LEARNING DISABILITIES AND SOCIAL SKILLS: REFLECTIONS

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I recall a conversation I had very early in my public school career with the mother of one of the students in our program for students with learning disabilities (LD). Over the previous three or four years, this mother had been a very strong and effective advocate for her son, managing to get him enrolled in one of the first LD classes in the city and making certain that he received every possible allowable service. Neal, her son, had made good progress in the program, and at this point we were returning him to the general education class full time with support services from special education.

As I discussed this administrative decision with Mrs. Davis, the mother, I expected her to be pleased about her son's progress and to express her appreciation of this school program. Instead, to my surprise, she responded by making two points. First of all, she was certain that Neal would not have made this progress if she had not spent countless hours in the evening tutoring him. In other words, we were not nearly rigorous enough in our teaching. And second, which was even more unnerving to me, she stated that we had failed to teach her son critical social skills. When pressed, she pointed out that Neal was a nice, quiet boy, but was too compliant. She had no confidence in his ability to resist inappropriate peer requests. If some of the neighborhood children told him to pilfer from the local store, for example, she was not sure that he would refuse.

Although I did not overtly contest her statements, my inner reaction was that Mrs. Davis was unrealistic in her expectations of the public schools. Nevertheless, that conversation has continued to resonate with me, and three decades later I am increasingly convinced of the truth of her words.

The Nature of Social Skill Deficits for Populations with Learning Disabilities

Johnson and Myklebust (1967) provided some of the earliest professional work that I encountered on social skills and learning disabilities. They presented the *socially imperceptive* child, defined as having difficulty with "the perception of the total social field, perception of oneself in relation to the behavior of others as well as to events and circumstances that involve others" (p. 295). These authors viewed social imperception as a specific learning disability, and saw socially imperceptive learners has having difficulty interpreting the behaviors of others, particularly in nonverbal communication such as reading the facial expressions of others. The research literature repeatedly has documented the difficulty children with learning and other mild disabilities have in comprehending nonverbal cues and with problem solving (e.g., Cartledge, Stupay, & Kaczala, 1996; Forness & Kavale, 1996; Nixon, 2001). Students with LD are also noted to have problems with attending to task, with social communication, and with peer acceptance (Nixon, 2001).

In their pioneering work, LD professionals such as Johnson and Myklebust (1967) assumed these social skill deficits represented a neurological learning disorder specific to learners with LD. Others have questioned this premise, however, noting that (a) some children with LD evidence no social skill deficits; (b) children with LD perform similarly to other at-risk groups, such as juvenile delinquents or children with academic deficits on social skill assessments; and (c) social skill deficits are not specific to children with LD (e.g., Gresham, 1993; Schumaker & Deshler, 1995). Furthermore, the source of the social skill deficit is considered to be immaterial; children need to receive appropriate interventions according to the nature of their social skill deficit, not based on speculation on some underlying cause. This more behavioral, skills training (SST) approach has dominated the field of social skills training and is the model that I have used in my own work.

Social Skill Interventions

Since the early writings on this topic in the 1960s and 1970s, formal social skill assessments (e.g., Gresham & Elliott, 1990), curricula (e.g., Cartledge & Kleefeld, 1991, 1994; Goldstein & McGinnis, 1997; Stephens, 1972, 1978; Walker et al., 1997), and numerous intervention studies (see Gresham, Cook, & Crews, 2004) have emerged. This work is reported to result in varying degrees of success. Schumaker and Deshler (1995), for example, reflecting on their research at the University of Kansas since 1978 with students with LD, conclude that these students can be taught complex social behaviors and can learn to apply these skills under naturally occurring conditions. More recently, however, researchers have begun to notice the rather modest gains reported in social skills studies and have begun to question the overall effectiveness of social skill research (Bullis, Walker, & Sprague, 2001; Gresham, Sugai, & Horner, 2001).

Nevertheless, there is good reason to view social skill interventions positively. While Gresham et al. (2004) note that much of the existing work is riddled with methodological errors, closer analysis shows that empirically valid studies produced modest to good returns. Furthermore, the scrutiny of past work gives us directions for future social skill interventions. As we continue our efforts to improve the social behaviors of students with mild disabilities, we must prepare to make changes in our instructional practice and our research practices, and to expand our focus for social skill intervention.

Changes in Instructional and Research Practices

Prepare teachers. All teachers must be thoroughly prepared to teach social skills. This is especially the case for general education teachers, who are likely to be the teachers who first encounter students with LD who present social skill deficits. These teachers can have the greatest impact on preventing or minimizing future behavior problems. Skilled and confident teachers are more likely to teach social skills as needed. In research studies treatment procedures must be implemented as prescribed; they must be closely monitored, and the fidelity of treatment must be clearly described.

Teach in classrooms. Social skill instruction must occur in the classroom and, to the extent possible, be taught by the classroom teacher. Much of the instruction reported in the research literature shows students being taught in small groups outside the classroom and then returned to the same classroom conditions with no adaptations to either reinforce or heighten the opportunities for newly taught behaviors to occur. Newly acquired behaviors are not likely to persist under such conditions.

Teach more. Social skill instruction should not be treated as a fad. Social skills are critical to school success and overall adult competence. There is no evidence that social skills are systematically being taught in our schools, and since a majority of students with LD evidence social skill deficits, social skill instruction must be an explicit and permanent part of the school curriculum. The lessons must be comprehensive and ongoing, for children will not acquire the desired levels of social competence with 10 weeks or 30 sessions of social skill instruction, for example. Social skills must be taught throughout the grades with developmentally appropriate lessons. Research studies need to be structured so that the intervention continues over an extended period of time, lasting throughout the school year and beyond, when possible.

Teach according to learner deficits. A major problem with the current social skill interventions is that social skill lessons are taught sequentially through published curricula, regardless of the specific needs of the learner. The lessons must be tailored to the learners, so that instructional activities might be revised and intensified accordingly. Instructional pace and movement through the curriculum must be based on skill acquisition, not simply focused on covering the material. Further, the lessons must reflect genuine need. Students are more likely to be responsive, and growth is more evident, if students see a real purpose in the social skill instruction they receive. Additionally, instruction needs to differentiate between those who possess the skill in their behavioral repertoire, but will not perform it, and those who do not know how to perform a given skill. The former may only require reinforcing contingencies, whereas the latter warrant direct social skill instruction.

Assess according to skills taught. Social skill findings are obscured by a tendency to assess skills that have not been taught. It does little good to spend several weeks teaching students to make positive comments to others, for example, and then assess the effects of this instruction on a standardized social skill instrument designed to measure a full array of social behaviors, with only one or two items on positive statements to others. The beneficial effects are not likely to be noted.

Teach with other interventions. Social skill instruction may not be the sole intervention indicated for some students, particularly those who evidence comorbid psychiatric disorders. In these cases other therapeutic interventions might be needed, for example, drug or family therapy (San Miguel, Forness, & Kavale, 1996), and social skill instruction might be part of a comprehensive intervention program (Gresham et al., 2004).

Expand the Focus

Prevention. Social skill instruction must begin early in the preschool and primary grades, when the child is most receptive to behavior change. Good social skill instruction early in the child's life can be instrumental in minimizing or preventing problem behaviors, which are likely to become more severe or resistant in later years. With relatively simple interventions, many students can be helped to be maintained in less restrictive settings and to have more positive school outcomes.

Culturally and linguistically diverse populations. As our public school populations grow in diversity, school personnel are increasingly challenged to understand and meet the behaviors students bring to the classroom. School personnel must be able to differentiate between cultural differences and behavioral deficits, to use culturally relevant and effective practices to bring about behavior change, and to be committed to the growth of every child no matter how great the difference or severe the behavior (Cartledge & Milburn, 1996).

Conclusions

There have been many changes in social skill instruction over the past three decades. Many of them are good, some continue to challenge us. I am just as convinced today as I was at the beginning of my career that children can be taught to be more adaptive. We cannot afford to fail, because this is germane to our educational mission. Perhaps not a perfect analogy, but I think of medical science confronted with a particularly resistant viral strain, unresponsive to existing medications. Ignoring the virus is not an option. Instead, medical research efforts are intensified and persist until they succeed in containing the virus and improving health. Similarly, despite the challenges, we must increase, not relax, our commitment to effective social skill interventions. Few things are more important than the successful education of all of our children, particularly those with special needs.

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