

Enhancing the Self-Esteem and Social Competence of Hyperactive Children: A Semi-Structured Activity Group Therapy Model

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This article proposes a semi-structured activities group model for addressing the fragile self-esteem and social discord often shown by hyperactive children. Included is a discussion of the amount of structure and types of activities necessary to foster effective group work with this client population. The author asserts that hyperactivity oftentimes is better conceptualized in terms of unmet exhibitionistic needs, the sensitive handling of which can impact the acquisition of healthy self-esteem. Another key focus is the role of shame in manifestations of aggression and externalization of blame that diminish the social competence of hyperactive children. Clinical vignettes are used to illustrate key points.

KEY WORDS: group therapy; hyperactive children; exhibitionism; shame.

Psychostimulant use is widely viewed as the preeminent treatment intervention for hyperactive children (Barkley, 1990), and frequently is the only mode of treatment made available to such children—a practice that might become more pervasive with the cost-cutting measures and rationing of services associated with managed health care. Nevertheless, while psychostimulant use can reduce disruptive behaviors and bring about increased attentiveness, it may fall short as regards addressing the injured self-esteem and diminished interpersonal functioning that are commonplace among hyperactive children (Landau & Moore, 1991; Whalen & Henker, 1985). The medicated hyperactive child may be less annoying and more focused, but not necessarily more liked by self and others, popular with his or her peers, or apt to engage interactions with others, be they neutral or positive (Hinshaw, Henker, Whalen, Erhardt, & Dunnington, 1989; Whalen, Henker, Collins, Finck, & Dotemoto, 1979). Underlying deficits in sociability and self-worth often go undetected and

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untreated, as parents, teachers, and other professionals rush to find remedies for conspicuous disruptive behaviors.

Group psychotherapy may offer certain advantages over individual psycho-therapy as regards facilitating the development of social competence and self-assuredness in hyperactive children. There is the obvious benefit of occasions for peer interaction. Also, it is unlikely that the one-on-one therapeutic relationship matches group psychotherapy in terms of eliciting the range and intensity of psychological vulnerabilities typically shown by hyperactive children. Furthermore, given the symmetry between interpersonal challenges encountered in group and other social domains (e.g., peer conflicts, sharing and cooperating, not interrupting, waiting one's turn in games), what is learned in group may be more readily transferable to everyday social situations than what is learned in the context of individual psychotherapy.

As such, it is surprising that there is a dearth of literature supporting group therapy as a treatment modality for hyperactive children. With prevalence rates of hyperactivity in children on the rise, more attention needs to be paid to devising group therapy interventions that might be effective with this client population.

Consequently, this paper amounts to a delineation and exploration of common dynamics and treatment issues that emerge in group work with hyperactive children. Suggestions for optimal levels of structure and types of group activities will be discussed. However, the bulk of the paper will focus on deficits in self-esteem and social competence that oftentimes co-exist with hyperactivity. It

will be proposed that the antics of hyperactive children can reflect archaic exhibitionistic needs that require sensitive handling by group leaders since they have important ramifications for the strengthening of self-esteem. In addition, there will be an in-depth exploration of the role shame can play in manifestations of aggression and externalization of blame that cripple the social functioning of hyperactive children.

The author's formulations, as well as the case vignettes supplied, are derived from his experiences co-leading a long-term, semi-structured activity group for preadolescent hyperactive children using a combination of self-psychology and operant conditioning techniques.

GROUP STRUCTURE

Children prone to exhibiting disruptive and impulsive behaviors are thought to benefit most from well-structured groups. Brown and Papagno (1991) underscore how internalization of the directives and firm structure provided by group leaders constitutes the superordinate goal for behaviorally disabled children. O'Brien (1992) cautions the therapist against adopting any techniques that might promote regressive experiences, due to their high potential for inducing disorganization and overexcitement-experiences that are notoriously difficult for hyperactive children to recover from. Nevertheless, little has been written about how an overemphasis on structure might rob group members of occasions to take initiative, problem solve, and negotiate solutions-all spontaneously generated to address challenging situations that arise in group. Arguably, group formats that rely too heavily on a preset curriculum, with predetermined tasks and activities and

compliance with directives issued by group leaders, run the risk of compounding the lack of confidence hyperactive children often have in their sense of initiative, judgment and spontaneous decision making.

Moreover, a certain degree of initiative taking and spontaneity are essential if the group experience is to be enjoyable. An added risk concerning overuse of structure is a reduction in the genuine pleasure and mutual satisfaction members derive from group. This can have an adverse impact on members' attendance, their emotional investment in the group experience, the strength of the bonds they develop, and even their motivation to show self-control and comply with rules. As for the latter, Slavson (1943) indicates how compliance with rules in group psychotherapy is best achieved not through appeals to morality (e.g., "Learning to cooperate and get along is what mature boys do") but through calling attention to the fun group members are missing out on by misbehaving (e.g., "You know, the more time you guys spend teasing each other the less time we will have to finish this fun basketball game that you decided to play"). Indeed, those who use time-outs and suspensions to reduce disruptive behavior in children know that the effectiveness of such methods is rooted in the deprivation of enjoyment children feel when they are prevented from participating. Not wanting to miss out on the fun becomes the impetus for future compliance.

It is conceivable that countertransference impacts the amount of structure imposed by group therapists. The fast-paced verbal and behavioral exchanges, animated play styles and rash actions that fill the group therapy room can catalyze tendencies towards overcontrol or helplessness.

permissiveness in group leaders. Such polarized countertransferential reactions have to be closely monitored if group leaders are to more objectively strike a balance between structure that prevents excessive loss of control, and flexibility that allows for initiative taking, playfulness, and spontaneity—all important aspects of self-esteem.

SEMI-STRUCTURED ACTIVITY GROUP FORMAT

One group format that offers promise with hyperactive children is a semi-structured activities group. Overall order is maintained through use of operant conditioning techniques in which members earn points for displaying specified prosocial behaviors (e.g., cooperation, sharing, listening, not interrupting) that can be cashed in for small toys during "store time" at the end of group. A measure of self-generated motivation is introduced by allowing each member to identify which small toys they want to work towards earning that group leaders might purchase for the "toy store." Leaders convey a sense of specialness to each member by purchasing and placing name tags on the items identified by each member as desirable.

Consequences for negative behaviors (e.g., name calling, fighting, leaving the play area without permission) are spelled out in advance and thought is given to "the punishment fitting the crime" (e.g., name calling results in points not being earned, time out and points deducted for minor episodes of physical aggression, and one-week suspension from group for major episodes of physical aggression). However, group leaders need to be mindful of how hyperactive children often demonstrate auditory processing and memory impairments which may impact their capacity to follow verbal commands and instructions

(Smith, 1986). Of relevance here is Woods' (1993) insight that "for some children a boundary can become real only when it is crossed" (p.74). Many hyperactive children need to directly experience the consequences for misbehaving to solidify their understanding of the rules.

To enhance members' confidence in their abilities to assertively negotiate and arrive at reasonable judgments, and to allow for some autonomy, group leaders can on occasion allow members to brainstorm as to reasonable consequences for infractions that arise, whether this be the child who has broken a rule generating and determining possible consequences, or the group as a whole serving this function. Indeed, *peers may* be more inclined to listen to each other than to the group leader (Woods, 1993). However, it is incumbent on group leaders to eliminate harsh and unreasonable consequences, or those that are overt or covert attempts to scapegoat the child who has transgressed.

Much thought has to be given to the desired setting and types of activities made available during a given group session. Ideally, access to a playroom, a playground, the local library and park, as well as nearby shops and entertainment centers, increases opportunities to acquire competencies in a wide range of social domains. As such, the playroom may function more as "home base" than the sole treatment setting. This approach is in line with Whalen and Henker's (1985) endorsement of innovative interventions that place hyperactive children "in a graded series of real-life situations-both the mundane and the provocative-and teaching them to generate, evaluate, and modify interactional strategies" (p.472). At each session, when

group leaders and members are collaborating as to the most desirable setting that day, group leaders have to gauge the amount of stimulation and looseness of structure that can be tolerated by members. Safety concerns, or the emotional needs of the group in the moment, may limit the type of milieu leaders are ultimately willing to agree to. For instance, a trip to the local candy store may be out of the question if the anger brewing between two group members shows signs of turning physical. And, leaders may limit milieu choices to those that have a stronger chance of building group cohesion when it appears fragile, such as small play spaces with enclosed physical boundaries.

One criticism that can be leveled at the use of an assortment of milieus in which to conduct group with hyperactive children is that it deprives them of needed consistency and predictability, and may contribute to the very disorganization these children need to master. A counterargument here is that it is not consistency and predictability in the setting, per se, but in the therapeutic style of the leaders (e.g., regularly present at group, responsive, attentive, consistently setting and enforcing limits) that is a key ameliorative agent with hyperactive children.

In devising group activities that members may select from, several criteria have to be borne in mind. In order to have appeal to hyperactive children, activities must be somewhat action-oriented, and not exert too many demands on the child to be stationary, seated and verbal. Conventional talk therapy is contraindicated with this client population since "asking children with significant developmental delays to use speech as their primary medium of communication is akin to demanding that they cure

themselves as a prerequisite to entering treatment" (Schames, 1986, p.36). Verbalization of feeling states, thoughts, interests, desires and the like may best be encouraged as members engage in activities, rather than as the core feature of the activity itself.

If activities are to have an ameliorative effect they have to blend action-orientedness with practices that draw upon capacities for impulse control, perseverance, and reflectiveness. Examples of these types of activities are as follows:

- (1)*The Treasure Hunt Game*: A cardboard box full of toys and snacks is hidden somewhere on clinic grounds. Teams are selected and given the task of finding numerous hidden written clues. Each written clue hints at the location of the next one, with the final clue providing obscure evidence as to the location of the "buried treasure." Members are told emphatically that they need to walk between sites at which clues are hidden and that the team to which anyone who runs belongs will have to all sit down for a minute. The "no running" rule, and the need to take time to decipher clues, all in an atmosphere of excitement and heightened anticipation, assist with the acquisition of impulse control and reflecting before acting.
- (2)*Game Stations*: Votes are taken on games that will be played. The three games that receive the most votes are used in the game stations. Members are divided into teams and either choose or are assigned to game stations. Teams need to wait ten minutes before switching game stations. Each time a team sticks to the game at their respective station for the entire ten minutes, the members in that team receive a snack. This activity is aimed at engendering perseverance and not giving up easily.
- (3)*Shopping Time*: Members are given the option of visiting a local candy or toy store. They are each allotted \$2.00 in spending money. Should they want additional money to purchase items, members can convert points they have saved for displaying prosocial behavior into money. However, it is made clear that if points are cashed in, there will be fewer of them to spend at the "toy store" at the end of group. Members who remain within the \$2.00 allotment without cashing in points, receive bonus points. Budgeting, reflecting on choices, and delay of gratification are all part of this activity.

A final note pertains to the selection of games and activities that are readily mastered. Since failure experiences of one sort or another tend to be ubiquitous among hyperactive children (O'Brien, 1992), group leaders' armamentarium needs to be replete with games and activities

that offer a strong potential for mastery and successful outcomes based on mild to moderate levels of attention, concentration and perseverance. In addition, group leaders need to become well acquainted with the cognitive and kinesthetic strengths and weaknesses of each group member for purposes of selecting a variety of games and activities that offer high potential for success for the greatest number of group members.

EXHIBITIONISM AND SELF-ESTEEM

In everyday language, hyperactive children are frequently observed "clowning," "horseplaying," "goofing off," "acting silly," or "showing off"-antics that can become intensified in peer group situations. Many clinicians are apt to view these as immature attention-seeking behaviors that need to be eliminated. However, when viewed from a self-psychology perspective, oftentimes the antics of hyperactive children are best conceptualized in terms of archaic exhibitionistic tendencies that have important ramifications for the development of self-esteem.

Self-psychologists propose that healthy self-esteem originates from adequate parental empathic attunement to "grandiose-exhibitionistic" needs that come into prominence during toddlerhood and persist in varying degrees throughout childhood (Kohut, 1977). The child is filled with a sense of pride and omnipotence as he or she displays newly formed physical attributes and psychomotor capacities, looking to caregivers for confirmation of his or her brilliance ("Look, daddy, I can do a cartwheel up high in the air," "Mummy, squeeze my muscles, they're so big"). Appreciation and joy shown by caregivers during these moments of exhibitionistic pride become part of the child's

self-experience and set the foundation for a sense of aliveness and self-worth.

However, disappointments are inevitable. Children cannot always perform impressive cartwheels and caregivers cannot always be available to provide undivided attention. When faced with failure the child who has experienced sufficient affirmation of his or her exhibitionistic displays will be able to internally summon forth such experiences to sooth any emotional pain and ease his or her wounded self-pride. Failures can also be more effectively coped with and learned from if caregivers are available with empathic communications that aid restoration of self-esteem; while modifying grandiose self-images ("You're still pretty good at doing cartwheels, even though you messed up on a few. Nobody can do perfect cartwheels all of the time").

Problems arise when the child's enthusiastic displays of competencies are met with either a pattern of indifference or overindulgence by caregivers. A "more demanding, insistent exhibitionism" (Miller, 1996, p.45) can be the consequence. It is precisely this type of exhibitionism, the clamoring to be seen, heard and responded to, that is often part of the clinical profile of hyperactive children in peer group situations. Such behavior may signal the persistence of unmet exhibitionistic needs and represent important occasions for group leaders to provide corrective experiences that bolster self-esteem.

David rushed into the group room eager to show off his yo-yo skills that he had been practicing all week. He boisterously announced "Look at what I can do." making his need for recognition quite conspicuous. The group leaders openly expressed amazement as David demonstrated the "Walking the Dog" and "Rocking the Cradle" techniques: "I can see that you've got those techniques down." "Bravo David, all your practice has paid off, you are so good with that **yo-yo**" Other group members were becoming restless while David was performing, and group leaders actively channeled their attention to David: "You guys, David deserves his day in the sun, can you believe how good he is with that yo yo," "Marvin. you know all about yo-yo's, don't you think David is getting

good at "Walking the Dog?" David beamed and smiled as group members and leaders alike admired him. Later that session, David sheepishly asked a group leader if it would be possible to hold group more often.

As the above example alludes to, indulging and affirming the exhibitionistic needs of any one group member carries the risk of alienating other group members and diminishing group cohesion. There is also the potential for hazardous levels of excitement within the group, whereby the exhibitionistic displays of one group member elicit animatedness and competitiveness in other group members, resulting in an overall atmosphere of unproductive disorganization. To counteract such negative events group leaders need to: (1) explicitly identify the legitimacy of any group member displaying strengths and being the central focus of group attention for brief periods, (2) actively encourage group members to provide mutual praise and admiration, and (3) be prepared to temporarily provide one-on-one attention to the child with acute exhibitionistic needs, while other group leaders concern themselves with preserving sufficient degrees of order and control within the group. An additional impetus for group members to remain attentive during displays of strength by others is the vicarious awareness that they too might receive collective admiration should the need arise.

Although collectively focusing on a child who is "showing off" can potentially lead to a more prolonged exhibitionistic display by him or her and jeopardize group cohesion, in my experience being the focus of positive group attention often de-energizes the exhibitionism and allows the child to redirect attention to the needs of the group as a whole.

Terrell began speaking rapidly about his interest in Bruce Lee and the video collection of karate movies he had amassed. Unsolicited, he launched into a demonstration of different **karate moves**. Group

leaders calmly asked other members to stand back and give Terrell room to "show his moves" and were mobilized to intervene in the event that Terrell's playful aggressiveness was misinterpreted as a provocation or invitation for everyone to "let loose." The grace and dexterity with which Terrell executed various karate movements **had** the group mesmerized. One member blurted out "Hey man, how the hell can you do that?" Terrell welcomed this question and showed everyone how he was double-jointed, bending his fingers back and laying on his stomach, reaching back to grab his ankles with both hands. The interest of group members was peaked as attention was focused on Terrell: "That dude is made out of rubber." "Hey. Gumby Boy" "What else can you do with your body?" Group leaders praised Terrell's physical prowess: "Terrell. you have been holding out on us, you can move your body around so well," "There are not too many people I know that can do what you are doing" Shortly after displaying his karate moves. Terrell quieted down and turned his attention to deciding on the group activities for the session.

Lastly, a noteworthy phenomenon in group psychotherapy with hyperactive children is the "exhibitionistic off-task behavior" that periodically emerges as new games and activities are about to commence. This is when group members engage in attention-seeking gestures that are tangential to the activity starting up. These types of behaviors may simply represent the child's preference to engage in an activity that promises to elevate his or her self esteem instead of performing a task, or participating in a group activity that has a high potential for failure. In such situations the child may need affirmation of his or her off task demonstrations before the underlying fear of failure can be sufficiently addressed to enable him or her to join in the group activity. This may have to be accomplished in the context of a one-on-one interaction with a group leader if group members urgently want to start an activity and resent any hindrance to this caused by the child's off-task behavior.

James drifted over to the monkey bars while all the other group members congregated to begin a game of basketball. He made it clear that he thought basketball was "bogus" and that he would rather do gymnastics on the monkey bars. One group leader walked over to be with him, while the others supervised the selection of basketball teams. James gradually became more daring on the monkey bars, and confidently expressed how he could land on his feet swinging off any of the bars no matter how high they were. Given James' superior gymnastic abilities the risk of accidents was slim. The nearby group leader enthusiastically praised James'

abilities: "Look at Tarzan, swinging so well, and able to land on his feet." James confessed that he was not the best basketball player in the group. The group leader impressed **upon** James that it was possible to be good at basketball without being the best. Minutes later one of the basketball teams needed a substitute and called on James to participate. James eagerly ran onto the court to fill in.

SHAME, AGGRESSION, AND REDUCED SOCIAL COMPETENCE

The prevalence of aggression in hyperactive children has been widely documented (Loney & Milich, 1982; Wheeler & Carlson, 1994). Propensities to become embroiled in peer conflicts, to vociferously blame others when confronted with the unpleasant consequences of actions, to carry "roughhousing" too far, and to misinterpret others' actions as malicious and warranting retaliatory aggression, are commonly observed by clinicians working with hyperactive children. The frequent co-occurrence of hyperactivity and conduct problems has even led some commentators to propose that they are both subtypes of an overarching disruptive behavior disorder (Trues & Laprade, 1983). Indeed, the combativeness shown by hyperactive boys may be the pivotal source of their diminished sociability since aggressive children are prime targets for peer rejection (Landau & Moore, 1991). Needless to say, lessening the frequency and intensity of aggressive responses are essential goals in group treatment aimed at building the social competence and likability of hyperactive children.

In the clinical and research literature, the preponderance of non-pharmacological strategies offered to reduce aggression in hyperactive children tend to be cognitive-behavioral in nature. Interventions derived from Meichenbaum's (1975) stress inoculation approach seem to be popular. Children are taught to interrupt the chain of automatic thoughts that are presumed to justify aggressive

responses, question the evidence for the need to respond aggressively, and rehearse adaptive ways of giving expression to anger and frustration. Other commonly practiced cognitive-behavioral techniques to reduce combativeness in children include prompting the child to reflect in advance on the potential consequences of hostile actions and challenging his or her beliefs regarding aggression being an acceptable means to solve interpersonal disputes (Eargle, Guerra, & Tolan, 1994). However, the overriding emphasis on the role of cognitions in precipitating and preventing aggressive reactions has tended to obscure the contribution of emotions. Of relevance here are shame experiences.

To feel ashamed is to suddenly and painfully have one's "basic flaws" exposed for all to see (Gorsuch, 1990). There is a debilitating sense that one is "all bad," defective, or unworthy of love. Sartre (1956) likens shame to an "emotional hemorrhage" in which the person is rendered disorganized and helpless. There may be a distressing awareness of the fragility of one's self esteem, such that others have the power to suddenly and massively alter one's self-experience for the worse, or in Self Psychology terms, inflict "narcissistic injury" (Kohut, 1977). A frequently employed defense against such painful affective experience is to convert shame into rage, to dominate and seek revenge against the person perceived to have provoked the shame. Wurmser (1981) calls this "turning the tables" and Kohut (1985) sees it as a manifestation of "narcissistic rage," whereby revenge is a desperate attempt to undo damage to the enfeebled self. In the act of converting shame into rage the individual desperately attempts to reinstate a sense of control and dominance in the face of the emotional

danger through attacking others and provoking feelings of shame in them. As Lansky (1992) points out: "The disorganization and helplessness are induced in others rather than experienced by the violent person himself" (p.149). However, such shame-avoiding tactics might temporarily alleviate painful feelings of disorganization and impotence, but ultimately sour the individual's relations with others and increase feelings of alienation (Nathanson, 1992).

Hyperactive children may be especially susceptible to shame and ways of managing it that lead to interpersonal problems. Possible early difficulties with fine and gross motor coordination, co-existing learning disabilities, and dependence on medication use to maintain self control, can leave them feeling defective or fundamentally impaired in some way. Parents, teachers, and peers may be given to view the hyperactive child's impulsive behavior as willfully enacted and intended to annoy, with the resultant negative social feedback possibly instilling in him or her a sense of "inner badness." Moreover, it is not uncommon for hyperactive children to be teased and ridiculed by classmates for not being able to complete schoolwork in a timely manner. In addition, classmates may be amused and entertained by the hyperactive child's "clowning" but have little interest in befriending him or her. Shame seems to follow hyperactive children around.

In group work with hyperactive children shame dynamics are often embedded in adversarial interactions between members. Conflicts can escalate rapidly as group members expose each other's flaws in a bid to deflect feelings of shame. Problems are frequently compounded by poor abilities to

read social cues and decipher when "playful bantering" has gone too far and borders on mockery and ridicule. Also, with other group members looking on there is considerable pressure to take aggressive action to "save face," to elevate one's tarnished image in the eyes of others.

George and Emilio awkwardly, but warmly, greeted each other as they arrived for group that day. After nine months of being in group they had decided to attend summer camp together and considered each other friends. As members started arriving, George began speaking excitedly about his admiration for Michael Jackson. There was all the money that he had, the cool dance moves, the packed concert halls. George could not resist performing the "moonwalk" for group members to see and he insisted that it was the "coolest dance move ever." Emilio and another group member began snickering and blurting out comments like, "Michael Jackson is a fruity booty, he likes little boys." and "Michael Jackson dances like a sissy." George retorted, "You're dissing my man. You are the one who dances like a faggot." and he got up out of his seat and performed some silly dance moves. Attempts by group leaders to point out the meanness of what was being said and how feelings would be hurt if it continued were ignored. Emilio sounded off, "At least I'm not weird looking." As he was rushing over to strike Emilio. George was physically restrained by several group leaders and escorted outside the room for a time out. Emilio was also required to take a time out.

After completing his time out George insisted that Emilio was to blame for his aggressive gesture and that he no longer considered him a friend. Emilio likewise blamed George for causing the conflict by talking about "some weird rock star who was no longer popular with kids."

The above vignette captures the key shame dynamics identified by Scheff and Retzinger (1991) as formidable precipitants of violent outbursts. These authors maintain that shame is likely to be converted into destructive rage when it is unacknowledged by aggrieved parties, leads to alienation from needed attachment figures, and is "communicated disrespectfully" (i.e., an individual's total character maligned, rather than some isolated misdeed). Accordingly, neither George nor Emilio acknowledge feeling ashamed by the other's derisive comments and the mutual shaming appears to cause a sudden rupture in their relationship such that their reliance on each other for needed closeness is jeopardized. They are able to lash out at each other because in the act of shaming their

attachment is broken-ally has become enemy. They feel justified in deriding each other because they are "cut off" from each other and lack any awareness of the shame the other has induced.

Creating a forum for shame to be acknowledged and interpersonal ties re-stored is no easy feat. Awareness and verbal processing of shame reactions can be extremely difficult for well-adjusted adults (Lynd, 1955), let alone hyperactive children. The fear may exist that to admit to a vulnerability is to deliver up ammunition that might be used by others for future attacks, especially if the hyperactive child is being raised in a family in which shaming is used as a means to eliminate undesirable behavior (i.e., "What's wrong with you, you're so active all the time, why don't you act normal"). Consequently, conflict resolution interventions subsequent to aggressive exchanges between group members have to be conducted with an eye towards preventing the reinjury of those who risk acknowledging shame. Prohibitions against actions that are likely to provoke shame, such as "name calling" and "finger pointing," may have to be explicitly spelled out and enforced by group leaders. Guidance may be necessary on how to express dislike of someone's actions without attacking his or her person-hood (e.g., "When you cheat at games I don't feel like being your friend," "It makes me mad when you talk over me"). Furthermore, group members may need help with realizing that to devalue someone's "hero," "heroine," or cherished role model, can be particularly hurtful since such figures may embody an individual's wished-for self. The lesson to be learned is that to berate someone's idealized sources of identification is to imply that the best person he or she can become is defective.

Another important feature of effective conflict resolution pertains to is group leaders framing interpretations in ways that allow for "face-saving" recognition of underlying shame by aggrieved group members (i.e., "When Mary made fun of your hairstyle, I think it led to you feeling ugly inside and you wanted to get back at her. It's the brave person who can admit to feeling crushed by mean things said by someone") and that draw out any muted desires to reestablish interpersonal closeness (i.e., "You just smiled when John burped, maybe that means you are ready to be friends with him again"). If closure is to be achieved there needs to be mutual willingness to identify "triggers," or "sore spots:" certain personality attributes, physical characteristics, likes or dislikes that individuals feel insecure about and need others to be considerate of. The goal is for aggrieved group members to acquire a concrete awareness of each other's vulnerabilities and vow to refrain from using them in hurtful ways. The ability to pinpoint one's own sensitivities can be a potent social skill for the hyperactive child if it succeeds in eliciting empathy and affiliative gestures in other group members. The resultant sense of closeness reduces the potential for acrimony and combativeness. At the same time, direct knowledge of what can insult others, and lead to alienation from or counterattack by them, can give the hyperactive child a measure of control in reducing negative interactions with others. Since hyperactive children can be prone to impulsivity and forgetfulness it may be necessary for group leaders to quietly remind a child on the verge of insulting someone else of that person's "sore spots" and previous agreements made to not violate them,

SHAME, EXTERNALIZATION OF BLAME, AND RESPONSIBILITY-TAKING BEHAVIOR

Some added thoughts are worth sharing on the role shame plays in tendencies to externalize blame often seen in hyperactive children. Included here will be a discussion of group therapy techniques to build a skill that is crucial to reduce friction in the social lives of these children; namely, responsibility-taking behavior.

Hyperactive children tend to "deny responsibility for negative social events" (Hoza, Pelham, Milich, Pillow, & McBride, 1993, p.284) and to attribute hostile intent to peers vis-a-vis social mishaps and minor provocations (Murphy, Pelham, & Lang, 1992). Commonly cited explanations for such phenomena tend to center on the faulty social cognitions of hyperactive children; in particular, their impulsive style of interpreting social cues or proneness to judge *peers* based on an incomplete assessment of the evidence (Whalen & Henker, 1985).

Nevertheless, a fuller explanation for many hyperactive children's tendencies to externalize blame and overattribute hostile intent to others needs to account for the role of shame and fragile self-esteem. Oftentimes, these children resort to externalizing blame in the context of being reproached for having acted offensively. Their quickness to implicate and accuse others, deflecting negative attention away from themselves, may actually indicate shame proneness and problems with self-esteem regulation. Arguably, overcome by shame, they experience a collapse in the distinction between being perceived as having acted badly, and being perceived as "all bad." To confess to some misdeed is akin to submitting that one is an unlikable person. To "own up" is to run the risk of feeling that one is worthy of being

disowned. In essence, externalization of blame is a signal that the child cannot tolerate the feeling of inner badness associated with being at fault. Projecting blame outwards becomes a desperate attempt to reinstate feelings of likability and self worth.

Needless to say, shame can disable important ego functions and leave the child void of internal access to positive self-images and attributes. Therefore, if attempts to engender responsibility-taking behavior are to be successful it is incumbent on group leaders to confront misbehavior while simultaneously conveying overall acceptance of the child. Tangible reminders of the child's strong points will need to be communicated if he or she is to assimilate even reasonable criticism, and learn from it. Experiences that induce shame are usually rapidly banished from consciousness, reducing their potential to be learned from. Facing a child with his or her misdeed, in a backdrop of positive recognition, increases the likelihood that thoughts, feelings, and mental imagery pertaining to the misdeed will be retained in conscious awareness longer and be more profoundly learned from. Ultimately, in this way answering to the negative consequences of his or her actions with less defensiveness becomes more psychologically possible, which might pave the way for less social friction.

An extensive clinical vignette is provided to illustrate the chain of events that can occur when underlying shame associated with being held accountable for objectionable behavior triggers tendencies to externalize blame in a child. Also, covered is an example of how the group leader can step in to sensitively call attention to a

transgression and prompt responsibility-taking behavior.

A group decision was made to play a football game at the park across the street from the clinic. One of the group leaders tossed a coin to see who the captains would be and, at the behest of the captains, allowed them to pick learns. Charles was the last robe selected out of the five boys who were in attendance. To soften any embarrassment Charles might have felt over being selected last. the group leaders eagerly agreed to his insistent pleas to be quarterback.

In the role of quarterback Charles repeatedly retained possession of the ball and attempted to gain yardage by running with it himself. His teammates were upset with his unwillingness to pass the ball, and with the group leaders for asking them to be patient with Charles: "Charles has a good arm, once he starts to use it you guys will see more of the ball." However, Charles continued to hold onto the ball and his passes frequently fell short of the mark. One of the group leaders sensitively conveyed to Charles that it was time to let someone else on the team play quarterback. Charles became furious and ran towards the street, motioning as if to step into oncoming traffic. A group leader hastily ran over to him and physically held him, communicating to him that for safety reasons Charles would need to return to the clinic. Charles angrily protested: "Take your hands off me. I hate you and all the kids in this group. They are all losers and my mammy does not want me to hang around with losers. You cannot make me do anything. If you don't take your hands off me my mommy will get you arrested for child abuse."

Charles was escorted to a seclusion room at the clinic and supervised. While there he continued to denounce everyone in the group and refused to have contact with any of the group leaders. When his mother arrived to pick him up he was told of the consequences for his behavior, Efforts were made to validate Charles underlying hurt feelings and to convey to him that he was an important member of the group as the consequences were shared: "Charles you know that I like you. You tell great jokes that make me laugh. I think that you were hurting inside when the other kids picked you last and no longer wanted you to be quarterback. However, because you did something very dangerous- attempting to run out on the street- I have decided to suspend you for two group sessions. I am unhappy with you because you tried to run out in the street. However. I am not going to stay unhappy with you and when you come back in two weeks I'm sure I will still laugh at your jokes." He listened attentively and made no effort to fend off the group leaders remarks.

When Charles rejoined the group several weeks later he was able to acknowledge that being chosen last in the football game had made him feel "ugly." "You felt ugly inside and started acting ugly;" replied one of the group leaders. This comment led to Charles and the group leader sharing a laugh and Charles apologizing for running off.

CONCLUSION

The benefits of group therapy for hyperactive children are hard to deny, especially when the group is structured in

such a way as to expose them to everyday challenges they encounter with peers and adults. This necessitates a degree of flexibility as to the location of group sessions and the amount of structure utilized. Highly structured groups, with a pre-set curriculum and standardized setting, may better suit the research needs of academics than the treatment needs of hyperactive children. Arguably, a semi-structured activities group format allows for greater initiative taking and spontaneous decision making, social skills often underdeveloped in hyperactive children. This type of group format may also leave openings for important underlying emotions and interpersonal processes to emerge that might not otherwise do so in highly-structured groups—most notably, exhibitionistic behaviors that have relevance for self-esteem building and shame dynamics that often underlie social discord.

A topic that needs further investigation concerns the difference between exhibitionistic behavior and hyperactivity per se. It has been the experience of the present author that what is labeled hyperactive behavior by parents and teachers oftentimes is an energized form of exhibitionism in which the child is fervent and relentless in his or her pursuit of recognition. Self-psychologists have much to teach us regarding how such exhibitionistic tendencies may signify the persistence of developmental needs that are linked to the formation of self-esteem. Clinicians need to differentiate between hyperactive children who do and do not display strong exhibitionistic tendencies, with developmentally-based treatment approaches being considered for the former.

Also worthy of further investigation is the role shame plays

in manifestations of aggression and externalization of blame in hyperactive children. Much has been written on shame and its vicissitudes in narcissistically vulnerable adults (Goldberg, 1991; Nathanson, 1992). Nevertheless, how shame-proneness might, in part, explain the combativeness and externalizing tendencies typically displayed by hyperactive children, has been relatively unexplored in the literature.

Ultimately, it is hoped that this paper generates interest in semi-structured group approaches to the treatment of hyperactivity and helps build an appreciation for the merits of conceptualizing disruptive and externalizing behaviors in terms of fragile self-esteem and shame proneness.

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