difficulty in portraying anger or sadness.

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