

## research

# A Clinical Intervention Program for Children with Asperger Syndrome and Their Parents:

## Promoting Children's Social Skills and Parents' Self-Confidence

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Children with Asperger Syndrome (AS) have a strong desire for social contact, yet are often unable to perform successfully in social settings. They have difficulties reading social cues, find most social interactions threatening, and often respond to new social situations in socially inappropriate ways. Consequently, they are often socially isolated, bullied and punished, which aggravates their depression and anxiety. Their desire for social contact can be a strong motivator, and therefore an asset for clinicians and researchers who aim to design successful treatment programs for children with AS.

Regrettably, the research literature describes few intervention programs that have significantly improved AS children's social experiences. Most treatment programs include children with other Autism Spectrum Disorders (ASDs), and programs specifically for children with AS are rare.

I, along with Dr. Leon Sloman at the Centre for Addiction and Mental Health and our colleagues at the Asperger's Society of Ontario, have devised and implemented a social skills program for children with AS and their parents. In addition to addressing the general difficulties of children with AS, we consider each participating child's individual characteristics and needs.

### *Why put children who fear social situations into social groups?*

First, groups enable children to meet peers with similar challenges and interests. This is in line with the views of various researchers, such as Tony Attwood, Ami Klin and Fred Volkmar.

Second, because social situations are difficult for children with AS, a group format emphasizes the children's social difficulties in 'real time,' allowing us to address these difficulties directly during the group's sessions. Third, groups provide an opportunity for each child to develop and practice appropriate social skills within a social context. Finally, a group format allows us to promote good two-way communication between children's and parents' groups and between individual parents and their child.

### *Why have children's groups and parent groups?*

First and foremost, we aim to improve our participants' general quality of life and expose them to social experiences in which they can be successful. We believe parents must be involved in the process of increasing their children's confidence in their ability to function socially by establishing what Dr. Sloman refers to as a "cycle of success—children experience improved relationships with their parents as well as positive social interactions with peers. Improved social skills lead to further positive social experiences and improved social confidence. Parents are an essential part of this cycle, since they are the link with the child's home and school environments and can help their child become more socially competent. If parents feel supported, educated and more confident about their abilities to cope with their AS child, their interactions with their child will improve. To truly impact the child's emotional and social needs, parents must be integrated into the therapeutic process.

### *What happens in the children's groups?*

On average, there are eight children, aged 9-13, in each group. Sessions are 75 minutes long, and run for 12 weeks. The groups are facilitated by highly experienced individuals--social workers, speech-language pathologists, psychiatrists, a psychiatric nurse and graduate-level psychology students. We make the children's groups fun and establish a supportive and accepting environment; we strongly discourage teasing and bullying. A high staff-to-child ratio (usually one facilitator for one or two children) enables us to focus on the individual needs. Every facilitator monitors one or two children for evidence of increased anxiety or any other change in mood throughout the session.

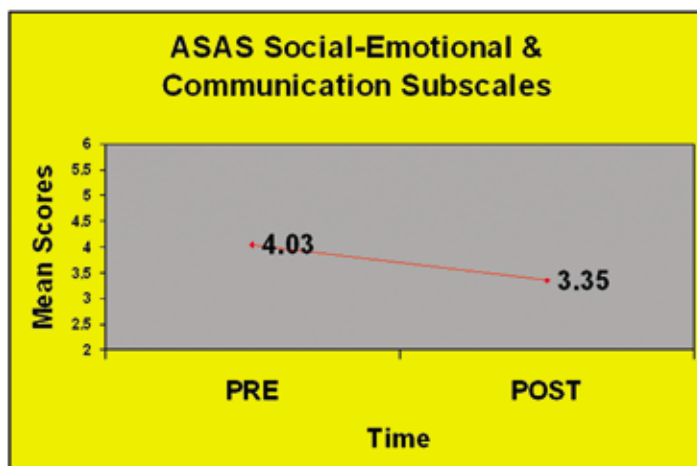


Fig. 1

At the beginning of each 12-week program, facilitators present the parents with a list of difficulties that are typical of children with AS. Each parent ranks these symptoms in order of importance and relevance to their child. With these results, we draw up a curriculum that is relevant to the current group of children, and establish a number of themes to cover in the course of the intervention. Examples include dealing with teasing and bullying, how to compromise, giving and receiving constructive criticism, perspective-taking and self-esteem.

Children share personal stories or events from their lives and participate in discussions and activities relating to each week's theme. Each child negotiates a new goal every week and signs a 'contract' that binds him or her to the goal. If the goal is achieved, the child wins a prize at the end of the session. Goals are social in nature, such as initiating conversation with another child, making eye contact while talking to others, or staying on topic when talking to another child or adult. The last 15 minutes of each session are usually devoted to free play in order to give children the opportunity to practice their individual social goals.

### **What do parents experience?**

The first objective is to educate parents about the main features of AS. The second is to teach them about the variety of ways to respond to their child's problems in socializing, anxiety and depression. The third objective is to teach parents how to advocate for their children in the school system. Groups are facilitated by an overseeing psychiatrist. Guest speakers, including psychiatrists, occupational therapists, and advocates for children in the school system often attend and speak to the parents. Topics in the parent groups include medication, children's and parents' anxiety and depression, and long-term prognosis.

Parents also meet with facilitators of the children's group at the end of each session to discuss their child's behaviour during the session and whether their child achieved his or her individual goal.

### **What we have found thus far: Results and Implications**

We used two measures to detect change over the course of the program. To see whether children's AS symptoms decreased over the course of the intervention, we used the Australian Scale for Asperger Syndrome (ASAS)--a questionnaire that parents fill out about their child's AS features. In analyzing our data from 27 children (21 boys and 6 girls) we have found that there was a general decrease in scores on this questionnaire, especially on the subscales that describe the social, emotional and communication difficulties of children with AS. According to the parents who filled out the questionnaire, there was a decrease in AS social

and emotional symptoms during the course of treatment (see fig. 1).

To measure whether parents benefited from the intervention, parents filled out a questionnaire on Parent Self-Efficacy in the Management of Asperger Syndrome. 'Self-efficacy' refers to the confidence a person feels in their abilities. Up to this point we have analyzed the data of 15 parents and have found that scores on this questionnaire were higher at the end of the intervention than at the beginning. This means that according to this particular measure, parents were more confident in their abilities to deal with their AS child at the end of the intervention than at the outset (see fig. 2).

However, many questions still remain unanswered. Did children learn new social skills, or did the improvement in social symptoms reported by parents result from children's decreased anxiety and improved self-esteem? Did children's more positive mood allow them to interact better socially? Did the positive changes result from improvements in parent-child relationships, regardless of children's AS symptoms?

Despite the limitations of our study, children and parents enjoy our program. Many children establish new friendships, and parents often facilitate these relationships by inviting children to their homes, leading to ongoing interaction outside the group's setting. This is a very significant outcome for these children who were previously socially isolated.

Currently, we have 18 children in our program. As we continue learning from the children and their families, the program evolves and improves. We have added new measures to better assess treatment outcomes, and look forward to analyzing and reporting our findings.

I'd like to thank Autism Society Ontario and Geneva Centre for Autism for awarding me the *Award of Excellence for Student Contributions to Autism Research* in 2004 for my work on this intervention program. ASO's interest in researching AS is vital for our continued efforts to help this population and their families.

## research

If you would like more information about the intervention, or would like to participate in this program, contact Dr. Leon Sloman at the Centre for Addiction and Mental Health, or the Asperger's Society of Ontario. For further information about our ongoing research efforts, contact Jonathan Leef at [j.leef@utoronto.ca](mailto:j.leef@utoronto.ca).

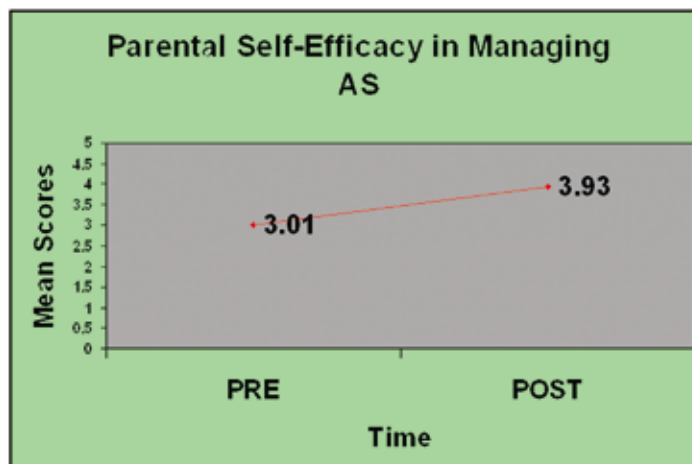


Fig. 2