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Teaching Social Skills to Students on the Autism Spectrum in a School Setting: A Guide for Teachers and other School Practitioners

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Abstract

Autism Spectrum Disorder (ASD) is a disorder characterized by deficits in social communication skills and interpersonal functioning [1]. These deficits make it difficult for children with ASD to engage in successful and meaningful interactions with their peers. This article will discuss how the Building Social Relationships (BSR) program [2,3]; can be modified into a format more amendable to a school setting. The information provided in this article will allow educators to structure the BSR program into manageable sessions, allowing flexibility in the school setting while complementing academic-based programming. This article will also summarize scheduling modifications that can be made to the original BSR program that better align it with the scheduling constraints of a school setting.

Keywords: Autism spectrum disorder; Social skill; Children; Social relationships

Abbreviations: ASD: Autism Spectrum Disorder; BSR: Building Social Relationships; VSM: Video-Self Modeling

Teaching Social Skills to Students on the Autism Spectrum in a School Setting

Autism Spectrum Disorder (ASD) is primarily characterized by a person's impairment in social interaction and social communication skills [1]. Difficulties may vary from child to child; however, difficulties tend to include poor joint attention, difficulty with initiating and responding to social overtures, and difficulty taking another person's perspective. Each of these areas is essential to developing and maintaining social relationships [4]. Some children on the autism spectrum can acquire skills during social skill training in highly structured settings, however, being able to generalize skills to naturalistic settings is difficult for children with ASD. In addition, research examining the use of social skills training in school settings has also reported minimal treatment effectiveness [5]. Being able to identify successful interventions for social skills is essential for promoting effective social interaction skills, adaptive functioning, and level of independence for children with ASD.

Many children with ASD participate in some form of social skills training. Primary settings for such services are typically outpatient clinics, and schools, but scheduling constraints often limit both the scope and intensity of social skills programming in the school setting. A common barrier to these services includes the time commitment it takes to deliver social skills programming efficiently and effectively, while at the same time, meeting the academic demands of the child's educational plan. Many educators agree that social- emotional learning is an essential aspect of the child's development, and empirical data demonstrate the importance of social skills in promoting positive outcomes and preventing deleterious life outcomes. Poor social skills have been associated to numerous negative social and emotional outcomes such as social failure, peer rejection, bullying, anxiety, depression, substance abuse, suicidal ideation, delinquency, and other forms of psychopathology [6-8]. Furthermore, positive social skills and social-emotional instruction have been associated with positive academic outcomes, such as improved grades and test scores [9]. In spite of this, and primarily due to the time restrictions and myriad testing demands placed on educators in a school system, social skill instruction often takes a "back-seat" to academic programming. This article will demonstrate an example of how one systematic social skill training curriculum, Building Social Relationships has been adapted and implemented in a school setting for students on the autism spectrum.

An Overview of the Building Social Relationships Program

The Building Social Relationships (BSR) program [5,3-11] is a research-based, systematic social skills program that includes over four-dozen available strategies to teach social skills and activate social cognition in children with ASD. The program provides both a conceptual framework for understanding social functioning and practical tools for assessing and teaching social skills to children on the autism spectrum (Figure 1). The conceptual framework of the BSR program views social interactions as an integration of three integrated components: social cognitive processing, emotional regulation, and behavioral execution (i.e., "Thinking, Feeling, and Doing"). These components do not work in isolation. Instead they work in concert, each capable of promoting or hindering successful social performance. Social cognitive processing involves knowing what to do (declarative knowledge) and how to do it (procedural knowledge). It also involves social problem solving, observational learning, taking another person's perspective, self-awareness, and attentional processing. Emotional regulation involves regulating emotions, such as anxiety, that might otherwise derail successful social performance. Finally, behavioral execution involves the performance (e.g., motor movements) of social skills in social interactions. To successfully improve social performance, social skills programming must address each of these three components.

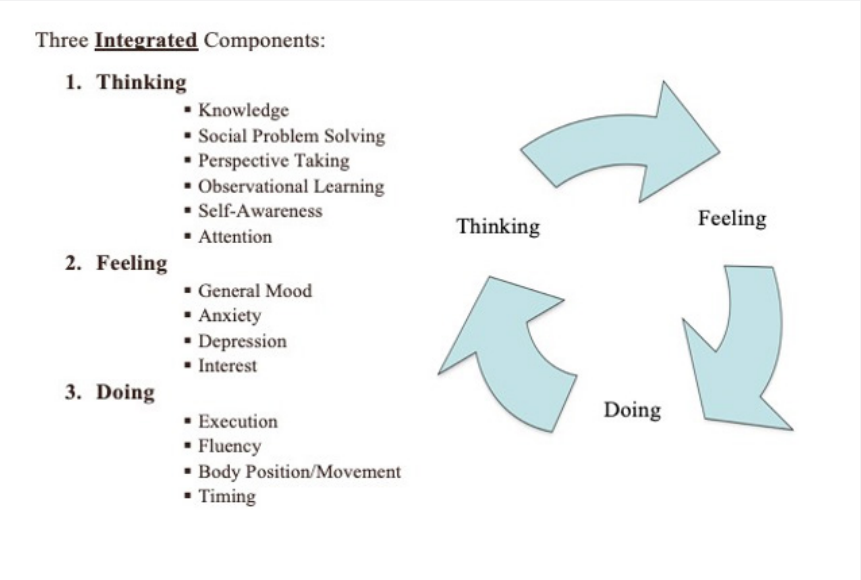

Figure 1: The Conceptual Framework of the Building Social Relationships program.

The BSR program provides an example of a systematic and research-based approach for teaching social interaction skills to youth on the autism spectrum. The program follows the following five-step plan:

a. Assess Social Functioning

b. Distinguish Between Skill Acquisition and Performance Deficits

c. Select Intervention Strategies

d. Implement Intervention

e. Evaluate and Monitor Progress

The first step of the BSR Program consists of conducting a thorough assessment of the individual's current level of social skills functioning. The purpose of the Step 1 assessment is to gauge present level of performance (baseline) and also to identify the specific skills, or "component" skills, that will be the target of the intervention. After the assessment is complete, step two is to discern between skill acquisition deficits and performance deficits. Step three uses this information for the selection of effective intervention strategies. After the social skills intervention is implemented (step 4), the outcome of the intervention is again evaluated (step 5) and modifications are made as necessary.

Implementation of the building Social Relationships Program in a School Setting

The BSR program is traditionally implemented and studied each year at the Social Skills Research Clinic, a university-based clinic at Indiana University, Bloomington. The program is implemented once-a-week for 9 weeks, and each session lasts 45 minutes. Throughout these sessions, clinicians (trained university graduate students) implement strategies that are tailored to children with ASD between the ages of 3 and 17. Each session is split into two instructional parts, based on the conceptual framework of the BSR program: social cognitive processing and

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social interaction skills. A third section of each session consists of data collection for progress monitoring purposes. Each of the sessions is taught with one peer mentor who is similar in age to the children on the autism spectrum who are in the group. The peer mentor is trained in appropriate interactions and is often utilized as a model for desired behavior [3]. This child is usually typically developing and exhibits average or above average social skills in comparison to the students enrolled in the social skills group. This is not only an opportunity to have children with social skills deficits observe their peers performing social interactions appropriately, but it also allows the child to practice interaction skills that are often difficult, in a supportive and reinforcing environment. Though traditionally implemented in a university-based clinic, the BSR program has also been modified to facilitate implementation in school settings [12]. The following section provides recommendations to school personnel on how to implement the BSR program in educational settings.

Identification of Group Participants

The BSR program was specifically developed to meet the myriad social needs of children on the autism spectrum. However, any child with social skill and social cognitive processing deficits, may benefit from the program. The program can be implemented on an individualized (one-on-one) basis, in a small group setting, or as a class-wide curriculum. The present article will describe the use of the BSR program as a small group intervention involving 2 to 4 children.

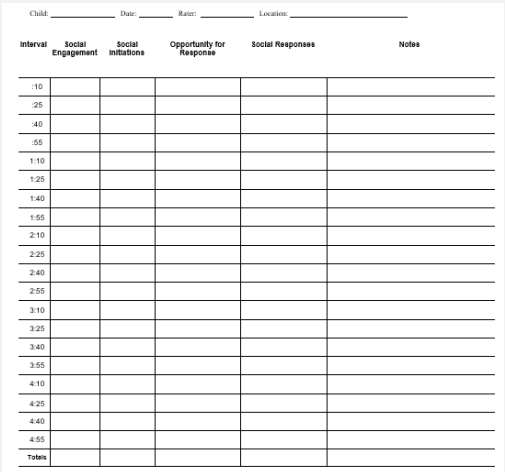
Children who are identified for the program may demonstrate deficits in both social skills (initiating and responding to initiations of others, turn-taking, etc.) and social cognitive processing (perspective taking, social problem solving, self-awareness, etc.)

Use of Peer Mentors

One of the primary features of the BSR program is the use of a peer mentor, or another similar-aged child who demonstrates adequate to above average social skills compared to the target participants. The peer mentor is often able to be trained within the context of university clinics; however, given the restrictions of the school systems it is recommended that the participating teacher or interventionist identify a child with average to exceptional social skills. Not only does this allow for the target participants to interact with a same aged peer throughout the day, but it also reduces the training component required that may serve as a barrier to intervention implementation. Additionally, having a peer within the classroom who acts as the peer mentor allows for children with social skills to develop friendships with a trusted peer in the classroom.

Step 1: Assessment of Social Functioning

The purpose of the Step 1 assessment is to identify the specific social skill deficits that will be the target of the intervention and to determine the present level of functioning for progress monitoring. Within the classroom setting this can be assessed a number of ways. If the teacher plans to implement the intervention, they may already be aware of the child's areas of difficulty when attempting to engage in social interaction; however, it is also recommended that a 5 - 10 minute systematic observation be conducted as well, in order to monitor and track progress across time (Figure 2). If there is an intervention specialist, or someone outside of the classroom, it is strongly recommended an additional teacher interview be conducted to provide a well-rounded understanding of the child. After information is gathered, it is recommended that the observation and teacher information be considered prior to implementation of skills as to determine whether the child struggles with social interactions due to 1) lacking a skill needed (skill acquisition deficit) or 2) having a skill, but not performing the skill at appropriate times (performance deficit). Once this is determined, the interventionist can determine what types of intervention will be required to promote the student's social success.



Child: _____ Date: _____ Rater: _____ Location: _____

Interval	Social Engagement	Social Initiations	Opportunity for Response	Social Responses	Notes
:10					
:25					
:40					
:55					
1:10					
1:25					
1:40					
1:55					
2:10					
2:25					
2:40					
2:55					
3:10					
3:25					
3:40					
3:55					
4:10					
4:25					
4:40					
4:55					
Totals					

Figure 2: Data collection sheet used in the BSR clinic and school-based program.

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The BSR program generally measures three outcome variables: social initiations, social responding, and social engagement. Observations should be conducted on a regular basis to allow for adjustment of intervention. If possible, it is recommended that these observations take place at approximately the same time each week, within a setting that lends itself to social interactions (e.g., free time, recess). Social initiations are defined as the child beginning a new social engagement sequence Social initiation are recorded using a frequency count during recess and during the last 5 minutes of each social skills group. Social responding is defined as responding to the initiations of other children. For social responding, it is recommended a response ratio be used rather than using a frequency count. Response ratio refers to the percentage of times a child responds to the initiations of other children. To calculate the response ratio, the frequency of responses is divided by the frequency of opportunities to (i.e., the number of times another child attempts to initiate with them). Social engagement is defined as sustained and unprompted interaction with other children. Social engagement is measured by using partial interval time sampling procedure, with 10-second intervals.

In addition to direct observation of social skills, the BSR program also uses the Autism Social Skills Profile-2 (ASSP-2) to identify skills to teach, and to assess progress throughout the program (Bellini, 2016; Bellini & Hopf, 2007). The ASSP-2 is an assessment tool that provides a comprehensive measure of social competence for youth on the autism spectrum. The items on the ASSP-2 represent a broad range of social behaviors typically exhibited by individuals on the autism spectrum, including initiation skills, social reciprocity, perspective taking, and nonverbal communication skills. The items on the ASSP-2 represent specific social behaviors that are commonly exhibited with youth on the autism spectrum. Administering the ASSP-2 has two purposes. First, it may be used as an intervention planning tool by identifying the specific social skill deficits of individuals on the autism spectrum. These skill deficits become the precise target of intervention. In addition, items on the ASSP-2 are phrased in a manner that allows them to be easily adapted for use as social goals on Individualized Educational Programs (IEP). The second purpose of the ASSP-2 is to assist in measuring intervention progress. Thus, it is well suited as a pre- and post-measure of social functioning.

Note: more information on the outcome variables and instructional strategies used in the BSR program, including operational definitions of the behavioral codes, a copy of the ASSP-2, and detailed descriptions of the instructional strategies, can be found in the BSR-2 book [3].

Step 2: Distinguish between Skill Acquisition Deficits and Performance Deficits

An essential aspect of the BSR program is to determine whether the child's identified skill deficits are skill acquisition deficits or performance deficits, or some combination of both [3]. Discerning between these two types of skill deficits allows us to select intervention strategies that match the type of skill deficit. *A skill acquisition deficit* refers to the absence of a particular skill or behavior. For example, a child on the autism spectrum may not know how to effectively join in play activities with peers. In the case of skill acquisition deficits, the child must be taught how to performance the skill. A *performance deficit* refers to a skill or behavior that is present but not demonstrated or performed. To use the same example, a child may have the skill (or ability) to join in play activities, but still fails to do so. In this case, if the goal is to have the child initiate play with other children, we would not need to teach that particular skill because he or she already has the skill in her repertoire. Instead, we would need to address the factor that is impeding performance of the skill, such as lack of motivation, anxiety, or sensory sensitivities. Distinguishing between skill acquisition deficits and performance enhancement deficits guides the selection of intervention strategies. As such, the strategies of the BSR program are divided into two categories: strategies that promote the acquisition of new skills and strategies that enhance or increase the performance of existing skills.

Step 3: Select Intervention Strategies

The strategies used in the BSR program are a collection of empirically validated techniques to target both social skills and/or social cognitive processing. The program contains thirteen of the evidence-based social skill strategies identified by both the National Professional Development Center for Autism [11] and the National Standards Report published by the National Autism Center [12]: video-modeling, modeling, social narratives, naturalistic interventions, visual supports, peer mediated instruction, parent implemented interventions, self-management, prompting, time-delay prompt fading, structured play groups, cognitive behavioral intervention, positive reinforcement, and social skills groups. Overall, there are over 50 strategies available to therapists in the traditional BSR program. The particular strategies utilized will be dependent on the unique needs of both the child (age, language and developmental level, type of skill deficits, etc.) and the setting in which the intervention is implemented (school, clinic, group, individual, etc.). Specific strategies that have been previously piloted within a school implemented program included the following evidence-based strategies: video self-modeling, peer mentors, behavioral rehearsal, prompting, social problem solving, joint attention activities, and perspective taking activities. A brief description of each of these strategies is provided below.

Video self-modeling

Video-self modeling (VSM) is a form of video modeling that has been deemed an evidenced-based practice for youth with ASD by the National Autism Center [12]. Video modeling is used to demonstrate the desired behavior of a child through watching another child perform the behavior on video [13,14]. VSM is similar, but instead uses the child herself, as the model. VSM in this

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way allows the child to see herself performing the desired task independently, and efficaciously. Since the target behaviors are usually not in the child's repertoire, or perhaps currently being performed at a novice level, often the children are not able to perform them fluently and independently at the beginning of the intervention. To address this, the children are provided frequent prompts during the recording of the target behaviors (e.g., prompting the child to initiate play with a peer). The videos are then edited, to remove all instances of the prompts, which we call "hidden supports." The videos are edited into 1 to 2-minute video clips that are then shown to the child multiple times throughout the week [8]. These videos are typically shown for approximately 2-8 weeks, however, throughout this current intervention, videos were switched depending on what skills were being taught during the session.

Peer mediated instruction

Peer Mediated Instruction [4,12] is also an evidence-based practice for teaching socially appropriate interaction skills to typically developing children and children with ASD. Children who are typically peer mentors may undergo a brief training that includes teaching them how to initiate and respond appropriately to their peers with ASD. The use of these peer mentors can also help to aid in generalizing the skills the child learns in social skills sessions, to those settings outside of the therapy setting (i.e. classrooms and recess). The use of peer mentors in social skill session allows the therapist to remove herself from the play interactions, and instead focus on facilitating engagement via prompting of the peer and child with ASD.

Behavioral rehearsal

Behavioral rehearsal is an effective approach to promote the fluent performance of social interactions skills in youth on the autism spectrum (Bellini, Benner, & Peters-Myszak). It can be considered both a social skill strategy and social-cognitive strategy (e.g., cognitive rehearsal). Behavioral rehearsal, also referred to as role-playing, involves acting out situations or activities in a structured environment. The goal is to practice newly acquired skills or previously learned skills that the child is having difficulty performing. It also allows for the positive and repetitive practice of skills to promote behavioral fluency.

Prompting

Prompting is another evidence based, and highly effective modality for teaching social interaction skills and activating social-cognitive processes in children on the autism spectrum [12]. Prompts are supports and assistance provided to the child to help him or her acquire skills and successfully perform behaviors [15,16]. Prompts can be used to teach new social skills and to enhance performance of previously acquired skills. In the present intervention, prompting was provided during behavior rehearsal, and during the filming stage of the VSM intervention.

Social problem solving

Teaching children on the autism spectrum how to problem solve has been a target of inquiry and intervention for researchers and practitioners [17,18]. Many different methods and techniques have been used to facilitate the development of social reasoning in children with and without ASD. Social problem-solving strategies can be used in individual and group social skills programs or they can be incorporated into a classroom curriculum.

Joint attention

Joint attention is the ability to shift attention between another person and an object or event [19]. By the second year of life, most children develop the ability to both initiate joint attention and respond with joint attention to another person's joint attention bid. However, youth on the autism spectrum show substantial impairments in this area of social cognition [20]. Initiating joint attention is exhibited behaviorally by directing another person's attention to an object with a point, eye gaze, or other verbal or nonverbal means. Responding with joint attention is exhibited behaviorally by attending. The joint attention activities of the BSR program typically focus on teaching the child to initiate joint attention (e.g., pointing to an object) or to respond with joint attention (e.g., following eye gaze) to the joint attention bid of another person.

Perspective taking

The ability to recognize and understand the feelings and thoughts of others is an area of weakness for many individuals on the autism spectrum. Effectively reading nonverbal behaviors is essential to reading emotions and to being able to take another person's perspective. Consequently, they are less able to modify their behavior to meet the emotional and cognitive needs of others. These nonverbal cues reveal not only what the other person is feeling but also what he is thinking. In spite of their inherent weakness in this area, children with ASD can be taught to read the emotions and to take another person's perspective [21,22]. The BSR program includes strategies to promote pre-perspective taking skills (reading non-verbal cues), and strategies that teach the child to infer the thoughts and interests of other people.

Step 4: Implement Intervention

The BSR school-based intervention should be implemented once or twice per week for 15- 30 minutes each session. The program takes place over a 9-week period so that outcome data can be collected and evaluated on a regular basis. The preferred format is to space the sessions a few days apart to spread the sessions throughout the week, and to allow the children an opportunity to practice the skills they have learned in each session, prior to participating in the second session of the week. When implementing this intervention within the school setting, it is most important to alternate instruction between social cognitive processes, and social interaction skills.

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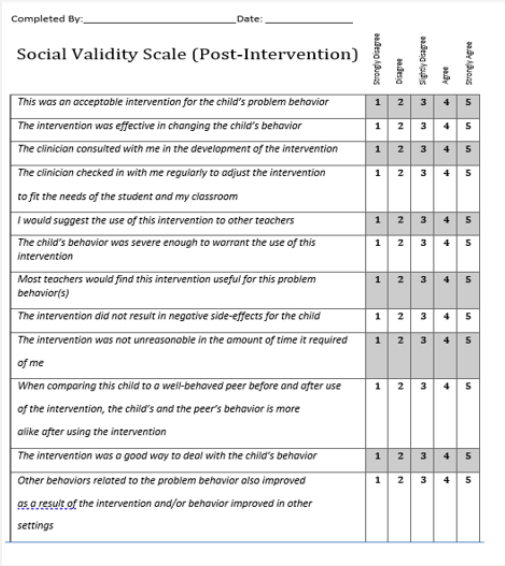
Specifically, if Session 1 is focused on a social cognitive skill, then the following session should be focusedon social interactions. Figure 3 provides an example of a session structure focused on teaching social cognitive skills on Day 1 and providing the opportunity to practice skills on Day 2. When implementing social cognitive sessions, it is recommended that between one and two social cognitive skills be taught to both the target children and the peer mentor. The first session may address either joint attention, perspective taking, social problem solving, or perspective taking. These skills can be taught through a variety of activities that help the target child and the peer mentor perform the tasks. Activities are implemented to activate the particular social cognitive process that was targeted during the session. When performing these social cognitive activities, the peer mentor and the interventionist typically demonstrate tasks for the target child first, and then the target child and the peer mentor are asked to perform the skills as well.



Completed By:_____Date: _____

Social Validity Scale (Post-Intervention)

	Strongly Disagree	Disagree	Slightly Disagree	Agree	Strongly Agree
This was an acceptable intervention for the child's problem behavior	1	2	3	4	5
The intervention was effective in changing the child's behavior	1	2	3	4	5
The clinician consulted with me in the development of the intervention	1	2	3	4	5
The clinician checked in with me regularly to adjust the intervention to fit the needs of the student and my classroom	1	2	3	4	5
I would suggest the use of this intervention to other teachers	1	2	3	4	5
The child's behavior was severe enough to warrant the use of this intervention	1	2	3	4	5
Most teachers would find this intervention useful for this problem behavior(s)	1	2	3	4	5
The intervention did not result in negative side-effects for the child	1	2	3	4	5
The intervention was not unreasonable in the amount of time it required of me	1	2	3	4	5
When comparing this child to a well-behaved peer before and after use of the intervention, the child's and the peer's behavior is more alike after using the intervention	1	2	3	4	5
The intervention was a good way to deal with the child's behavior	1	2	3	4	5
Other behaviors related to the problem behavior also improved as a result of the intervention and/or behavior improved in other settings	1	2	3	4	5

Figure 3: Social Validity Scale used in the school based BSR Program.

During the social skills practice sessions, the target child is taught how to join in a conversation or into a play activity with his peer mentor. He is also taught how to ask questions and take turns with other children. These skills are taught using the strategies described earlier (e.g., VSM, prompting, behavioral rehearsal). If needed, the interventionist is present to prompt the target child or the peer mentor. These sessions are utilized to help both children perform the social skills that they would need to maintain social engagement. When they are performing the activities, it is recommended the interventionist record footage for the VSM strategy. This video footage is then edited to remove the interventionist's prompts, resulting in a 30 to 60 second video of the children performing the targeted skills successfully. Each session (both cognitive and practice skills) is then ended with a video. These videos can target any specific skill the interventionist is interested in improving, such as asking questions about others and initiating or joining play appropriately.

Different skills can be taught during the social cognitive sessions and the social interaction sessions each week to provide variety for children participating in the sessions. The timing of the skills should continue to be based on the needs of the children. Meaning that the number of times a skill is reviewed can be determined based on the target child or children's need to adequately be able to perform the skill. It is important for the child to be able to perform and engage in different activities to help broaden their abilities to engage with others.

In addition to implementation during the structured social skills sessions, VSM videos can also provide to the child's teachers to watch prior to engaging in a social activity (e.g., recess, lunch, free time). These VSM videos can often serve as an addition to the main social skills intervention. Specifically, this is feasible to boost the child's exposure to appropriate social interactions while simultaneously utilizing few resources. It is likely best to use the last session's VSM video, but different videos may be useful if the child requires exposure to a past VSM video to be successful in a specific scenario. This can be done daily for most effective usage. VSM may continue to be used after social skills instruction has ceased to help children maintain their learned social skills.

Step 5: Evaluate and Monitor Progress

Whereas the purpose of the Step 1 assessment was to identify skills to teach, and establish baseline levels of functioning at the beginning of the program, the purpose of the Step 5 assessment is to evaluate the outcomes of the social skills program. To monitor progress on the outcome variables of social initiations, social responding, and total social engagement, it is recommended

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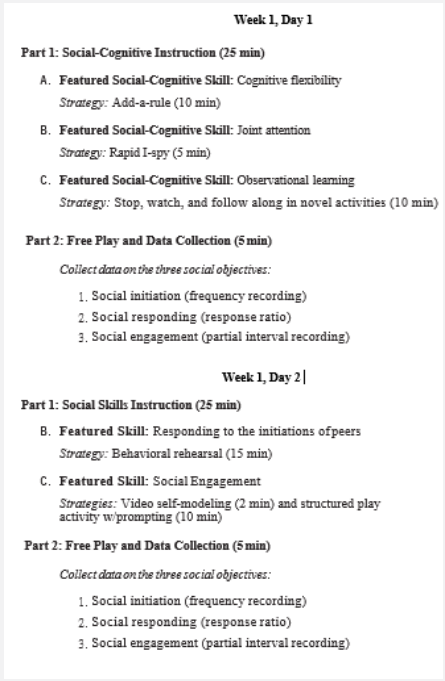
that baseline, intervention, and maintenance data be tracked across 5 minute intervals during a free play activity during the session, and also in a naturalistic setting (e.g., lunch, recess). These observations should take place at the same time of the day for each child, in the same location. A partial interval recording system with 10-second intervals is typically used to measure the three intervention goals (i.e., initiation, responding, and total engagement). These data collection methods are utilized before, during, and at the conclusion of each 9-week segment of the social skill program. At the conclusion of the 9-week program, the outcome data reviewed, and modifications are made based on the data, prior to beginning a new 9-week program.

Additionally, social validity can be measured informally throughout the intervention by speaking with teachers (or if the teacher is the interventionist, parents), to gauge the acceptability and feasibility of the intervention goals, procedures, and outcomes. Questions cover topics such as how the child is progressing socially within the classroom throughout the duration of the intervention. Additionally, a social validity form can be utilized mid-way through the intervention (Figure 3) for an example of the social validity scale used in the BSR school-based program). A teacher's social validity ratings may indicate anecdotal information that is not captured through observations alone and allow for understanding of how well the child is able to generalize their abilities.

Final thoughts on the School Based Building Social Relationships Program

Social skills programming must be implemented in a systematic, but flexible way to help children acquire and perform social skills across multiple settings and with multiple people. The program has demonstrated efficacy in a university-based clinic setting, [9] but effectiveness and feasibility in the school setting requires further examination. One important modification to the structure of the BSR program is the accommodation made to fit the intervention into a traditional school schedule. The traditional BSR program consists of one 45-minute session each week and each session targets both social skills, and social cognitive processing. As a result of the time constraints within school systems, it is recommended the BSR program be restructured into two 20-30-minute sessions each week. One session will focus on social skill instruction; and one will focus on social cognition (Figure 4). Additionally, Video Self-Modeling (VSM) can be utilized to supplement the instruction that the target children receive during the sessions throughout the week. For instance, the child can view video clips of target behavior on the days she does not participate in the social skill group. The goal of showing the video clips on a regular basis is to promote the generalization of skills across settings and persons. It is recommended that the clips be shown immediately prior to recess or lunch in order to prime the child to perform the target behavior during these naturalistic settings.



Week 1, Day 1

Part 1: Social-Cognitive Instruction (25 min)

A. **Featured Social-Cognitive Skill:** Cognitive flexibility
Strategy: Add-a-rule (10 min)

B. **Featured Social-Cognitive Skill:** Joint attention
Strategy: Rapid I-spy (5 min)

C. **Featured Social-Cognitive Skill:** Observational learning
Strategy: Stop, watch, and follow along in novel activities (10 min)

Part 2: Free Play and Data Collection (5 min)

Collect data on the three social objectives:

1. Social initiation (frequency recording)
2. Social responding (response ratio)
3. Social engagement (partial interval recording)

Week 1, Day 2

Part 1: Social Skills Instruction (25 min)

B. **Featured Skill:** Responding to the initiations of peers
Strategy: Behavioral rehearsal (15 min)

C. **Featured Skill:** Social Engagement
Strategies: Video self-modeling (2 min) and structured play activity w/prompting (10 min)

Part 2: Free Play and Data Collection (5 min)

Collect data on the three social objectives:

1. Social initiation (frequency recording)
2. Social responding (response ratio)
3. Social engagement (partial interval recording)

Figure 4: Examples of BSR school-based "Session Structure Plans.

The present article discusses the feasibility of implementing a systematic and effective social skills programming in a school setting. However, access to effective programming and trained clinicians will vary greatly from district to district. To address this, the second author has developed a manualized version of the BSR program (BSR-M) to make implementation more manageable

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and efficient for practitioners [24]. In addition to the clinical data collected at the Social Skills Research Clinic, the BSR-M program has been piloted within a school district in the state of Iowa with promising results [10]. In the BSR-M program, target skills are determined in advance of the 9-week program and session structure plans lay out every minute of every session for the practitioner. In addition, the strategies and techniques have been "manualized" or structured for the therapist or instructional team.

Preliminary data indicate that the BSR-M program produces comparable efficacy to the traditional BSR program (Bellini, 2020). The BSR-M program targets both social behaviors and social cognition and the strategies have been selected to target both skill acquisition performance deficits. The ultimate goal of the BSR-M program, however, is to expand implementation of social skills interventions to multiple settings, and with additional children who will benefit greatly from effective social skills programming.

Figure 1: The Conceptual Framework of the Building Social Relationships program.

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