FASD Hub Australia

Information on Fetal Alcohol Spectrum Disorder (FASD) for all Australians

FACT SHEET FOR HEALTH PROFESSIONALS 3

Social communication problems among children with FASD

The FASD perspective

Some individuals with FASD can find it difficult to interact and socialise effectively with others. For example, it can be hard to initiate and manage play and conversations, express and interpret emotions, and observe and comply with social rules. These difficulties among individuals with FASD have been associated with compromised neurobiology, social cognition, emotion recognition and regulation, executive functioning and language [1]. Environmental factors and sensory processing difficulties may also influence social competence among individuals with prenatal alcohol exposure (PAE) [1].

Social skills and social communication are complex behaviours, and difficulties with these can have a negative impact across the lifespan. Potential problems with the higher-level language and cognitive abilities such as those needed to infer meaning and to perceive cause and effect can make it hard for those with FASD to correctly interpret the perspectives and intentions of others. Parents have reported that children with FASD demonstrate weaker social skills and empathy compared to typically developing children [2]. In the classroom, while attempts to interact with peers are common students with FASD have been observed to be less successful in their attempts compared to their fellow students [3].

Among adolescents with FASD or PAE, difficulties with social competence are also common; they have been found to be more impulsive and take less care when responding to social problems compared to their peers [1]. Adolescents can struggle with peer acceptance and are more likely to exhibit behaviours considered to be problematic [1]. Weak comprehension and memory skills, problems with framing messages and justifying actions, as well as difficulties with self-advocacy can have lifelong implications [1, 4]. Even in the adult years, attempts to socialise by individuals with PAE may not reflect the social behaviours expected for the age group [1].

Individuals with FASD have reported that their social difficulties with friends, peers and colleagues, together with cognitive and mental health difficulties have a negative impact on self-concept and daily functioning [5]. Social exclusion, mental ill health and development of maladaptive and anti-social behaviours have been reported among those with FASD, and individuals with FASD or PAE are overrepresented in special education, justice and psychiatric populations [6].

Assessment

The Australian Guide to the Diagnosis of FASD [7] includes assessment of social skills and social communication as part of the domain, 'Adaptive functioning/social skills/social communication' (p.30). An individual's performance in this domain is considered by a multi-disciplinary assessment team (i.e. speech pathologist, occupational therapist, psychologist, paediatrician) when a potential FASD diagnosis and services are being considered. Due to the variability of how FASD can present and the complexity of social skills and social communication, assessment should be informed with the family, and will ideally consider the social processing demands of various settings (e.g. home, school, work).

Intervention Evidence Base

To date, evaluated programs that target social skills and social communication among individuals with FASD are limited. Three studies have investigated controlled trials of a manualised-social skills program with children, aged 6-12 years with FASD or PAE (mean VIQ=94), and their parents [8-10]. The program included explicit instruction, modelling, rehearsal, feedback, home practice, and the central component of parent coaching. Results from these studies showed that children, who received 1 x 90-minute session each week for 12 weeks, had significant improvements in their knowledge of appropriate social skills [8, 9], self-concept (including academic status and freedom of anxiety) [9], hostile attributions on peer group entry [10] and parent-reported social skills and problem behaviours [8]. These gains were maintained at 3-month follow-up in each study however these studies lack longer-term follow up. While parents of the children reported increased confidence in helping their children to initiate and maintain friendships, they did not rate their children's self-control differently following the intervention, and teachers' ratings did not change [9].

Among children with FASD who received the manualised social skills intervention, neuroleptic medication was found to be more efficacious compared to stimulant medication (as monotherapy and in combination with neuroleptics) [11] however an insufficient evidence base limits clinical guidance of psycho-pharmacological interventions for individuals with FASD [12].

A single-case study with a 9-year old child with FASD (VIQ=72) revealed that role play, social problem solving using a simple visual checklist, modelling, and language therapy (specifically development of mental state vocabulary) can be effective in improving social skills and social communication. Following 2 weeks of individual and 4 weeks of small group intervention, improvements were evident for vocabulary related to mental states, formulation of more complex responses during verbal reasoning, and generation and selection of socially appropriate choices [13]. Caregiver reports demonstrated that the child also initiated more questions to better understand what others had said.

Among adolescents with FASD, qualitative investigation of an arts-based theatre skills training program found that the participants (*n*=3, Indigenous descent, aged 9-14 years) experienced improvements in self-confidence, interpersonal relationships, and emotion recognition and self-control [14]. The intervention was implemented over 5 x 4 hr sessions for 4 weeks and was co-facilitated by a professional theatre artist as well as occupational therapy students.

Generalising learned behaviours can be hard for individuals with FASD [9, 13]. Therefore, it will be important to plan social skills and social communication interventions in settings that are relevant to the daily functioning and priorities of the individual and family.

Conclusion

A small, but growing evidence base demonstrates the benefit of structured interventions improving social competence of individuals with FASD. For younger children, there is good evidence for interventions which involve both children and their caregivers [15], and preliminary evidence exists for social skills and social communication interventions with adolescents. While there is limited evidence for intervention with adults with FASD, there is no reason to think that those with FASD would not benefit from interventions for social communication used with other populations.

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