
BRIEF REPORT

Adaptation of the Children's Friendship Training Program for Children with Fetal Alcohol Spectrum Disorders

Elizabeth A. Laugeson
Blair Paley
Amy M. Schonfeld
Erika M. Carpenter
Fred Frankel
Mary J. O'Connor

Elizabeth A. Laugeson, PsyD, is Child Psychologist and Postdoctoral Fellow, Department of Psychiatry and Biobehavioral Sciences; Blair Paley, PhD (E-mail: bpaley@mednet.ucla.edu), is Associate Clinical Professor, Department of Psychiatry; and Mary J. O'Connor, PhD, ABPP (E-mail: moconnor@mednet.ucla.edu), is Adjunct Professor, Department of Psychiatry and Biobehavioral Sciences; all are affiliated with the Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine, 760 Westwood Plaza, University of California, Los Angeles, CA 90024.

Amy M. Schonfeld, PhD, is Clinical Psychologist, 468 Pennsfield Place, Suite 200, Thousand Oaks, CA 91360 (E-mail: amyschonfeld@gmail.com).

Erika M. Carpenter, PhD, Harbor Regional Center, 21231 Hawthorne Boulevard, Torrance, CA 90503 (E-mail: drerikacarpenter@yahoo.com).

Fred Frankel, PhD, ABPP, is Professor in Residence, Department of Psychiatry and Director of the Children's Friendship Program, Department of Psychiatry and Biobehavioral Sciences, 300 Medical Plaza, Suite 1402, University of California, Los Angeles, CA 90095 (E-mail: ffrankel@mednet.ucla.edu).

Address correspondence to: Elizabeth A. Laugeson, Department of Psychiatry and Biobehavioral Sciences, Semel Institute for Neuroscience and Human Behavior, David Geffen School of Medicine, 760 Westwood Plaza, Ste. 68-230, University of California, Los Angeles, CA 90024 (E-mail: elaugeson@mednet.ucla.edu).

ABSTRACT. Previous research attests to the marked impairments in social functioning exhibited by children with Fetal Alcohol Spectrum Disorders (FASD), suggesting that such children are in need of social skills intervention. Recently, an existing evidence-based manualized behavioral treatment for improving children's friendships was implemented and demonstrated to be effective with children aged 6-12, diagnosed with FASD. In the present report, we describe methods for adapting this behavioral intervention in line with the specific cognitive and behavioral deficits seen in children with FASD and other developmental disabilities to enhance treatment efficacy. doi:10.1300/J019v29n03_04 [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-HAWORTH. E-mail address: <docdelivery@haworthpress.com> Website: <<http://www.HaworthPress.com>> © 2007 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Fetal Alcohol Spectrum Disorders, Fetal Alcohol Syndrome, developmental disabilities, friendship, social skills, social skills training, behavioral intervention, manualized treatment, treatment adaptation, treatment modification

INTRODUCTION

The term Fetal Alcohol Spectrum Disorders (FASDs; Warren et al., 2004) is currently used to define the full range of physical anomalies and developmental disabilities associated with exposure to alcohol in utero (Streissguth & O'Malley, 2000). Although Fetal Alcohol Syndrome (FAS), defined by a characteristic pattern of facial anomalies, growth retardation, and central nervous system abnormalities (Jones & Smith, 1973), represents the most severe manifestation on the spectrum, behavioral teratogenesis is evident in individuals without the full syndrome but who nonetheless experience significant neurocognitive and behavioral problems (Stratton, Howe, & Battaglia, 1996; Mattson & Riley, 1998). The incidence of FASDs is estimated to be 1 in 100, indicating these disorders represent a significant public health concern (May & Gossage, 2001).

Perhaps as a consequence of their neurocognitive and behavioral problems (Mattson et al., 1999), children with prenatal alcohol exposure also exhibit considerable social skills deficits, including failure to consider the consequences of actions, difficulty understanding social cues, indiscriminant social behavior, and difficulty communicating in social contexts

(Carmichael-Olson et al., 1998; Carmichael-Olson, Morse, & Huffine, 1998; Streissguth, 1997). Moreover, researchers have found that children with prenatal alcohol exposure are more impaired interpersonally than other developmentally delayed children, suggesting that social deficits in these children are not simply a consequence of their cognitive deficits (Thomas et al., 1998; Whaley, O'Connor, & Gunderson, 2001).

Importance of Social Skills Training for Children with FASDs

Poor peer relationships have been associated with increased risk for juvenile delinquency and early withdrawal from school (Kupersmidt, Coie, & Dodge, 1990; Paetsch & Bertrand, 1997; Patterson et al., 1998). Studies of adolescents and adults with FASDs indicate that social deficits such as poor choices in peer relationships are maintained well past childhood (LaDue, Streissguth, & Randels, 1992; Streissguth, Aase, & Clarren, 1991) and may be contributing factors to delinquency and school failure (Schonfeld, Mattson, & Riley, 2005), thus representing a particularly important area for early intervention. Early identification has been shown to result in more positive outcomes for individuals with prenatal alcohol exposure (Streissguth et al., 2004); however, FASDs are often undiagnosed and systems are commonly ill-equipped to serve these individuals (Forness & Kavale, 1997; Kavale & Forness, 1998), resulting in few appropriate treatment options for them.

Modifying Children's Friendship Training (CFT) for Children with FASDs

Recent meta-analyses of the literature suggest that previous social skills training programs do not produce large, socially meaningful, long-term, or generalized changes in social competence among individuals with developmental disabilities (Gresham, Sugai, & Horner, 2001). The limited efficacy demonstrated by such programs may be because of omitting parents as an integral part of the intervention, not teaching ecologically valid social skills, and not including homework assignments/homework review as part of the treatment sessions. CFT addresses, each of these limitations (Frankel & Myatt, 2003). One might argue that previous social skills programs used with children with developmental disabilities have not incorporated accommodations for the particular learning difficulties and/or cognitive deficits of the patient population. This limitation was addressed by modifying CFT with specific treatment adaptations

to account for social, cognitive, and behavioral impairments common among children with FASDs. The modifications of CFT were demonstrated, on a randomized controlled sample of 6- to 12-year-old children with FASDs, to result in improvements in social performance and a decrease in problem behaviors in both parent and teacher reports (Frankel et al., in press; O'Connor et al., 2006) and were sustained over a 3-month follow-up period (O'Connor et al., 2006). The present paper describes specific modifications made to the program to enhance its efficacy with this particular population of children.

Description of CFT

CFT is a manualized, evidence-based social skills intervention developed by Frankel and Myatt (2003) that has been field-tested on over 1000 children in multiple clinical and research settings, and has been shown to be effective for children with autism spectrum disorders (Frankel & Myatt, in press), attention-deficit/hyperactivity disorder, and oppositional defiant disorder (Frankel, 2005; Frankel, Myatt, & Cantwell, 1995; Frankel et al., 1997). A central component of CFT is parental assistance to children in establishing social networks and in practicing newly learned skills outside of the social skills group. Owing to the cognitive limitations and emotional and behavioral difficulties of children with FASDs, the researchers anticipated that parental involvement would be a particularly important aspect of treatment.

Targeted skills. CFT focuses on critical child and parent behaviors that have been shown to discriminate accepted children from rejected children, including social network formation with the aid of the parent (Parke et al., 1994); informational exchange with peers, which lead to common-ground activities (Black & Hazen, 1990); peer entry into a group of children already at play (Gelb & Jacobson, 1988); in-home play dates, which are supervised by parents (Frankel, 1996); and conflict avoidance and negotiation (Rose & Asher, 1999; Fonzi et al., 1997). These skills are taught using validated intervention strategies, including didactics in a small group setting, modeling, coaching, behavioral rehearsal, performance feedback, and parent-assisted homework completion (Elliot & Gresham, 1993). In CFT, children and parents attend separate but concurrent sessions that are 60-minutes in length and meet weekly for 12 weeks. The parent and child sessions are each led by a group leader, and the child group has 1-2 coaches to assist in behavioral management and in providing performance feedback to the children. A comprehensive description of the manualized intervention can be found in Frankel and

Myatt (2003), and results of the adapted treatment are discussed in Frankel, Paley, Marquardt, and O'Connor (in press) and O'Connor et al. (2006).

TREATMENT ADAPTATION FOR CHILDREN WITH FASDS

A description of the treatment adaptations is organized in the following section according to the specific areas of deficit frequently observed in children with FASDs.

Language and Learning Difficulties

To address difficulties in expressive and receptive language, verbal learning, and memory frequently exhibited by children with FASDs (Schonfeld et al., 2001), a number of steps were taken to promote comprehension of the material.

Breaking down material into simpler components. Children were taught the rules of appropriate social behavior by breaking down material into simpler, smaller components. For example, in the adapted treatment, the rules for peer entry were broken down into three basic steps: (1) Watch, (2) Wait, and (3) Ask; thereby making the steps easier to recall.

Increased opportunities for exposure to and rehearsal of new material. The original manualized intervention typically involves the presentation of material in a brief interactive model, with the focus upon in-session behavioral rehearsal and parent-assisted homework assignments. The adapted treatment outlines how coaches would have children repeat the rules and steps of each lesson during relevant real-play activities and during reunification with parents at the end of the group. In addition, children were asked to repeat steps/rules immediately following the didactic lessons to aid comprehension and retention.

Presentation of information in multiple formats. To address difficulties with verbal learning, material was presented in multiple formats to enhance learning. In the adapted treatment, material was not only presented orally but also written in simple language on a blackboard for children to read and review. Parents were also encouraged to use both verbal and nonverbal modes of communication when prompting the children during homework exercises.

Use of buzzwords. The adapted intervention featured simple key phrases that conveyed more complex social skills concepts, known as “buzzwords.” Buzzwords were incorporated into the intervention to assist children in remembering basic steps and rules of appropriate social behavior and to provide a common language for parents, coaches, and group leaders to communicate those rules. By using “buzzwords,” parents were able to coach their children unobtrusively, while still providing performance feedback during critical teachable moments.

Summarizing children’s responses. In an effort to review the children’s homework efforts in a manner that could be understood by all of the children in the group, the child group leader would succinctly summarize each child’s response. Essentially, the child group leader would allow children to describe their attempts at homework completion and would then reflect back the steps followed by the children so that other group members could understand what was being communicated.

Use of simpler language appropriate to the children’s developmental level. Verbal material was modified to be consistent with the children’s developmental level to facilitate better understanding and recall of concepts. Analogies, metaphors, and figurative language were avoided, since the children with FASDs were observed to have difficulty understanding abstract language.

Memory and Executive Functioning Difficulties

Several strategies were used to accommodate the deficits in executive functioning seen in children with FASDs (Rasmussen, 2005), including problems with working memory, planning and sequencing, flexibility, inhibition, and task initiation.

Increased use of verbal prompts. To address working memory deficits, additional verbal prompts were used to increase children’s abilities to retain and manipulate multiple pieces of information as they attempted to achieve various social goals. For example, children who were unable to recall the various steps of peer entry were provided with verbal cues to help them recall and apply those steps.

Role-playing. The CFT procedure calls for role-playing to model and provide practice with a number of social scenarios. The adapted treatment utilized role-playing to a greater extent than the original program in order to augment learning. Role-plays typically depicted just one rule or step from the lesson, rather than an entire series of behaviors in a social repertoire. Appropriate social behaviors were enacted to be more easily identifiable, whereas inappropriate behaviors were exaggerated.

The group leader would model various social behaviors with a coach, and children were asked to identify what was right or wrong with the role-plays. Children were then given the opportunity to practice the behavior themselves during behavioral rehearsal with one another.

Homework rehearsal and review. In order to facilitate the children's ability to remember rules of social behavior, parents were encouraged to review the specific steps of a homework assignment with the child before they attempted it, relying on the use of "buzzwords" for instruction and review. Additionally, to help children learn from and remember their homework, parents would review the details of the homework attempt with their child immediately after it was completed. This allowed parents to provide performance feedback while the memory of the scenario was still fresh in the child's mind. It also facilitated later recall when the child was asked about the homework assignment by the child leader. In some cases, parents were also instructed to review with their child the previous week's homework immediately before the session to promote increased memory during the session.

Behavioral Issues

Because children with FASDs often exhibit difficulties with impulsivity, response inhibition, and understanding contingencies, an effort to minimize the impact of these problems was made through the use of a number of structural and behavioral modifications.

Regular review of clear and explicit rules. CFT outlines simple specific rules for group behavior. These were established and reviewed at the beginning of every session in the presence of the parents in order to provide consistent and concrete parameters of behavior. The review of the rules prior to every session and in the presence of parents further augmented the original intervention and was considered necessary as a means of establishing clear expectations for these children. In addition, the rules of outdoor play activities were reviewed in the classroom prior to going outside in order to prepare the children for the transition to a less structured real-play group activity.

Positive reinforcement techniques. The use of stars, tokens, and verbal praise are described in the CFT program to reinforce positive target behaviors. The adapted treatment used these reinforcement techniques more frequently in order to minimize some of the behavioral problems sometimes seen in children with FASDs. The use of concrete reinforcers (i.e., stars, tokens) was also important in making behavioral consequences

more explicit for the children, who were observed to often have difficulty understanding contingencies.

Individualized behavior programs. Some children presented with particularly challenging behaviors in the groups (i.e., tantrums, aggressive behavior, defiance). To increase these children's chances for successful completion of the program, more intensive behavioral interventions were initiated on an individual basis and involved parents' providing incentives for specific behavioral goals. The adapted intervention utilized this technique for a greater number of children than suggested in CFT. Children were informed that if they earned a certain number of stars for good behavior on a given day, they would receive some predetermined desired reward immediately after the session. However, children were also informed that in the event that they received a warning or time-out, they would lose a star, thus setting up a response cost.

Inadequate Play Skills and Peer Networks

Game playing deficits. Many of the children with FASDs had difficulty playing common indoor games (e.g., "Go Fish," "Sorry®") and outdoor activities (e.g., soccer, basketball), likely as a function of their neurocognitive and executive functioning difficulties (Rasmussen, 2005), as well as deficits in their fine and gross motor skills (Kyllerman et al., 1985). Although these types of problems are most likely easily recognizable by peers, many parents were unaware of their child's inability to play certain games or sports. The approach used to compensate for deficits in game playing abilities was the initiation of scheduled game playing time with parents to provide opportunities for the children to become proficient in games they would likely be playing with peers. Parents were also given a list of developmentally appropriate games to assist them in choosing suitable play activities to practice with their child.

Lack of peer networks. As part of CFT, parents are instructed to help establish peer networks for their children; however, many parents in our sample reported that they had exhausted all of their options for finding new playmates for their children because of their children's negative reputations with peers. Parents were advised that they could increase their child's social network by enrolling them in extra-curricular or after school activities (Frankel, 1996). Although this is always a helpful option in CFT for expanding a child's peer network, this method was observed to be of particular benefit to the children with FASDs. Parents were encouraged to enroll their children in activities with other children

of a similar developmental (rather than chronological) age to increase their child's chances for social success and acceptance.

DISCUSSION

This report describes how CFT was adapted to the unique challenges associated with working with children with FASDs. It is important to note that although modifications were made to the original CFT program these modifications primarily involved augmentation in how the treatment was delivered, rather than changes in the content or components of the intervention. That is, the basic integrity of the intervention was preserved, including the focus on developing social skills that have been empirically demonstrated to discriminate accepted from rejected children. Specific adaptations were made that allowed the children with FASDs to learn, retain, and apply these key skills more easily, such as breaking down skills into smaller, more manageable steps, presenting information in multiple formats, and using simple “buzzwords” to cue their memory for more complicated concepts.

This report highlights the value of allowing clinical observations and experience to inform the modification of empirically validated treatments, but also attests to the robustness of the manualized intervention utilized with these children. Although the CFT program had been well established as being efficacious with a variety of children, it had never been tested with children with FASDs, who presented with marked impairments in their cognitive and executive functioning, as well as significant behavioral problems. The ability to modify this program to meet the needs of this particular population of children was likely a function of the fact that the key skills targeted in this program are empirically derived and the rationale for targeting such skills is clearly articulated in the CFT manual. Reviewing homework assignments with parents at the beginning of each session and helping them overcome obstacles to implementation allows CFT to be readily adaptable to a wide variety of populations.

Although CFT is a highly structured program, it also has sufficient flexibility to allow for adaptations in the manner in which key skills are taught. Lack of flexibility may be one of the primary reasons some therapists are reluctant to use manual-based treatments (Addis & Krasnow, 2000), and indeed, manualized interventions may be most efficacious when they can be used in a flexible manner (Connor-Smith & Weisz, 2003). However, in adapting treatments, it is important that such changes be made in a clinically and empirically informed manner, and that careful

consideration is given to whether any changes might compromise the essential integrity of the intervention. In adapting CFT for this sample, group leaders were provided with training on the characteristics of children with FASD. Additionally, all changes were made in collaboration with and under the supervision of the first author of CFT, and all modifications to the program were systematically and clearly documented, as described in this report.

This paper highlights the potential to adapt treatments for children with FASDs or other developmental disabilities by taking into account their particular patterns of deficits. Such an approach will likely be helpful in reducing barriers to treatment and enhancing the generalizability of manualized interventions.

AUTHORS' NOTES

Elizabeth A. Laugeson is the recipient of an NIH-funded fellowship to develop and study an evidence-based social skills intervention for developmentally delayed teens; and a collaborator on a number of studies investigating the effectiveness of social skills interventions for children.

Blair Paley is Co-Principal Investigator on a study to improve education on Fetal Alcohol Spectrum Disorders for medical students and professionals; an Investigator on another study aimed at disseminating a manualized social skills intervention for children with FASD into the community; and Co-Director of the UCLA FASD Clinic.

Amy M. Schonfeld has recently completed a postdoctoral fellowship awarded by the National Institutes of Alcohol Abuse and Alcoholism (NIAAA) studying the effects of prenatal alcohol exposure on neuropsychological functioning and how these effects impact social skills and treatment response following intervention.

Erika M. Carpenter is a postdoctoral fellowship at UCLA; she developed a social skills training program for 4- to 6-year-olds entitled COMPASS, which she now runs as a private clinical and research program in the community. She is dedicated to ecologically valid research, presently conducting autism research for a nonprofit agency.

During the past 17 years Fred Frankel has supervised the UCLA Children's Friendship Training program, which has treated over 1,000 children in over 120 groups.

Mary J. O'Connor's primary research is on the impact of prenatal alcohol exposure on the socioemotional functioning of children. All of her funded studies are designed with the long-term goal of developing best practice models in the prevention and treatment of prenatal alcohol exposure.

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