Tutorial: Friendship and Peer Acceptance

WHAT ARE FRIENDSHIP AND PEER ACCEPTANCE?

As the term is used here, friendship implies a two-direction, mutual relationship of liking. By definition, then, there cannot be a one-sided friendship. When two children are friends, they like each other; there is some degree of mutual emotional connection. In addition, they tend to have shared interests and activities. Furthermore, in most friendships the two individuals are (roughly) equal in the relationship (symmetry) and they both bring something meaningful to the relationship (reciprocity). Friendships can be weak and short-lived, but they are often both intense and complex – and they are surely mutual. To say that friendships are symmetrical and reciprocal is not to say that two children of differing abilities cannot be friends. It is rather to say that they both bring something to the relationship and they both value what the other brings.

In a reciprocal relationship, friends seek each other out, both talk and both listen. They both support one another when challenged and remain loyal. They acknowledge and respect each others' perspectives. In these respects, friendships require attention and effort.

In contrast to friendship, peer acceptance and rejection can be one sided. For example, a child may like the group members and wish to be a member of a group, but the group may reject him. Similarly, a group may accept a child, but the child may choose not to associate with the group. Furthermore, acceptance implies a lower degree of emotional connection than is implied by friendship. And acceptance need not be symmetrical or reciprocal. That is, if one child brings very little to the relationship and is on a much different level than the other, mutual acceptance is possible but friendship is unlikely.

Both friendship and peer acceptance in childhood have long been known to influence the child's current life and also adult outcome – and in different ways. For example, peer rejection in childhood has been shown to be a predictor of problems in later school performance, adult vocational competence, aspiration level, and adult social participation. Lack of friends in pre-adolescence predicts depressive symptoms in adulthood. Peer rejection and lack of friendship in combination predict trouble with the law. Childhood friendships, in contrast, are strong predictors of strong family relationships in adulthood and adult sense of self-worth.

These are just a sample of findings in the research literature on friendship. The general point is that friendship and peer acceptance are both important for children and should be facilitated in the case of socially vulnerable children.

WHY ARE FRIENDSHIP AND PEER ACCEPTANCE IMPORTANT FOR MANY STUDENTS AFTER TBI?

Outcome studies have shown that children and adolescents with TBI tend to have fewer friends than their uninjured peers. In one study, almost 40% of children with moderate-to-severe TBI had no friends or at most one friend, whereas all of the uninjured peers had more than one friend. Many children and adolescents with brain injury state that their most troubling concerns after the injury are the absence of meaningful, lasting friendships and the difficulty finding new friends. These children understandably feel socially isolated, a condition that can easily lead to depression. **(See Tutorial on Depression.)**

There are many potential reasons why maintaining old friendships and gaining new friends are especially challenging for children and adolescents with TBI. In some cases, cognitive difficulties result in placement at a lower grade or in a new school, which interferes with maintenance of old friendships. Significantly weakened cognitive and academic performance can also result in difficulty maintaining the same interests as old friends and keeping up with social interaction. In one study, neuropsychological test performance did not predict number of friendships, but academic performance did; students who maintained their academic performance at reasonably high levels had more friends than those who did not. Physical impairments may also play a role in friendship by reducing the opportunities to engage in the same activities as old friends or potential new friends, activities like sports, dancing, and other activities that require reasonable physical abilities.

Problems with behavioral self-regulation and social interaction are even more likely to interfere with maintenance of old friendships, creation of new friendships, and peer acceptance. Students who are impulsive, aggressive, egocentric, or socially awkward generally have difficulty making friends and being accepted by peers. **(See Tutorials on Behavior; Social Competence.)**

WHAT ARE THE MAIN THEMES IN INSTRUCTION AND SUPPORT FOR STUDENTS WHO HAVE DIFFICULTY WITH FRIENDSHIP AND PEER ACCEPTANCE (See also Tutorial on Social Competence)

Understanding the Problem

As always, the first task for parents and teachers is to correctly understand the problem. Because friendship is important and loss of friends common after brain injury, parents and teachers should anticipate the problem and do what they can to promote friendship and peer acceptance. Specifically they should try to understand why the student may be losing friends and then address those issues.

Environmental Compensations and Strategies

Nothing that parents and teachers do can guarantee that students with brain injury will maintain friendships or acquire new friends. However there are strategies that can be implemented to increase the likelihood of ongoing friendships.

While the child is hospitalized:

Two-Way Communication: In the event of extended hospitalization, communication between peers at school and the hospitalized student should be encouraged. Peers can send letters; they can also create video greetings, showing what they are working on at school and expressing enthusiasm for the student's recovery and quick return. Similarly, the hospitalized student can be encouraged to send mail or e-mail messages to friends and peers. Video messages, possibly illustrating hospital routines, might be used both to stay in touch and to demystify the hospitalization for peers.

Hospital Visits: When the student with brain injury is stable and able to interact with others, parents should encourage visits from friends and peers. Parents or hospital staff should be available to provide explanations to peers about unusual equipment and about the student's impairments. Furthermore, hospital staff should ensure that there are fun activities that the peers and the student with brain injury can engage in during the visit. The activities may require adaptations and coaching for peers so that the student with brain injury can be included. A simple example is a card holder so that a student with hemiplegia can play cards with peers.

When the child is out of the hospital:

Avoidance of Extended Home-Bound Instruction: Following discharge from the hospital, an extended period of home-bound instruction (e.g., several weeks or more) may have the effect of increasing the social anxiety in the student with brain injury. At the same time, the extended absence makes it more likely that alliances at school will have changed and that the student will therefore have greater difficulty re-entering his social network. Finally, the longer the student is away from school, the further he is likely to fall behind in academics. Therefore, if a period of homebound instruction is necessary, it should be as limited as possible.

When the child returns to school:

Classroom Placement: A variety of factors need to be considered in making decisions about classroom or grade-level placement after severe brain injury. In students with more severe injuries, the degree of cognitive and academic losses may rule out pre-injury classroom and grade-level placement. With less severe injuries, decision makers should balance social and academic considerations. Considerable support may be required to enable the student to benefit from the curriculum in a classroom with pre-injury peers. However, the value of meaningful social relationships is sufficiently powerful in many cases to justify the needed supports.

Education for Peers: If the student returns to school with unusual equipment, physical impairments, unusual behavior, a marked change in personality, or other changes that may confuse or alarm peers, proactive explanations should be provided to them. In some cases it might be useful for a member of the rehabilitation hospital team to talk to peers at school. More often a respected teacher is chosen for this job, possibly with the assistance of hospital staff. In other situations, the student with brain injury can make a presentation to peers about his experiences and possible difficulties that he may face on returning to school. Creating this presentation could be facilitated by staff at the hospital before discharge. Ideally the student with brain injury is cast as a returning hero with an exciting story to tell. It is also helpful for the student to outline how peers can make the transition back to school easier for the "returning hero".

Attractive Opportunities for Friends and Peers in the Home: To increase the likelihood that peers will enjoy spending time with the student with brain injury in his home, parents should try to have enticing activities for the peers. For example the latest video games might make visits enjoyable even if there are difficulties interacting with the student with brain injury.

Extra-Curricular Activities: The extra time needed to complete homework together with greater than normal fatigue might cause parents and teachers to overlook the importance of extra-curricular activities. However, it is often during such activities that friendships are formed. Extra-curricular activities might take place at school or in connection with activities at church or other organizations.

Peer Buddies: In selected cases, a volunteer peer buddy can at the same time help the student with brain injury and also provide valuable social interaction. Buddies might help the student navigate busy corridors, carry books and materials, and complete assignments as the student tries to make up school work. Peer buddies should be selected from a social set that is acceptable to the student with brain injury. In creating a peer buddy system, school staff should be sensitive to the possibility that the student might consider the system infantilizing. Knowing that true friendships are symmetrical and reciprocal, staff should also seek ways in which the student with brain injury can contribute to the buddies as opposed to simply receive assistance from them.

Schedules to Facilitate Positive Peer Interaction: In some cases, it is necessary for students with brain injury to have schedules that are quite different from their peers. These differences might include a variety of therapy sessions, rest periods, hallway navigation when the hallways are not busy, and others. These additions to and modifications of the schedule should be balanced against the social value of schedules that are more typical and allow for as much social interaction as possible. For example, the objectives of speech-language therapy might be achievable in choir, voice lessons, and drama class. The objectives of

physical therapy might be achievable in physical education class, with appropriate adaptations. In these ways, educational planners can balance ongoing needs with normal social experiences.

Helping the Student Maintain or Acquire Friends:

Please see the Tutorial on Social Competence for additional suggestions.

Three Critical Social Skills for Young Children: Studies have shown that acceptance and popularity for young children with or without disability are associated with three critical social skills: (1) the ability to initiate social interaction or enter into ongoing social interaction (e.g., play, conversation); (2) the ability to maintain that interaction; (3) the ability resolve conflicts effectively and peacefully. With this as background, school staff and parents should have scripts to preset the student prior to social times at school or home, and to coach the student in using these scripts during the activity itself. Presetting and coaching may be useful in helping the student with brain injury to incorporate these skills in everyday interaction. A variety of communication skills contribute to each of these three general social competencies. Creating scripts and organizing a program of context-sensitive social coaching is often the role of the school's speech-language pathologist. **(See Tutorial on Social Competence)**

Critical Social Skills for Older Children: Older children and adolescents have a similar list of critical social skills: (1) The capacity and interest to play or otherwise interact with one another frequently; (2) the ability to avoid fights; (3) the ability and motivation to advocate for one another. Once again, presetting and coaching may be useful in helping the student with brain injury to incorporate these skills in everyday interaction.

Alternative Sources of Potential Friends: In the case of adolescents whose abilities and domains of possible activities have been substantially altered by the injury, it may be inevitable that old friends drift away despite well-conceived efforts to maintain those friendships. Engagement in a variety of social activities might help the student acquire new friends. Some students with brain injury form new friendships in the rehabilitation hospital or in other ways come to know and like students who have similarly experienced a life-altering brain injury. Their shared experiences often create a bond that can support a deep friendship. Furthermore, the friendship attributes of symmetry and reciprocity may be more likely to be present in such relationships than in the case of relationships with pre-injury friends who now may have considerably different levels of functioning and domains of activity from the student with brain injury.

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