DOCUMENT RESUME

ED 304 846 EC 212 541

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TITLE Instructional Interventions to Improve Social Competence. Chapter Eighteen.
PUB DATE 88
NOTE 25p.; In: Robinsin, Greg A., Ed., and others. "Best Practices in Mental Disabilities. Volume Two"; see EC 212 523.
PUB TYPE Guides -- Non-Classroom Use (055)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Elementary Secondary Education; Generalization; *Interpersonal Competence; Maintenance; *Mental Retardation; Models; *Skill Development; *Social Behavior; Social Cognition; *Social Development; *Teaching Methods

ABSTRACT

A conceptual framework of social competence is presented to formulate actions that will enhance the social competence of learners with mental disabilities. This chapter discusses the individual's culturally determined inputs; the processes of social affects, social skills, and social thinking; and the desired social outcomes. The history of social competence training is reviewed, followed by a rationale indicating the need for improving social competence. No single approach to building social competence is cited as being totally satisfactory. The approach selected for use will depend on a wide range of variables including age, mental ability, practice opportunities, communication skills, and a host of concerns related to the unique needs of individuals. Instructional techniques are presented for improving social affect, developing social cognition, and teaching specific social skills. Procedural steps for teaching social skills involve establishing the need, identifying the skill components, modeling the skill, role playing the skill, practicing, and generalization. The paper concludes with a teaching approach to maintenance and generalization. (JDD)

Chapter Eighteen

Instructional Interventions To Improve Social Competence

Laurence R. Sargent

OVERVIEW

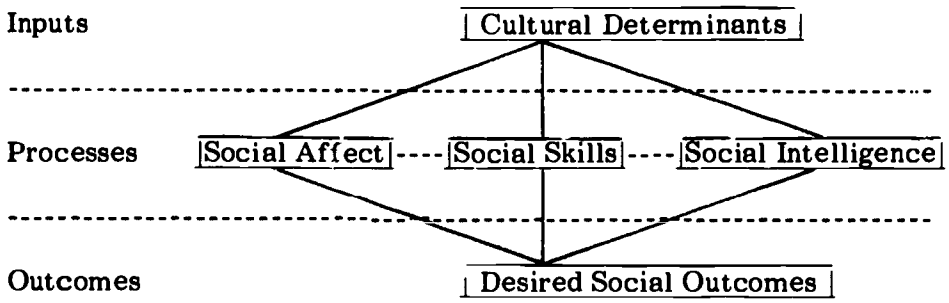
For most children and adolescents, social competence develops through incidental learning and intellectual maturation. Unfortunately, children with disabilities, and especially children with mental disabilities, are notoriously inadequate in their incidental learning and have significant delays in intellectual growth. They commonly exhibit learning deficits in areas of discrimination, attention, memory, and generalization (Ellis, 1963; Fisher & Zeaman, 1973; Zeaman & House, 1963) which contribute to impairment of social affect, social skills, and social cognition. Consequently, individuals with mental disabilities frequently fail to accrue acceptance by peers and adults. Moreover, many children with disabilities tend to incur social rejection as the result of exhibiting interfering and socially repugnant behaviors.

There are many long term consequences of social rejection and poor social competence. Early studies indicate that individuals identified during childhood as social isolates were likely to have difficulty (e.g., with the law, alcohol, divorce) during adulthood (Gresham, 1981). Further, rehabilitation literature indicates that most individuals with mild and moderate mental disabilities who lose jobs do so primarily for lack of adequate social skills and other socially inappropriate behavior. Due to the great importance and lasting effect, programming provided for individuals with mental retardation must include efforts to build social competence.

Conceptual Framework of Social Competence

Understanding the notion of social competence is critical for professionals choosing to address the needs of learners with mental disabilities. Social competence consists of a huge mix of interacting and overlapping variables. To make sense of these variables, a conceptual framework is necessary for purposes of determining how to address social competence problems. The following mechanistic model consisting of inputs, processes and desired outcomes is presented for purposes of formulating actions that will enhance the social competence of learners with disabilities.

SOCIAL COMPETENCE



To explain this overly simplified framework, the model will be turned upside down and the outcome component will be discussed first. The outcomes represent the needs and desires of the individual with a disability; plus, they reflect the aspirations of parents, professionals, and care providers to see that the individual becomes a productive and happy adult. It is hoped that the individual student or client will attain the following:

1. Self-esteem
2. Self-confidence
3. Peer acceptance
4. Acceptance by family and significant others
5. Friendships
6. Strong personal relationships
7. Community acceptance
8. Acceptance in the work place
9. Social independence
10. A supportive social milieu

These outcomes are attained through the interaction of life experiences and the efforts of professionals acting on the lives of individuals with mental retardation. The interventions must occur during the person's entire developmental period.

With these targets for intervention identified, the model will be turned upright and cultural determinants of social competence will be identified. In this mechanistic model, the input component consists of cultural determinants which are values and social standards by which individuals live. These are the dynamic raw materials of social competence which vary according to community size, ethnic mix, region of the country and traditions of the community. Failure to function within these cultural boundaries will often deter both social acceptance and the development of feelings of self-efficacy. For the purposes of this model, some of the major cultural determinant categories are as follows:

1. Community values
2. Standards for adult/child relations
3. Family member role expectations
4. Privacy standards
5. Standards of decency (e.g taboos, etc.)
6. Work ethic

7. Standards of fairness

8. Independence expectancy

9. Temporal standards (e.g. how long to chit chat, and how late is acceptable)

10. Standards of social responsibility

11. Community tolerance of differences

12. Aesthetic conventions and values

13. Situational conventions:

    a. Table manners
    b. Church manners
    c. Theater manners
    d. Public courtesies
    e. Classroom manners
    f. Work place conventions

14. Many others

Cultural determinants are the ingredients of social competence which must be acted upon to arrive at the desired outcomes. The actions occur through the three process elements of the model where the individual adjusts and matches his or her behavior to this myriad of values and rules.

The three process components of this framework include social affect, social skills, and social intelligence. Each component warrants attention and failure to address all areas results in a partial attempt to achieve the desired outcomes.

Social affect is an overt process component of social competence. As used in this framework, social affect relates to how the individual appears to others. Social acceptance is more easily attained by individuals with desirable social affect consisting of the following:

1. Cheerfulness

2. Enthusiasm

3. Confidence

4. Optimism

5. Risk taking

6. Independence

7. Good posture

8. Good Grooming

9. Sense of humor

10. Affection

11. Assertiveness

There are teaching materials and methods specifically designed to improve student affect, but it appears that attention to the affective dimension can be addressed in all activities and instruction. However, attention to affect alone will not create a more socially competent individual.

Social skills and behaviors are other overt aspects of social competence. These behaviors can be taught directly, taught through infusion into life experiences, and can be acquired incidentally by imitating competent peers and adults. Many social skills and behaviors fall into the following categories:

1. Interaction initiatives (e.g., starting a conversation)

2. Interaction responses (e.g., responding to a complaint)

3. Personal social behaviors (e.g., dealing with embarrassment)

4. Setting specific skills and behaviors:

    a. School Behavior
    b. Work place behavior
    c. Public setting behavior
    d. Family setting behavior

Direct instruction of overt aspects of social competence holds great promise, but the overt aspects are insufficient if they are the only elements of social competence that an instructional team deals with. Techniques used to teach social skills must be combined with those developed to enhance social intelligence.

The third process component, social cognition, is by definition one of the most difficult areas encountered by a person identified as having mental retardation. Social cognition represents an individual's ability to understand, interpret, and take appropriate actions relevant to different social settings, personal interactions and complexity of situations (Greenspan, 1979). Among nonhandicapped students, many of these abilities are acquired developmentally. Categories of social cognition partially adapted from Greenspan (1979) include:

1. Role taking/empathy

2. Social discrimination and inference

3. Social understanding/comprehension

4. Understanding motives of others

5. Moral and ethical judgments

6. Referential communication

7. Social problem solving

Despite the inherent difficulty in this area of personal growth, individuals with mental retardation can progress as the result of intervention. Strategies for social problem solving may be taught, experiences may arranged to enhance social discrimination, moral and ethical judgments may be reinforced, and opportunities may be provided to practice social problem solving.

Over the years, professionals have attempted to deal with social development of individuals with disabilities by experimenting with a variety of interventions. The following literature review represents a history of attempts to improve the social functioning of individuals with disabilities.

History of Social Competence Training

During special education's early years, lack of social competence was acknowledged as a factor in the development of children with mental disabilities, but there were few instances where social skill training was addressed in a structured format. During the 1950's leading authorities on teaching children with mild mental retardation suggested that social competence was most affected by the school experiences. They hypothesized that social skill development occurred at a slower rate but was no different in substance from the social skill development of nonchildren with disabilities. Further, they asserted that the negative attitudes and poor social behaviors exhibited by youngsters with disabilities occurred as a result of frustration and failure experienced in regular education classrooms. The remedy proposed by these authorities was to separate youngsters with disabilities into special classes and provide them with more concrete learning experiences and less frustrating academic tasks. They suggested the major impact on social development would occur when teachers created non-threatening classroom environments. In turn, the less threatening academic atmosphere would ensure success experiences resulting in enhanced self-concept and decreases in showing off, teasing and stealing other children's things that were believed to be part of the youngsters' with mild mental retardation behavioral repertoires (Johnson, 1963; Kirk & Johnson, 1951).

During the 1960's educators began questioning some of these traditional views of programming. Safe environments were criticized to some extent for not challenging youngsters with disabilities (Kolstoe and Frey, 1965). One of the preponderant methods for teaching social skills, or for that matter all subjects, was the use of life experience units. In essence, the teaching of social skills was blended into all aspects of instruction. For example, a unit on teen dating would include instruction related to etiquette, cost, transportation, vocabulary and a number of other aspects related to dating (Meyen, 1972). According to Kolstoe (1970), units of experience lent themselves to both teaching social competency and providing practice in the implementation of the concepts in social situations. Further, Kolstoe recommended that social drama be used in response to specific questions which might occur in the home, school or neighborhood and that it not be "systematically contrived to fit a list of ethical or moral concepts" (p. 113).

One major exception to the void in development of training programs in the social and emotional areas was the Social Learning Curriculum (Goldstein, 1974)

developed at the Curriculum Research and Development Center in Mental Retardation at Yeshiva University. This special curriculum addressed social interaction skills and provided information to pupils related to their community and everyday living environment.

Since the development of that curriculum, special education service delivery models changed focus and attempted to program for students with disabilities for the least restrictive environment. When reasonable and appropriate, the preferred placement of pupils with disabilities, according to state and federal law, became the regular classroom. In part, these students were expected to show social skill growth simply as a result of integration (Dunn, 1968). Mainstreaming advocates premised their support upon assumptions that increases in social interaction, social acceptance and modeling would occur (Birch, 1974; Christophos & Renz, 1969; Mercer & Algozzine, 1977). Unfortunately, as will be discussed in the following section, not all children with mental disabilities benefited from their integration into regular classrooms.

The Need for Improving Social Competence

A significant reason for addressing social competence is that modern educational practices are focused on providing instruction in the least restrictive environment. With educational efforts directed toward preparing individuals with mild and moderate mental disabilities to live in their own communities with nonhandicapped people, social competence becomes essential for success in these mainstream school, community and work settings. The second reason for addressing social competence is an awareness that structured learning activities are educationally more fruitful than previous instructional techniques which relied on skill acquisition through tangentially related activities (Lloyd & Carnine, 1981). This leads to the conclusion that programming for social competence should not be left to chance if it is to be done effectively.

In contrast to the expectations of mainstreaming proponents, Gresham (1982) asserts that children with disabilities do not interact more, are not better accepted, and do not model the desired social skills of their peers when physically integrated with them. This assertion is supported by considerable research conducted with children identified as mentally retarded (Apolloni & Cooke, 1978; Ballard, Coreman, Gottlieb & Kaufman, 1977; Gottlieb, 1974; Gottlieb, 1975; Gottlieb, Semmel & Veldman, 1978; Jenkins, Speltz, & Odom, 1986; Van Bourgondien, 1987). Instead of urging abandonment of mainstreaming, Gresham (1982, 1984) makes a case for teaching social skills to pupils with disabilities for the purpose of enhancing their ability to benefit from integration.

In contrast to Kolstoe's (1970) admonition that social skill training through the use of social drama should not be systematically contrived, the methodology for teaching other skills appears to be more effective when instruction is very structured. After reviewing research on academic instruction, Stevens and Rosenshine (1981) concluded that the most successful teachers are those that selected and directed activities, approached the subject matter in a direct fashion, organized learning around questions they posed, and occupied the center of attention. Further, they concluded that the most efficient process for teaching occurs in a three step sequence including: demonstration, prompting and practice.

During the practice phase student must experience a high level of success to sustain learning gains, and learning will be enhanced when pupils receive feedback on their efforts.

Similarly, researchers found that students with mild mental disabilities often learn best when instruction is offered in a systematic sequenced format. Close, Irvin, Taylor and Agosta (1981) indicated that instructional assistance (consisting of verbal cues, modeling and prompting), systematic feedback, and repeated correct practice ensures learning. They used a variation of direct instruction technology to teach community living skills to adults with mild mental disabilities. Based on the effectiveness of learning formats, similar approaches appear to be needed to teach social skills to pupils with mild mental retardation.

What to Teach

One of the major determinants of social acceptance appears to be the perception of interfering behavior by others. Greater social rejection occurs for misbehaving children than for children with disabilities who are simply perceived as cognitively deficient (Gottlieb, Semmel & Veldman, 1978; MacMillan & Morrison, 1980). Similarly, children who are learning disabled tend to be rejected by peers and were found to emit negative verbal behaviors in the regular classroom (Bryan, 1974). Some of the behaviors found most important to gaining social acceptance in the regular classroom are: attending, complying, volunteering, following directions, speaking positively about academic material, and remaining on task (Cartledge & Milburn, 1980). Gottlieb (1982) indicated that for young children, teacher acceptance appeared to be a major determinant in social acceptance by peers. In addition to facilitating acceptance among peers, these behaviors encourage greater acceptance on the part of the regular class teachers and result in the child with a disability having more positive interactions with teachers. Therefore, learning teacher pleasing behaviors is an important part of developing social competence. For young children, a good place to start would be with one of several lists of kindergarten survival skills (McCormick & Kawate, 1982). Other behaviors, such as, aggression and acting out must be reduced through use of behavior change methods.

Personal interaction skills are equally important to ensure success in the school and community setting. Several authors identify behavior such as: helping, sharing, smiling, greeting others, speaking positively to others, and controlling aggression as behaviors which are necessary for adequate social interaction. In addition, recognizing emotions, complimenting, positive physical contract, asking for information, extending invitations, giving information, taking turns, listening, eye contact, participating, expressing enthusiasm, and good grooming were all found to contribute to positive social interaction (Cooke & Appolloni, 1976; Gottman, Gonso & Rasmussen, 1975; Gronlund & Anderson, 1963; Mesibov & LaGreca, 1981; and Oden & Asher, 1977).

For elementary children, Stephens' (1978) developed a list of 136 social skills. He divided these skills into environmental behaviors, interpersonal behaviors, self-related behaviors and task related behaviors. These skills were identified by having 200 teachers rate skills which are most necessary to succeed in the regular classroom. Stephens' lists of social skills extend beyond Gresham's (1981) definition which addressed only social interaction and social acceptance and include eating properly, disposing of trash, traveling to and about the school, and personal hygiene.

In addition to the list of social skills, Stephens developed a curriculum based on direct instruction strategies for teaching all of these skills.

At the secondary school level. Goldstein, Sprafkin, Gershaw, and Klein (1980) produced a list of social skills and structured learning activities meant for use with adolescents with behavioral disorders. Goldstein and his associates documented considerable success with their structured learning approaches they called "Skillstreaming." They grouped skills according to a hierarchy: (1) beginning social skills such as complimenting, (2) advanced social skills (e.g., asking for help and apologizing), (3) dealing with feelings, (e.g., expressing affection), (4) alternatives to aggression (e.g., negotiating), (5) dealing with stress (e.g., being left out), and (6) planning skills (e.g., making a decision). McGinnis and Goldstein (1984) later adapted the original Skillstreaming model for use with elementary age students.

Another perspective on what to teach relates to the assumption that the area of social cognition must be addressed if the individual is to become socially competent. individuals with mental disabilities have been identified as more egocentric and therefore require more training in role taking--understanding what others are perceiving, thinking, and feeling. In addition, they are deficient at social inference (i.e., the ability to interpret what is happening around them), decision making, and problem solving. Furthermore, shortcomings in the understanding of social processes like friendship are frequent (Greenspan, 1979).

Elias and Maher (1983) suggest a social-cognitive problem solving skills framework upon which school based programming can be conducted. It is their contention that a specific set of skills make up social skill competence. The skills which they list are:

1. an expectation by individuals that they can take personal initiative in a situation and gain a favorable outcome,

2. a sensitivity to others' feelings and perspectives,

3. the ability to set a clear goal and consider various possible consequences,

4. the ability to plan specific steps to aid in reaching a goal,

5. the behavioral repertoire needed to implement their plans,

6. the persistence to continue using their problem solving skills in the face of obstacles, and

7. the ability to refine their problem-solving strategies in light of experience.

Vaughn, Ridley, and Cox (1983) identified several skills which fit into the social cognition category and they designed an instructional program around them. The content of their instructional program includes:

1. Fundamental language concepts (e.g. same, different, etc.)

2. Cue Sensitivity--Children are taught to become aware of key factors in a social situation and react differently depending on the situation.

3. Goal Identification--Children are taught to proceed from goals producing long range gratification.

4. Empathy--Children are taught to take the role of another.

5. Alternative Thinking--Students are taught to predict likely outcomes for problem situations using alternative problem solving strategies.

6. Consequential Thinking--strategies for predicting likely outcomes of problem solving methods are taught.

7. Procedural Thinking--Students are taught how to get from a chosen alternative to a desired goal.

8. Integrating skills--All of the components of the interpersonal problem solving approach are incorporated into a single process.

Although there are many skills and behaviors which must be taught to increase the social competence of individuals with mental disabilities, the timing of instruction is also important.

When to Teach

In some form or another, social competence must be taught at all times in a child's life. In particular, reinforcement of social affect and socially appropriate behavior will always be warranted. However, not every social competency must be addressed as soon as it is perceived as a deficiency. Decisions on when to teach a particular skill are related to the characteristics of individual children. Browning and White (1986) emphasized that instruction should match the ages of the children and their cognitive abilities. For example, a child with a mental age of four is not likely to have a well developed concept of what is "fair" and what is "not fair." If the child is still young, he or she may develop these concepts with little intervention. In contrast, some students have so many deficits that it is necessary to tackle the most obtrusive problem or potentially most valuable skill first. In other words, a system of priorities must be established for the individual.

Many students classified as mentally disabled are by definition deficient in their social competence. In these cases it is appropriate to address social skill training systematically. Preshcoolers may be taught kindergarten survival skills, elementary age children may be taught teacher pleasing behaviors, and adolescents have great need for assistance with personal interaction skills. In addition to direct teaching, most students with mental disabilities benefit from adult interventions to facilitate interactions with peers. This is a continuous and longitudinal need.

Assessment is often the first part of a systematic approach to teaching social skills. The most time efficient assessment is the use of teacher rated checklists which accompany many social skills training materials (Goldstein, et. al., 1980; Sargent, 1983; Stephens, 1978). By rating student behavior, teachers can identify specific social skill deficits. Four types of deficits are most prominent.

1. Skill Deficits--The student cannot perform a particular social skill.

2. Skill Inadequacy--The skill is performed but some critical steps are left out.

3. Performance Deficit--The student can perform the skill, but does not do it frequently enough.

4. Self-control Deficit--The student has excessive or repugnant behaviors which he or she seems unable to reduce in frequency.

Deficits 1 and 2 require instruction, while deficits 3 and 4 require individual behavior change plans.

Determining when to teach a particular skill can be accomplished by responding to the following questions:

1. Is the skill deficient or inadequate?

2. Does the student have the cognitive ability to learn the skill?

3. Will the student have an opportunity to practice the skill?

4. Does changing the student's behavior have importance to significant others in the student's life?

5. Is the skill needed in current or future environments?

6. Is acquisition of the skill essential to the individual's ability to remain in his or her current environment?

Affirmative answers to these questions may lead to the conclusion that the skill should be taught immediately. If an answer is negative to any of questions 2--5, the skill may be taught at a later date. If the response to question 6 is affirmative, the skill may be taught, but the behavior may have to be shaped through use of behavioral analysis techniques rather than being taught through more cognitive-based instruction. Methods for teaching social skills are discussed in the following section.

How to Teach!

No single approach to building social competence appears to be totally satisfactory. The approaches selected for use will depend on a wide range of variables including age, mental ability, practice opportunities, communication skills, and a host of concerns related to the unique needs of individuals. Further, improving social competence must be planned longitudinally. Attention to these needs must be given throughout a student's entire school career. It is unlikely that a lesson or two on how to make friends will result in the individual establishing close personal relationships. The individual must have sufficient self-esteem, confidence and risk taking ability to make friends. At the same time, they must have the following: the ability to understand how their close friend feels and thinks, the moral and ethical judgments to be respected by a friend, and the ability to solve social problems that assist in sustaining friendships. To state this more broadly, the individual must manifest sufficient social affect, display appropriate social skills, and exercise social cognition to become socially competent.

Improving Social Affect

As mentioned earlier, it was once believed that if we simply dealt with the self-concept of children with mild mental disabilities by removing them from the frustrations of regular education then socially maladaptive behaviors would disappear. Not all, but several studies indicate that students in special classes do tend to have somewhat better self-concepts than similarly students with disabilities in regular education classes. However, this does not mean that they have better social skills or that they are better liked by others. It only means that they think better of themselves.

With the current mandate to educate children in the least restrictive environment, it is very important to work on social affect in a variety of ways. Because affect is part of all social behavior, this aspect of social competence is best taught when integrated into all instructional areas as well as being taught directly. Building a healthy social affect should begin as soon as a child enters school. Attempts to shape affective behaviors such as cheerfulness, good posture, good grooming, independence, and optimism should be ongoing throughout the student's school career. Regular and special education teachers can positively impact social affect in a variety of ways including (a) providing instruction and activities in which the individual with a disability can be successful; (b) reinforcing smiling, making eye contact, and expressing enthusiasm; and, (c) providing appropriate opportunities to demonstrate assertiveness. Furthermore, clear, simple, informative feedback on behavior such as posture and grooming will assist in developing an affect which contributes to social acceptance.

In many cases, efforts to build social affect will be beyond the scope of what the special education teacher can do alone. Success has been achieved through the use of peer confederates reinforcing and prompting interactions (Strain & Odom, 1986), adult confederates (Sargent, 1983), and classmates (McGinnis & Goldstein, 1984). Strain and Timm (1974) were able to increase cooperative play of handicapped and nonhandicapped peers by reinforcing the nonchildren with disabilities for initiating interactions and cooperative play.

Simply integrating students into regular classes is unlikely to improve social affect and social skills (Gresham, 1982; Jenkins, Speltz, & Odom, 1986; Johnson, Johnson, & Maruyamma, 1983). However, planned interventions can facilitate interaction and improved self-concept. A procedure which works well in regular class settings is cooperative learning where students engage in cooperative goal setting. The use of this procedure with students with mental disabilities has shown that students with disabilities engaged in twice as much interaction in cooperative learning environments as they do in competitive learning situations. Moreover, their self-esteem was better, and the new relationships were maintained during periods of free play (Johnson & Johnson, 1983). To date, no other attempts to improve social affect have proven to be as powerful as cooperative learning strategies. Another benefit of this approach is that nonhandicapped students are more accepting of their peers with disabilities (Ballard, et. al., 1977).

A few instructional techniques of a more directive nature have been used to improve social affect. In most instances these techniques are combined with attempts to deal with social cognition. A variety of materials were published

in the late 1960s and early 1970s to teach children to understand feelings and be optimistic. Typically, these materials contained stories and were followed by group discussions. There are no published studies of their use with children with mental disabilities. Recently, Browning and White (1986) used interactive video media to deal with affective concerns including "being positive" and "being responsible." This methodology of teaching social affect through presentation of a story or film followed by discussion directly resembles instruction in other areas as well.

Developing Social Cognition

Social cognition and social affect are so closely linked that most authors do not separate the two. Much of what the professional literature describes as affective instruction will be identified as social cognition in this chapter. Work in the area of social cognition has been worthwhile, but some research indicates that it must be accompanied with specific skill instruction to be successful and have long term benefits for individuals with mental disabilities (Castles & Glass, 1986). Although not as powerful as social skills training, instruction in the arena of social cognition addresses some important elements of social competence untouched by most specific skill training approaches. An additional positive attribute of training in social cognition is that students are given strategies for dealing with a wide range of problems and conditions. In contrast, specific skill training tends to focus on narrowly defined operations. The majority of the research has been conducted in areas such as role taking ability and social problem solving.

The Social Learning Curriculum (Goldstein, 1974) represents one of the earlier attempts to address the area of social cognition. Lessons were focused on discussion of social problems and alternative ways to solve them. The methodology for teaching skills such as social problem solving included the story followed by discussion format. More recently, Elias & Maher (1983) developed a model for teaching social-cognitive problem solving skills. To teach these skills, they used television video tapes, discussion and role playing. They further point out that knowledge of children's cognitive ability at different ages is very important. According to the authors, use of video tape and film is especially valuable for the following reasons:

1. TV activates a range of sensory modalities. It also stimulates motivation, attention, and is easily recalled.

2. There is a synergistic learning effect when television is combined with discussion that promotes learning of a general cognitive strategy.

Some of the materials that they recommend are video tape materials that can be obtained from:

Catalogue of Television And Audiovisual Materials
Agency for Instructional Television
Bloomington, Indiana

Examples of age-appropriate materials include "You and Your Feelings" for second graders and "But They Might Laugh" for coping with embarrassment (fourth grade). Materials such as these have worked well with a variety of children, but they have not been validated specifically for children with mental disabilities . Nevertheless, their usage with this group seems warranted.

Vaughn, Ridley, and Cox (1983) have validated problem solving training procedures for children and preschoolers with mental disabilities. Their procedures included discussions, modeling, and rehearsal. Through these processes, students demonstrated significant gains in interpersonal problem solving compared to controls. Students increased response repetoires to include trading, sharing, getting assistance from others, and waiting.

Another useful approach for enhancing social cognition is the use of techniques of cognitive behavior modification. This is accomplished by teaching response strategies to students which they can apply at appropriate times. The individual uses verbal self-instruction to deal with problem situations. Students are taught to verbalize their thinking during simulated problem solving and decision making sessions. Strategies are rehearsed and then applied when needed. Browning and White (1986) used this procedure in conjunction with videos focused on areas including "being positive," "relating to others," "knowing your rights," and "being responsible." In addition to verbal rehearsal of strategies, they use self-talking, workbooks, homework, role plays, and expansion games. Bash and Campbell (1980) have a similar procedure they call "thinking aloud" where students verbally rehearse their responses and possible alternative solutions to social problems. The difficulty with these procedures is that they are highly reliant on language, a skill which many individuals with mental disabilities are less facile. However, with adequate practice, cognitive behavior modifications have been used successfully with individuals with mental disabilities.

The methodology used to teach social problem solving, role taking, social inference and other areas of social cognition is very similar to techniques used to train specific social skills discussed in the following section.

Teaching Specific Social Skills

Several authors advocate direct instruction of social skills (Cartledge & Milburn, 1980; McGinnis & Goldstein, 1984; Mesibov & LaGreco, 1981; Sargent, 1983; Stephens, 1979; Strain, Shores & Timm, 1977; Strain & Wiegerink, 1976). The procedures used for direct instruction are all very similar. They rely heavily on modeling, role playing, practice, and feedback. The area of social skills differs slightly from social thinking in that social skills are overt behaviors related to specific social needs such as making an introduction, sharing, or staying our of fights. Since the procedures are basically a synthesis of other models with attention given to the learning characteristics of mentally retarded learners, the instructional procedures from Project SISS (Sargent, 1988) will be presented.

When teaching social skills, it is necessary to adapt instruction to match the learning characteristics of individuals who are mentally disabled. Accommodation for deficits in discrimination, attention, memory, and generalization needs to be built into instructional planning. In nearly all previous attempts to teach social skills to learners with mental disabilities, the students failed to generalize the skills learned (Flemming and Flemming, 1982). Generalization is not likely to occur unless strategies which enhance the likelihood of generalization are employed, and without generalization, social skills training has little empirical and social validity.

Procedural Steps for Teaching Social Skills

The Project SISS (Systematic Instruction of Social Skills) Program (Sargent, 1988) is based a six (6) step direct instruction procedure. The methodology is similar to that developed by Goldstein et. al (1980) and Stephens (1978) but includes accommodations designed to address the learning deficits commonly exhibited by mentally handicapped students:

Step #1: Establishing the Need

All direct instruction lessons begin with establishing the need for the skill. Essentially, the teacher creates conditions or provokes thinking which will make students personally aware of the need to acquire and exercise a particular social skill. Lessons may begin with questions, a story or a puppet skit that introduces the needed skill. Through discussion of personal experiences or the introductory story, students identify reasons why a skill is necessary and establish consequences for knowing or not knowing the skill. For the most part, consequences should be elicited from students rather than be provided by the teacher. The purpose of this step is to enhance attention to instruction by making the topic personally meaningful.

Step #2: Identify the Skill Components

After establishing a need for the skill, the teacher should list the skill components determined through task analysis. For intermediate-aged and older students, the steps should be written on poster board or the chalk board. The listing of skill steps provides language mediators for later performance of the skill and it focuses attention on the key elements of the social skill. Once the skill components are listed, a variety of techniques should be used for rehearsal. For young children rote rehearsal should be imposed for part of the instruction and rehearsal should be cued to elicit recall and recitation. Rote rehearsal may consist of unison reading of the skill component listed on the chalk board, repetition of a poem that presents the skill components, writing the skill steps on homework forms, or daily recitation of the components. For older children, a verbal elaboration strategy is more age-appropriate and more successful than rote rehearsal. Verbal elaboration consists of teacher-lead discussions covering each step of the skill. Through discussion, a variety of aspects of the skill steps are repeated, paired with associative information, and made personally relevant to the students. All of these rehearsal procedures address the short-term memory problems of these students.

Step #3: Model the Skill

Both live and symbolic modeling are effective when teaching social skills. Live modeling may consist of a teacher, another adult, or a competent peer acting out how the behavior should be performed. Symbolic modeling serves the same purpose, but uses video tapes, movies, and puppets to demonstrate the skill. Modeling also helps maintain attention to the lesson. When puppets are used with primary level children they become engaged. The older students seem to appreciate seeing their teacher and others they know perform before them.

Due to the poor discrimination skills of youngsters with disabilities, each of the skill components must be identified during the course of modeling the entire skill. This can be done during symbolic modeling by stopping and narrating the scene being

played out. For live modeling, the teacher or other competent model can provide a running narrative of what they are thinking and doing. When using this procedure, the teacher is able to demonstrate the cognitive steps associated with the particular social skills.

Modeling the skill more than one time is usually necessary. After a skill has been acquired, the skill should be modeled in different contexts to demonstrate that the skill needs to be generalized to a variety of conditions or settings. For example, the skill for responding appropriately to name calling might be modeled for playground, home, classroom and school bus settings. The person doing the name calling may be an adult, a peer, or a sibling.

Step #4: Role Play of the Skill

During the role playing portion of the lessons, a number of attempts are made to address the learning deficiencies of youngsters with disabilities. Attention to the lesson is facilitated by the active role taking, and the skill components are actively rehearsed during role playing sessions. In addition, attention is enhanced by giving pupils feedback responsibilities. Feedback assignments may be made verbally or through the use of feedback cards. When giving verbal assignments, the teacher simply tells each student to watch for a single specific skill component. The feedback cards do the same as verbal assignment, but may be collected after each role played situation and redistributed to give class members a new skill component to concentrate on while a fellow student performs.

Feedback coming from classmates as well as teacher serves the following purposes:

1. Feedback can enhance the pupils discrimination of specific skill components.

2. Feedback helps to shape the skill to a refined performance level.

3. Feedback serves as a reinforcer and helps maintain the skill once it is acquired.

Generalization deficiencies also are addressed during role playing sessions. By creating a number of simulated conditions, pupils are provided with a variety of circumstances under which the skill should be used. When possible each time a different student role plays the skill it should be for an altered circumstance. For example, if one student role plays negotiating with a supervisor, the next might role play negotiating with a parent and then with a co-worker.

Step #5: Practice

For a new skill to be mastered, maintained, and eventually generalized, that skill must be practiced. Children with disabilities need considerable practice in learning academic skills and the same efforts must be made to teach social skills. Practice may be carried out in a variety of ways. The following list is a compilation of suggested practice activities:

1. Whole skill prompts--A typical prompt to an elementary school pupil would be something like: "Show me how you are supposed to pay attention," and "Tell me how to ask someone to play and then you can go ask someone to play." The nature of the prompts must be changed to fit the particular child.

2. Coaching - Coaching simply means telling the student what to do and then providing feedback.

3. Skill challenges - A skill challenge occurs when a contrived social or classroom situation is created where a pupil must demonstrate use of a particular skill.

4. Homework - The lessons generally call for formal homework at the junior and senior high levels and informal homework for elementary age children.

5. Skill review sessions- These sessions consist of a review of reasons for using the particular skills, the skill components, and modeling by one or two proficient class members.

6. Daily role playing - Through feedback given during and after the role play practice sessions, skills will be shaped to correct performance.

7. Skill of the Week - When a new skill is introduced, it may be emphasized by posting the skill components.

8. Reteaching the lesson - The same lesson may be retaught (usually in an abbreviated form) at a later date.

9. Reteaching at Different Levels - Several of the social skills will need to be retaught as students become older.

Step #6: Generalization

Unless efforts are made to facilitate generalization the instruction provided in the classroom is likely to be for naught. The recommended procedures are often easy to neglect, but teachers should be vigilant in their efforts to program for generalization. Special education teachers must remember that many of their students are under their stimulus control. Social skills that occur in the special class will not always occur in other environments. Some recommended methods include:

1. Prompting skill use in different environments

2. Feedback in different environments

3. Reinforcement in different environments

4. Reteaching in a different setting

5. Reteach or practice with a change in student constellation

6. Instruct and practice the skill with a different trainer

7. Self reporting - Ask students to report on their own use of the skill.

8. Self-monitoring - Students may be asked to monitor their own skill use.

9. Reinforce generalization

10. Train to loose parameters

11. Concentrate training on only good models

In addition to the steps taken directly to facilitate generalization, many actions which enhance generalization can be integrated into all other aspects of instruction.

Performance Deficits and Follow-up

Not all pupils will meet the performance criteria for each of the social skills introduced in the structured learning lessons. In many cases, the lessons should be repeated and followed up with a variety of interventions. In some cases, a skill will be adequately learned, but after instruction, the pupil still will have a performance deficit. Performance deficits exist when a student can perform a particular social skill but does not exercise the skill frequently enough. A number of procedures may be used to improve upon performance and self control deficits. The methods include use of interdependent contingencies, token economies, behavioral contracts, social reinforcement, prompting and cuing procedures, peer instruction, self-monitoring and cognitive behavior modification. These are common special education procedures and will not be discussed in this chapter.

To give students opportunities to practice and maintain their skills it is necessary to follow-up with interventions which will facilitate interactions. Most of these have been mentioned earlier under the section on teaching social affect. They include use of cooperative learning strategies, peer teaching, use of confederates, organization of non-competitive games, social drama, and buddy systems.

Teaching Approach to Maintenance and Generalization

For nondisabled populations, coaching as a teaching method proved to be as effective as modeling (Oden & Asher, 1977). In contrast, La Greca, Stone, and Bell (1983) found that modeling was more successful than coaching alone for teaching social skills to students with mental disabilities. Although slightly weaker as an initial teaching strategy, coaching remains a powerful maintenance and generalization strategy. The Boys Town Schools Social Skills Curriculum and training model (Black, Downs, Bastien, & Brown, 1984) is a coaching approach which contains some very useful components that can be effectively adapted for use with students who have intellectual deficiencies. Based upon the Teaching-Family Model developed by Phillips, Fixsen, Phillips and Wolf (1979), the curriculum and teaching strategies are focused at improving the social behavior of institutionalized, behavior disordered adolescents. As a feedback and reteaching system, the Complete Teaching Interaction component is a structured and very useful tool for facilitating maintenance and generalization of learned social skills. At Boys Town, this procedure is used for initial instruction of a social skill. This technique is recommended as part of follow-up procedures to direct instruction for students with

mental disabilities because it appears to be too reliant on verbal instruction to be used as the only approach to teaching social skills.

The Boys Town model is based upon the premise that social skills teaching is most effective when the problem actually arises. For example, when a student fails to accept criticism it is time to teach that skill. To be able to teach the skill, the teacher must be very accurate at observing and describing behavior. Teacher competence in these skills is recommended before implementing the procedures described in this model. Once the behavioral deficiency is identified, the teacher or other educator initiates a ten step teaching interaction consisting of the following steps:

1. Expression of affection which may include smiles, physical contact, use of the students name, or a statement of affection.

2. Initial praise/empathy is a positive statement related to a students accomplishments or a statement of concern about the student's feelings.

3. Describe inappropriate behavior--tell the student exactly what he or she was doing inappropriately.

4. Describe appropriate behavior--this involves describing or demonstrating an alternative behavior.

5. Rationale is provided to the student to point out the benefit or consequences for engaging or not engaging in certain behaviors.

6. Request acknowledgement as a check for understanding. Some steps may need elaboration or repeating if the student does not understand.

7. Practice is required to make sure the student truly understands how to perform the skill.

8. Feedback is provided to the student to reinforce and/or correct performance during the practice component.

9. Consequences are provided to teach students the relationship between their behavior and the results of their behavior.

10. General Praise is offered to end the session positively and reinforce the student for participating in the teaching/learning experience.

This model gives its users a powerful way to react to the specific deficits and instructional needs of students who need help in this area. A final point bears repeating: since it is primarily a coaching approach, it is recommended as a support or follow-up methodology rather than an initial instruction method.

SUMMARY

Enhancing the social competence of individuals with mental disabilities should be considered an ongoing goal of special educators. This goal cannot be accomplished

unless needs are addressed broadly and longitudinally. Efforts should be directed at improving the following areas: social affect, social skills, and social thinking.

Social affect represents appearances that the individual presents to others. These behaviors, such as, cheerfulness and good posture, can be taught through infusion into other learning activities. They are reinforced thorough attempts to facilitate interaction and cooperation with others.

Social skills represent overt behaviors used in a variety of social contexts. They include groups of skills related to initiating and responding appropriately in personal interactions and numerous skills related to socially acceptable behavior in a variety of environments. Many of these skills can be taught directly, but instruction must include components that facilitate generalization.

Social cognition represents the thinking or cognitive component of social competence. Some aspects of social cognition can be enhanced through use of techniques such as role playing, training the use of strategies, and cognitive behavior modification.

Research evidence indicates that no single approach to improving social competence is sufficient. Educators must continually reinforce appropriate social affect, teach social skills directly, and instruct individuals on the use of thinking strategies to understand and solve problems in social situations.

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