

UTILIZING VIDEO FEEDBACK TO INCREASE
APPROPRIATE SOCIAL BEHAVIORS WHEN USED IN
CONJUNCTION WITH PEER TUTORING

By

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Master of Science in Educational Psychology
Oklahoma State University
Stillwater, Oklahoma
2009

Submitted to the Faculty of the
Graduate College of the
Oklahoma State University
in partial fulfillment of
the requirements for
the Degree of
DOCTOR OF PHILOSOPHY
July, 2013

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CONJUNCTION WITH PEER TUTORING

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ACKNOWLEDGEMENTS

I would like to extend my gratitude to the staff at the Nebraska Department of Health and Human Services, DD Services Division. I would like to especially thank the Behavior Support Team for their encouragement and assistance. Their partnership, help, and friendships are invaluable to me.

I wish to express my thanks to my fellow doctoral students and friends who were a constant source of encouragement through the different stages of my graduate student life at Oklahoma State University. I am indebted to my friends for their assistance in my study.

I would also like to thank my dissertation committee members, Drs. Terry Stinnett, Gary Duhon, Georgette Yetter, and Robert Davis, for their time and ongoing support during this process.

Finally, I would like to thank my family for enabling me and supporting me while I achieve my dream. To my brother, John, and especially to my parents, Vu Bui and Yen Ly: thank you for believing in me.

Name: LEVITA YEN BUI

Date of Degree: JULY, 2013

Title of Study: UTILIZING VIDEO FEEDBACK TO INCREASE APPROPRIATE
SOCIAL BEHAVIORS WHEN USED IN CONJUNCTION WITH PEER
TUTORING

Major Field: EDUCATIONAL PSYCHOLOGY

Abstract: The ability to integrate, adapt and strive in the community has become a focal point in research with individuals who have an intellectual disability. However, research regarding teaching social skills to adults who are preparing to transition into the community is limited.

The purpose of this study is to utilize peer tutoring with adults who have a mild intellectual disability. Furthermore, a video feedback component will be added in an attempt to enhance the effects of peer tutoring. This overall aim is to increase social skills in adults who are currently living in an institutionalized setting and who may be able to transition into a community residential setting in the future.

The results of this study provide preliminary support for a peer tutoring intervention and video feedback in order to enhance social skills with adults who have a mild intellectual disability. Peer tutoring is an intervention that is generally used with children and youth in school settings when increasing social skills. The data suggest that peer tutoring is an effective strategy for increasing social skills in adults with mild disabilities. The data also demonstrated that video feedback does enhance the effects of peer tutoring despite the high levels of appropriate behavior that peer tutoring facilitated.

TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION	1
Integration into the Least Restrictive Environment	2
Social Barriers	2
Institutional Settings	5
Peer Tutoring	6
Video Feedback	7
Limitations in the Current Literature	8
Rationale for the Study	8
Research Questions	9
II. REVIEW OF LITERATURE.....	10
Social Cognition.....	11
Adaptive Behavior	12
Social Competence.....	14
Social Outcomes	19
Inclusion.....	22
Inclusion in the Schools	22
Integration into the Community	26
Social Skills Training.....	27
Peer Tutoring	29
Video Feedback	30

Chapter	Page
III. METHODOLOGY	34
Setting	34
Participants.....	34
Target Participants	34
Jane	35
Dan.....	36
Erica	36
Peer Tutors	37
Richard.....	38
Wilma.....	38
Materials	38
Variables	39
Dependent Variables.....	39
Independent Variables	39
Peer Tutoring	39
Peer Tutoring + Video Feedback	40
Experimental Design.....	40
Procedure	40
Peer Tutoring	41
Peer Tutoring + Video Feedback	41
Coding Procedure.....	42
Reliability.....	42
IV. RESULTS	44
Jane	44
Dan.....	45
Erica	45
V. DISCUSSION.....	48
Limitations	50
Future Research	50

Chapter	Page
REFERENCES	51
APPENDICES	56

LIST OF FIGURES

Figure	Page
1.....	47

CHAPTER I

INTRODUCTION

The ability to integrate, adapt and thrive in the community has become a focal point in research with individuals who have an intellectual disability. However, research regarding teaching social skills to adults who are preparing to transition into the community is limited. Social skills education and training are more focused with the children and youth in schools when they have more frequent exposure to peers. Those who have an intellectual disability are recognized by displaying significantly below average intellectual functioning accompanied by limitations in adaptive functioning such as communication, social/interpersonal skills and functional academic skills (American Psychiatric Association, 2000). Individuals who fall into the “Mild” category constitute as the largest percentage with the diagnosis. In addition, these individuals have minimal impairment in sensorimotor areas and typically learn social and cognitive skills in early ages. Many children who have mild cognitive impairments are almost indistinguishable from the typically-functioning population until they become older. As adults, they are more likely to be more independent and live in a group setting or are able to live alone in the community with minimal assistance and support. However, the discrepancies become magnified when compared to others who do not have an intellectual disability. The characteristics

of those with mild intellectual disabilities overlap considerably with moderate intellectual disabilities, and learning and behavioral difficulties cannot be readily distinguished from one another using current definitions (Gresham, MacMillan, and Bocian, 1996).

Integration into the Least Restrictive Environment

Individuals with an intellectual disability may face obstacles that hinder their success in community settings. Some of the factors which can contribute to the success of being integrated into a community setting include the ability to display adequate social skills, personal independence, and the ability to adapt to new social situations. Education of social skills should be based upon a continuum, as is aging and growth. It is important to teach children in the schools and as equally important in facilitating successful integration into the community as adults with disabilities. Academic and social competences are two domains of personal competence as described by Greenspan (1981). It was conceptualized as a multidimensional construct that included adaptive behavior, social skills, and peer relationship variables (Gresham & Reschly, 1988). Another author emphasized that there is a distinction between social competence and social skills (McFall, 1982). Individuals with mild disabilities struggle with these two competencies daily in a social setting. Social competence is often overlooked, yet its contribution is essential to an individual's ability to cope efficiently with a variety of change in their life (Greenspan, 1981).

Social Barriers

Positive relationships facilitate the formation of positive self-image in people. Those who are affected by a disability are less likely to be able to develop such relationships. According to Leffert and Siperstein (2000), for a student to function successfully, he/she must be able to cope with a large and diverse group of peers, be able to adapt to a variety of social settings and the fast-changing nature of everyday social interaction. The goal of social skill interventions for adults with mild to moderate handicaps often focuses upon preparing them to enter and succeed within the least restrictive settings.

The interventions are especially useful when the individuals are taught skills that facilitate home adjustment and contribute to overall peer acceptance in the classroom setting. Social skills education may assist those with intellectual disabilities by providing skills which can result in stronger relationships within the community.

Individuals with disabilities exhibit more social behavior deficits and inappropriate social behaviors than do those without disabilities (Schumaker, Pederson, Hazel & Meyen, 1983). Various strategies have been employed to improve social behaviors, including reinforcement, modeling, and feedback (Amish, Gesten, Smith, Clark, & Stark, 1988). It is clear that integration into the community as well as full inclusion with people in the typically functioning population is important. However, it is quite difficult for an individual to develop meaningful relationships with coworkers, peers, or people in the general public if he or she displays a social skill deficit. Social interaction with others is often a focus when teaching social skills to children and adults with disabilities. According to parent and teacher report using the Child Behavior Checklist, the most distinguishable characteristic between children with mild and moderate intellectual disabilities and their nondisabled peers were social problems (Dekker, Koot, van der Ende, & Verhulst, 2002). There has been mixed results regarding social outcomes for those who have a mild intellectual disability. Some adults with an intellectual disability may face social exclusion which leads to unemployment, poverty, isolation. Furthermore, participation in the community is less likely to occur (Emerson, Malam, Davies & Spencer, 2005). Yet, some researchers have shown that with social skills intervention, many people with intellectual disabilities can obtain jobs, get married, have children, and even own their own homes (Hall, Strydom, Richards, Hardy, Bernal & Wadsworth, 2005).

Impairment in social functioning is a characteristic of individuals with disabilities such as an intellectual disability. Social skill deficits need to be examined when diagnosing individuals with an intellectual disability. The degree of social skill impairment often represents the difference between

self-reliance and independence, and dependency (Sukhodolsky & Butter, 2007). Patterns of social interaction and levels of social adjustment remain stable throughout a person's life, regardless of the complexity of the skill (Rubin, Bukowski & Parker, 1998). For example, peer interactions in preschool involve parallel play. In middle school, stable relationships begin to emerge, and complex social relationships are formed in adolescence (Sukhodolsky & Butter, 2007). Those authors posit that social skills impairments are typically reflected in at least one of three areas, including the development and stability of peer relationships, the level of the child's social interaction skills, and the child's ability to process social information and cues. When the child matures into adulthood, these deficits can be problematic when establishing or maintaining romantic relationships and other relationships.

Murray and Greenburg (2006) found that peer alienation was positively associated with anxiety and depression. Students with high-incidence disabilities completed a questionnaire designed to measure aspects of their social relationships with parents, teachers, peers as well as their perception of school. Social, behavioral and emotional competence was also observed. The results indicated that the quality of children's relationships with caregivers was associated with behavioral and emotional adjustment. Students who experienced alienation in relationships with teachers had more externalizing behavior problems. Students with disabilities are more likely to experience peer rejection and are more likely to experience emotional and behavioral problems as well as develop aggressive patterns of behavior. While it is important to explore strategies for intervening in the lives of children to enhance their social, emotional and academic skill, interventions should be utilized throughout adolescence and into adulthood in order to facilitate progressive success when these individuals transition into the community setting.

As students become older and more aware of their surroundings, they are more susceptible to depression as well as anxiety due to the nature of their disorder. For older students, the anxiety and Depression may be due to failure and criticism (Li & Morris, 2007). If individuals were more prepared for social expectations as well as adaptation, feelings of anxiety as well as depression could be considerably lessened. Mild intellectual disability is not as debilitating as more severe levels of intellectual disabilities, because those with mild intellectual disabilities still have the capacity to recognize social cues. Because of this ability, these individuals may be aware of social rejection and the dynamics of social relationships, possibly linking to depression and anxiety as well.

Those with intellectual disabilities are more likely to interpret social situations as negative, even if the situation was perceived as neutral by others without a disability (Leffert & Siperstein, 2000). In particular, the students in the study had difficulties of social perception by failing to recognize and interpret social cues about classmates' intentions. These students were able to be taught social generalization skills and how to appropriately handle the situations without needing to bring in a third party, such as a teacher.

There is evidence to support that for those with an intellectual disability, stigmatization can have a negative impact on mood and lower self-perception (Dagnan & Waring, 2004). Thirty-nine individuals who had an intellectual disability each completed three scales that assessed their perceptions of their own stigmatization, evaluation beliefs, and how the participants saw themselves in relation to others. Results support the assertion that the perception of stigma is associated with how individuals evaluate each other.

Institutionalized Settings

Social skills in an institutionalized setting may be perceived differently. In an institutionalized setting, various direct support staff members are employed to support individuals whose disabilities range from moderate to profound. In addition to communication abilities,

communication style and interaction between staff members and clients may be a barrier for the development of a relationship that is collaborative in nature (Jahoda, Selkirk, Trower, Pert, Stenfert, Dagnan et al., 2009). When the client is ready to move into a community setting, collaborative conversations are needed for the individual to thrive and have a more independent lifestyle.

Peer Tutoring

For many adults with intellectual disabilities to be adequately integrated into community settings, social skill interventions are often needed. Peer tutoring is an intervention that is often used to increase appropriate social behavior in the classroom with younger populations, but there is limited research regarding its effectiveness with adults with mild intellectual disabilities. Social behaviors have been defined as social acceptance, specific characteristics of peer interactions, aggressive behavior, and social acceptance (Bolich, 2001). For children and youth, measurements of the effectiveness of peer tutoring include teacher ratings, interviews, direct observation and administration of rating scale instruments. Peer tutoring can enhance social skill acquisition and promote the generalization of social behaviors in an integrated classroom. It involves typical peers as models for appropriate social interaction (Bolich, 2001). Generalization of social skills from the classroom may occur in community settings if given the opportunity. In both the classroom setting and the residential setting, it is important to note that peer tutoring can benefit the individual with the disability, and may also benefit the person who is serving as a peer tutor. Peer tutoring may benefit the peer tutor by creating empathy and sensitivity for their peer, which enhances their knowledge of disabilities (Eiserman, Shisler, & Osguthorpe, 1987). Peer tutoring interventions are used as a means of increasing appropriate social behavior in the classroom (Bolich, 2001). In its simplest form, peer tutoring involves a student assisting another student learn a skill or task (Franca, Kerr, Reitz, & Lambert, 1990; Sprick, 1981). Schumaker and Hazel (1984) define social skills as any cognitive function or overt behavior in which an individual engages while interacting with another

person or persons (p. 422). The authors further define cognitive functions as the ability to empathize, react to social cues, as well as anticipating and making appropriate decisions based upon the presented social behavior. Overt behaviors include verbal and nonverbal interactions such as eye contact and body language.

Often, for children with disabilities to be included in the general education classroom, social skill interventions are needed. Peer tutoring is an intervention that is often used to increase appropriate social behavior in the classroom.

Video Feedback

Video feedback is a method employed by many educators to enhance communication skills. It is useful because it incorporates feedback in the form of video so it is easily observable, and the target participant is able to evaluate their own behavior (Fukkink, Trienekens, & Kramer, 2011). A video component of an intervention would allow the interventionist to rewind, pause, and play a segment that is pertinent to a skill in social skills training. Behaviors such as eye contact, hand gestures, and verbal initiation or response may be more apparent to the observer. A variation of video feedback includes positive modeling, which focuses on successful interactions by the participant in order to reinforce the target behavior (Fukkink et al. 2011).

Various strategies have been employed intending to improve social behaviors which include reinforcement, modeling, and feedback (Amish, Gesten, Smith, Clark, & Stark, 1988). These strategies have emphasized both inclusion in “normalized” classroom settings as well as community settings. However, it is more difficult for students and adults to develop meaningful relationships with teachers and peers if they display social skills deficits. Therefore, social interaction with peers is an intervention focus when attempting to integrate people with intellectual disabilities into the least restrictive environment.

Limitations in the Current Literature

More research is needed in the domain of mild intellectual disabilities. Furthermore, social skills should be taught in a continuum of all age ranges from children to adults. By doing so, acceptance from peers as well as people in the general public setting who do not have a disability may likely increase. Research is also necessary in developing tactics to teach social skills to adults with mild intellectual disabilities. Those with an intellectual disability would greatly benefit from learning how to accurately interpret available social cues and everyday challenges such as developing meaningful relationships by communicating their needs clearly. By being more adaptive and interpreting social situations more accurately, it might create more positive self-concepts and improve the quality of life. Though research regarding peer tutoring with children and adolescents is abundant, there is limited research with the adult population who have an intellectual disability.

Rationale for the Study

The purpose of this study is to utilize peer tutoring with adults who have a mild intellectual disability. Furthermore, a video feedback component will be added in an attempt to enhance the effects of peer tutoring. This overall aim is to increase social skills in adults who are currently living in an institutionalized setting and who may be able to transition into a community residential setting in the future.

Research Questions

1. Is a peer tutoring intervention effective in improving the frequency of social interactions between individuals with intellectual disabilities and their peers?

It was hypothesized that the peer tutoring intervention would be more effective than no intervention.

2. Does the addition of video feedback component increase levels of the peer tutoring intervention?

It was predicted that the additional video feedback component will enhance the peer tutoring intervention and will further increase the levels of peer interaction between adults with a disability and their non-disabled peers.

3. Will the learned social behaviors generalize to a natural setting, when adults with disabilities interact with other non-disabled peers?

It was hypothesized that the learned social behaviors will generalize when speaking with a direct support staff member.

CHAPTER II

REVIEW OF THE LITERATURE

The ability to integrate, adapt and thrive in the community has become a focal point in research with individuals who have an intellectual disability. However, research regarding teaching social skills to adults who are preparing to transition into the community is limited. Social skills education and training are more focused with children and youth in schools when they have more frequent exposure to peers. Those who have an intellectual disability are recognized by displaying significantly below average intellectual functioning accompanied by limitations in adaptive functioning such as communication, social/interpersonal skills and functional academic skills (American Psychiatric Association, 2000). Individuals who fall into the “Mild” category constitute as the largest percentage with the diagnosis. In addition, these individuals have minimal impairment in sensorimotor areas and typically learn social and cognitive skills in early ages.

Many children who have mild cognitive impairments are almost indistinguishable from the typically-functioning population until they become older. As adults, they are more likely to be more independent and live in a group setting or are able to live alone in the community with minimal assistance and support. However, the discrepancies become magnified when

compared to others who do not have an intellectual disability. The characteristics of those with mild intellectual disabilities overlap considerably with moderate intellectual disabilities, and learning and behavioral difficulties cannot be readily distinguished from one another using current definitions (Gresham, MacMillan, & Bocian, 1996).

Social Cognition

A basic effect of an intellectual disability is that people with them experience limitations in their daily life performance as a result of intellectual impairment (Leffert & Siperstein, 2002). Literature also emphasizes the limitations of behavioral skills that individuals with mild or severe levels of intellectual disabilities possess. However, the research does not adequately describe the subtle but significant limitations in everyday social functioning. For example, people with mild disabilities rarely exhibit impairment in areas of self-care and domestic/home living skills. The difficulties that they often experience reflect in domains of adaptive skill, such as work, travel and leisure (Leffert, & Siperstein, 2002).

People with mild intellectual disabilities cope with a continually changing environment on a day-to-day basis, and being able to adapt is necessary. Interaction with others, social cues or problems, and specific social cues emitted by another individual change frequently in different environmental settings such as work or school.

Leffert and Siperstein (2002) suggest that individuals with mild intellectual disabilities must be able to encode and interpret social cues such as simple conversation. Also they should discern whether or not a person is interested in carrying on a conversation or whether they seem uninterested. Social perception is the process that individuals observe information available in their surroundings as forms of external social cues to internal cues to cause a change in their own emotional state. Social cues can include physical actions, words, facial expressions and body language that tell about people's behaviors (Leffert & Siperstein, 2002). Those who have mild

intellectual disabilities often lack these skills that can enable them to fully adapt to society.

Adaptive Behavior. Both children and adults use social adaptation skills. Social adaptation is defined as being able to continually adjust one's behavior in response to changing social circumstance (Leffert & Siperstein, 2002). However, those with an intellectual disability may misperceive social interaction. Even in the most familiar social environment, many variables such as mood, actions, and verbiage change continuously, this may pose a problem to those with cognitive deficits. Thus, regardless of setting, social adaptation and the ability to utilize appropriate social and communication skills are useful. Adaptive behavior consists of multiple domains with many discrete behaviors or skills that are useful in daily functioning and social interaction.

Peer rejection and social skill deficiencies are associated with later adjustment problems (Kamps and Tankersley, 1996). Children who are diagnosed with mild intellectual disabilities are more aware of their surroundings, but lack some social and daily skills that assist with integration and conformation in the community. These deficits affect relationships that the children develop in school and later in life. Misconceptions about these children can lead to differential treatment by peers and teachers, and also misperceptions about what constitutes effective intervention for those with aggressive behavior. Social groups and hierarchies are formed through relationships and perceived social dominance. Adolescents and children who are highly aggressive in childhood tend to be less accepted socially and are more likely than others to have adjustment problems in adulthood (Parker & Asher, 1987). Disruptive behavior can result in exclusion of those who are aggressive and from social groups. Children who have mild cognitive disabilities may be more likely to display aggressive behavior, leading to poor peer acceptability.

Maughan, Collishaw, and Pickles (1999) conducted a study that was aimed at providing evidence on the social circumstances and adaptation of individuals with mild intellectual

disabilities in adult life, as well as give detailed exploration of factors that influence adult outcomes. They also examined the contributions of childhood factors which contribute to variations in adult functioning. Participants were selected from the British birth cohort studies, the National Child Development Study (NCDS). Of the 13,473 children in the original birth cohort, 275 participants qualified for the study as falling into the mild intellectually disabled range. There were data on prenatal and obstetric complications, indicators of family size, social class and parental education, school placement, school attainments, behavior problems as well as life as an adult. For adults with mild intellectual disabilities, results indicated that living situations and material conditions were poor. For adult men, unemployment was four times more likely than the comparison group and only a quarter of the men in the mild intellectual disabilities group were married or in cohabitating relationships. Roughly one in six men reported that they suffered from a longstanding illness or disability. The women in the mild intellectual disabilities group were less likely to be employed compared to women in the norm group and more depressed than the men in the mild intellectual disabilities group. Approximately half of the women who had mild intellectual disabilities were receiving welfare benefits in their early thirties. In comparison with men, the women in both the mild intellectual disabilities and comparison groups had established marital or cohabitating relationships by their early thirties and most had at least one child. Almost 40% of the women in the mild intellectual disabilities group had children in their teens (approximately five years earlier than the women in the comparison group), and had begun their first relationship at least two years before the women in the comparison group. Though men in the mild intellectual disabilities group had fewer partnerships than the men in the comparison group, both groups were similar in age in regards to first establishing relationships and average age of having their first child.

In regards to employment, the authors noted that the only marked differences between women in the mild intellectual disabilities group and the comparison groups arose in the proportion of who had not worked outside of the home between the ages of 23-33. Twenty-five percent of women who had mild intellectual disabilities did not have jobs between the ages of 23-33 compared to 5.6% of the women in the comparison group. Among the men, over half of the intellectually disabled group were registered as disabled, and were not employed between the ages of 23-33.

It is important to note the differences between men and women of the mild intellectual disabilities group and those in the comparison group, such as age of first relationship and age of first becoming a parent. The implications could be maturity level, and the need to seek partnerships in order to feel accepted. It is not surprising that the data revealed age discrepancies for levels of employment in the early adulthood. More than half of the people in the mild intellectual disabilities group were registered as disabled, contributing to the unemployment statistic. This implies that there should be more programs that educate and train individuals with mild intellectual disabilities to be more prepared when they reach adulthood, beginning with social skills training which will ultimately assist with job retention.

Social Competence

Academic and social competences are two domains of personal competence as described by Greenspan (1981). It was conceptualized as a multidimensional construct that included adaptive behavior, social skills, and peer relationship variables (Gresham & Reschly, 1988). Another author emphasized that there is a distinction between social competence and social skills (McFall, 1982). Individuals with mild disabilities struggle with these two competencies daily in the school and social settings. Social competence is often overlooked, yet its contribution to an individual's ability to cope efficiently with a variety of change in schools and society (Greenspan, 1981).

In a study conducted by Leffert, Siperstein, and Millikan (2000), social-cognitive processing skills of children with intellectual disabilities were investigated by focusing on social perception and strategy formation. These processes have been found to be important for meeting the challenges of the classroom. Social perception refers to an individual's ability to interpret relevant social verbal and nonverbal cues (Maheady, Harper & Sainato, 1987). The student must also be able to encode and interpret these cues in order to accurately interpret specific problems in a social situation. Leffert et al. (2000) assessed the social perception and strategy generation skills of children with and without an intellectual disability. Participants included fifty-nine elementary school children with mild intellectual disabilities and fifty-eight comparison children without an intellectual disability. The children with an intellectual disability were drawn from self-contained special education classrooms. Those without an intellectual disability were randomly selected from general education classrooms within the same school as the children with a cognitive impairment. To assess the ability of children to perform the social-cognitive processes of social perception and strategy generation, the participants were interviewed individually and shown videotaped stimuli. The videotaped stimuli included types of situations that children typically experience: a negative event in which a child's attempt to initiate play is refused by a peer, and a negative event in which a child's activity is disrupted by a peer (blocks get knocked over by peer). Other vignettes depicted similar social situations where the child is faced with hostile intention or ambiguous reaction. Each child was presented with all eighteen vignettes and asked to imagine being the protagonist. After the vignette, a structured interview took place. Results showed that children with an intellectual disability had difficulty encoding the benign intention cues (a situation where no harm was intended, although it was a negative situation). However, children in both groups had difficulty interpreting benign intention cues when the conflict included peer entry rather than when the conflicts had peer provocation. Both groups were able to distinguish if

another child was being hostile. It is important to note that while both groups were able to identify hostile cues, children with mental retardation were more likely to attribute 'mean' intent to more than half of the situations where benign cues were present compared to students without an intellectual disability. This suggests that students with an intellectual disability are more likely to perceive accidents and unintentional situations as intentional and directed at them.

Overall, children with intellectual disability expressed a lower rate of avoidant, assertive and accommodating strategies than children without intellectual disability. Children with intellectual disability also showed less ability to differentiate between peer entry and peer provocation conflicts. The children with intellectual disability over-focused on the negative event and disregarded the benign social cue that the situation could have been a mistake. The authors found that in addition to the limitations in social perception experienced by children with an intellectual disability, they also do not generalize social adaptation strategies for different social problems. The study highlighted the importance of encoding and interpretation of social skills in the classroom as well as being able to generalize in order to solve problems. To avoid social rejection from their peers, children with intellectual disabilities must engage in successful social interaction as well as use their social skills to be able to adapt to ever-changing situations. Leffert and Siperstein (2000) suggest that both general and special education teachers can help these children meet the challenges of daily life at school by helping the student focus both on discrete observable social behaviors as well as stimulating the development of underlying social-cognitive skills.

Similarly, Basquill, Nezu, Nezu, and Klein (2004) found that aggressive males with a mild intellectual disability displayed more deficits in overall social problem-solving, regardless of the type of problem as compared to non-aggressive males with a mild intellectual disability. Participants included 45 males ranging in age between 19 and 50 years. Their intellectual

functioning level corresponded to the “mild” range. Participants were asked to respond to 10 vignettes (4 ambiguous, 3 hostile, 3 non-hostile) by answering four questions while being videotaped. The questions assessed constructs such as the respondent’s comprehension of the vignette, his appraisal of the interpersonal intent of the actors toward the target individual, and his own likely behavioral response. Results indicated that the non-aggressive groups were more likely to identify positive and negative consequences, but no differences were found when concerning their ability to generate “high quality” alternative solutions. Aggressive individuals were found to be significantly less accurate in identifying interpersonal intent regardless of the type of situation. In general, the data suggests that adults with an intellectual disability tend to perform better on more general problems as compared to those situations that involve hostile intent (Basquill et al., 2004).

Conversely, adults with an intellectual disability are vulnerable to stressful social interactions. Hartley and MacLean (2009) found that stressful social interactions with the highest prevalence involved hearing others argue or when someone else does not listen to the individual. Stressful interactions which involved more serious and intentional negative actions of others had the highest level of severity (e.g., damaged property, told private or bad things about you). Though environmental engineering techniques such as “argument-free” zones could be established, teaching social skills to these individuals may be more appropriate and would have more long-term benefits.

Quality of relationships, competencies in the general social setting and inappropriate social behavior have been found to impact acceptance of individuals with intellectual disabilities by those without disabilities. Children with an intellectual disability who display inappropriate styles of interaction, including distractibility, overly loud tone of voice, and developmentally less mature speech, contributes to peer rejection (Van Bourgondien, 1987). Hemphill and Siperstein

(1990) investigated the relationship between mildly disabled childrens' conversational competence and their acceptance by their non-disabled peers. Children who have difficulty managing aspects of conversation, continuing conversation and interaction may have trouble making friends. This can lead to peer rejection and being perceived as socially incompetent. Children with mild intellectual disabilities experience delays in many aspects of language development (Abbeduto & Rosenberg, 1987). These children are more likely to display depressed conversational abilities, and show problems with questioning strategies and topic- relevant responding. These are the same problems that evidence when initiating and maintaining social interaction and they have been linked to peer-rejection in studies with normally developing children.

Conversational competence in normally developing childrens' responses to mildly disabled peers, was examined using an experimental situation that allowed the manipulation of the levels of competency while controlling for other important factors. Participants included ninety-four general education students who were enrolled in fourth through sixth grade. Four videos were created for two target students. The target participants included a sixth-grade boy and a girl who had mild levels of intellectual disability. They were selected for their relative language competence and were able to initiate conversational sequences on a variety of topics and were able to follow up with appropriate responses. Each child was paired with an unfamiliar same-sex partner who did not have intellectual disabilities.

Each target was taped twice, once unrehearsed and the second time following prompts and coaching. The result was two video tape versions: one in which the child with disabilities displayed relatively competent conversational skill, and the second where the child displayed poor conversational skills. Participants were randomly assigned to two conditions: competent (where the target student displayed competent conversation skills) and incompetent (where the

target student lacked conversational skill). Results indicate that girls are harsher than boys at rating conversational competencies of a student. Only 15% of the students perceived the incompetent target as a “good conversationalist,” whereas over half (51%) of the students perceived the competent target as a “good conversationalist.” Further analysis revealed that student perception of conversationalist was not dependent upon gender or whether the target was labeled as being in a special education classroom. The participants were more positive toward the target child who was perceived as having good conversational skills than the target child who did not display appropriate skills. Hemphill and Siperstein (1990) suggest that the portrayal of a child with less desirable conversational skills appear to be a signal to other students that this is not someone who is hostile or unpleasant, but rather, as someone who has difficulty making friends.

Individuals who lack conversational skill and the ability to interpret social situations are at higher risk for being rejected by their peers. Recognizing social cues are imperative for integration in the general education setting and eventually, community settings. It is increasingly important for individuals with mild intellectual disabilities to be taught these skills, since these skills are utilized from youth through adulthood. The implications of the studies suggest that if students with mild intellectual disabilities are better prepared for adaptation in the classroom, they are more likely to be welcomed and not face peer-rejection as often. The ability to interpret social situations and utilize appropriate social skills is imperative to facilitate as well as maintain successful relationships.

Social Outcomes

Gresham and MacMillan (1997) posited three beneficial social outcomes that could result from educating children with disabilities in the general education classroom. The first might be increased peer acceptance and decreased peer rejection. The second could provide mutually

beneficial and positive social interactions between children with disabilities and nondisabled children. Finally, nondisabled children might provide healthy modeling for those with disabilities (Gresham & MacMillan, 1997). Inattentiveness and disruptive behavior such as disruption of the classroom and other school activities are two behaviors that classroom teachers dislike the most (Gresham & MacMillan, 1997). The teacher may feel that their lesson is not valued, and the student does not learn if they are inattentive, and disruptive behaviors distract the other students from learning. These behaviors have led to significant referrals to special education services in schools. Gresham and MacMillan (1997) reviewed empirical research that focused on the social and affective functioning of children with mild disabilities. Students with mild disabilities tend to be less accepted than their nondisabled peers in the general education classroom (Gresham & MacMillan, 1997). One reason that children with mild intellectual disabilities are referred for evaluation for special education is because the student does not meet the teacher's social behavior standards (Gresham & MacMillan, 1997). It may be more difficult for a teacher to tolerate disruptive behavior displayed by a child who has a mild disability than by a child with severe disabilities. That is, teachers expect more from a child who does not appear to have a disability because they should know how to behave themselves, whereas teachers may believe that a child with a more severe disability cannot control their actions. Standards by teachers are also varied; students who are perceived to be smarter receive more teacher attention, greater opportunities to respond, more praise and more verbal cues (Gresham & MacMillan, 1997).

Children spend the majority of their days in schools, interacting with teachers and peers. Students who receive support from their relationship with teachers had fewer behavioral problems, had greater social competencies and adjusted better in the academic setting than those students who had conflict in their relationships with teachers (Pianta, 1994). Children with a

larger number of friends in elementary school had greater gains on measures of academic performance and school liking than did children with fewer classroom friends (Ladd 1990).

If a child with an intellectual disability is socially successful in the school setting, they would be more likely to succeed in the community setting as an adult. There are many variables that influence social outcomes for people with intellectual impairment at different stages of their lives. Hall et al. (2005) investigated social outcomes in adulthood of children with intellectual impairment with a British birth cohort. The researchers identified 111 people with mild intellectual disabilities and 23 with severe intellectual impairment from an initial cohort of 5,362 people in 1946. The control group (normal intellectual functioning) included 3,904 participants. The children in the cohort had various tests and interviews, including intelligence tests, every 2 years until the age of 16. Since childhood, the cohort had a follow-up every 5 to 8-year intervals. When the members of the cohort were 42-43 years old, adult data were collected. Hall et al. considered social variables during childhood at various ages (i.e. type of school participants attended, if the participant was a member in a club, parental home ownerships), learning achievement, adult socio-economic status, education, marriage and children, home ownership, as well as adult social networks and community use.

A descriptive analysis of the childhood data revealed that many of the children with an intellectual disability were not living at home when they were 7 years old, those with a mild impairment were more likely to attend a mainstream school and participate in clubs than the participants who had a severe impairment. At age 43, nearly all of the participants with a severe intellectual disability had a problem with one or more areas of learning achievement, and more than half of those with mild intellectual disabilities had problems in one or more areas with the most common subject being writing. In adulthood, 67% of those with a mild intellectual disability and 21% of those with a severe intellectual disability had one or more jobs, compared

to 89% of those who did not have an intellectual disability (only 1 person with a mild disability had a job that included supervising others). Although the rates of having a job were comparable to the control group, people with an intellectual disability earned less money and were more likely to be employed by jobs in the manual labor field. Those with an intellectual disability were also less likely to achieve higher education (5% compared to 60% of those who did not have a disability). Participants with severe intellectual disabilities were unlikely to marry or have children but a majority of those with a mild impairment did marry (73%) and have children (62%), and 54% of the individuals with a mild impairment owned their own home. The results of the study suggested that although many with a mild intellectual disability struggled with academic achievement, these individuals are likely to successfully integrate into the community when compared to adults who do not have an intellectual disability.

Inclusion

Inclusion in the Schools. Special education policies can impact teachers and students. Students with mild intellectual impairments are at particular risk for becoming lost in the policy discourses that surround their education but that may or may not address their unique individual needs (Reid & Valle, 2004). Students with disabilities engage in more interactions when they are in an inclusive classroom than those who are in settings with fewer peers without disabilities (Hauser-Cram, Bronson & Upshurt, 1993).

Guralnick, Neville, Hammond and Connor (2008) examined changes in the types of inclusive placements for children with mild developmental delays as they transitioned from full inclusion in preschool and kindergarten programs to the first and second grades. Ninety preschool and kindergarten students with mild developmental delays were followed during a three-year study. Full inclusion was defined as settings in which the student with Individualized Education Plan (IEPs) spent the entire school day in a class where most (more than 50%) of the children did

not receive special education services.

During first two years of the study, a series of measures were administered to collect data regarding children's cognition, language, adaptive behavior, behavioral problems, and social competence. These measures included the WPPSI-R (to assess intellectual level and obtain a full scale intelligence score). Older children were assessed with the Wechsler Intelligence Scale for Children (WISC-III). The Test for Auditory Comprehension of Language-Revised (TACL-R) was used to assess the students' language level. Behavioral problems and general social functioning were assessed by teachers as well as parents. Results from the study reveal that 88.1% of those students who were initially enrolled in preschool and 85.4% of those enrolled in kindergarten were still in full-inclusion settings by Year 2 of the study. By Year 3, 46.7% of those who began in preschool and 32.4% of those who began in kindergarten were in full-inclusion settings.

Full inclusion in preschool and kindergarten suggests a high level of commitment by families. There was a continuingly strong commitment to full inclusion from Year 1 to Year 2. By Year 2, 78 of the 90 students in the sample remained in a full-inclusion program. By Year 3, only 25 students remained in full-inclusion programs, 6 in partial specialized programs, 33 in partial inclusion, and none in completely specialized programs. Cognitive and language levels are important factors associated with variations in placements during first and second grades. This suggests that additional work remains to develop and implement the types of special instructional accommodations for cognitive and language levels. Without a strong support program to develop cognitive and language skills, a shift from full-inclusion to partial inclusion will continue, despite strong commitment levels displayed by parents and families to inclusion. Though other characteristics displayed by child, such as their adaptive behavior, behavior problems, and social

competence are presumed to be factors in placement, the authors found no significant difference on these variables among the groups enrolled in first and second grades at Year 3.

Positive teacher perception is important in the movement to fully include students with mild intellectual disability in the general education classroom. In past research, general educators were characterized as being resistant to integration (Coates, 1989). However, others suggest that teachers in the general classroom are supportive (Villa, Thousand, Meyers, & Nevin, 1996). Several factors influence teachers' perspectives on the issue of integrating students with disabilities (Soodak, Podell, & Lehman 1998). These issues include the severity and the nature of the disability, such as a learning disorder as opposed to intellectual disability. Other studies found that teachers are less willing to integrate students with disabilities in their classroom if it requires more responsibilities on their part (Houck & Rogers, 1994). Soodak, Podell, & Lehman (1998) conducted a study in which teacher responses were explored to gain an understanding of what variables affect their stance and predictability on the issue of inclusion. Participants included 188 general education teachers who were enrolled in graduate education classes at three universities in the New York metropolitan area. Thirty-six percent of the participants reported having students with special needs in their present classes. Each participant received a packet that contained four surveys. One survey contained hypothetical scenarios of integrating a student with different special needs (mental retardation, a behavior disorder, and a physical disability in which a wheelchair was needed, a hearing disability or a learning disability) into their classroom. The other surveys asked the participants to use a Likert Scale to indicate their willingness to engage in specific teaching strategies and also to rate their own self-efficacy and effectiveness as teachers. School conditions and classroom climate were also described in a separate survey.

Results from the study contribute to the understanding of teachers' responses to inclusion by identifying student, teacher and school factors that relate to these reactions. Soodak, Podell, and Lehman (1998) found that teachers are unreceptive (i.e. hostile) to the inclusion of students with intellectual disabilities and behavior disorders. More experienced teachers were found to also be hostile towards students with learning disabilities. Of these three disabilities listed, teachers were only anxious about the inclusion of students with intellectual disability. Furthermore, they were fearful but not found to be hostile to the inclusion of students with physical disabilities. As a result of the analysis conducted, students with intellectual disabilities were also perceived as threatening to teachers.

Implications of the study suggest that full inclusion in education may be possible by addressing these variables that are found to relate to teacher hostility and anxiety. It may be possible to facilitate successful inclusion by helping teachers work effectively with their students and collaborate with other teachers (Soodak, Podell, & Lehman, 1998). Dore, Dion, Wagner, and Brunet (2002) evaluated the feasibility and benefits of inclusion of students with mild intellectual disabilities in general education high school classes. The authors explored academic gains made by adolescents with intellectual disabilities in regular education classes, quality of peer relations, and the feasibility of inclusion in high school. Participants included two 15 year-old girls named Lucy and Melanie who displayed no behavior problems or physical handicaps, and were in their first year in high school. Both girls displayed mild to moderate deficits in all areas. The students attended a self-contained classroom until March break. Thereafter, the students were integrated into a regular classroom full-time.

Results from the study indicated that the participants were less often engaged in group activities and separate individual work accounted for the majority of their time spent in the classroom. Social interactions in the cafeteria were observed to determine if the students were a

part of a group or network. On average, Lucy devoted an average of 53.3% of her lunchtime to social interactions before her transfer, and 46.6% of her time afterwards. During lunch time, she interacted with the same two friends (from the self-contained classroom). Melanie was less socially active, interacting just 15.8% before the inclusion, and 13.6% after inclusion. She did not have any frequent friends that she chose to interact with.

Five of the eight teachers believed that social integration was inadequate; however, five of eight teachers were satisfied with the inclusion, both at the beginning and the end of the experiment. Their satisfaction was based upon Lucy and Melanie's classroom involvement, social integration and the absence of change in class routine. Two teachers were unsatisfied with the inclusion, because they had not employed the use of a teaching assistant (the other five had). One teacher reported that inclusion was too great of a commitment, even with the support of a teaching assistant. The inclusion of the two students revealed mixed results. The majority of the teachers in the study felt that they were satisfied with the progress made by Lucy and Melanie. By including them into their classrooms, they had little modifications made to their daily instruction. However, the decreases in social interaction suggest that the students experienced peer rejection by regular classroom students. The authors suggest that full inclusion in high school is feasible, and to some extent, beneficial for students with an intellectual disability.

Integration into the Community. Recent movements to transition individuals with an intellectual disability into community-based settings and "de-institutionalization" efforts have not produced uniformly better results for everyone (Mansell, 2006). Educators, parents, and others responsible for assisting those with an intellectual disability can anticipate the needed support when integrating into community independence. The degree of independence that one has in the community depends on the individual's level of adaptive behavior (Woolf, Woolf, & Oakland, 2010). General adaptive behavior is "the collection of conceptual, social, and practical skills that

have been learned by people in order to function in their everyday lives” (Schalock et al., 2010). Generally, adaptive behaviors of those working independently and in supportive settings do not differ. In addition, adaptive behavior does not change from a group setting and those who live in the community (Woolf et al., 2010).

Variables that may affect successful community placement include quality of life (Brown, 1999), rural versus urban communities (Nicholson & Cooper, 2013), and higher levels of adaptive behavior (White & Dodder, 2000). Social exclusion is a term that describes objective aspects of participation such as employment, and social aspects of participation such as the opportunity to form friendships and relationships with others (Burchardt, Te, & Piachaud, 2002). Having a sense of belonging within a group or being part of a society may be hindered if one does not have the ability to initiate or maintain a meaningful conversation.

Social Skills Training

Impairment in social functioning is a characteristic of individuals with an intellectual disability. Social skill deficits are imperative when diagnosing individuals with an intellectual disability. The degree of social skill impairment often represents the difference between self-reliance and independence, and dependency (Sukhodolsky & Butter, 2007). Individuals with disabilities exhibit more social behavior deficits and inappropriate social behaviors than do those without disabilities (Schumaker, Pederson, Hazel & Meyen, 1983). Patterns of social interaction and levels of social adjustment remain stable throughout a child’s life, regardless of the complexity of the skill (Rubin, Bukowski, & Parker, 1998). For example, peer interactions in preschool involve parallel play. In middle school, stable relationships begin to emerge, and complex social relationships are formed in adolescence (Sukhodolsky & Butter, 2007). The authors posit that social skills impairments are typically reflected in at least one of three areas, including the development and stability of peer relationships, the level of the child’s social interaction skills, and the child’s ability to process social information and cues.

Instruction, modeling, rehearsal, corrective feedback and reinforcement for appropriate performance are common techniques used in Social Skills Training (SST) procedures (Merrell & Gimpel, 1998; Spence, 2003). The overall goal of SST is to train specific behaviors that are pertinent to improving social skill deficits. Targeted behaviors may include eye contact, appropriate social responses, smiling, and behaviors that facilitate appropriate social interaction. Observational measures comprise the majority of studies of social interaction in children with intellectual disability (Sukhodolsky & Butter, 2007). Kopp, Baker, and Brown (1992) compared 15 preschool age children with mild intellectual disabilities to their nondisabled peers. The children were divided into groups of three and were observed during brief periods of play when they were offered toys and encouraged to play closely together. The researchers coded the behavior as not playing or engaging in solitary, social, or parallel play. They found that children with ID showed less social behavior interactions and engaged in more solitary play. The children were also observed to be more than two times less likely to laugh and smile in response to their peers.

Conversational interactions in 12 high school students with moderate disabilities and 12 nondisabled peers during lunch time were observed by Hughes, Rodi, Lorden, Pitkin, Derer, and Hwang et al., (1999). It was observed that interaction between students with and without disabilities was minimal. There were differences in the number of social interactions as well as the content of the conversation. The children with a disability had fewer social interactions, but there was no difference on the appropriateness of the social responses. This indicates a positive outlook for those with mild disabilities, and implies that the frequency of social interactions must improve, but the students are competent in what is considered a socially appropriate response.

Social interaction occurs in many different settings and requires adaptability and social awareness when transitioning from one setting to another. Matson, Kazdin, and Esveldt-Dawson

(1980) increased six specific behaviors when training adolescent boys with moderate intellectual impairment. The behaviors included: physical gestures, facial expression, eye contact, number of words spoken, voice intonation, and verbal content. Role playing was utilized in order to train the students. The researchers reported significant improvement for all of the target behaviors.

Bornstein, Bellack and Hersen (1977) used SST on four students whose ages ranged from 8 to 11. All four students had at least three verbal or nonverbal behavior deficits (i.e. poor eye contact, short speech duration, inaudible responses, and inability to make requests). Role play was also utilized in the experiment, where the research would read a prompt and the target student responded. The researcher provided the student with feedback on their performance and discussed the feedback to ensure that it was understood. The researchers also incorporated a modeling component, where they would perform for the students what was socially appropriate.

Various strategies have been employed intending to improve social behaviors, including modeling, feedback and reinforcement (Amish, Gesten, Smith, Clark, & Stark, 1988). It is clear that integration into the community as well as full inclusion classrooms is important. However, it is not feasible for the student to develop meaningful relationships with teachers and their peers if the student displays a social skill deficit. Social interaction with peers is an area that many interventions focus on when teaching social skills to students with disabilities.

Peer Tutoring. For many children with disabilities to be adequately integrated into the general education classroom, social skill interventions are often needed. Peer tutoring is an intervention that is often used to increase appropriate social behavior in the classroom. Measurements of the effectiveness of peer tutoring include teacher ratings, interviews, direct observation and administration of rating scale instruments. Peer tutoring can enhance social skill acquisition and promote the generalization of social behaviors in an integrated classroom. It involves typical peers as models for appropriate social interaction (Bolich, 2001). It is important

to note that peer tutoring can benefit the student with the disability, and it may also benefit the student who is serving as a peer tutor. Peer tutoring may benefit the peer tutor by creating empathy and sensitivity for their peer, which enhances their knowledge of disabilities (Eiserman, Shisler, & Osguthorpe, 1987). Peer tutoring interventions are used as a means of increasing appropriate social behavior in the classroom (Bolich, 2001) or in generalized settings, such as the cafeteria (Kohl & Stettner-Eaton, 1985). In its simplest form, peer tutoring involves a student assisting another student learn a skill or task (Franca, Kerr, Reitz, & Lambert, 1990; Sprick, 1981). Schumaker and Hazel (1984) define social skills as any cognitive function or overt behavior in which an individual engages while interacting with another person or persons (p. 422). In addition, cognitive functions were defined as the ability to empathize, react to social cues, as well as anticipating and making appropriate decisions based upon the presented social behavior. Overt behaviors investigated included verbal and nonverbal interactions such as eye contact and body language.

Peer tutoring is an intervention used in order to teach appropriate social skills to students with various forms of disabilities. Laushey & Heflin (2000) assessed treatment effects on the percentage of appropriate social skills using a reversal design. The participants were two five-year-old males enrolled in Kindergarten. Each of the participants in the study were assigned a buddy (peer tutor). The tutors were trained to stay with, play with, and talk to their buddy. The buddy system structure was removed and the children returned to the passive proximity condition in one phase, and during the second phase, the buddy system was reinstated in order to evaluate the effects. Results indicated that the buddy system elicited more appropriate social skills with the participants than the passive proximity approach.

Video Feedback. Video feedback is a method employed by many educators to enhance communication skills. It is useful because it incorporates feedback in the form of video so it is

easily observable, and the target participant is able to evaluate their own behavior (Fukkink, Trienekens, & Kramer, 2011). A video component of an intervention would allow the interventionist to rewind, pause, and play a segment that is pertinent to a skill in social skills training. Behaviors such as eye contact, hand gestures, and verbal initiation or response may be more apparent to the observer. A variation of video feedback includes positive modeling, which focuses on successful interactions by the participant in order to reinforce the target behavior (Fukkink et al. 2011).

Embregts (2000) assessed the effectiveness of a video feedback and self-management package on the frequency of inappropriate social behavior that was exhibited by children with mild intellectual disabilities. The researcher videotaped six students who were diagnosed as either mildly intellectually disabled or as a borderline intellectual functioning with an associated disorder according to the DSM-III-R. The research was conducted at a residential facility for children with mild intellectual disabilities. Each participant was videotaped during lunch and dinner time, and during group meetings. While the participants viewed the video, they monitored, recorded, evaluated as well as reinforced their appropriate behaviors. Results show that five of the six participants decreased inappropriate behavior during intervention. The participants also maintained appropriate behavior during the maintenance stage of the study. The present study suggested that video feedback is effective in reducing the number of inappropriate social behaviors as well as increasing the number of appropriate social behaviors. Due to the nature of this study, generalization to natural settings and maintenance occurred easily for each participant.

Video feedback has been employed in order to teach verbal social interaction skills to children with Autism. Maione and Mirenda (2006) increased the frequency of social initiations and responses from a young male with Autism. The participant's language ability was scored significantly below his age level according to the *Clinical Evaluation of Language*

Fundamentals-Preschool (CELF-P; Wiig, Secord, & Semel, 1992). During the video modeling phase, the participant watched three 1-minute video vignettes for interactive play. Following the video, neither the researchers nor his parents talked to him about the video or during the video viewing. The second phase included video modeling plus feedback. After viewing the modeling video, the researcher showed the participant a videotape of himself and a peer engaging in the play activities and helped him evaluate whether he was engaged in appropriate or inappropriate talking. Video modeling, feedback and prompting was the third phase in the study. In addition to video modeling and feedback, the researcher provided a verbal prompt (“remember to talk when you are playing”) as well as a visual prompt (a happy face with the word “talk” below). Results indicated that the participant engaged in more unscripted and scripted verbalizations with video modeling + video feedback + prompting. While video modeling alone was effective in increasing the number of verbal utterances, feedback and prompting were even more effective in addition to video modeling. The results of the study are limited because it only included one participant. There could have been an effect from earlier interventions, which included discrete trial teaching and interventions that included methods of applied behavioral analysis.

Effects of video-feedback interaction training for professional caregivers of children and adults with intellectual disabilities have been investigated by Damen, Kef, Worm, Janssen and Schuengel (2011). Participants were clients and caregivers of a care organization for people with visual disabilities and varying levels of intellectual disabilities. The quality of interaction between professional caregivers and the persons with visual and intellectual disabilities living in group homes were investigated by using the video-based Contact program. Changes in quality were investigated along four aspects of client-caregiver interaction: confirmation of client signals by the caregiver, sequences of client initiatives followed by caregiver responses, sequences of caregiver initiatives followed by client responses, and affective mutuality as an overall rating of

the quality of the relationship. Video-feedback sessions followed group training sessions. Overall, the researchers found that the interventions were effective at increasing the frequency that caregivers responded to clients, for the proportion of initiatives taken by clients that were responded to by caregivers, but no significant increase in client responsiveness was observed.

Conversation skill and interactions between adults are simple, yet complex skills that are necessary in group environments. Rapport may be enhanced through positive interactions, and is especially important when direct support staff members are supporting clients who are vulnerable. The nature of staff-client social interactions was investigated by Reunzel, Embregts, Bosman, van Nieuwenhuijzen, and Jahoda, (2013). Results collected from fifteen direct staff members who worked with individuals with borderline to mild intellectual disabilities indicated that interactions within a residential facility or group home are primarily dominated by staff. Direct questions were more the most frequently used by staff and a very small proportion was asked by clients. In addition, staff explicitly solicits clients into responding more than clients did and therefore a dialogue between the two could not be maintained.

CHAPTER III

METHODOLOGY

Setting

This study was conducted at a large 24-hour residential facility in the Midwest that supports adults who have an intellectual disability as their principal diagnosis. This facility was established in 1887, and began as a facility that focused on treatment of children and adolescents aged 5-18. Through the years, the population has aged and many individuals have transitioned into the community. In 1967, the facility served 2,624 individuals but now supports 128 individuals. The facility is comprised of 4 Intermediate Care Facilities (ICF). Each of the ICFs has 3-4 homes and 8-10 individuals live in a home.

Participants

Target participants. Three adults with disabilities living at the residential facility were invited to participate in the study. Participants included 2 females and 1 male with mild levels of intellectual disability as defined by the DSM-IV-TR. They were between the ages of 25-34 years. Two were Caucasian and one was Native American. In addition to an intellectual disability, all three participants had additional diagnoses from the facility psychiatrist which included Bipolar Disorder, Anxiety disorder, ImpulseControl disorder, Mood Disorder, and Borderline Personality

Disorder. The information regarding current psychiatric diagnosis, intellectual functioning levels, and adaptive behavior scores were collected from previous psychological and psychiatric reports. All three of the participants (Jane, Dan, and Erica) were verbal and understood the concept of the study.

These target participants were nominated for the study by members of an Interdisciplinary Team (IDT) and a behavior analyst who was assigned to the individual's ICF based upon the following criteria: a) diagnosis of mild or moderate intellectual disability, b) inappropriate or infrequent interactions with housemates as perceived by the IDT, behavior analyst, and facility social skills trainer, and c) report by members of the IDT, behavior analyst, and social skills trainer that the individual has a social skill deficit.

All three individuals had IQ scores that ranged from 40-69 with moderate to mild deficits in adaptive functioning. A possible explanation for such a wide range in measured IQ is that the scores were an artifact of the intelligence test that was chosen by the on-staff psychologist at the time of the assessment. The participants also participated weekly in on-campus group sessions that focused on social skills. The social skills trainer reported that topics during sessions were often initiated by the individual, but staying on-topic was a subject that was briefly addressed.

Jane. Jane was a 34-year-old Caucasian woman who had lived at the residential facility for nine years. She met the criteria for Borderline Personality Disorder and an intellectual disability in the mild range. Jane's cognitive and adaptive functioning was assessed using the *Wechsler Abbreviated Scale of Intelligence (WASI)* and the *Vineland Adaptive Behavior Scales – Survey Interview Form, 2nd Edition (Vineland-II)* in 2011. She had obtained a standard score of 55 on the WASI and a standard score of 43 on the Vineland-II, which placed her within the 'low' range. Jane was able to communicate verbally and was able to write. She enjoyed many social activities but displayed impairment related to communication. The members of the IDT noted that

she often made off-topic comments during a conversation which hindered their ability to effectively communicate with her. She attended group social skill sessions inconsistently for seven years before attending the classes on a regular basis for the last three years. The sessions occurred once a week and lasted one hour. In addition to the group sessions, Jane would attend individual session for thirty minutes once a week.

Dan. Dan was a 25-year-old Caucasian male who had lived at the residential facility for six years. He met the criteria for Bipolar Disorder, NOS, as well as mild intellectual disability. His cognitive and adaptive functioning was assessed in 2012 using the *Kaufman Brief Intelligence Test, Second Edition* (K-BIT2) as well the *Vineland Adaptive Behavior Scales – Survey Interview Form, Second Edition* (Vineland-II). He had obtained a standard score of 40 on the K-BIT2 and a standard score of 25 on the Vineland-II. Dan was able to communicate verbally and enjoyed interacting with people and playing sports. Members of the IDT noted that he often made off-topic comments and would switch topics rapidly. Dan had attended social skill sessions for three years. He attended individual sessions for an hour once a week.

Erica. Erica was a 29-year-old Native American female who had been living at the residential facility for six years. She was diagnosed with Mood Disorder, NOS, Borderline Personality Disorder, and an intellectual disability in the mild range. Her cognitive functioning was evaluated in 2010 using the WASI, in which she obtained a standard score of 69. Her adaptive functioning was assessed using the *Scales of Independent Behavior-Revised* (SIB-R) in which her scores placed her in the ‘limited’ range (a standard score had not been reported in her psychological evaluation). She was able to communicate verbally as well as read and write. Erica enjoyed participating in social activities and watching sports. Staff members reported that Erica would attempt to gain attention during times that her housemates were in ‘crisis mode.’ Erica would engage in self-injurious behaviors that would warrant attention from staff members. The

IDT members agreed that Erica should initiate conversation to appropriately gain positive attention instead of causing self-harm to communicate her needs. Erica attended social skill sessions inconsistently for several years before attending on a weekly basis for the past two years. She attended group sessions once a week for one hour and also had an individual session once a week for thirty minutes.

Approval to conduct the research was obtained from Oklahoma State University's Institutional Review Board and the CEO and director of the Department of Human Health Services at the residential facility. Guardian and participant consent was obtained as well as approval from the Interdisciplinary Team members. Furthermore, once consent was obtained from the guardian, individual, and team members, the Human and Legal Rights Committee at the residential facility approved the research. Consent was also obtained from staff members who participated in the study. The objectives and procedures of the study were explained to the guardians and members of the interdisciplinary team, and they had the opportunity to ask any questions they had pertaining to the study. After consent and assent were obtained, baseline data were collected to evaluate the extent of social skill deficits, and to measure interaction levels with peers through direct observation.

Peer tutors. In addition to the three target participants, two peer tutors were selected by the primary researcher. The peer tutors were adults who were employed at the facility who did not have an intellectual disability. The peer tutors were selected because they both had frequent interaction with individuals with disabilities as well as having a record of good work attendance. In addition, 2 direct staff members were selected to engage the target participant in conversation at the end of the peer tutoring session as generalization of skills. These two staff members were selected because they appeared to have good rapport with the participants and had good work attendance.

Richard. Richard was a 58-year-old Caucasian man who had worked at the residential facility for over 30 years. He taught social skills classes that incorporated an eclectic mix of counseling techniques such as how to cope with an anxiety provoking situation as well as how to approach and build relationships with others. He reported that he did not use a structured method but preferred to adapt from multiple techniques and let the participant lead the session.

Wilma. Wilma was a 30-year-old Caucasian woman who was completing her Doctoral Internship at the residential facility. Wilma was familiar with the participants and had a good rapport with them before she was solicited as a peer tutor.

Direct Staff Members. Direct staff members were solicited to participate in the study if they had good rapport with the participants. The staff members who participated in the study were all men who worked in the homes that the participants lived in.

Materials

Several documents were created and used throughout the duration of the study. Two observation sheets were created to collect data for “on-topic” remarks and “conversation initiation.” Interactions with a staff member following the peer tutoring phase were taped using a portable digital audio recorder. An RCA digital voice recorder model VR5320R was used in this phase because it was only necessary to listen to the two people interacting to record data. Furthermore, a digital audio recorder was less intrusive in the natural setting. During the Peer Tutoring + Video Feedback phase, a Sony camcorder model DCR-DVD650 was used to record the conversational exchange between the target participant and the direct staff member. This method was chosen to provide visual feedback to the target participant. The camera was positioned in a discrete area in order to limit distraction to the target participant and direct staff member. In addition, the technology allowed for research assistants to view recorded sessions for inter-rater reliability.

Dependent Variables

Social interaction is the major dependent variable under investigation. Percentage of on-topic comments was recorded for Jane and Dan, whose target behaviors were to stay on-topic. Rate was calculated for the target behavior of conversation initiation for Erica. Staying on topic and conversation initiation were the two target behaviors that were observed. Each generalization session lasted 5 minutes and the numbers of appropriate communicative exchanges were measured during this phase, with an additional 5 minutes for the primary researcher to review the tape with the target participant. Dependent variables were skills that were individualized to fit the needs of each participant.

Independent Variables

The independent variables were the social skills interventions which included a peer tutoring intervention (PT) and a peer tutoring + video feedback intervention (PT + VF). The baseline phases for each participant were collected for a minimum of three data points in the home setting and vocational setting. Observations were scheduled when social skills were easily observed, such as during meal times and when the participant was around other individuals. The setting in which the interventions occurred a room in the building that in which the participant lived in. Two rooms that were utilized were small conference rooms that had minimal noise levels. Participants sat at a table and were positioned at an angle of 45 degrees with respect to one another. Depending on the intervention, the digital recorder or the camcorder was positioned pointing towards the participant from the back of the room to minimize distraction.

Peer Tutoring. The peer tutoring intervention included contact between a pre-selected peer tutor without disabilities and the adult with an intellectual disability (target participant). The peer tutors rehearsed a script from the *Walker Social Skills Curriculum: The Accepts Program* (Walker, McConnell, Holmes, Todis, Walker, & Golden, 1983) for five minutes which included

defining the target behavior, giving examples, and scripted role playing. The following five minutes were guided practice with the peer tutor in which the peer tutor reinforced or provided performance feedback to the target individual. The peer tutoring session took ten minutes each day for an average of four times a week.

Peer Tutoring + Video Feedback. The video feedback component immediately followed the peer tutoring session when the individual was interacting with a staff member assigned in the home. At the end of the session, the target participant reviewed portions of the videotape with the primary researcher. The participant observed his or her social interaction with the staff member and discussed how well they responded to conversational cues with the researcher. Feedback was provided during the viewing of the video and occurred for approximately four days a week.

Experimental Design

The study used a small “n” experimental design due to the limited number of participants. A non-concurrent multiple baseline design across subjects was utilized because consent was not obtained at the same time for all participants. Phases within the design consisted of the baseline phase, the peer tutoring phase, and the peer tutoring plus video feedback phase.

Procedure

Three individuals who had been diagnosed with a mild intellectual disability as well as identified as having a social skill deficit were identified and solicited for participation. The purpose of the study was explained and consent was obtained from the both the participant and the participant’s guardian. The baseline phase measured the dependent variables before intervention was implemented. Baseline was collected for a minimum of three days in the living unit and at vocational settings at various times of the day where interaction with staff members was frequent such as breakfast, lunch, and dinner. The interventions were administered four days a week either in the morning or in the afternoon, depending on the participant’s individual

schedule.

Peer tutoring. Once the data collected during the baseline phase were stable for each time period and setting, the peer tutoring intervention was introduced for the participant. A script was read to the participant to introduce the session and explain why staying on topic or why conversation initiation was important. The script pertained to the skill taught and was from the *Walker Social Skills Curriculum*. Each training lasted approximately 5 minutes. Following the script, a five minute practice with corrective feedback and praise occurred. After the peer tutoring component, the peer tutor left the room and the participant was engaged in a conversation by a direct support staff member who had experience working with the individual through daily interaction and who had reported good rapport with the individual. The primary researcher gave the direct support staff member a conversation topic to discuss with the participant before the conversation occurred. The staff member was instructed to engage the participant in a causal conversation and to not provide feedback regarding on-topic or off-topic statements. The conversation topic was also changed every day to avoid a practice effect. Conversation topics were broad and did not include a topic that could potentially upset the participant, based on prior experience with topics that elicited agitation. The conversation was recorded by using a digital recording device and was later analyzed by the primary researcher.

Peer Tutoring + Video feedback. Once the participant demonstrated an increase in social skill during the peer tutoring phase, he/she was exposed to the peer tutoring + video feedback phase. During this phase, the participant met with the peer tutor at the scheduled time, completed the peer tutoring component, and then engaged in a conversation with the direct staff member. Their conversation was recorded by the primary researcher using a video camcorder that recorded the participant's interaction with the staff member. Following the conversation, the primary researcher viewed the session with the participant. The camcorder used allowed for the primary

researcher to play, pause, rewind, and fast-forward the session with sound. Feedback was given when the participant displayed appropriate target behaviors as well as during areas that they were off-topic or did not initiate a conversation. The primary researcher also asked the participant if they believed they were on-topic or not, and why. Approximately 80% of the video was watched, with minimal time used to fast-forward.

Coding Procedure

Raters coded each 10-s interval on the 5-min digital recorder session and on the videotape as appropriate based on an operationalized definition of appropriate verbal behavior. Any verbal responses that were “on-topic” were counted. Opportunities to appropriately respond were also coded. An opportunity was defined as “a verbal prompt or cue that evokes a verbal response from the individual.” Every time the participant verbally responded, there was an opportunity. However, not all opportunities evoked an appropriate “on-topic” response. Similarly, for the target behavior of “conversation initiation,” each time Erica verbally initiated a conversation (making a statement that evokes a response), the frequency was coded and a rate was recorded for the data point. Rate per minute was calculated for all of the data collected.

Reliability

Reliability and accuracy of the data collected were ensured by having an inter-rater reliability rate of 80%. At least 26% of the material recorded was reviewed by a secondary team member who was trained by the primary researcher on how to code specific behavior. A total count IOA was used to express the percentage of agreement between the total number of responses. Peer tutors were trained by the primary researcher twice before meeting the target participant. The Behavioral Skills Training model was utilized through modeling, practice, and feedback for the procedures. Opportunities for questions were available to both peer tutors at the end of the training session. During the first peer tutoring session with Dan, the peer tutor did not

adhere to the script. Therefore, training was completed again with the peer tutor and the data point was omitted.

CHAPTER IV

RESULTS

Figure 1 depicts results for all three participants. During the baseline period, Jane's behavior was variable and then stabilized over time. Baseline data were collected during seven sessions before the Peer Tutoring phase was introduced. Overall, Jane made appropriate on-topic comments at an average rate of 1.6 comments per minute within a five minute observation. With the initiation of Peer Tutoring, there was an immediate level change. The overall rate of on-topic comments averaged 7.5 comments per minute. Jane demonstrated an average rate of 9.7 on-topic comments during the PT + VF phase. The PT + VF intervention was variable with a range of 8.2-11 comments per minute. In addition to being variable, the target behavior appears to have reached a ceiling of 11 comments per minute. Topics discussed with the direct staff member included activities that she enjoyed doing in the spring time, i.e., trips to Branson, Missouri, foods that she liked to cook, meals that she liked to prepare with her mother, and activities that relaxed her. These topics were not discussed for two days in a row to avoid a practice effect. Inter-rater agreement was conducted for 26% of the data collected with a reliability of 88%. Jane had only one peer tutor and one staff member that was the generalization stimulus. Despite having the most consistent staff members working with her, her data were the most variable out of the three participants.

Baseline data collection lasted five sessions for Dan. During this time, he was on-topic for an average rate of 2.2 comments per minute during the intervals observed. When PT was initiated, Dan demonstrated a level change and was on-topic for an average rate of 7.5 comments per minute of the intervals observed in three sessions. During the PT + VF phase, Dan demonstrated an average rate of 9.8 on-topic comments per minute during the intervals observed. Topics discussed with the direct staff member included shopping trips, purchases he would like to make, video games, games and activities that he enjoyed watching, and sports he enjoyed playing. Dan demonstrated a sharp increase in appropriate responding during the final phase of intervention. Dan had one peer tutor assigned to him, but a second peer tutor substituted once for the assigned peer tutor. Dan also had two staff members who would alternate as the generalization stimulus. Despite having different staff members as peer tutors and generalization stimuli, Dan was able to stay on-topic for the majority of the sessions. Interobserver agreement was conducted for 57% of the data collected with a reliability of 92%.

Baseline data were collected for Erica for a total of four sessions. These sessions occurred while she was at home and at work. During meal times at home, Erica did not initiate conversation (BL 1). However, she did initiate conversation while she was at work in a one-on-one setting. Therefore, more baseline data points were collected while she was at work in order to better represent the peer tutoring phase where she was working one-on-one with a peer tutor and staff member. During the baseline observations, Erica initiated conversation an average rate of .45 times per minute in the five minute observation. Once the respondent answered her, she did not initiate another conversation. During the PT phase, she initiated conversation an average rate of 4.15 times per minute during the five minute conversation. During the PT + VF phase, Erica displayed an average rate of 5.4 initiations per minute during the five minute observation. Erica had two peer tutors and three staff members who were the generalization stimuli due to

scheduling conflicts. Despite the number of people who interacted with Erica during intervention, she was able to initiate conversation with multiple people. Inter-rater agreement was conducted for 33% of the data collected with a reliability of 82%.

Appropriate Verbal Behavior

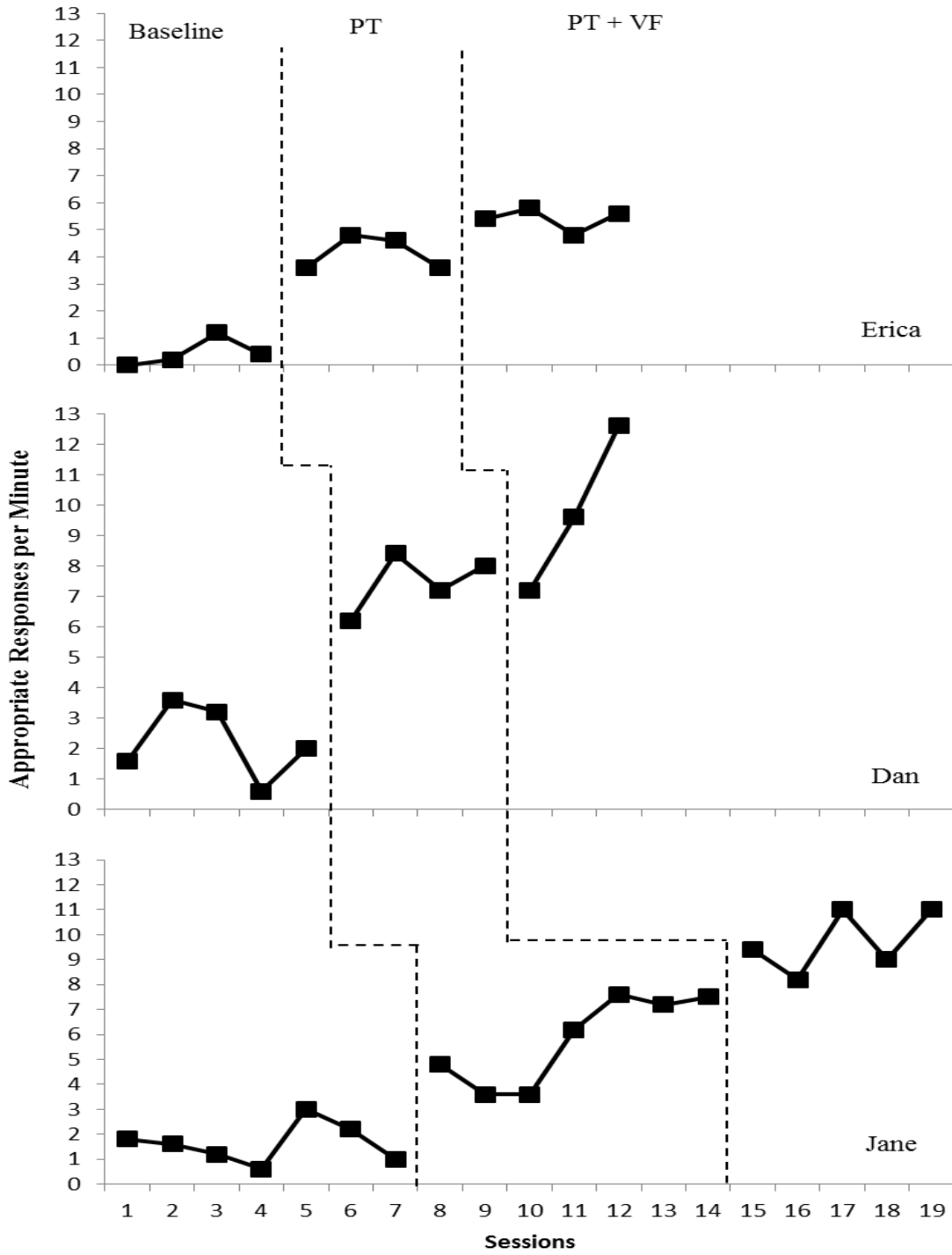


Figure 1 Utilizing peer tutoring in conjunction with video feedback to increase appropriate verbal behavior.

CHAPTER V

DISCUSSION

The results of this study provide preliminary support for a peer tutoring intervention and video feedback in order to enhance social skills with adults who have a mild intellectual disability. Peer tutoring is an intervention that is generally used with children and youth in school settings when increasing social skills. However, the literature is limited when applying this intervention to adults. Furthermore, the effects of video feedback have not been studied in conjunction with Peer Tutoring. The data suggest that peer tutoring is an effective strategy for increasing social skills in adults with mild intellectual disabilities. The data also demonstrated that video feedback does enhance the effects of peer tutoring despite the high levels of appropriate behavior that peer tutoring facilitated. In addition, the data collected during the intervention phases suggest that peer tutoring is effective even when there are multiple peer tutors who intervene with the participant.

The target behaviors for each participant were individualized to fit his or her needs. All three participants were considered candidates to transition into the community. Each participant needed to be able to appropriately communicate his/her needs or stay on-topic to establish and maintain meaningful relationships.

It may be important to consider the cognitive level of the individual when utilizing an intervention such as video feedback. The participants all had mild cognitive deficits with a dual diagnosis of a mood or personality disorder. None of the participants had a communication disability and were able to comprehend the study and the scripts that were used. It should be noted that the raters scored “yeah” as appropriate on-topic verbal behavior but that this did not occur often. One variable to consider was that the effect of the video feedback was delayed. The participants viewed the video immediately following their session with the direct support staff member, but it was not until 24 hours later that generalization data were collected. Despite this variable, the video feedback was effective at enhancing the effects of peer tutoring.

All three participants in the study reported to the primary researcher that they enjoyed viewing their performance during the video feedback phase. Dan appeared to be the least excited about the intervention, as it occurred in the morning. There was also one day when he refused to participate; therefore the data collection phase was shorter for him. With the vulnerable population, it was significant to consider the potential harm in persisting participation when the individual was agitated. There were also days when Erica and Jane were described by staff members to be agitated and to reduce the possibility of the behavior escalating into a ‘crisis mode,’ data collection did not occur that day. However, intervention and data collection occurred at least four times a week. The participants’ previous and current participation in the social skills group that is offered at the residential facility was considered before and during the interventions. Despite being exposed to social skills groups, all three participants’ baseline levels were considered fairly low. In addition, interdisciplinary team members specifically suggested that the skills intervened on would be to stay on-topic for Jane and Dan. Initiation of conversation was not a primary topic discussed in the social skills group.

Limitations

Limitations to the study that need to be considered include the sample. This particular sample includes individuals who live at a 24-hour residential facility, so the intervention effect for individuals in different settings is unknown. Guardian consent is not feasible for all of the individuals who live in the living unit with the target participant. Opportunities to utilize the skills learned may be limited in the community setting, as conversation and settings vary. These skills taught are basic and foundational, but in order to further build upon the skills, more research is needed to teach individuals how to successfully build and maintain relationships in the community. In addition, calculating the percentage for on-topic comments would be more appropriate than rate. However, rate was chosen as the main unit of measurement for all three target behaviors. In addition, a more conservative and meaningful index of IOA such as *Trial-by-Trial IOA* would decrease the chances of overestimating actual agreement.

Future Research

Future directions for this research include a more detailed evaluation of peer tutoring scripts for adults with mild intellectual disabilities. In addition, video feedback alone should be investigated as a possible intervention to increase social conversational skills for adults with mild intellectual disabilities to compare which intervention would be most effective with this population. Finally, future research can investigate if peer tutoring or video feedback will be as effective with adults with other developmental disabilities such as Autism.

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APPENDICES

HUMAN & LEGAL RIGHTS COMMITTEE REQUEST

Name:
DOB:

Date of request:		Address:	
Reason for Review:	<input type="checkbox"/> Annual Review <input type="checkbox"/> New Program <input type="checkbox"/> Revision to program	<input type="checkbox"/> Psychotropic medication <input type="checkbox"/> Enhanced safety plan <input type="checkbox"/> Supportive/safety device	<input type="checkbox"/> General anesthesia <input type="checkbox"/> Pre-sedation <input checked="" type="checkbox"/> Other

List intrusive procedures/restrictions:	There are few to no risks of participation in this study as the target behavior and procedures are similar to those used in the and home setting. The individual's personal information will remain confidential. ID numbers will be assigned to protect the individual's identity.
Rationale:	The information provided will assist researchers in better developing more efficient and effective social skills interventions for individuals with disabilities.
Brief Description of what has been tried before:	
Description of Risk of use versus Risk of not using this recommendation:	
Positive Training Component and criterion for reducing/eliminating:	Peer Tutoring component: a BST member will serve as the peer tutor to train appropriate social skills that the IDT has chosen for [Individual]. Currently, the social skill to be taught will be staying on topic. The Video Feedback component will provide feedback to [Individual] regarding his interaction with a direct support professional. This project should take approximately 3-5 weeks to complete.
QDDP:	
Date IDT Approved	
Date of Guardian approval	
Date submitted for review	

NOTE: Written informed consents from the guardian for medical procedures / psychotropic medications may be found in the Health Record, Consents Section. Written informed consents for the Ambulatory Surgical Center (Dental), may be found in the ASC Record.

HUMAN & LEGAL RIGHTS COMMITTEE REQUEST

Name:
DOB:

QDDP:	
Reason for Review	
Interim Approval, if needed: (Given by/Date)	

Committee Review:	
Date	<input type="checkbox"/> Approved <input type="checkbox"/> Approval pending receipt of informed consent <input type="checkbox"/> Approval pending receipt of changes <input type="checkbox"/> Approval pending receipt of additional information <input type="checkbox"/> Not Approved <input type="checkbox"/> Reviewed and not restrictive <input type="checkbox"/> Committee discussion/follow-up only

See attached form for committee discussion.

Name	Signature	Date

Original to QDDP
 Copies: Human Rights file
 ERecords Drive

Email to QDDP

I will be collecting my dissertation data here at [site]. The purpose of my study is to use Video Feedback to increase appropriate social behaviors when used in conjunction with peer tutoring. I would like to invite (name of individual) to participate in my study. (NAME) will have his/her social behaviors observed in the individual's home during times of appropriate socialization.

There are three phases involved: Baseline (when the individual is observed in the settings to measure social skills before intervention), Peer Tutoring (a staff member who works with the individual to teach him/her appropriate social skills and give direct feedback), and Video Feedback (a video camera will record a 5 minute segment of the individual interacting with his/her staff in the home).

The information provided will assist us in better developing a more efficient and effective social skills intervention for individuals with disabilities. Similar uses of this intervention have been proven to work to increase appropriate social skills in individuals and will likely benefit the individuals who participate in the study. This study has been approved by Oklahoma State University's Institutional Review Board, State of Nebraska DD Services Director, and [site] Medical Director.

The individual's identity will be kept confidential, and only identified through the use of ID numbers. As a QDDP, you do not have to do anything extra, and (NAME) was selected because he is already attending [person's] social skills groups.

I would like to have a special IDT meeting to discuss the project and how it would benefit (NAME). If possible, I would like to invite (NAME)'s guardian to attend either in person or via phone to obtain consent for participation.

Thank you for your time,

Levita Bui, M.S.

Staff Consent Form

Project: Utilizing Video Feedback to Increase Appropriate Social Behaviors When Used in Conjunction with Peer Tutoring

Investigators: Levita Bui, M.S. & Terry Stinnett, Ph.D., Oklahoma State University

Purpose: The purpose of this research is to aid in the development of social skills interventions among individuals with intellectual disabilities. The purpose of this project is to increase appropriate social behaviors such as eye contact and conversation between individuals with intellectual disabilities and their non-disabled peers through two forms of interventions (Peer Tutoring and Video Feedback).

Procedures: You will be assigned to an individual with a disability who is displaying a deficit in appropriate social skills. In this peer tutoring component, you will be trained how to give praise to the individual with a disability when they perform a correct task such as eye contact or appropriately respond in conversation. The training sessions will take approximately 10 minutes, and will occur for 1 day in order for the primary researcher to give instruction and practice with the advocates. A training session would consist of the primary researcher teaching you what task needs to be improved upon (e.g. eye contact), and what to say to the peer in order to praise him/her for their behavior. The intervention will take place in the home. It will last approximately 6 weeks with each 10 minute session taking place 4 days a week.

By signing, you are giving permission to participate in this study as well as permission to have the data available for future publication after the study is over. Your data that is collected will be kept confidential at all times during the study through the use of an ID number which will be given to you at the beginning of the study.

Risks of Participation: There are few to no risks of participation in this study as the target behavior (social skills) and procedures are similar to those used in the general and special education setting. Your personal information will remain confidential. Participant names will not be used at anytime during this study. Only the ID numbers we provide after collecting consent forms will be used.

Benefits: The information you provide will assist us in better developing a more efficient and effective social skills intervention for individuals with intellectual disabilities. Similar uses of this intervention have been proven to work to increase appropriate social skills in individuals and will likely benefit the individuals who participate in the study.

Confidentiality: Your identity will be linked with information collected in this study

through the use of research ID numbers. The data will be permanent records, as they will be video recordings.. The data will be kept confidential. Only the principal investigator, research assistants and the advisor will have access to the data. Data will be stored for five years after the study is complete, and then destroyed. The information obtained in this study will be reported in individual format; pseudo names will be used, and may be published in scientific journals or presented at scientific meetings. However, individual quotes and excerpts from the video recordings will not be used. The Oklahoma State University Institutional Review Board has the authority to inspect consent records and data files to assure compliance with approved procedures.

By signing, you are giving permission to participate in this study as well as permission to have your data available for future publications after the study is over. Your identity will be kept confidential at all times during the study through the use of an ID number which will be given to you at the beginning of the study.

Contacts: You may ask questions regarding this research and have these questions answered before agreeing to participate in the study. You may also ask questions during the study. You may call Levita Bui, M.S., [#], or Terry Stinnett, Ph.D., [#] at any time to discuss this research. If you have any questions about the research and your rights as a research volunteer, you may contact Dr. Shelia Kennison, IRB Chair, 219 Cordell North, [#] or irb@okstate.edu.

Participants' Rights: You are free to decide whether or not you will participate in this study or to withdraw your participation at any time without reprisal or penalty. In the case of withdrawal, all data that had been collected will be destroyed in order to protect your confidentiality.

Please check one box below and return in the enclosed envelope. Thank you.
I have read and fully understand this information.

I DO **I DO NOT**
agree to participate in this research study at [site].

Name (please print)

Signature

Date

Levita Bui, M.S.
Graduate Student OSU
School Psychology

Terry Stinnett, Ph.D.
Professor OSU
School Psychology

Guardian & Participant Consent Form

CONSENT FOR RESEARCH

Name:
DOB:

Project: Utilizing Video Feedback to Increase Appropriate Social Behaviors When Used in Conjunction with Peer Tutoring

Investigators: Levita Bui, M.S., Terry Stinnett, Ph.D., Oklahoma State University

Purpose: The purpose of this research is to aid in the development of social skills interventions among individuals with intellectual disabilities. The purpose of this project is to increase appropriate social behaviors such as eye contact and conversation between individuals with intellectual disabilities and their non-disabled peers through two forms of interventions (Peer Tutoring and Video Feedback).

Procedures: The target individual will have his/her social behaviors observed in the social skills classroom as well as the individual's home during times of appropriate socialization. There are three phases involved: Baseline (when the individual is observed in a natural setting to measure social skills before intervention), Peer Tutoring (a staff member who is familiar with the individual to teach him/her appropriate social skills and give direct feedback), and Video Feedback (a video camera will record a 5 minute segment of the individual interacting with his/her peer, a direct support staff member, in the home setting). During the Video Feedback phase, the primary investigator will replay the video with the individual and both will discuss how well they performed or if there was a situation that could have been improved. The interdisciplinary team members will determine the social skill that the individual is lacking, and they will be the targeted skills.

Comparing these two procedures will determine if Video Feedback enhances the learning outcome for individuals when used with Peer tutoring. The intervention will take place in the individual's home (10 minutes). It will last approximately 6 weeks with each 10 minute session taking place 4 days a week. Only individuals who have had permission returned will participate in the study.

By signing, you are giving permission for the individual you support to participate in this study as well as permission to have their data available for future publication after the study is over. Their data will be kept confidential at all times during the study through the use of an ID number which will be assigned to them at the beginning of the study.

Risks of Participation: There are few to no risks of participation in this study as the target behavior (social skills) and procedures are similar to those used in the community and home setting. The individual's personal information will remain confidential. Upon request the guardian can have access to individual

data. Individual names will not be used at any time during this study. Only the ID numbers we provide after collecting consent forms will be used.

Benefits: The information provided will assist us in better developing a more efficient and effective social skills intervention for individuals with disabilities. Similar uses of this intervention have been proven to work to increase appropriate social skills in individuals and will likely benefit the individuals who participate in the study.

Confidentiality: The individual’s identity will be linked with information collected in this study through the use of research ID numbers. The data will be permanent records, as they will be video recordings. Only the primary researcher, advisor, and research assistants will be able to access the data. The data will be kept confidential.

Only the principal investigator, research assistants and advisor will have access to the data. Data will be stored for five years after the study is complete, and then destroyed. The information obtained in this study will be reported in individual format and fictional names will be used. These may be published in scientific journals or presented at scientific meetings. However, individual quotes and excerpts from the video recordings will not be used. The Oklahoma State University Institutional Review Board has the authority to inspect consent records and data files to assure compliance with approved procedures. By signing, you are giving permission for the individual you support to participate in this study as well as permission to have their data available for future publications after the study is over. Their identity will be kept confidential at all times during the study through the use of an ID number which will be assigned to them at the beginning of the study.

Contacts: You may ask questions regarding this research and have these questions answered before agreeing to participate in the study. You may also ask questions during the study. You may call Levita Bui, M.S., [#], or Terry Stinnett, Ph.D., [#] at any time to discuss this research. If you have any questions about the research and your rights as a research volunteer, you may contact Dr. Shelia Kennison, IRB Chair, 219 Cordell North, Stillwater, OK, 74078, [#]or irb@okstate.edu.

Participants’ Rights: You are free to decide whether or not the individual you support will participate in this study or to withdraw their participation at any time without reprisal or penalty. In the case of withdrawal, all data that had been collected will be destroyed in order to protect participant confidentiality. Your signature below authorizes the use of video in the [site]for training purposes as noted above. Not to exceed 365 days.

Name		Signature	Date
Participant			
Guardian			

Levita Y. Bui Pre-Doctoral Psychology Intern	Terry Stinnett, Ph.D. Professor OSU, School Psychology
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Oklahoma State University Institutional Review Board

Date: Wednesday, October 31, 2012

IRB Application No: ED11176

Proposal Title: Utilizing Video Feedback to Increase Appropriate Social Behaviors When Used in Conjunction With Peer Tutoring

Reviewed and Processed as: Expedited

Status Recommended by Reviewer(s): Approved

Protocol Expires: 10/30/2013

Principal Investigator(s):

Levita Bai
305 1/2 S. Duncan
Stillwater, OK 74074

Terry Sirmatt
445 Willard
Stillwater, OK 74078

The IRB application referenced above has been approved. It is the judgment of the reviewers that the rights and welfare of individuals who may be asked to participate in this study will be respected, and that the research will be conducted in a manner consistent with the IRB requirements as outlined in section 45 CFR 46.

The final versions of any printed recruitment, consent and assent documents bearing the IRB approval stamp are attached to this letter. These are the versions that must be used during the study.

The reviewer(s) had these comments:

The application as modified 10/31/12 is approved.

As Principal Investigator, it is your responsibility to do the following:

1. Conduct this study exactly as it has been approved. Any modifications to the research protocol must be submitted with the appropriate signatures for IRB approval.
2. Submit a request for continuation if the study extends beyond the approval period of one calendar year. This continuation must receive IRB review and approval before the research can continue.
3. Report any adverse events to the IRB Chair promptly. Adverse events are those which are unanticipated and impact the subjects during the course of this research; and
4. Notify the IRB office in writing when your research project is complete.

Please note that approved protocols are subject to monitoring by the IRB and that the IRB office has the authority to inspect research records associated with this protocol at any time. If you have questions about the IRB procedures or need any assistance from the Board, please contact Beth McTernan in 219 Cordell North(phone: 405-744-5700, beth.mcternan@okstate.edu).

Sincerely,



Sheila Kennison, Chair
Institutional Review Board

Protocol for Peer Tutoring: On-Topic

Peer Tutor: “Hi [name], today we are going to talk about staying on topic when we talk to others. Making sense, or staying on topic is important because it allows a good conversation to occur and continue.

-Read script and discuss for 5 minutes.

Peer Tutor: “Let’s practice some scenarios. Do you want to talk about (past trips, future trips, what he likes to go shopping for)? Practice for 5 minutes.

Peer Tutor: “Thanks for working with me today. I’ll see you tomorrow afternoon.”

(At this time, [Name] will be prompted to engage in a conversation by one of his staff members, and I will observe.)

Thanks!

Protocol for Peer Tutoring Conversation Initiation

Peer Tutor: “Hi Erica, today we are going to talk about starting a conversation with others. Starting a conversation with others allows us to make friends and also get attention in a positive and friendly way.

-Read script and discuss for 5 minutes.

Peer Tutor: “Let’s practice for a few minutes. It will be up to you to initiate a conversation with me, and to keep the conversation going. If there is a long pause, you need to bring up something else to talk about. Practice for 5 minutes.

If there is a pause longer than 5 seconds between sentences, prompt her to initiate another conversation and give her feedback. You may also model for her too by providing an example of a conversation starter.

Peer Tutor: “Thanks for working with me today. I’ll see you tomorrow afternoon.”

(At this time, Erica will be prompted to engage in a conversation by one of her staff members, and I will observe.)

Thanks!

Script for Erica-Adapted from *The Walker Social Skills Curriculum: The Accepts Program*
Program: Starting

Step 1: DEFINITION AND GUIDED DISCUSSION

Definition:

“Starting means finding someone to talk to. What does Starting mean?”

FINDING SOMEONE TO TALK TO (Reinforce or correct)

“Let’s say this another way: finding someone to talk to is called *starting*. Finding someone to talk to is called what?”

STARTING (Reinforce or correct)

“Let’s try some more: Sam was at work. Sam found someone to talk to. Sam was doing what?”

STARTING (Reinforce or correct)

“How do we know Sam was *starting*?”

HE/SAM FOUND SOMEONE TO TALK TO (Reinforce or correct)

“You are having a break. You find someone to talk to. You are doing what?”

STARTING (Reinforce or correct)

Guided Discussion:

“Starting is the first thing you need to do to initiate a conversation. This is how you start: First, you find a person to talk to. When you start, what do you do first?”

FIND A PERSON TO TALK TO (Reinforce or correct)

“Next, you should look at the person and say something. What should you do next?”

LOOK AT THE PERSON AND SAY SOMETHING (Reinforce or correct)

“Asking how someone’s day is going is another way of starting. Talking about the weather is another way to start. What are some other ways to start?” (Discuss/suggest examples such as asking the person about their plans for the weekend, or how you feel, etc.)

“Starting is how you get to talk and interact with people. How do you get to talk and interact with people?”

START(ING) (Reinforce or correct)

“Finding someone to talk to is called *starting*. Finding someone to talk to is called what?”

STARTING (Reinforce or correct)

Step 2: Criterion Role Plays

“Ok, now we are going to practice starting. Let’s say that you and I are by ourselves at the Snack Place. Pretend we don’t know each other very well. What would you say to me?”

Prompt different ways of starting, if needed. Reinforce or correct as needed.

“Ok, now let’s say that I am a staff member and you are stressed about work. What would you say to me?”

Prompt different ways of starting, if needed. Reinforce or correct as needed.

“Pretend that everyone here is celebrating a special event. You sit down next to a friend, and say what?”

Prompt different ways of starting, if needed. Reinforce or correct as needed.

“Let’s say that the weather outside is nice. What are some things that you can say to me to start a conversation?”

Prompt different ways of starting, if needed. Reinforce or correct as needed.

End! Now practice for 5 minutes. Don’t say anything, and let her start the conversation. You may respond to the conversation that she initiates, but don’t try to keep the conversation going by asking another question. If she doesn’t start in 5 seconds, prompt her to begin by saying, **“This is a good time to start a conversation, what would you say?”** If you answer her question and she doesn’t respond or keep the conversation going, tell her **“this is a good time to say something else to keep the conversation going, or to start a new topic to avoid it being awkward.”**

Script for Jane and Dan- Adapted from *The Walker Social Skills Curriculum: The Accepts Program : Making Sense*

Step 1: DEFINITION AND GUIDED DISCUSSION

Definition:

“Making sense means talking about the same things. What does making sense mean?”

TALKING ABOUT THE SAME THINGS (Reinforce or correct)

“Let’s say this another way. Talking about the same things is called *making sense*. Talking about the same things is called what?”

MAKING SENSE (Reinforce or correct)

“Nick and Scott are talking about the same things. Nick and Scott are doing what?”

MAKING SENSE (Reinforce or correct)

“How do we know Nick and Scott are making sense?”

THEY/NICK AND SCOTT ARE TALKING ABOUT THE SAME THING (Reinforce or correct)

“When you and your friend talk about the same things you are making sense. When you and your friend talk about the same things you are doing what?”

MAKING SENSE (Reinforce or correct)

Guided Discussion:

“Talking about the same things shows people you are listening. When you listen to what a person is talking about, then you can talk about the same thing. If someone talks to you about work and you talk about work too, you are making sense. If someone talked to you about what he had for lunch and you talked about your math worksheet, would you be making sense?”

NO (Reinforce or correct)

“If a friend talked to you about what she did on Saturday and you talked about what you did on Saturday, would you be making sense?”

YES (Reinforce or correct)

“If a group of your friends were talking about a new movie you had just seen, what should you talk to them about?”

THE NEW MOVIE (Reinforce or correct)

Step 2; Criterion Role Plays

“Let’s pretend you just learned how to tell time and you have a brand new watch on. Someone comes up to you and asks you what time it is. What should you do to make sense?”
(Criterion: Participant suggest telling the person what time it is).

“Pretend your whole home goes jogging around the campus every day after lunch. Let’s say I come running up to you with some new running shoes on and start talking to you like this: “Hey look, I just got a new pair of shoes!” What are some things you might say to make sense?” *(Criterion: participant makes sense by saying something about the shoes)*

“Let’s say your home has just come back from a trip to the zoo. Everyone is talking about the animals they saw. Let’s say one person says, ‘I saw a big lion sleeping in the shade’. What are some things you could say to make sense?” *(Criterion: Participant makes sense by talking about a zoo).*

Informal Contracting:

“Today I want you to make sense when someone talks to you. What are you going to do today?”

MAKE SENSE (Reinforce or correct)

Observation Form Conversation Initiation

Name:	Date:
Time:	Peer Tutor:
Setting/subject:	Name of Observer:

	0-10	11-20	21-30	31-40	41-50	51-60
1m						
2m						
3m						
4m						
5m						

F: _____/Time: __ =Rate _____

Observation Form: Staying on-topic

Name:	Date:
Time:	Peer Tutor:
Setting/subject:	Name of Observer:

	0-10	11-20	21-30	31-40	41-50	51-60
1m	+	+	+	+	+	+
	O:	O:	O:	O:	O:	O:
2m	+	+	+	+	+	+
	O:	O:	O:	O:	O:	O:
3m	+	+	+	+	+	+
	O:	O:	O:	O:	O:	O:
4m	+	+	+	+	+	+
	O:	O:	O:	O:	O:	O:
5m	+	+	+	+	+	+
	O:	O:	O:	O:	O:	O:

+ = Appropriate response (on task) O: Opportunity to respond

F: _____/Time: __ =Rate _____

VITA

Levita Yen Bui

Candidate for the Degree of

Doctor of Philosophy

Dissertation: UTILIZING VIDEO FEEDBACK TO INCREASE APPROPRIATE
SOCIAL BEHAVIORS WHEN USED IN CONJUNCTION WITH PEER
TUTORING

Major Field: Educational Psychology

Specialty: Intellectual Disabilities/Developmental Disabilities

Biographical:

Education: 2004-2007 Bachelor of Arts, Major in Psychology,
University of Kansas

2008-2009 Master of Science in Educational Psychology,
Oklahoma State University

Completed the requirements for the Doctor of Philosophy in Educational
Psychology at Oklahoma State University, Stillwater, Oklahoma in July, 2013.

Experience:

Professional Memberships:

National Association of School Psychology (NASP) 2008-Present

American Psychological Association 2008-Present

Oklahoma School Psychology Association (OSPA) 2008-2010

School Psychology Graduate Organization (SPGO) 2008-2012