

# Effective School-Based Mental Health Interventions: Advancing the Social Skills Training Paradigm

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**ABSTRACT:** *Psychotherapeutic interventions with children have not been as successful in practice as laboratory studies suggest. Two weaknesses frequently cited include the failure of treatment gains to generalize to other times and settings and the lack of individualization. Although social skills interventions have inherent appeal and appear appropriate to address many of the social and emotional problems encountered by children and youth, they have not demonstrated effectiveness despite their widespread use. This article outlines four steps to improve social skills interventions that take advantage of the unique environments of schools and increase the likelihood that social skills interventions can achieve individualization and generalization. (J Sch Health. 2000;70(5):191-194)*

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School-based mental health services present a unique opportunity to improve the effectiveness of mental health care for children. School-based programs are especially timely as funding for community mental health services is diminishing and studies indicate that clinic-based treatments are marginally effective<sup>1</sup> despite laboratory studies that consistently document the effectiveness of various treatments.<sup>2</sup> One failure of therapy has been the failure of treatments to generalize to the settings where clients exhibit problems. While methods have been developed to improve generalization, they frequently are not implemented. Schools provide a rich environment to improve treatment outcomes by providing numerous opportunities for the generalization of behavior change.<sup>3</sup>

## CURRENT STATUS OF SOCIAL SKILLS INTERVENTIONS

School mental health professionals frequently use social skills interventions to respond to the serious social problems that occur among children who exhibit behavioral or emotional disorders such as ADHD, depression, and learning disabilities.<sup>4-7</sup> Recognizing social skill deficits and developing effective interventions have been the focus of extensive study due to their relationship to various disorders of childhood and the potential long-term, negative impact on social, psychological, and academic achievement.<sup>8-11</sup> A recent study<sup>10</sup> indicated that approximately 75% of students with learning disabilities manifest poor peer interactions and inappropriate or inadequate behaviors and can be differentiated from their nonlearning disabled peers via measures of social competence. Learning disabled students tended to exhibit fewer positive social behaviors, showed less initiative in peer interactions, demonstrated lower rates of peer reinforcement, and displayed less cooperative behaviors than non-learning disabled peers. Similarly, children diagnosed with attention deficit/hyperactivity disorder (ADHD) often experience peer rejection and exclusion due to their disruptive and aggressive behavior. These behaviors contribute to missed opportunities for social learning and have long-term adverse effects on academic performance and social-emotional development.<sup>11</sup>

Greene et al<sup>9</sup> provided strong evidence of a significant relationship between the presence of social impairments and the likelihood of tobacco, alcohol, or other drug abuse.

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In fact, social impairment was found to be the sole significant unique predictor of drug and alcohol abuse and smoking in their sample. Nonsignificant predictors in their study included ADHD, oppositional defiant disorder, conduct disorder, major depression, high risk status, multiple anxiety disorders, family expressiveness, and socioeconomic status. Their results suggest that social impairment plays the pivotal role in increasing the likelihood of children abusing substances as they progress through adolescence.

To date, however, little empirical data exists to support the assumption that school-based interventions to improve social skills among children with emotional and behavioral disorders are effective. Meta-analyses of recent social skills outcome studies indicated the amount of change effected by social skills programs was minimal.<sup>12</sup> Quinn et al<sup>7</sup> pooled the findings of 35 studies related to social skills training of children with emotional and behavioral disorders. Results of the analyses indicated the mean effect size was only .199 across studies. Further analyses revealed only 58% of the children across studies made gains and the change was approximately eight percentile ranks on outcome measures. In addition, negative effect sizes were reported in one-fourth of the studies (ie, children not participating in the programs had better outcomes than those who did). These findings are similar to other meta-analyses where effect sizes ranged from .2111 with learning disabled students to effect sizes in the .40 range with general education students.<sup>7,10,13,14</sup> While effectiveness varies widely across the studies, rarely did it reach the level of effecting clinically significant change.

## IMPROVING SOCIAL SKILLS INTERVENTIONS

There is a trend within the field to apply the same model of social skills training to all children regardless of the presenting problem. Gresham<sup>14</sup> noted that most social skills programs ignore the specific deficits children are experiencing and utilize similar approaches across children. The author's meta-analyses of social skills programs indicated the same programs will not work for all children. Children possess varying degrees of the skills in question, requiring different interventions as demonstrated by the low effect sizes of social skills programs conducted with children with learning disabilities or emotional problems.<sup>7,10</sup>

It is important to understand not only the type of deficits involved but also the factors that might contribute to the deficits. Elliot and Gresham<sup>8</sup> posited that social skills deficits can be a function of a lack of knowledge, lack of performance, or lack of social reinforcement. Many social

skills programs are not as effective as they might be because they do not match the skills training to the type of social skills deficits the children are experiencing. For example, teaching a child methods to join a group of peers may be missing the mark completely if the child already knows how to but lacks the self-confidence to do it. Many children know what they should or could do; they just have trouble getting themselves to do it. Programs should be tailored to the missing skills and the type of student participating in the program.<sup>7</sup>

The second major problem facing almost all psychotherapeutic interventions, including social skills programs, is a failure to generalize across situations.<sup>14</sup> Generalization is defined as "the occurrence of relevant behavior under different, nontraining conditions (ie, across subjects, settings, people, behaviors, and/or time)."<sup>15</sup> Generalization is considered a crucial element for success. Without this skill, behaviors taught in one setting do not translate to other settings resulting in continued difficulty for the child.<sup>3</sup> After conducting a meta-analysis of social skills treatment outcome studies, Beelman et al<sup>13</sup> concluded that no long-term or follow-up effects of social skills training programs could be determined. They argued that in short-term posttest studies, effect sizes were decreasing by the time posttreatment testing occurred. They stated "in summary, the generalization of changes across time remains a decisive problem" in social skills training.<sup>13</sup> Thus, a child's ability to translate skills learned in therapeutic interventions into appropriate behavior on the bus or playground is difficult and rarely achieved.

Social skills training programs have not achieved lasting effects or generalized from clinical settings to actual practice in children's typical environments. Metaanalyses have consistently revealed that most programs demonstrate minimal short-term gains that tend to fade over time, leaving children in the same position they were in prior to treatment. However, the problem might be less with the method, which has inherent appeal, and more with failure to tailor the intervention to the specific deficit and the intervention setting.

### **SCHOOL-BASED SOCIAL SKILLS PROGRAM**

The traditional format of social skills programs, such as small group meetings away from the children's environment, do not enhance the development and generalization of skills. Some have recommended that interventions occur within the settings where behavior change is targeted.<sup>14</sup> An ecological model allows children to improve deficits in their regular social environment and might afford greater opportunity for learning and generalization.<sup>11</sup> Schools provide an ideal setting to take advantage of the strategies most often recommended to achieve individualization and generalization. This environment is where many children exhibit their most serious problems including academic failure, problematic peer relations, and delinquent behaviors. This is also the setting that most concerns parents of youth with problems. For example, more parents of adolescents with ADHD rated school problems as concerns than any other of the 16 problem situations from the Home Situation Questionnaire.<sup>16</sup> However, to be successful the social skills intervention must be modified to take advantage of the unique opportunities available in schools. A

school-based social skills training program should incorporate generalization techniques including utilizing current functional contingencies, training diversely, and using functional mediators.<sup>17</sup> In addition, intervention strategies should be individually prescribed for each child based on assessment procedures. The general strategies are: 1) identification of the deficient skills for a child or group of children; 2) training these skills in isolation; and 3) gradual programming for the generalization of these skills in various settings. The program is then assessed, revised, and repeated to ensure the needs of the children are being met. The generalization work at the end of training takes the most time and effort and differentiates common social skills groups from those that focus on the generalization of skills. Application of these strategies in a school-based setting is described elsewhere.<sup>3</sup>

### **Step 1: Identify Key Skills**

Social contingencies change across environments and age groups. Therefore, creating a list of desired social skills must be tailored to the specifics of the particular school and the population served. For example, eye contact is a frequently taught social skill, but might not elicit much reinforcement for youth in all settings or in certain age groups. The clinician's initial task should be to assess the current social functional contingencies. This requires the clinician to observe the child's behavior in a variety of settings. Considerable information usually can be obtained by talking to teachers, lunch room aides, and other adults who spend time with the target child and the child's peer group. The purpose of the observation is to assess the target child's behaviors, particularly behavioral excesses and deficits, peers' responses, and effective social behaviors used by peers. The clinician must sort through the various behaviors to identify those linked to the punishing responses of peers and adults. For example, an eight-year-old child who fidgets in his seat probably does not receive a great deal of negative feedback or rejection from peers as a result of the fidgety behavior. However, if that same child frequently perceives provocation, even where none exists, and as a result exhibits anger, accusations, and tantrums, he is likely to be punished by peers through teasing, rejection, or isolation.

The behaviors that most consistently lead to peer rejection will comprise the list of targeted social skills. To replace these targeted behaviors with socially appropriate behaviors, it is important to observe other youth in the school and identify social behaviors that consistently lead to reinforcement from peers. While it is tempting to simply teach skills that adults believe are appropriate, these are not always the skills that lead to peer acceptance. In addition, different cultures, settings, and peer groups within a school reinforce social behaviors differently from each other and differently than many adults. The clinician must identify the desirable behaviors in the specific social environment in which the child functions in order to teach skills most likely to result in peer acceptance. At the end of this functional social assessment, the clinician is ready to formulate a hypothesis about the critical behavioral excesses and deficits. These behaviors should be prioritized and teaching strategies developed. For the greatest effectiveness, only a few skills should be addressed at any one time.

## Step 2: Teach the Skill in Isolation

Teaching the identified skills in isolation is probably the easiest and shortest portion of this type of intervention. Children usually can learn to demonstrate certain behaviors in small groups or with a therapist in a short period of time. These settings are usually not as emotionally charged as a playground or lunch room, making it relatively easy for the child to understand these skills and exhibit them in role plays. In addition to simply teaching the skills and role playing, it is important to assist the child in developing a repertoire of social behaviors for each targeted situation. This is necessary since the responses of peers or adults will vary and the target child needs to be able to respond accordingly. For example, a seven-year-old boy who wants to join an activity at recess may encounter a welcoming response from a peer following a request to join. On the other hand, he might also be ignored or receive a sarcastic response. If joining an activity at recess is a goal for this child, he will need a variety of strategies that will enable him to respond to each scenario.

## Step 3: Practice in Controlled Settings

Shortly after learning a behavioral repertoire to use in a targeted situation, children should practice in a controlled setting. Although these situations should be orchestrated by the clinician, they should replicate real situations and include other children. These situations allow clinicians to develop functional mediators, test the probable social contingencies, and determine if the diversity of responses trained is adequate. Practice in controlled settings forms an important bridge to successful generalization. The clinician should choose a controlled practice setting that closely approximates the child's environment and provides a wealth of challenging social interactions. Careful work in this part of the program decreases the likelihood that the target children will fail in public and miss the salient functional contingencies critical to changing behaviors. Clinicians need to stay actively involved in these practice sessions to facilitate skill development. This portion of training can take quite a few sessions before the child can reliably demonstrate the skills in a variety of situations. However, it is not necessary to achieve perfection in this phase of the program before moving on to the next stage.

## Step 4: Prompt/Assess in Uncontrolled Settings

Progressing to this phase of the intervention is contingent on the child demonstrating some ability to exhibit the target skills in the controlled practice settings. In this phase, prompts and assessment procedures are used in the natural environment to encourage the generalization of the target behavior.

Because the therapist is rarely present in this environment, teachers, parents, and other adults will need to assist in the prompting and assessment process. These adults can be trained to implement prompts such as verbal reminders and visual cues. They also can assist the assessment process by completing rating scales, making descriptive notes, recording frequencies, and using daily report cards. These data help therapists assess progress, determine whether additional assessment or skill development is needed, and adjust existing strategies.

Counseling sessions with the student should continue during this phase. The sessions provide a means of gather-

ing information related to the functional contingencies operating in response to the new behaviors, coaching the child on modifications to the plans, maintaining assessment tracking and motivation, and addressing new issues. As with most behavioral interventions, the process of implementation, assessment, and revision should be repeated until the behavioral goals are achieved.

## SUMMARY

The research literature suggests that traditional methods of social skills training with children with emotional and behavioral disorders result in minimal change. Nevertheless, social skills groups continue to be one of the most frequently practiced mental health interventions. Strategies suggested to increase effectiveness include individualizing programs to meet the specific needs of each child in a particular social setting and focusing on a series of planned, structured activities to increase generalization. School-based clinicians are in an ideal setting to achieve the necessary level of interaction with the child, the child's peers, or adults in the child's environment to achieve clinically significant improvements.

In fact, a recent review of the literature suggested that social skills training programs should be seen as part of an "evidenced-based system of care" that includes other effective interventions.<sup>12</sup> Studies have found the combination of parent training and social skills interventions more effective than either intervention alone.<sup>18,19</sup> Many other techniques such as peer tutoring also warrant continued study.<sup>20</sup>

Although somewhat labor intensive, the knowledge gained through observation and assessment of children experiencing problems can benefit all the children in the school. Schoolwide programs that help parents and teachers know when to praise, ignore, or focus attention on certain behaviors have been shown to effectively improve social skills among all children.<sup>21</sup> Helping educators and parents create a more positive social environment reinforces and improves the social skills interventions and increases the likelihood of success.

The necessary steps for improving the effectiveness of interventions to improve children's mental health include pooling the latest knowledge on treatment outcomes and related research and developing interventions that take advantage of the unique opportunities provided in school settings. Given the severity of children's mental health problems that stem from negative peer interactions, development of effective school-based interventions to improve social skills should be a high priority in the field. ■

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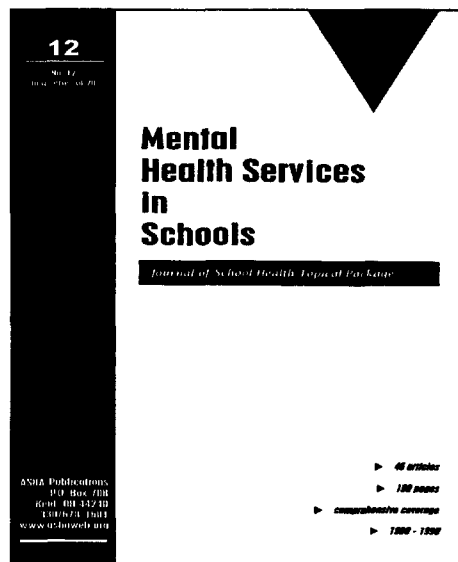
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