Social coping strategies in pre-school play. How do children with disabilities succeed in play groups with other children?

By Liv Vedeler
In cooperation with:
Hungnes, Bodil; Ruud, Ellen; Bakken, Randi L. & Tolgensbakk, Anne

Abstract: Research literature has documented links between peer difficulties in early childhood and later poor social, emotional and academic adjustment. Since children with disabilities have more problems than others with peer relations, objectives in early childhood education should include helping children with disabilities to cope with social tasks in peer groups. This article presents four case studies concerning children with different disabilities, focusing on their social coping-strategies in play-groups in inclusive pre-schools. The analysis is mainly qualitative, based on data from video observations and field notes. The children with disabilities used less successful social coping strategies than their non-disabled peers, and seemed to have difficulties with coherence in play and social interchanges. Intervention strategies are discussed in the light of salutogenic theory.

This article focuses on pre-school children with disabilities and their social coping strategies in play groups in inclusive pre-schools. How do they succeed with their personal social goals in peer groups compared to their normal peers? Four case studies are reported of children with four different kinds of disabilities included in normal peer groups. The children were observed in free play in pre-school or school settings, and their peer relations and social coping strategies assessed. Intervention strategies are discussed in the light of salutogenic theory.

Introduction

Research into peer relationships and problems associated with poor social coping in peer groups has accumulated over the last 20 years (Asher 1983, Guralnick 2001, Hartup 1992, Kupersmidt 1990, Parker et. al. 1995, Rose-Krasnor 1997). Problems generally start early, and can be observed as early as in pre-school children's play groups (Guralnick 1990, 1999a, 2001). If these children do not get help, social problems may persist (Guralnick 1998, Parker & Asher 1987). Longitudinal studies document links between peer difficul-

ties and poor social, emotional and academic adjustment later on (Guralnick 2001, Newcomb et. al. 1993, Parker et. al 1995, Welsh et. al. 2001). Fortunately most children are socially competent and able to establish good peer relationships. However, many children with disabilities seem to have difficulties in social coping and have little success in establishing relationships with peers (Guralnick 2001, Wilson 1999). An important objective in inclusive education is therefore to teach these children to cope with social tasks in peer groups and to help them establish friendships (Guralnick 1999b, Vandell & Henbree 1994).

Pre-school children are met with three important social tasks in play groups. The first has to do with peer group entry. By what social strategies will a child get access to the play group and be accepted by the peers? Gaining entry to a play group is no easy social task and requires social competence on the part of the child. The second social task concerns how to maintain play and develop the play theme in communication with your peers after you have got access to the play group. To be creative and competent in maintaining and developing play within the play theme's frame of reference makes you an attractive and popular playmate. The third social task has to do with resolving conflicts. Conflicts are something that frequently occur during peer interactions in play. Disputes over possessions or territory are common, and so are disagreements about social control, play ideas, roles and rules. Sometimes conflicts turn into hostile or aggressive interactions, but often the conflicts are resolved by more competent strategies like arguments, compromises or negotiations.

There is documentation to the effect that children with developmental disabilities are often less socially competent in establishing peer relationships. They exhibit less play that is maintained, and display more negative behaviour especially during conflicts. They also have less success in peer group entry. (Guralnick & Hammond 1999, Guralnick 2001). Similar problems have been identified for children with other disabilities, although not as well documented (Brinton et. al 1998, Guralnick 2001, Hundert & Hopkins 1992, Paul-Brown & Caperton 2001). There is also documentation to the effect that children with disabilities often have difficulties when participating in socio-dramatic play with role-taking, decontextualisation and decentration. This often results in conflicts with their peers (Vedeler 1996, 1997). Many teachers report that they are worried about significant peer-related social competence problems exhibited by children with disabilities, and the long-range consequences this may have. Useful intervention strategies are often asked for. An important aspect of successful intervention is assessment of children's strengths and difficulties, so that teachers may know what to build

on and how to compensate for or repair weaknesses (Guralnick 1999a). A theoretical frame of reference that may be useful in working with development of social competence in children is Antonovsky's salutogenic model. This model provides a fruitful perspective by highlighting the fact that all intervention and rehabilitation should focus on the individual's strengths and resources, and not on disorders and difficulties. (Antonovsky 1996, Beresford 1994, Folkman et. al. 1986, Lazarus & Folkman 1984). The model conceives of the individual as actively and creatively seeking to manage stresses (and problems) as they are encountered. Antonovsky´s theoretical frame of reference (1996) is concerned with what is positive, and what promotes health in a wide meaning of the health concept. He focuses on the importance of promoting in individuals a sense of coherence and helping them to cope with their problems. By sense of coherence is here meant a generalized orientation towards the world which perceives it on a continuum as *comprehensible, manageable and meaningful*. The notion of "coping" is also central in this model (Beresford 1994, Sommerschild 1998). Coping is viewed in terms of management as opposed to mastery, and is a process or ongoing complex interaction between an individual and the environment.

As stated earlier, pre-school children's personal social goals in interaction with peers can be categorised as:

- Gaining entry to a play group (peer group entry)
- Maintaining play
- Resolving conflicts

Research provides reports on which social strategies are required in order to achieve these personal goals successfully, and on which social strategies turn out to be less successful (Guralnick 1999, 2001, Gottman 1983, Corsaro 1979). Since children with disabilities seem to have more problems in this respect than other children, is that due to their impairment? Do they have in common some less successful strategies for coping? Or can typical coping strategies be observed as being characteristic of particular disability groups? For instance, what social problems must a child with a hearing loss deal with in coping with normal hearing children in play groups? Or children with language impairment? Or children with other disabilities?

Below four different case studies are reported on from integrated pre-schools focusing on social coping strategies observed in children with language impairment (Ruud 2001), children with prenatal and drug exposure (Hungnes 2000), children with hearing loss (Bakken & Tolgensbakk 2001) and children with socio-emotional problems (Vedeler 1996, 2000).

The first three case studies are master theses from Norwegian universities. All four case studies are concerned with

children with disabilities and their interaction with non-disabled playmates in inclusive pre-schools and the coping strategies they use in obtaining personal social goals as listed above. The children with disabilities are compared with their non-disabled peers, all observed in play groups during free play in pre-school or school settings. The methods of data collection were video observations and qualitative observation (field notes with descriptions) combined with structured observations with the use of categories from "Assessment of peer relations" (Guralnick 1999a).

Coping strategies are usually defined as actions, behaviors and thoughts used to deal with a stressor or a problem (Folkman et al 1986). The definition includes the notion of appraisal, i.e. how phenomena are perceived, interpreted and cognitively represented in the minds of the individuals (Beresford 1994). The notion of coping strategies or more precisely social coping strategies is here used in connection with conceiving of children as actively and creatively seeking to manage tasks and problems when trying to achieve their personal goals in getting access to a play group, maintaining play and resolving conflicts. The purpose of the case studies is to explore the ways in which disabled children cope, with varying degrees of success, when seeking to achieve their personal social goals in play groups.

Case study 1: Social coping strategies in play. How children with language impairments take social initiatives in play compared to children without language impairment.

Research questions

What kind of coping strategies did boys with language impairments use when taking social initiatives in play groups compared to the boys without language impairments? What kind of response did they get?

Method

The participants were four boys, four years old. When they were tested on Reynell Developmental Language Scales (1976), the test result for the two language impaired boys was two standard deviations below the average in their age group (standard score less than stanine 3), and the test result for the two boys without language impairment was above stanine 8. The children had no other impairments and they came from Norwegian speaking families. The play groups consisted of three of the four boys in different constellations. Nine observations were taken, with 30 minutes videotaped from each. The videotapes were transcribed and analysed according to categories in "Assessment of peer relations" (Guralnick 1999). Since the play group was already established, peer group entry was not a goal. However, taking the initiative and maintaining play was important. Therefore a combination of categories for peer group entry and maintaining play was used in combination with descriptions.

Results

Typical of the boys with language impairment in trying to get the others' attention was making noise, using violent movements, or exhibiting behavior irrelevant to the other children's activities. More than 50% of their utterances and behavior was of this kind. However, sometimes they used positive behavior like imitation or doing something relevant to the other children's activity, but also more negative behavior like insistence or aggressive language or acts. The two boys without language impairments had much less negative behavior and more acceptant and creative communication. Above all they showed much more coherence both in their language use and in their behavior than the children with language impairments did. The boys with language impairments got a response from the others notwithstanding the strategies used. But they were met with more acceptance when the initiatives they made were related to the other children's play.

Conclusion

The two boys with language impairments had problems with coherence. Too often they did not communicate in context. They had difficulties in maintaining and developing play, using irrelevant objects, language and behaviour.

The boys without language impairments more often gave information relevant to the other children's play activity, and presented new ideas that made their play more challenging. However, the boys with language impairments were not often ignored or rejected by their peers. But the observer noted that the children without language impairments often wanted to play games demanding more advanced language than the boys with language impairments could cope with. In those cases the children with language impairments were ignored. This often resulted in aggressive and destructive behavior from the children with language impairments, or they retreated to solitary play.

Case study 2: Social skills in 6 year old children with prenatal alcohol and drug exposure (foetal alcohol and drug syndrome.)

Research questions

How are social skills, important for peer group entry, maintaining play, and conflict resolution, in 6 year old children with prenatal alcohol and drug exposure (foetal alcohol and drug syndrome) compared to children without impairments?

Method

Seven 6 year-old children participated in the study. Four of them were diagnosed with foetal alcohol and drug syndrome but had no other disability. They were adopted or lived in foster homes. Three children were ordinary children without impairments. The children were observed in free play in peer groups in

inclusive school settings. The groups consisted of three to four children in different constellations. 61 half hour video observations were taken with a focus on peer group entry, maintaining play, and conflict resolution. Descriptions and video strips were analysed according to categories for peer relations and children's social coping strategies in peer groups.

Results

The children with foetal alcohol and drug syndrome were compared to the normal children. When we look at *peer group entry*, the children with foetal alcohol and drug syndrome more than the other children tended to stand near or watch peers, appearing to wait for an opportunity. The children with foetal alcohol and drug syndrome often attempted to play using objects and actions unrelated to peers' activity, and posed questions that seemed irrelevant to the group. They also acted aggressively toward peers when rejected. In *maintaining play* they did not, like the normal group, remain within theme or role of play activity or keep to the frame of reference. They rarely adapted their behavior to the peers' ideas and suggestions or in accordance with changing demands of the evolving pretend play theme. While the other children seemed to have a shared understanding like common awareness of prevailing social rules and coherent, connected and relevant exchanges in more than 60% of the observations, the children with foetal alcohol and drug syndrome did so in only 6% of the observations. In rule play or games the children with foetal alcohol and drug syndrome did not seem to understand the rules in 94% of the observations, compared to 59% of the observations for the other children. The children with foetal alcohol and drug syndrome also seemed to be less flexible and at the same time less assertive than the normal children. In construction play the children with foetal alcohol and drug syndrome showed less creativity and less endurance than the others. There seemed to be no main differences in strategies for *conflict resolution*, between the children with foetal alcohol and drug syndrome and the other children. But the children with foetal alcohol and drug syndrome tended to use more hostile or aggressive strategies, and fewer strategies like arguments, compromises or negotiations, than the other children. The children with foetal alcohol and drug syndrome also tended to reject or contradict peers' reactions without providing a reason, more than the other children did. The children with foetal alcohol and drug syndrome often seemed to lack communication clarity.

Conclusion

The children with foetal alcohol and drug syndrome were less enthusiastic in play, and played with less display of feelings than the other children. They gave less positive response and seemed to have less shared understanding with others. They did not seem to differ

much from the other children in play involvement, but they were more aggressive and less coherent in their behavior, using irrelevant acts, objects and language. They were also notably unclear in their communication.

Case study 3: Social interaction between 6 year old children with hearing impairments and their normal hearing playmates.

Research questions

What characterizes the interaction between pre-school children with hearing impairments and other children in inclusive play groups?

Which strategies are used by the children with hearing impairments for peer group entry? Which strategies are used for maintaining play? What are the reasons for conflicts and what strategies do they use for conflict resolution?

Methods

Two 5 year old children with a moderate hearing loss (41-56 dB), each of them included in an ordinary Norwegian pre-school together with other children, participated in the study. They were observed in free play in groups of 2-7 children. Data collection was done by video observations combined with field notes. Dialogue sequences from the video were transcribed and analyzed together with the descriptions from the play episodes. Data from 48 play episodes were analysed (24 for each child with hearing impairment). The analysis focused on social coping strategies in peer group entry, maintaining play, and conflict resolution. Interpretations were made in the light of the play context and the situation, and using theory in explaining the data.

Results

For *peer group entry* the most used and most successful coping strategy of the children with hearing impairments was to stand near and watch peers, wait for an opportunity, and gain attention through eye-contact and gestures. There were also individual differences between the two children with hearing impairments. One of them successfully used humour, and offered toys related to the peers' play. The other one politely used requests for direct access to the play activity. However, the children with hearing impairments often used less successful strategies for peer group entry like attempting to redirect peers' activity, for example by introducing new play themes. Because of their hearing impairment these children had problems in gaining information about the play going on in the group and therefore tried to gain control by taking over, redirecting the play or introducing something new. This often resulted in conflicts with the group. In addition to these less successful strategies common to the two children with hearing impairment, they also used some unfortunate individual strategies. One of them often demanded support from grown-ups or used different kinds of intrusive

strategies. The other one criticized his peers or acted aggressively towards them.

After they had gained access to the play group, it was interesting to observe the children with hearing impairment and their strategies in *maintaining play*. Both engaged in role play (pretend play). In developing the roles and the play theme they were inventive and creative. They could also take the others' perspective and cooperate, and they knew how to use conciliatory strategies. But they also often took over the play and used intrusive strategies. They seldom asked relevant questions or tried to seek more information, and often exhibited irrelevant behavior and communication, particularly when they felt insecure or stressed, were uncertain of the play proceedings, or when loosing control. They preferred to have only few children in the play group and usually refused access to new children. This can probably be attributed to the fact that children with hearing impairments, because of their hearing disability, have difficulties in getting adequate knowledge of what is going on in the play process, and so use different coping strategies to gain control. In maintaining play the children with hearing impairments, like all the other children, exhibited individual differences. One of them was more responsive than the other. She was good at taking initiatives and knew how to build alliances and to cooperate. But she also easily gave up, lacked concentration in play and displayed egocentric and irrelevant behavior. The other one often used humour and was creative in developing the play script. On the other hand he tended to be intrusive and demanding in role play. In *conflict resolution* they could both make compromises, present alternative suggestions and provide reasons for their standpoints, and they wanted to take control. They preferred to set the premises and did not easily adapt to the group. They often insisted, threatened and tended to be aggressive. However, their individuality also showed in their coping strategies in conflict resolution. One of them was assertive, took control over the play material, did not accept proposals from the peers, and was insistent and non-responsive to requests. Sometimes he also became aggressive. The other one often took "time off", and appealed for help from grown-ups.

Many of the reasons for conflicts were conflicts regarding social control and misunderstanding of the situation. There were also many conflicts that had to do with disagreement over ideas. Typical of the children with hearing impairments was the fact that they did not ask for clarification.

Conclusion

The children with hearing impairments tended to use more of the less successful strategies than the other children did, even if they could also exhibit excellent social strategies. Much of their behavior tended however to be irrelevant in the play context and seemed to

lack coherence. This can be attributed to their problems in understanding because of their hearing impairment, and consequently difficulties in getting hold of what was going on in the play group and how the play process developed.

Case study 4: Social coping in a 5 year old boy, Tom, with socio-emotional problems. A case study from inclusive play groups in pre-school.

Research questions

What are the strengths and weaknesses in Tom's social coping strategies in peer group play as seen in peer group entry, maintaining play and conflict resolution? Is he more successful with some children than with others?

Method

Tom, a 5 year old boy in pre-school, was referred to the school psychologist because of behavior problems. He did not get along with his peers, was generally rejected or ignored by the peers, and the pre-school teachers were worried because of his temper tantrums and "clinging behaviour" towards grown-ups. He was diagnosed as having socio-emotional problems. Tom lived with both his parents and an elder sister, he had a normal IQ, was healthy and big for his age, and had normal language development, except for some pragmatic difficulties and an often irrelevant mode of communication. Tom was observed together with other children in the free play sessions, in play groups of 2-5 children. Data consisted of 9 video observations of 30 minutes' duration each, and field notes from socio-dramatic play and construction play. The children's dialogues were transcribed and analyzed together with analysis of the videos and field notes. The focus of the analysis here too is peer group entry, maintaining play and conflict resolution.

Results

Tom seemed to be a lonely child, usually playing with nobody in the free play sessions. He seldom took social initiatives. Sometimes he tried to get access to a play group, but with varying success.

For *peer group entry* he often used strategies that failed. He attempted to play with non-responsive peers who had rejected him regularly in the past. He used objects and actions unrelated to peers' activity, and his communication was often irrelevant and out of context. As a result he was usually rejected or ignored. However, a positive development was also noted with one playmate, a new boy in the class a little younger than Tom but skilled in language use and play, Tom had more success. With him Tom used direct requests to play, and got a positive response. Tom was accepted by the new boy and included in play with him.

When Tom now and then (usually with the help of teachers) got access to the

play group and was engaged in developing and *maintaining play*, the other children accused Tom of not knowing how to play. And that was correct. He did not know how to pretend and had difficulties in taking a role in socio-dramatic play and in remaining within the theme or role of play activity. He exhibited little coherence in his behavior and often acted irrelevantly and out of context. He seldom provided relevant information when requested by peers, and usually did not have a shared understanding of tasks or activities in the interactions with the others. Tom seemed however to understand the concept of ownership and general classroom rules regarding sharing and turn-taking with peers. The new boy who was an able playmate and clear in his communication was intent in involving Tom in pretend play despite Tom's irrelevant communication and behavior. Little by little Tom seemed to learn "pretend" and to exhibit reciprocity by matching his own behavior to his peer's activity and initiatives.

In *conflict resolution* Tom was seldom assertive. He rarely initiated a conflict, but was often a recipient of exchanges resulting in conflict. Here too he often had irrelevant responses. He seldom if ever provided reasons, rationale or alternative suggestions. But Tom was healthy and strong for his age, and several times he successfully defended his new peer in conflicts regarding possessions and space. Even if this was done in a somewhat aggressive way, it was accepted by the other children.

Conclusion

Typical of Tom was lack of coherence in communication and behavior, and problems with shared understanding. He had difficulties in getting access to play groups, did not know how to play, as the other children put it, and was unclear in his communication with peers. But, this also depended on the peer in question. Together with a "right" peer his coping strategies improved.

Discussion

In presenting and summarizing the results it is important to keep in mind that the children participating in these case studies are few, and the assessment results cannot be generalized. It should also be kept in mind that although the individual child may have a disability, his or her functioning will depend as much upon how the child is met by grown-ups and the other children, and on how the (play) context is organized.

The concepts and way of thinking in the salutogenic model and in coping theories may be useful in implementing interventions for helping children with disabilities to acquire successful social coping strategies and develop social competence. Like other children the disabled children in these case studies differ in social competence, and they use social coping strategies characteristic of their individual personalities. But, as hypothesized, the disabled children seemed to have generally less success-

ful coping strategies than their peers in trying to reach personal social goals like peer group entry, maintaining play and resolving conflicts. Many of these problems may be attributed to their specific disabilities. The language impaired boys used noise and violent movements to get their peers' attention, and had difficulties participating in play demanding advanced language. The children with foetal alcohol and drug syndrome had difficulties with concentration and shared understanding. The hearing impaired children had problems in gaining information about the play going on, and therefore often used unfortunate strategies in order to get control. Strategies to that end were demanding support from grown-ups, redirecting or taking over the play, and minimalizing the number of children participating in the group. The boy with socio-emotional problems did not know how to play, had irrelevant behavior and communicated out of context.

It seems that these children´s less successful coping strategies in some ways may be attributed to characteristics that follow from their disability. There is however one main problem the children with disabilities seemed to have in common. They had too little sense of coherence as exhibited in their behavior and communication. Sense of coherence in this connection means that the children in question should find it meaningful to get access to and participate in sociodramatic play, construction play and games. That is, the play must be comprehensible for the child, it must be something that he/she can manage, and it must seem meaningful to participate.

The children´s coping strategies may be perceived as attempts to comprehend the situations, and to manage the tasks of peer group entry, maintaining play or resolving conflicts. Now and then the tasks seemed to be too difficult or gave too little meaning for the children, so they retreated to solitary play or they exhibited behavior that resulted in conflicts they did not successfully cope with. How then can grown-ups help these children and in inclusive play settings teach them more successful social coping strategies important for peer group entry, maintaining play and conflict resolution? This is generally also important for long term social and academic development.

Several educational strategies have been successfully tried out. For instance "Training supervisors in collaborative team approach to promote peer interaction of children with disabilities in integrated pre-schools" (Hundert & Hopkins 1992), "Peer intervention programs" with inventory of resources, including peers (Guralnick 1997), "Educational use of play" (Vedeler 1999), and "Inclusive practices for pre-school-age children with specific language impairments" (Paul-Brown & Caperton 2001). More individualizing intervention is also recommended (Guralnick 2001). For individualizing approaches

the notion of developing in the children a better "sense of coherence" may be useful. For the individual child activities and tasks must be meaningful, manageable and comprehensible if he is to be motivated and find it worth while to involve himself in a constructive way. Play themes in socio-dramatic play, construction play and games in inclusive play groups ought to be organized in accordance with the individual child's interests and capabilities to that effect.

To help the child developed better social coping strategies an assessment of personal resources in the child as well as resources in the environment is useful. For instance, which abilities have you noticed in the child, and how can you promote them? What kind of play context including play material is available that can be motivating and usable for a child with language impairments, concentration difficulties, hearing loss, socio-emotional problems or other disabilities? Does the child lack play skills and if so how to help him get it? Would it be possible to build smaller inclusive playgroups with children who fraternize, and behave in a good way towards the child in question? Can the play context be organized so that it will be comprehensible, manageable and meaningful for the child with a disability as well as for the other children? How can the other children learn to use clear communication and to be helpful so that the child with a disability is able to manage the play situation and understand what is going on?

With this in mind grown-ups may teach the children useful strategies for peer group entry, maintaining play and conflict resolution, either by instructions and/or modelling with use of peers thoughtfully chosen. In play, peers are very often the best teachers, also for teaching clear communication, provided they function as good models in accordance with what is known about model learning (Bandura 1977a, 1977b). With these notions as a frame of reference it is possible to build an individualized program for children with disabilities with objectives of developing social competence, a program that can at the same time be included in the general pre-school program, provided that this is not too rigidly structured.

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The Author:

Liv Vedeler is professor emeritus at the department of special education, University of Oslo, Norway. She has been involved in a number of research projects on integration/ inclusion in nursery schools and adapted education in early school years. She has been a member of the Primary School Council and the Council for School Development in Norway

Address:
Liv Vedeler
University of Oslo
Department of special education
Box 1140, Blindern
N-0318 Oslo

E-mail:
liv.vedeler@isp.uio.no