CHAPTER I

CONCEPTUAL FRAMEWORK

1.0.0. INTRODUCTION

The term adolescent is derived from the Latin word “adolescere” which literally means “to grow” or “to grow to maturity”. It is a period when children become physically, psychologically, emotionally as well as socially matured (Hurlock, 1980, Santrock & Yussen, 1987, Verma, 1979, Musen & Conger, 1990). School is a place where young people experiment with social roles and develop new aspects to their sense of self.

Adolescence has been referred to as a turbulent transition both for the young and their caregivers throughout generations and across the world. According to Smith & Carlson (1997), the adolescent population may be especially susceptible to stressful events, and perceive some events as more stressful than an adult. Adolescents differ from adults in the way they behave, solve problems, and make decisions. The environmental and biological changes at adolescence lead to new social encounters and heightened awareness and interest in other people. The importance of evaluating other people may be associated with increased attention to socially salient stimuli, particularly faces, and the processing of emotional information. Recognition of facial expressions of emotion is one area of social cognition that has been investigated during adolescence (Herba and Phillips, 2004). Scientists have identified a specific region of the brain called the amygdala which is responsible for instinctual reactions including fear and aggressive behavior. This region develops early. However, the frontal cortex, the area of the brain that controls reasoning and helps us think before we act, develops later. This part of the brain is still changing and maturing well into adulthood. Adolescents’ brains function differently than adults when decision-making and problem-solving. Their actions are guided more by the amygdala and less by the frontal cortex.

American Academy of Child and Adolescent Psychiatry (2012) reported that in references to the stage of their brain development, adolescents are more likely to:

- act on impulse
- misread or misinterpret social cues and emotions
- get into accidents of all kinds
- get involved in fights
- engage in dangerous or risky behavior.

Those who are less resilient may turn to unhealthy actions or negative beliefs about themselves to cope with the difficulties encountered in their lives (Smokowski, 1999). Vulnerable youth are at greater risk for failing out of school, choosing harmful associates, experiencing desolation and homelessness, experimenting with substance use, and unsafe sexual encounters. Not having adequate individual or environmental compensatory factors during such times leads such youth into hopelessness and suicidal or homicidal tendencies (Sharma, 2015).
1.1.0. SOCIAL COGNITIVE DEVELOPMENT DURING ADOLESCENCE

Adolescence is the transitional period between late childhood and the beginning of adulthood, and marks the beginning of the reproductive lifespan in humans. Adolescence involves sexual maturity in terms of hormones and physical development of the body, and is also characterized by an increase in the complexity of group interactions and thus social behaviour (Lerner and Steinberg, 2004). Adolescence is a period of development and consolidation of the social self, of one's identity and understanding of the self in relation to the social world (Coleman and Hendry, 1990). Anecdotal evidence and self-report data suggest that children seem to become progressively self-conscious and concerned with other people's opinions as they go through puberty and the period of adolescence (Steinberg, 2005). The psychosocial context of adolescents is markedly different to that of children and adults. Relationships with peers, family and society go through distinct changes during this time. Adolescents begin to assert more autonomous control over their decisions, emotions and actions, and start to disengage from parental control. At the same time, the school context involves an intense socialization process during which adolescents become increasingly aware of the perspectives of classmates, teachers and other societal influences (Berzonsky and Adams, 2003).

Changes in social behaviour are driven by both social and biological factors. During adolescence, it is likely that peer interactions and societal influences as well as genetically determined hormonal milieu influence social behaviour. However, since the recent discovery that the brain matures considerably during adolescence, evidence has emerged pointing to the role of neural maturation in the development of social cognition during adolescence.

1.2.0. WHAT IS LEARNING DISABILITY

Learning disabilities arise from neurological differences in brain structure and function and affect a person’s ability to receive, store, process, retrieve or communicate information. While the specific nature of these brain-based disorders is still not well understood, considerable progress has been made in mapping some of the characteristic difficulties of LD to specific brain regions and structures. Learning disabilities may also be a consequence of insults to the developing brain before or during birth, involving such factors as significant maternal illness or injury, drug or alcohol use during pregnancy, maternal malnutrition, low birth weight, oxygen deprivation and premature or prolonged labor. Postnatal events resulting in LD might include traumatic injuries, severe nutritional deprivation or exposure to poisonous substances such as lead. Learning disabilities are both real and permanent. Yet some people never discover that learning disabilities are responsible for their lifelong difficulties in such areas
as reading, mathematics, written expression and in comprehension. Others are not identified as having LD until they are adults. Many individuals with LD suffer from low self-esteem, set low expectations for themselves, struggle with underachievement and underemployment, have few friends and, with greater frequency than their non-LD peers, appear to end up in trouble with the law.

Learning disabilities are perhaps best described as unexpected, significant difficulties in academic achievement and related areas of learning and behavior in individuals who have not responded to high-quality instruction and for whom struggle cannot be attributed to medical, educational, environmental or psychiatric causes.

1.2.1. COMMON TYPES OF LEARNING DISABILITIES

The common types of learning disabilities with their characteristics are summarized in the tabular form which is as follows:

<table>
<thead>
<tr>
<th>Type of LDs</th>
<th>Area of Difficulty</th>
<th>Symptoms include trouble with</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dyslexia</td>
<td>Processing language</td>
<td>Reading, writing, and spelling</td>
<td>Letters and words may be written or pronounced inaccurately</td>
</tr>
<tr>
<td>Dysecalculia</td>
<td>Math skills and concepts</td>
<td>Computation, remembering math facts, concepts of time, money, grasping math concepts, etc</td>
<td>Difficulty learning to count by 2s, 3s, 4s</td>
</tr>
<tr>
<td>Dysgraphia</td>
<td>Written expression</td>
<td>Handwriting, spelling, expressing ideas on paper</td>
<td>Illegible handwriting, difficulty organizing ideas, getting thoughts on paper</td>
</tr>
<tr>
<td>Dyspraxia</td>
<td>Fine motor skills</td>
<td>Coordination, manual dexterity</td>
<td>Trouble with scissors, buttons, drawing, writing</td>
</tr>
<tr>
<td>Information Processing Disorders</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Auditory Processing Disorder</td>
<td>Interpreting auditory information</td>
<td>Language Development, reading</td>
<td>Difficulty anticipating how a speaker will end a sentence.</td>
</tr>
<tr>
<td>Visual Processing Disorder</td>
<td>Interpreting visual information</td>
<td>Reading, writing and math</td>
<td>Difficulty distinguishing letters like “h” and “n”</td>
</tr>
<tr>
<td>Other Related Disorders</td>
<td></td>
<td></td>
<td>Can’t sit still, loses interest quickly, is easily distracted, may daydream</td>
</tr>
</tbody>
</table>

Table 1.1 Exhibiting the Classification of learning Disability

Source: Learning Disabilities Association of British Columbia (LDABC), 2015.
1.3.0. MAGNITUDE AND PREVELANCE OF LEARNING DISABILITY IN INDIA

The LD movement in India is of more recent origin and comparable today with that of the western LD movement of nearly half a century ago. During the last decade or two, however, there has been an increasing awareness and identification of children with LD in India. Despite this growing interest, we still have no clear idea about the incidence and prevalence of LD in India.

Rao (2003) stated that children with learning disabilities are at a disadvantaged position when compared with children who can cope with the normal learning system. These children usually tend to drop out from the school system or the system rejects them, causing concerns for the parents. The problem is not a new phenomenon and it is there since the evolution of the mankind. A systematic focus was paid on learning disabilities from 60s onwards in the west and some models were developed to take care of the special needs of these children. In UK the Education Act of 1981 highlighted the identification of children with special education needs and to provide them wherever possible education in ordinary schools. Most of the European countries and Australia also have followed similar policy. Further he mentioned that in India there is neither legislation nor policy of such nature. Ironically, this subject comes under no man’s land resulting in lack of knowledge and education practices for these children who constitute 10 per cent of the school going population. 

Education for All is given special focus by Government of India which is also guaranteed by constitution. In order to make it possible we have an obligation to systematically work for these groups, which otherwise naturally get excluded in the school system due to their special needs.

The Ministry of Social Justice & Empowerment (2003) reported that the 86thAmendment to the Constitution of India has made it all the more imperative for us to work towards a situation where all children, including those with disabilities, are included in education programmes appropriate for them. UNDP (2003) developed a model for achieving zero rejection of children with disabilities.

In the course of deliberations regarding this project, the attention of the Project Steering committee was drawn to the plight of children with learning problems, especially specific learning disabilities who, it is estimated, constitute 10 per cent of the children in schools.
At present, in India, LD is considered the prerogative of a few in the big cities. Even Directors of State Education are known to express doubts at the existence of any such disability. The various reasons for their state of affairs can be envisaged as following:

i. At school level learning disability goes unnoticed because of lack of teacher training.
ii. It was in recent past certain Universities emphasized the importance of special education and tried to incorporate it into the teacher training syllabus. But, still it's not focused on Learning Disability.
iii. Most children with Learning Disability is labeled as ‘dumb’ or ‘lazy’ or “useless” and are considered as burden to the school and they simply ask them to leave the school.
iv. It’s also learnt that, in certain cases parents are very adamant and refuses to accept that their child has learning disability, though certain schools has special education cell as parents are uncooperative.
v. The unavailability of indigenous testing tools is another setback in detecting adolescents with learning disability. India is a multilingual and multicultural background with an estimate of 850 languages in daily use. The proficiency of Indian students in English is unsuitable with the language of the testing instruments (Thomas, Bhautej and John 2003).

Yet there have been some researchers and medical institutions who tried to find out the actual prevalence rate of learning disabilities either in their own state or in all over country.

An epidemiological study (1995-2000) of child and adolescent psychiatric disorders in urban and rural areas of Bangalore, was done by the Dept of Psychiatry, Epidemiology and Biostatistics, National Institute of Mental Health and Neuro Sciences, Bangalore to determine prevalence rates of child and adolescence psychiatric disorders. The total prevalence rate in 4-16 year old children in urban middle class, slum and rural areas was 12%. However the children with LD were eventually excluded from this study as most of them lacked adequate schooling as per the ICD-10-DCR (International Classification of Disease, 10th Revision, Diagnostic Criteria for Research) criteria for LD. In addition, many of the assessments were incomplete due to lack of cooperation for the lengthy testing for Learning Disabilities (Srinath, et al., 2005).

The prevalence study on Learning Disability conducted at the L.T.M.G. Hospital, Sion, Mumbai (2006) reveals that of the total number of 2,225 children visiting the hospital for certification of any kind of disability, 640 were diagnosed as having a Learning Disability. These children came from the lower, middle and upper middle socioeconomic strata of society. Referral was due to their poor school performance.

Studies conducted by the Sree Chithira Thirunal Institute of Medical Sciences and Technology in Kerala in 1997 revealed that nearly 10% of the childhood population has developmental language disorders of one type or the other and 8-10% of the school population has learning disability of one form or the other.

The Institute for Communicative and Cognitive Neurosciences (ICCONS), Kerala, has been conducting research programs in child language disorders and developing research and rehabilitation programs for learning disabilities. Screening for LDs for Classes I to VII in schools with follow up assessments by experts in 10 panchayats in Kerala revealed that 16% of these school children have a learning disability (Suresh,1998). According to the 2001 Census of India, number of people reported to be disabled amounted to 21.9 million. 48.6 per cent of these were the persons having visual disability, the largest group and 5.8 per cent were those with hearing impairment was the smallest group (Rao, 2008).
Speech (7.49 per cent), mobility (27.87 per cent), and intellectual disabilities (10.33 per cent) were other disabling conditions found to be prevalent. There is high negligence, however, to unnoticeable disability (Sakhuja, 2004). The researches on LD have begun recently in India (Ramaa, 2000). For a long period, academic problem associated with learning disability experienced by students were less attended in classrooms (Karanth, 1998). Since, greater numbers of students are experiencing problem in non-academic and academic areas; the study of LD is progressing reportedly. Based on statistics, learning disability has become the most widespread disability (Suresh & Sebastian, 2003; Tandon, 2007) with 10-14 per cent of 416 million children in India (Krishnan, 2007; Krishnakumar, 1999; Mehta, 2003). The estimations reveal presence of five students among an average-sized classroom (Thomas, Bhanutej, & John, 2003). Dyslexia is the most common and most carefully studied of the SpLDs [specific learning disabilities], affecting 80 per cent of all those identified as learning disabled (Karande, Sawant, Kulkarni, Galvankar, & Sholapurwala, 2005). The incidence of dyscalculia was reported to include 6 per cent of all school-aged children according to study conducted in southern parts of India (Ramaa & Gowramma, 2002). Attention Deficit Hyperactivity Disorder (ADHD) was conventional along with learning disability (Crawford, 2007).

The graphical presentation of the prevalence rate of learning disability has been presented below:

![Graphical Presentation of the Prevalance Rate of Learning Disability](image)

SCTIMST: Sree Chithira Thirunal Institute of Medical Sciences and Technology
According to the *Annual Report of India (2013-14)* in census there were 2.19 crore persons with disability in India who constituted 2.13 per cent of the total population in which highly prevalence was found in locomotor disability with 20 per cent. This time hearing and visual disability were found within almost same percentile (19 per cent and 19 per cent respectively). Speech (7 per cent), Mental (8 per cent) and other disabilities (18 per cent) were other disabling conditions which were found in the 2011 census of India. The currently recognized 15 per cent prevalence rate of learning disability is considered to be inflated (*Ahmad, 2015*). The limited training of teachers in this area with limited awareness among administrators, parents and teachers are the main reasons behind compounding of this conventionality.

### 1.4.0. **CONCEPT OF SOCIAL COMPETENCE**

Humans live within a social context, and social learning stems from their social interactions (*Hartup, 1979*). Several developmental theories acknowledged the importance of social interactions in the lifetime development of humans.

*Various theories of development, including those written by Freud, Erickson, and Piaget emphasize the importance of social groups and interactions in an individual’s development. The study of the social interactions of children began in the 1930’s with investigations into the nature of peer groups and the associations between children’s characteristics and their relative positions within these peer groups (Ladd, 1999). How well an individual interacts with others can be looked at in terms of his or her social competence. It is through interactions with others that children begin to understand their social world and develop social skills that will help them to interact appropriately with other individuals in their environment (i.e., social competence; Hartup, 1979). The study of social competence began in full force in the 1950’s and 1960’s when research found that children’s social competence was related to future mental health and adjustment (Dodge, Asher, & Parkhurst, 1989). Roff (1961) found that social incompetence in early and middle childhood could be linked to maladaptive outcomes in adulthood. Other researchers linked social incompetence to later truancy, school discipline problems, and eventual school dropout. Social competence is an overarching domain that encompasses the skills required to function socially and be successful during social interactions (Semrud-Clikeman, 2007; Waters & Sroufe, 1983). Social competence is characterized by the potency dimension of social measurements. As one of the components of the social behavior, it is acquired through social interaction and cultural interaction in different socio-cultural settings. The success of an individual in the society*
depends largely upon the extent to which he has acquired the richness and potency of social competence desirable for his self-actualization, growth and development. For a successful interpersonal interaction, a high order social competence works as essential prerequisite of an adolescent. Daily interactions with teachers and peers, participation in a variety of school activities, and various demands for decision-making give students the opportunity to elaborate their social skills.

However conceptions of social competence often assume specific outcomes, implying but not making explicit culturally based value, social competence also suggests that major part of it is a set of component skills of procedure applied conditionally. These might include perception of relevant social cues, interpretation, and realistic anticipation of obstacles to personally desired behavior anticipation of consequences of behavior for self and others, generation of effective solution to interpersonal problem, translation of social decisions into affective social behavior and expressions of a positive sense of self-efficiency. Katz (1995) analyzed that social competence is must for consideration as an important development goal for all children. Pertiwi (1999) studied that individuals who have competent skills are able to use the knowledge to make positive relationship with other people meanwhile, La Fontana and Cillesen (2002) reported that social competence can be seen as behavior pro-social, altruistic and can work together.

1.4.1. MODELS OF SOCIAL COMPETENCE

In the 1980s, with the rise of information processing model in the study of cognitive psychology, psychologists proposed similar models to describe social interactions and define social competence. These models were called Social Information-Processing Models of Social Competence that have significantly advanced our understanding of children’s social adjustment. The models of the social competence are summarized in tabular form as given on the next page:

Table 1.2 Exhibiting the Summary of Models of Social Competence

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Name of the Researcher</th>
<th>Year</th>
<th>Description of the Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Goldfried and D’Zurilla</td>
<td>1969</td>
<td>Gave four steps in social interactions: Identifying and recognizing the problematic situation Generating possible solutions to the problems Deciding on the most appropriate solution</td>
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</table>
Implementing this solution. This model served as a basis for future information-processing models of social competence.

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<tbody>
<tr>
<td>2.</td>
<td>Gresham</td>
<td>1984</td>
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<tr>
<td></td>
<td>Identified three sub domains of Social Competence: Adaptive behavior Social skills Peer acceptance The third aspect could be looked at as an outcome or result of socially competent behavior.</td>
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<tbody>
<tr>
<td>3.</td>
<td>McFall</td>
<td>1982</td>
</tr>
<tr>
<td></td>
<td>Competence is viewed as “a general evaluative term referring to the quality or adequacy of a person’s overall performance in a particular task. It includes the following major social skill processes: Decoding skills Decision skills Encoding skills</td>
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<th></th>
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<tbody>
<tr>
<td>4.</td>
<td>Dodge</td>
<td>1986</td>
</tr>
<tr>
<td></td>
<td>Formulated an integrative model of social competence that is based on the information-processing principles put forth by above-mentioned theories, proposed six steps model: Encoding the social cues in the environment Engage in a mental representation and interpretation process Clarifying goals Accessing or constructing a response Response decision The behavioural enactment In this model, the steps exist in dynamic relation to each other and each output is also an input for the next operation.</td>
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<tbody>
<tr>
<td>5.</td>
<td>Rubin and Rose-Krasnor</td>
<td>1986</td>
</tr>
<tr>
<td></td>
<td>Devised a similar model of how children process social information. The steps they outlined were: Selecting a social goal Examining and interpreting the environment Accessing and selecting strategies Implementing a strategy Evaluating the outcome of the strategy.</td>
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</tr>
</tbody>
</table>

It can be observed from the tabular presentation that Social competence encompasses many related interpersonal skills and is manifested in emotional self regulation, social cognition, positive communication, and pro-social relationships with family members, peers, and teachers (Bornstein, Hahn & Haynes, 2010).

After knowing the importance of social competence in human lives, it is more important to discuss it within the context of adolescent stage. Whether he is learning disabled or non learning disabled. Because adolescent stage is the stage of storm and stress where an adolescent relationships and the interpersonal exchanges of ideas, perspectives, and actions experienced
within them supposedly promote the development of social cognition and social competence, a destructive cycle of negativity may eventuate. If social relationships and social exchange promote the development of social cognition and social skills, and if the lack of mature and competent social thinking and behavior negate opportunities for the development and maintenance of productive social relationships, an adolescent comes quickly to realize what the costs of poor social skills may be, both interpersonally and intra-personally. When an adolescent is learning disabled then the situation becomes more serious.

1.4.2. SOCIAL COMPETENCE IN LEARNING DISABLED AND NON LEARNING DISABLED ADOLESCENTS: AN EMPIRICAL SUPPORT

The recent marked shift from the sole focus on the core cognitive competence of adolescents to their holistic development has emphasized the development of various personal and interpersonal competencies. Social, emotional, moral competencies are some of the competencies considered necessary for positive adolescent development. Social and emotional competencies have been related to positive adaptive outcomes, psychological well-being (Chae & Lee, 2011; Williams & Galliher, 2006), and school, home and peer adjustment (Mpofu, Thomas & Chan, 2004; Chen et al., 2010) among adolescents. The quality of the interpersonal interaction with the peers and other significant people at school and home are extremely important for positive adolescent adaptive outcomes. Such interactions obviously involve the ability for emotion management and regulation. Saarni (2000) reported that social competences change over the life course, and depend on the development of capabilities such as social awareness, social skills, and self-confidence. For example, young children learn to play games with others, but also learn important forms of self-control, including patience, sharing and temper management, and empathy with others. Later on they have to develop more integrated forms of self-regulation, with an emphasis on fitting in and achieving, as well as increased coordination of social skills and understanding of social scripts as they unfold.

In adolescence, however, attaining social competence is a uniquely complex task that requires the development of sophisticated behavioral repertoires to meet the growing demands of peer relationships and educational or vocational challenges. Social competence assessed by adolescents may vary as it lays different meanings based upon their perceptions. As influence over behavior shifts in adolescence from being primarily parental to a combination and interaction of parent and peer influences, potential differences and conflicts between the behavior valued by parents and by peers may become increasingly important. Denham et al.
(2009) reported that low levels of social competence are associated with academic failure, behaviour problems, and mental health difficulties across the lifespan and substance abuse in adolescence.

Adolescents currently face more potentially negative experiences at younger ages than ever before, including drugs, suicide and violence (Holmes, 1995). Consequently, it is appropriate to identify the factors which protect adolescents from these negative experiences. Emerging theories of youth development such as resiliency, self-efficacy, and risk protective factors have stressed social competence as an important dimension of successful adolescent development. An understanding of the development, maintenance, and enhancement of social competence is useful in determining how to protect adolescents from negative influences and assist them in reaching their optimal potential. Socially competent adolescents have a sense of belonging, are valued, and are given opportunities to contribute to society (Gullotta, 2000), which to a large extent is made possible within the various social environments where adolescents live such as family, school, and community. Family variables such as parenting style and family communication patterns are found to be strongly influence adolescent’s social competence (Peterson & Leigh, 2001). A powerful social support empowered by supportive relationships and supportive socio-cultural facilitates the development of social competence. The social and cultural barriers such as race, gender and status inhibits the development of social competence. (Bloom, 1999). Popular and socially competent adolescents are able to consider others’ perspectives, can sustain their attention to the play task, and are able to keep them cool in situations involving conflict. They are agreeable and have good problem-solving skills. They enter a group using diplomatic strategies, such as commenting upon the on-going activity and asking permission to join in. They uphold standards of equity and show good companions and fun play partners.

If we talk about social competence of learning disabled adolescents then Teachers and parents have always recognized the central role of social development in the lives of students with learning disabilities (LD). The pioneers of the field of learning disabilities, Kirk (1962), Johnson and Mykelbust (1967) and Orton (1957) also acknowledged social skills as a significant
challenge for many of these students. Yet it was not until 1974 that two research articles were published that made the quality of these children's social lives impossible to ignore. Bryan (1975) who is the pioneer in research on social competence of children with Learning disability reported that mainstreamed children identified as LD were not only less popular than other children, but that their communicative environment with typical non-LD peers was more hostile. These startling findings ignited an explosion of research on the social development of students with LD.

Social competency lays foundation to be socially adapt in various areas of life. It is difficult for adolescents with learning disability to become proficient in these skills. The troubles associated with adolescents who are causing difficulties in classroom and in adulthood are communication, direction sense, listening and finishing a task. While maintaining relationships children and grown-ups must exhibit social adeptness confined within the boundaries of their traditions to make them less dependent and more successful. As for those who showed socially inappropriate behaviours were less liked by their friends and observed to face uninterrupted problems in life (Pavri & Luftig, 2000). Social competency plays an important role for people who are working with learning disabled students. Mellard (1992) analyzed that encoding time required to produce information in various social and educational situations by majority of adolescents with learning disability was more than the average. The most important phase in child’s development is to learn to interact with others successfully with further possible future effect.

Osman (2011) referred that learning disabled adolescents like to spend more time in solidarity, watching TV, surfing internet and playing games rather than showing interest in interaction with their peers due to problems in making and keeping them. Haager & Vaughn (2003) reported that indeed not every learning disabled adolescent experiences problems related to social areas. It has been observed that all LD adolescents are not unacceptable by the society, but the adolescents who perform well in other fields like athletic, comedy and so on are appreciated in the society, when they are also facing learning disabilities. Adolescents with learning disability are found to be as smart as or smarter than their peers (Brayan, 1999). But when they are left to figure out things themselves or had been imparted with education in conventional ways tend to
experience difficulty in encoding, decoding information, logical reasoning, reading, spelling and writing. The trouble in expressing, calming and reading non-verbal cues lead them to experience difficulty with friends and in the classroom. They have difficulty in expressing their emotions, reading non-verbal cues and settling their aggression leading to troubles in the classroom and with schoolmate.

Smith (2001) described that many adolescents with learning disability are teased and taunted all their lives, and they feel so rotten about themselves, that even when they succeed they are not comfortable with themselves…..Usually, as early as in kindergarten, children with learning disability are smart enough to figure out that their peers are able to recognize letters and play with symbols successfully and they are not. Some LD and NLD adolescents, seem born to make life easy for parents and for themselves as well. They show a developing attitude towards life, care for others, better qualities of peer acceptance since they develop social awareness in early stages of life and continue it as they grow but lack of qualities to win friends and upkeep with them for many learning disabled adolescents become the one major problem in their life. Use of technology like calculators and computers can ease the writing, arithmetic and logical calculations but can’t alter the loneliness which learning disabled adolescents experience in recess at school or in family outing. For an intellectual interpersonal relation and functioning social competence provides the skills necessary. These skills to earn a positive response or feedback from others include both verbal and non-verbal behaviours that are socially valued.

Osman (2011) studied that social disabilities might be conceptualized on three major levels:

- **Firstly, a cognitive deficit who does not know to react to a given situation-knowing not to yell or be loud in temple or dealing with strangers to offer them assistance.**
- **Secondly, a performance deficit which observed in children or adolescents having the skills but are unable to apply them. They understand what they should do, the apt behavior, but their own requirements cross their cognitions. Some children cannot afford losing, thus they use unfair means to confirm their victory knowing they shouldn’t cheat.**
- **Thirdly, they lack the ability of evaluation of their own or other’s behavior. They do not understand the consequences of their own doing and hence does not require monitoring on their actions. Each experience is fresh with little generalization, ramifications and anticipations are non-existent.**

In addition, socially disabled students are less capable to respond or to behave in social matters compared to students of their age who react in concordance with society. Thus, they act,
unknowingly of the consequences which may arise due to their social behavior. Often it is observed that learning disabled students display inappropriate behaviours in the classroom. Teachers reported more negative engagement between these students with their peers (LaGreca & Stone, 1990; Sitlington, 1996). These students experiences difficulties to relate with simple rules of classroom and are not able to properly communicate with their peers, an inclusion to their problems (Pavri & Luftig, 2000). Learning disabled adolescents are unable to make understand themselves to others. Since, they face problems in clarifying questions, they create themselves a large gap to bridge for group working and to achieve self-control (Bender & Wall, 2001). For children with learning disability, lack in social competency is responsible for poor performances in academic field.

Coleman & Minnett (1993) suggests that academic performance is so crucially related to social competency that researchers are focusing to make social competence as number one criteria for categorizing learning disabled children. However, this idea may seem very extreme but it exhibit its need for students to perform better in classroom and society. Studies of social competence and peer interactions continue to examine the behavioral determinants of children’s peer relationships, the hypothesis that social skills deficits account for poor social functioning, the origins of these skills and deficits, and types of peer relationships and relationship features. Innovative research efforts include an attempt to determine how and to what degree a child’s behaviors and peer relationships separately contribute to development and adjustment. The researcher has summarized the list of variables studied by the researcher along with social competence within the age group of adolescents in the tabular presentation given on the next page:

Table 1.3 Exhibiting the Summary of the Variables attended by the Researchers along with social competence within the age group of adolescents in India and Abroad

<table>
<thead>
<tr>
<th>S.N.</th>
<th>Name of the Researcher</th>
<th>Year</th>
<th>Variables Studied</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Spivack</td>
<td>1976</td>
<td>Social Problem-Solving Skills</td>
</tr>
<tr>
<td>2.</td>
<td>Berg</td>
<td>1982</td>
<td>Social Problem-Solving Skills</td>
</tr>
<tr>
<td>3.</td>
<td>Gresham and Elliott</td>
<td>1984</td>
<td>Performance</td>
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<td></td>
<td></td>
<td></td>
<td>Self-Control</td>
</tr>
<tr>
<td>4.</td>
<td>LaGreca and Stone</td>
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<td>Solovyjouiene</td>
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<td>Xinyin</td>
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<td>Abhilasha</td>
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<td>31</td>
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<td>2010</td>
<td>Self-Esteem, Social Relations</td>
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It can be observed from the Table 1.2 that researchers have also examined the affective and physiological correlates of social competence and the complex interplay of emotional dispositions, emotional regulation, and behavioral regulation in socially competent and incompetent children. The role of sex/gender in children’s peer relationships as well as cultural and ethnic similarities and differences in children’s social competence and peer relationships are also being studied through current research efforts. But there is also need to examine or assess the other variables or domains of social competence which contribute directly or indirectly in adolescent’s social life.

Many researchers explored the social competence with other subsequent variables like Resilience, emotional competence, mindfulness, personality development, emotional intelligence, behaviour and many more including social problem-solving skills, conflict resolution, self-efficacy and self-control. The researcher found last four variables most relevant and related to social competence. That is why the present study deals only with these four variables along with social competence in learning disabled and non learning disabled adolescents. However the social competence has been explained by the researcher in previous pages but it is also important to know about the role of Social problem-Solving Skills, Conflict
resolution, Self-Efficacy and Self-Control in Social Competence of learning disabled and non-learning disabled adolescents.

1.5.0. SOCIAL PROBLEM-SOLVING SKILLS IN LEARNING DISABLED AND NON-LEARNING DISABLED ADOLESCENTS

It has long been recognized that adolescence is a time of personal change and transition; a developmental period where the adolescent is faced with establishing social relationships that differ in many ways from those of childhood. In addition, adolescents are increasingly faced with developing the ability to solve social problems independently. Almost without exception, problems in adolescence involve interpersonal relationships and require the development and use of effective social skills.

Learning Social problem-solving skills is a significant contributor to an individuals' socio-emotional wellbeing (Pearson & Hall, 2006). The term social problem-solving refers to problem-solving as it occurs in the natural environment or real world. It is defined as the self-directed cognitive–behavioural process by which a person attempts to identify or discover effective or adaptive solutions for specific problematic situations encountered in the course of everyday living. (D'Zurilla & Maydeu–Olivares, 1995; D'Zurilla & Nezu, 1982, 1999). The most widely used approach by D'Zurilla & Nezu describes problem-solving in terms of two main ingredients. Firstly, “Problem orientation” i.e. whether you have a “positive” or “negative” attitude towards life’s problems in general. Positive Problem Orientation (PPO) is described as a constructive problem-solving cognitive set that involves the general disposition to appraise a problem as a challenge for benefit rather than a threat, believe that problems are solvable, believe in ones’ personal ability to solve problems successfully, to believe that successful problem-solving takes time, effort, and persistence, and committing oneself to solving problems with dispatch rather than avoidance. Negative Problem Orientation (NPO) is the dysfunctional or inhibitive cognitive emotional set that involves the general tendency to view a problem as a significant threat to well being, doubt one’s personal ability to solve problems successfully and become frustrated and upset when confronted with problems in living (D'Zurilla & Maydeu–Olivares, 1995; D’Zurilla & Nezu, 1982, 1999). The second ingredient of social problem-solving is the “Problem-solving style”, which can be classed as either unhelpful (termed “impulsive/careless” or “avoidant”) or helpful (termed “rational”). Impulsivity Style – (IS) is a dysfunctional problem-solving pattern characterized by active attempts to apply problem-solving strategies and techniques. However, these attempts are narrow, impulsive, careless, hurried, and incomplete. Avoidance Style (AS) is another dysfunctional problem-solving dimension characterized by procrastination, passivity or inaction, and dependency. Rational Problem-solving (RPS) is a constructive problem-solving style that is defined as a rational, deliberate, systematic, and skillful application of effective or adaptive problem-solving principles and techniques. (D’Zurilla & Maydeu–Olivares, 1995; D’Zurilla & Nezu, 1982, 1999).

Good problem-solving skills can promote healthier, pro-social decisions in a variety of areas that affect the adolescent, including those choices that affect their interpersonal relationships.

Ronning et al. (2003) argue persuasively for the importance of considering individual differences in problem-solving. They contend that research concerned primarily with methods
and knowledge acquisition is incomplete because the processes used when solving a problem may depend both on the characteristics of the problem and on the knowledge possessed by the problem-solver. Gange (1999) proposes that successful problem-solving require intellectual skills, verbal knowledge, and cognitive strategies. These capabilities are learned and thus will vary among adolescents, but can be improved with proper training and instruction.

Although the social status and interactions of children with LD do appear to differ in some ways from those of their peers, the processes underlying these differences are less understood (Pearl, 1992). Thus, the focus within the field of LD has shifted toward identifying differences in various social cognition skills between children with and without LD in an attempt to explore possible explanations for these children's difficulties in the social realm (Bryan, 1991). By 1991, approximately twenty studies had been done on whether social skills training with children who are learning disabled would improve their social skills. The studies showed that one could improve social skills in children, but that such a change did not necessarily improve the child's social acceptance with non-learning disabled peers (Vaughn, Hogan, Kouzekanani, and Shapiro, 1990). Some research studies show that adolescents with LD may have more social problems, being more likely to be rejected than the control group, and they may show higher signs of aggression (Swanson and Malone, 1992). Researchers at the University of Georgia hypothesize that in some children who have a "right hemispheric dysfunction", the brain may also have trouble processing nonverbal cues, difficulty with Social problem-solving tasks, and issues with speech prosody and social skills (Semrud-Clikeman and Hynd, 1990).

Several studies have explored differences between children with and without LD in social problem-solving skills, an important aspect of social competence (Spivack, Platt & Shure, 1976). Carlson (1987) presented 48 second-through fifth grade LD and NLD boys with four open-ended hypothetical, peer-related social situations, and interview about their goals and strategies. It is that boys with LD to be deficient in the quality and quantity of strategies spontaneously chosen in resolving two of the four situations that dealt with peer conflicts. Three other studies (Berg, 1982; Schneider & Yoshida, 1988; Silver & Young, 1985) that used role-playing measures of social problem-solving skills (Platt & Spivack, 1975; Spivack et al., 1976) found children and adolescents with LD to be deficient in identifying a social problem, in generating alternative solutions to hypothetical social situations.

Swanson & Malone’s (1992) conducted a meta-analytic synthesis of the literature regarding the social competence of adolescents with LD showed that these adolescents, spent 80 per cent less on task time than did NLD adolescents, and evidenced more interfering problem behaviours (i.e., internalizing and externalizing) than 78 per cent of NLD adolescents. Bryan, Sonnefeld, and Greenberg (1981) reported that adolescents with LD were as aware as NLD adolescents of
the effectiveness of different integration strategies. *Learning Disability Association of Canada* (2006) reported that Learning disabled individuals have also been found exhibiting poor responses in problem-solving, cue understanding and development in social matters. Furthermore, *American Psychiatric Association; APA, (2000)* concluded that social and recruitment domains are the areas of difficulty for learning disabled adults. Difficulties with anxiety, withdrawal, depression, and low self-esteem are common within the LD population (*Klassen, & Hannock, 2011; Nelson & Harwood, 2011*).

Adolescents who have learning disabilities may lack the key social skills necessary for success in the educational setting, as well as, social interactions later in life (*Bovey & Strain, 2003*). Many times learning disability of adolescent can negatively impact not only their academic functioning, but their social awareness as well. In some instances, adolescents with a learning disability do not pick up on social cues and need to be taught appropriate social problem-solving skills. *Seevers & Jones-Blank (2008)* examined that many adolescents with learning disabilities are less socially skilled than same aged peers. When they are asked to use cognitive social behaviors, students with learning disabilities may be less able to do so then their peers.

Studies of the social problem-solving skills and competence of adolescents with and without Learning Disability focused exclusively on only one or two aspects of the social-cognitive process, mainly on the processes of perception of social stimuli and on generating possible solutions to various hypothetical social situations. However, competent social problem-solving skills and social behaviours are determined by more than one cognitive process, as suggested by above-mentioned studies.

### 1.6.0. CONFLICT RESOLUTION IN LEARNING DISABLED AND NON LEARNING DISABLED ADOLESCENTS

Conflict is a normal and necessary part of healthy relationships. Two people cannot be expected to agree on everything at all times. When conflict is mismanaged, it can harm the relationship. But when handled in a respectful and positive way, conflict provides an opportunity for growth, ultimately strengthening the bond between two people. Learning how to resolve conflict, rather than avoiding a conflict or confronting it with a wrong approach is very crucial. By learning the
skills needed for successful conflict resolution, disagreements can be overcome with confidence to keep personal and professional relationships strong and growing.

Conflict is an inevitable part of relationships. Although conflict often is perceived as negative, conflict has the potential to positively contribute to both relationship quality and personal development (Scott, 2006). Effective conflict resolution is associated with overall social competence in adolescents through the component skills of problem-solving, decision making, communication, and coping (Van Slyck, Stern & Zak-Place, 1996). Adolescence is a malleable phase. It is the period of transition between childhood to adulthood. It is a period when rapid physiological changes and demands for new social roles take place. The adolescents, due to these changes often face a number of conflicts and dilemmas. Conflicts reflect the complex and sometimes inconsistent wants, values and expectations of individuals and groups. Conflicts can occur on different levels. Interpersonal conflicts occur between strangers, acquaintances, friends, parents and children. Intrapersonal conflicts occur within one self (Wenden, 2008). When conflict is poorly managed it has a negative impact on adolescent’s relationships. However, teaching adolescents the skills for resolving conflict can help significantly. By learning to manage conflict effectively adolescent’s skills for getting along with others can be improved. Adolescents are much happier, will have better interpersonal relationships and intrapersonal attitudes when they know how to manage conflict well. Effective conflict resolution involves managing the emotion evoked in a conflict situation using a negotiation or problem-solving process to determine a mutually acceptable solution (Katz & Lawyer, 1993).

The purposes of conflict resolution are to provide an environment in which each learner can feel physically and psychologically free from threats and danger and can find opportunities to work and learn with others for the mutual achievement of all. Van Slyck & Stern (1991) believed that competence in conflict resolution skills can lead to increased social and academic achievement in the short run and a more harmonious world in the long run. The conflicts faced during early adolescence can be both interpersonal and intrapersonal. Frequency of conflicts varies with each relationship the adolescent is with viz. conflict with parents, conflict with siblings, conflict with friends, conflict with self and conflict in school. Each area of conflict is unique.

The transformation from childhood to adolescence creates a disturbance felt not only by adolescents, but by their parents as well. Adolescents’ and parents’ contrasting desires and experiences contribute to increase in conflict resulting in the deterioration of interaction between the adolescent and the parent. Adolescents also experience a decline in the desire for companionship with their parents leading to increase in conflict and distance in relationships with their parents (Shehata, 2010). This chasm will widen if adolescents are not taught to identify and resolve conflicts.

Siblings represent a significant source of conflict for most children and adolescents. Peer relationships become more complex and diverse, and adolescents must learn to negotiate varying relationship dynamics, including conflict with their peers. At adolescence conflict
with self, affects their psyche. Changes occur simultaneously at both the body and psyche level during this stage. Each teenager is an individual with a unique personality, inherent behavior and unique existing circumstances as well as special interests, likes and dislikes. However, there are also numerous conflicting issues that everyone faces during the adolescent years. An adolescent’s self identity generally focuses on simple characteristics, such as physical appearance, perception of self by peers, etc. along with abstract and multifaceted ideas. Sometimes there is a conflict between the different components of self.

During adolescence, mental, hormonal and physical changes exhibit direct or indirect implications on cerebration, socio-economic development, physiological maturation. In terms of socio-economic development social competence skills are learned. With increase in promotion of social competencies in adolescents has proved to be primary means of inhibiting psychological and social problems such as drug use and delinquency, however exhibited augmentation in academic achievement (Johnson, Johnson, & Dudley, 1992). A number of studies revealed that lack in social problem-solving skills (Dodge & Frame, 1992; Farrington, 1991) but supportive attitude of aggression and violence in violent adolescents’ play positive role in conflict resolution skills. (Guerra, Huesmann, & Hanish, 1995). In fact, the major ingredient of aggression reduction programs in schools is conflict resolution skills taught to learning disabled adolescents (Guiliano, 1994). Alike for all social competencies family conditions, parenting styles, temperament, peer pressure to adhere to group norms, cultural factors summarized by gender and ethnic socialization do also impact conflict resolution skills (Brofenbrenner, 1993). There has been a critical connection between child socio-cultural context and conflict resolution styles suggested by many researchers. Lind et al. (1994) found that adolescents’ choices were influenced by both ethnicity and gender for conflict sort-out styles such as appealing and negotiation.

A large number of studies displayed significant difficulties when learning disabled children were compared with non learning disabled children which are (i) Augmentation in difficulty level to understand social situations, (ii) Lower qualitative and quantitative strategies, approach in sorting social problems, (iii) Poor and ineffective means of attaining social objectives they pursue (Kavale & Forness, 1996; Lewandowski & Barlow, 2000; Swanson & Malone, 1992). The difficulties regarding adjustment, social and emotional performance is in relationship with poor social adeptness of learning disabled children for which they face acceptance or negligence
by class (Greenham, 1999; Vaughn, Elbaum, & Boardman, 2001). Social situations presuming the activation of a large portion of individual’s social skills, such as interpersonal conflict, place more stress on the social competence deficits of children with LD. The management of interpersonal conflict is a critical parameter of the individual’s social adjustment, since a failure in conflict resolution adversely affects interpersonal relationships and may lead to the complete social isolation of the individual, or his/her transformation into the permanent victim of other’s demands and aggression (Mishna, 2003; Wilmot & Hocker, 2001).

1.7.0. SELF-EFFICACY IN LEARNING DISABLED AND NON LEARNING DISABLED ADOLESCENTS

Self-efficacy is “the belief in one’s capabilities to organize and execute the courses of action required to manage prospective situations” (Bandura, 1995). These self-beliefs are form in adolescents from four sources: (i) mastery experience (performance on previous similar tasks); (ii) vicarious experience (modeling, or the observation of others’ performance on similar tasks); (iii) verbal persuasion (feedback from significant others); and (iv) physiological and emotional reactions (e.g., anxiety) to specific tasks. In other words, self-efficacy is a person’s belief in his or her ability to succeed in a particular situation. Bandura (1994) described these beliefs as determinants of how people think, behave, and feel. Adolescent’s sense of self-efficacy can play a major role in how one can approach to their goals, tasks, and challenges.

Bandura (1997) said that there are many ways for human accomplishments and personal keep-up to gain momentum through a robust sense of efficacy. People with greater certainty in their capabilities face difficult tasks as challenges to achieve instead of their avoidance. Due to such attitude of mastering challenges create deep interest and participation in activities. They are capable of maintaining strong commitment for themselves in attaining damping goals. They are propulsive and substantial in their efforts at the times of failures or set-backs. They abruptly restore their self-efficacy sense after these failures. They take failures as a result of less efforts or deficiency in knowledge and skills which can be acquired to reverse these set-backs. They are certain that they can control threatening situations with assurance. Such an attitude of productive results help to boost accomplishments, reduce depression and short-term stresses.
A strong sense of efficacy enhances adolescent’s accomplishment and personal well-being in many ways. Adolescents with high assurance in their capabilities approach difficult tasks as challenges to be mastered rather than as threats to be avoided. Such an efficacious outlook fosters intrinsic interest and deep engrossment in activities. They set themselves challenging goals and maintain strong commitment to them. They heighten and sustain their efforts in the face of failure. They quickly recover their sense of efficacy after failures or setbacks. They attribute failure to insufficient effort or deficient knowledge and skills which are acquirable. They approach threatening situations with assurance that they can exercise control over them. Such an efficacious outlook produces personal accomplishments, reduces stress and lowers vulnerability to depression. Self-efficacy can also be defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how adolescents feel, think, motivate themselves and behave.

Klassen (2007) concluded that the degree of self-efficacy an adolescent establishes will impact the level of performance demonstrated by him. An adolescent’s true level and possession of certain skills can be negated by the level of self-efficacy. The development of self-efficacy has been identified as a metacognitive task. Self-efficacy has naturally demonstrated a declination upon the onset of adolescence. Previous experience, comparison with others, verbal persuasion, and affective and psychological states affect self-efficacy (Feldman et al., 2011). Bandura (1997) identifies supportive relationships as a factor which will increase personal efficacy.

Although researchers have explored several fields related to social settings of individuals with LD (Gans et al., 2003; Stone & May, 2002) but poor attention has been given to the beliefs of self-efficacy in Learning Disabled individuals, even when self-efficacy has set-forth a significant motive to learn (Zimmerman, 2000). Lackaye and Margalit (2008) described that Learning Disabled students compared to peers without learning disabilities have exhibited lower academic self-efficacy. Only a small number of studies have examined the self-efficacy beliefs of adolescents with learning disability. Feldman, Kim, and Elliott (2011) determined that when Learning Disabled students are provided with personal testing accommodations they performed
better on test with high test taking self-efficacy, when they are provided with individualized testing accommodations. However, all adolescents are capable in identifying their ambitions, things they would like to alter, and things to set-forth in motion for achievement but in case of Learning Disabled adolescents categorizing these plans into action seems complex to them. Salomon (1999) has found that adolescent’s self-efficacy lays down the pathways to approach goals, tasks, and challenges. But learning disabled adolescents feel weak sense of self-efficacy in such things like: Getting rid of difficult tasks; Believe that challenging tasks and conditions are out of their capabilities; Focus on failings and negative results; and losing confidence in personal abilities.

Adolescents with learning disabilities are not only faced with the typical developmental tasks and challenges of overcoming this natural decline in self-efficacy, but they are also grappling with specifically identified learning impairments in one or more academic domains. Klassen (2008) concluded that Metacognitive awareness in students with learning disabilities is lower when compared with their peers without learning disabilities. With measured lower metacognitive awareness, adolescent students with learning disabilities have a decreased ability to form self-efficacy.

Most self-efficacy researches have shown that individuals with LD rate their self-efficacy beliefs comparatively lower than their peers (Hampton & Mason, 2003; Tabassam & Grainger, 2002). However, an important difference emerges in the interpretation of these mean differences in self-beliefs. In another sense, although individuals with learning disability display lower self-efficacy than their non-learning disabled friends, their general expressions of self-confidence still determined over predictions of their subsequent academic performance. This apparent academic overconfidence may result in inadequate preparation for academic challenges, because accurate self-assessments are necessary for students to take responsibility for their own learning (Heath, & Suls, 2004). Dunning et al. (2004) stated that Miscalibrations of self-efficacy beliefs are not trivial—accurate self-assessment allows students to plan more effectively, to become more academically autonomous, and to apply their learning efforts appropriately.
1.8.0. SELF-CONTROL IN LEARNING DISABLED AND NON LEARNING DISABLED ADOLESCENTS

Gresham and Elliott (1984) proposed that these children could have one of four deficits: skill deficits, in which children did not have the knowledge or cognitive abilities to carry out a certain behavior, performance deficits, self-control skill deficits, and self-control performance deficits, in which children had excessive anxiety or impulsivity that prohibited proper execution of the behaviors or skills they knew and understood.

Bertrams & Dickhauser (2009) reported that a significant relationship between self-management (the capacity to control oneself) or pass impulsive break-through and performance in schools. Moreover, referring to various ranges of desired outcomes, self-control is defined as an important ability for achieving success in life that goes up and down with academic achievements (Baumeister, Leith, Muraven, & Bratlavsky, 1998; Gailliot, Plant, Butz, & Baumeister, 2007; Tangney, Baumeister, & Boone, 2004). It has been cited that for adjustments in life, in successful academics, in an adolescent’s life, self-management or self-control skills have played as significant competencies. Self-control has attracted substantial attention. Duckworth and Kern (2011) concluded that more than 3% of all publications are indexed in the PsycInfo database by the keywords self-control and its related terms including self-discipline, delay of gratification, self-regulation, and impulse control.

Self-control is generally defined as the ability to resist short-term impulses in order to prioritise longer-term goals. Baumeister, Vohs, and Tice (2007) stated that Self-control is the capacity for altering one’s own responses, especially to bring them into line with standards such as ideals, values, morals, and social expectations, and to support the attainment of long-term goals. This involves exerting self-control over behaviours, feelings, and thoughts in order to conform to rules, plans, promises, ideals, and other standards. Gottfredson and Hirschi (1990) elaborated six inter-related characteristics of lack of self-control including: (i) impulsivity and inability to delay gratification, (ii) lack of persistence, tenacity, or diligence, (iii) partaking in novelty or risk-seeking activities, (iv) little value of intellectual ability, (v) self-centeredness, and (vi) volatile temper. These characteristics are believed to come together for individuals with low self-control. Furthermore, Gottfredson and Hirschi (1990) posit that self-control is malleable during the first 10–12 years of life, but after this point, while self-control tends to improve with age as socialization continues to occur, it is largely unresponsive to any external intervention effort. Thus, although absolute levels of self-control may change within adolescents (increasing rather than decreasing), relative rankings between adolescents will remain constant over the life course.

Behaviorists have demonstrated that after successful training in self-management or self-control, there is a decline in adolescents’ disruptive and inattentive behaviours. The individual
characteristic of social competence that may be directly affecting adolescents is self-control. The ability to conquer over self-behaviour as a repertoire of skills can be conceptualized under self-control. Many studies have explored the correlational relationship between self-control and achievement and adjustment outcomes. These studies find that self-control is a significant predictor of attainment even when prior achievement is taken into account (Duckworth, 2010; Duckworth, Tsukayama, & May, 2010; Moffitt et al., 2010; Wolfe & Johnson, 1995). Greater childhood self-control has been associated with better physical health, less substance dependence, higher personal finances, and fewer instances of criminal offending in adulthood (Moffitt et al., 2010).

Correlational evidence suggests that childhood self-control predicts achievement and adjustment outcomes, even in adulthood. Experimental studies find that self-control can be improved up to age 10 (Piquero et al., 2010). However, fewer experimental randomized studies exist indicating that self-control is malleable after that point, particularly for adolescents and young adults. Although self-control may be considered a personality trait—the factors that underlie it—may be influenced by the strategies one utilizes to delay gratification. Therefore, while adolescents may have different innate levels of self-control as a personality trait, the degree to which they demonstrate self-controlled behaviour may depend on their meta-cognitive skills as well as their environment. A majority of the research that has been conducted has explored the development of self-control during two periods: preschool and adolescence. The studies that have focused on the preschool period have tried to determine when self-control emerges and its developmental trajectory (Kochanska, 2001). In contrast, because the adolescent period is characterized by sweeping biological, emotional, cognitive, and social changes, the research has focused on topics such as sensation seeking and impulsivity and their relation to risk-taking behavior and psychopathology (Harden, 2011 & Steinberg, 2010). These environmental changes, in addition to natural maturation, may result in some interesting changes to self-control during this period. Recently, a new perspective on self-control has emerged that is informed by advances in psychological science (Hofmann, 2009). According to this view, failure at or low levels of self-control in adolescents may stem from strong impulses, weak control, or a combination of both.

Kremon and Block (1998) believed that endogenous factors (such as temperament and characteristics of neurons) have a large effect on the development of self-control in adolescents. The sex chromosomes result in differences in brain and endocrine functioning, which results in different psychological and physical inclinations. All these differences can
affect adolescent's behavior directly or indirectly to some degree. The dual systems of self-control have different developmental curves in adolescents aged 14 to 16 years. Specifically, the poor-control system remains stable, whereas the good-self-control system improves by the ages. Wills, Sandy & Yaeger (2000) concluded that better incidence of self-control reflects that the chances to approach situations with more cerebration, monitoring actions, e.g. focused attention, optimism, ambitiousness, dependability and problem-encountering skills, whereas poor self-control exhibits tendency to encounter situations without considering the approach. Wills & Cleary (1999) revealed that Poor self-control has been shown to be positively associated with learning disabled adolescent and peer substance use. Poor self-control has been shown to be inversely related to substance-use resistance efficacy. This may indicate that learning disabled adolescents who are high in poor control have less confidence in their ability or less intentions to refuse substance offers (Wills et al., 2000).

Vygotsky’s theory was that “social interaction plays an important role in student learning. It is through social interaction that students learn from each other” (Woolfolk, 2009). Vygotsky explored three different types of speech: social, private, and internal. He referred to social speech as the instructions given by adults to children. Private speech allows children to process what the adult has said and try to apply it to similar situations. Self-control is an example of private speech because children are using for themselves the same “language that adults use to regulate behavior” (Wilhelm, 2001). One of the common complaints from both regular and special educators, is that students with learning disabilities lack self-control. Some of them exhibit inappropriate behaviors throughout the school environment. Self-control models usually include self-assessment, self-evaluation, self-recording, and self-reinforcement. The student should have the necessary skills and understanding of the steps toward performing the target behavior. The student will then be the judge of his or her own progress. Self-reinforcement trains students to give themselves praise which eliminates the need for external reinforcers (Lloyd, 2010).

2.0.0. EMERGENCE OF THE RESEARCH PROBLEM

It is well-established fact that some adolescents seem perplexed, learning basic skills that many take for granted. Some of these adolescents continue to demonstrate problems of learning as
they proceed through school. These adolescents often have unexpected under-achievement or discrepancy between ability and achievement (Kulkarni, et al., 2006). These discrepancy and failure at academic level adversely affects their behavioral and social aspect. If appropriate strategies have to be implemented by teachers and parents then, it is very much necessary to be aware of their psycho-social problems. Gresham and Elliott (2008) reported that merely placing adolescents in the regular classrooms cannot ensure adequate development of social skills. Social skills are difficult to acquire and require systematic instruction. Especially for learning disabled adolescents regular classroom provides a social context to acquire social skills from classmate and expand their social relation. Some adolescents with learning disabilities possess order of social competence superior or equal to their peers. However, deficiency in social skills creates feelings of inferiority for a large subgroup of LD adolescents and adults. Lavoie (2005) has enumerated the basic characteristics of Learning Disabled Adolescents in terms of their manifested social behavior as they are more likely to choose socially unacceptable behaviours in social situations. Learning disabled adolescents are less likely to predict consequences for their social behavior and to adjust to the characteristics of their listener in discussions or conversations. Adolescents with learning disabilities are unable to accomplish complex social interactions successfully. They are more prone to rejection by their peers and class students and are not likely to adjust into varying social situations. The threshold limit of tolerance in LD adolescents is less for irritations and set-backs. Alexander and Slinger (2004) revealed that 75 per cent Learning disabled adolescents have social difficulties such as making and keeping friends in comparison to their normal peers. In fact, social and psychological problems are very much interconnected (Raskind, 2005). The social rejection of adolescents results in low self-control, feeling of loneliness, which in turn may lead to psychological difficulties such as conflict resolution, frustration, etc. (Marsh et al., 2006). The adolescents when leave the school should appreciate the importance of getting along with others and of acting towards them in ways which would be socially favorable to them. They should be sufficiently sensitive to the reactions of other people to avoid over compensatory behavior such as showing off, boasting and lying. These adolescents may have
difficulties in understanding, remembering, grasping the work and its demand. Wozeniak (2002) and Campbell (2000) reported in different studies that learning disabled adolescents have lower social competence in comparison to non learning disabled adolescents. Hanneman (2007) reported that learning disabled adolescents differs significantly in their self-concept. LD adolescents have lower self-concept, which adversely affects their social competence.

Consequently, it is appropriate to identify the factors, which help in protecting adolescents from these experiences. Emerging theories of adolescent’s development such as self-efficacy, and risk or protective factors have stressed social competence as an important dimension of successful adolescent development. An understanding of the development, maintenance, enhancement of social competence is useful in determining how to help and protect adolescents from negative influences and assist them in reaching their optimal potential. Recognition of various psycho-social problems of the adolescents is an important element in the approach to the solution of the problem faced by them, which will further be helpful in developing the potentialities, confidence and competence to make them more self-sufficient and independent.

Social incompetency in learning disabled adolescents may lead to multi-pronged conflict in their survival in the society especially the inferiority complex which may further lead them to commit such as heinous in their lives, which definitely is a crime against humanity and may never be desired and wished for. So perceiving and analyzing the conflicts of the socially incompetent learning disabled adolescents and resolving them amicably enhance and motivate them to lead a respectable and esteemed life like other adolescents. There are umpteen examples of successful learning disabled adolescent who have excelled and surpassed so-called abled ones in every aspect of activity and fields. Once they have been properly motivated, guided and uplifted, where ever situation warranted. So, researcher wishes to explore the nuances of their abilities within their disabilities which definitely may give them a respectable life.

3.0.0. JUSTIFICATION OF THE RESEARCH PROBLEM

There are different aims and objectives of education and one of the crucial in these aims is social development of adolescents according to their abilities, so that they can behave in a socially approved manner in society. Social competence plays an integral part in how well a
adolescent’s transition is into adulthood. Without adequate social skills adolescents may experience trouble in the areas of employment, daily living skills, independent living and participation in the community. A lack of social competency can be due to situational factors: it often involves perceived behaviours. Tur Kaspa et al., (1994) indicated that the majority of adolescents with a learning disability need more time than average to encode and produce information in various social and educational situation which increased level of social awareness and self-consciousness that accompanies the advances social reasoning of adolescents.

Lack of social competence in adolescents encompass more than just difficulties and delays in academics, they go on to include many problems in other areas, mainly relating to behavior and social skills. Lerner (2000) described that there are many different kinds of socio-behavioral problems also which are found in adolescents due to lower social competence like distractibility, social skills disabilities, poor self-concept, hyperactivity, withdrawal, dependency and other problems. Lisa et al. (2003) reported that the adolescents with learning disabilities have an increased prevalence of psycho-social adjustment problems as compared to their normal peers. Some adolescents who are unable to learn or adjust in school become frustrated, anxious, depressed or even angry about their lack of academic achievement (Ramaa and Gowramma, 2002). Their academic struggles and failure are often met with disapproval by teachers, peers, and parents. Such disapproval can take the form of negative labeling of the adolescents. In fact, as a result of constant struggle and failure, a negative self-image may develop even when others offer support and encouragement.

It is observed from the reviewed studies that the socialization process leading learning disabled adolescents for their futuristic social roles, are getting the big threat in school system and its social environment. They do not muster their positive roles and social interaction due to severity of the problem of poor social competence and related skills. It is happen in their sequential social development that they are exposed to social threats, become isolated, live in their own private world, cut-off from their groups and remain and behave as socially isolated children. All these problems are not only having immediate effects but put a full stop to make them sociable
and socially-oriented in future. When these adolescents, today socially neglected and live with these parameters, the researcher has observed from the survey, it may be possibilities that they will become the socially ill-equipped youth in future who will never done to upgrade their social mobility.

Studies on conflict resolution skills and styles in adolescents are few however most have examined conflict within school-settings. DeCecco and Richards (1998) interviewed junior high school and high school students about their perceptions of common social conflicts. Turner et al., (1995) investigated the extent to which conflict resolution and social competency promotion programming would be differentially effective based on gender of the participant. In addition to understanding contextual factors in the development of social competence, there is also a need to understand the psychological factors that are involved in or related to their emergence. Self-efficacy has been identified as an important psychological component in the development of social competencies and adolescent risk behavior as reported in the literature of Bandura 1990; 1991; Chung & Elias, 1996). Self-efficacy is acquired via direct experience, vicarious experience, verbal persuasion i.e., encouragement, and emotional arousal. Thus, if an adolescent has the knowledge to resolve social problems without the use of violence or passivity, adolescent is only likely to act accordingly if the confidence to do so exists (Bandura, 1991).

Most of the researches in the field of self-control assumes that self-control is in general better than impulsiveness. Some developmental psychologists argue that this is normal, and people age from infants, who have no ability to think of the future, and hence no self-control or delayed gratification to adults. As a result almost all research done on self-control is from this standpoint and is impulsiveness the more adaptive response in experimental design. More recently some in the field of Developmental Psychology have begun to think of self-control in a more complicated way that takes into account that sometimes impulsiveness is the more adaptive response. In their view, a normal individual should have the capacity to be either impulsive or controlled depending on which is the most adaptive.

It is evident from the discussion in the preceding pages that there is a marked line of differences between learning disabled adolescents and non learning disabled adolescents when the question
arises of their psycho-social make-up. It can be concluded that learning disabled adolescents have unique psycho-social characteristics which are different from the non-learning disabled adolescents. The most important element in the approach to the solution of the problems presented to school and community is recognition of adolescent as an individual and his various relationships with his or her family, community, peers, and other social institutions. It is not possible that a single piece of research can either satisfy all the questions or bring some significant change in the existing scenario but it is sure to add in the database of social competence in adolescents. In this background of researches the researcher has found it justifiable to identify, explore and study psycho-social structure of non learning disabled adolescents in general and learning disabled adolescents in particular. It is the need of the hour to bring timely changes in education for such children to develop their potentialities, confidence, and competencies, and make them independent, instead of just the liability to the society or nation. The exploration of psycho-social aspect of low social competence in Learning Disabled adolescents will be helpful in developing and designing the essential educational infrastructure for them. Thus, besides adding in formulation of social adjustment and social enhancement of adolescents, it could also help in development of the methodology for teaching and also help in improvising an effective teaching-learning environment for them. Moreover, the researcher can develop the necessary insight for fulfilling their learning demands in order to realize the Constitutional obligation, by giving them thrust in the blooming of their psycho-social perspectives of personality to master them in better hierarchy of social engineering.

4.0.0. STATEMENT OF THE RESEARCH PROBLEM

After making an exhaustive survey and its critical pertaining to the variables under consideration the researcher felt it feasible to study the problem as expressed below:

*Predictors of Social Competence in Learning Disabled and Non Learning Disabled Adolescents: Social Problem-Solving Skills, Conflict Resolution, Self-Efficacy and Self-Control*
5.0.0. OPERATIONAL DEFINITIONS OF THE TERMS USED IN THE RESEARCH PROBLEM

The above stated research problem has the following key terms which require specific explanations in order to communicate their precise definitions in the present context. The terms which need detailed contextual definitions are mentioned here:

5.1.0. Social Competence

A major concern for empirical research is that social competencies are generally not well defined or measured. Social competencies comprise interactions between individual characteristics, social demands, and simulative characteristics. They have to be understood as relativistic, as very different social competencies are required and valued in different contexts (Argyle et al., 1985). Behaviours which are functional in one context might be dysfunctional in another, implying that the assessment of social competencies involves culturally based value judgments. These values are however subject to change.

Social competencies are conceptualized differently across disciplines, and even within disciplines there is no agreed consensus of their definition. Within psychology social competencies are defined as personality traits (Sarason, 1981) which can influence the personal capabilities like sympathy, tolerance, self-realization, cooperation skills, ability of adjustment and interaction with others in provided social conditions or social environment (Argyle, 1994; Tajfel, 1981); as people’s belief about their efficacy (Bandura, 1997), as social (Gardner, 1999) or even emotional intelligence (Goleman, 1995). Within pedagogy it is summarized as lifelong inter socio-cultural learning. In economics social competencies are sometimes described as ‘soft skills’ constituting abilities like team work, motivation among colleagues and clients, and flexibility. Economic terms such as social capital are used in sociology (Putnam, 2000; Halpern, 2005). Based on variety of definitions it is must to accomplish a practical definition that acknowledges differences in focus, components and skills. So that some researchers tried to define the concept of social competence, which are given below:
Arendt (1958) defined “Social competencies can be broadly defined as the capabilities enabling individuals ‘to live together in the world’ comprising aspects of interpersonal, intercultural, social and civic competencies”.

McFall (1982) defined that the person’s judgment to react on any given situation is equivalence to social competence. The necessary factors regarding children’s and adolescent’s social competence include their behavior, reaction, adjustment, and judgment despite of their lack of concentration into situation into situations and social behavior. (Dirks et al., 2007).

Rubin (1992) defined “social competence as the ability to achieve personal goals in social interaction while simultaneously maintaining positive relationships with others over time and across situations”. Even after such a broad definition it is probably difficult to properly defined general social competence because it may vary with age and demands of particular situations which require a specific set of skills and behavior to cope up with practical world.

In context of present study, the social competence is operationally defined as adolescent’s ability to establish and maintain high quality and mutually satisfying behaviors and to avoid negative treatment. It is social, emotional and cognitive (academic) skill, and behavior that individual needs for successful social adaptation. It includes the factors *viz.* pro-social attitude, social competition, social leadership, social tolerance, and social maturity.

### 5.2.0. Social Problem-Solving Skills

The term social problem-solving skills can be defined as follows:

Elias & Clabby (1998) defined that Social Problem-Solving Skills are those skills that students use to analyze, understand, and prepare to respond to everyday problems, decisions, and conflicts.

Social problem-solving, according to D’Zurilla and Nezu (1999) involves the ability to recognize a problem when it arises, define the problem clearly and accurately, produce a diversity of possible solutions, anticipate outcomes, formulate an effective action plan that has stepwise stages, and carry out the action plan effectively.

High Reach Learning (2007) defined Social Problem-solving skills as the ability to analyze a situation and then form a workable solution.
According to Richard (2002) Social problem-solving skills are life skills that give each person greater control and autonomy. They are key to maintaining employment and relationships. The ability to develop and maintain appropriate interactions is recognized as an important influence on success. This is because the establishment of relationships is a vital social skill in both a child's and adult's life.

The term social problem-solving can be defined in present context as the self-directed cognitive behavioral process by which a person attempts to identify or discover effective or adaptive ways of coping with problematic situations encountered in the course of everyday living.

5.3.0. Conflict Resolution
Conflict resolution is a process aimed to eliminate the roots of conflict. The term conflict resolution is sometimes wrongly cited as dispute resolution. Conflict resolution strategies overwhelm compromise, reconciliation and diplomacy. The process of settling and argument, making a subject of lawsuit and ombudsman processes (formal complaint) are commonly referred with dispute resolution. However, some describe them as conflict resolution. Process of settling and mediation are often referred to as alternative dispute resolution. The conflict resolution can be defined as a process of working through opposing views in order to reach a common goal or mutual purpose.

Conflicts Resolution may be defined in terms of the issues that caused it, the strategies used to address it, or the outcomes or consequences that follow from it. Conflict Resolution is primarily concerned with interpersonal conflict, although intrapersonal conflicts may also be triggered in the course of resolving an interpersonal conflict.

Schellenberg (1996) broadly defined conflict resolution as gives systematic coverage to five main ways people may try to resolve their conflicts: coercion, negotiation, adjudication, mediation, and arbitration. The main theories of conflict, both classic and contemporary, are reviewed under four main categories: individual characteristics theories, social process theories, social structural theories, and formal theories.
5.4.0. Self-Control

Self-control is state of self-governance of every action for which I am responsible. I use my self-control for better direction sense. Use of self-control governs me of my actions which are inappropriate for me or harmful to me or someone else. Self-control inhibits me from danger and provides tools to attain peace and be victorious. Self-control is an ability to conquer one’s emotion and manage problems efficiently in future. In Psychology, it is referred as self-regulations to alleviate functions in Decision-making which can deplete at the time of ego at peak. Self-control is the process of learning to regulate one’s own behaviour in a manner maximally rewarding or satisfying (Barkley, 1997).

Lapowsky (2013) defined “self-control as Thinking about values encourages abstract thinking, which has long been considered a key factor in self-control. This research has implications for the workplace. Self-control is about competition between immediate and delayed gratification”.

In present study the definition of self-control state the condition of inhibiting constitutive or habitual behaviours, feelings, aggressive emotions that would otherwise interpose with goal concentrated behavior.

5.5.0. Self-Efficacy

Self-efficacy is a term which is representative of a theory generated by Albert Bandura. Self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave. Such beliefs produce these diverse effects through four major processes. They include cognitive, motivational, affective and selection processes.

Bandura (1997) formally defined perceived self-efficacy as personal judgments of one’s capabilities to organize and execute courses of action to attain designated goals, and he sought to assess its level, generality and strength across activities and contexts.....Self-efficacy can be defined as the perception of what one believes that they can do with the skills that they have, under various circumstances.
Kirk (2013) defined self-efficacy as the belief in one's capabilities to achieve a goal or an outcome. Students with a strong sense of efficacy are more likely to challenge themselves with difficult tasks and be intrinsically motivated.

In present perspective the term Self-efficacy is defined as people's beliefs about their capabilities to produce designated levels of performance that exercise influence over events that affect their lives. Self-efficacy beliefs determine how people feel, think, motivate themselves and behave. Such beliefs produce these diverse effects through four major processes. They include cognitive, motivational, affective and selection processes.

5.6.0. Learning Disabled Adolescents

The most commonly used definition, from the federal special education law, the Individuals with Disabilities Education Act (IDEA), uses the term Specific Learning Disability (SLD).

According to the IDEA, SLD is “a disorder in one or more of the basic psychological processes involved in understanding or in using language, spoken or written, which disorder may manifest itself in the imperfect ability to listen, think, speak, read, write, spell, or do mathematical calculations. Such term includes such conditions as perceptual disabilities, brain injury, minimal brain dysfunction, dyslexia, and developmental aphasia. Such term does not include a learning problem that is primarily the result of visual, hearing, or motor disabilities, of mental retardation, of emotional disturbance, or of environmental, cultural, or economic disadvantage.”

The National Joint Committee on Learning Disabilities (NJCLD), a national committee of representatives of organizations committed to the education and welfare of individuals with learning disabilities, offers another definition of learning disabilities (LD). According to NJCLD

“Learning disabilities is a general term that refers to a heterogeneous group of disorders manifested by significant difficulties in the acquisition and use of listening, speaking, reading, writing, reasoning, or mathematical skills. These disorders are intrinsic to the individual, presumed to be due to central nervous system dysfunction, and may occur across the lifespan. Problems in self-regulatory behaviors, social perception, and social interaction may exist with learning disabilities but do not, by themselves, constitute a learning disability. Although learning disabilities may occur concomitantly with other disabilities (e.g., sensory impairment, mental retardation, serious emotional disturbance), or with extrinsic influences (such as cultural differences, insufficient or in appropriate instruction), they are not the result of those conditions or influences.” (NJCLD, 1990).

5.7.0. Non Learning Disabled Adolescents

In present study non learning disabled adolescent were defined as those adolescents who don’t suffer from some foundational psychological process relating to speaking, writing languages, understanding cerebration and mathematical calculations.
6.0.0. OBJECTIVES OF THE STUDY

The main aim of the present research is to study that how Social problem-solving skills, Conflict resolution, Self-efficacy and Self-control all together as well as separately predict the Social competence in Learning Disabled adolescents. In order to achieve this aim, the researcher has laid down the following objectives:

1. To study the Social problem-solving skills, Conflict resolution, Self-efficacy, Self-control and Social competence of Learning disabled (LD) and Non Learning disabled (NLD) adolescents.

2. To study the independent effect of Social problem-solving skills, Conflict resolution, Self-efficacy and Self-control on Social competence of Learning disabled and Non Learning disabled adolescents.

3. To study the interactional effect of predictive variables viz. Social problem-solving skills, conflict resolution, self-efficacy and self-control on social competence of Learning disabled and Non Learning disabled adolescents.


5. To predict the contribution of predictive variables viz. Social problem-solving skills, Conflict resolution, Self-efficacy, Self-Control and criterion variable viz. Social competence of Learning disabled and Non Learning disabled adolescents.

7.0.0. HYPOTHESES OF THE STUDY

In order to achieve the above-mentioned objectives the researcher has formulated the following hypotheses:

1. There exists no significant difference between Learning disabled and Non Learning disabled adolescents in reference to Social Problem-Solving Skills, Conflict resolution, Self-efficacy, Self-control and Social Competence.
2. There exists no significant effect of predictive variables Social Problem-Solving Skills, Conflict resolution, Self-efficacy and Self-control on Social Competence in Learning disabled and Non Learning disabled adolescents when treated independently.

3. There exists no significant interactional effect of all predictive variables on Social competence of Learning disabled and Non Learning disabled adolescents.

4. There exists no significant inter-correlation between predictive variables and on criterion variable in Learning disabled and Non Learning disabled adolescents.

5. There exists no significant contribution of predictive variables in prediction of criterion variable.

8.0.0. SIGNIFICANCE OF THE STUDY

It is very important to understand the nature of psychological aspect of adolescents and its impact on their interaction and adjustment with society, parent, teachers and peers. With the in-depth knowledge of psycho-social aspect of adolescents better educational plan can be developed and attempt can be made to provide them with necessary support, so as to retain them in general education system. Being a learning disabled does not mean that a student cannot learn, but of course need a different and specific way to learn unlike the normal children. The adolescent with low social competence have to be trained to use their learning preferences, along with adjustment so that it may not cause much interference in school. These students need a different and more individualized attention of teacher. Educational planning for such adolescent must be forward-looking, giving due attention to their current and future needs, in which they are expected to adapt and function after leaving the school.

The adolescent with low social competence face many challenges other than educational problems, such individual also suffers with various emotional, social, psychological and behavioral problems. Teachers, parent, and peers either ignore or blame them branding it as laziness, attitude or aggression. For promoting the adolescents in respectful manner it is important that purposeful attention and appropriate intervention at right time should be provided to them in both educational and psycho-social arena. The most difficult aspect of this problem
for both learning disabled and non learning disabled adolescents is their psycho-social aspect. This area proves to be extremely difficult even more than the academic aspect. Various psycho-social difficulties arise as the result of discouragement, rejection, and failure in school. Turner and Forneris (2007) indicated that life skills training can help problem-solving and using social supports. Therefore, social skills training are clearly important in improving social and emotional competence among children and its effects have been proved by many researches.

The results of this research were also useful for educators in general and teachers in particular, because the knowledge of the level of social competence will enable them to plan their educational programme keeping in view the needs and ability of adolescents. With better understanding of their social problems and needs, teacher can set more realistic aims and objectives for modifying their behaviors and help them in enhancing the social skills and adjustment. With the revelation of the psycho-social domain, they can easily come into the notice of society and it can bestow upon them necessary services for their potential development so that, in turn, they can give their contribution in the progress of the society. As a high degree of human development cannot be accomplished without uplifting the learning disabled students as they constitute a significant proportion of school-going adolescents. If problem of these adolescents is not attended properly then the economic loss of the society will be immeasurable.

The study projected the realities of their status and also helped in highlighting the frontiers to their problems and understanding of area hitherto neglect and posed an appeal to social conscience through concentrated and objective discussion. It also helped in assisting in integration of the adolescents into society by enhancing their social competence.

Adolescents with learning disabilities require specialized interventions in home, school, community and work place settings, appropriate accommodation for success in social life. Adolescents with learning disabilities are intelligent and having abilities to learn despite difficulties in processing information. Living with learning disabilities can have an ongoing impact on friendship, school, work, self-esteem and daily life.

The outcomes of the study would certainly be of paramount importance in imparting and enhancing the social competence of the Learning Disabled Adolescents. It would be an eye
opener and an auspicious course for those who directly interact or react with these Learning
Disabled Adolescents namely the parents, the teacher and the peer group. The parents are the
primary and vital educators for these Learning Disabled Adolescents. They should create such
an ambience where the adolescent’s disability is never felt as bane for the family. Parent’s
behavior should be supportive and enthusiastic which enhance his/her social competence despite
his/her disabilities. The teacher’s should intervene by training such curricular activities where
these Learning Disabled Adolescents are never ignored. Teachers should invigorate these
Learning Disabled Adolescents in order to excel them in their opted field.

In India approximately 13 to 14 per cent of all school children suffer from learning disorders
(Sadaket, 2009). And most of the cases are not diagnosed, due to various reasons like lack of
resources, awareness, over populated class rooms etc. here the researcher has inclination to
study and explore the alternative approaches and social strategies to address learning disabled
adolescent’s social competence to give them right space in our rhetoric school system. Further
the researcher come across a number of researches on Learning disability where a large number
of variables have been found their place, operating the field but it is also evident that social
competence is either leftover or treated along with some other perspective. There is no specific
law or policy addressing the concerns of parents and children with learning disability. Moreover
standardized methodology or programs, is yet to be designed for them. The researcher hopes,
that this study work as a base to ameliorate the status of social competence in learning disabled
and non learning disabled adolescents. The study would help in decision-making about
instructional methodologies and supportive programs in schools. Thus reinvestigating of the
best practices which suits to this heavy mass of adolescents is necessary in India. This will result
in better cooperative relationship with everyone involved in a child’s education like parents,
teacher and mentors, which is crucial for his success in academics. Hence the need of policy
innovation becomes more urgent.