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# The Development of Social Competence in Children with Disabilities

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Children with disabilities experience unique challenges in developing social skills critical to achieve their social goals. Although there are individual differences, children with delays and disabilities may struggle to communicate with others, understand gestures, and take other people's viewpoints. These differences may prevent children with disabilities from initiating and sustaining social interactions and, in turn, from developing high levels of social competence (Hebbeler & Spiker, 2016).

To support social development of children with disabilities, it is important to promote positive relationships within the family system as well as the teaching of social skills in inclusive early learning environments (Mahoney et al., 2020). The Collaborative for Academic, Social, and Emotional Learning (CASEL) is a framework for

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supporting social emotional learning (SEL) from preschool through high school and across home and school settings (Weissberg et al., 2013). CASEL focuses on five SEL core competencies that include self-awareness, self-management, social awareness, relationship skills, and responsible decision-making. These social and emotional competencies provide a foundation for children to adjust to challenges, develop positive relationships with peers and adults, and engage in learning tasks in ways that can benefit children with disabilities (Durlak et al., 2011).

In this chapter, we first introduce two theoretical frameworks that can guide research and practice relevant to social competence of children with disabilities. Second, we discuss personal and contextual factors that either facilitate or hinder social development of children with disabilities in everyday interactions. Third, we address cultural understandings of disability that influence children's socialization within family and community contexts. Finally, we conclude with the implications of using social intervention approaches for children with disabilities in home, school, and community-based contexts.

### **Theoretical Frameworks**

Bronfenbrenner's bioecological model of human development (Bronfenbrenner & Morris, 2006) and Bandura's social cognitive theory (Bandura, 2012) help explain the development of social competence in children with disabilities through interactions between personal and contextual factors. First, the bioecological model of human development suggests that the primary engine of development is proximal processes, the interactions between the individual and their environments that occur regularly and over an extended period of time (Bronfenbrenner & Morris, 2006), and these sustained interactions either facilitate or ameliorate the individual's development. Personal characteristics, broadly defined, also make significant contributions to whether the impact of environmental factors are minimized or maximized. Having a disability is one of the key personal characteristics that evokes various responses from the individual's interpersonal and structural environments. Because the individual does not have control over this personal characteristic, it is important to provide sustained,

enriching environments that positively actualize the individual's developmental and learning potential. Additionally, the bioecological model emphasizes the importance of taking cultural beliefs and norms into account as part of the contextual and systemic factors that influence an individual's development.

The second theoretical framework, social cognitive theory, also proposes personal, environmental, and interactive processes as the mechanism of human development (Bandura, 2012). Bandura proposed that a child's development is impacted by the interplay of individual differences in how children process new social information (cognition), how they respond to the information (behavior), and how their environment either supports or ameliorates the learning process (i.e., triadic reciprocal causation model). Children with disabilities develop within a dynamic interrelationship between their unique personal factors, their behavior, and the environments' response to their characteristics and behavior.

These two theoretical frameworks set the stage for understanding how personal factors and contextual factors interact with each other to facilitate social development of children with disabilities. There is a dynamic interplay between children's personality, language, and communication skills and various environmental and cultural factors. Additional personal factors (e.g., comorbid disabilities) and contextual elements (e.g., enrollment in high-quality inclusive educational programs) also influence the development of social competence in children with disabilities.

### **Personal Characteristics Associated with Social Competence of Children with Disabilities**

Children with disabilities exhibit various levels of social competence depending on their personal characteristics. In this section, we describe characteristics of children with five different types of disabilities and the impact of disability on social competence. The five categories of disabilities include physical disabilities, visual impairment, Down syndrome, mild intellectual and developmental disabilities and learning disabilities, severe disabilities, and autism spectrum disorders (ASD), the latter of which is thoroughly discussed in Chapter 39

(this volume). It is important to note that children with the same disability may share common attributes, but there is also significant heterogeneity within disability categories.

### *Children with physical disabilities*

Children with physical disabilities, including mild physical disabilities, are at-risk for increased difficulty with peer relationships, such as experiencing fewer friendships and lower popularity, while also experiencing more social rejection, isolation, and peer victimization (Bennett & Hay, 2007). Limitations in mobility may lead to social isolation due to barriers presented by the required use of mobility devices, special transportation needs, assistance needed from others for movement, and obstacles to physically accessing spaces or activities where peers are located (Whittingham et al., 2010). In addition, children with physical disabilities tend to encounter fewer opportunities for engagement in activities with peers. As such, young children with more severe physical disabilities may experience more difficulty in developing social competence.

Delays and disabilities that co-occur with physical disabilities may complicate children's development of social competence. For example, children diagnosed with cerebral palsy with different speech-language profiles demonstrate lower levels of social skills regardless of a diagnosed speech-language delay; children with more severe communication impairments had even more limited social skills (McFadd & Hustad, 2013).

### *Children with visual impairment*

Children with visual impairment can develop similar levels of social competence relative to their peers without disabilities and build close relationships with others. However, children with visual impairment (i.e., low vision and blindness) are likely to have moderate levels of social skills, which can impact their social interactions, social competence, and abilities to form peer relationships (Zebehazy & Smith, 2011). Problems in social skills of children with visual impairment can be noticed in infancy (Dale & Salt, 2007). Children with visual impairment experience unique challenges in building foundational skills for

developing social cognition, such as perspective-taking and joint attention (Zebehazy & Smith, 2011). The presence of visual impairment may delay other skills that promote social interactions such as observing, interpreting, and understanding subtle verbal and nonverbal or visual (e.g., facial and physical gestures) social cues. Children with visual impairment also struggle with self-monitoring their social behaviors (Jindal-Snape, 2005).

The severity and the timing of a child's visual impairment influence the development of their social competence (Pinquart & Pfeiffer, 2013). Compared to those without visual impairment, children and adolescents with visual impairment have less frequent social interactions with peers, engage in more solitary play activities, experience more difficulty in initiating or sustaining interactions, and tend to be more isolated from peers due to their preferences for interactions with adults (Celeste, 2006; D'Allura, 2002). As children with visual impairment get older, they may experience fewer friendships and smaller social networks, which might increase the risk of loneliness (Veerman et al., 2019).

Having visual impairment can limit children's social interactions with peers; however, verbal skills, body language, and expression and recognition of emotions can facilitate the quality of their social interactions (Caballo & Verdugo, 2007). In addition, personality traits of children with visual impairment, such as extroversion, are with their ability to build friendships with others (Veer associated man et al., 2019). Focusing on enhancing social interaction skills for children with visual impairment may increase their overall social competence, which provides opportunities for establishing and maintaining peer relationships into adulthood and decreased feelings of loneliness later in life.

### *Children with Down syndrome*

A commonly held belief is that children with Down syndrome do not experience difficulties in developing social competence due to their general social nature (Cebula et al., 2010). Children with Down syndrome seem to display a normative trajectory for essential sociocognitive skills such as joint attention, imitation, empathic behaviors, and non-verbal pointing and requesting (Cebula et al., 2010). However,

children with Down syndrome experience global intellectual delays that intensify with age and achieve sociocognitive milestones more slowly than those without Down syndrome.

Adding complexity to the social profile of children with Down syndrome are the nuances found within their sociocognitive skill development. For example, although children with Down syndrome tend to reveal less internal distress, their empathic responses are more robust when an adult shows distress (Cebula et al., 2010). Dieleman et al. (2018) reported that parental descriptions of internalizing behaviors (e.g., anxious and withdrawn behavior) for their children with Down syndrome increased with age in Belgium and the Netherlands. The researchers speculated that this might reflect their ability to show personal distress as they grow older.

Emotional knowledge includes the ability to reflect on one's own emotions, recognize emotions in others, label observed emotions, and identify reasons for emotions in oneself and others, which is foundational for successful social interactions and learning (Durlak et al., 2011). A challenge for children and adults with Down syndrome is to use information gained through their emotion knowledge and social referencing to direct their actions (Cebula et al., 2010). In addition, adolescents with Down syndrome continue to have difficulty understanding others' emotions and processing emotion-related information as illustrated by a recent study that assessed their emotion knowledge using video-recorded scenarios (Channell et al., 2014). Further research is needed to examine how children with Down syndrome can learn to generalize and fluently use emotion knowledge in live situations as well as use emotion knowledge for self-regulating behavior in social interactions.

Children with Down syndrome sometimes experience comorbidity with other disabilities, such as attention-deficit/hyperactivity disorder (ADHD) and ASD, which can further delay cognitive, social-emotional, and behavioral outcomes. In addition, difficulties with cognitive development for children with Down syndrome tend to be interwoven with language delays, with receptive language skills being stronger over time than expressive language (Davis, 2008). These delays coupled with delays in speech and communication can impact play skills of culturally and linguistically diverse children with Down syndrome, especially those involving symbolic thinking and communication (Joginder Singh et al., 2014).

### *Children with mild intellectual and developmental disabilities or learning disabilities*

Intellectual or developmental disabilities may negatively impact children's social functioning. In the United States, developmental disabilities refer to a set of conditions inhibiting children's physical capabilities, learning-related abilities, and behavioral functioning (Centers for Disease Control and Prevention, 2019). The prevalence rate of developmental disabilities in children in the United States is approximately 1 in 6 (Zablotsky et al., 2019), and, globally, 52.9 million children under the age of five are reported as having developmental disabilities (Olusanya et al., 2018). Of these children, 95% are from low-and middle-income countries.

Children with mild intellectual and developmental disabilities (MIDD) experience difficulties in social understanding that leads to difficulty with social functioning (Smogorzewska et al., 2019). Children with MIDD are generally perceived as being antisocial or as displaying inappropriate behaviors during peer interactions (Zion & Jenvey, 2006). Children with MIDD could have negative social interactions due to a lack of communication skills which adds more challenges in initiating and maintaining peer interactions (Smogorzewska et al., 2019; Thirion-Marissiaux & Nader-Grosbois, 2008). Many children with MIDD also have delayed development of theory of mind abilities (Baurain & Nader-Grosbois, 2013). This delay in the ability to interpret and predict the behavior of others naturally causes interpersonal problems for children with MIDD (Alevriadou & Giaouri, 2011; Thirion-Marissiaux & Nader-Grosbois, 2008). Children with MIDD also encounter difficulties in recognizing and understanding others' facial expressions (Bloom & Heath, 2009; Tipton et al., 2013; Wiener & Schneider, 2002). For children with MIDD, delays in their social and cognitive development may contribute to ongoing challenges in developing peer competence which could lead to difficulties creating and sustaining friendships (Guralnick et al., 2007). Children with MIDD who are socially isolated are more likely to be bullied, and those who engage in aggression may be viewed by peers and teachers as bullies (Estell et al., 2009).



*Children with severe intellectual and developmental disabilities*

Without a singular definition, severe disabilities can be conceptualized as diagnoses of moderate, severe, or profound intellectual disability (Rossetti & Keenan, 2018). Severe disabilities include ASD, multiple physical or sensory disabilities comorbid with intellectual disability, and other disabilities that require a continuum of daily supports across multiple environments (Rossetti & Keenan, 2018). Children with severe disabilities may struggle to develop social competence. Initiating interactions with and appropriately responding to peers can be a significant challenge, especially for those with communication difficulties. Chung et al. (2012) observed social interactions between peers and 16 children in middle childhood and early adolescence who identified under categories of ASD or intellectual disability and who used Augmentative and Alternative Communication (AAC) Systems (e.g., communication books). The researchers affirmed prior research findings that children with severe disabilities directed more of their interactions with adults than with peers, even when in the presence of peers. Children with severe disabilities rarely initiated social interactions towards peers and inconsistently responded to peers' initiations. When they did initiate a peer interaction, it was typically to express a want or need.

Some of the social issues facing children with severe disabilities may be explained by the responsiveness or lack of responsiveness of their peers since social interactions require two-way communication. Peers may be less responsive than adult communication partners for children with severe disabilities who use AAC (Therrien et al., 2016). Further, some peers may hold negative attitudes towards individuals with significant disabilities, which may decrease their motivation to interact. A thematic literature review of 13 empirical studies spanning the past 30 years of research on friendships between students with and without severe disabilities from kindergarten through Grade 12 shows qualitative differences in the friendships between the two groups (Rossetti & Keenan, 2018). These friendships may be more asymmetrical with typically developing peers taking a leader or helper role more often than children with severe disabilities. Thus, the relationship may appear more similar to acquaintances than close friends. Importantly, the severity of a student's disability did not determine

whether they developed or derived satisfaction from a quality friendship (Rossetti & Keenan, 2018). However, barriers to friendship may arise that are associated with severe disability, such as physical mobility or reactivity to sensory input.

In summary, the types and characteristics of disabilities may impact children's social development in conjunction with other individual differences, such as language and communication skills and personal factors, such as temperament.

### **Contextual Factors Associated with Social Competence of Children with Disabilities**

In addition to personal and developmental characteristics, various contextual factors influence how children with disabilities develop social competence. In this section, discussion focuses on how external experiences and supports impact the development of social competence in children with disabilities. Three external factors are described: intervention programs, family-school partnerships, and technology supports.

#### *Classroom-based intervention programs*

There are a variety of evidence-based programs that support the development of children's social competence, including classroom-based intervention programs. Classroom-focused curricula directly teach children social and emotional competencies and help teachers use positive behavior guidance strategies (January et al., 2011). These programs tend to focus on warm, secure adult-child relationships, predictable routines, and positive behavioral supports to reinforce rules and resolve conflicts (Bierman & Motamedi, 2015). Some programs, such as I Can Problem Solve (Shure, 1992), focus on social information processing that links covert thinking to social perceptions, social goals, and social problem solving that, in turn, promotes children's theory-of-mind abilities and social skills (Smogorzewska & Szumski, 2018). Other approaches focus on emotions, using attachment theory (Denham & Burton, 2003), differential emotions theory (Izard, 2002), or developmental models of self-regulatory processes (Bierman et al., 2008).

Examples of evidence-based social competence programs include Incredible Years (Webster-Stratton, 2001), BEST in Class (Conroy et al., 2015), and Second Step developed by the Committee for Children. While classroom-based intervention programs were not developed specifically for children with disabilities, research has found evidence-based social competence programs effective for a range of disabilities (Espelage et al., 2015; Reinke et al., 2021). Randomized control trials have demonstrated their effectiveness in improving children's social skills, peer relationships, and academic outcomes (Weissberg et al., 2013). Incredible Years has been implemented with culturally and linguistically diverse children and families (Webster-Stratton & Bywater, 2019). In addition, social competence programs have been developed specific for their cultural contexts, such as Aprender a Convivir (Benítez et al., 2011) in Spain, Projet PRIMAIR (Petermann & Natzke, 2008) in Luxembourg, and Fun Friends (Barrett, 2007) in Australia; all of which have demonstrated a decrease in children's challenging behaviors and an increase in their social competence (Justicia-Arráez et al., 2015; Pahl & Barrett, 2010).

Recently, some classroom-based programs have focused on improving teachers' social competence so that they can create a more positive classroom climate and respond to children's social and emotional needs (Schonert-Reichl, 2017). The Prosocial Classroom Model (Jennings & Greenberg, 2009) addresses teachers' own SEL in combination with teachers' promotion of positive and effective classroom and behavior management. Attending to teachers' social emotional competence is necessary to reduce their stress, a key mitigating factor in teachers' use of inappropriate discipline such as suspension and expulsion (Zinsler et al., 2019).

Many social competence programs incorporate professional development for teachers so they can implement the program with fidelity. Positive behavioral interventions and supports (PBIS) is a tiered framework that includes an emphasis on professional development for teachers. PBIS is based on a public health model of increasing supports for children utilizing evidence-based practices that have been associated with positive social and academic outcomes (Fox & Hemmeter, 2009). The PBIS framework includes universal strategies for all children focused on clear expectations and positive relationships, followed by targeted social teaching strategies for some children and

individualized function-based interventions for children with severe challenging behavior (Horner et al., 2010). PBIS includes data-based decision making and professional development for teachers as foundational components (Johnson, 2017). A growing literature has demonstrated the positive impact of PBIS on teachers' skills and child outcomes in early childhood learning environments (Benedict et al., 2007; Hemmeter et al., 2016) and K-12 settings (Bradshaw et al., 2015; Estrapala et al., 2020; James et al., 2019; Noltemeyer et al., 2019).

While PBIS is intended to include all children in an early childhood program or school, professionals may struggle to include children with disabilities in the effort (Shuster et al., 2017). For example, 69% of PBIS state coordinators did not have strategies identified to include students with disabilities in their school-wide PBIS (Landers et al., 2012). This is unfortunate, as a school-wide PBS framework has the potential to address the social competence needs of children with disabilities (Shuster et al., 2017). In addition to efforts to more intentionally include children with disabilities, the PBIS framework also makes efforts to include more explicit guidance around providing a culturally responsive model of tiered supports to children from culturally and linguistically diverse backgrounds (Bal, 2018; Leverson et al., 2016).

Overall, it is important that children with disabilities are supported in inclusive educational settings and in their homes and communities, with the use of effective interventions that focus on improving their SEL. Efforts would ideally combine child-led social curricular approaches with teacher-focused support and vertically aligned frameworks such as PBIS that attend to professional development, school and home connections, and fidelity of implementation (Osher et al., 2010). This kind of combination would provide horizontal alignment of approaches to ensure that a variety of prevention and intervention strategies are utilized to meet the needs of all children (Cook et al., 2015).

### *Family-school partnerships*

It is important for professionals to partner with families and community members to ensure positive social outcomes for children (Haines et al., 2015; Sailor & McCart, 2014). Trusting family-school

partnerships are associated with improved student outcomes (Tschanen-Moran, 2014) and lower parental stress (Burke & Hodapp, 2014). Essential to effective family-school partnerships are ongoing and productive conversations and a positive school culture created and maintained by an involved administrator (Patrikakou, 2011).

Unfortunately, families of children with disabilities frequently experience problematic family-school partnerships (Turnbull et al., 2011). This is especially the case for low-income parents and for culturally and linguistically diverse (CLD) families who have children with disabilities (Harry, 2008; Shapiro et al., 2004). Various issues explain negative family-school partnerships for families of children with disabilities, including deficit views of families, differences in cultural perspectives regarding disability and parent-professional roles, professionals utilizing a dominant role in communication and decision making, and inadequate translation services for CLD families (Shapiro et al., 2004; Turnbull et al., 2011). These power imbalances and communication issues contribute to families' disengagement and disempowerment in their partnerships with professionals (Hughes et al., 2008; Leiter & Krauss, 2004).

Family-school partnerships for families of children with disabilities have the potential to empower families to advocate for their children. Edwards and Da Fonte (2012) outline a five-point plan to support families of children with disabilities, including (1) being positive, proactive, and solution-oriented, (2) respecting families' roles in their children's lives, (3) communicating and listening to families' concerns, (4) considering simple, natural supports, and (5) empowering families with knowledge about special education law and their rights. It is especially important to intentionally promote positive family-school partnerships when children with disabilities have key school transitions, such as from preschool to kindergarten as well as during other significant life events, such as illnesses, hospitalizations, or family changes (McIntyre et al., 2010). Families who experience positive school partnerships and receive information about special education and their legal rights become better advocates for their children and their children do better in school (Burke et al., 2018).

### *Technology as a mechanism for support*

Technology may be used to enhance the promotion of social competence of children with disabilities. Various types of technology are utilized to support children's social competence, including the use of communication devices (Thiemann-Bourque, 2012), video cameras, televisions, and iPads for video modeling (MacPhearson et al., 2015), portable electronics for displaying social stories (Sansosti & Powell-Smith, 2008), and high-tech robotics to model and support children's social skills (Vanderborght et al., 2012). Single case research design studies have found the use of technology to be as or more effective than technology-free intervention delivery (Steed et al., 2021). The use of technology in the form of digital media has also been effective when used as part of comprehensive social emotional curricula (Webster-Stratton, 2001).

Telehealth may be used to provide specialized support to children with disabilities in their homes or community-based settings (Edelman, 2020). Telehealth technologies include video, web-based, telephone-based, and/or telemetry/remote monitoring used to provide training or social support to parents and/or instructional support to children. More than 95% of telehealth studies reported significant improvements in caregiver satisfaction and comfort with the approach (Chi & Demiris, 2015). Using technology in intervention delivery for social skills has the potential to lighten the instructional load on interventionists, increase the efficiency of intervention implementation, and allow the provision of support from specialists from a distance (Steed et al., 2021); and support teachers' professional development around the use of social emotional interventions (Baggett et al., 2010). Remote coaching using elements of video-based observation, video-based feedback, and/or email feedback are effective in increasing teachers' use of social emotional supports (Fox et al., 2011; Sheridan et al., 2010).

There are some potential challenges for using technology to promote social competence of children with disabilities. For example, some of the available technology was designed for older learners and is not developmentally appropriate for young children (Arnold, 2018). Additionally, there are cautions about the neurological implications of children spending too much time in front of screens

(Kabali et al., 2015). The American Academy of Pediatrics recommends less than 1 hour of screen-time per day for young children and suggests the use of educational and prosocial screen content for older children, along with healthy habits, such as unplugged spaces and times in the home (Chassiakos et al., 2016). Another challenge is inequitable access to technology devices and internet across populations and communities. Lack of access to devices or the internet is associated with fewer financial, educational, or cultural resources (Fernandez et al., 2019; Rice & Haythornthwaite, 2006). It is important to understand and address issues related to digital divides in a particular community or region before implementing small-or large-scale social emotional interventions that require technology, to ensure equitable access for all children.

### **Cultural Understanding of Disabilities and Inclusion**

Cultural understandings of disability are an additional influence on the development of social competence in children with disabilities (Rubin et al., 2001). Globally, definitions of disability are linked to other social and cultural constructs, such as the meaning of difference, individual rights, and understandings of race, class, poverty, and gender nested within historical and political contexts (Skinner & Weisner, 2007). Understandings of disability are based on cultural models of ability and discourses about healing and personal and religious beliefs (Skinner & Weisner, 2007). These sociocultural definitions of disability influence family members' understanding of their child's potential for development, place in the family, and participation in their communities and society at large (Klingner et al., 2007). In Asian families, religious beliefs may intersect with cultural models of disability such that parents view their children with disabilities as punishment for sins committed by themselves or ancestors (Lo, 2010; Yan et al., 2014). In South Asian cultures, families may believe that a child with disabilities has been taken over by a *djinn* or spirit (Baker et al., 2010). Families with these cultural understandings of disability may keep their children's disability private and hesitate to seek supportive services outside of caring for the child's basic needs at home (Ravindran & Myers, 2011).

Many countries have religious and/or cultural explanations of disability that blame family members for the disability (Gabel & Peters, 2004). Iranian parents of children with ASD tend to believe that the cause of ASD is largely attributed to something mothers have done, resulting in cultural shame (Samadi, 2020). Similar beliefs are shared by South Indian mothers of children with intellectual disabilities with blame largely falling on mothers due to something they have done during prenatal care or bad parental traits (Edwardraj et al., 2010). In the United States, the blame for disabilities has shifted over time from mothers who lacked parental warmth to a new pressure for mothers to use all available resources to cure them (Sousa, 2011). The warrior-hero archetype fits with the American medical model of disability that emphasizes intervention to remediate the disability (Skinner & Weisner, 2007). The American medical model of disability is associated with earlier identification of the disability than in other countries; however, it is also associated with a view of the individual with a disability as having deficits and placing pressure on parents, especially mothers, to “fix” their child (Mitra, 2006). Other cultures may place less emphasis on intervention, such as with some Pakistani (Mirza et al., 2009) and Sunni Muslim (Jegatheesan et al., 2010) families who believe a child’s disability may be explained as “Allah’s will,” resulting in less of an emphasis on remediating the disability and greater acceptance.

Cultural conceptualizations of ability and disability can hinder or promote the involvement of children with disabilities in family life, their community, and long-term contributions to society (Ryan & Runswick-Cole, 2008). Globally, children with disabilities are at risk for social exclusion from school and community life due to the devaluation of disability (Ditchman et al., 2016). Many countries have attempted to curb social exclusion of children with disabilities through physical inclusion of children with disabilities in educational settings with children without disabilities (Curcic, 2009). Most developed and developing countries have established law and/or federal policies requiring the inclusion of children with disabilities in educational settings. In the United States, the passage of Public Law 94-142 in 1975 and its subsequent reauthorizations require that children with disabilities receive their education along with typically developing peers to the maximum extent appropriate (Katsiyannis et al., 2001). In Turkey,



children with disabilities began to attend inclusive education programs around 1983; however, widespread implementation was not achieved until the Special Education Law was passed in 1997 (Seçer, 2010). In Australia, policies of inclusion are situated within a social justice agenda that ensures equitable inclusion of all excluded and at-risk groups of children in mainstream educational settings (UNESCO, 1994). Arab countries, like many developing countries, have more recently joined the global movement toward more inclusive education for children with disabilities (Gaad, 2010).

Despite laws and policies encouraging inclusive education, high-quality inclusion remains a formidable challenge. In the United States, rates of inclusion have increased only 5.7% over the last 35 years, and roughly 50% of young children continue to receive their education in segregated special education settings (Barton & Smith, 2015). In low- and middle-income countries, children with disabilities have lower rates of school attendance and are less likely to start school early (Mitra et al., 2013; Mizunoya et al., 2016). Across 30 countries, children with disabilities are ten times less likely to attend school than children without disabilities (World Health Organization, 2011). Reasons for continued barriers to meaningful and effective inclusion of children with disabilities include the stigma attached to disabilities, negative perceptions and beliefs about the impact of inclusion on children without disabilities, and poor preparation of educators to support children with disabilities (Barton & Smith, 2015).

### **Implications and Conclusion**

Understanding both individual and contextual factors associated with the development of social competence is critical to provide children with disabilities and their families with necessary and effective supports in the home, school, and community. First, the development of social competence for children with disabilities is nuanced, which necessitates individualized assessment of children's social skills and differentiated intervention. Children's disabilities need to be understood in association with the individual child's characteristics, family's needs and goals, and their cultural contexts. Second, various classroom-based social competence programs exist for families and programs to

utilize. However, families and teachers should explore which social interventions address the child's unique needs and are most easily and effectively adapted for children with disabilities. Finally, cultural beliefs about disability should be considered along with the degree to which a child is included in social spaces in their community when approaching family partnerships for children with disabilities. It is important that all children with disabilities are honored and supported on their journey towards developing social competence.

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