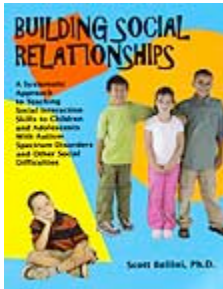




## Making (and Keeping) Friends: A Model for Social Skills Instruction



Contributed by:  
[Dr. Scott Bellini](#)  
Research Associate



*"I am not asking for my child to be the life of the party, or a social butterfly. I just want her to be happy and have some friends of her own. She is a wonderful kid, and I hope someday others can see that."*

### Social Skill Deficits in Autism Spectrum Disorders

Indeed, many parents of children with autism spectrum disorders (ASD) echo this sentiment concerning their child's social functioning. They know that their child has many wonderful qualities to offer others, but the nature of their disability, or more precisely, their poor social skills, often preclude them from establishing meaningful social relationships. This frustration is amplified when parents know that their children want desperately to have friends, but fail miserably when trying to make friends. Often, their failure is a direct result of ineffectual programs and inadequate resources typically made available for social skills instruction. For most children, basic social skills (e.g., turn taking, initiating conversation) are acquired quickly and easily. For children with ASD, the process is much more difficult. Whereas, many children learn these basic skills simply by exposure to social situations, children with ASD often need to be taught skills explicitly. The present article addresses social skill deficits in children and adolescents with ASD by providing a five stage model for social skills instruction, with particular emphasis placed on an emerging intervention strategy, videotaped self-modeling (VSM).

### Lack of "Know-How" Versus Lack of Social Interest

Impairment in social functioning is a central feature of ASD and is well documented in the literature (Attwood, 1998; Rogers, 2000). Typical social skill deficits include difficulties with: reciprocity, initiating interactions, maintaining eye contact, sharing enjoyment, empathy, and inferring the interests of others (APA, 1994). The cause of these skill deficits varies, ranging from inherent neurological impairment (e.g., limbic system dysfunction) to lack of opportunity to acquire skills (e.g., social withdrawal). Most important, these social skill deficits make it difficult for the individual to develop, and keep meaningful and fulfilling personal relationships.

The long held notion that individuals with autism spectrum disorders lack an interest in social interactions is often inaccurate. Many individuals with ASD do indeed desire social involvement, however, these individuals typically lack the necessary skills to interact effectively. One young man I worked with illustrates this point quite well. Prior to my visit, the school staff informed me of his inappropriate behaviors and his apparent “lack of interest” in interacting with other children. After spending the morning in a self-contained classroom, Zach was given the opportunity to eat lunch with the general school population (a time and place that produced many of the problem behaviors). As he was eating lunch, a group of children to his right began a discussion about frogs. As soon as the conversation began, he immediately took notice. So too did I. As he was listening to the other children, he began to remove his shoes, followed by his socks. I remember thinking, “Oh boy, here we go!” As soon as the second sock fell to the ground, Zach flopped his feet on the table, looked up at the group of children and proclaimed, “Look, webbed feet!” The other children (including myself) stared in amazement. In this case, Zach was demonstrating a desire to enter and be a part of a social situation, but he was obviously lacking the necessary skills to do so in an appropriate and effective manner.

This lack of “know-how” could also lead to feelings of social anxiety in some children. Many parents and teachers report that social situations typically evoke a great deal of anxiety from their children. Individuals with ASD often describe an anxiety that resembles what many of us feel when we are forced to speak in public (increased heart rate, sweaty palms, noticeable shaking, difficulties concentrating, etc.). Not only is the speaking stressful, but just the thought of it is enough to produce stomach-gnawing butterflies. Imagine living a life where every social interaction you experience was as anxiety provoking as having to make a speech in front of a large group! The typical coping mechanism for most of us is to reduce the stress and anxiety by avoiding the stressful situation. For individuals with ASD, it often results in the avoidance of social situations, and subsequently, the development of social skill deficits. When a child continually avoids social encounters, she denies herself the opportunity to acquire social interaction skills. In some individuals, these social skill deficits lead to negative peer interactions, peer rejection, isolation, anxiety, depression, substance abuse, and even suicidal ideation. For others, it creates a pattern of absorption in solitary activities and hobbies; a pattern that is often difficult to change.

## **A Five Step Model**

1. Identify Social Skill Deficits
2. Distinguish Between Skill Acquisition and Performance Deficits
3. Select Intervention Strategies
4. Implement Intervention
5. Assess and Modify Intervention as Necessary

The following section will summarize the proposed “Five Step Model” of social skills instruction. Before implementing social skills instruction, it is important to begin with a thorough assessment of the individual’s current level of social skills functioning. Once the assessment is complete, the next step is to discern between skill acquisition deficits and performance deficits. Based on this information, the selection of intervention strategies takes place. Once intervention strategies are implemented, it is then imperative to evaluate and modify the intervention as needed. Although I use the term “Steps,” it is important to note that the model is not perfectly linear. That is, in real-life applications social skills instruction will not follow a lock-step approach from step one to step five. For instance, it is not uncommon for me to identify additional social skill deficits (step one) while I am in the middle of the implementation process (step four). In addition, I am continually assessing and modifying the intervention as additional information and data is accumulated.

### **Identify Social Skill Deficits**

The first step in any social skills training program should be to conduct a thorough evaluation of the individual’s current level of social functioning. The evaluation should detail both the strengths and weakness of the individual related to social functioning. The assessment should involve a combination of observation (both naturalistic and structured), interview (e.g., parents, teachers, playground supervisors), and standardized measures (e.g., behavioral checklists, social skills measures). I have developed a social skills profile to assist in the identification of typical social skill deficits in individuals with ASD. Kathleen Quill (2000) also provides an excellent social skills checklist for parents and professionals in her book, *Do-Watch-Listen-Say*. It is important for the child’s team to ascertain current level of functioning and effectively intervene at the child’s area of need. For instance, if the evaluation reveals that the child is unable to maintain simple one-on-one interactions with others, then the intervention should begin at this level and not at a more advanced group interaction level. After a thorough assessment of social functioning is complete, the team should then determine whether the skill deficits identified are the result of skill acquisition deficits or performance deficits.

[Author’s Note: A detailed description of social skills assessment is beyond the scope of this article. If you would like more information on this topic, including a copy of the social

skills profile form that I currently use, please contact me at the IRCA via email at [sbellini@indiana.edu](mailto:sbellini@indiana.edu)].

### **Skill Acquisition versus Performance Deficits**

Social skills training programs typically focus on one of two areas: skill acquisition deficits and/or performance deficits (Gresham, 1995). A skill acquisition deficit refers to the absence of a particular skill or behavior. For example, a child with an autism spectrum disorder may not know how to effectively initiate a conversation with another person; therefore, he/she will often fail to initiate interactions (can't do). A performance deficit refers to a skill or behavior that is present, but not used. To use the same example, a child may have the skill (or ability) to initiate a conversation, but for some reason, chooses not to do so (won't do). Careful consideration should be used to discern between a skill acquisition deficit and a performance deficit. A good rule of thumb is to ask the question, "Can the child perform the task with multiple persons and across multiple settings?" For instance, if the child only initiates interactions with mom at home and not with his peers at school, then you should address the initiation difficulty as a skill acquisition deficit. I hear the statement a lot from school personnel, "The child interacts fine with me, so it must be a performance deficit, right?" Not quite. In my experience, children with ASD tend to interact better and more easily with adults, because adults typically make it easy for them; the adults do most of the conversational "work" for the child. To use a baseball analogy, just because Tommy can hit Dad's soft, underhand pitches at home, doesn't mean he has mastered the skill well enough to hit pitches thrown by his peers on the playing field. Sometimes adult interactions with children with ASD are similar to throwing a child a soft, underhand pitch. Although they are positive and well intended, they do not adequately prepare the child for more difficult peer-to-peer interactions.

The benefit of using a skill acquisition/performance deficit model is that it guides the selection of intervention strategies. Most intervention strategies are better suited for either skill acquisition or performance deficits. The intervention selected should match the type of deficit present. That is, you would not want to deliver an intervention designed for a performance deficit, if the child was mainly experiencing a skill acquisition deficit. For instance, in the example above, if Tommy has not mastered the skill of hitting (skill acquisition deficit), all the reinforcement in the world (including pizza!) will not help Tommy hit the ball during the game. If we want him to be a skilled hitter, we need to provide Tommy additional instruction on the mechanics of hitting a baseball. The same is true for social skills. If we want a child to be socially fluent, then we need to deliver effective social skills instruction. In contrast, if Tommy does have sufficient hitting skills, but lacks the motivation to "do his best," then the reward of cheese and pepperoni may be all he needs to excel on the playing field. Too often, social skill deficits and inappropriate behaviors are wrongly conceptualized as performance deficits. In my experience, the vast majority of social skill deficits in individuals with ASD can be attributed to skill acquisition deficits. Therefore, it is essential to focus on skill

development when implementing social skills instruction.

Once a thorough social profile is completed and the team is able to attribute the social difficulties to either skill acquisition or performance deficits, social skills instruction is ready to begin. There are a variety of strategies that can be delivered to children with ASD. The most important thing is that the strategies being delivered are appropriate to the unique needs of the child and that a logical rationale can be provided for using the intervention. The following strategies provide a sampling of techniques that can be implemented to teach successful social interaction skills to children and adolescents with ASD. Many of the strategies listed below are designed to address skill acquisition deficits. However, some of the strategies (in particular, videotaped self-modeling) work equally well in addressing performance deficits. In addition, it is imperative that the child be reinforced continually for his effort and participation in the program.

### **Selecting and Implementing the Intervention**

#### **Accommodation and Assimilation**

When selecting intervention strategies, it is important to consider the notion of accommodation versus assimilation. Accommodation, as it relates to social skills instruction, refers to the act of modifying the physical or social environment of the child to promote positive social interactions. Examples of this include: training peer mentors to interact with the child throughout the school day, autism awareness training for classmates, and signing your child up for various group activities, such as little league, or Boy or Girl Scouts. Whereas accommodation addresses changes in the environment, assimilation focuses on changes in the child. Assimilation refers to instruction that facilitates skill development that allows the child to be more successful in social interactions. The key to a successful social skills training program is to address both accommodation and assimilation. Focusing on one and not the other sets the child up for failure. For instance, one family that I worked with did a wonderful job of structuring playgroups for their child, and keeping their child active in social activities. However, they were becoming increasingly frustrated with the fact that their son was not making friends on his own and still having negative peer interactions. The problem was that they were putting the cart before the horse. They provided their child with ample opportunity to interact with others, but they weren't providing him the skills necessary to be successful in those interactions. Similarly, providing skill instruction (assimilation) without modifying the environment to be more accepting of the child with autism also sets the child up for failure. This happens the moment an eager child with autism tries out a newly learned skill on a group of non-accepting peers. The key is to teach skills and modify the environment. This ensures that the new skill is received by peers with both understanding and acceptance.



## **Social Skills Strategies**

As stated previously, social skills often need to be taught explicitly to children and adolescents with ASD. Traditional social skills strategies (such as board games about friendships and appropriate classroom behavior) tend to be too subtle for many children with ASD. For instance, a school counselor was frustrated with the progress she was making with a student with autism. She stated that the program was showing positive results with “other kids in the group,” but the student with autism didn’t seem to “get it.” Indeed, he was not “getting it!” The reason was quite apparent. The school counselor was attempting to teach the students about the concept of “friendship.” This is acceptable for some children, but for children with ASD it tends to be a too subtle form of instruction. That is, instead of spending countless hours teaching the child about “friendship,” the instruction should have focused on skills the child could use to make and keep friends. Experience tells me that the concept of friendship is much easier to understand once you have a friend or two! The following section summarizes various social intervention strategies that have been designed to promote social interaction skills in children with ASD, including peer-mediated instruction, thinking-feeling activities, reciprocity instruction, social stories, role-playing, and video-taped self-modeling.

### **Peer Mentors**

The use of peer mentors is one example of an effective strategy for children with ASD. Peer mediated interventions have been frequently used to promote positive social interactions among peers (Strain & Odom, 1986; Odom & McConnell, 1993). Peer mediated instruction allows us to structure the physical and social environment in a manner to promote successful social interactions. In this approach, trained peers participate in the intervention by making social initiations or responding promptly and appropriately to the initiations of children with ASD during the course of their school day. Peer mentors should be classmates of the child with ASD, have age-appropriate social and play skills, have a record of regular attendance, and have a positive (or at least neutral) history of interactions with the child with ASD. Peer mentors should also be made aware of the behaviors associated with autism in a manner that is respectful and developmentally appropriate for the age group. The use of peer mentors allows the teacher and other adults to act as facilitators, rather than participate as active playmates. That is, instead of being a third wheel in child-child interaction, the teacher prompts the peer buddies to initiate and respond appropriately to the child with ASD. The use of peer mentors also facilitates generalization of skills by ensuring that newly acquired skills are performed and practiced with peers in the natural environment.

### **Thoughts and Feelings Activities**

Recognizing and understanding the feelings and thoughts of self and others is often an area of weakness for individuals with ASD and is essential to successful social interactions. For instance, we continually modify our behavior based on the non-verbal feedback we receive from other people. We may elaborate on a story if the other person is smiling, looking on intently, or showing other signs of genuine interest. On the other hand, if the other person repeatedly looks at her watch, sighs, or looks otherwise disinterested, we may perhaps cut the story short (I said perhaps!). Individuals with ASD often have difficulty recognizing and understanding these non-verbal cues. Because of this, they are less able to modify their behavior to meet the emotional and cognitive needs of other people.

Picture cards can be used to ascertain the child's level of awareness concerning the feelings of others. The pictures should portray characters participating in various social situations while emoting various feelings. The child is asked to identify how the characters are feeling based on facial expressions, posture, and the situation portrayed in the picture. This requires the child to make inferences based on the context and cues provided in the picture. Once mastery is achieved on the picture cards, move to video footage of social situations (make sure your machine pauses with a clear picture). A thought bubble activity can also be used to infer the thoughts of others. The idea is to teach the child that we can often determine what others are thinking by listening to what they are saying. For instance, if Michael is talking about basketball, he is probably thinking about basketball as well. During the sessions, the child is read statements (similar to the one just described) and asked to fill in the thought bubble for the character. For instance, for the one example above, the child would write the word "basketball" in a thought bubble to describe what Michael was thinking. In addition, if-then statements can be used to infer the interests of others. For instance, if Michael is talking about basketball and thinking about basketball, then he probably likes basketball as well. Recognizing the interests of others is extremely important for initiating interactions and ultimately developing friendships. Patricia Howlin's book *Teaching Children with Autism to Mind-Read* offers helpful information and resources in this area of instruction. In addition, there are a number of software programs on the market that address both emotions and perspective taking abilities.

## Facilitating Reciprocal Interactions

Another area of concern for individuals with ASD is lack of reciprocal interactions. Individuals with ASD often engage in one-sided interactions that lack give and take. In conversations, these children rarely ask questions of others, or rarely talk about the interests of others. To address this, I created an activity called, "Newspaper Reporter." For this activity, the child is required to play the role of a newspaper reporter and ask questions of others. The form consists of rather simple questions, including a person's name and age, hobbies and interests, and favorite foods. The goal is simply to get the child in the habit of asking questions, thereby increasing the give and take of

conversations. Later in the sessions, the child should be encouraged to ask additional probing questions to gain more information from the other person (in the spirit of great investigative journalism!). This often becomes a favorite activity for children, as they often ask for extra forms to take home. A chess timer can also be used for verbal individuals with ASD to facilitate give-and-take in interactions. In this activity, the person with ASD is instructed to ask another person a question, and then press the chess timer (or similar device). After answering the question, the other person then poses a question to the person with autism and then presses the timer herself. This back-and-forth interaction proceeds for a specified time period with the goal of eliminating the timer from the interaction altogether. This activity tends to be quite difficult for even the most verbally fluent adolescents.

## Social Stories

A Social Story is a frequently used strategy to teach social skills to children with disabilities. A Social Story is a non-coercive approach that presents social concepts and rules to children in the form of a brief story. This strategy could be used to teach a number of social and behavioral concepts, such as making transitions, playing a game, and going on a field trip. Carol Gray (1995) outlines a number of components that are essential to a successful Social Story, including: the story should be written in response to the child's personal need; the story should be something the child wants to read on her own (depending upon ability level); the story should be commensurate with ability and comprehension level; and the story should use less directive terms such "can," or "could," instead of "will" or "must." This last component is especially important for children who tend to be oppositional or defiant (i.e., the child who doesn't decide what to do until you tell him to do something...then he does the opposite!). The Social Story can be paired with pictures and placed on a computer to take advantage of the child's propensity towards visual instruction and interest in computers. I have found that children with ASD learn best when Social Stories are used in conjunction with Role-Playing. That is, after reading a Social Story, the child then practices the skill introduced in the story. For instance, immediately after reading a story about raising your hand before speaking, the child would practice raising his hand to be called on (for more comprehensive guidance on creating a Social Story, see Gray, 1995).

## Role Playing/Behavioral Rehearsal

Role-playing is used primarily to address basic interaction skills. Often times, individuals with ASD have great difficulty initiating social interactions and getting other children to engage in activities with them. They are often dependent on the advances of other children; which can be infrequent. Many children with ASD only engage in activities with other children if the other child initiates the interaction. Role-playing consists of acting out various social interactions that the child would typically encounter. During the role-play scenarios, the child could be required to initiate a conversation with another person as



the other person is engaged in a separate task. He would then have to ask to join in, or ask the other person to join him in another activity. The latter typically proves to be most difficult for children with ASD. During the first few sessions, it is not uncommon for the child to get “stuck” in conversations and interactions, often for minutes without knowing what to say or how to proceed. During the early sessions, the child should be given ample time to process and respond to the role-play scenarios. As the sessions progress, speed and proficiency should gradually increase.

### Videotaped Self-Modeling

Social skills are primarily acquired through learning that involves observation, modeling, coaching, social problem solving, rehearsal, feedback, and reinforcement-based strategies. Videotaped self-modeling (VSM) is one means of instruction that allows the interventionist to use this entire range of strategies to promote skill acquisition, enhance skill performance, and remove interfering problem behaviors. VSM is an intervention where individuals learn skills by observing themselves performing the targeted skill. A strength of VSM is that it allows the individual to learn, both through observation and through personal experience. The use of video taped self-modeling (VSM) has been shown to be effective in treating children with a variety of disorders including: selective mutism, attention deficit/hyperactivity disorder (ADHD), social anxiety, aggressive/disruptive behavior, motor problems, and autism spectrum disorders (Buggey, 1999; Harvey, 2000). Recent research suggests great promise for the use of video-modeling in social skills instruction for children with ASD. Alcantara (1994) used a video priming technique to teach children with autism how to purchase items from a store. The use of video instruction increased both the effectiveness and efficiency of the children’s purchasing behaviors, and generalized to other stores not portrayed on the videotape. Buggey and colleagues (1999) used VSM to increase responding behaviors in preschool children with ASD. The children in the study viewed videotapes of themselves answering questions while engaging in play activities. Although answering questions was a low frequency behavior for these children, the videos were edited to portray the children as fluent in their responses. Charlop-Christy et al. (2000) found that video-modeling was more effective than live modeling in teaching daily living skills to children with ASD. In addition, the children viewing the video model demonstrated better generalization of skills across settings. Similarly, Sherer et al., (2001) demonstrated that video modeling was an effective way to teach conversation skills for some children with ASD. In a recent article, Charlop-Christy and Daneshvar (2003) used video modeling to teach perspective taking to three children with ASD between the ages of 6 and 9. The researchers concluded that the video modeling intervention was a quick and effective procedure for teaching perspective taking and promoting generalization of newly acquired skills.

The use of VSM has many benefits for individuals with ASD. First and foremost, VSM allows us to capitalize on the individual’s propensity towards visual learning by

presenting a visual representation of the target skill instruction (i.e., showing the child during social interactions). In addition, personal experience suggests that watching videos is often a highly desired activity for many children with ASD, thereby, increasing motivation and better attention to the instructional task. Another strength of VSM is that it lessens our reliance on “Social Autopsies,” where we dissect and analyze a social encounter with a child after it has already taken place. Instead, VSM allows the individual to examine and analyze a social situation as it is taking place on the video (with the luxury of pause and rewind). Finally, VSM allows us to implement a social problem solving intervention. Social problem solving is beneficial in addressing the various social information processing deficits present in individuals with ASD and can easily be incorporated into the VSM intervention.

VSM interventions typically fall within two categories: positive self-review (PSR) and video feed-forward (Dowrick, 1999). PSR refers to individuals viewing themselves successfully engaging in a behavior or activity. PSR can be used with low frequency behaviors (i.e., a behavior that the individual can sometimes do, but with some difficulty) or behaviors that were once mastered, but are no longer. In this case, the individual is simply videotaped while engaging in the low frequency behavior, or videotaped while receiving assistance to complete the task. An example of PSR can be applied to my miserable golf game (which, by the way, can be characterized as a skill acquisition deficit). To implement the intervention, I can videotape myself hitting the ball 10 times, with the hopes that I will hit at least one good shot (low frequency behavior). After editing the tape, the positive self-review intervention would involve me repeatedly watching that one good shot. The goal would be for me to learn from what I did right, not from what I did wrong. PSR works well for individuals who need additional assistance to complete tasks successfully. For instance, the child could be videotaped interacting with peers while an adult provides assistance through cueing and prompting. The cueing and prompting could then be edited out so that when the child views the videotape, she sees herself as independent and successful.

Video feed-forward is another category of VSM interventions. Video feed-forward interventions are typically used when the individual already possesses the necessary skills in her behavioral repertoire, but may not be able to put these skills together to complete an activity. For instance, the child may have the ability to get out of bed, brush her teeth, get dressed, and comb her hair (morning routine), but can not perform these skills in the proper sequence. A video feed-forward intervention would videotape her engaging in each of these tasks and then splice the segments together to form the proper sequence. The same can be done with typical social interaction sequences. For instance, the child could be videotaped demonstrating three different skills: initiating an interaction, maintaining a reciprocal interaction, and appropriately terminating the interaction. The three scenes could then be blended together to portray one successful, and fluent social interaction.

### **Assess and Modify the Intervention**

Although “Assess and Modify” is listed as the last stage in the intervention process, it certainly is not the least important. In addition, it also is not the last thing to think about when designing a social skills program. Typically, as soon as I am able to identify the social skill deficits to be addressed, I begin to develop the methods for evaluating the efficacy of the intervention. To use a basic example, if the target of the intervention is social initiations, then I might take baseline data on the frequency of initiations with peers and adults. I would then continue to collect data on social initiations throughout the implementation stage. Accurate data collection is essential in evaluating the effectiveness of the intervention. It allows us to determine whether the child is benefiting from the instruction, and how to modify the program to best meet the child’s needs. In school settings, accurate data collection is a legal imperative. When I work with school teams, the focus is on integrating the social skills program with the child’s behavioral and social objectives. As such, Stage 5 is typically a very important aspect of IEP development, implementation, and integrity.

### Case Example

The following case study illustrates the use of VSM for a young girl diagnosed with autism. “Kelly,” was a 6-year-old girl with low average verbal ability. Although her vocabulary was in the average range for children her age, she seldom used her language spontaneously with classmates and teachers. She spoke only when asked direct questions and interacted only when others initiated the interactions. Consequently, Kelly spent the majority of her playground time by herself, with little peer interaction. A social skills assessment concluded that she had significant skill deficits in initiating interactions, and maintaining interactions with peers. A social skills intervention was designed to increase the frequency and length of social interactions with peers. Data on peer interactions (initiations and responses to peers) were collected in both a structured playgroup, and during recess. Two peers mentors were selected to participate in a structured playgroup with Kelly. The peers were instructed to initiate and to respond promptly to Kelly’s initiations. The peers were also provided developmentally appropriate information regarding autism and Kelly’s behaviors, which included hand-flapping. Also prior to the playgroup, Kelly was read a social story related to initiating social interactions. Each time the story was read, Kelly was given the opportunity to practice initiation skills via a role-playing procedure. The children participated in a playgroup three days a week for two weeks. During the playgroups, Kelly was prompted to initiate interactions with the peers, and she was prompted to respond promptly and appropriately to the peers when they initiated interactions with her. The playgroups were videotaped over the two-week time period. The video footage was then edited to exclude the continual prompting and coaching provided to Kelly. The edited tapes portrayed Kelly fluently interacting with her peers. The tapes were shown to Kelly in 5-minute increments for two weeks. For Kelly, the VSM procedure facilitated immediate increases in initiations and responses to peers in both the play setting and on the playground. By the end of the

school year, Kelly had developed relationships with two other children, friendships that continue to this day.

The purpose of this article is not to provide an all-inclusive list of social skills strategies available for children with ASD. Instead, the present article presents a social skills training model that assists families and professionals in the delivery of social skills instruction. In addition, not all programs are appropriate for every child. Great care and planning needs to be put forth to ensure that the strategies used in the program meet the individual needs of the child. Therefore, a multi-dimensional intervention strategy that addresses the individual characteristics (both strengths and weaknesses) of the child is imperative. In the example above, Kelly received weekly social skills instruction, in addition to speech and occupational therapy. Kelly needed a full compliment of strategies to be successful socially. As her mother told me, Kelly may never be the life of the party or a “social butterfly.” However, with the delivery of an effective social skills program, Kelly has been given an opportunity to develop the skills necessary to develop meaningful personal relationships. And the rest of us have been given the opportunity to meet a truly wonderful child.

## References

- Alcantara, P. R. (1994). Effects of videotape instructional package on purchasing skills of children with autism. *Exceptional Children*, 61, 40-55.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders (4th ed.)*. Washington, DC: Author.
- Attwood, T. (1998). *Asperger's Syndrome: A guide for parents and professionals*. Philadelphia, PA: Jessica Kingsley Publishers.
- Buggey, T. (1999). Videotaped self-modeling: Allowing children to be their own models. *Teaching Exceptional Children* (4) 27-31.
- Buggey, T., Toombs, K, Gardener, P., & Cervetti, M. (1999). *Journal of Positive Behavioral Support*, 1, 205-214.
- Charlop-Christy, M. H., & Daneshvar, S. (2003). Using video modeling to teach perspective taking to children with autism. *Journal of Positive Behavior Interventions*. Vol. 5, 12-21.
- Charlop-Christy, M. H., Le, L., & Freeman, K. A. (2000). A comparison of video modeling with in-vivo modeling for teaching children with autism. *Journal of Autism and Developmental Disorders*, 30, 537-552.
- Charlop, M. H., & Milstein, J. P. (1989). Teaching autistic children conversational speech using video modeling. *Journal of Applied Behavior Analysis*, 22, 275-285.

Dowrick, P. W. (1999). A review of self modeling and related interventions. *Applied & Preventive Psychology*, 8, 23-39.

Gray, C. A. (1995). Teaching children with autism to read social situations. In A. Quill (Ed.), *Teaching Children with Autism: Strategies to Enhance Communication and Socialization* (pp. 219-242). New York, NY: Delmar.

Gresham, F. M. (1995). Best Practices in Social Skills Training. In A. Thomas & J. Grimes (Eds.), *Best Practices in School Psychology*.

Gresham, F. M. & Elliot, S. N. (1984). Assessment and classification of children's social skills: A review of methods and issues. *School Psychology Review*, 13, 292-301.

Harvey, A. G., Clark, D. M., Ehlers, A., & Rapee, R. M. (2000). Social anxiety and self-impression: Cognitive preparation enhances the beneficial effects of video feedback following a stressful social task. *Behaviour Research and Therapy*, 38, 1183-1192.

Howlin, P., Baron-Cohen, S., & Hadwin, J. (1999). *Teaching children with autism to mind-read: A practical guide*. New York, NY: Wiley Publishing.

Odom, S. & McConnell, S. (Eds.) (1993). *Vanderbilt/Minnesota social interaction project play time/social time: Organizing your classroom to build interaction skills*. Tucson, AZ: Communication Skill Builders.

Quill, K. (2000). *DO-WATCH-LISTEN-SAY: Social and communication intervention for children with autism*. Baltimore, MD. Brookes Publishing.

Rogers, S. J. (2000). Interventions that facilitate socialization in children with autism. *Journal of Autism and Developmental Disorders*, 30, 399-409.

Sherer, M., Pierce, K. L., Paredes, S., Kisacky, K. L., Ingersoll, B. Schreibman, L. (2001). Enhancing conversation skills in children with autism via video technology. *Behavior Modification*, 25, 140-159.

Strain, P. S., & Odom, S. L. (1986). Peer social initiations: An effective intervention for social skill deficits of preschool handicapped children. *Exceptional Children*, 52, 543-552.

---

Bellini, S. (2003). Making (and keeping) friends: A model for social skills interaction. *The Reporter*, 8(3), 1-10.

