Effect of a social skills training group on everyday activities of children with attention-deficit–hyperactivity disorder

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This preliminary study compared the daily living skills of children with and without attention-deficit–hyperactivity disorder (ADHD), and the influence of a social skills training group on these skills. Twenty-seven children with ADHD (2 females, 25 males; age range 5 to 8y, mean 6y 6mo, SD 10mo), and 24 children without ADHD (8 females, 16 males; age range 5 to 8y, mean 6y 11mo, SD 10mo) performed the Assessment of Motor and Process Skills (AMPS). Fourteen of the children with ADHD used medication daily. Nine of the total group with ADHD were randomly selected to attend group treatment which focused on social skills training, through meaningful occupations (e.g. art, games, cooking). Children were evaluated at the beginning of group treatment and after 10 sessions. Ten children without ADHD were evaluated at similar intervals. Children with ADHD initially achieved significantly lower scores on the AMPS in all process skills ($p<0.001$) and in the coordination motor subtest ($p<0.005$) than children without ADHD. Children with ADHD significantly improved from the first to the second evaluation and no longer differed from the children without ADHD after treatment ($p<0.008$). The results emphasize the need for a focus upon occupation in assessment and treatment of children with ADHD.

Attention-deficit–hyperactivity disorder (ADHD) is described as different combinations of attention deficits, hyperactivity, and impulsiveness (American Psychiatric Association 1994). This chronic behavioural problem is the most common reason for referral of children to mental health centers (Goldstein 1995, Cantwell 1996).

The symptoms of ADHD, as they appear in the Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition (DSM-IV; American Psychiatric Association 1994), interfere with functioning in at least two of three contexts: at home, in school, and/or in social contexts (American Psychiatric Association 1994, National Institutes of Health 2000). The behavioural difficulties of children with ADHD can also affect functioning in personal care (bathing and eating), in school and homework preparation (Barkley 1997, Segal 1999), and can cause disturbances in various social situations, such as difficulties in coping with group situations and behavioural disturbances in the classroom that lead to social rejection (Goldstein 1995, Lock 1996, Dulcan 1997, Farone et al. 1998, Merrell and Wolfe 1998, Buttross 2000, National Institutes of Health 2000).

OCCUPATIONAL THERAPY AND ADHD
The 1990s were a turning point in the professional thinking of the various health services, including the field of occupational therapy (OT), which places emphasis on an individual’s participation in their surroundings, relating to the client as a full partner in the process (World Health Organization 2001, Law 2002). Consequently, occupation was given a central role, in accordance with the approach from which the field of OT arose. Nonetheless, the central role of occupation in the paediatric field began to develop only in recent years and there is a trend towards re-examining the methods of evaluation and intervention so that they can truly reflect this role as well as reflect the daily functional level of the child at home and in school (Law et al. 1997, Coster 1998, McLaughlin 1998, Primeau and Ferguson 1999).

According to the OT practice framework (American Occupational Therapy Association 2002), the main areas of occupation for children are social participation, activities of daily living (ADL), instrumental ADL (IADL), education, and play and leisure, where improving performance skills is aimed at improving occupational performance. Occupational performance is the result of a dynamic relationship between persons, environment, and occupation (Law et al. 1997).

Despite this trend, children with ADHD are mostly referred to an occupational therapist because of difficulties that accompany the attention problems (e.g. motor, perceptual, and sensory deficits; Parush 1994, Mulligan 1996) and the evaluation and intervention of OT is related mainly to impaired body functions, including those that are cognitive, sensory, and movement-related. In the literature on OT there are very few descriptions of performance or treatment of children in areas of occupation. We found no study examining the functional ability of children with ADHD in daily tasks; therefore, the first objective of the present study was to examine the functional ability of these children for daily tasks compared with children without ADHD.

Because of the multitude of symptoms in children with ADHD, there is a preference for multimodal treatment in these children that combines medical, emotional, and social treatment (Barkley 1990, Braswell 1993, Jones 1994, Richters et al. 1995, Searight et al. 1995, Cantwell 1996, Dulcan 1997,
Pelham et al. 1998, National Institutes of Health 2000). Recently, the conclusion from a large randomized clinical trial was that the primary factor in multimodal treatment was the use of medication (MTA Cooperative Group 2004a,b). Yet, few studies have examined the efficacy of such treatment over time and found that this multimodal treatment has the same beneficial effect as treatment with medication in such a way that in the future it might be possible to reduce the medication dosage (Braswell 1993, Cantwell 1996, Dulcan 1997). It seems that there is a need for more studies investigating the effect of multimodal treatment.

Although, as mentioned, social skills dysfunction is stated in the literature as the main difficulty of children with ADHD, no papers on OT intervention focusing on communication and interaction skills were found. Therefore, the second goal of this study was to investigate the effect of such OT intervention on the occupational performance of children with ADHD. This preliminary study examined the efficacy of group therapy, focusing on communication and interaction skills combined with an instruction group for parents as part of the multimodal treatment.

SUMMARY
It can be seen that children with ADHD have difficulties in functional areas relating to socialization, learning, and daily tasks. In addition, integration of performance skills and the relationship between the child and their environment and occupations are impaired. In the literature there is little treatment of the difficulties that children with ADHD may encounter while performing daily tasks, and these are mainly described through reports of parents (Barkley 1997). No study compared the functioning of children with ADHD in daily tasks with that of children without ADHD. The first objective of the present study was to examine the functioning in daily tasks of children with ADHD compared with those without ADHD. The second objective relates to the efficacy of OT intervention. The effect of training in social skills with the instruction of parents has been examined so far through questionnaires and reports of the children, parents, and teachers, but there no study was found that examined the effect of such treatment on the functioning of these children in daily tasks. Therefore, the second objective of this study was to examine the effect of multimodal treatment on the functioning of the child with ADHD. We examined the effect of OT intervention, which focuses on improvement in social skills and instruction of parents, on functioning in daily tasks according to the Assessment of Motor and Process Skills (AMPS; Fisher 1997) evaluation.

Method
PARTICIPANTS
Fifty-one children, aged 5 to 8 years (mean 6y 9mo, SD 10mo), participated in this study. Participants were divided into two groups: children with ADHD (2 females, 25 males; mean age 6y 6mo, SD 10 mo), and children without ADHD (8 females, 16 males; mean 6 years 1mo, SD 10mo). All children attended mainstream schools at the time of the study.

The children with ADHD were selected from the Jerusalem Child and Family Developmental Center (Jerusalem, Israel) where they were diagnosed by a paediatric neurologist based on the criteria of the DSM-IV. In addition, they scored higher than 15 on the Conners’ Teachers Rating Scale (CTRS28 [scale 28]) and the Conners’ Parent Rating Scale (CPRS48 [scale 48]; Conners 1990). The children without ADHD were selected from the same schools as children with ADHD, had no known developmental problems, were not under therapy for any other reason, and scored lower than 15 on both the CTRS28 and the CPRS48. No significant difference was found between the groups for age and parents’ education.

Fourteen of the children with ADHD used medication daily, but did not use medication during the treatment or the

Table I: Procedure for studying effect of occupational therapy (OT) social skills group-intervention on children with ADHD

<table>
<thead>
<tr>
<th>Time</th>
<th>First assessment</th>
<th>OT group intervention</th>
<th>Second assessment</th>
<th>Break</th>
<th>OT group intervention</th>
<th>Third assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>With ADHD</td>
<td>n=27</td>
<td>10 weeks</td>
<td>n=9</td>
<td>Week 10</td>
<td>4 weeks</td>
<td>n=9</td>
</tr>
<tr>
<td>Without ADHD</td>
<td>n=24</td>
<td>–</td>
<td>n=10</td>
<td>Week 19</td>
<td>–</td>
<td>–</td>
</tr>
</tbody>
</table>

–, children without ADHD were not assessed at this stage.

Table II: Difference between children with (n=27) and without (n=24) ADHD, t-test and summary statistics

<table>
<thead>
<tr>
<th>Item</th>
<th>t-test</th>
<th>p</th>
<th>With ADHD, mean (SD)</th>
<th>Without ADHD, mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Process scale (total score)</td>
<td>-5.79</td>
<td>0.001*b</td>
<td>0.53 (0.55)</td>
<td>1.38 (0.38)</td>
</tr>
<tr>
<td>Energy</td>
<td>-4.03</td>
<td>0.001*b</td>
<td>3.23 (0.35)</td>
<td>3.59 (0.28)</td>
</tr>
<tr>
<td>Using knowledge</td>
<td>-3.08</td>
<td>0.003*a</td>
<td>3.04 (0.44)</td>
<td>3.36 (0.29)</td>
</tr>
<tr>
<td>Time</td>
<td>-3.51</td>
<td>0.001*b</td>
<td>2.71 (0.59)</td>
<td>3.22 (0.44)</td>
</tr>
<tr>
<td>Space and objects</td>
<td>-3.50</td>
<td>0.002*</td>
<td>2.65 (0.59)</td>
<td>3.08 (0.30)</td>
</tr>
<tr>
<td>Adaptation</td>
<td>-2.00</td>
<td>0.054</td>
<td>2.19 (0.52)</td>
<td>2.43 (0.29)</td>
</tr>
<tr>
<td>Motor scale (total score)</td>
<td>0.65</td>
<td>0.531</td>
<td>3.24 (0.09)</td>
<td>3.25 (0.10)</td>
</tr>
<tr>
<td>Mobility</td>
<td>-0.57</td>
<td>0.713</td>
<td>3.96 (0.001)</td>
<td>3.97 (0.01)</td>
</tr>
<tr>
<td>Coordination</td>
<td>-2.67</td>
<td>0.005*a</td>
<td>3.17 (0.59)</td>
<td>3.53 (0.38)</td>
</tr>
<tr>
<td>Strength and effort</td>
<td>-1.24</td>
<td>0.222</td>
<td>3.08 (0.45)</td>
<td>3.22 (0.22)</td>
</tr>
</tbody>
</table>

*p<0.01; *p<0.001.
assessed. No change in medication use occurred during the study. In addition, no significant difference in performance, as measured by the AMPS, was found between those who took medication compared to those who did not.

INSTRUMENTS

AMPS

AMPS is an assessment of performance ability in ADL or IADL tasks chosen by the participant. It is the only assessment of everyday and self-care tasks that is standardized and suitable for children under school age (Primeau and Ferguson 1999). During an AMPS task observation, the person is expected to perform two or three tasks, chosen from a variety of which are listed in the assessment, in their usual manner. The tasks are divided into 13 major groups, e.g. beverage/cereal preparation and table setting. While performing the tasks, 16 motor and 20 process skill items are rated on a four-point rating scale, with scores ranging from 1 (deficit: skill item deficit is severe enough to result in task breakdown, danger, or an unacceptable slowing of the task progression) to 4 (competent: no evidence of a skill item deficit affecting performance). Because the AMPS scoring includes four facets (skill item complexity, rater severity, task difficulty, and person ability), the multi-faceted Rasch model (Linacre 1993) was used to analyze the AMPS scores. This measurement model allows a therapist to determine the ADL ability of the client, while taking into account the relative challenge of each of the ADL tasks the client performed. As a result, clients who performed different ADL tasks can be directly compared. In addition, the measurement model also allows us to generate ADL ability measures that are adjusted to account for the severity of the rater who rated the participant’s performance. As a result, measures of participant ability are not biased by the particular rater who observed the performance. More detailed description of the use of the many-faceted Rasch analysis to develop the AMPS has been reported elsewhere (Fisher 1993, 1997; Magalhaes et al. 1996). Two ability measures were calculated from the raw data, these were the motor and process ability measures, which are expressed in logits and can range from −3 (less able) to +4 (more able). Each score has its own cut-off point, with scores above this point indicating independent level and scores below this point indicating dependent level.

AMPS was administered to the participants in accordance with the standardized procedure delineated in the AMPS manual (Fisher 1997).

PROCEDURE

Participants were referred to OT by a physician from the Jerusalem Child and Family Developmental Center. The first author (DG), who was trained and calibrated as an AMPS rater, collected the data. Two therapists conducted the group and another two, the evaluations (one was the first author, DG). The initial assessment was administered in the clinic in one session in accordance with the procedure described in the AMPS manual (Fisher 1997). To offer the children a reasonable number of activities to choose from, one of the parents of each participant was interviewed, one or two days before testing, to determine a list of at least five tasks of the AMPS task choices that the child performed at home and was familiar with. Based on this interview, five or six tasks were offered to the children to decide which they were willing to perform. Participants were evaluated after giving consent to participate in the study. Ethical permission was obtained for this study from the ethical committee of the Jerusalem Child and Family Developmental Center.

Of the 27 children with ADHD, nine were randomly selected to participate in an OT social skills training group, focusing on communication and interactions skills. The group was conducted by two registered occupational therapists and was based on principles of behavioural and cognitive models (Braswell 1993, Cousins and Weiss 1993, Hoagwood et al. 2000). A parallel parents’ group was conducted by a social worker and a psychologist. All meetings had a fixed structure, including relaxation exercises at the beginning of the session, followed by different activities (arts, games, cooking), and finally, cleaning up the room together. None of those activities were from the AMPS tasks. Each meeting had a social theme, with the goal of acquiring social skills such as listening, waiting in turn, and learning how to behave when irritated by another child. The activity was suited to the specific social skill (e.g. a game that requires waiting in turn). The session lasted an hour, with the parents joining the group for the last 15 minutes to inform them on details of the specific session and homework given to the children, and to give guidance on how to implement skills practiced in the group at home.

In all there were 15 weekly sessions, with a one-month break after the tenth meeting. This group of children was evaluated, in addition to their initial assessment, after 10 weeks (second evaluation) and again after the last meeting (third evaluation), altogether 9 weeks after the second evaluation, and 19 weeks after first assessment (Table I).

Of the 24 children without ADHD, 10 were randomly selected and evaluated (in addition to the initial assessment) after 10 weeks, in parallel to the second evaluation of the children with ADHD who participated in the OT social skills training group (Table I).

![Figure 1: Score dispersion of motor and process abilities among children with and without ADHD.](image-url)
DATA ANALYSIS
The dependent measures included the motor and the process ability measures of the AMPS. In addition, the mean scores of the subscales were included in some of the analyses.

To test for differences between the children with and without ADHD on the AMPS performance, two separate t-tests were done for each of the dependent measures.

To test for differences between the three assessments in the group of children with ADHD who participated in the group therapy, a one-way analysis of variance (ANOVA) with repeated measures on the last factor was performed for each of the dependent measures.

To test for differences between the first two assessments and between children with and without ADHD, two-way ANOVAs were performed on each dependent measure: 2 (diagnosed group) × 2 (assessment) with repeated measures on the last factor.

Post hoc tests were performed after significant ANOVA tests using simple contrasts (Bonferroni procedure), to test for significant differences between the means (Rohlf and Sokal 1981, Kirk 1982). The level of significance was set at 0.05 for all statistical tests.

RESULTS
DIFFERENCES BETWEEN CHILDREN WITH AND WITHOUT ADHD IN ADL/IADL PERFORMANCE

Process scale
There was a significant difference between the children with and without ADHD in the AMPS process scale (Table II). Children without ADHD performed better than children with ADHD (Fig. 1). In addition, there was a significant difference between the two groups in all the process subscales; the children without ADHD outperformed those with ADHD (Table II).

Motor scale
There was no difference between the children with and without ADHD in the AMPS motor scale (Table II). In addition, there was no significant difference between the two groups in the motor subscales, except for the coordination subscale in which the children without ADHD outperformed the children with ADHD (Table II).

DIFFERENCES BETWEEN THE THREE ASSESSMENTS
To test for differences between the three assessments in the children with ADHD who participated in the OT social skills training group, a one-way ANOVA with repeated measures on the last factor was performed for each of the dependent variables. There was a significant difference between the three assessments in both the process and motor scales ($F[2,16]=5.573$, $p<0.015$ and $F[2,16]=12.482$, $p<0.001$ respectively). As depicted in Figure 2, in both process and motor scales post hoc analyses revealed a significant improvement from the first assessment to the second and first to the third (see Table III for means). There were no significant differences between the second and third assessments.

DIFFERENCES BETWEEN ASSESSMENTS AND DIAGNOSED GROUP
To test for differences between the first two assessments and between children with and without ADHD, two-way ANOVAs were performed on each of the dependent measures: 2 (diagnosed group) × 2 (assessment) with repeated measures on the last factor. The main effects of diagnosed group and assessment were not significant on both the process and the motor scale (see Table IV for results). Interaction between assessment and diagnosed group was significant on both the process and the motor scales (see Table III for means). Post hoc analysis revealed that children with ADHD who participated in the OT social skills training group improved from the first to the second assessment whereas for the children without ADHD there was no difference in performance between these two assessments on either scale (Figs 3 and 4). In addition, in the process scale there was a significant difference between the two groups only in the first assessment, where the children without ADHD outperformed the children with ADHD. In the motor scale there was no significant difference between the two groups in either assessment.

DISCUSSION
Children with ADHD have difficulties in functioning in the areas of social interaction and learning and everyday tasks. There is very limited reference in the literature to the difficulties children with ADHD might experience when performing ADL, and where these difficulties are reported they are from the parent’s perspective (Barkey 1997). This study investigated the ADL and IADL abilities of children with ADHD compared with children without ADHD, and the effect of OT social skills training on ADL/IADL performance, as measured by the AMPS.

DIFFERENCES BETWEEN THE CHILDREN WITH AND WITHOUT ADHD IN ADL/IADL PERFORMANCE
This study confirms that children with ADHD have more difficulty in ADL and IADL performance compared with children without ADHD. This difference was significant mainly in the process scale, including all its subscales, but, additionally it was found to be significant in the coordination subscale of the motor scale. These difficulties were demonstrated by the children’s difficulties in attending to a given task, difficulties in following instructions and terminating the task, difficulties
in organizing actions, talking too frequently, and difficulties related to space and objects. For example, children with ADHD were often observed spilling sugar without noticing, asking irrelevant or unnecessary questions, neglecting to clean up after themselves when they had finished a task, and forgetting to use tools agreed on initially and consequently using inappropriate tools. These results agree with the difficulties ascribed to children with ADHD according to DSM-IV (American Psychiatric Association 1994).

In the motor scales, as expected, children demonstrated difficulties only in coordination. These results confirm reports in the literature about difficulties of children with ADHD with fine motor manipulation, control of handwriting, and motor coordination (Barkley 1990, 1997; Searight et al. 1995; Whitmont and Clark 1996; Kadesjo and Gillberg 1998; Raggio 1999). Barkley (1997) stated that children with ADHD have difficulties in motor activities that demand inhibiting and sequencing the motor action. It is possible that the motor coordination difficulties which children with ADHD in this study exhibited were related to their impulsive behaviour (Raggio 1999). Gillberg and colleagues (Kadesjo and Gillberg 1998, Rasmussen and Gillberg 2000, Gillberg 2003, Gillberg and Kadesjo 2003) found that there was considerable comorbidity between ADHD and Developmental Coordination Disorder, with about half of each diagnostic group also meeting criteria for the other diagnosis. This might explain the findings of coordination difficulties exhibited by the children with ADHD in this study.

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Table III: Summary statistics for process and motor scale performance for each assessment across participants with and without ADHD

<table>
<thead>
<tr>
<th></th>
<th>Process scale, mean (SD)</th>
<th>Motor scale, mean (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>First assessment</td>
<td>Second assessment</td>
</tr>
<tr>
<td>ADHD</td>
<td>0.58 (0.52)</td>
<td>1.36 (0.92)</td>
</tr>
<tr>
<td>Without ADHD</td>
<td>1.36 (1.16)</td>
<td>1.16 (0.27)</td>
</tr>
</tbody>
</table>

– children without ADHD were not assessed at this stage.

Table IV: Analysis of variance of group (with and without ADHD) by assessment time on process and motor scales

<table>
<thead>
<tr>
<th></th>
<th>Process scale</th>
<th>Motor scale</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>F(1,17)</td>
<td>p</td>
</tr>
<tr>
<td>Diagnosed group</td>
<td>2.13</td>
<td>0.163</td>
</tr>
<tr>
<td>Assessment time</td>
<td>2.97</td>
<td>0.103</td>
</tr>
<tr>
<td>Diagnosed group × time</td>
<td>9.67</td>
<td>0.008a</td>
</tr>
</tbody>
</table>

*p < 0.01; **p < 0.001.

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Figure 3: Interaction between assessment and diagnosed group in Assessment of Motor and Process Skills process scale.

Figure 4: Interaction between assessment and diagnosed group in Assessment of Motor and Process Skills motor scale.
EFFECT OF OT SOCIAL SKILLS TRAINING GROUP ON ADL PERFORMANCE

Results of this study showed that the OT social skills training group was found to be effective. Children with ADHD improved from under the cut-off point before the social skills training group intervention to above the cut-off point after the intervention. This improvement was found for both the process and the motor scales, but it is important to note that only in the process skills, which present the main difficulties for children with ADHD, was there a significant difference between the two groups before the intervention. Even more important is the fact that this difference disappeared by the end of the group intervention, at which time the children with ADHD performed equally as well as the children without ADHD. Thus, children with ADHD performed better in activities such as meal preparation, sweeping the floor, taking care of plants, and getting dressed after the intervention. This improvement was not found for the children without ADHD, indicating that the improvement of the children with ADHD was directly due to the OT social skills training group. In future studies we recommend adding an additional control group of children with the same medical status who do not participate in the group intervention.

The fact that there was no significant improvement between the second (end of first part of intervention) and the third (end of second part of intervention) assessments may raise the question of the necessity of the second part of the group intervention. Yet, it is possible that continuing the group allowed consolidation and maintenance of the skills acquired and prevention of deterioration in performance. Braswell (1993) stressed the importance of extending group intervention for children with ADHD for at least 12 weeks. It seems that the ability of the children with ADHD to perform above the cut-off point for a long period of time was due to the continuation of the group even after participants reached independence. Further study is needed to clarify the ideal length of intervention. Such a study should also assess the child’s ability long after the intervention is withdrawn.

The group intervention in this study focused on acquiring social skills through meaningful occupations, such as games, arts and crafts, and cooking, while organizing a familiar context, including participation of the parents in the process and encouraging them to change their demands upon the children based on the individual child’s abilities. Coping with the different roles and the social themes in the group, together with suitable and usually self-chosen activities, allowed the children with ADHD to directly confront their social difficulties in the appropriate context of a meaningful activity. A few studies found that group treatment focusing on improving social skills also improved social behaviour, and indirectly improved problem-solving ability in a social situation, as well as socializing with friends (see Braswell 1993, Cousins and Weiss 1993). This study went further and showed that focusing on social skills helped to improve the occupational performance of ADL and IADL as well.

It is important to note that this is a preliminary study, with a small sample. A larger sample is needed to be studied to reinform its results. In addition, because this study used non-blinded assessments, future study should include blinded assessment to overcome this limitation.

This study demonstrated the importance of a multimodal approach. Intervention that included both parents and children, and encompassed the social, motor, and process skills of the child within the context of occupations relevant to them, was found to be beneficial. It seems that improving social skills helped the children perform a wide range of occupational activities, including ADL and IADL (Kielhofner 1995, Baum and Law 1997, Law et al. 1997, Primeau and Ferguson 1999).

Including the parents in the process allowed better implementation of skills acquired. The increased awareness of the family of the child’s difficulties and abilities allowed the family to focus on areas needing help, to cooperate more willingly in the intervention process, and to transfer the learned skills to the home. This study reinforces the importance of family centered intervention (Law et al. 1995, Baum and Law 1997, Baum 1998, Coster 1998, McLaughlin 1998, Primeau and Ferguson 1999). Further study is needed to investigate the inclusion of the school system as part of a child’s daily activities and natural context, long-term effect, differences between the types of ADHD, and to compare other types of intervention.

DOI: 10.1017/S0012162205001052

Accepted for publication 20th September 2004.

References


**List of abbreviations**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Definition</th>
</tr>
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<tbody>
<tr>
<td>ADL</td>
<td>Activities of daily living</td>
</tr>
<tr>
<td>AMPs</td>
<td>Assessment of Motor and Process Skills</td>
</tr>
<tr>
<td>IADL</td>
<td>Instrumental activities of daily living</td>
</tr>
<tr>
<td>OT</td>
<td>Occupational therapy</td>
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</table>

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