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Social Competence Model for Adolescents: Reflections from an Intervention Study

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Abstract:

This study was performed as part of pre-testing the *Social Competence Model* for enhancing social competence of adolescents through Life Skills, developed as part of the UGC Major Project. The *Social Competence Model* focuses on five domains of social competence viz. self concept, pro-social behaviour, goal orientation, resilience, and rational thinking. The intervention was conducted among 37 students selected from a government school of which 34 students completed the 18 hours intervention programme. Paired sample t- test of pre and post test scores revealed significant changes in all domains of the social competence model viz. self concept, goal orientation, pro-social behaviour, resilience and rational thinking. Significant changes were observed in all the sub domains of pro-social behaviour viz. empathy, communication, assertiveness and cooperation ($p<0.05$). Correlation revealed consistent positive change among all the participants in the domains of self concept, communication skills and problem solving skills. The study thus confirmed the efficacy of the *Social Competence Model* for enhancing the social competence of adolescents.

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Introduction

Social Competence is defined as the "capacity to coordinate adaptive responses flexibly to various interpersonal demands and to organize social behaviour in different social contexts in a manner beneficial to oneself and consistent with social conventions and morals" (Bierman, 2004). The multifaceted construct of Social Competence includes the personal knowledge and skills developed by individuals to function effectively in life situations. (Leffert, Benson, & Roehlkepartan, 1997). Other elements comprise of social assertion, frequency of interaction, positive self-concept, social cognitive skills, popularity with peers and the like, as listed by Dodge (1985). Various skills such as social, emotional, cognitive and behavioural and perceptions in the nature of motivational and expectancy sets are all part of this complex and multidimensional concept**.** The potential of social competence to contribute to the mental health of individuals has been established through research. The proposed study looks at Social Competence as a capability of individuals which contributes to their success and general well being. It attempts to explore the feasibility of an intervention for enhancing the Social Competence of adolescents using the WHO Life Skills Education model (WHO, 1997).

Components of Social Competence

Several components of Social Competence have been identified based on various criteria. Kostelnik et al's (2002) definition lays down six categories of competence namely adopting social values, development of a sense of positive self identity, acquisition of interpersonal knowledge and skills, self regulation in accord with societal standards, planning and decision making, and development of cultural competence.

The Collaborative for Academic, Social and Emotional learning (CASEL; 2003, 2007), laid down five core competencies as a foundation for effective personal development. These are self

awareness, social awareness, self management, relationship skills and responsible decision making.

Yet another definition comprising four categories of foundational competencies was laid by Broderick and Blewitt (2010). These include firstly affective processes constituting empathy, valuing relationships and sense of belonging; cognitive processes including cognitive ability, perspective taking and making moral judgements; social skills that consist of making eye contact, use of appropriate language and asking the relevant questions; and lastly, high social self-concept.

Adolescent Social Competence

Social Competence (Guralnick, 1990), in the early stages of development is understood as the ability of young children to 'successfully and appropriately select and carry out their interpersonal goals.' They become capable of engaging in satisfying interactions and activities with adults and peers (Katz et al., 1995). Thus, it may be said that being socially competent is marked by effectiveness and appropriateness in one's interactions and relationships with others and is generally related to factors such as peers' acceptance, emotional health, social adjustment, and also school readiness. There is a direct relation between children who are socially assertive, cooperative and friendly and their social and academic performance in addition to higher levels of psychological resilience. Children who are socially incompetent by contrast demonstrate negative behaviours and are susceptible to problems with respect to their social interactions.

Social Competence of adolescents is determined by the social environments in which they live and interact such as family, school and community. Thus, adolescents who are seen as being socially competent have a sense of belonging, are valued and are given opportunities to contribute to society (Gullotta, 1990), which in turn are affected by their social environments. Peterson & Leigh (1990) confirm that family variables such as parenting styles and family communication patterns strongly influence adolescent social competence.

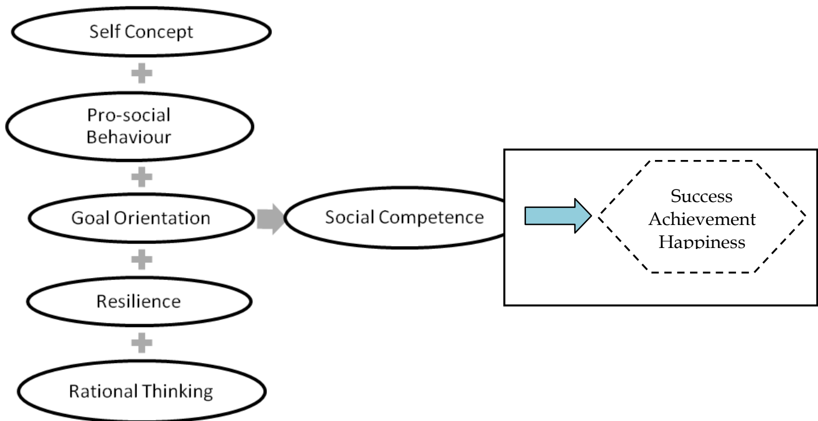
Several positively contributing factors such as strong social support, supportive relationships and a supportive socio- cultural and physical environment are seen as being catalysts in the process of development of social competence. On the contrary, elements such as race, gender, ethnicity and socio economic status that give rise to cultural and social barriers hinder effective social competence as pointed out by Bloom (1990). Thus, it is of critical importance to address the various affective, cognitive and behavioural components of social competence such as stress management, problem solving and social skills training respectively as an attempt to developing and augmenting social competence (Caplan et al, 1992). Here, the promotion of social competence in school settings gains importance as Weissberg, Barton & Shriver (1996) rightly view the school setting as being "highly promising and appropriate educational strategy for preventing high risk behaviour." As schools are the nurturing grounds with regard to children, and social competence is essential for effective human interactions and relations, social competence must be treated as important developmental goal for children (Katz, McClellan, Fuller, & Walz, 1989).

This study was performed to assess the feasibility of a Social Competence model rooted in WHO core Life Skills (WHO, 1997) for enhancing the well being of adolescents. The Social Competence model focuses on five aspects viz. self concept, pro- social behavior, goal orientation, resilience, and rational thinking.

The Social Competence Model

The authors developed a model of social competence after a careful review of literature and expert focus group discussions and consultations. In the proposed model, a person having a good self concept, goal orientation, pro-social behaviour, resilience and rational thinking skills is said to be socially competent. Fulfillment of these five domains would make individuals socially competent, which will in turn help them to attain success, happiness and achievement in their life. These factors are very much correlated in a way that absence of any one factor will prevent the person from becoming socially competent. The domains of social competence are linked to the core life skills listed by WHO. The self concept is

related to self awareness; pro-social behaviour is concerned with the skills of empathy, communication skills, interpersonal relationships and coping with emotions; goal orientation is connected to self awareness, critical thinking, creative thinking and decision making; resilience is associated with coping with stress, coping with emotions and problem solving skills, and rational thinking is related to critical thinking and decision making.



The Intervention

An 18-hour duration intervention module for enhancing the social competence of the adolescents was developed as part of the University Grants Commission Major Project after a careful review of available literature, expert consultation and a series of workshops. WHO core life skills model (WHO, 1997) was used for developing the module. The module covered the five domains of the Social Competence Model viz. self esteem, goal orientation, pro-social behaviour, resilience and rational thinking. An intervention manual was prepared based on the Social Competence Model. A trained person along with the principal researcher implemented the intervention.

Materials and Methods

This study was conducted to pre-test the 18 hour duration intervention module for enhancing social competence of adolescents. The study participants included 36 adolescents studying in the 9th standard of a Government Higher Secondary School in Kerala state in India. 34 students completed the 18 hours

intervention. The five domains of the social competence model were assessed. The variables assessed included self esteem; goal orientation; empathy, communications skills, assertiveness and cooperation as measures of pro-social behaviour; emotional stability and problem solving skills as measures of resilience; and decision making skills as a measure of rational thinking.

The Social Competence was assessed using

- Rosenberg self esteem scale (10 items,4 point Lickert scale, maximum score 40);
- Emotional stability scale (Goldberg,1990) (15 items, 6 point Lickert scale, maximum score 90);
- and tools to assess
    - decision making (10 item,5 point Lickert scale, maximum score 50);
    - goal setting (4 item, 5 point Lickert scale, maximum score 20); problem solving (6 item, 5 point Lickert scale, maximum score 30),
    - communication skills (3 item, 5 point Lickert scale, maximum score 15);
    - assertiveness(4 item, 5 point Lickert scale, maximum score 20);
    - empathy (4 item, 5 point Lickert scale, maximum score 20);
    - and cooperation (3 item, 5 point Lickert scale, maximum score 15).

In all the tools higher score indicate a high level of the domain measured. The independent variables were assessed using an 18 item socio-demographic questionnaire.

Pre and post tests on the variables were performed before and after the intervention. SPSS version 17 was used for data entry and analysis. Both descriptive and inferential statistics were used in the analysis.

Results

General characteristics of the population

Age: The mean age of the respondents was 14.06 years.

Gender: 66.7% of the respondents were boys and 33.3% were girls;

Religion: 50% of the respondents were Hindus, 33.3% practiced Christianity and 16.7% belonged to Islam religion.

Siblings: 52.8% of the respondents had one sibling and 25% of the respondents had two siblings, 11.1% had three siblings and 8.3% of the respondents were the only child of their parents.

Academic performance: 38.9% of the respondents scored between 80%and 60% in exams, 36.1% scored below 40% , 16.7% of the respondents scored between 80% and 100% and 8.3% scored between 60% and 40% in exams.

Parents: 86.1% of the respondents' parental marital status was married, and 13.9% was widow/widower.

Family functioning: 66.7% of the respondents opined that their family functioning was very good, 22.2% opined it as good, 8.3% as average and 2.8% opined that the family functioning was too bad. Regarding the quality time spent with parents, 75% mentioned it as very good, 13.9% as average, 8.3% as good and 2.8% as very bad.

The effect of the intervention

The researcher performed paired sample t test to understand the effect of the intervention in the domains of social competence.

Table 1: Self Concept of Respondents

		Mean	Max Score	N	Std. Deviation	Paired Sample Correlation	Paired Differences		t	df	Sig. (2-tailed)
							Mean	Std. Deviation			
Pair 1	Self Esteem pre	21.82	40	34	4.01	.603 P=.000	-2.71	6.48	-2.435	33	.020
	Self Esteem post	24.53		34	8.05						

Table 1 depicts the self concept of the respondents before and after the intervention. The maximum score possible in the self esteem scale is 40 with a higher score indicating higher self esteem. The results show moderate level self esteem before (21.82± 4.01) and after (24.53±8.05) the intervention. The self esteem of the respondents showed an increase of 2.71 after the intervention. The Pearson correlation between the baseline and after the intervention is 0.603, a high positive correlation. The significant correlation indicates a consistent increase in self esteem of all the participants. Since the significance value of the t statistic is 0.020 ($p<0.05$), it could be concluded that the average increase of 2.71 score of self esteem is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the self concept of the study participants.

Table 2: Goal Orientation

		Mean	Max Score	N	Std. Deviation	Paired Sample Correlation	Paired Differences		t	df	Sig. (2-tailed)
							Mean	Std Deviation			
Pair 1	Goal Orientation pre	11.71	20	34	1.77	-0.311 p=0.073	-2.00	5.44	-2.142	33	0.040
	Goal Orientation post	13.71		34	4.63						

Table 2 shows the goal orientation of the respondents before and after the intervention. The maximum score possible in the goal orientation assessment is 20 with a higher score indicating better goal orientation. The results show moderate level self esteem before (11.71± 1.77) and after (13.71±4.63) the intervention. The self esteem of the respondents showed an increase of 2.00 after the intervention. The Pearson correlation between the baseline and after the intervention is -0.311, a negative correlation. The significant value of correlation is 0.073 (p>0.05) the increase in goal orientation is not consistent for all the participants. Since the significance value of the t statistic is 0.040 (p<0.05), it could be concluded that the average increase of 2.00 score of goal orientation is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the goal orientation of the study participants, though the variation is not consistent with all the participants.

Table 3: Pro-social Behaviour

		Mean	Max Score	N	Std. Deviation	Paired Sample Correlation	Paired Differences		t	df	Sig. (2-tailed)
							Mean	Std Deviation			
Pair 1	Empathy pre	14.41	20	34	4.22	.053	-2.00	5.65	-2.065	33	.047
	Empathy post	16.41		34	3.99	p=0.767					
Pair 2	Communication pre	19.06	30	34	4.08	.453	-1.85	4.97	-2.175	33	.037
	Communication post	20.91		34	5.23	p=0.007					
Pair 3	Assertiveness pre	9.21	20	34	1.84	.225	-2.71	6.20	-2.544	33	.016
	Assertiveness post	11.91		34	6.35	p=0.201					
Pair 4	Cooperation pre	9.94	15	34	2.75	-.066	-2.79	6.53	-2.495	33	.018
	Cooperation post	12.74		34	5.74	p=0.710					
Pair 5	Prosocial Behaviour Pre	52.62	85	34	7.54	.213	-9.35	16.06	-3.396	33	.002
	Prosocial Behaviour Post	61.97		34	15.87	p=0.227					

Table 3 presents the components of pro-social behaviour viz. empathy, communication skills, assertiveness skills and cooperation. The cumulative score of the domains was taken as the score of pro-social behaviour.

Empathy: The table shows the Empathy of the respondents before and after the intervention. The maximum score possible in the empathy is 20 with a higher score indicating better empathy. The results show moderate level empathy before (14.41± 4.22) and high level after (16.41±3.99) the intervention. The empathy of the respondents showed an increase of 2.00 after the intervention. The Pearson correlation between the baseline and after the intervention is .053, a positive correlation. The significant value of correlation is 0.767 (p>0.05) the increase in empathy is not consistent for all the participants. Since the significance value of the t statistic is 0.047

($p<0.05$), it could be concluded that the average increase of 2.00 score of empathy is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the empathy of the study participants, though the variation is not consistent with all the participants.

Communication: The table shows the scores of communication skills of the respondents before and after the intervention. The maximum score possible in the communication assessment is 30 with a higher score indicating better communication skills. The results show moderate level communication before (19.06± 4.08) and after (20.91±5.23) the intervention. The communication of the respondents showed an increase of 1.85 after the intervention. The Pearson correlation between the baseline and after the intervention is 0.453, a positive correlation. The significant value of correlation is 0.007 ($p<0.05$) the increase in communication is consistent for all the participants. Since the significance value of the t statistic is 0.037 ($p<0.05$), it could be concluded that the average increase of 1.85 score of communication is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the communication of the study participants consistently.

Assertiveness: The table shows the assertiveness of the respondents before and after the intervention. The maximum score possible in the assertiveness assessment is 20 with a higher score indicating better assertiveness. The results show low level assertiveness before (9.21± 1.84) and moderate after (11.91±6.35) the intervention. The assertiveness of the respondents showed an increase of 2.71 after the intervention. The Pearson correlation between the baseline and after the intervention is 0.225, a positive correlation. The significant value of correlation is 0.201 ($p>0.05$). The increase in assertiveness is not consistent for all the participants. Since the significance value of the t statistic is 0.016 ($p<0.05$), it could be concluded that the average increase of 2.71 score of assertiveness is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the assertiveness of the study participants.

Cooperation: The table shows the cooperation of the respondents before and after the intervention. The maximum score possible in the cooperation assessment is 15 with a higher score indicating better cooperation. The results show moderate level cooperation before (9.94± 2.75) and high after (12.74±5.74) the intervention. The cooperation of the respondents showed an increase of 2.79 after the intervention. The Pearson correlation between the baseline and after the intervention is -.066, a negative correlation. The significant value of correlation is 0.710 (p>0.05) the increase in cooperation is not consistent for all the participants. Since the significance value of the t statistic is 0.018 (p<0.05), it could be concluded that the average increase of 2.79 score of cooperation is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the cooperation of the study participants, though the variation is not consistent with all the participants.

Pro-social behaviour: The table shows the pro-social behaviour of the respondents before and after the intervention. The cumulative scores of empathy, communication skills, assertiveness skills and cooperation were used for arriving at the scores of pro-social behaviour. The maximum score possible in the pro-social behaviour assessment is 85 with a higher score indicating better pro-social behaviour. The results show moderate level pro-social behaviour before (52.62± 7.54) and after (61.97±15.87) the intervention. The pro-social behaviour of the respondents showed an increase of 9.35 after the intervention. The Pearson correlation between the baseline and after the intervention is .213, a positive correlation. The significant value of correlation is 0.227 (p>0.05) the increase in pro-social behaviour is not consistent for all the participants.

Since the significance value of the t statistic is 0.002 (p<0.05), it could be concluded that the average increase of 9.35 score of pro-social behaviour is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the pro-social behaviour of the study participants, though the variation is not consistent with all the participants.

Table 4: Resilience

		Mean	**Max Score**	**N**	**Std. Deviation**	**Paired Sample Correlation**	**Paired differences**		**T**	**df**	**Sig. (2- tailed)**
							Mean	Std. Deviation			
Pair 1	Emotional stability pre	31.41	90	34	5.18	-.435	-5.55	16.36	-1.981	33	.056
	Emotional stability post	36.97		34	13.43	p= 0.010					
Pair 2	Problem solving pre	16.52	30	34	5.82	.461	-3.02	7.59	-2.326	33	.026
	Problem solving post	19.56		34	8.25	p=0 .006					
Pair 3	Resilience pre	47.94	120	34	6.72	-.036	-8.58	21.29	-2.352	33	.025
	Resilience post	56.52		34	19.96	p= 0.840					

Table 4 indicates the components of resilience viz. emotional stability and problem solving skills. The cumulative score of the domains was taken as the score of resilience.

Emotional stability: The table shows the emotional stability of the respondents before and after the intervention. The maximum score possible in the emotional stability assessment is 90 with a higher score indicating better emotional stability. The results show low level emotional stability before (31.41± 5.18) and after (36.97±13.42) the intervention. The emotional stability of the respondents showed an increase of 5.55 after the intervention. The Pearson correlation

between the baseline and after the intervention is -0.435, a negative correlation. The significant value of correlation is 0.010 ($p<0.05$) the increase in emotional stability is not consistent for all the participants. Since the significance value of the t statistic is 0.056 ($p>0.05$), it could be concluded that the average increase of 5.55 score of emotional stability is due to chance variation and could not be attributed to the intervention. Hence, it could be concluded that the intervention was not effective in enhancing the emotional stability of the study participants.

Problem solving: The table shows the problem solving skills of the respondents before and after the intervention. The maximum score possible in the problem solving assessment is 30 with a higher score indicating better problem solving skills. The results show moderate level problem solving before (16.52± 5.82) and after (19.55±8.24) the intervention. The problem solving of the respondents showed an increase of 3.02 after the intervention. The Pearson correlation between the baseline and after the intervention is 0.461, a positive correlation. The significant value of correlation is 0.006 ($p<0.05$). The increase in problem solving skills is consistent for all the participants. Since the significance value of the t statistic is 0.026 ($p<0.05$), it could be concluded that the average increase of 3.02 score of problem solving is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the problem solving of the study participants consistently.

Resilience: The table shows the resilience of the respondents before and after the intervention. The maximum score possible in the resilience assessment is 120, with a higher score indicating better resilience. The results show moderate level resilience before (47.94± 6.72) and after (56.52±19.96) the intervention. The resilience of the respondents showed an increase of 8.58 after the intervention. The Pearson correlation between the baseline and after the intervention is -0.036, a negative correlation. The significant value of correlation is 0.840 ($p>0.05$) the increase in resilience is not consistent for all the participants. Since the significance value of the t statistic is 0.025 ($p<0.05$), it could be concluded that the average increase of 8.58 score of resilience is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the

intervention was effective in enhancing the resilience of the study participants, though the variation is not consistent with all the participants.

Table 5: Rational Thinking

		Mean	Max Score	N	Std. Deviation	Paired Sample Correlation	Paired Differences		t	df	Sig. (2-tailed)
							Mean	Std. Deviation			
Pair 1	Decision Making pre	29.47	50	34	4.69	0.296 P=.090	-5.05	8.82	-3.341	33	0.002
	Decision Making post	34.52		34	8.99						

Rational thinking ability of the respondents was assessed by understanding the decision making skills.

Decision making: Table 5 displays the decision making of the respondents before and after the intervention. The maximum score possible in the decision making assessment is 50 with a higher score indicating better decision making. The results show moderate level decision making before (29.47± 4.69) and after (34.52±8.99) the intervention. The decision making of the respondents showed an increase of 5.05 after the intervention. The Pearson correlation between the baseline and after the intervention is 0.296, a positive correlation. The significant value of correlation is 0.090 (p>0.05) the increase in decision making is not consistent for all the participants. Since the significance value of the t statistic is 0.002 (p<0.05), it could be concluded that the average increase of 5.05 score of decision making is not due to chance variation and could be attributed to the intervention. Hence, it could be concluded that the intervention was effective in enhancing the decision making of the

study participants, though the variation is not consistent with all the participants.

Discussion

Results yielded the differences between the duration planned and actual duration of sessions. Need for modification of some of the activities based on appropriateness and feasibility was identified. Developing assessment tools took more time than the planned time. Only 15 hours of the 18 hour sessions could be finished in the three days workshop. The modules later have been modified for a 15 hour duration intervention.

Paired sample t- test of pre and post test scores revealed significant changes in all domains of the social competence model viz. self concept, goal orientation, pro-social behaviour, resilience and rational thinking. Further, significant changes were observed in all the sub domains of pro-social behaviour viz. empathy, communication, assertiveness and cooperation ($p<0.05$). Although, there was increase in the mean values of emotional stability, the difference in mean was not statistically significant ($p>0.05$). Adolescents showed a significant improvement in the perceived level of competence in all domains except emotional stability.

Assessment of the domains was performed before and immediately after the intervention. Scores obtained were of perceptual changes and not exact behaviour changes. Perceptual changes are expected to bring changes in the behaviours, fostering social competence among the adolescents. Correlation values showed consistent changes in all the participants in the domains of self concept, communication and problem solving skills. However, consistent progress was not observed in other domains.

Consistent improvement in self concept and communication could be attributed to the strength of the intervention to help the participants to be more reflective about themselves from a strengths perspective. The intervention focused on limitations as opportunities for growth. The approach provided confidence to the adolescents to face life challenges and to overcome their limitations. Opportunities provided for effective communication and increased self image contributed to the perception of enhanced

communication skills. Positive concept of the self, contributed greatly to the perceived self efficacy in problem solving.

Inconsistent changes across participants in other domains might be due to the macro approach used by the research process as most of the domains were very personal and needed a micro approach. Diversity of the group with different levels of needs and diverse socio-cultural factors also would have contributed to this result. Importance of family variables (Peterson & Leigh, 1990), socio-cultural factors (Bloom, 1990), and affective, cognitive and behavioural components (Caplan et al, 1992) in the enhancement of social competence has been cited by authors. However, from a systemic and strengths perspective, strengthening the social competence of an individual can trigger their capacity to overcome the ecological constraints to reach success and achieve their goals in life. In addition to that, school has been identified as a potential place to build up the competence of children (Weissberg, Barton & Shriver, 1996).

Limitations and Implications for further research

The study had a number of observable limitations. Firstly, the study did not use a control group for confirming the effect of intervention. This issue is addressed as the next part of the study uses an experimental design with control group confirming to an RCT protocol.

Secondly, the assessment was in a perceptual level of change and not based on demonstrated behaviour. The larger study tried to overcome this limitation by adding one more level of assessment, 6 months after the completion of intervention.

Thirdly, the study could not address other factors such as parenting, interaction of teachers and other ecological factors. Further research could be performed with due considerations to these factors.

Fourthly, the study used a promotive and preventive paradigm and, adolescents with strong potential issues were not given special attention. Future research could focus on this limitation by

developing an intervention plan for adolescents with specific issues.

Lastly, the study had no mechanisms for ensuring the sustenance of gains received through the intervention, except the involvement of school counsellor in the intervention process. Researchers could develop strategies for maintenance of the positive changes demonstrated by the participants.

Conclusion

The study confirmed the feasibility of the social competence model in enhancing the social competence of adolescents. The results have helped in improving the intervention methodology for an efficient implementation with a large number of children spread across 10 different schools. The study has contributed a methodology for social work profession to address the self efficacy of children using the social competence model developed out of the WHO core life skills.

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Declaration of Interest: The authors alone are responsible for the content and writing of the paper.

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