Social Skills of Individuals with Intellectual Disabilities

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Abstract
Most research on mental health of individuals with intellectual disabilities (ID) has focused on deficits. I have studied close interpersonal relationship, social exposure, self-assertiveness of 30 adults with ID, 24-56 years of age. This group has socials skills on average level, but individuals with ID were reported to have close personal relationship on average and high level. Close interpersonal relationship is only one social skill of individuals with ID, where level is high. Further research is needed to elucidate social skills by new methods and research instruments prepared only for these individuals.

Keywords: Intellectual disability, social skills, intelligence quotient, rehabilitation

Introduction

In 1905, Binet and Simon published their article on the first test to evaluate intellectual ability (Binet & Simon, 1905). Thus they began a distinct revolution in psychology. The level of intellectual functioning expressed by the intelligence quotient (IQ) was recognized in the twentieth century as one of key determinants of human functioning in society. It became a kind of a fetish whose role, as it soon turned out, was greatly exaggerated. An individual with a high IQ and developed complex cognitive processes (thinking and reasoning) was treated as an individual potentially satisfied with life. "Intelligence manifests itself in thinking and may even be defined as an ability to cope with difficult problems due to processes of thinking and reasoning" (Nęcka et al., 2006, p. 481). Nevertheless, the belief that a high IQ (well above the norm) is a measure of the quality and satisfaction with life is not entirely justified (Campbell, 1976; Herrnstein & Murray, 1994; Strelau, 1997). A period of interest in other determinants of functioning in life situations started in psychology. Their nature is social, therefore "such concepts as *social intelligence and social skills or interpersonal skills* and since the beginning of the nineties *emotional intelligence and emotional competence* became popular. The concept of social skills belongs to the same group" (Matczak, 2007, p. 5). The concept of social skills is complex and closely linked to the level of human functioning in society. This term defines basic equipment of every individual to enable functioning in a social group (Argyle, 1994; 1998). This applies to both individuals with intellectual norm and to intellectually disabled. Both of these groups live in different social space: family, local community or society.

In 2002, the American Association on Mental Retardation (AAMR) published its next book tit. *Mental retardation, Definition, Classification, and System of Supports*, in which there is a new definition of mental retardation with not only guidelines for the diagnosis of individuals suspected of this kind of disability, but also the concept of support. Luckasson (2002) and other co-authors of the manual stressed the role of adaptive behavior in the lives of people with intellectual disabilities displayed in their cognitive, social and practical skills. For the first time the definition of this type of disability treated equally limitations in intellectual and social functioning (Luckasson et al., 2002). The most recent definition of the American Psychiatric Association (APA) of 18 May 2013, included in the classification of mental disorders *Diagnostic and Statistical Manual of Mental Disorders* – DSM-5, confirms the assumptions of 2002. In this codification intellectual disability is a condition that is characterized by lower intellectual functioning and limits of adaptation in three domains: conceptual, social and practical (APA, 2013). Intellectual disability in this classification is classified as neuro-developmental disorders and divided into four basic levels (categories): mild, moderate, severe and profound. In addition, global developmental delay and unspecified intellectual disability were classified to a group of disorders associated with intellectual

disability (APA, 2013).

Adaptive behavior, such as active and passive speech, taking care of one's own safety, mobility etc., are a set of skills necessary to function in society regardless of the environment in which an individual with intellectual disability lives. This individual requires support in each of these domains (Schalock, 2004). While testing intelligence level of an individual with this type of disability seems to be mastered (Wechsler, 1997), the study of adaptive behavior levels generates difficulties due to lack of reliable and valid diagnostic tools. One of the recognized research instruments to measure skills of adaptive behavior (conceptual, social and practical) for adults and children from birth to 89 years of age is the adaptive behavior assessment system developed by Harrison and Oakland in 2000 (Harison & Oakland, 2000; 2003a; 2003b). This system seems to meet research expectations in this field (Sattler, 2002). It may be useful when planning support in functioning of an individual within 10 adaptive skills (Kostrzewski, 2006). Similar difficulties are encountered while examining social skills of individuals with moderate and severe intellectual disabilities. The problem is an objective study of the level of performance of activities related to social life and emotions, which accompany an individual in everyday life.

Social skills can be defined "as determinants that conditions effective functioning in social situations" (Matczak, 2007, p. 5). It is a direct consequence of social training, which is also affected by other components. The concept of skills can be treated in singular or plural, as a whole made up of several components, for example assertiveness, empathy skills or building emotional bonds. The term will be used further in plural, as a collection of individual, specific social skills.

Social skills are related to social and emotional intelligence. Both of these types of intelligence can be considered as the basis for the development of human ability to live in society. Social intelligence was introduced to a set of psychological concepts by Thorndike in 1920. It is an ability to understand and manage people (Strelau & Zawadzki, 2008). Emotional intelligence manifests itself in the ability to understand and experience own emotions as well as other individuals' emotions and the ability to control emotions. This term was established in 1990 by Salovey & Mayer (Mayer et al., 2001). Emotions also constitute a base for both types of intelligence. This approach is of great importance for the diagnosis of individuals with intellectual disabilities who are not deprived of feelings and are fully capable of empathizing. This means that nothing stands in the way to study emotional and social intelligence of individuals with intellectual disabilities and their social skills.

Goleman (2007) describes the development of social skills. "Components of social intelligence, which I present here, can be classified into two broad categories: social awareness, which is what we sense in others, and social performance, which is what we do with that knowledge" (Goleman, 2007, p. 107). According to Goleman, social awareness includes:

- "Primary empathy: empathizing with others; recognizing nonverbal signals of emotions.
- Tuning : listening carefully; tuning to others.
- Empathic relevance: understanding thoughts, feelings and intentions of others.
- Social cognition: knowledge about how the social world functions" (Goleman, 2007, p. 107).

"The spectrum of social skills include:

- Synchrony: smooth contact at non-verbal level.

- Self-presentation: a compelling self- presentation.
- Impact: shaping the outcome of social interaction.
- Caring: taking care of the needs of others and acting in accordance with them" (Goleman, 2007 p. 107). The components that make up social intelligence are also elements of social skills, which have become the subject of this study.

Method

Participants

The randomly selected sample consisted of adult participants of therapy workshops (100%), which is an institution for professional and social rehabilitation of individuals with intellectual disabilities. The surveyed group consisted of 30 clients of two therapy workshops from one province in Poland. Among them there were individuals with moderate (18 persons) and severe (12 persons) level of intellectual disability. The age of participants ranged 24 - 56 years of age. While selecting the sample an important principle in social research was applied – a margin of error of the sample (Babbie, 2006). Table 1. shows demographic and diagnostic characteristics of the entire study sample. Comparison of respondents allows to spot the differences: gender (66.7% = females; 33.3% = men), age and degree of intellectual disability (60% = moderate; 40% = severe). Education of respondents is as follows: primary school (53.4%), primary school with middle school (16.6%), vocational school (13.4%) and school preparing for job (16.6%). Respondents lived in urban areas (63.3%) and suburban areas (36.7%).

Table 1. *Participant Demographics*

Overall *N* = 30 ID only		
Adult age	24-56 years	
Adult gender	F = 20	M = 10
Level of ID	moderate = 18 persons	severe = 12 persons
Geographical location Suburban	11	
Urban	19	
Respondent educational level Primary school	16	
Primary school + middle school	5	
Vocational school	4	
School preparing for job	5	

Recruitment

Selection of the sample was conducted among a group of individuals who communicate by means of verbal messages. The period of their participation in therapy workshops was not taken into account, although the data showed that each respondent had been involved in the institution activities for at least two years. Family and financial situation

was not a subject of the studies, therefore the data on this issue will not be analyzed. The individuals qualified to the study were participants of activities in the institution which is to prepare them for life in society, and for work, among others, on the open market. The study was conducted individually with each respondent who assessed their own individual effectiveness in performing tasks and activities listed in the questionnaire using a four-level scale, as described in words (definitely good, not bad, rather poor, definitely bad). If a tested person did not understand intentions of the question, an evaluator provided explanation controlled by formal requirements (Babbie, 2006). In case of incomplete answers, an evaluator applied an admissible form of asking extra questions (Babbie, 2006). The time of survey – according to the KKS-A(D) (KKS-A(D) – the Social Competence Questionnaire) instruction – as not determined. Each individual study took an average from 30 to 40 minutes.

Procedure

The aim of the study was to assess the level of social skills in adults with intellectual disabilities of moderate and severe degree who were subject to social training in therapy workshops. The point of interest was the level of social skills of participants of therapy workshops, regardless of their gender or age, assessed by means of the Social Competence Questionnaire (KKS-A(D)) by Matczak (2007). Therefore, social skills measured by KKS-A(D) are defined as "complex abilities conditioning efficiency to cope with particular type of social situations, obtained by an individual in the course of social training" (Matczak, 2007, p. 7). In connection with such scope of the study, the following questions were asked:

1 / Can Social Competence Questionnaire KKS-A(D) be used as a tool to study individuals with moderate and severe intellectual disabilities?

2 / What is the level of social skills of individuals with moderate and severe intellectual disabilities measured by KKS-A(D)?

3 / What is the level of social skills of individuals with moderate and severe intellectual disabilities measured by KKS-A(D), determining the effectiveness of behavior in the following situations: intimate situations, social exposure situations, situations requiring assertiveness?

In order to determine the level of social skills of individuals with moderate and severe intellectual disabilities KKS-A(D) – Social Competence Questionnaire by Matczak (2007) was used for adult non-students, which is a "self-descriptive questionnaire, and its items represent different activities or tasks expressed in an infinitive form" (Matczak, 2007, p. 10). KKS-A(D) is a standardized tool for observational research techniques of a survey. KKS-A (D) consists of three scales examining the effectiveness of behavior in the following situations:

- scale I – close interpersonal relationship (intimate situations), for example confiding to someone with personal problems, comforting a loved one, listening to confidences of others;
- scale ES – social exposure, for example handing flowers to a public person, public acknowledgment for receiving an award;
- scale A – situations that requires assertiveness, for example refusing to lend money to a loved one, refusal to religious agitators.

KKS-A(D) contains 60 diagnostic items and 30 non-diagnostic items, which are not taken into consideration when calculating the result. Diagnostic items allow to obtain the total score. Non-diagnostic items apply to activities unrelated to social character. These include five groups:

- artistic activities, for example “Arrange flowers into a bouquet”, “Decorate an apartment
- for a carnival party”;
- technical activities, for example “Repair a broken doorknob”, “Replace a plug in an electrical cord”;
- intellectual activities, for example “Solve crossword”, “Play chess”;
- sport activities, for example “Swim crawl”, “Throw a ball into a basket”.

Each scale has a fixed number of its own diagnostic items and the number of points that can be scored:

- Close interpersonal relationship – 15 items, max. - 60 pts., min. - 15 pts.;
- Social exposure – 18 items, max. - 72 pts., min. - 18 pts.;
- Self-assertiveness – 17 items, max. - 68 pts., min. - 18 pts.

The final result of the study is the sum of points obtained from answers to all diagnostic questions (max. - 240 pts., min. - 60 pts.), but it is not the sum of individual scales involved. The questionnaire contains 90 items and answers are scored on a scale (definitely good-4, not bad-3, rather poor-2, definitely bad-1). The points must be added up and then the numbers from confidence intervals specified in the KKS-A(D) must be used to get real results with probability of 85% for individual study and with probability of 95% for the group study. Levels and confidence intervals are also expected error term in the sample. The result obtained in this way can be related to sten scores specified in KKS-A(D).

Results

The results are provided in Table 1 including gender, age and degree of intellectual disability, raw scores obtained in a particular scale, level of social skills and total score. As shown in table 2, adults with moderate and severe intellectual disabilities obtained results with no significant difference. The respondents scored in different scales the following numbers of points:

- Close interpersonal relationship scale – mean result 42 pts.; min. result 24 pts., max. result 59 pts.;
- Social exposure scale – mean result 42 pts .; min. result 18 pts., max. result 69 pts.;
- Self-assertiveness scale – mean result 41 pts.; min. result 23 pts., max. result 61 pt.;
- Total score – mean result 160 pts.; min. result 98 pts., max. result 229 pts.
- The results of the studies allow to conclude that:
- 56.6% of respondents have an average level of social skills, and 36.6% of the respondents have a low level of skills;
- 53.3% of respondents have an average level of social skills in terms of efficiency in intimate situations and at the same time 23.3% of respondents have a high level of skills;
- 56.6% of respondents have a low level of social skills in terms of efficiency of behavior in situations requiring social exposure;
- social skills in terms of assertiveness are equal in size to low and average level (46.6%).

Table 2. *Level of Social Skills – Individuals with Intellectual Disability (Moderate and Severe Level)*

No.	Participant with ID			Close interpersonal relationship – scores and level	Social exposure – scores and level	Self - assertiveness – scores and level	Total result – scores and level
	Gender	Age (years)	Level of ID				
1.	F	31	severe	45 – a	51 – a	45 – a	178 – a
2.	F	36	severe	39 – l	47 – a	38 – l	149 – a
3.	M	31	moderate	40 – a	41 – l	39 – l	169 – a
4.	F	36	severe	59 – h	69 – h	61 – h	229 – h
5.	F	30	moderate	46 – a	47 – a	46 – a	177 – a
6.	M	24	severe	49 – h	45 – a	47 – a	168 – a
7.	F	28	moderate	41 – a	34 – l	37 – l	150 – l
8.	F	27	moderate	48 – a	56 – a	42 – a	179 – a
9.	F	27	moderate	40 – a	37 – l	37 – l	149 – l
10.	M	35	severe	24 – l	36 – l	27 – l	108 – l
11.	F	26	moderate	38 – l	32 – l	27 – l	126 – l
12.	F	30	severe	42 – a	29 – l	41 – a	144 – l
13.	F	35	moderate	36 – l	28 – l	23 – l	116 – l
14.	M	28	severe	23 – l	29 – l	28 – l	98 – l
15.	F	25	severe	50 – h	48 – a	30 – l	183 – a
16.	F	27	severe	39 – a	36 – l	32 – l	129 – l
17.	F	56	moderate	40 – a	18 – l	27 – l	118 – l
18.	F	33	severe	44 – a	40 – l	42 – a	154 – a
19.	F	37	moderate	40 – a	47 – a	37 – l	168 – a
20.	F	25	moderate	32 – l	45 – l	45 – a	149 – l
21.	M	50	severe	40 – a	38 – l	51 – a	171 – a
22.	M	30	severe	42 – a	38 – l	43 – l	156 – l
23.	M	31	moderate	50 – h	34 – l	45 – a	171 – a
24.	M	31	moderate	52 – h	42 – l	52 – h	178 – a
25.	F	28	moderate	48 – a	33 – l	33 – l	163 – a
26.	F	28	moderate	37 – l	56 – a	48 – a	176 – a
27.	M	34	moderate	50 – h	53 – a	52 – a	195 – a
28.	M	26	moderate	53 – h	52 – a	57 – a	202 – h
29.	F	28	moderate	39 – a	51 – a	40 – a	165 – a
30.	F	29	moderate	41 – a	52 – a	52 – a	193 – a
Result				7 – l 16 – a 7 – h	17 – l 12 – a 1 – h	14 – l 14 – a 2 – h	11 – l 17 – a 2 – h

l – low level; a – average level ; h – high level

Table 3 summarizes the minimum and maximum numbers of specific scales in KKS-A (D) and in the study and an average for the overall result.

Table 3. *Results of Research – Social Skills of Individual with ID*

Social skills by KKS-A(D)	Results in KKS-A(D)		Results of study - individuals with ID		
	minimum	maximum	minimum	maximum	medium
Total result – scores	60	240	98	229	160
Close personal relationship – scores	15	60	24	59	42
Social exposure – scores	18	72	18	69	42
Self -assertiveness – scores	17	68	23	61	41

Discussion

To the author's knowledge, this is the first study of social skills of individuals with moderate and severe intellectual disabilities conducted by means of this tool in Poland. The obtained results allow to formulate a few conclusions. Firstly, it can be assumed that the obtained results allow to use KKS-A(D) in vocational (vocational guidance) and social rehabilitation for adults with moderate and severe intellectual disabilities. The results can indicate whether an individual may perform work that requires frequent contacts with other people, or whether it is better when their professional activity involves a minimum level of such relations. Secondly, the results of KKS-A(D) show which individuals have serious deficits in social skills, which is an automatic indication to work with them to improve these deficits. The scores of particular scales reflect (of course not fully) adaptive difficulties which can be significantly minimized as a result of social training. An individual is perceived by immediate surroundings through their effectiveness in social situations. The criteria for this effectiveness are: as follows: achievement of one's own goals and behavior consistent with social expectations (Matczak, 2007). KKS-A(D) diagnosis of adults with intellectual disabilities allows to identify those social skills that must be developed or shaped competence to be developed or shape from the ground up to meet these criteria. Thirdly, the studies have shown that age and sex of respondents do not have statistical significance in the study of social skills in adults with moderate and severe intellectual disabilities. Fourthly, the results have indicated that the majority of respondents have a low level of efficiency of behavior in situations requiring social exposure and assertiveness. It is a valuable directive to continue work with those individuals in rehabilitation program implemented in therapy workshops.

Rehabilitation of disabled individuals is to bring them to possibly fullest performance of social roles and life tasks by maximum elimination of difficulties and limitations faced by these individuals. Rehabilitation is also a process of elimination of psychological barriers that exist in a disabled individual. Equipping individuals with intellectual disabilities with appropriate social skills will undoubtedly affect the effectiveness of rehabilitation in terms of social and professional life.

Conclusion

Social skills and their role in life of an individual with moderate and severe intellectual disabilities should be an indicator for individual and group rehabilitation programs, education and therapies in other institutions such as primary schools, middle schools or schools preparing for work. These institutions, which are a part of the system of social support for

individuals with this type of deficits, may / must become an important factor in improving social skills of individuals with intellectual disabilities (Żółkowska, 2004). Social skills also affect social development of individuals with moderate and severe intellectual disabilities in the context of their functioning at home, school and social inclusion (Lerner et al., 2005; Lerner et. al., 2011). Future research requires the use of tools which study other social skills, such as peer relationships, acceptance of an individual in local community or communication skills. This tool may study social skills which enable social functioning and have a form of a self-descriptive questionnaire allowing individuals with moderate and severe disabilities to express their own opinions about themselves.

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