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Chapter 1

The Role of Social Skills in Childhood Adjustment

INTRODUCTION

Social behavior permeates all aspect of life for children and affects their later adjustment and happiness. A person's ability to get along with others and to engage in prosocial behaviors determines popularity among peers and with teachers, parents, and other significant adults. The degree of social skill is directly related to the number and type of prosocial acts performed by others toward the person evincing social behavior. Furthermore, this behavior has great impact in a number of areas. Social skills or the lack of them has been directly related to rates of juvenile delinquency (Roff et al., 1972), dropping out of school (Ullman, 1975), and in later life, bad-conduct discharges from the military (Roff, 1961) and mental health problems (Cowen et al., 1973). Social skills deficits have been termed a defining characteristic of mental retardation (Grossman, 1983) and deficits in this area are very problematic in visually and hearing impaired children (Matson & Helsel, 1985). With respect to these latter two groups, social skills deficiencies have been linked to major problems in adjustment with peers at school and in the home setting. Similarly, particular personality characteristics and the individual's overall stability seem to be greatly affected by social skills difficulties. For example, Kagan and Moss (1962) have concluded that social interaction anxiety, sex role identification, and patterns of sexual behavior were related to problems in this area. As noted, these deficits can and often do result in lifelong problems (Barclay, 1966; Brown, 1954; Guinouard & Rychlak, 1982). Furthermore, it is not uncommon for negative stereotypes about these children to develop among their peers (Koslin et al., 1986; Sherif et al., 1961).

The role of social skills in conduct problems is worth special note. Problems of conduct disorders represent about one-third to one-half of all family and school referrals for mental health services (Gardner & Cole, 1986). Other facts suggest the incredible magnitude of the problem. Conduct disorder is the most common referral to behavior therapists (Robins, 1981); just one form of this disorder, school vandalism, costs $600 million yearly, along with 70,000 serious assaults on teachers (Tygart, 1980). And, unlike many childhood problems which decline with age, antisocial behaviors persist (Olweus, 1979; Shechtman, 1970). Furthermore, many serious problems in adulthood are likely to be associated with earlier conduct disorder and aggression, such as child abuse, battering one's marriage partner, alcoholism, emotional disorders, violent crime, and other social ills. Furthermore, even in childhood, conduct problems may coexist with a number of other problems, including depression, hyperactivity, and learning disabilities (Puig-Antich, 1982; Ross & Ross, 1982).

These data show the pervasive nature of conduct problems, the genesis of which is primarily social in origin. For the teacher or clinician, the serious nature of this social skills deficit is self-evident. This recognition may account in part for the widespread popularity of social skills training and research.

Yet another problem is the relationship of social skills to various forms of psychopathology. Much of the early social skills treatment and assessment research with adults focused on the effects of social skills training on schizophrenic persons. Most prominent among these researchers have been Hersen and Bellack (1976), who have demonstrated in numerous studies with chronic schizophrenics that increasing adaptive social behaviors markedly improves the person's adaptation to the community. Similar problems have been noted with respect to social behaviors and depression. Among the persons who popularized this relationship are Lewinsohn (1975) and Beck and associates (Beck et al., 1978). Social withdrawal and self-motivated isolation are among the behaviors that these persons exhibited. Lewinsohn (1975) in particular has addressed this problem directly with the development of a training component of his treatment for depression in adults that was aimed specifically at teaching proper social skills along with recording these adaptive responses as they occurred. The value of this approach and the overlap of these problem areas in children has been confirmed empirically by Helsel and Matson (1984). These researchers found a strong relationship between social behaviors and depression in children 4 to 10 years of age. Similarly, they found that there were considerable differences in these groups by age.

It is also likely that subtypes of childhood depression exist and that

the type and severity of social skills deficits that exists and their severity may be altered considerably. Much more research is needed to further describe these phenomena. This area of research is still a relatively new one ; there are far fewer researchers in clinical child psychology and child psychiatry than is the case for mental health professionals working with adults. Therefore it may be some time before these problems can be resolved. Fortunately, developmental psychologists, school psychologists, social workers, and special educators have also become involved in the social skills area and have been instrumental in advancing research and practice.

With children, more so than adults, the nature of how social skills develop is an important consideration. Children who are unacceptable to their peers may be deprived of a number of important experiences, and this may lead to further maladaptation (Bierman & Furman, 1984). These considerations harken back to theories such as those of Kohlberg (1973), who addressed the issue of stages of moral development. From the skills building theorectical perspective, these responses could be viewed as particular social behaviors that are developed through modeling, practice, and reinforcement. In addition to moral reasoning, some researchers have described other theoretical constructs which may fit into the social skills paradigm. These are altruism, avoidance of conflict, learning to reinforce others, and enhancing peer acceptance (Asher et al., 1977).

Since the child's behavior does not occur in isolation, we must consider the interactional effects of social behavior with the variations in behavior based on the responses of others. The behavior of two primary interactional groups — the peer group and the family — can, to a large degree, determine what and how social skills training for the targeted child should be performed. It has been suggested that gaining peer acceptance may be directly related to social skills adequacy (Combs & Slaby, 1977). However, negative views of the child may develop over time, thus, the more unskilled and less popular the child, the more difficult it may be to overcome these stereotypes (Koslin et al.m, 1986; Sherif et al., 1961). The other potential problem group of greatest concern is the family. It has been found, for example, that marital discord and child behavior problems are closely related (Emery, 1982; O'Leary & Emery, 1985) and may be due either to the child or to the parents' reciprocal relationship (Forehand et al., 1986). Thus, the child's behavior must be studied broadly, and treatment often may need to be given in a family context.

We hope the reader has been intrigued by what has been presented up to this point — namely, that a large number of areas of the child's present and future life are related to appropriate social functioning.

However, it is also important to stress that the severity of problems that may accrue due to social skills deficits is considerable. Persons who evince these problems to a large degree may, as previously noted, experience increased adjustment problems as they get older, producing a snowball effect that can result in minimal adaptive functioning in adulthood. These persons may, as a result, become unproductive members of society and, as such, become a drain on the resources of society. The cost in psychological and physical suffering as well as the overall negative financial and social cost can be considerable for those persons affected.

It should be pointed out that these effects are not just for isolated cases; the magnitude of the problem is considerable. Gronlund (1959), for example, found that 12% of children in normal classrooms reported having only one friend, while 6% of children reported having no friends at all. Hymel and Asher (1977) have replicated this study, with similar results. Related to these data are findings that social withdrawal, often defined as passive and slow in speech, has also been a frequently reported problem (Gottman, 1977; Patterson, 1964). Obviously, these data provide reason for concern on the part of the professional.

Unlike other problem areas, extremes in either direction can be evident with social skills. Aggression and conduct problems, as well as social withdrawal and isolation, are frequent with children. Conduct disorders are the most frequent reason for children — by and large males — being referred by school personnel to psychologists and social workers (Gardner & Cole, 1987). Similarly, conduct problems seem to be particularly recalcitrant to treatment; often, the long-term prognosis is worse than what is seen with many severe forms of psychopathology.

It is evident from these problems that social skills are likely to effect a very broad range of psychological response patterns. It seems then that attention is required from a variety of professional disciplines to help remediate these very frequent social/interpersonal problems. Most certainly educators would be among those who should be acquainted with these problems and be involved with their solution. Similarly, clinical psychologists, school counselors, and child psychiatrists are likely to encounter these social skills deficits in almost every child with whom they have professional contact. Given the magnitude and severity of these problems, it would seen that social skills deficits should be seen not only as a major part of the underlying etiology of emotional, personality, and adjustment problems of children but as an area where efforts may have very beneficial preventative effects as well. Therefore, not only will definitions of the problem and settings where these deficits occur be reviewed, but issues in the early identification of social difficulties will be discussed.

WHAT ARE SOCIAL SKILLS?

There has been some confusion concerning what exactly social skills are and how they should be defined. The positive feature of this confusion has been that a broad group of professional disciplines (e.g., social work, education, special education, school psychology, developmental psychology, clinical psychology, psychiatry, and psychiatric nursing) have been interested in studying and developing solutions for this problem. Similarly, persons with a number of theoretical orientations have had interest in this topic, including behavioral and developmental psychologists, school psyschologists, psychiatrists, and educators. Among the behavioral groups there have also been a number of subtypes, including operant conditioning social learning theory, and cognitive behavior therapy. These theories will be reviewed later.

A final problem has been the confusion that has resulted due to the various types of subpopulations of children that have been studied and treated. With the general childhood population, interpersonal skill has been the typical definition that has been used. In the case of mentally retarded persons, however, the definition of social skills has been expanded to include an inordinate number of behaviors, including dressing and hygiene skills. These behaviors do not fit a definition of social skills that would be best with respect to consistency across the broad range of populations that have received treatment. However, it does point out the confusion that has existed among persons working in the field as a whole.

Assuming that the narrower definition of interpersonal responses is used, what specifically are these interpersonal behaviors and what are the parameters of these responses? A brief review of these two issues will follow. They are of considerable importance given that they have been major topics for research and clinical practice.

It should be kept in mind that the socially skilled person is one who can adapt well to his or her environment and who can (particularly in the case of children) avoid conflict of both a verbal and physical nature through communications with others. On the other hand, the socially unskilled person is said to often engage in conduct problems such as fights with other children, is unpopular with peers and adults, and does not get along well with his or her teacher or other professionals. This child is also frequently perceived as being uncaring about the rights and privileges of others and as being very self-centered in his or her behavior. Many of the behaviors that fall within the general rubric of conduct disorder have been quantified in the social skills literature. Children with poor social skills that have implications for conduct

problems often do not follow the accepted rules of society and receive attention for socially unacceptable behavior such as cursing, talking back to adults, arguing with peers, and refusing to recognize the rights of others (for example, refusing to take turns or always "cutting ahead" on the lunch line).

The socially skilled person — that is, the person who learns to perform social skills or is motivated to evince social skills already in his or her repertoire — can have many positive implications. This person is much more likely to receive the types of reinforcers that most of us would view as socially acceptable. These reinforcers can operate on a range of parameters and are described well by Kelly (1982). A brief review of each of these parameters will follow.

The first category mentioned by Kelly as a benefit of social skills training is the building of relationships. The purpose of relationship building is to establish friendships with others and to sustain existing relationships. It should be pointed out that this goal is even more critical for children if we look at this issue from a development level, since these young people are in the process of learning how to get along with others. It is also important to note that children engage in much of their relationship building through nonverbal behaviors.

Play and other nonverbal responses should be monitored as closely as possible for the child to get along with peers. It is also important for the child to learn to discriminate how to build relationships with adults as compared to children. Obviously, the skills that are needed to deal with grownups vary considerably from what one needs to do with other children and even among adults. The needed skills may be quite different (e.g., teacher versus parent). The reader can see that this is a very complex issue for the child; it should be kept in mind that the child may do well with one group of persons and not the others. Evaluating these problem areas is a major topic of concern for the clinician, teacher, and parent.

Second, social skills may also bring about secondary gains. Thus, for example, the child may mind the teacher in class so that he or she may get a good grade in deportment, which may prove to be pleasing to the parent. This skill is important in that it translates to social skills that the child may need as an adult. For example, the salesperson in a store will attempt to be pleasant to a potential buyer not so much for the purpose of making a friend but rather as a way of obtaining a purchase which provides him or her a commission, which results in a larger pay check. For most of us, this monetary reward would be a positive outcome. This type of secondary gain is something that we engage in almost daily.

A third and perhaps most important category of social skills for children to master is the ability to handle the unreasonable behavior of

others. Children who typically get in trouble at school and home with respect to social interpersonal skills are poor in their ability to deal with the inappropriate social behaviors of others. For example, if another child teases the individual or makes derogatory statements, how does the person react? Obviously, it may be difficult to eliminate all problems that can result in conflict, but in many instances the child's responses markedly escalate the seriousness of the situation. In reviewing the social skills literature, it should come as no great surprise that the conduct-disordered child is particularly poor in his or her ability to deal with these types of situations. The problem is compounded by the fact that the child may derive reinforcement from his or her closest friends for making derogatory comments or fighting with others. Similarly, the home environment may be such that behaviors of this type are encouraged.

Knowing the situations where social skills should be used is another area that deserves attention. This problem is particularly great with young children who are mentally retarded, since in many cases they do not have the necessary skills that should be performed in various situations. Typical of this problem is the small child who tells Grandpa that Mommy said she wished he would get rid of that ugly old winter coat that he wears all the time. Stories of this type, which are embarrassing to the parents, are of course common, due to the child's failure to discriminate properly. Another group that has particular problems in this situation includes persons with major physical difficulties, such as hearing or visual impairments. These persons cannot pick up on the same cues that others can attend to; as a result it may be difficult for them to discriminate among social situations, particularly if very fine visual or auditory discriminations are required. Also, these children tend to be particularly immature for their age, further compounding this situation (Matson & Helsel, 1986).

A final problem area to be discussed is the failure to display skills that the child has in his repertoire. One study performed at the University of Pittsburgh clearly demonstrates this motivational problem. The children in the study were between 6 and 12 years old. Sixteen children on a psychiatric inpatient unit received a positive event prior to social skills assessment. Sixteen matched children did not receive a positive event prior to assessment (Kazdin et al., 1982). Those who had the positive event prior to assessment performed better. These results were replicated under different conditions. In a study by Kazdin et al., (1981), two groups — one comprised of normal and one of psychiatrically impaired children — were reinforced for doing their best while the other group was not. Those who were rewarded performed much better. These data suggest that mood and rewards for performance may be important factors in social skills.

It should be evident to the reader that appropriate social skills are of considerable importance. However, the concern over social skills and other mental health issues is of only recent origin. The historical development of mental health services for children will constitute the next issue for discussion.

HISTORICAL DEVELOPMENTS

The area of childhood development and emotional problems is of recent origin when compared to the written history of mankind or even the short history of psychopathology and adjustment problems. Thus, while references to psychopathology can be dated to prehistoric times (Ollendick & Hersen, 1983; Schwartz & Johnson, 1981), the concept with children is of more recent origin. In general, during the Greek and Roman periods, persons who were deranged, were adjusted poorly to the community, or had serious physical or sensory handicaps were ridiculed, banned from society, or worse. During the Dark Ages, demonology was a strongly held belief; it was felt that persons deserved what they got and that a handicap or psychosis was a punishment from God. Thus, no real attempt to treat problem children was forthcoming. Martin Luther, one of the great religious reformers, felt that deranged persons should be burned at the stake. To further compound the problems, it was not generally recognized that children had different thought processes than adults or even that mental development occurred. Children were in effect treated as small adults, yet they were also viewed as the property of their parents. Furthermore, there were no child-protection provisions in the laws of most European countries and children were forced to work at a very young age. All of these factors led to very unpleasant situations for children at that time.

The 18th and early 19th centuries saw the first systematic attempts to resolve the mental health and adjustment problems of children. Many of these early developments can be credited to educators of the period. For example, Froebel (1903) founded the first kindergarten and applied the discovery method of education to the very young. Perhaps even more importance were the early ideas of Herbart (1901) who introduced the concept that children advance through various stages of cognitive development, an area that has become one of the most heavily researched in the entire field of psychology. Given the view that children had the same basic cognitive processes as adults, the recognition of intellectual differences based on normal development was a major step in advancing the concepts of child psychology and education.

The 19th century also saw a number of very important developments. The recognition that even children with major social and genetic deprivation could be helped to at least some degree was realized. The classic case was that of the Wild Boy of Aveyron, who had grown up in the wilderness with hardly any contact with humans. Itard, a French physician, took this boy and attempted to educate him. This attempt, while not particularly effective, at least developed interest in possible treatments.

In the United States the interest in childhood disorders began to receive attention soon after the American and French Revolutions. While the information often lacked a sufficient data base, they did demonstrate the growing interest in this problem (Swanson & Reinert, 1979). Efforts in this area dealt primarily with classification and education based on academic performance, or in some cases the identification of children with adjustment problems. The information generated was general and there was no specific data base. It is only within the last 20 years that a major taxonomy of childhood psychopathology has begun to emerge and social skills research has begun to flourish. The developments in this area have been significant and rapid and will be reviewed next.

The history of social skills and its development as a popular area for consideration by professionals began primarily with research on adults. Work with children followed shortly thereafter and has become increasingly popular. A major advantage of social skills work is that it cuts across a wide range of professional disciplines, providing a common language to researcher, clinicians, and teachers. It has broad applicability since it relates to most emotional and adjustment problems of children (Ollendick & Cerny, 1981).

The developments of a conceptual basis for social skills training came out of social learning theory. Similarly, the treatment modalities that have been used have been primarily based on this theoretical notion. The idea was that many of the responses that help us adapt to our environment and those around us are learned behaviors. It is generally assumed that observations of others greatly determine the types of response that we are likely to display and the behaviors that prove to be successful. These behaviors are reinforced and therefore are likely to be those which we continue to perform.

The treatment of these problems in a manner that can be supported by experimental verification is a recent phenomenon, with the first studies appearing in this context was with adults and dealt specifically with assertiveness. Typical of this research were studies that emphasized social learning treatment methods in the amelioration of college males' fear and general inability to ask females for dates (McFall & Lillesand,

1971; McFall & Marston, 1970). Assertiveness training for women also became a popular notion (Richey, 1981). In both of these lines of research, the emphasis was on teaching appropriate assertiveness. That is, a person could be viewed as overly passive or overly aggressive, depending on the particular social context in which the response was made and whether the person was male or female. A number of other demographic behaviors also proved to be important. For example, an employee who tends to be less outspoken with his or her employer than his or her children may be adaptive in social functioning. This problem is perhaps of even greater complexity with children when it is considered that their behavior is typically viewed as being more appropriate if it is passive with adults. Also, it should be kept in mind that the particular values of a family may markedly affect the degree, type, and quality of these interactions.

The emphasis on assertive behaviors of college men and women, while still considered important, soon gave way in the research literature to a much broader interpretation of social skills deficits. The latter term referred to assertiveness but also to a large number of other problem behaviors that were interpersonal in context. Researchers and clinicians began to think of social skills as a quantity of behavior that could be inappropriate in extremes, either too frequent or infrequent, depending on the person or situation. For example, when asked a question an individual could give an answer that was one word or the response could take an hour. Either or these extremes would be inappropriate in most situations.

The focus also changed from generally normal persons who were having minor adjustment problems to persons with serious emotional problems. This development was encouraging and probably due to the power and effectiveness of the technology. The application of these procedures to more severe populations was best exemplified by the work of Hersen and Bellack, who did a great deal of research with chronic schizophrenic patients.

A term first used by Zigler and Phillips (1962), "premorbid social competence," was frequently used to describe these seriously disturbed persons, stressing the relationship of serious mental illness and the inability to adjust due to very poor interpersonal skills. The potential preventive nature of social skills training also became a major rationale for this type of patient; the reader may recall that this issue has been alluded to with respect to children. Similarly, chronic schizophrenics were found to relapse much more frequently if they were returned to families that were highly socially dysfunctional (Liberman et al., 1982). These points are strong arguments for social skills training.

Two examples of social skills should be sufficient to give the reader an

idea of how rapidly expansion has occurred. Hersen and Bellack (1976) worked with persons who had been hospitalized several times, usually for 90 days or less. The problems these persons experienced were broken down into discrete social behaviors such as eye contact, quality of speech, content of speech, appropriateness of affect, speech latency, and other specific behaviors. These persons were treated using behavioral strategies in an effort to improve their ability to tolerate others. The hypothesis was that the individual did not possess the necessary skills to function in an acceptable interpersonal fashion.

A second group of researchers at UCLA, directed by Robert Paul Liberman, used a similar methodological approach. Their efforts have involved employing antipsychotic medications — an approach which is generally viewed as the treatment of choice in conjunction with behavior therapy (Liberman & Davis, 1975). Additionally, they have focused on the home environment and regulating what they call expressed emotions of the afflicted person and his or her family. The work of this group and other researchers who are working with these adult populations is beginning to look at the differing forms of schizophrenia, the course of the disorder, and how best to promote generalization (Liberman et al., 1982).

The efficacy of social skills training and its popularity and effectiveness in treating chronic schizophrenia resulted in this method also being used with depression in adults. Lewinsohn and his associates at the University of Oregon were perhaps the first to recognize and formulate a theoretical model for the treatment of depression which emphasized social skills deficits and excesses as a primary treatment component. They postulated that large amounts of positive reinforcement in the depressed person's environment are not used to the best possible advantage. This situation is the case because of the general social withdrawal which is evident and because a primary function of treatment is reestablishing pleasurable experiences by the contingent reinforcement of appropriate social behaviors (Liberman & Davis, 1975). In a number of experiments they determined a relationship between the frequency of pleasant activities and mood (Lewinsohn & Graf, 1973; Lewinsohn & Libert, 1972). In addition to the positive effects noted in these studies, it has been found that normally adjusted persons engage in more pleasurable activities than persons with depression. This conceptualization, particularly for unipolar depressives, has become a popular one. Several groups of investigators have been doing research in this area and have largely confirmed Lewinsohn's assumptions. Similarly, in a large controlled treatment outcome study, Hersen et al., (1980) found that social skills training led not only to improved interpersonal functioning but to significant reductions in vegetative symptoms

of unipolar nonpsychotic persons. Much activity seems to be occurring in this area of psychopathology research, and much more experimentation with, and advances in, this area are likely in the next few years.

Given the success of social skills treatment with adults and its general relationship to a fairly broad range of problems, it is no wonder that social skills programs with children also became popular. There is no need to go into a history of this problem, since research in the area is of such recent origin. However, it is likely that much of the clinical work now going on was stimulated by the successes that have been noted with respect to college students, women's assertiveness, chronic schizophrenia, and depression.

While the history of social skills training is very short, this situation also holds for the general area of childhood psychopathology and adjustment. Although training has been used with education problems for some time, the techniques that were applied tended not to have a systematic base, nor did they have a consistent theoretical underpinning. It is only within the last 30 years that well-defined and specified assessment and treatments have been developed. Largely, these have been within the general purview of operant conditioning or social learning theory.

The research on social skills has been largely with mentally retarded, learning disabled, or emotionally disturbed children. Oftentimes this work has been related to the improvement of school adjustment or to further enhance mainstreaming and/or normalization. Most of the initial research was done by psychologists with an applied behavior analysis background. Most of these professionals were trained in an operant laboratory, doing animal research. Thus, the research that emerged was an extension of the operant tradition. Persons with this background are still doing social skills research, but the research has become more diffuse, with professionals in clinical child psychology, school psychology, developmental psychology, and special education contributing substantially to the literature. Each of these groups has taken a somewhat different approach to the problem; this is viewed as a particularly healthy development, since it has resulted in a much more diverse approach with a greater range of theoretical views and available assessment and treatment strategies. Each of these approaches to the topic will be discussed briefly.

Clinical child psychologists have typically emphasized persons with more serious problems, to the extent that these individuals have been referred for treatment in an outpatient mental health clinic or the children have been hospitalized. Among the hospital settings that have been reported in research studies on the topic, the most typical have been inpatient units of large university medical schools or institutions

for mentally retarded or psychiatrically impaired persons. University programs tend to be small, 5 to 25 beds, with children staying approximately 60 to 90 days. The movement toward treatment in the least restrictive environment has had a major impact. Also, money has become a major issue. Patient stays used to be much longer, but the development of new insurance guidelines on maximum payments of psychiatric hospitalization has greatly affected the approach to care. The 90-day limit is usually adhered to very closely since hospitalizations tend to be very expensive $600 to $800 per day not being uncommon. Of course, the number and professional training of the staff tends to be extraordinarily high. Often there are two staff per child, although the staffing ratios are spread out over three shifts. Thus, the treatments and assessments that are used tend to be very elegant and highly effective. A major criticism of this approach, however, is that most facilities do not have the trained staff or the numbers to duplicate these programs. Also, generalization is often a problem when a child changes treatment settings. Thus, one must consider how effective the treatment component may be over time. This area is one that requires additional study.

State hospitals are the second inpatient setting where clinical child psychologists frequently work. These facilities tend to be very large, often housing 500 to 1,000 patients. Unfortunately, facilities of this sort typically do not have the high staffing ratios associated with medical centers, and thus the type and sophistication of the programs are compromised somewhat. Also, the hospitalized persons are, on average, more severely disturbed and their problems are more chronic than those of persons placed in medical centers. As a result, the focus of treatment tends to differ in many instances. Rather than primarily conducting a diagnostic and treatment workup, treatment is begun but followed up in the community. In the institution the emphasis is often on trying to enhance adjustment — often in very minimal ways, including getting along better with other patients and attending to basic hygiene care, since the clients are so severely impaired. Furthermore, the institutionalized persons are likely to be on psychotropic medications due to the nature and chronic course of their problems. Thus, the treatment of social skills in the latter case is likely to focus on enhancing basic skills and the maintenance of existing ones. Conversely, children seen in the medical school situation on an inpatient basis are more likely to be experiencing adjustment problems that have not been clearly identified previously. In addition to having less recalcitrant problems, it is also likely that they are not on, nor have they been on, psychotrophic medications. Thus, to some degree the behavior problems these children experience may be more amenable to treatment than is the case with the adult populations.

The school psychologist, developmental psychologist, and special educator are more likely to be working with children who have not developed problems so severe as to warrant hospitalization or outpatient psychological treatment. However, the philosophy of treatment may differ to some degree from one of these disciplines to another. Moreover, the school psychologist in most cases will not be in a position to provide services directly. Given the large number of children for whom the school psychologist is responsible — typically, two to four schools and perhaps as many as 900 children — this approach is not feasible, even if only 5% to 10% of the children are experiencing social skills deficits. Additionally, school psychologists are also responsible for doing a large number of psychological assessments, which may vary from standard intellectual assessments to evaluations of academic achievement to evaluations of emotional problems. Thus, it is not surprising that those professionals within school psychology advocate the use of their work time for the development of treatment plans as well as assessing problem behaviors within a consultative model. This emphasis seems to be growing and as such shows a movement of school pyschology from a field primarily geared to assessment toward an intervention model of professional services.

With this approach the school psychologist would serve primarily as a trainer and provider of backup support for the teacher, who would provide the child's treatment. This approach might consist of the school psychologist doing an initial assessment, helping the teacher develop a treatment plan, and then allowing the training to be done either by reinforcement of the behaviors during the day in routine classroom situations, or in social skills groups that might take up 30 minutes to an hour three to five times weekly during the regular school day. These meetings could be followed by a weekly meeting with the school psychologist to review progress.

The development psychologist takes a somewhat different view. The emphasis in this research has been on the differences in social responding across age group. Obviously, what is considered acceptable social responding for a 6-year-old would not be the same as for a 12-year-old. Similarly, the popularity of children as perceived by other children and the issue of the effects peers have on their behavior over time has been a major issue for research. Most of the emphasis has been on the school and home environment. While these persons have not been as involved in the direct provisions of services, their efforts have been instrumental in identifying developmental issues that are of clear importance in the assessment and treatment of children.

Special educators have been particularly active in recent years with respect to social skills training. Unlike regular educators, these teachers

typically have classes of 8 to 15 students and a teacher's aide. The regular classsroom teacher, on the other hand, may have 20 to 30 students with the same amount of help. Thus, assessment and training of social skills is more feasible with special education populations in the school setting. Secondly, most (90% to 98%) children in special education classes have social interpersonal problems; the fact that they are having academic and/or emotional problems further exacerbates the situation. The skills that are trained may vary tremendously depending on the skill and cognition level of the persons to be trained. Many learning disabled children may have great potential and very few deficits. On the other hand, persons in the severe and profound range of mental retardation may have serious visual, hearing, or physically handicapping limitations. In these instances the development of social skills curricula has been slow in coming. The emphasis in special education has been to make the development social skills a part of the curriculum. Thus, special class time is set aside and the special education program itself is geared toward goals such as getting along better with other children and acquiring the skills needed to do so. In the case of children with major cognitive deficits resulting in their classification as severely or profoundly mentally retarded, social skills training may constitute orientation responses of the eyes to persons that are talking or smiling at others. While these may seem like small gains to many individuals, such responses prove to be very gratifying to parents, siblings, and many teachers. Thus, the range and scope of social skills training has expanded markedly in recent years.

SUMMARY

A more detailed description of various special populations will follow later. Suffice it to say that we are supportive of the concept of "zero reject" with respect to social skills training of children (Matson & Mulick, 1983). It should be mentioned that there are basically four settings in which social skills training is most likely to occur with a wide range of children. These include clinic or hospital settings, the home, the school, or the community. To date, the published research has primarily emphasized the clinic, hospital, and school as settings for intervention. This evolution of course makes sense, since these are the places where professionals most frequently see children and have a good deal of control over children's behavior. It is likely that this particular emphasis will continue. However, it should be pointed out that the performance of social skills is probably more important in the