by Holly J. Zumpfe and Steven Landau Control of the state of the stat

Many children with AD/HD are the most rejected among their classmates.

FREQUENTLY, children with Attention-Deficit/Hyperactivity Disorder (AD/HD) may present serious difficulties with attentional and behavioral control in a variety of settings. Consequently, they may have management problems at home and school, and are at elevated risk for achievement delays and learning disabilities. To make matters worse, some of these children also experience seriously disturbed peer relations. For example, some children with AD/HD reveal they have few (if any) friends, and play with those much younger than themselves. Sadly, our research indicates that some classmates may consider them aversive playmates and objectionable work partners in the classroom. Using sociometric methods of data collection, in which students are asked to nominate among classmates, "whom they like the most" and "whom they like the least" (or "dislike the most"), it has been shown, repeatedly, that many children with AD/HD are the most rejected among their classmates. In fact, some researchers have suggested the social problems of these children may be central to an understanding of their overall psychopathology.

For parents and educators, these social concerns must be taken seriously. Research in developmental psychology makes it clear that any child with peer problems may be deprived of a number of important learning experiences, including the principles of egalitarian interactions (i.e., to "give and take" with others). Additionally, the notion of social competence is central to all federal and state legal definitions of developmental disabilities in comparison with assessment of adaptive behavior. Thus, successful development and peer relations seem to overlap conceptually and behaviorally.

Second, children with peer problems may experience higher levels of loneliness and other emotional effects, including serious worry about their social problems. Obviously, being disliked can be extremely painful. Take the anecdote of a second grade boy, described by Putallez and Gottman (1983), revealing (with spelling errors intact) the suffering he experienced:

"i can hide. i am a little boy. i don't have friends but i have som friends but win i wait at the busstop som people haet me and some like me...one day i was moving so people would not tesz me in ne more but again they tesz me" (p. 13).

Social stigmatization of this sort further diminishes self-esteem and subsequent opportunities for peer interactions. Thus, a vicious cycle emerges in which rejection leads to less chance to practice appropriate social behaviors, which then evokes greater exclusion.

Third, we know that rejected children (including those with AD/HD) are the recipients of teasing and other forms of peer victimization. Teasing can lead to explosive retaliatory behavior, especially from those with AD/HD, (e.g., fighting back) that exacerbates an already negative reputation.

Finally, research consistently documents that children's negative reputation or status—especially peer rejection—is extremely durable, recurrent and often escalating. Those who are disliked by classmates during the elementary years often experience rejection in high school and continue to have relationship problems throughout adulthood. Unfortunately, many parents of children with AD/HD do not have information about how their son or daughter is functioning in the social domain. Most peer problems occur at school,

and most teachers tend to focus on disruptive class-room behavior and academic performance difficulties. Parent conferences at school should address, among other things, how well the child with AD/HD is getting along with others.

Do all children with AD/HD experience the same peer problems?

Even though there is limited research addressing this question, and findings are not consistent, children with different types of AD/HD may experience different problems in the social arena. Those who are Hyperactive/Impulsive and Inattentive (i.e., AD/HD-Combined Type) may be rejected or more disliked by peers than those whose primary problems involve inattention exclusively (i.e., AD/HD-Predominantly Inattentive Type). Peer relations of children in the latter group may include solitary, disengaged and onlooking behavior, with lower levels of sustained social interactions. These children tend to be ignored and neglected. In contrast, those with AD/HD-Combined Type are more likely viewed as aversive playmates, and tend to be actively disliked. One explanation for this difference rests with the fact that children with AD/HD-Combined Type may be more socially disruptive; they may start fights and rely on hostile explanations or attributions to account for the behavior of others. In addition, they may be more likely to present additional problems that further alienate them from peers. The most likely culprit is comorbid difficulties with aggression and Conduct Disorder, and evidence is clear that many forms of aggression (but not all) evoke peer rejection.

An important issue when considering these peer problems involves the distinction between a social skill vs. social performance deficit. As explained by Landau, Milich, and Deiner (1998), reconciling this difference can determine which intervention is suitable for the child. For example, children who have a social skill deficit have not mastered age-appropriate social behavior and do not know how to make and keep friends. They lack the ability to accurately read social cues and often use inappropriate communication in social exchanges. In contrast, those with a social performance deficit have these necessary skills or knowledge (i.e., they know how to behave appropriately), but are unable to apply their skills in everyday interactions with other children. In other words, their problems are best understood as an inability to "perform what they know."

To date, there is controversy regarding which hypothesis explains the peer problems of children



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with AD/HD. However, work in our lab supports the performance-deficit position, which is also consistent with Barkley's (1997) unifying theory of AD/HD. We should assume that children who present a social skill deficit would benefit from social skills training (SST) in which they learn age-appropriate social behavior, reading of social cues and social perspective taking. In contrast, those with a social performance deficit should be trained to develop control strategies (e.g., anger management training) so they can apply what they already know. This distinction has been lost in many intervention efforts What does the treatment research suggest?

There is no doubt that psychostimulants (e.g., methylphenidate) are the most effective treatment to reduce socially aversive and disruptive behaviors in children with AD/HD. Unfortunately, medication-related

improvements will not make these children better liked (i.e., peer rejection remains relatively unaffected). There are several explanations for this disappointing fact. Once disliked, improved social behavior following medication tends to be discounted by peers who are already "turned off." Second, the short-acting effects of psychostimulants can leave the child in a non-medicated state during school periods when children most likely engage in unsupervised free-play (e.g., lunch and recess or when school is dismissed). Our research (Day & Landau, 2002) provides a potential third explanation: the child's medication status at school may be stigmatizing in itself, and this may further reveal to others the "unusualness" of a child with AD/HD. This stigma is then exacerbated when classmates witness, due to the short half-life of some medications, both improved and deteriorating behavior

throughout the school day.

Because of the above, we must assume medication alone will not address the peer problems of children with AD/HD. However, while on medication, these children may be more responsive to psychosocial (i.e., non-pharmacological) interventions in school. These other programs, which include anger management, attribution retraining and behavior management in the classroom (especially response-cost and timeout) should be used in conjunction with medication (see Landau et al., 1998, for a review of relevant psychosocial or social skills training programs).

We offer the following suggestions:

- Parents should not assume their son or daughter is without peer problems simply because the teacher has not reported such.
- If a child with AD/HD is having peer problems, assume they may be chronic and

require systematic intervention. Many social skills training (SST) packages were designed for 10-12 sessions and to be dispensed once per week. This is insufficient: an on-going intervention for the entire school year may be necessary.

- There are no known SST interventions designed explicitly for children with AD/ HD. As such, the nature of peer difficulties of each child should be assessed, and a treatment selected based on the strengths and limitations of each child.
- Best evidence indicates SST programs should be delivered in small groups (i.e., 4-8 same gender classmates), not one-onone. This will increase the chance for positive feedback from peers and successful transfer from the training group to the classroom. In addition, some of the more popular children should also be included in these groups. Their presence may reduce the stigma of participating and help their less popular peers interact more positively with the other students.

 SST objectives should be infused in all classroom activities. For example, if the child with AD/HD is trained to self-monitor and keep a daily log of interpersonal conflicts, this should be done throughout the school day and prompted by the teacher when necessary. The trainer must communicate regularly with teachers so training objectives can be reinforced by all adults in school.

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■ Parents should be involved in these interventions through home/school collaboration. This will strengthen school-based success and aid transfer to social activities after school. The SST described by Sheridan, Dee, Morgan, McCormick, and Walker (1996) provides an excellent example of parent involvement.

If an individual assessment of social problems is conducted and an intervention is planned involving teachers and parents, and the child's unique characteristics (i.e., not relying on packaged programs), there is reason to remain hopeful that the disturbed

peer relations of children with AD/HD can be addressed.

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References

Barkley, R. A. (1997). Behavior inhibition, sustained attention, and executive functions: Constructing a unifying theory of AD/HD. Psychological Bulletin, 121, 65-94.

Day, J. & Landau, S. (2002). The message of medication: Peer perceptions of persistence, treatment acceptability, and social acceptance of a boy with AD/HD. Unpublished manuscript.

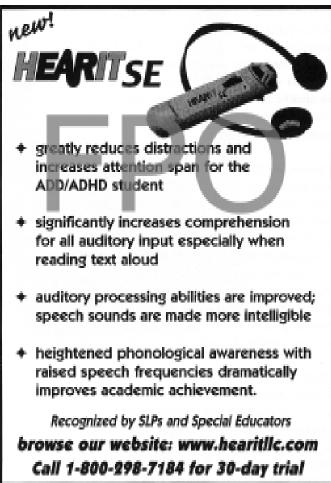
Landau, S., Milich, R., & Diener, M. B. (1998). Peer relations of children with attention-deficit hyperactivity disorder. Reading and Writing Quarterly: Overcoming Learning Difficulties, 14,

Putallez, M. & Gottman, J. (1983). Social relationship problems in children: An approach to intervention. In B. Lahey and A. E. Kazdin (Eds.), Advances in clinical child psychology (pp. 1-43). New York: Plenum Press.

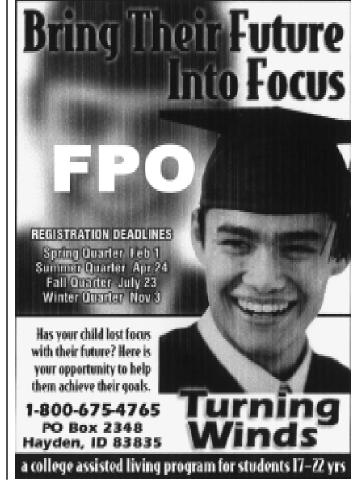
Pfiffner, L. J., Calzada, E., & McBurnett, K. (2000). Interventions to enhance social competence. Child and Adolescent Psychiatric Clinics of North America, 9, 689-709.

Sheridan, S. M., Dee, C. C., Morgan, J. C., McCormick, M. E. & Walker, D. (1996). A multimethod intervention for social skills deficits in children with AD/HD and their parents School Psychology Review, 25, 57-76.





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