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TRAINING IN SOCIAL SKILLS: AN ALTERNATIVE TECHNIQUE FOR HANDLING DISRUPTIVE CHILD BEHAVIOR[1,2]

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Summary.—The purposes of this study were to examine the type of response to different situations displayed by children with or without conduct disorders and to assess the efficacy of the social skills training program herein proposed for modifying styles of interpersonal relationship in children. The sample included 315 children, 8 to 12 years of age. Those exhibiting conduct problems were 164 boys, and those having no conduct problems were 151 boys. All participants shared a low socioeconomic and cultural status and attended schools located in poor districts of Mendoza City in Argentina. Analysis showed that the groups trained in social skills improved in social interaction by reducing disruptive behaviors, whereas the groups without social skills training showed no behavioral changes. These data were confirmed by the teachers' assessments. These results suggest social skills training seems an efficient therapeutic approach to the attenuation of behavior disorders of boys.

Aggressiveness continues to be one of the main concerns of mankind, and different scientific disciplines have attempted explanatory frameworks for this phenomenon. Likewise, various intervention strategies have been proposed to help reduce violent behaviors, unfortunately still so frequent in our society.

Disruptive child behaviors, such as aggressiveness, impulsivity, oppositional defiant disorder, and attention-deficit hyperactivity disorder, among others, are likely to emerge during the early school years, being a continuous source of concern for parents and teachers alike. Escalations in problem behaviors are commonly observed as children progress through their school years. The resulting maladjusted styles of social interaction certainly have negative effects on both the child and those related to him.

Other factors influencing the early learning of social behavior are teaching of appropriate societal rules, reinforcement or punishment of social responses, and the opportunity to display behavior in different situations (Caballo, 1993).

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Once the child has developed a style of interpersonal relations based on aggressive or oppositional behavior, he transfers this mode of communication to other contexts and sets up social networks grounded on socially inadequate behaviors. This failure in the child's social ability to fulfill a given task competently encourages the use of training programs focused on social skills.

The common objective of social skills training programs is teaching specific behaviors associated with social interaction. Michelson, Sugai, Wood, and Kazdin (1987) found that all techniques used for developing social skills adhere to one of two general models. The first model considers that children showing inadequate social behavior can be lacking in social skills, thereby exhibiting a poor repertoire of responses that may prevent them from achieving satisfactory social interaction. The second points out that children with social adjustment problems can exhibit poorly developed skills due to the incidence of affective or cognitive problems. Integration of both models is necessary to reach a better understanding of disruptive child behavior. Most conduct-disordered children are likely to have deficient social skills resulting from the confluence and interplay of emotional, affective, cognitive, and socio-environmental problems that influenced their early social learning. Assessment and early treatment of conduct disorders act as preventive factors by reducing escalations in disruptive behavior (Kazdin, Siegel, & Bass, 1992; Ison & Fachinelli, 1993; Tolan, Guerra, & Kendall, 1995; Lyons-Ruth, 1996).

As Caballo (1993) suggested, training in social skills is often chosen as a technique for attenuating marital conflicts, social anxiety, depression, antisocial conduct, etc. In dealing with children, such training is applied for reducing aggressive, impulsive, inhibited behaviors, while increasing assertive conducts in interpersonal relations (Michelson, *et al.*, 1987; Trianes Torres, Rivas Moya, & Muñoz, 1992; Arón & Milicic, 1993; Caballo, 1993; Furlong & Smith, 1994; Pepler, Craig, & Roberts, 1995; Ison & Rodríguez, 1997; Wahlberg, 1998).

Teaching staffs in schools located in peripheral quarters of Mendoza City, Argentina, where this study was carried out, reported that conduct disorders of children cause growing concern. Teachers feel that they are losing control of their students, which generates an atmosphere of tension and disorder in the classroom. For this reason, a training program focused on social skills was applied, intended both to reduce disruptive child behavior and to provide teachers with child management techniques that could help them regain control over the class. The objectives of this study were to examine the types of responses to different situations displayed by children with or without conduct disorders and to assess the efficacy of the social skills training program herein proposed for modifying styles of interpersonal relationship in children.

Method

Sample

The sample included 315 individuals, ranging in age from 8 to 12 years. The group with conduct problems was composed of 164 boys, and the group without conduct problems of 151 boys. All participants shared a low socioeconomic and cultural status and attended schools located in poor districts of Mendoza City, Argentina.

Participants were randomly assigned to a Treatment or a Control Group, each in turn divided into two subgroups. The Treatment subgroups were 90 children with conduct disorders and 81 children without conduct disorders. Both subgroups were administered social skills training. The Control subgroups were 74 children with conduct disorders and 70 children without conduct disorders. Neither subgroup was administered social skills training.

Inventories

For selecting children with and without conduct disorders, teachers were asked to complete two assessment procedures, the Self-control Rating Scale and the Child Behavior Report.

The Self-control Rating Scale (Kendall & Wilcox, 1979) was used to assess children's self-control. Percentile norms for the items in this scale were based on the results of a previous study (Ison, 1995) to meet the characteristics of the local population. According to these norms, scores of 231 total points were indicative of lack of self-control. This corresponds to percentile 75.[3]

The Child Behavior Report (Ison & Fachinelli, 1993; Ison & Soria, 1997) was used to assess the type and frequency of children's conduct problems. It examined physical and verbal aggression, negativism, transgression, impulsivity, hyperactivity, attention deficit, self-aggression, inhibition, and acceptance of the child by his peers. Scores of 4 or higher indicated impulsivity, hyperactivity, attention deficit, and acceptance, while scores of 2 or more indicated negativism, transgression, self-aggression, and inhibition. Transformed to percentile norms, these values correspond to percentile 75.

The results obtained from both scales were later compared to check the consistency of the diagnoses previously made.

Once the teachers had completed the above-mentioned inventories, the 315 children selected for this study were administered a third procedure, the Children's Behavioral Scenario (Wood, Michelson, & Flynn, 1978). A total of six social skills were evaluated with this technique: (1) Positive statements, (2) Negative statements, (3) Requests–Compliance with commands, (4) Con-

[3]The kind permission for use of the Self-control Rating Scale (Kendall & Wilcox, 1979) of Dr. Phillip Kendall is gratefully acknowledged.

versational skills, (5) Externalization of feelings and emotions, and (6) Impulsivity control. The Children's Behavioral Scenario was intended to elicit the children's display of social skills. This technique provides information about the social responses (aggressive or assertive) exhibited by the children and was individually administered to test the selected children for deficits in their social skills.

Procedure

Both the Self-control Rating Scale and the Child Behavior Report were administered to entire classes to select children with and without conduct disorders. After evaluating a total of 749 boys between 8 and 12 years of age, 315 were selected for this three-year study. Of these selected children, 164 were identified as having conduct disorders and 151 has having no conduct disorders.

Identification of children with conduct disorders was based on two criteria, scores greater than 150 on the Self-control Rating Scale and percentiles over 75 for every factor considered on the Child Behavior Report for all ages (Ison & Soria, 1997). Children without conduct disorders were identified according to the criteria of scores lower than 75 on the Self-control Rating Scale and percentiles equal to or lower than 50 for each of the nine factors evaluated on the Child Behavior Report.

Once the children were identified, the Children's Behavioral Scenario was administered to assess the type of response elicited from every group by having the children display a number of social skills.

Subsequently, the children were randomly assigned to the Treatment and Control groups. Once the groups were formed, training in social skills was started. On account of the universality of its principles, the training program proposed by Michelson, *et al.* (1987) was used as a model, although with minor modifications that were deemed suitable to the participants' sociocultural context. The program consisted of 14 teaching units. The teaching sessions forming each of these units were designed to last about 30 min. twice a week.

Topics dealt with in the teaching units (one per unit) were understanding of social skills, giving and accepting a compliment, learning appropriate ways of making complaints, apologizing, learning how to say no, asking favors appropriately, understanding others' behaviors, asking others to change inadequate behaviors, beginning, listening, and ending a conversation, empathy, nonverbal social skills, interacting with adults, making decisions, working cooperatively, and coping with problems.

Statistical Treatment

A multivariate analysis of variance with repeated measures was carried out to assess the effects of the treatment on the different groups. The Tukey

Honestly Significant Difference (*HSD*) test was used to evaluate which social skills were modified in the different groups given treatments. The same test was used to examine the teachers' evaluations. Two measures were taken to assess behavioral modifications in children. The first was provided by the child himself by responding to the Children's Behavioral Scenario and the second by the teacher by completing both the Self-control Rating Scale and the Child Behavior Report. If not otherwise specified, p values less than .05 were interpreted as significant.

Results

Data were analyzed in three ways. First, the types of response given by children with and without conduct disorders while displaying a number of social skills were examined. Second, the results obtained from intragroup comparisons were analyzed. The two Treatment subgroups, i.e., with and without conduct disorders, were compared before and after receiving a 5-mo. social skills training, and both Control subgroups (not trained in social skills) were also evaluated at the beginning and at the end of this 5-mo. period. Third, ratings by the teachers were evaluated for all groups (Treatment and Control). Social skills were divided into six categories: (1) Positive statements, (2) Negative statements, (3) Request–Compliance with commands, (4) Conversational skills, (5) Externalization of feelings and emotions, and (6) Impulsivity control. Two types of response were considered: *Aggression* and *Assertiveness* for each of the aforementioned social skills.

Assessing Social Skills in Children With and Without Conduct Disorders Before Training

Aggressive responses.—As shown in Table 1, mean scores were significantly higher for children in the group exhibiting conduct problems than those in the group having no conduct problems for every category considered. The children in the former group responded more aggressively than those in the latter group when displaying the following social skills: making positive statements ($F_{1,313}=7.80$, $p<.005$), making negative statements ($F_{1,313}=16.29$, $p<.0001$), making requests–complying with commands ($F_{1,313}=12.40$, $p<.0005$), displaying conversational skills ($F_{1,313}=7.75$, $p<.005$), externalizing feelings and emotions ($F_{1,313}=16.84$, $p<.0001$), and controlling impulsivity ($F_{1,313}=41.02$, $p<.000001$).

Assertive responses.—Compared to children in the group showing conduct problems, those in the group having no conduct problems exhibited more assertive behaviors when making positive statements ($F_{1,313}=6.27$, $p<.01$), making negative statements ($F_{1,313}=8.46$, $p<.003$), externalizing feelings and emotions ($F_{1,313}=8.39$, $p<.004$), and controlling impulsivity ($F_{1,313}=25.18$, $p<.000001$); cf. Table 1.

TABLE 1

MEANS AND STANDARD DEVIATIONS OF AGGRESSIVE AND ASSERTIVE RESPONSES OF BOYS WITH (n = 164) AND WITHOUT (n = 151) CONDUCT DISORDERS WHEN DISPLAYING SOCIAL SKILLS PRIOR TO SOCIAL SKILLS TRAINING

Social Skills	Aggressive Responses				Assertive Responses			
	Conduct Disorders		No Conduct Disorders		Conduct Disorders		No Conduct Disorders	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Positive statements	0.71[a]	1.81	0.23[a]	1.09	6.50[a]	2.27	7.14[a]	2.21
Negative statements	1.27[b]	2.59	0.33[b]	1.20	8.70[b]	3.46	9.78[b]	3.10
Requests–Complying with commands	2.12[c]	3.02	1.07[c]	2.03	5.56	3.10	6.04	3.22
Conversational skills	0.82[d]	2.60	0.20[d]	0.94	8.19	3.43	8.50	3.33
Externalizing feelings and emotions	1.55[e]	2.36	0.60[e]	1.62	6.31[e]	2.28	7.09[e]	2.42
Controlling impulsivity	5.76[f]	4.65	2.65[f]	3.89	4.20[f]	3.44	6.08[f]	3.20

Note.—Analysis of variance for groups with conduct disorders vs no conduct disorders: [a]$p \leq .01$ for aggressive and assertive responses; [b]$p \leq .003$ for aggressive and assertive responses; [c,d]$p < .005$ for aggressive responses; [e]$p \leq .004$ for aggressive and assertive responses; [f]$p < .0001$ for aggressive and assertive responses.

Social Skills Training (Treatment)

Children with conduct disorders.—This subgroup significantly reduced aggressive behavior in the social skills of externalization of feelings and emotions ($F_{1,178} = 3.65$, $p < .05$) and impulsivity control ($F_{1,178} = 10.25$, $p < .001$).

In comparing pre- and postsocial skills training scores, a significant increase in assertiveness was observed in the display of four social skills, namely, negative statements ($F_{1,178} = 4.29$, $p < .03$), request–compliance with commands ($F_{1,178} = 23.29$, $p < .000003$), externalization of feelings and emotions ($F_{1,178} = 5.18$, $p < .04$), and impulsivity control ($F_{1,178} = 7.70$, $p < .006$).

Children without conduct disorders.—No significant differences in aggression or assertiveness were observed in the children's display of the social skills considered.

No Social Skills Training (Control)

Children with conduct disorders.—In analyzing the results of the comparison between the first and second evaluations, significantly reduced aggression was observed only in making negative statements ($F_{1,146} = 3.59$, $p < .05$).

Children without conduct disorders.—No significant differences in aggressiveness or assertiveness were observed in the display of the various social skills between the first and second evaluations.

Teachers' Reports

Table 2 shows the mean scores on both the Self-control Rating Scale and the Child Behavior Report rated by the teachers. For children with conduct disorders who had been trained in social skills, ratings showed a significant decline on four components of the Child Behavior Report: physical and verbal aggression ($F_{1,178} = 31.14$, $p < .000001$), transgression ($F_{1,178} = 8.41$, $p < .004$), impulsivity ($F_{1,178} = 18.63$, $p < .00002$), and hyperactivity ($F_{1,178} = 13.66$, $p < .0002$). A significant increase in acceptance by peers was also observed ($F_{1,178} = 4.05$, $p < .04$). Self-control, assessed on the Self-control Rating Scale, increased significantly ($F_{1,178} = 13.57$, $p < .0003$). for children without conduct disorders, also trained in social skills, neither on the Self-control Rating Scale nor on the Child Behavior Report were significant differences in mean ratings observed. For children who had not been trained in social skills, no significant differences were observed either on the Self-control Rating Scale or on the Child Behavior Report (Table 2).

TABLE 2

MEANS AND STANDARD DEVIATIONS FOR CHILD BEHAVIOR REPORT AND SELF-CONTROL RATING SCALE SCORES FOR CONDUCT-DISORDERED BOYS TRAINED (n = 90) AND NOT TRAINED (n = 74) IN SOCIAL SKILLS

Conduct Disorders Social Skills Training	Trained Boys				Not Trained Boys			
	Pretest		Posttest		Pretest		Posttest	
	M	*SD*	*M*	*SD*	*M*	*SD*	*M*	*SD*
Child Behavior Report								
Physical and verbal aggression	18.19	6.73	12.92	5.82†	19.01	5.38	18.01	5.21
Negativism	3.53	1.63	3.01	3.51	3.45	1.32	3.02	1.39
Transgression	2.65	2.30	1.65	2.29†	2.89	2.14	2.53	2.23
Impulsivity	5.94	2.28	4.48	2.23†	5.65	2.30	5.38	2.18
Hyperactivity	4.67	2.30	3.44	2.10†	4.63	2.20	3.84	2.39
Attention deficit	4.47	2.02	4.85	10.39	4.20	1.99	3.89	2.13
Self-aggression	1.47	1.46	1.03	1.30	1.36	1.63	1.30	1.52
Inhibition	1.98	1.28	1.83	1.21	1.97	1.32	1.87	1.38
Acceptance	2.69	1.13	3.05	1.24*	2.67	1.22	2.97	1.21
Self-control Rating Scale								
Self-control	168.71	26.26	152.67	31.58†	162.08	32.88	154.86	31.76

Note.—Analysis of variance involved pre- and postsocial skills training for Evaluations 1 and 2. *$p < .04$. †$p < .004$.

DISCUSSION

The first objective of this study was to examine the types of response exhibited by children with and without conduct disorders while displaying different social skills. Results showed that disruptive children, compared with children showing appropriate behaviors, emitted aggressive responses in social activities involving making positive or negative statements, making requests or complying with commands, displaying conversational skills, externalizing feelings and emotions, and controlling impulsivity. Disruptive children adopted oppositional, defiant, or aggressive styles of communication, both verbally and by gesture, when they had to express their need for something or ask something of others.

When the child starts attending school, these maladaptive patterns of communication are rejected not only by the adults but also by his peers, which brings about isolation of the child and adds to his aggressiveness. This can turn into a vicious cycle that accentuates behavior problems. Learning and incorporating prosocial conducts enables the child's behavior to be redefined by both classmates and teachers and leads to improved emotional adjustment, academic achievement, a change in the teacher's attitude toward the child and, hence, an overall improvement in the classroom context.

As for the second objective, the social skills training program used was an efficient tool for modifying styles of interpersonal relationship in children. Children in the conduct problem group who had been trained in social skills attained a significant reduction in their aggressive responses while expressing feelings or emotions or in controlling aggressive-impulsive reactions and showed an increase in assertive responses when making negative statements, e.g., in making a request or complying with a command. In contrast, those children who had not received training in social skills were able to reduce aggressive responses only when expressing disagreement, thereby exhibiting increased assertive responses with that sole skill.

These results indicate that participants in the social skills training program succeeded in attenuating their aggressive responses and in increasing the assertive ones in higher proportions than did children who had not been trained. As mentioned above, the latter showed a significant reduction in only one of the six social skills evaluated, which seems to indicate that certain aggressive behaviors tend to decrease independently of a psychoeducational intervention.

These results were ratified by the teachers' reports which indicated that children with conduct disorders who participated in the social skills training attained significantly reduced aggressive behaviors on four of the factors included in the Child Behavior Report: physical-verbal aggression, transgression, impulsivity, and hyperactivity. Children in this group significantly increased in acceptance by peers and self-control. On the other hand, children with conduct disorders who had not been administered the social skills training only exhibited reduced physical-verbal aggression and hyperactivity. With regard to the groups of children without conduct disorders who either had or had not received training in social skills, no significant differences were observed for any of the skills considered.

Finally, the results of this study suggest that training in social skills can be regarded as an efficient technique for encouraging prosocial conduct in children having disruptive behaviors. It is worth noting that the social skills training model of this study is a useful tool for the treatment of aggressive behaviors of boys and, more importantly, that it transcends national and cultural boundaries. The favorable results obtained using the model proposed by Michelson, *et al.* allow the conclusion that this model is certainly applicable to our sociocultural reality. Moreover, it can be generalized and extended across cultures, only requiring a few minor adjustments pertinent to each particular context.

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