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Social and Emotional Skills Development for ADHD

Tarika Goel

Department of Psychology (Shift II), Women's Christian College, Chennai, India
Email: *taru.goel2003[at]gmail.com*

Abstract: ***Attention Deficit Hyperactivity Disorder is characterized by a persistent inability to sustain attention on tasks as well as a pervasive pattern of hyperactivity / impulsivity. ADHD is evident in childhood years and hence is a developmental disorder. The present case study is of a client aged 10 diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). A Mental Status Examination was conducted and a comprehensive report is presented. The presenting complaints of the client include distractibility, inattention, communication and academic concerns, and anger outbursts. Problem areas were identified and treatment plans are recommended. Interventions were designed to target the specific issues of a lack of social and emotional skills. The interventions were shown to be effective as the client exhibited an improvement in said skills after the intervention. The implications of such effectiveness are important in clinical settings as well as for parents and teachers.***

Keywords: ADHD, Social Skills Training, Emotional Skills Training

1. Introduction to Attention-Deficit/ Hyperactivity Disorder

Attention Deficit Hyperactivity Disorder (ADHD) is a common neuro-behavioral disorder, characterized by inattention, over activity, and impulsivity, and is most frequently identified and treated in primary school. People with this disorder have a great deal of difficulty sustaining their attention on a task or activity (Taylor, 2012). As a result, their tasks are often unfinished and they often seem not to be listening when someone else is speaking. In addition to this serious disruption in attention, some people with ADHD display motor hyperactivity. Children with this disorder are often described as fidgety in school, and unable to sit still for more than a few minutes. Such restlessness in a classroom can be a considerable source of concern for teacher and peers, who can get frustrated by their impatience and excessive activity. In addition to hyperactivity and problems sustaining attention, impulsivity—acting apparently without thinking—is a common complaint made about people with ADHD (Nolen-Hoeksema, 2013a).

ADHD is considered a chronic and debilitating disorder and is known to impact the individual in many aspects of their life including academic and professional achievements, interpersonal relationships, and daily functioning (Harpin, 2005). ADHD can lead to poor self-esteem and social function in children when not appropriately treated (Harpin et al., 2016). Adults with ADHD may experience poor self-worth, sensitivity towards criticism, and increased self-criticism possibly stemming from higher levels of criticism throughout life (Beaton, et al., 2022).

Some children with ADHD tremendous trouble learning socialization skills in helping them to pay attention, control their impulses, and organize their behaviors so that they can accomplish long term goals (Nolen-Hoeksema, 2013b).

The symptoms of ADHD include a persistent pattern of inattention and/or hyperactivity that interferes with functioning or development.

Treatment of attention-deficit/hyperactivity disorder:
Treatment for ADHD has proceeded on two fronts: psychosocial and biological interventions. Psychosocial treatments generally focus on broader issues such as improving academic performance, decreasing disruptive behavior, and improving social skills. Typically, the goal of biological treatments is to reduce the children's impulsivity and hyperactivity and to improve their attention skills (Barlow & Durand, 2013a).

Demographic details of the Client

Initials	JSV
Age	10
Sex	Male
Education	IVth Standard
Socioeconomic Status	Middle-Class
Employment	Student
Marital Status	Unmarried
Diagnosis	Attention-Deficit/ Hyperactivity Disorder
Source Of Information	Case File

Presenting Complaint
The presenting complaints of the client include getting easily distracted, significant inattention concerns, writing difficulty, academic concerns, communication concerns, anger outbursts, and age-inappropriate behavior.

Duration of the Complaint
The above-mentioned complaints have been prevailing since the client's early life.

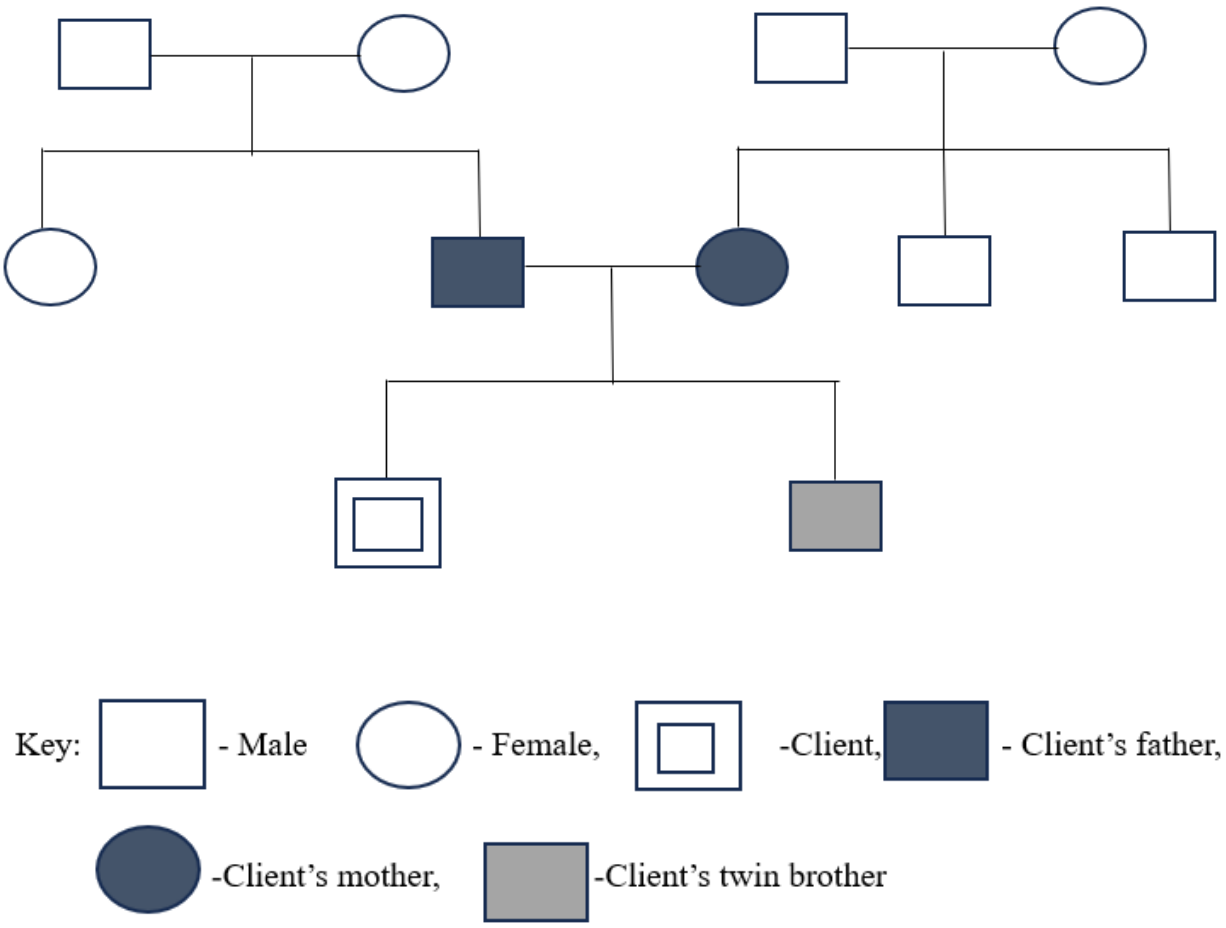
History of the Complaint
When the client was 2 and a half years old there were complaints regarding sensitivity to sounds and social interaction difficulties. The primary complaints of the client such as distraction, communication concerns, academic difficulties have been present since early in life.

Prenatal and Early Years
The client was born out of non-consanguineous union and no complications were present during the pregnancy. The client was a pre-term baby delivered through cesarean

delivery. Immediate birth cry was present and the client had a low birth weight of 1.1 kg. The client was kept in NICU as he had neonatal jaundice and he received phototherapy for it. The client's milestone developments were normal but later there were deteriorations in speech. There is no reported history of seizure or head injury or high grade fever for the client.

Family History

The client's parents are well-educated. The client's mother is a teacher and his father is an IT professional. The client has a twin brother who attends a normal school. There is a history of delayed speech in the family. Figure 1 represents a genogram highlighting a pictorial representation of JSV's family tree and genetic lineage.



Educational History

The client's schooling started at the age of two and a half years in play school which was followed by regular schooling. There were complaints from the school regarding his mingling issues and sensitivity to sounds. Currently, the client is in the IVth standard and is studying in a special school for children with learning disabilities and other mental disorders such as ADHD and autism spectrum disorder. The client does not have any friends at the school and does not initiate conversation or play with his peers.

Occupational History

This is not applicable to the client as the client is a child.

Marital and Sexual History

This is not applicable to the client as the client is a child.

Medical History

There is no history of any medical illness or medication for the client.

Premorbid Personality

As the client's complaints developed very early in life, after his birth, an illustration of premorbid personality is not applicable.

Mental Status Examination

Appearance and Behaviour:

The client was well-groomed and appropriately dressed for the setting. The client fidgeted with his hands and objects kept on the table and appeared to be distracted. The client did not make eye contact and stared straight ahead or frequently shifted his gaze. The client's posture was slouched and his gait was very slow. The client's facial expressions were very neutral, devoid of any emotions.

Thought Process and Thought Content:

The client spoke slowly and very softly and his speech was slurred. The client took long pauses before responding, as he seemed to drift away in his thoughts. The client spoke in very short sentences and seemed uninterested in talking.

Although the client spoke in short sentences, he was able to present the same in a coherent manner. Self-talk was present in the client. The client exhibited thought derailment as he showed diversion to irrelevant topics and had to be brought back to the ongoing conversation. The client's content of speech showed no evidence of hallucinations or delusions.

Mood and Affect:
The client's predominant mood was uninterest. Flat affect was observed in the client. The client's affect was appropriate to his mood and speech.

Intellectual Functioning:
The client has good reading and writing ability which is, however, below average for his age. The client has difficulty with spelling some words correctly. The client showed less than average performance in immediate memory during the forward and backward digit span test. The client was able to count backwards from a particular number. The client exhibited below-average intelligence.

Sensorium:
The client had an awareness of his surroundings as well as an awareness of self. The client exhibited a distorted orientation in terms of time period as he did not seem aware of the current year.

2. Summary

The client JSV is a 10-year-old male diagnosed with Attention-Deficit/Hyperactivity Disorder (ADHD). The presenting complaints include distractibility, inattention, communication and academic concerns and these complaints have been prevailing since the client's birth. There is a family history of delayed speech and the client experienced deterioration in speech early in life. The client is currently enrolled in a special school and does not engage in social interactions or have any friends. His gait is slow and he often drifts away in his thoughts and exhibits thought derailment. The client has been diagnosed by a psychiatrist in the past as having borderline or below-average level of intelligence with an IQ of 72. The client has a distorted orientation of time but is aware of his surroundings and self.

3. Treatment Recommendations

The following are some treatment recommendations for the client:

- The client has significant issues with attention and is prone to distraction. Thus, tasks or strategies to enhance attention and minimize distractibility can be implemented to manage this complaint. This could include introducing timers as the client is performing a task; having a clutter-free study space to reduce distractors; giving a single, simple instruction at a time or performing outdoor activities including exercise on a regular basis.
- Socializing skills can be inculcated in the client which can encourage interaction and communication with peers and the development of friendship with other students at the school.
- Individual attention should be given to the client to help with academic concerns of reading and writing.
- As the client has difficulties in managing emotions, regulation of emotions can be taught to the client in an age-appropriate manner to facilitate greater awareness and more sustainable management of emotions.
- Introducing physical activity in the client's daily routine at home and/or school can help alleviate some symptoms of ADHD and enhance executive functioning as well.

Treatment Plan
An in-depth analysis of JSV's case has led to the identification of the following problem areas:
1) Lack of social communication skills
2) Lack of emotional regulation skills

In line with the above problem areas, the following treatment plans were proposed:
1) Social skills training.
2) Emotional skills training.

Goals:
1) To help the client initiate social interaction and learn the rules of social interactions.
2) To help the client recognize and manage emotions in a healthy manner.

Treatment Plan

1) Social Skills Training
The client seems to lack social communication skills such as those of maintaining eye contact, initiating conversations, mannerisms, etiquette, social rules and making friends. Thus, the treatment plan was to conduct social skills training with the client, encompassing a broad range of skills that are expected of an individual in different social contexts.

The essential skill of maintaining eye contact was targeted first. For this, the client was shown animated photos of two individuals speaking to each other while maintaining eye contact. In the photographs, a line was drawn connecting the eyes of one speaker to those of the other to direct the attention of the client towards their eye contact. The similarity between all the photos was pointed out, which was that the individuals were looking into each other's eyes while speaking. It was also specifically pointed out that the people talking to each other are not looking elsewhere but are looking only at each other. This approach was used as looking at the images could give the client a better understanding of how to be while talking to someone and thus facilitate better learning of the skill of eye contact because of the visuals and colours as that could engage the client more. Then, the client was asked to look into the eyes of the facilitator throughout the entire session and whenever the client broke eye contact for a brief period of time, the facilitator asked the question, "Where should you look when someone is talking to you?" and this would help the client maintain eye contact again.

Next, the client was introduced to the different ways of greeting people and initiating conversations, such as by saying "Hi, how are you?", "Good morning", "Hello". The client was also taught how to introduce himself while starting a conversation with someone including his name, his age and his hobbies, for example, "Hi, my name is JSV, I'm

10 and I like to play video games." Subsequently, the client was shown animated videos of individuals initiating conversations and engaging in it while asking questions and sharing information with each other, such as about their hobbies, about their family, their favourite books/movies, food, subject, etc. This approach was included as it could have helped the client learn and remember the skills better by observing and hearing people perform those skills, rather than just being explained.

The client was then introduced to the concept of taking turns while interacting with someone. For this, a pencil was taken and the client was instructed that the person who has the pencil in his/her hand is allowed to speak while the other person will listen to what is being said. The pencil was moved back and forth between the client and the facilitator as each person spoke. Children with ADHD tend to interrupt conversations and speak out of turn. Thus, this exercise was to help the client learn how to wait for their turn and listen while the person speaks and then speak during their turn.

The next aspect of social skills training included imparting knowledge of manners and etiquette that is, expected behavior in social situations. For this, index cards were shown to the client. Each index card included "Thank You", "Please", "I'm sorry", "You're welcome", and "Nice to meet you". The index cards were shown one by one and the situations in which the respective phrase is used were discussed. The concept of personal space was also introduced to the client. It was explained that every individual has their own space and that individuals should not get too close to each other. Short statements were read out in which the individuals performed a behavior which was socially not acceptable. The client was asked to identify what the individual's mistake was and how they should have behaved instead. The following were the statements that were given-

- Andrew was playing in a park when Alex bumped into Andrew. Andrew felldown while Alex walked away and continued to play near the slide. What was Alex's mistake and what should Alex have done after bumping into Andrew?
- Priya and Alia were sitting together in class. Priya grabbed Alia's eraser from her hand and started to use it. What was Priya's mistake and what should she have done instead?
- Some guests visited Akshay's house. Akshay ran into his room as soon as they came, without meeting them. What should Akshay have done instead?
- 2 women were talking and a third woman interrupted one of them while they were talking and started talking to them. What was the woman's mistake and what should she have done instead?

The client was able to answer the first and the third questions but not the second and fourth ones so, it was explained to the client how the behavior exhibited by the individual in the story was wrong and how they should have acted instead, such as in the second one by asking for permission and in the fourth one by saying "Excuse me". This aspect of the treatment plan also aimed at reinforcing manners and etiquette expected in social situations.

Then, role-playing was conducted wherein first, the facilitator took on the role of a person, such as a new friend, with whom the client asked to initiate conversation. It was observed that while making conversation, the client maintained eye contact on his own, indicating the effect of the first aspect of the treatment, which was establishing eye contact. Then, the client initiated the conversation by saying "Hello, my name is JSV. I study in 4th grade and my hobbies include playing games with dinosaurs." As the conversation progressed, it was observed that the client did not speak out of turn but waited for the facilitator to respond first. Thus, the aspect of the intervention that targeted this skill seemed effective as the client executed it without being told to do so. The client also asked the facilitator about her favourite subject, movies and hobbies, thus indicating that the client incorporated the aspect that targeted sharing of information. The next part of the assessment aimed at determining the effectiveness of the treatment plan aimed at manners and etiquette.

For this, a cardboard was divided into four quarters. Each quarter contained a picture of a social situation along with a question about how one should behave in that particular situation. The following were the situations included in the manners chart along with the questions that were asked and the response given by the client-

- In the first picture, a boy was sitting in class when a classmate walked up to him. The question was how should the boy greet and initiate a conversation with the classmate? The client answered that he would say Hi, how are you? Do you want to sit next to me?
- In the second picture, there was a long queue outside a store and a boy had just arrived at the store. The question was whether the boy should stand at the back or break the queue. The client responded that he should go to the back of the line and wait until his turn arrived.
- In the third picture, two men were talking and a boy wanted to talk to one of them. The question was how should the boy do so? The client answered that the boy should say "excuse me" first.
- In the fourth picture, there was an individual sitting on a bus with empty seats next to him. The question was, if someone entered the bus, should they sit right next to the stranger? The client said that they should sit away in the empty seats farther from the stranger already sitting. When the client was asked the reason for his answer, he said that they should not get too close to the stranger.

Therefore, the client was able to answer all the questions accurately which reflected an incorporation of the knowledge of mannerisms and etiquette which was imparted to the client during the intervention.

2) Emotional Skills Training

The first aspect of emotional skills training included emotional recognition. A paper was presented to the client with pictures of certain emotional expressions on one side and the names of the emotions on the other side, such as happy, scared, nervous, shy, excited, angry, disgusted, and confused. The task was to match the expression to the respective emotion. The client made a few errors but was able to match most of the expressions to their emotions. The errors were identified and explained to the client by showing

more photographs of those emotional expressions until the client was able to redo the task accurately. Different scenarios were discussed along with the emotion that would be applicable in that scenario. The client was unable to recognize those emotions so, the task was made simpler by giving examples to the client of emotions and when they are likely to occur— happiness occurs in a scenario where you feel good such as when someone praises you, sadness in a situation when something goes wrong such as if one's toy breaks, anger when one is frustrated like when someone takes your things without asking, excitement when you look forward to something such as going out, scared such as when one watches a horror movie or has to give a speech in front of people and so on.

The client had a tendency to have anger outbursts and react strongly when things did not go his way. He was susceptible to getting upset frequently. Thus, emotional management was the next aspect of emotional skills training that was aimed at. The client was first asked how he usually behaves when he is angry to which the client responded that he often yells and sometimes even hits someone. To target this, the client was asked to read the following story-

"There was a boy, Peter. When something happened that Peter did not want, he would get very angry. However, Peter had a special secret to manage his anger. When he sensed his anger was increasing, Peter would inhale deeply and would count to 10. Every time he inhaled and exhaled, he noticed that his anger would reduce. Peter learned that this method of inhaling and exhaling was like magic, which helped him deal with his anger. So, whenever Peter felt angry, he could recall his secret and was able to manage his anger."

The above story was then discussed with the client. The client was asked what Peter did when he was angry. It was pointed out that the boy did not yell or hit but rather took a few deep breaths and counted to 10 and that this method helped him. This way, the client was taught a more adaptive way of coping with his anger.

The client was asked if he would ever share his sadness or anger with anyone and he responded that he wouldn't. So, the next phase of emotional skills training included the sharing of emotions, highlighting the importance of social support in coping with difficult emotions. The following story was read by the client- "Once, a girl was very sad and she went to her mother and told her why she was sad. The girl then felt better and she also smiled. She realised that sharing her sadness with someone made her feel better and so, every time she was upset, she would talk about it with someone." This story aimed at imparting the importance of sharing emotions which the client would not usually do.

The intervention for emotional skills training also included empathy that is, recognising how another individual would be feeling in a particular situation. For this, the client was first asked how would he feel in a certain situation such as when he saw a horror movie, when he was frustrated or was going to an arcade and other such situations which would involve a situation. The client was then asked if he could feel these emotions others could too. Then, the following situations were discussed with the client-

- In a movie, a boy's pet dog gets stolen and he desperately tries to search for him but is unable to find him.
- A girl takes part in a competition and wins first prize.
- A boy breaks his classmate's toy.
- Andy was going on a vacation tomorrow.

The above situations were analyzed in terms of the emotion that the individual would have felt. The client was able to accurately judge what emotion the individual would feel as he was first asked to apply the situation to himself and then to the respective individual.

As part of an assessment for emotional recognition, the client was presented with a few statements such as

- A friend invited you to a party. How does that make you feel?
- You scored a low grade. How would you feel?
- Your parents told you that you will be going to an amusement park soon. How does that make you feel?
- Your parents got you a surprise gift on your birthday. How would that make you feel?

The client was asked to label these emotions and the client did so accurately. This was in contrast to earlier when the client was unable to identify emotions when asked but as the client was given examples and was imparted the skills of such recognition, he was able to judge the situation well for its emotional consequences.

Towards the end of the intervention, the client was asked how he would behave when he would get angry. The client responded that he would breathe in and out and count to 10. This response was significantly different to the client's response in the beginning wherein he said he would yell and throw tantrums. Another question was presented to the client– would he share his feelings with someone such as a parent or keep them to himself and the client chose the former, saying that he would feel nice if he spoke about it.

Thus, the first goal of helping the client initiate social interaction and learn the rules of social interactions was met as the client demonstrated eye contact, was able to perform adequately in a role-playing scenario, and demonstrated knowledge of mannerisms and etiquette during post-treatment assessment. These behaviors were observed as lacking earlier but improved as a result of the intervention. The most significant improvement was seen in the maintenance of eye contact as observed in the subsequent sessions with the client, without him being prompted to do so.

The second goal of helping the client recognize and manage emotions in a healthy manner was also met as the client showed greater emotional recognition skills towards the end of the treatment along with exhibiting better knowledge of adaptive coping mechanisms for managing emotions.

For the treatment plans, the client was provided with reinforcement each time he responded with the right answer or each time he cooperated. The reinforcers included colorful index cards with encouraging phrases such as "Good job", "You did well", "Amazing", "Phenomenal" and "Excellent" which served to motivate the client.

4. Implications

The effectiveness of the interventions implemented provides implications for clinical settingswherein the applications of such treatment can facilitate the social and emotional development of children with developmental disorders in whom such skills are lacking. Even for those children in the nonclinical populations, such skill training can be useful tools for teachers and parents.

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