SOCIAL COMPETENCE AS RESILIENCE FACTOR IN MENTAL HEALTH AND DISABILITY RESEARCH AND PRACTICE

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1. Social competence as resilience factor

This paper addresses the relation between social competence in children and young adults and resilience processes. Resilience increases the ability of a person or system to cope successfully with the challenges of life in the presence of significant adverse risks (Rutter 1985). It can be seen as a sector resource, which is acquired through interaction with the surroundings. It is the ability to activate coping mechanisms despite difficult life situations (Petermann & Schmidt 2006). Resilient children are expected to adapt successfully even though they experience risk factors that are against good development.

There is a major consensus that resilience factors or underlying resilience processes show buffering effects in the presence of adverse life conditions (e.g. Werner 1993; Lösel & Bender 1994; Festinger 83, Laucht et al 1999). Within the evidence based scope of resilience factors (see Pretis & Dimova, 2004) social competence and contact to non-disabled peers are assessed as protective (Petermann & Hmid 2006).

Current research highlights, that social competence is a complex and multidimensional concept. Krudt-Clikert, 2007 associates social, emotional, cognitive, affect regulation, skills for processing or respective taking as important acts with the construct of social competence. Further motivational factors (e.g. self-efficacy, need for social adaption) are also included within the multidimensional concept. The concept describes that social competence is the foundation upon which expectations for future interaction with others is built, and upon which individuals develop perceptions of their own behavior (p. 1).

However the concept of social competence also reflects problems towards conceptualization and assessment (Waters & Sroufe, 1983). The authors describe a huge integrative potential of the concepts, never trying to find concrete indicators, the approach runs the risk that this broad concept gets lost. Abilities related to real life adaption, coordination of activity, cognition and behaviour are also included to the concept. Rose-Kraassnor (2006) highlights transactional, context-dependent, and goal-specific characteristics. Most of the authors agree that social competence has diverse component variables, which may vary along continuous dimensions and which are constructed through social interaction in different contexts (Topping et al. 2000). Arendt (1958) – on a more anthropological level defines social competencies as capabilities enabling individuals 'to live together in the world'. Therefore social competence is not a homogenous entity (Topping et al., 2000), however social competence is of interest both to social scientists across disciplines but also within related to labour market issues.

Schoon (2009) summarizes in a broad sense that “social competencies reflect adjustment in the milie, school, work, in society at large, and in old age, requiring more context specific definitions of the construct, as well as a focus on particular facets of social competence, such as empathy, selfcontrol, trust, respect for other people, or civic engagement” (p. 2).

On a practical level – within childhood and adolescence – Guralnick et al. (2007) describe 3 major fields that contribute towards social competence, especially to minimize the risk of social exclusion for children with disabilities:

a) to come into contact with peers;
b) to share common “realities” and follow common rules;
c) to solve conflicts.

On a broader philosophical level (I have, I can, I-am-factors):

I have children with whom I can play and interact;
I can come into contact with them, join games and solve conflicts;
I am respected by other children and in broader context – by others persons.

Especially the concept of regulating emotions can be seen as one key issue related to conflict management for adolescents with mild learning difficulties. Numerous face to face training programs can be identified in this context, highlighting the early preventive necessity of intervention (see for ex-
ample in the German speaking area the program of Petermann and Petermann (2009, 2012) or the US program “Dinosaur Child Training Program” (Webster-Stratton, 1990). The list of other associated personality traits or constructs focusing on social competence seems endless: self-control, trust, respect, self-esteem, and self-efficacy, also extraversion or other personality traits of the “Big five” are seen as relevant related to the concept of social competence.

For Stamatoff (2013) the concept of social competence can be seen as a system of social skills that provide effective social interaction and joined problem solving. From Stamatoff’s point of view empathy, gratitude, problem solving and acceptance followed by expression of emotions, self-assertion analysis of the situation, encouragement and self-regulation or even sharing and helping others be included within this concept.

2. Research question

Both constructs are assessed as multidimensional, time- and situation dependent and difficult to be operationalised. Based on these methodical limitations of both constructs the research question of this paper arises to which extents training of social competencies can contribute towards resilience?

3. Method

This paper is based on desktop research using literature review within peer-reviewed data bases (medline, psychlit...). Major findings are summarized and discussed.

4. Results

There is an overall scientific consensus, that training programmes on social competences can make a difference for the participants, however a big variety in training programs, conceptualisation, evaluation methods etc. can be seen.

Major components of the programs consisted in:

a) rising self-awareness (understanding conflicts, the power of personal beliefs or unspoken rules of the working place),
b) increasing interpersonal skills (stop and think, expressing concerns and dealing with criticism),
c) increasing problem solving skills (like problem and goal, information and inside, choices and consequences or closing communication),
d) intervention e.g. with the parents.

Despite numerous available programs, the level of evidence is mostly assessed as poor: Carter and Hughes (2005) analysed 26 empirical intervention programs, which aimed to improve social interaction in adolescents with intellectual disabilities. The authors summarized that perceived effects were related to intervention components, participant characteristics, school and contextual variables, measures of social interaction and observation procedures.

12 of the interventions where skill based, 14 were support based. Skill based methods addressed direct training of social skills in order to increase social interactions with peers. Support based interventions focused on arrangement of e.g. school environments.

Related to the skill based intervention (12 Studies) effects were found in all 12 studies related to e.g., increased social initiations over all interactions, correct social responses, increased activity engagement. It means that these 12 studies of the sample showed increased social competences after the training. The programs included concrete social skill training, self-management, joined computer playing with non-disabled participants, leisure skill activities or using communication books within the training package.

The support based intervention also showed significant improvement – with exception of one study. Support based interventions show increased social related initiations, significantly more verbal comments, more frequent cooperative than individualistic settings, increased social contacts more frequent interactions, increase of specific appraised statements (p. 186). The authors summarize that the interventions were found to be effective within a wide range of students.

Heinrich (2013) analysed programmes based on their level of evidence and concluded that level 1 studies (well established) techniques can only be observed within in behavioural training programs for parents if children/adolescents with social disorders. Level 2 studies (probably efficacious) include cognitive behavioural therapy, interaction therapy and multidimensional therapeutical approaches. Espe-26
cially through multidimensional therapies the cost-efficiency relation was calculated with 1: 5 (1 invested euro in multidimensional social competence trainings) would produce savings of 5 euros (especially concerning the prevention of anti-social behaviour of young people).

However, for children with disabilities these positive findings (Guralnick 2007) have to be limited: intensive preventive social competence training programs with young children with mild intellectual impairments made a difference for the children, however the levels of social functioning of typically developed children could not be reached. Also the SGSCC analysis (2013) revealed, that not all subconstructs of social competence were equally assessed as easy to be fostered: The best prevention effects from the side of professionals were seen in the field of motivation, self efficacy and problem solving.

In general, a conclusion about the appropriateness of an intervention for particular students is complicated by the variation, the level of details and contents. Important to consider is the degree in which intervention effects generalize. This aspect was assessed in 16 studies. The conclusion of the authors emphasizes the use of multiple dimension and methods (Carter and Hughes 2005, 191).

5. Discussion

Talking to professionals they usually wonder how social competencies can be trained without the relevant context. Social competence is a resilience factor which is active in situ, it means in the concrete situation of interacting with others. This means, that “the others” have to be included – in vivo or at least in terms of cognitions, role plays or anticipations into the training. This aspect is also seen as a big challenge within computer-based programs which aim to promote social competences. Like in the INCAS QUEST game within the SGSCC project (www.games4competence.eu) the necessary interaction process has to become an integrative part of the virtual (computer game) reality. Beside this cognitions and emotions and (within face to face trainings) have to be addressed to represent multi-dimensional trainings which are able to make a difference for the learners.

Coming back to the research question, whether social competences can be seen as resilience factors, the necessary interactive and inclusive character of social competence has to be highlighted. Social competence needs also interaction partners who communicate in a social competent way. Especially within the field of aggressive behaviour this aspect has to be highlighted. Contact to peers can be assessed as a resilience factor, if the peers do not show problematic behaviours themselves. Organising social competence trainings with homogeneous vulnerable groups usually does not show the same sustainable effects as initiating peer contacts with typically developed peers. And this might be the most difficult aspect of social competence trainings for persons with learning difficulties: these trainings need to include contacts to non-disabled peers. Communication and interaction, however does not take place per se, it always follows a purpose and it might be much more challenging to motivate typically developed adolescents to participate in a social competence training program with peers with learning disabilities than the disabled learners themselves.

Or as one of our participants in the SGSCC pilot runs expressed it: “To increase our social competences we also need the (non-disabled) OTHERS”.

REFERENCES


Stamatov, R. (2013). Development of Social Competencies Unit, Creativeness Unit. Presentation within the Kickoff meeting of the SGSCC Project, 7.2.2013, Plovdiv, Bulgaria.


www.games4competence.eu retrieved 31.3.2015