Chapter 1: Statement of Purpose

Children who suffer from Attention Deficit Hyperactive Disorder (ADHD) usually have poor social perception skills and therefore have a hard time making friends. This research paper will be measuring the way these children feel about their peer group before and after applying an intervention program based on drama therapy techniques that aim to improve social competency. The effectiveness of the social competence intervention program will be evaluated according to the following criteria: the child's ability to communicate with his or her peers and the ability to decode emotions based on facial expression, body language, and vocal cues. This study aims to help children gain a better understanding of the social cues of others, leading to an improvement in their peer relations. Drama therapy techniques such as improvisation and role play will be used to help children gain the tools they need to better understand the responses of others (Guli, 2004). Drama therapy techniques that explore self-expression, positive communication, space and distance, concentration, organization, speech, and symbolism will be used.

Primary research question

Can a social competence intervention program using drama therapy improve peer relations among children with Attention-Deficit Hyperactivity Disorder?

Chapter 2: Literature Review

Children who suffer from ADHD

There are three subtypes of ADHD: predominantly inattentive, hyperactive and impulsive, or combined. About 3-5% of school aged children have one of these forms of ADHD. There is no standard psychometric test that clearly diagnoses ADHD so children are evaluated by parents and teachers based on symptoms noted in behavioural rating scales. Therapies for children with ADHD target areas such as eye contact, social cause/effect, turn-taking, sharing, showing of affection, approaching others, following a conversation, and conflict resolution (O'Regan, 2005).

Some of the symptoms of ADHD include mild deficits in working memory and motor responses, impulsivity, and a slower processing speed. Studies have shown that highly creative individuals who are not diagnosed with ADHD can exhibit ADHD symptoms, especially when it comes to an inability to filter out information.

In 1845, a German physician by the name of Heinrich Hoffman was the first doctor to give a description of attention deficit hyperactive disorder. This then led to nursery rhymes and children stories being written about "Fidgety Phil, Harry Hurricane, and Tommy Tornado" (Hoffman, 1845). Between 1960 and 1969 more emphasis was put on the label ''hyperactive child syndrome'' and between 1970 and 1979 attention deficits were emphasized. It was not until 1980 to 1989 the name became ''ADHD'' and the diagnostic criteria emphasized inattention, impulsivity, and hyperactivity (Wilcoxson, 2005). The frequent changes in the name of this disorder may reveal how uncertain researchers have been about its defining criteria.

According to Mikami and et al. (2007) sluggish cognitive tempo (SCT) is a

syndrome of low alertness and slow processing. It characterizes a distinct subset of children with ADHD-Inattentive type ---perhaps 30%. Growing evidence suggests that children with ADHD-Inattentive type are more likely to be passive and withdrawn around their peers than children with ADHD-Combined type. Therefore children with ADHD-Inattentive types have a harder time making friends and may face more social rejection.

Research by Schredl (2010) showed that the dreams of children diagnosed with ADHD included more threats and misfortunes, and negative outcome towards the dreamer. Dream frequency and length did not differ between children with or without a diagnosis. The results may be due to the fact that children who suffer from ADHD are usually more exposed to discrimination at school, rejection from peers, and a family atmosphere that is characterized by criticism. So their dreams may reflect the reality of their waking world in which others are often perceived as threats.

According to Healey & Rucklidge disruptive disorders such as oppositional defiant disorder occur in 50% of ADHD cases. Anxiety disorders occur in 30% of ADHD cases. Children who are diagnosed with ADHD are often also diagnosed with a learning disability such as dyslexia, dyspraxia, and dyscalculia. Co-morbidity is high and different medications can be used to alleviate symptoms. Most children diagnosed with ADHD are prescribed Ritalin (as cited in Guli, 2004, p. 18).

Medication vs. the ability to play

According to Wheeler (2009) the biomedical perspective supports the idea that ADHD deficits have been linked with particularly low levels of activity in the prefrontal cortex neurotransmitters which control impulses and regulate attention. These dysfunctions are believed to be genetic in 70-95% of cases and can be proved by scientific methods such as neuroimaging.

Psycho-stimulants increase the arousal of the central nervous system and help children become more focused, concentrated, less aggressive, and fidgety. The existence of ADHD as a medical condition is questionable especially since the diagnostic criteria is based on subjective opinion and results in medication being prescribed that have many side effects. The dominance of the biomedical perspective can be attributed to the hierarchy of professions. The medical community of doctors has historically been involved in the assessment and management of ADHD (Wheeler, 2009).

As stated by Wheeler (2009) although the biomedical paradigm suggests neurological dysfunction as the main cause of ADHD, there is no definitive test which can prove the existence of the disorder in a child. Neuroimaging can show the activity of certain neurotransmitters in a child's brain but this does not necessarily prove the child suffers from what is referred to as ADHD.

The diagnosis for ADHD is made using the diagnostic criteria in the *Diagnostic and statistical manual of mental disorders* (DSM-IV). The categories are not based on scientific data but on experts' opinions. The criteria checklist relies on subjective judgements, evidenced by the fact that many children with the same diagnosis display different symptoms.

Labelling a child as suffering from ADHD can have positive and negative effects. Parents may view the label as constructive because it enables access to resources and funding to help the child. Pressure is also sometimes taken off the parents out of their relief that the child's difficulties are not necessarily their fault. Educational institutions receive financial benefits when ''special needs'' funding is allocated to children with the title of ADHD. However at school the labelled child may

then be at risk of being exposed to negative and self-fulfilling attitudes (Wheeler, 2009).

According to Hazell (2002) new research in the UK warns physicians to prescribe psychostimulants with caution. Personal communication with parents and teachers suggests that teenagers give or sell their tablets to peers. Although the volume is likely to be small, teenagers are using Ritalin as a recreational drug or as a study aid. Ritalin gives teenagers an amphetamine-like rush similar to the high received from cocaine. Some parents have also reported that they buy Ritalin for their children in order to boost their performance during exam times because it helps young people stay focused and concentrated.

According to Brock et al (2009) stimulant medication has many side effects and some of the most common include appetite suppression, weight loss, stomach pain, sleep problems, and/or headaches. Many of these side effects go away with time but still need to be monitored closely by a doctor.

Secondary treatments for ADHD include noradrenergic reuptake inhibitors such as Atomoxetine. They take more time to work than stimulants so they have to be taken over a period of several weeks. Noradrenergic reuptake inhibitors are most often prescribed in children with comorbid ADHD and anxiety disorder (Brock et al, 2009). It is also the first medication considered for people with ADHD combined with substance abuse or tics. Similar side effects are experienced as with stimulants with the exception of increased suicidal ideation.

When one medication seems to be ineffective the dose is adjusted or another prescription is tried. It is argued by Brock et al (2009) that further medication has been used to treat children with ADHD even though this form of treatment has not been

approved by the Food and Drug Administration (FDA). This is the use of tricyclic antidepressants and alpha-adrenergic agonists in medical trials. This includes antidepressants such as Wellbutrin, Tofanil, Pamelor and alpha-adrenergic agonists such as Catapres and Tenex.

These medications are mainly prescribed to improve mood and reduce hyperactivity but do not improve memory or attention. Tricyclic antidepressants are mainly used in combination with Ritalin. The same is also true for selective serotonin reuptake inhibitors. In severe cases of ADD Prozac is combined with Ritalin to improve grade point average. The manipulation of serotonin and increase in dopamine seems to make children struggling with ADHD less aggressive and better at social information processing (Brock et al, 2009).

According to Cherkes-Julkowski, Sharp, & Stolzenberg (1997) stimulant medication appear to promote sustained attention and concentration. By enhancing dopamine effects in the brain Ritalin has shown to have positive effects on classroom behaviour and academic performance. Poor working memory and information processing improve greatly for some children taking stimulant medication. However stimulant medication does not normalize functioning. Children medicated with stimulants such as Ritalin and Dexedrine have intelligence equal to a normal test group, but showed significant delays in maturation on tasks requiring motor and visual analyses.

According to Borg (2009) there have been suggestions that the increase in ADHD diagnosis may be due to a radical decrease in children's play time. The amount of play children engage in has been decreased due to changing lifestyle, limited opportunities to play outside because of overprotective parents, and increased technologies such as the

internet and video games. Play is a phenomenon that has survived the test of time through the years and in most areas of the world. Research has outlined the positive aspects play has on children such as enhanced creativity, problem solving skills, social interaction, and teaching morality and fairness amongst others (Borg, 2009).

Until the frontal lobe has reached a maturation point, play is an important aspect of a child's life. When the maturation point has been reached in a satisfactory way, play behaviour begins to decrease in a natural way but spontaneity does not go away. It is argued by Panksepp (2007) that psychostimulant medication reduces playfulness by affecting intensity and spontaneity which then results in atypical play.

According to Cattanach (1995) play is a powerful tool in the lives of children and it creates a reality of its own; a chance for human beings to explore their worlds and their identities. Play is the place where children first discover the separateness of the self from others and begin to develop a relationship with the world.

In pretend play, children explore their understanding of familiar social situations within imaginary contexts where they make cultural conventions their own. Children's play behaviour not only increases their understanding of the objects and events around them but also their relationships with other people in various situations. This is especially evident when children play out emotional tensions and themes (Peter, 2003).

According to Chmelynski (2006) not enough people acknowledge the power of play in child development. Play turns on genes in the brain that allow children to exert control over attention and regulate emotions that later also control behaviour. When engaged in rough and tumble play children learn about aggression in a healthy way

through facial cues. Children need a safe space where they are encouraged to indulge in play to promote growth.

Smilansky (1990) identifies dramatic play as a distinct form of human play. She makes an important distinction between dramatic play that is an activity involving make-believe and role-taking and "its more mature form" – socio-dramatic play, which requires cooperation between at least two children. The socially interactive and negotiated dimension of play is one of its principal strengths in children's learning and development.

Teaching social competence through the wide application of drama in society

In certain educational programs intervention is aimed towards creating change in behaviour and attitude when it comes to children getting along with one another and being able to take care of themselves. This is done through interactive methods such as role-play, video games, and group work which has shown self-reported reductions in risk behaviour in adults. Examples of intervention programs involving children and well-being include anti-bullying interventions and learning about multiculturalism.
The use of theatre based activities is increasing in health promotion as well, but knowledge about its effectiveness for well-being is limited (Joronen, et al, 2008).

Only a few health promotion programs have primarily or only used drama methods. The reason for this is because teachers have only limited knowledge about drama and lack the experience to use these methods properly. The educational drama approach is based on educational theories of cooperative, interactive, and student-focused learning. Drama can create a safe space for critical reflection and growth (Joronen, et al, 2008).

Two forms of educational drama are used most in school settings: Theatre in Education (TIE) and Drama in Education (DIE). TIE consists of various structured activities usually devised around a topic important to the school and the child's life. Theatre in Health Education (THE) is a part of TIE and combines health education with theatre-related activities (Joronen, et al, 2008).

These programs originated from drama taught in schools but are now more concerned with personal exploration and themes around personal issues, developing imagination, and building social skills (Joronen, et al, 2008). The goal of both programs is to help children address potentially sensitive matters in the fields of personal, social, and health education. Drama is based on learning that is intended to transition from fiction to reality, which is a kind of rehearsal for real life.

Drama activities can create therapeutic encounters for children with ADHD as they learn through a hands-on approach using their personal strengths while harnessing their need to exert energy. Drama can reframe ADHD features from negative behaviours to adaptive strengths. High energy and attention seeking can be transformed and channelled for successful interactions within a playful context (Portrie-Bethke, et.al, 2009).

According to Voeller children can fall into three categories of social competence deficits: type 1 describes children with aggressive behaviours, type 2 describes children who are withdrawn, passive and lacking in aggressiveness and type 3 describes children with an inability to regulate behaviour even though they are aware of the feelings of others. Type 3 children appear disorganized and unintentionally disruptive. Children from these three categories would most often be diagnosed with Pervasive Developmental

Disorder and Attention Deficient Hyperactive Disorder (as cited in Guli, 2004, p. 17).

Research by Vaughn and Hogan argues that children who can better interpret the emotional responses of other children would be expected to communicate with them more effectively and therefore be more readily accepted. An integration of drama activities and the use of creativity reveals that the arts may be an effective method of intervention for populations with deficits in social perception (as cited in Guli, 2004, p.17).

Social competence includes age-appropriate cognition, absence of maladaptive behaviour, positive relations with others, and effective social behaviour. An early intervention to help increase social awareness is necessary to help children minimize delays and maximize their chances of reaching normal milestones in development (Shaffer, 2010).

As stated by Dodge another subset of social competence problems that children diagnosed with ADHD have includes difficulty accurately perceiving and integrating the nonverbal cues in social interaction, such as facial expression, vocal tone, and nonverbal gestures. Children like this may mistakenly think that the actions of other children are hostile and so they may select a response that is not appropriate (as cited in Guli, 2004, p. 42).

According to Bandura, social cognitive theory identifies human behaviour as an interaction between the personal factors of individuals and the environment they are in. “Human beings have basic capabilities which include symbolization, forethought, vicarious learning, self-reflection and regulation. A person’s ability to achieve certain goals that they have set for themselves influences human functioning. One of the major premises of social cognitive theory as well as drama approaches is that children can learn

by observing others and by receiving feedback from others'' (Joronen, et al, 2008).

Creative drama is defined by The Children's Theatre Association of America as "an improvisational, non-exhibitional, process-centered form of drama in which participants are guided by a leader to imagine, enact and reflect upon human experiences."

Creative drama provides an opportunity for clients to role play, to analyze roles, and to work as a team in creative tasks that require emotional control. The literature in drama supports the use of creative drama as the preferred term for dramatic experiences that are created for the development of participants. In creative drama, no scripts, technical aides, or audience are used. The goal of creative drama is to develop acceptable social skills in order to avoid negative relations with peers and adults (Freeman, et.al, 2003).

As argued by Shaffer (2010) most studies show that children with ADHD score the same as normal children in a control group on a measure of creativity, however some research has argued that children with ADHD are actually more creative than the control group and therefore would greatly benefit from creative activities.

Many creative theorists argue that attention to a wide array of stimuli allows an individual to consider possibilities that others may not think of because of their narrow focus. These thoughts and feelings can be channelled through drama where internal stimuli can be explored externally (Healey and Rucklidge, 2006).

Some creative theorists argue that attention to a variety of stimuli allows an individual to consider possibilities they may have missed if they had a more narrow focus. It is argued that the inability to filter out information and a high IQ makes

individuals open to receive more information. Creative children may experience similar cognitive deficits such as the inability to filter out information as that found in children who have been diagnosed with ADHD (Healey and Rucklidge, 2006).

What distinguishes creative children from children who have ADHD is that creative children that have a high IQ are able to process the vast array of information they receive. They also transform this information into ideas whereas children with ADHD may not be able to effectively process the information they receive. It is also important to distinguish that high IQ and creativity are in fact two separate domains, and one is not the result of the other.

Drama Therapy and Play Therapy

Drama therapy is defined by the National Association for Drama Therapy as "the systematic and intentional use of drama/theatre processes, products, and associations to achieve the therapeutic goals of symptom relief, emotional and physical integration and personal growth" (Landy, 1994).

The definitions of drama in education and in therapy both refer to cooperative games, story dramatization and improvisation. Educational drama as well as drama therapy uses techniques borrowed from Viola Spolin and Augusto Boal. Drama therapy and educational drama both help students explore various ways of finding new solutions to an old problem (Guli, 2004).

Structured drama therapeutic techniques can be divided into several categories including: nondirective techniques, psychodrama, puppets and dolls, mask making, experiential techniques, story-telling techniques, games, and sand-tray play. Children who have behavioural problems benefit from these therapies because it allows them to act

out a make-believe world that does not carry immediate consequences (Arad, 2004).

According to Guli (2004) the role of the drama therapist is to provide a safe space for a group or individual to create shared meaning by exploring personal issues through imagination. Some of the drama therapeutic techniques will be discussed below.

According to Chansky (2004) when working with children who suffer from anxiety drama therapy has proven to be a powerful tool. Through drama therapy the anxiety can be given a name and externalized. The anxiety can be projected through a puppet, figurine, doll, or a drawing that is then embodied. The child takes control and gives the anxiety a body and voice. To help the child differentiate anxious thoughts from regular thoughts a child can pick up a toy or puppet to represent themselves and can pick another toy to represent the worry. The child has both characters confront one another and come to a negotiation regarding how they are going to live with one another.

Jone's (1996) study found the following :

> Dramatic projection, for example, contains the definition that "in Drama therapy individuals can take on a fictional character or role, they can play with small objects, create scenery or enact myths. As this happens, they project aspects of themselves into the dramatic material". (p. 101)

Storytelling can also help children with anxiety and other disorders explore their issues and find new options.

According to Silverman a client can be guided through a meaningful exploration with a chosen myth or fairy tale character as a way of working through difficult personal material. The process is guided by a trained therapist and goes through the stages of creative process. Working with the right character, story, and dramatic moment provides a safe space to connect the challenge in the story with the client's own personal problem.

Research by Rogers and Evans (2007) supports the idea that role play, or socio-dramatic play, significantly enhances the development of children's cognitive and social skills. In adopting roles, children negotiate a consensus of meaning with their peers regarding the themes of their play and the nature of their roles.

Extended periods of uninterrupted role play enable children to develop and demonstrate the sustained and complex narratives possible in their age range. Listening to children's views about play preferences, use of space and lay-out of the learning environment will help them feel understood in an environment that lets them act freely (Rogers and Evans, 2007).

Role play in a drama therapy environment allows for autonomy as any topic can be explored through play without rules that constrain and frustrate the child. In therapy the use of observation is an effective tool for assessment and a way of auditing children's responses to role-play (Landy, 1994). There are different types of role play. When a client is assigned a role the performance is of a different quality then when a client decides to play out a particular role, then the role is based on the previous reflections of the client.

Improvisational role play is the most common in drama therapy and can be defined as a subclass of role playing in which the subject assuming they accept the circumstances, makes up their own behaviour as they go along (Forrester, 2000). The subject is simply being themself dealing with a somewhat novel problem situation. By using improvisational role play a clinician can observe the subject's degree of eye contact, quality of body movements, or more abstract qualities such as the imagination and expression (Snow and D'Amico, 2009). In this situation the client either is assigned

a role or plays one of their choice. According to Freeman (2000) the strengths of using improvisational role play in clinical settings include social, cultural, and educational learning.

To gain insight into a client's personality a variety of media can be used. Among some of the most valuable yet least understood of these materials are puppets (Irwin, 1993).

According to Gil (1994) puppets are helpful when used in therapy because they are easy to manipulate, offer richness in symbolism, and provide opportunities for spontaneity. Puppets create a non-threatening environment where the projection of emotional aspects and interpersonal relationships can be explored through the characters.

Children can project their feelings onto the puppets and talk about their feelings or thoughts as if they belong to the puppet or doll, this way the child does not have to acknowledge those feelings as his/her own (Gil, 1994).

According to Carter and Mason (1998) puppets were first used by counselors to help hospitalized children cope with illnesses and separation from parents. Children who struggle with verbalizing their emotional issues can use puppets to help express themselves in a way that they find nonthreatening. Puppet can be used by children with different challenges including post-traumatic stress disorder, anxiety, obsessive compulsive disorder, learning disabilities, cerebral palsy as well as social concerns such as inappropriate behavior, neglect, teenage pregnancy, parenting, and child abuse. This play therapy technique can help children with behavioral problems learn new ways to approach difficult situations in an environment that helps them feel like they are in control through play mediums that come naturally to them.

Drama therapy can help children with behavioral problems to better understand their own responses in social situations and receive the desired response from others that enhance their development. An example of this is mirroring. The use of mirroring in drama therapy can help children understand the emotions of others and how their body looks when they are experiencing a particular emotion (Rhode, 2005). This then provides children with physical cues as to how others are feelings and how to react to them in that state.

As stated by Laub (2008) emotional attunement helps us to time our questions, to decide when to stay silent and when to reflect important words and experiences. Mirror neurons in the brain reflect an emotion we observe in someone else. These cells in the anterior brain are often called the "empathy neurons." When a child can show empathy, he or she can better understand how to make friends and be more socially appropriate.

According to Ruch (2007) whether one is putting oneself in someone else's shoes or mimicking their outward qualities, imitation tends to be thought of as a kind of internalization and assimilation of experience which leads to a genuine and long lasting enrichment of the personality. The mirroring process enables the child and the practitioner to gain insight into one another's feelings and responses.

Play therapy is defined as a variety of play and creative arts techniques to alleviate psychological and emotional conditions in children that are causing behavioral problems and are preventing children from accomplishing their goals (Axline, 1950). Play therapists use a variety of creative techniques depending on the interest of the client. Unlike drama therapists they do not specialize in one therapy such as drama, art, or music but integrate all of them equally (Axline, 1950).

According to (Landreth, 2002; Ray, 2006) in play therapy it is important that the therapist has certain skills that are demonstrated in the sessions such as (a) reflecting nonverbal behaviour; (b) reflecting verbal content; (c) reflecting feelings; (d) facilitating decision making and returning responsibility; (e) facilitating creativity and spontaneity; (f) esteem building and encouraging; (g) facilitating relationship; and (h) limit-setting (as cited in Bratton, S., et al. 2009).

Children under the age of 10 have not yet developed their cognitive and verbal abilities so they are not able to fully participate in talk forms of counseling. Children's natural form of communication occurs through play. Child- centered play therapy has its roots in person-centered counseling that was developed by Carl Rogers. The child-centered play therapy model emphasizes that the therapeutic relationship is the strongest tool to help children to self-actualize (Campbell & Knoetze, 2010). According to Landreth (2002) children are understood to develop a sense of themselves, including perceptions about who they are, abilities, values, and ideals based on the child as person and the child's perceived experience of reality. Axline (1993) strongly felt that all people no matter what age have a drive towards maturity, independence, and self-direction.

According to Cochran & et al. (2010) a study predicted that children who have conduct problems have an increase likelihood of substance abuse as well as long term behavioural problems such as those described as conduct disorder in the DSM. Child-centered play therapy allows the client to form a connection with the therapist on their own terms in their natural environment dealing with play. The therapist is not there to correct behaviours but to take cues from the child as to when to reflect, reinforce, and

listen to them without judgement. The therapist responds to ways of "being" in the play space as opposed to "doing" (Campbell & Knoetze, 2010). When a child is at risk of developing conduct disorder they need unconditional positive regard from their therapist so they feel cared for despite their challenges.

According to Kawai (2009) it is important to first form a fusion between the therapist and client. This fusion may happen naturally through the therapeutic relationship or it may happen through symbolic play. Once the union is formed it is important to create separation and test the reaction of the client. An example would be watching a child play with paint. The child mixes different colours of paint together in one cup or on one pallet to symbolize unity. When the child is ready the therapist will separate each colour on the palette or pour each colour into a different cup and watch how the child responds. Part of building a secure attachment between client and therapist is being able to model a relationship that contains both unity and separation in a manner that is healthy.

Chapter 3: A discussion of the questions' relevance to art, drama, or music therapy in clinical practice:

In this research, drama therapy techniques such as role play, embodiment, and storytelling were used to help children improve their peer relations. Play therapy techniques such as puppetry and drawings were also incorporated.

These activities are social and often involve physical contact, communication, and negotiation. Within a drama therapy context children can see their ideas being accepted and incorporated by other group members. Through drama therapy children can experience what it is like to be in someone else's shoes and this can help them with empathy which is a component of social competence. Children can try out various roles and receive instant feedback (McNiff, 2009).

The first session of the social competence intervention program using drama therapy started with the creation of a contract followed by a couple of games. The group discussed what drama therapy is and why it is important. The children expressed their ideas around privacy and explained that safety is important to them. Being respectful, not interrupting, and no aggression of any kind was something the group included in the contract. The group then proceeded to the first activity. The participants were first told to introduce themselves and afterwards were asked to do a physical gesture using their body. An example would be one of the boys introduced himself and then started using his body to make gestures that were symbolic of a monster.

Most of the participants needed some encouragement because they seemed shy and hesitated to present themselves and their gesture. As the activity continued the more extraverted participants jumped around and showed the group a series of dance moves that looked like break dancing.

For the second activity the participants were asked to pretend to change a small

bean bag into any object they desired. Once the object was transformed they were asked to pass it to the person next to them. Three boys in the group turned the bean bag into tissue to wipe their nose or bum with. The group laughed with hesitation not then knowing what the boundaries of the group were. The first official session ended with the participants asking for more time to play.

In session two of the program the children were put into partners and given one piece of paper and crayons. The pairs were told to sit back to back and one child was asked to tell a story and the other child was asked to listen and draw the story that they heard. The purpose of having the children back to back was so the person telling the story could see the picture at the end. This way the child does not dictate how the picture should look but gets to see if their partner was really listening to their story at the end.

This exercise went very well. Most of the children felt like their story was heard and really enjoyed seeing someone else draw their story. Two groups of participants asked if they could take their drawings home or get a photocopy so the pairs would not have to fight for the original copy of the picture. The themes that were present in most of the drawings were dragons, volcano's and fire. Three groups had a volcano in their story, one group had a volcano set fire to a bed, and two other groups had a fire breathing monster.

According to Arad (2004) imagery around powerful animals help people to understand others, our common origins, and ourselves. By relating to an image like a dragon, we actually relate to its characteristics and symbolic meaning. This can force us to realize the vast range and complexity of strengths and weaknesses, successes, and failures that are symbolized by a single animal image and metaphorically by any human being.

One group struggled with this activity and it was because the teller told a short story and thought the listener would expand on the information given in the drawing but the partner drawing was actually waiting for more details so he knew what else to draw. The child drawing did not assert himself and ask for more details from the story and the child telling the story thought he gave a complete story so he waited for his drawing to be completed. When all the groups showed off their pictures at the end this group barely had anything drawn on their page.

In a situation like this the fact both participants were back to back probable did not help what was the absence of communication. When the group leaders intervened the artist told the storyteller that he needed more information and the storyteller was surprised and said “Oh, I didn’t know because I could have talked about dragons if I knew you needed more information”. At this moment the therapist suggested that the boys role play what happened between them during the activity. However this time they were given an opportunity to change the ending. While in role play the boys asked each other questions and seemed more satisfied with each other’s reactions.

In session three of the program the group was asked to define in their own words the meaning of feelings. Several examples were given such as: when someone hurts your feelings you may feel sad, and feelings can change depending on the day. The children were asked if feelings affect their lives and how they show their feelings. One of the boys asked if he could show the group how his body looks when he is angry. He then stomped around the room and slammed the door shut. The other children laughed nervously and we talked about how those physical gestures make people feel. A small number of children stated that anger expressed through physical aggression makes them

scared and uncomfortable.

The therapist then put the name and picture of four different emotions, each in one corner of the room. The emotions were sad, happy, nervous, and angry. The therapist asked the participants to listen to each sentence the therapist read out loud and then go to the first emotion they relate to when in that situation. The sentences were ‘’You just made a new friend’’ ‘’A good friend of yours said they don’t want to play with you anymore’’ and ‘’You had a disagreement with your parents’’. The statement that showed the greatest level of variability was about making a new friend. Half of the children went to the corner of the room which was labelled happy but many children also went to nervous and some children went in between happy and nervous. We discussed the presence of two different feelings about the same thing and both feelings were validated.

One child went to the corner of the room labelled sad and had a hard time standing still or keeping a straight face. He quickly became distracting by talking over the therapist and calling out to children who were listening.

This particular child is on the autistic spectrum and has an incredible difficult time making friends. His classroom teacher described him as a loner who routinely stalks children to get their attention. The therapist sympathized with the child’s frustrations around making friends by saying ‘’It is hard to make friends sometimes’’ and asking the children for some examples of a time they tried to make a new friend and felt rejected. Once the scared and nervous feelings around making friends was normalized the boy later said he would be happy to make a new friend.

The second part of the activity was the making of a body map. The therapist explained that certain emotions are felt in different parts of our body. The body map

came with a legend which symbolized sadness in the colour blue, anger in red, happy in yellow, and nervous in green. The children were asked to colour in their body map with the feeling that is most present in that specific part of their body. The therapist encouraged the participants to focus on their own body map and to decide on the colors privately because it can be personal for some people.

The therapist later asked if any participants wanted to share their body map and talk about where they experience certain feelings. Four children were happy to share their body map but most children kept it close and turned their paper over so other people could not see their body map. The researcher validated the feelings of those participants who did not want to show their body map to the rest of the group. The therapist thanked them for their willingness and honesty in this particular group.

When the therapist observed the body maps after wards most of the children had coloured blue on the face of the body to represent that they feel sadness on their face. Some children used two colors to represent two different feelings in parts of their body such as their heart. Many children felt anger in their feet, hands, and shoulders. Most children coloured in their entire body and three participants left parts uncoloured. When the therapist asked the participants, they said they feel very little in those areas. The most common area of the body left uncoloured for these children was the upper body or the chest.

In later sessions such as six the group discussed what happens when an individual's feelings on the inside don't match what is seen on the outside, and vice versa. The children were asked to draw how they feel they look as a person on the inside and how they look to others on the outside. Sometimes what a person says does not

match their facial expression or body language. The group then developed strategies to help interpret what a person is really feeling. Situations were described in which visual and auditory cues didn't match.

It is argued by Arad (2004) that children's drawings can be seen as a language of expression since they have a difficult time expressing themselves verbally. Drawings can assess personality traits, cognitive maturation, and be used as a projective technique.

Many tests have been developed and standardized based on children's drawings. Drawings give the client permission to explore repressed feelings and emotions. Drawing techniques are most commonly used by therapists to engage clients, gather information about their life, and gain insight into family dynamics.

In sessions seven and ten of the social competence intervention program puppets were used to tell stories on the topic of taking another person's point of view. According to Gardner (1993) in a story telling technique the child is asked to tell a story with a beginning, middle, and an end. The therapist then chooses the relevant themes in the story to discuss. In order to take it further the therapist can introduce a healthier and more mature ending to the story to help model alternative behaviour for the client so their ability to solve conflicts strengthens (as cited in Arad 2004).

During the social competence intervention program children were asked to tell a story using a puppet. The therapist would then ask other participants what they remembered in that particular story. As the viewers answered they were encouraged to talk clearly, make eye contact, and to look for physical cues from the storyteller to know if they remembered things accurately or not.

According to Gil (1994) puppets are helpful when used in therapy because they

are easy to manipulate, offer richness in symbolism, and provide opportunities for spontaneity. Puppets create a non-threatening environment where the projection of emotional aspects and interpersonal relationships can be explored through the characters.

As argued by Carter and Mason (1998) Puppets should represent a variety of cultural backgrounds, ages and social class. Social class can be expressed by what the puppet is wearing. Symbolic puppets such as a witch, pirate, wizard, wild and tame animals should be included since they are especially valued by children. Puppets can be soft and cuddly or hard and made of various fabrics. The main goal is to represent puppets which symbolically relate to the problems of the child.

During this stage the therapist paid attention to the storytellers linguistic and cognitive skills through their use of words, the concepts evoked, questions that were answered and avoided. The therapist also asked the children what parts of the story they liked most/least. The children had an opportunity to take ownership by creating a title for their story as well as a lesson (Irwin, 1993).

In the social competence intervention program using drama therapy children were encouraged to practice expressing themselves before a group as well as practicing being a witness to others. This helped create an exchange of creative energy, expression, and community building (McNiff, 2009).

In sessions eight and nine the group was introduced to role play. In session eight the discussion was how to deal with teasing and bullies. Feelings and fears around teasing were normalized and the group brainstormed ideas about what to do in these situations. The therapist asked the group to share some personal stories around being bullied. Once the stories were shared a role play took place and the protagonist got the opportunity to

select participants in the group to play various roles within their story. Everyone seemed excited and different possibilities were role played as to how the story could have ended to leave the protagonist feeling more satisfied and safe.

One of the shy little girls in the group was asked to tell the group about a time when she was bullied. She was hesitant but proceeded to tell the story. She became louder and more animated as the story went on. She took charge and started quickly nominating people to play the bullies in her story. She whispered to them how they need to act and when the scene started she corrected the people she thought did not play the character of the bully accurately. The therapist was amazed by how this little girl took ownership of her story and how assertive she became. Most of the time this little girl appeared passive and did not want to participate, it was refreshing to see this other side of her. The therapist reflected how in control she was and she lite up with a beautiful smile.

In session nine the participants were asked to create role plays around initiating conversation and making friends. The children seemed to enjoy practicing approaching other children and introducing themselves. Emphasis was placed on letting others know what your name is and that you would like to participate in the same activity as the person you approached. During this time interpretations were reframed about what might happen when children don't want to play with you, what people have experienced in the past, and what it all means.

One of the boys in the group talked about being at a friend's house and not knowing what to do when his friend started kicking his dog. The boy said he was uncomfortable and didn't want his friend to kick his dog but was too scared to say anything because he feared losing his friend. The group brainstormed ideas around what

the boy could have done including telling the other boy's mom, telling the boy to stop, or locking the dog out of the room. The boy said he wanted to role play telling his friend that he wants him to stop. He seemed satisfied with the role play and thought it was really funny having another member of the group play the dog. He also discovered that pretending to his friend that kicking the dog was funny was not a reflection of how he was truly feeling.

Role play in a drama therapy environment allows for autonomy as any topic can be explored through play without rules that constrain and frustrate the child. In therapy the use of observation is an effective tool for assessment and a way of auditing children's responses to role-play (Landy, 1994).

The termination process started in session six when the participants were reminded that the drama therapy group was intended to last ten weeks. At that point many of the participants asked for clarification about the last session and told the therapist which of the remaining sessions if any they would be absent.

According to Many (2009) termination provides a good opportunity for a therapist to provide the child who is struggling with a new experience of loss; one that is controlled, predictable, and paced. Through this experience the therapist can help the child and caregiver develop a new model for loss, one that permits for loses that are a natural part of healthy growth and change.

Termination was truly felt in the last two sessions when the children started asking the therapist why she was leaving and if she would come back to visit. Feelings around loss and change were discussed. Some children talked about when certain members of the group left due to graduation or discharge and how they are still

remembered and missed.

During the last session of the social competence intervention program using drama therapy the children displayed signs of affection mixed with feelings of frustration towards the therapist. As a closing ritual the therapist asked the group to give each other imaginary gifts. The children were encouraged to mime the size and weight of the gifts they gave and received. Many of the children gave each other imaginary animals, castles, and sports equipment. The gifts were usually mimed as being big and heavy.

The children said they have something special they would like to give to the therapist as a way to say goodbye. The children started to argue who would give the therapist a present first and several of the children gathered around the therapist asking her to open their present next. The presents the therapist received were a castle, a dress, a kitten, chocolate, a bomb, poison, death, an explosion, and a big screen television.

Several of the boys in the group gave gifts that were a mix of something nice and something mean, like a dress and a bomb or a kitten and poison that they then asked the therapist to pretend to drink. All the girls in the group gave sweet presents while the boys more openly explored their ambiguous feelings about the therapist's departure.

The therapist thanked all the children for every one of their gifts and interacted with each of them. When the dress was received the therapist pretended to try it on and when the pretend poison was given the therapist drank it and faked a dramatic death. There is no other situation like the termination of therapy sessions where a child can explore the experience of separation and loss and be aided by someone who is close yet objective (Many, 2009).

The ten week social competence intervention program using drama therapy

incorporated a wide range of drama therapy techniques and provoked considerable participation from the children.

Chapter 4: Method and timing of the data collection, analysis, and research paper writing

Participants

The children who were included in this study were part of a hospital after-school

program where they worked on making friends, solving problems, and doing homework. These children were viewed as clients and participants and the investigator had the dual role of therapist and researcher.

There were ten participants in total nine of which were boys and one girl. All the children were between the ages of seven to nine.

The children were diagnosed with different subtypes of ADHD including hyperactive-impulsive, inattentive, and combined type. Due to the nature of such a small sample size analyses between subtypes was not explored. Children were diagnosed more than once and diagnosis were not always the same. Some of the children were diagnosed before entering the program, and then they were diagnosed while in the program, and once more at the end of the program. Children who were considered ‘’non-clinical’’ and had no diagnosis or social deficits were excluded from the program at the hospital as well as this research.

The inclusion criteria for this group included a diagnosis of some kind relating to social deficits and a difficulty getting along with peers. Most of the children had received a prior or current diagnosis of ADHD which was confirmed by either a psychologist or psychiatrist before entering the study. The children part of the after school hospital program were assessed using the *Connors' Teacher Rating Scale- Revised (S)* and the *Child Behaviour Checklist for Ages 6-18.* Before the hospital staff assessed the participants and made a diagnosis, these tests were filled out by the child's parents and teachers.

Some of the scores were inconsistent. At times parents rated their child low on a particular measure while the teachers rated the child high on that same measure. An

example from this study is that some of the parents rated their child high on the oppositional scale and the teachers rated them low or vice versa. What appeared to be more consistent were the ratings on the ADHD scale. Both parents and teachers would rate the child either low or high, however this would not always match with the diagnosis given by a psychiatrist or psychologist. Although some parents endorsed the symptoms of ADHD, they seemed not to believe that their child was significantly impaired by them (Healey & Rucklidge, 2006). Some of the assessments seemed to imply that although ADHD symptoms are common in this population a full diagnosis of ADHD might not be.

Seven of the nine children had a co morbid disorder of ADHD and something else. Two of the ten children had a language disorder and two other children were on the autistic spectrum. One child was diagnosed as a selective mute and another child was diagnosed with sleep terror disorder. Two of the ten children also suffered from parent-child relational disorder. In the files of these seven children all of them had also been diagnosed with Oppositional Defiant Disorder.

Two out of the ten participants were taking stimulant medication to treat ADHD. The researcher is not aware if the data collected on the Connors' Teacher Rating Scale-Revised (S) or the Child Behaviour Checklist for Ages 6-18 was before or after the children were taking medication.

Study design

The methodology chosen to answer the research question is mixed methods with the qualitative phase being more dominant than the quantitative phase (Tashakkori &

Teddlie, 2003). The proposed program will aim to strengthen social skills by giving children increased knowledge of how to respond to other people; this will be accomplished through short term, solution- focused group interventions. Similar programs using cognitive behavioural therapy already exist at the hospital but the rationale for developing such a new drama therapy program using mixed methods is that this approach provides the most appropriate way to answer my research question. Triangulation is also one of the reasons for this chosen methodology (Andrew & Halcomb, 2007).

According to Andrew and Halcomb (2007), the advantage of triangulation is that ‘‘Significant findings from one method of data collection can be specifically explored by another data collection method thereby enhancing the findings’’ (p. 148).

This study is a stepping stone to possible future research using the same concept with revised methodology, and a larger sample size. If it leads to significant change among the test subjects, it will hopefully contribute to the field of drama therapy.

Data collection

The quantitative component of my study is a standardized test completed by the participants that measures their peer relations before and after treatment. The test is a self-report questionnaire called the Index of Peer Relations (IPR) and is a 25-item scale. The IPR has high internal consistency and a low standard error of measurement. The validity of this measure is also high since it significantly distinguishes between clients’ self-evaluation and a therapist’s evaluation (Corcoran, 1987).

The Pre-Test

Ten children were assigned to attend the drama therapy sessions and all ten completed the self-questionnaire. The self-questionnaire is a standard measure called the Index of peer relations and it measures how the children feel about their peer group. When the questionnaires were handing out the participants were reassured that this task was not to write a test but instead to answer a series of questions about how the participants feel about the children around them for the purpose of sharing knowledge with the researchers.

The participants were informed that there are no right or wrong answers and that they should focus on their questionnaire without looking at the answers of the person next to them. The researcher read the questions out loud one at a time.

There was confusion over the definition of ‘’peer’’ and ‘’peer group’’. The question which several participants pointed out was question number six which asked the

children to rate on a scale of one to five how much of the time they feel ‘’My peers are a bunch of snobs’’. The participants wanted to know the definition for snobs, peers, and peer group. The definition of snob is: ‘’One who tends to patronize, rebuff, or ignore people regarded as social inferiors and imitate, admire, or seek association with people regarded as social superiors’’. To simplify this for the participants the researcher said the definition of snob is someone who looks down on you and thinks they are better than you. The participants seemed satisfied with this answer. The researcher also defined peer and peer group as ‘’the social group you are part of with people who are the same age as you’’. The researcher was asked to elaborate on the definition of peer and proceeded to simplify by saying ‘’your peers are not necessarily your friends but other people your age who share a similar environment as you such as school’’.

Seven of the children finished the questionnaire within 10 minutes and did not

wait for the researcher to read all the questions before answering them. Despite the instructions to follow along with the whole group many children lacked the patience especially when a couple of children needed extra attention. Two children needed fifteen more minutes to complete the questionnaire and needed help from an assistant to read the questions several times before they could match the question with an answer. One of these children had a learning disorder and the other child had a language delay which explains the need for extra time.

The only female participant in the group finished the questionnaire in twenty five minutes which is how long it took for the researcher to read all 25 questions out loud and wait for everyone to answer including the two boys who needed more time. The female participant could have finished the questionnaire with the other seven children in ten

minutes but chose to wait for the researcher and followed her lead.

The boys that rushed ahead and finished the questionnaire early were asked to turn the questionnaire over so no one looked at their answers. At this point, five of the boys drew pictures on the back of the questionnaire and two other boys had a quiet conversation amongst themselves.

The Post-Test

The post test was taken ten weeks after the social competence intervention program using drama therapy. The post-test was the same self-questionnaire as the one used in the pre-test called the Index of Peer Relations (IPR). This test was administered directly after the program had ended.

The group had changed at this point of assessment with only seven of the original participants present to write the post-test. One of the ten participants wrote the post-test one session earlier and another participant wrote the post-test two sessions earlier before the completion of the program. Both these participants graduated from the after-school hospital program in which this research was a component of. They wrote the post-test the same day they graduated and this might have affected the scores. The third original participant did not write the post-test the same day as everyone else because he was discharged from the program. He wrote the post-test the day he was discharged which was session five of the program.

The seven original participants wrote the post-test with several new participants that were introduced into the program to replace the three that had left. Two additional girls and one boy were introduced into my research at a time when most of the sessions had passed. These participants integrated into the group well and expressed their liking for drama therapy however they were not included in the quantitative part of this research. They completed the post-test with all the other participants but never wrote a pre-test so these subjects produced no scores for the researcher to compare.

Once again when the questionnaires were handing out the participants were reassured that this was not a test but instead a task to answer a series of questions about how the participants feel about the children around them. It was said that these questionnaire were done for the purpose of sharing knowledge with the researchers and would remain completely anonymous.

The participants were informed that there are no right or wrong answers and that they should focus on their questionnaire without looking at the answers of the person next to them. The researcher read the questions out loud one at a time.

There was once again confusion over the definition of ‘’peer’’ and ‘’peer group’’

however this time a couple of children wanted to define it because they remembered what it meant from the first questionnaire. The researcher insisted on defining the term ‘’peer, peer group, and snob’’. The same definitions were given as in the pre-test to keep consistency.

The instructions were to follow along as the researcher read the questions out loud. This time unlike during the pre-test all the children listened to these instructions and waited although some children took longer than others to write down the answer. Three children expressed difficult in answering the questions and the researcher’s assistants approached them to help without influencing their answers. One boy with a learning disorder kept asking if he had the right answer and said several times that he does not understand what he is supposed to be doing even when he received extra help. The whole group had answered all the questions thirty minutes after the post-test began.

The qualitative component of my study will included a social competence intervention program and observations made while I adopted the dual role of therapist and researcher. The main method used to collect data was observation (Stake, 2010). Most of the observations took place in scheduled group sessions, however, I also had the opportunity to observe how these children interact even prior to the pre-test outside of my interventions; for example, while the children were doing school work, at snack time, and during free play time.

An active form of participation that the researcher partook in was participant observation (Stake, 2010). The researcher involved herself in whatever the participants were doing in order to gain a new perspective. It can be a way to get close to the participants and live an experience being in their shoes. It is argued by Geertz (1988) that we are too quick to presume that our participant experience approximates theirs. If anything, our participation may alter their involvement.

The social competence intervention program was administered over a course of ten weeks with the goal of helping children identify body language, vocal cues, initiate conversation, and resolve conflict. These topics will be explored through the use of drama therapy techniques and games. Once the ten-week intervention is complete, children will complete a post-test measuring their peer relations.

During the ten sessions, drama therapy activities were used to collect data about how the children reacted to the measures of social competence. To help children learn and explore the various criteria, drama therapy techniques such as mirroring, role play, and games addressing emotions were used to generate data (Emunah, 1994).

Once observations were made data was collected and document on the researcher's computer under a private file with a password. After each session, a summary was written regarding the themes, actions, and reactions of the participants towards one another and the activities proposed. Pictures were taken of the art work created by the participants and then given back to them.

In order to reduce harm and empower the participants, labeling of this group was discouraged. According to Lichtman (2006) labeling children as having a certain

disorder can create a negative self-image for participants. When conducting therapy with these clients the reframing of certain definitions was encouraged. For example, instead of saying children who have a behavioral disorder, a preferred statement would be children who have problems with social perception.

The children understood that the therapist was obligated to keep confidentiality unless the information was damaging to the participant or to others (Lichtman, 2006). Consent forms were signed by the children's parents explaining how certain personal responses will be documented in research. The identities of participants were not revealed but the parents and children still needed to understand that and take home a written document that stated this (Lichtman, 2006). The consent forms were transparent regarding the researcher's intentions and plan of action. No deception, misrepresentation, or setting people up was used (Lichtman, 2006).

Data analysis

Quantitative data

Data was retrieved for the quantitative component through the collection and comparison of the IPR scores from the pre and post-test. Data analysis began at the end of data collection. The pre and post- test is a questionnaire designed to measure the way the children feel about their peer group. The index of peer relations was used. It is scored by reverse-scoring the items listed at the bottom of the scale, totalling these and other item scores, and then subtracting 25. The IPR has a cutting score of 35 (+/- 5) with scores above 35 indicating the respondent has a clinically significant problem and scores below 35 indicate no such problem exists. Higher scores indicate the presence of problems with peers (Corcoran, 1987).

When a researcher uses the same individuals for a before-after comparison, they are said to be dependent samples because one set of scores is dependent on the other. A research design that involves dependent samples is one where the observations from one sample are related in some way to those from the other (A. Aron, E. Aron, & Coups, 2008).

Participants	Pre-test Score	Post-test Score
# 1	40	52
#2	43	55
#3	47	48
#4	47	50
#5	51	39
#6	44	53
#7	46	28
#8	41	47
#9	38	38
#10	37	50

Table 1

Scores above 35 indicate a clinically significant problem and all the scores in this pre and post- test indicate that this is still the case with all the children except one at the hospital who participated in this study. Higher score indicate more of a problem with peers, and seven out of the ten participants had higher scores on the post-test after the intervention program than on the pre-test. One participant had the same score on the pre and post-test. Two participants had significantly lower scores on the post-test than the pre-test showing an improvement in peer relations after the social intervention program.

Participant #7 had a score on the post-test that was no longer indicative of a clinically significant problem with ones peer group (Corcoran, 1987).

Participants sum total (subtracting the post-test score from the pre-test score)
Top row: Participants Bottom row: D value (D=X2-X1)

# 1	# 2	# 3	# 4	# 5	# 6	# 7	# 8	# 9	# 10
12	12	1	3	-12	9	-18	6	0	13

Table 2

To calculate the difference between scores for all participants, the post-test score was subtracted from the pre-test score. Once a single score for each participant had been calculated all the single scores get added together to calculate a sum. For the researcher to get the mean difference the sum of the numbers is divided by the total number of participants (A. Aron, E. Aron, & Coups, 2008). In this particular research the sum total is 26 and it was divided by the number of participants which is 10 to calculate the mean difference which is 2.6 (MD: 26/10 = 2.6).

The mode is the most frequently occurring number in a distribution. Chart two identifies the mode number as 12. The median is the middle score within a data set. Numbers are lined up from lowest to highest and the middle number is identified. If two middle numbers are present because of an even distribution then the two middle numbers are added together and divided by two to get the median. In this research the median score is 10.5 (12+9/2=10.5).

The researcher's hypothesis is that this social competence intervention program using drama therapy will help children with Attention Deficit Hyperactive Disorder improve their peer relations. The null hypothesis is an alternative hypothesis that states there is no effect, no change or no difference (A. Aron, E. Aron, & Coups, 2008). So

according to the null hypothesis the social competence intervention program using drama therapy will show no change for children with Attention Deficit Disorder improving their peer relations. The researcher always tries to reject the null hypothesis.

(D-MD)	(D-MD) SQUARED	SD= 10.458	n= number of participants	df= n-1	SM= SD/ square root of n	t= MD/SM
9.4	88.36		n= 10	df= 9	SM= 10.458/3.162	t= 2.6/10.4
9.4	88.36				SM= 3.307	t= 0.25
-1.6	2.56					
0.4	0.16					
-14.6	213.16					
6.4	40.96					
-20.6	424.36					
3.4	11.56					
-2.6	6.76					
10.4	108.16					
	SUM=984.4					

Table 3

To complete the statistical calculation the researcher used a significance level of 0.05 and the critical t for a one-tailed test at this significance level with df=9 is -1.833. The t score has to exceed the critical value of -1.833 to reject the null hypothesis. The t score in this particular study is 0.25 and is higher than the cut-off so we reject the null hypothesis. The null hypothesis assumes that the social competence intervention program using drama therapy showed no change in improving peer relations.

Even though for most participants the intervention program showed no improvement in peer relations the sample size is too small to make generalizations about the effects this study would have on the greater population. For the two participants whose scores showed an improvement in peer relations, it is not evident whether the scores were improved because of the social competence intervention program or whether it occurred due to other circumstances in the participant's life (Gravetter and Forzano, 2009).

According to Lincoln and Gruba (1985) whenever the same group of people is observed repeatedly over time, time-related factors can threaten internal validity. These time related threats include history, instrumentation, testing affects, maturation, and statistical regression. Any differences found between the pre-test and post-test observations could be explained by these factors.

The reason a researcher measures effect size is to provide information about the absolute size of the treatment effect that is not influenced by any outside factors such as sample size. When the researcher evaluated the effect size in this study using Cohen's d the result was 0.2. This score signifies that the mean difference was around 0.2 standard deviations. This displays a small effect size (Gravetter and Forzano, 2009).

Qualitative data

Data analysis for the qualitative element of my research began early and while still collecting the data. Data was analyzed and organized into categories on the basis of themes, concepts, or similar features (Andrew& Halcomb, 2007). The children were observed before the pre-test to document how they responded with regard to communication, negotiation, integration and response to the body language, facial

expressions, and vocal cues of other children.

Data was collected and organized by the researcher and hospital staff. An occupational therapist and psych educator were in the therapy space to provide a different perspective. The staff members debriefed with the researcher after each session and discussed some of their thoughts and observations. The researcher also had the hospital staff look over the session summaries that were written and the photographs that were taken of the participant's artwork. Much time was given to member checking through meetings after each session and a once a week staff meeting during the week. The hospital staff taught me how to recognize undesirable research bias.

Time- line

Step 1**:** A person unaware of the research question will be asked to observe how these children (outside of drama therapy) react to their peers with regard to making eye contact, negotiating, identifying body language, facial expression, and vocal cues. Done before pre test. Researcher at this time gathers consent forms and addresses any concerns.

Step 2: The Pre Test: Index of Peer Relations (IPR)

Step 3: The ten week social competence intervention program using drama therapy

<u>Session 1: Establishing Group Identity</u>
Objectives:
- Introduce group members to each other
- Establish the group as a place where it is safe to share feelings, express personalities and ask questions
- Create a contract
- Normalize difficult feelings
- Discuss what DT is and why is it important?

DT Activities : Name and gesture
Object Transformation

<u>Session 2: Focusing Attention</u>
Objectives:

-Discuss how focusing attention is an important part of getting along with others
- Practice focusing attention and self-control, both visual and auditory
- Begin to give and take cues with a partner through mirror activities
- Increase trust and cohesion among group members.
DT Activities: Get one person to tell a story and another person to draw the story

Session 3: Emotional Knowledge
Objectives:
- Discuss feelings and how they affect our lives
- Review vocabulary and meanings of different feelings
- Discussion: How do we show our feelings? What affects our feelings? Where in our body do we feel them?
DT Activities: Embody various emotions
Draw a body map and identify where in your body you feel certain emotions

Session 4: Facial Expressions and Body Language
Objectives:
- Discuss how we know what others are feeling by giving and taking cues in facial expression and body language, and how this helps us to get along with others
- Move with different emotions and receive feedback about how these were expressed
- Practice interpreting others emotions through their movements and facial cues
- Discussion: How do we know what someone is feeling?
DT Activities: Experience making a variety of facial expressions and see them mirrored by other
Emotional masks

Session 5: Vocal Cues
Objectives:
- Experiment with using vocal expression in different ways in front of peers
- Discuss how we also know how people are feeling by their voice tone
- Discussion: What is it about a person's voice that tells us how they are feeling?
DT Activities: Practice saying the same sentence with a variety of emotions
Sound orchestra

Session 6: When Cues Don't Match
Objectives:
-Discuss situations in which visual and auditory cues don't match.
-Develop strategies to help interpret these situations.
-Discussion: Sometimes what someone says does not match facial expression or body language. What are some strategies to use when we are not sure what someone means? How do you know? What does the person want to show? What do you think the person is really thinking and feeling?
DT Activities: Inside/Outside drawings

Session 7: Taking Another's Point of View

Objectives:
- Discuss what it means to think/see from another person's point of view
- Express personal point of view about several opinions in group settings
- Allow others to express different opinions
- Discuss what communicating successfully means in real life—figuring out the face, voice and body language at the same time, often with different intensities

DT Activities: Storytelling using puppets

Session 8: Dealing with Teasing

Objectives:
- Discuss being teased or left out. Encourage sharing of experiences
- Normalize feelings and fears about being teased
- Reframe our interpretations about why this might happen or have happened in the past and what it means
-Brainstorm ideas about what to do in these situations

DT Activities: Artist and sculptor

Session 9: Initiating Conversation

Objectives:
- Normalize feelings of shyness or anxiety about initiating conversation
- Develop self-talk to help overcome anxiety about initiating conversation
- Discuss successful and not-so-successful ways to start conversation
- Practice ways to initiate conversation
- Discussion: Sometimes it is hard starting conversations with people. Who has had this experience? What are some things you could say to start conversation? How do other people let you know that they want to talk with you?

DT Activities: Role-play

Session 10: Closure

Objectives:
-Recap what has been worked on and discussed
-Ask what they enjoyed and what was challenging
-Validate their experiences
-Activities they want to do again

DT Activities: Storytelling using puppets (request from participants)
Toasts
Group Photo

Step 4: The Post Test: Index of Peer Relations (IPR)

Step 5: Look over the session summaries and calculate the scores of both tests

Chapter 5: Results and Limitations

After the ten-session intervention where a program was modified to use drama therapy as a way to enhance social perception, a conclusion that was drawn is that at the post-test two children had scored lower on the same measure designed to test peer

relationships. The results state that two children felt they were able to improve their peer relations after the program and one child's scores showed that he no longer has a clinical problem with social perception.

My sample size consists of ten participants so the results were not generalizable. The small effect size also states that the results were not statistically significant. However this study proved to be beneficial for some participants who felt they developed stronger skills to be able to form healthy relationships with their peers. Recent literature suggests that the most beneficial treatments for ADHD are family-based, behavioural-oriented, multimodal, and multisystem approaches as opposed to medication alone, placebo, or cognitive behavioural treatment alone (Portrie-Bethke, et.al, 2009).

Some bias might have been present during the pre and post- test. The researcher was part of the process and read the interview questions out loud during the pre-test. During the post-test the researcher had her assistants who were blind to the research question and research process to read out the questions. During both questionnaires the researcher was present in the room along with her assistants.

It is argued by Gravetter & Forzano (2009) that investigator limitations include the observer effect. In this particular study the participants may have had a reaction to the presence of the hospital staff observing the group while they were writing their pre and post -test and this may have influenced their answers.

The following exclusion criteria were applied: (1) the intervention was for a clinical population and was not an intervention that would necessarily be used in a school-based setting (2) the interventions were structured creative art therapy techniques

that mainly incorporated drama therapy (3) the intervention only lasted ten sessions and not every child was present for all ten and make up dates were not an option (4) the primary outcome (improving peer relations) would not be statistically significant due to such a small sample size (5) the study was multi-factorial with creative art therapy techniques being applied as well as psych educational techniques.

A further limitation is the fact that there are few methodologically strong studies in the field of drama and theatre interventions. A common problem in intervention studies is the lack of follow-up after a long period of time has passed.

Inter diagnostician reliability was not assessed and some psychologist and psychiatrist talked about different diagnosis's regarding the same child. The children were diagnosed when entering the program and would be assessed again at the end of the program. In this ADHD sample all three subtypes of ADHD were present. Hyperactive-impulsive and combined seemed prominent but a diagnosis of inattentive type was also present. Due to such a small sample size this was not taken with much consideration (Healey & Rucklidge, 2005).The groups also had unequal numbers of male and female participants with nine out of the ten participants being male. Differences in functioning based on gender were impossible to assess. Not all participants were present for every session that pertained to the program and make up days were not an option. Some participants missed several sessions due to holidays or sickness.

Children's home environment plays a big role in how they develop. This study did not include the children's parents and did not give the participants an opportunity to learn about social competence by having their parents as a model.

According to Lautha, et al (2009) several studies have shown positive effects of

parent training programs when dealing with parents who have children with behavioural problems. These programs can increase childrearing competence, improve attachment, reduce parental and child stress, as well as improve self-esteem for both parent and child.

Parents are taught how to deal with everyday problem situations such as asking a child to do chores, go to bed, or interact socially. These parenting programs address what needs to change in the home, building strong attachment between child and parent, emotional regulation, changing routines, instructing through consequences, making clear rules without inappropriate punitiveness and learning how to play together. Parental self-reports revealed that after certain intervention programs parents found their child less demanding, attachment to their children became stronger, and child's hyperactivity declined (Lautha, et al, 2009).

Perhaps if the parents were included in this particular program the things learned in it may have been also incorporated at home so the children could improve their peer relations as well as their parental relations.

The researcher took on a dual role as a researcher and creative art therapist to the participants. It was a matter of gradation from personal to impersonal and interpretations made were based on the researcher's personal experience when she was in the role of the therapist. This kind of dual role can make it difficult to stay objective when the transition happens into the role of the researcher.

According to Stake (2010) the weakness of qualitative research is that it is too personalistic and subjective. Its movement towards a rigorous and disciplined science is slow. New questions emerge more than answers and ethics need to be monitored closely. Methods for more accuracy such as triangulation exist. People perceive the world in

terms of concepts and relationships. Qualitative researchers are more interested in naturalistic and holistic observation than they are interested in cause.

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Informed Consent to Participate in Research

This program will take place Wednesdays during group time.

Concordia University

You are being asked to participate in a research study. This form provides you with information about the study. Monika Sawka can answer any questions you may have

regarding your child's participation in this study. Please read the information below and ask questions about anything you don't understand before deciding whether or not to have your child take part. Your child's participation is entirely voluntary and he/she can refuse to participate without penalty or loss of benefits to which your child is otherwise entitled.

Title of Research Study: Can a social competence intervention program using drama therapy improve peer relations among children with Attention-Deficit Hyperactivity Disorder?

Principal Investigator(s) Monika Sawka (current student at Concordia University who is completing her final year of her Masters degree in drama therapy). Her practicum placement is at the hospital that your child attends. She can be contacted at (514) 481-1703.

What is the purpose of this study?

My study aims to help children gain a better understanding of the social cues of others. This may help children improve their peer relations. Drama therapy activities will be used to teach children how to be more socially appropriate. Drama therapy techniques that explore self-expression, positive communication, space and distance, concentration, organization, speech, and symbolism will be used.

What is the procedure of the study?

Children will be asked to complete a pre-test measuring their peer relations. A social competence intervention program using drama therapy will then be administered over ten weeks with the goal of helping children identify body language, vocal cues, initiate conversation, and resolve conflict. These topics will be explored through the use of drama therapy techniques and games. Once the ten-week intervention is complete children will be asked to write a post- test again measuring their peer relations.

How will your privacy and the confidentiality of your research records be protected?

Authorized persons from Concordia University and The hospital have the legal right to review your child's research records and will protect the confidentiality of those records to the extent permitted by law. Your child's research records will not be released without your consent unless required by law or a court order.

If the results of this research are published or presented at school meetings, your child's identity will not be disclosed.

Documents are coded so that no personally identifying information is visible on them and will be kept in a secure place (e.g., a locked file cabinet in the investigator's office). Files regarding your child's progress will be reviewed only for research purposes by the

investigator and her professors and associates. The documents will be erased after they are transcribed or coded.

What are the possible discomforts and risks?

There are few known risks to this study. Participation in a therapeutic space may bring up feelings that are uncomfortable. During these times your child will be provided additional support and you will be informed about the techniques and activities utilized.

If you wish to discuss the information above or any other risks, you may ask questions now or call the Principal Investigator listed on the front page of this form.

Signatures:

_____

Signature and printed name of person obtaining consent **Date**

You have been informed about this study's purpose, procedures, possible benefits and risks, and you have received a copy of this Form. You have been given the opportunity to ask questions before you sign, and you have been told that you can ask other questions at any time. Your child voluntarily agrees to participate in this study.

_____

Printed Name of Subject **Date**

_____

Signature of Parent Giving Consent **Date**

_____

Signature of Principal Investigator **Date**

IPR

1 = Rarely or none of the time

2 = A little of the time

3 = Some of the time

4 = A good part of the time

5 = Most or all of the time

1. ----------I get along very well with my peers.

2. ----------My peers act like they don't care about me.

3. ----------My peers treat me badly.

4. ----------My peers really seem to respect me.

5. ----------I don't feel like I am ''part of the group''.

6. ----------My peers are a bunch of snobs.

7. ----------My peers really understand me.

8. ----------My peers seem to like me very much.

9. --------- I really feel ''left out'' of my peer group.

10. ----------I hate my present peer group.

11. ----------My peers seem to like having me around.

12. ----------I really like my present peer group.

13. ----------I really feel like I am disliked by my peers.

14. ----------I wish I had a different peer group.

15. ----------My peers are very nice to me.

16. ----------My peers seem to look up to me.

17. ----------My peers think I am important to them.

18. ----------My peers are a real source of pleasure to me.

19. ----------My peers don't seem to even notice me.

20. ----------I wish I were not part of this peer group.

21. ----------My peers regard my ideas and opinions very highly.

22. ----------I feel like I am an important member of my peer group.

23. ----------I can't stand to be around my peer group.

24. ----------My peers seem to look down on me.

25. ----------My peers really do not interest me.

Any format changes will be indicated below and must be
revised for the final submission only

TITLE PAGE (considered page i but not numbered)
Title page must be set up as per sample found in the Thesis Preparation
Guide at
http://graduatestudies.concordia.ca/documents/publications/graduatehandbooks/thesisprep
arationguide.pdf

SIGNATURE PAGE (considered page ii but not numbered)
3-5 copies of the signature page to be provided and brought to oral
defense by student (Please check with your graduate program assistant)

ABSTRACT Numbered as page iii
Must be provided and set up as per the thesis guide

ACKNOWLEDGEMENTS and/or DEDICATION

TABLE OF CONTENTS Numbered as page iv
Add List of Tables and/or Figures

LIST OF TABLES, LIST OF FIGURES
TABLES AND FIGURES
REFERENCES / BIBLIOGRAPHY / WORKS CITED
APPENDICES

OTHER All page numbers should be at the bottom of the page and centered.

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PAGE NUMBERING
All introductory pages are numbered with small roman numerals starting with the Abstract (page iii). Please note that the title and signature pages have no page numbers. The text of the thesis (ie; Introduction) starts at page 1 and continues consecutively until the last page including References/Bibliography and Appendices, if any.

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On final submission, thesis must have 1.5"(3.81 cm) left-hand margin and 1" (2.54 cm) top, bottom and right-hand margins. If the size of a table or figure does not fit in the standard margins, margins may be reduced to 1 inch on the left and half-inch top, bottom and right.

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Dolly Grewal, ext 3803
Address: 2145 Mackay, Room S-103, Montreal, Quebec, H3G 2J2

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---------- Original Message ----------
Subject: For Dolly Grewal
From: "Monika Sawka" <msawka@ualberta.ca>
Date: Mon, July 18, 2011 8:59 pm
To: thesisdeposit@graduatestudies.concordia.ca

Hello Dolly Grewal,

I was asked to submit to you an electronic version of my preliminary paper so you can check the formatting . My advisor is Bonnie Harnden and she has approved my research paper.

Thank you!

Monika Sawka (Creative Art Therapies Department)