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DIMENSIONS OF SOCIAL AND PERSONAL SKILLS IN CHILDREN AND ADOLESCENTS: AGE AND GENDER DIFFERENCES

***[1,2,3]Tania Gaspar, [2,3]Ana Cerqueira, [2]Catia Branquinho and [1,2,4]Margarida Gaspar de Matos**

[1]University of Lisbon, ISAMB
[2]Aventura social, University of Lisbon, Faculty of Human Kinetics, Lisbon, Portugal
[3]Lusiada University of Lisbon/CLISSIS, Portugal
[4]WJRC/ISPA

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ABSTRACT

Personal and social skills play a key role in children and adolescents' development, as well as their psychological wellbeing. Was used the Scale "For me it's Easy" to assess personal and social skills in children and adolescents. The study includes 960 Portuguese children and adolescents with a mean age of 12.5 years (SD = 1.61). Included were 56.8 % boys of different educational levels. The studied version of the instruments demonstrated good psychometric properties and the factor structure identifies 5 dimensions of personal and social skills (Basic Skills, Problem Solving, Emotional Regulation, Interpersonal Relationships and Defining Objectives). Differences were found in the social and personal skills related to gender and related to age. The behavior of the different dimensions of social and personal skills was studied. It was found that there was a strong relationship between social and personal skills and psychological well-being in children and adolescents. The study contributes to the research and evaluation of intervention in children and adolescents, especially in the prevention and promotion of personal and social skills and healthy development.

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INTRODUCTION

Most adolescents are healthy, but an important number of them present evitable death, illness and diseases. Adolescents' health related behaviors influence not only their life, wellbeing and health status during adolescence but also their adult health and even the health of their future children. Health and wellbeing in adolescence must be understood in an ecological perspective, adolescences' health and opportunities are influenced by different levels, such as individual characteristics; interpersonal relationships with family, friends and other people from their community; the resources of the community; and even in a broader way by the political context (Bronfenbrenner, 2005; Blum and Dick, 2013). Therefore, it is very important to promote healthy adolescents, protecting young people from risky behaviors and/or promoting socioemotional skills to face the inevitable risks.

***Corresponding author:[1,2,3]Tania Gaspar,**
1University of Lisbon, ISAMB
2Aventura social, University of Lisbon, Faculty of Human Kinetics,Lisbon, Portugal
3Lusiada University of Lisbon/CLISSIS, Portugal
4WJRC/ISPA

WHO (2014) identified several health issues related to adolescence. Amongst them are mental health, violence, substance use and other addictions, sexual behavior, obesity and sedentary life. In order to improve young people's wellbeing, it is important to build roads for the future that are evidence-based, thus supporting educational, health and social services and policies. It is also fundamental to make recommendations that promote high quality strategies, which must be age and social appropriate for adolescents, and finally, understand health issues for adolescents considering the specificities of risk groups, such us, adolescents with low socioeconomic status, adolescents with a low level of education, and migrant adolescents. Studies focusing on children's subjective well-being include interactions between demographics (e.g. age, gender and socioeconomic status), personal characteristics (Self Perceptions, Psychological Well-being, General Mood) and interpersonal characteristics (Social Relationships with Family, Peer Group and Community) (Caldera and Hart, 2004; Gaspar, Matos, Ribeiro, Leal, Erhart, and Ravens-Sieberer, 2012). Effective school health promotion and prevention programmes are amongst the most cost effective investments, because both promote health and

education (Blum and Dick, 2013; Gaspar, *et al* 2012; WHO, 2014). Adolescents are at school for most of their day, therefore school is a privileged setting for delivering universal and selective prevention interventions that can help adolescents increase their competence to cope with life challenges, namely school failure, interpersonal relationships, health behaviors (addictions, eating behavior and sexual behavior) and emotion related management (Fydenberg, 2008; GTES, 2007; Matos *et al*., 2008; Matos and Sampaio, 2009).

Roth and Brooks-Gunn (2000) claimed that pupils with school failure have higher rates of anti-social behavior, and less subjective wellbeing (Gaspar, *et al*, 2012). School-based programs have been evaluated regarding their efficacy in promoting personal factors, such as communication skills, cognitive problem solving skills, emotion regulation, social relationships and future expectations, and leisure/work schedule management. A meta-analysis of after-school programs that seek to enhance the personal and social skills of children and adolescents indicated that, compared to controls, participants demonstrated a significant increase in their self-perceptions and bonding to school, positive social behaviors, school grades and levels of academic achievement, and a significant reduction in problematic behaviors (Blum and Dick, 2013; Matos, *et al*, 2012; Matos, Tomé, Gaspar, Cicognani and Moreno, 2016; Reddy, 2013). The promotion of personal and social competence aims at helping people to become aware of their strengths and difficulties in dealing with life, and increasing personal, social and interpersonal competences such as communication, problem solving, emotion regulation maintenance, promotion of social relationships and social capital, and future positive expectation. Those competencies are associated with a decrease of interpersonal violence and other risk behaviors, by means of increasing the interpersonal repertoire of responses used to deal with threats, challenges and interpersonal difficulties, and increasing subjective wellbeing and quality of life (Gaspar, Matos, Pais-Ribeiro, Leal, and Albergaria, 2014; Matos, *et al*, 2012; Ramiro, Reis and Matos, 2014). Some groups of adolescents for instance, being a girl (Gaspar, *et al*, 2012), having special needs education (Gaspar, Bilimória, Albergaria and Matos, 2016), school failure (Gaspar, Rebelo, Mendonça, Albergaria, and Matos, 2014), having low socioeconomic status (Gaspar and Balancho, 2016; Gaspar, Matos, Luszczynska and De Wit, 2016; Reddy, 2013) present more health needs, thus they can be considered risk factors related to heath and subjective wellbeing. The impact of those risk or the developmental and psychological consequences can be reduced if adolescents develop social and personal skills to face the risk and improve positive developmental opportunities (Blum and Dick, 2013; WHO, 2014).

Age and Gender differences in young people's health and wellbeing

The international Health Behavior School-Aged Children report (Currie *et al*, 2000) a collaborative study of the World Health Organization, identify meaningful differences in the prevalence of health and social indicators by gender, age group and levels of family affluence. The findings highlight important health inequalities and contribute to a better understanding of the social determinants of health and well-being among young people.

Gender and social conditions are important variables to characterize, understand and intervene in adolescent's health protection and promotion (APF, 2008; Matos and Aventura Social, 2012). On the one hand, related to gender differences, boys in general engage more in externalizing or expressive forms of health behaviors, such as drinking or fighting, while girls tend to deal with health issues in a more emotional or internalizing way, often manifesting as psychosomatic symptoms or mental health problems. Clear differences between gender and age can be found in the children and adolescents' subjective wellbeing. For instance, the girls' perception of their wellbeing is inferior in almost all dimensions with the exception of "Social Support and Peers", "School Environment" and "Social Acceptance and Bullying". Adolescents (the older group, ages between 12 and 16 years old) presented an inferior perception of wellbeing in all measures except in the "Financial Resources" and "Social Acceptance and Bullying" (Bisegger *et al*. 2005; Ravens-Sieberer *et al*. 2001; 2005; The KIDSCREEN Group Europe, 2006).

Gender differences for some health behaviors tend to increase during adolescence, indicating that this is a crucial period for the development of health differentials that may track into adulthood. Targeting adolescents' health from a gender perspective has considerable potential to reduce health differentials based on gender in adulthood. On the other hand, evidence collected over the last few decades show that low socioeconomic situations are associated with increased health risks and less access to health and health education. As a result, health inequalities are now highlighted in contemporary international policy development. The WHO Commission on Social Determinants of Health claims that the vast majority of inequalities in health within and between countries are avoidable and yet they continue to be experienced by young people across Europe (Inchley, *et al*., 2016). In Europe gender, age and socioeconomic differences in adolescent's health and wellbeing can be found that results in health inequalities that must be identified and reduced by creating better health and educational tools in order to implement the already created policies.

MATERIALS AND METHODS

Sample

The sample included 960 children and adolescents, 56.7% were boys. In terms of age group, 24.5% presented 8 to 12 years of age, 25.1% from 13 to 15 years and 50.4% were 16 or more years. The mean age was 15.3 years and the SD was 3.7.

Instrument

The instrument was built based on the social skills checklist (Goldstein and McGinnis, 1997) and the emotional self-regulation questionnaire (Moilanen, 2007). According to international guidelines, the translation of some items of the questionnaires included a Back translation process. The initial scale had 50 items, was tested with children, adolescents, teachers of 1st, 2nd and 3rd cycles and psychologists. Suggestions and contributions indicated by these, namely, in the exclusion of some items, alteration of the formulation of others, were included in the final version used here.

The final version consists of 43 items that include competencies from the simplest to the most complex, in the various contexts of the child and adolescents, such as "For me it's easy to say thank you"; "It is easy for me to defend my rights"; "It's easy for me to deal with schoolmates." This final version can be used as a global skills measure (α = 0.91), and included five dimensions, namely, problem solving (α = 0.86), basic skills (α = 0.79), emotional regulation (α =0.74), interpersonal relationships (α =0.67), and defining goals (α =0.61). For the global analyses of this scale, the following items from defining goals dimensions should be inverted: 31, 32, 33, 34 and 40. Two complementary instruments were also used to deepen the study of the "For me it´s easy" scale. One of the complementary instruments evaluates a personal variable (subjective well-being) and another that evaluates a social variable (Social support). To measure subjective well-being, the KIDSCREEN-10 scale was used (Matos, Gaspar and Simões, 2012). That scale presented good internal consistency of fidelity (Cronback's alpha = 0.82) and good fidelity / stability test-retest (r = 0.73; ICC = 0.72) and allows accurate and stable evaluation of subjective wellbeing.

The KIDSCREEN-10 scale allows to differentiate groups; Low results refer to feelings of sadness, dissatisfaction and dissatisfaction with family life, peers and school life, and high results indicate the opposite: feelings of happiness, well-adjusted and satisfied with family, school and peer group. The instrument results in a global value, where a one-dimensional measure represents the overall value of the complete versions of KIDSCREEN (KIDSCREEN-52 and KIDSCREEN-27), suitable for large and epidemiological studies (The KIDSCREEN Group Europe, 2006). The Portuguese version presents good metric properties and the confirmatory factor analysis has an adjusted model (Matos, Gaspar and Simões, 2012). In order to measure satisfaction with social support, the Social Support Satisfaction scale (Ribeiro, 1999) was used. The scale is composed of 15 affirmative phrases for self-filling. The subjects mark the level with which they agree with the affirmation (if applicable to the individual), on a Likert scale ranging from "Totally Agree" to "Totally Disagree". The 15 items are distributed among four dimensions or factors, generated empirically, to measure the following aspects related to Satisfaction with Social Support: "Satisfaction with Friendships", "Intimacy", "Family Satisfaction" and "Social Activity". The Social Support Satisfaction Scale (Ribeiro, 1999) was translated and adapted for Portuguese children and adolescents by Gaspar, Ribeiro, Matos, Leal e Ferreira (2009) and obtained an internal consistency of α = 0.77.

Procedure

The present study analyses the social and personal skills in children and adolescents in school context. The initiative to carry out the project started from the schools involved. Thus, after deciding the directions of the schools involved, the objectives of the study were presented to the school community (teachers, students and parents). The data collection was carried out with students from 4 schools in Lisbon. The parents of the participating students gave their consent. The instrument was self-fulfillment and voluntary participation. For the data analysis SPSS 20 software was used to perform descriptive statistical analysis, exploratory factorial analysis, correlations and ANOVA.

RESULTS

Most of the participants presented positive values related to their socioemotional skills dimensions, subjective wellbeing and social support. The higher value was related to basic skills (M=4,01) and the lower value was related to defining goals (M=3,12).

Table 1. Descriptive – Socioemotional skills dimensions, subjective wellbeing and social support and pre and post intervention differences

Dimensions	M (range 1-5)	SD
Global skills	3.56	0.53
Problems solving	3.59	0.66
Basic skills	4.01	0.64
Emotional regulation	3.36	0.72
Interpersonal relationships	3.39	0.61
Defining goals	3.12	0.78
Subjective Wellbeing	3.80	0.64
Social Support	3.43	0.62

Significant statistical differences can be found by gender. On the one hand, boys presented a more positive perception related to subjective wellbeing, social support and some of the socioemotional skills, such as, problem solving and emotional regulation. On the other hand, girls presented a more positive perception related to basic skills and interpersonal relationships.

Table 2. ANOVA – Socioemotional skills dimensions, subjective wellbeing and social support and gender differences

Dimensions	Boy		Girl		*F*
	M	*SD*	*M*	*SD*	
1 Global skills	3.55	0.52	3.54	0.53	n.s.
2 Problems solving	3.59	0.64	3.48	0.70	5.703**
3 Basic skills	3.97	0.64	4.07	0.63	5.832**
4 Emotional regulation	3.37	0.69	3.28	0.75	3.770**
5 Interpersonal relationships	3.39	0.60	3.46	0.61	3.771**
6 Defining goals	3.13	0.75	3.21	0.75	n.s.
7 Subjective Wellbeing	3.88	0.63	3.59	0.67	46.083***
8 Social Support	3.48	0.62	3.38	0.63	5.584**

***p < , 001; ** p < , 01

Significant statistical differences by age can be found. For almost all variables, younger students presented a more positive perception related to socioemotional skills dimensions. In relation to interpersonal skills significant statistical differences by age were not found. The correlation between Socioemotional skills dimensions are statistically significant and in most cases high, range between 0,91 (correlation between problem solving and global skills) and 0,17 (correlation between definition of goals end emotional regulation). Subjective wellbeing presented the higher correlation with problem solving (0,55) and social support presented the higher correlation with problem solving (0,25) and with subjective wellbeing (0,44). Problem solving looks to be the variable with higher correlation with socioemotional skill, subjective wellbeing and social support. In order to understand the impact of different variables in children and adolescents' socioemotional skills three regression models were developed. In the Regression Model 1 in table 5, regarding age and gender related to socioemotional skills, an adequate model was achieved [F=4,246; (2,584); p<.01] and the explained variance (Adjusted R squared) was 1%.

Table 3. ANOVA – Socioemotional skills dimensions, subjective wellbeing and social support and age group differences

	8 to 12 years old		13 to 15 years old		16 or more years old		*F*
Dimensions	*M*	*SD*	*M*	*SD*	*M*	*SD*	
1 Global skills	3.69	0.58	3.49	0.53	3.50	0.48	12.535***
2 Problems solving	3.83	0.70	3.44	0.65	3.45	0.62	30.019***
3 Basic skills	4.15	0.68	3.94	0.65	3.98	0.60	7.371***
4 Emotional regulation	3.45	0.85	3.25	0.71	3.32	0.63	4.641**
5 Interpersonal relationships	3.38	0.66	3.46	0.58	3.42	0.60	n.s.
6 Defining goals	3.26	0.84	3.18	0.72	3.10	0.71	4.012**
7 Subjective Wellbeing	3.96	0.63	3.78	0.64	3.64	0.66	18.850***
8 Social Support	3.30	0.59	3.52	0.61	3.47	0.65	7.491***

***p < , 001; ** p < , 01

Table 4. Correlations – Correlations between Socioemotional skills dimensions, subjective wellbeing and social support

	1	2	3	4	5	6	7
1 Global skills	---						
2 Problems solving	0.91***	---					
3 Basic skills	0.80***	0.65***	---				
4 Emotional regulation	0.76***	0.62***	0.55***	---			
5 Interpersonal relationships	0.76***	0.57***	0.54***	0.44***	---		
6 Defining goals	0.42***	0.24***	0.20***	0.17***	0.38***	---	
7 Subjective Wellbeing	0.52***	0.55***	0.44***	0.40***	0.32***	0.04	---
8 Social Support	0.23***	0.25***	0.22***	0.16***	0.18***	0.11***	0.44***

Table 5. Impact of demographic, subjective wellbeing and social characteristics in subjective wellbeing in adolescents – Regression models- dependent variable socioemotional skills

	Unstandardized Coefficients	Standardized Coefficients		
	B	*Std. Error*	*Beta*	*t*
Model 1				
Constant	3.76	0.11		
Gender	0.03	0.04	0.02	0.56 (n.s.)
estAge	-0.02	0.01	-0.12	-20.82***
Model 2				
Constant	1.83	0.18		
Gender	0.13	0.04	0.12	30.37***
Age	-0.01	0.01	-0.03	-0.87 (n.s.)
Subjective wellbeing	0.42	0.03	0.51	12.66***
Social Support	0.01	0.03	0.01	-0.01 (n.s.)

dependent variable socioemotional skills ***p < ,001

In the Regression Model 2 in table 5, regarding age, gender, subjective wellbeing and social support an adequate model was achieved [F=51.326; (4,582); p<.001] and the explained variance (Adjusted R squared) was 26%. Socioemotional skills are better explained if we include subjective wellbeing.

DISCUSSION

The present study aims to understand and to characterize social and personal competencies in children and adolescents. Taking into account the different dimensions of the competences, age and gender. In a global perspective children and adolescents presented positive results related to their level of social and personal skills. They presented more positive results in basic skill dimensions and less positive results in defining goals dimensions. That result is coherent with a developmental perspective, that first adolescents developed and consolidated more basic skills and then are developing more complex skills such us defining goals (APA, 2002). Gender differences related to different social and personal skills were found; boys tend to present a higher level of skills related to problem solving and emotional regulation, and girls tend to present a higher level of skills related to basic skills and interpersonal relationships. On one hand, several studies (Cecconello and Koller, 2003; Coelho, Marchante and Sousa, 2015; Del Prette, Teodoro and Del Prette, 2014; Else-Quest, Hyde, Goldsmith and Van Hulle, 2006; Hample and Petermann, 2005; 2006; Leppänen and Hietanen, 2001; Macdermott, Gullone, Allen, Ring e Tonge, 2009) revealed that girls present a higher level of social skills. Girls present a higher level of social awareness and social sensibility (Coelho *et al*, 2015; Macdermott *et al*., 2009), social empathy (Del Prette *et al*., 2014), seek more social support (Hampel and Petermann, 2006), girls are better at inhibiting inappropriate behavioral responses (Else-Quest *et al*, 2006), girls have greater skills in the domain of social cooperation (Faria, 2001) and better skills at the interpersonal level (Leppänen and Hietanen, 2001) than boys. On the other hand, girls present more inadequate emotional responses, such as difficulty in dealing with negative emotions, limited access to emotional self-regulation strategies (Neumann, Van Lier, Gratz and Koot, 2009) and maladaptive coping strategies, a high level of emotional stress (Hampel and Petermann, 2005; 2006). The boys present higher levels of self-esteem, self-concept of problem solving (Faria and Azevedo, 2004), leadership ability (Coelho *et al*., 2015), social assertiveness (Faria, 2001) and greater emotional stability (Faria and Azevedo, 2004) when compared to girls. Differences by age were found; the younger adolescents (8 to 12 years old) presented higher levels of social and personal skills when compared with older adolescents (16 or more years old). Younger adolescents present more and adaptive coping strategies and less problems with aggressive

and externalize behaviors (Hampel and Petermann, 2005; 2006). Our final results revealed a strong relation between social and personal skills and psychological wellbeing. Nair, Ravinfranath and Thomas (2012) reinforce that social skills are strongly correlated with growth and development, emphasizing that these competencies are positively related to well-being.

On the same line of thought, Leme, Del Prette and Coimbra (2015) concluded with their research that social skills are the good predictors of the psychological well-being of adolescents. The development of psychosocial skills presents itself as a potential protection factor in child development (Cunha and Rodrigues, 2010) and are positively related to all indicators of psychological wellbeing (Segrin and Taylor, 2007; Segrin, Hanzal, Donnerstein, Taylor e Domschke, 2007). Beauchamp and Anderson (2010) making a deeper analysis, conclude that a failure to acquire the main personal and social skills has profound consequences for the individual and can compromise the future development and adjustment of the subject. Both personal and social skills can contribute to psychological suffering, social isolation, reduced self-esteem and is reflected on the level of their quality of life and wellbeing.

The study allows to deepen and to know in greater depth the behavior of the social and personal skills in children and adolescents, taking into account the specificities related to the gender, linked to the age and essentially study the behavior of the different dimensions of the skills. The conclusions allow a fundamentally greater knowledge for program delineation and psychological interventions in order to effectively promote social and personal skills in the process of adolescence. As limitations of the study, the sample can be considered and although large, is a sample for convenience, not allowing the generalization of the results. It would be interesting to replicate the study in representative samples in our country but also translate, validate and apply the instrument in other cultures. The complementary use of qualitative methodologies would support a greater understanding of the process and could bring complementary information to the effectiveness of the intervention involving the adolescents in the construction of their own health, competences and well-being.

Recommendations for Health Interventions

Portuguese school populations are, in the majority, issued from medium to low SES and are increasingly multicultural with the arrival of a large number of immigrants from Africa and elsewhere. For interventions to be effective, parents and health and education professionals must have adequate skills and training to meet the specific needs of these target populations Programs should promote well-being, social and problem solving skills, school attendance and success, and not merely preventing risk behaviors. Older children, girls, poor pupils, migrants and pupils with a chronic disease can easily become disengaged from school and drop out because curriculum, teachers, and school systems as a whole are unable to bridge cultural gaps due to a limited understanding of what school "for all" entails. Further, since risk behaviors are embedded in the psychosocial context, preventive intervention should be implemented at school, family, and community levels. Politicians, educators, health professionals, and other professional groups are encouraged to face the challenge of implementing effective interventions based on an understanding of gender, developmental and cultural diversity.

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