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Social Proficiency of Down Syndrome People in Today's Era

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Abstract
The point of view of children with Down syndrome in respect of socially competency/proficiency has not been supported by empirical data. Conversely, the emerging evidence indicates that beginning in infancy and throughout the lifespan, individuals with DS show difficulties interpreting social and emotional cues, communicating about social and emotional experiences, understanding mental states such as desires and beliefs in self and others; and, regulating and acting on cognitions and emotions in an adaptive way during peer interactions. These developmental skills are considered key components of social competence and may be implicated in the challenges that individuals with DS often face with regard to social adaptation regardless of their IQ status. In particular, difficulties in social competence may be linked to several adjustment problems observed among individuals with DS later in life, including the areas of self-identity development, peer relationships, and mental health. This paper will focus on social competence in individuals with Down syndrome and the developmental implications of social ability across the lifespan.
Keywords: Children, Down syndrome, social competency, mental state

Introduction

The first steps in social development are seen within the first few weeks of life, as babies begin to make eye-contact and to smile when they are picked up and talked to. They are beginning to learn about the significance of facial expression, tone of voice and body movement and how these indicate how someone feels. Babies with Down syndrome show very little delay in responding to their care givers.

Down syndrome (DS) occurs as a result of the presence of all or a portion of an extra copy of chromosome 21 and is the most common non-inherited organic cause of mental retardation. The genetic anomaly of DS has powerful and specific influences on the development of the child but also inadvertently affects significant people like parents, siblings, teachers, and friends in the child's life. The unique profile of disabilities associated with DS that includes medical, motor, social, affective, and cognitive features may interact with contextual features of the child's family, peer group, school, community, and culture to determine variability in development [1, 2, 3]. Of particular interest is the wide variability in social adaptation among people with DS which cannot be accounted for by IQ status alone [1, 2]. The implication is that there are potential environmental sources of the developmental variation in outcome that have not been explored.

Discussion

One possible candidate is the construct of social competence, typically discussed with regard to an individual's success at meeting major personal and societal goals that are adaptive at the relevant developmental stages [1, 3]. Social competence is pertinent to understanding developmental adaptation throughout the lifespan and is particularly relevant in the lives of children with DS who must strive for social inclusion and participation.

Moreover, the construct of social competence is well elaborated and easily amenable to empirical investigation; it integrates characteristics of individuals and their environments, defines the relation between these two sources of influence as dynamic and transactional and acknowledges both continuity over time and the possibility of discontinuity across contexts [2, 3, 4].

During infancy, social competence may be evident within the parent-child relationship as consistency in engaging with, and responding to the other, establishes a secure and stable attachment that is integral to the infant's very survival. Later in development as the child is increasingly able to control his behaviour and choose his environments, social competence appears to transform into something more akin to a personal characteristic of the child [3, 5].

However, variability in the availability of social resources and in the quality of the parent-child relationship jointly influence a child's ability to generate and coordinate flexible, adaptive responses to demands and capitalize on social opportunities in the environment [1, 3, 4]. This is consistent with the social ecological model of development that proposes that the child is embedded within various sociocultural systems that interact

to either support or hamper his development [1]. These dynamic systems are conceptualized as different spheres of influence and include those that have a distal (indirect) effect and those that have a proximal (direct) effect on the individual [5].

Indirect influences are thought to emanate from macrosystems, which encompass the patterns, beliefs and values of the culture in which the child exists, and the exosystems which comprise the various formal and informal social structures in the child's environment, including the neighbourhood, schools, and government policies on education and health [3, 4].

Direct influences include the child's interaction with significant persons or events in their daily lives like parenting customs, sibling and peer relations and teaching practices. Risk and protective factors may be present in each of the socio-cultural systems like family, peer network, school, and community may operate through distal and/or proximal effects that influence the course of the child's development in adaptive or maladaptive ways [1, 5].

Infancy and the preschool years parent-child interactions, compared to other newborn animals, the human infant could be described as 'premature' since it relies almost exclusively on his caregivers for sustenance and nurturance. The implication is that an infant's survival and ultimately their social development are intricately linked to protective mechanisms that are inherent in the parent-child care-giving relationship [3, 5]. For example, crying, smiling, grasping, or calling by the child typically result in bringing the parent close to the infant.

The social development of children with Down syndrome will be influenced by the delay that they usually experience in learning to talk. In the second year of life, typically developing babies begin to develop spoken language skills, with many children having at least a 50 word vocabulary by 18 months, and to be talking in two or three word utterances by two years of age [1, 3, 5]. Clearly, the ability to use words to communicate greatly increases a child's ability to manage social situations, to ask for what they want and to explain how they feel. Children's rapidly growing understanding of language allows parents to explain actions and to reason with them. Although spoken language development is delayed for children with Down syndrome, they usually understand more than they can express. Signing will help children to understand and to express themselves before they are speaking. Non-verbal communication skill is a strength for most children with Down syndrome and their non-verbal skills help to develop their expressive language skills.

Most children with Down syndrome continue to be sociable and keen to interact with both children and adults in their primary school years, though the extent of an individual child's sociability will be affected by personality and temperament [6]. Some children will be shy, quiet and somewhat withdrawn when they enter school, others will be active, sociable and outgoing.

At five years of age, most children with Down syndrome will have significant speech and language delay, affecting their ability to communicate in the classroom, at home and in community settings [5, 6]. However, they usually understand more than their expressive language indicates and they are good at picking up the non-verbal communication cues such as tone of voice, facial expression and body posture [6]. Many will still be using signs to support their communication.

Most children with Down syndrome are capable of age-appropriate social behaviour and should be expected and encouraged to behave in a manner that is appropriate for their chronological age [1, 5]. They will learn the routines in school by watching and imitation and should be encouraged to conform to the class and school expectations for their age. It is good for their self-esteem and self-identity to be treated in an age-appropriate way, encouraged to make choices and to take some responsibility in their daily lives, in the same way as the other children.

In Albania we do lack behind in infrastructure national wide based, however in recent years there are established couple of centers in regards of helping children with autism spectrum disorder. So, more serious long term infrastructure and trained human resources should be available to this subgroup population.

Conclusions

Down syndrome as other medical disorder can be managed and expect better outcome if there is situated applicable programs in national level with absolute impact in medical care, social and economic level.

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