Deficits in interpersonal and social functioning are key characteristics of schizophrenia, as defined by DSM-III-R (American Psychiatric Association, 1987). These deficits seem to be particularly persistent, pervasive problems as many adult schizophrenic patients have been socially isolated and withdrawn from childhood (Lewine et al., 1978, 1980). Deficits in social functioning are a significant source of stress for persons with schizophrenia, have a negative impact on their community functioning, and contribute to relapse (Anthony and Liberman, 1986; Falloon et al., 1984). Such deficits in schizophrenic patients are more than a consequence of positive and negative schizophrenic symptoms. Schizophrenic patients exhibit social skills deficits, even with positive symptoms in remission and in the absence of a manifest negative syndrome (Wallace, 1984; Jackson, 1988; Bellack et al., 1989).

Social skills training (SST) has been employed with schizophrenic patients for over two decades in an attempt to remediate poor social functioning (Herson and Bellack, 1976; Liberman et al., 1989; Wallace et al., 1980) This chapter is a review of SST with schizophrenic patients, focused on the impact of SST on schizophrenic individuals’ functioning in the community.

22.1 THE PRINCIPLE OF SOCIAL SKILLS TRAINING

The key assumption underlying SST is that many schizophrenic patients either have never learned, or have forgotten, socially skilled behaviours for coping with important interpersonal situations (Goldsmith and McFall, 1975). These skills deficits are seen as the key reason for patients’ poor social functioning and social isolation, and it is presumed that acquisition and utilization of skills will improve patient functioning. From within this theoretical framework, therapy is an active, directive process designed to teach patients skills. Implicitly it is presumed that use of skills will be prompted and reinforced in the patients’ environment sufficiently to maintain the behaviours (i.e. patients will have people with whom they interact who respond positively to the use of social skills; and patients will feel little anxiety, or will achieve desired goals, when using the skilled behaviours in their day-to-day lives).

The numerous attempts to define social skill vary greatly in their emphasis (Bellack, 1983). Wallace et al. (1980) suggested there are four major elements commonly included in definitions of social skills:
(1) patients’ internal states, i.e., their feelings, attitudes, and perceptions of interpersonal contexts;

(2) the topography of patients’ behaviour — the rates of behaviours such as eye contact, hand gestures, body posture, speech dysfluencies, voice volume and latency of verbal response;

(3) the outcomes of interactions, as reflected in the achievement of patients’ goals; and

(4) the outcomes of interactions as reflected in the attitudes, feelings, behaviours, and goals of other participants.

Elements 3 and 4 are the most important components of the definition of social skills as they reflect the adaptiveness of the person’s social behaviour. Element 1 is important, though it is inappropriate to overemphasize the subjective perceptions and feelings of schizophrenic patients. For example, lying around in bed for prolonged periods may feel comfortable for the patient in the short term, but may be maladaptive. Element 2 is important in so far as it is possible to define the specific behaviours which are adaptive on criteria 3 and 4.

Anthony and Liberman (1986) provide a representative example of a definition used in SST which focuses on elements 3 and 4. They define social skills as those skills which allow the individual to: ‘Promote problem solving, engage others in successful affiliative and instrumental relationships, mobilize supportive networks and engage in work’ (p. 544). This definition (and most others like it) lack detail about exactly what these social skills are. This lack of specificity reflects the large variations in what constitutes social skill in different situations, which is an issue reviewed in detail by Mueser and Douglas (Chapter 11).

Early SST programmes with schizophrenic patients conceptualized social skill as a relatively stable set of overt responses, and targeted changes in topographical features of those behaviours. For example, Bellack et al. 1976, targeted appropriate speech duration, intonation and gestures. Kale et al. (1968) taught just one discrete behaviour, a simple greeting, ‘Hello’. Serber and Nelson (1971) trained patients in assertive responses. However, it became evident that a simple list of overt behaviours was not an adequate conceptualization of social skill.

Two fundamental changes have occurred in the social skills targeted in SST. First, in more recent reports of SST, interpersonal communication has been taught within a context of life skills, focusing on general classes of behaviour viewed as adaptive (Brown and Munford, 1983; Wallace and Liberman, 1985; Liberman et al., 1989). Definition of specific therapeutic targets usually relies on the therapist applying principles underlying these classes of behaviour to specific situations problematic for patients. For example, assertion has widely assumed to be an adaptive means of responding to interpersonal conflict (Lange and Jakubowski, 1976), though it is clear this is not universally so (St. Lawrence et al., 1985). SST therapists need to guide clients as to when assertion is appropriate, and help them formulate appropriate assertive responses to specific problem situations.

Second, recent SST programmes also focus on a more comprehensive range of social skills incorporating social perception and social problem-solving skills, as well as overt behaviours. The comprehensive model of social skills adopted in many recent SST programmes was first described by Argyle and Kendon (1967), and is presented schematically in Figure 22.1. Essentially social skill is argued to be a analogous to any serial motor skill. The individual first must be able to accurately perceive the social situation. That input has to be translated into the definition of achievable personal goals, the identification of a range of possible responses, and selection of an appropriate response. Finally, the selected response has to be made skilfully.

Representative examples of SST programmes which incorporate this more comprehensive range of social skills, including social