LEARNING HOW TO

Get Along

by Laura A. Guli, M.A., and
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IT IS SATURDAY MORNING, the first day of group therapy at the University of Texas at Austin. Six children ages 8–12 sit in a circle, avoiding each other's eyes. They have varying "diagnoses," reading like the headings from a neuropsychology textbook: Attention-Deficit/Hyperactivity Disorder (AD/HD), Nonverbal Learning Disabilities (NVLD), high-functioning autism and Asperger's Syndrome. Underneath these labels, they are kids, brought together by parents and teachers who have referred them for help with social difficulties. Although they want to fit into their social world, they have been unsuccessful. As one 11-year-old girl with AD/HD put it, "I have no friends at my school. Exactly none. No best friends. No stuff like that."

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While much consideration is paid to the cognitive and academic difficulties experienced by children with learning disabilities, less focus is placed on their social difficulties. Yet, many children with learning disabilities 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. Many children with NVLD also suffer from AD/HD, making social situations even more challenging.

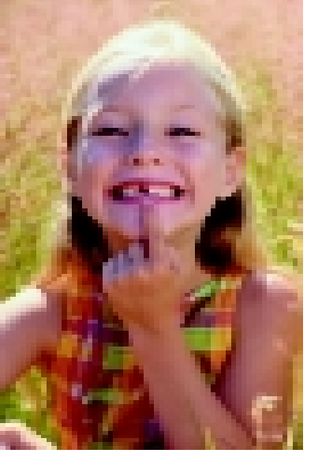
Although many social skills interventions for children exist, few have shown lasting change (Teeter & Semrud-Clikeman, 1997). This finding may be partially because the child's actual social environment is rarely included in the intervention itself. For example, although a child may learn an appropriate social "script" in the presence of a therapist, at school it may not help when the child is faced with an unpredictable situation with peers. Barkley (1998) argues that social difficulties for children with AD/HD are due to deficits in performance, not a lack of skills, so intervention must take place on the playground, in the hall or wherever the social difficulty arises. Many interventions also assume that children can accurately perceive and integrate nonverbal information, focusing instead on training them in appropriate social responses.

The Social Competence Intervention Program (Glass, Guli & Semrud-Clikeman, 2000) is a pilot program at the University of Texas at Austin that attempts to address social difficulties of children with NLVD and AD/HD. Unlike traditional social skills programs, it has adapted creative drama activities to address perceptual and integrative deficits. Combined with therapeutic problem solving and discussion in a group setting, these types of activities have the potential to be a powerful tool for change. Creative drama activities target many areas of skill deficits in AD/HD and NVLD, such as accurate perception, sensory integration, use of space and movement, body awareness, physical self-control and, of course, communication. Since creative drama exercises also emphasize trust and cooperation, they help children acquire positive social experiences and allow them to work together to reach a goal. When children experience the group as a safe environment, anxiety and inhibition is lessened, and they take the first steps toward social success.

Two girls (Ann and Jenny) stand in front of each other silently, "mirroring" the other. To do this, they must pay close attention to the subtle changes in each other's expressions and movements. This task requires both physical control and cooperation. Ann raises a hand, and Jenny follows. Ann makes a silly face in the mirror, Jenny makes the silly face back. During this exercise, both Ann and Jenny see how accurate their perception of the other's movements and expressions are, as well as how well their own attempts to communicate succeed. Ann moves faster and is a bit frustrated that Jenny can't keep up, so she slows down to accommodate her. Suddenly, Ann raises her leg high, almost over her head. Off balance, both girls fall on the floor, giggling.

The organization of the activities in the intervention follows the processes of social interaction: perception (input), interpretation (integration) and response (output). Difficulty with any of the three processes will make it more difficult to interact successfully; therefore, intervention activities are organized so that they address each process. Although the program content is generally the same, the program emphasis differs somewhat for children with AD/HD and children with NVLD and autistic spectrum disorders. The program stresses perspective taking, self-awareness, self-control and gradations of emotional response for children with AD/HD. For children with NVLD, it stresses perception and integration of cues, abstract thinking and body awareness.

For example, the group begins by focusing on one's own emotional awareness and the accurate perception of general emotions. The group might play "emotional sentences," during which children are given "nonsense" sentences and told to say their sentences with a variety of emotions that either match or do not match the



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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 often was elsewhere. Several children commented on what they had learned from the activities and particularly from watching themselves on videotape. For example, one of the children was made aware of his difficulty in portraying anger or sadness.

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,
- the 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, and
- 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. ■

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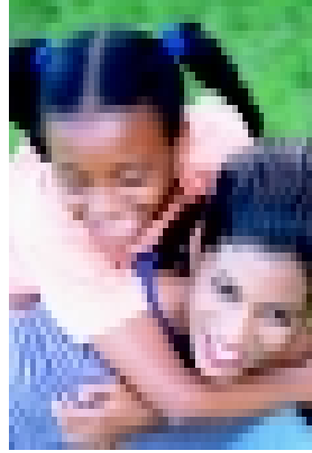

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