Part I

PRINCIPLES, FORMAT, AND TECHNIQUES FOR SOCIAL SKILLS TRAINING OF CLIENTS WITH SCHIZOPHRENIA

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Schizophrenia and Social Skills

If asked to define schizophrenia or explain it, you would probably refer to hallucinations and delusions, the prototypical symptoms. But stop and form an image of a typical patient with schizophrenia. In imagining specific clients and what they are like, you likely think about their appearance and behavior. Even when florid symptomatology is controlled by medication, most individuals with schizophrenia seem a little different or "off center."

It may be difficult to follow their train of thought in a conversation. They may even say some things that sound slightly odd or unrelated to the topic. The person's face and voice may be unusually inexpressive, and he or she may avoid looking at you during the conversation. In fact, you may feel that the person is not really listening to you. Overall, you are apt to feel a little uncomfortable.

Critical factors that lead to your unease can be subsumed under the rubric of *social skills deficits*. Social skills are interpersonal behaviors that are normative and/or socially sanctioned. They include such things as dress and behavior codes, rules about what to say and not to say, and stylistic guidelines about the expression of affect, social reinforcement, interpersonal distance, and so forth. Whether they have never learned social skills or have lost them, most people with schizophrenia have marked skill deficits. These deficits make it difficult for many clients to establish and maintain social relationships, to fulfill social roles (e.g., worker, spouse), or to have their needs met.

In this chapter, we present an overview of the behavioral model of social skills and how the model applies to schizophrenia. We describe the specific behaviors that constitute social skills and then discuss other factors that interfere with social behavior in schizophrenia, especially information-processing deficits. We then describe some social situations that are especially difficult for clients with schizophrenia.

THE BEHAVIORAL MODEL OF SOCIAL SKILLS

Definition of Social Skills

Many definitions of social skills have been developed, but most specific definitions fail to account for the broad array of social behaviors.

> Rather than providing a single, global definition of social skill, we prefer a situation-specific conception of social skills. The overriding factor is effectiveness of behavior in social interactions. However, determination of effectiveness depends on the context of the interaction (e.g., returning a faulty appliance, introducing oneself to a prospective date, expressing appreciation to a friend) and, given any context, the parameters of the specific situation (e.g., expression of anger to a spouse, to an employer, or to a stranger). (Hersen & Bellack, 1976, p. 562)

More specifically, social skills involve the

> ability to express both positive and negative feelings in the interpersonal context without suffering consequent loss of social reinforcement. Such skill is demonstrated in a large variety of interpersonal contexts . . and it involves the coordinated delivery of appropriate verbal and nonverbal responses. In addition, the socially skilled individual is attuned to realities of the situation and is aware when he is likely to be reinforced for his efforts. (Hersen & Bellack, 1976, p. 562)

Two aspects of this definition warrant special mention. First, socially skilled behavior is situationally specific. Few, if any, aspects of interpersonal behavior are universally or invariably appropriate (or inappropriate). Both cultural and situational factors determine social norms. For example, in U.S. society, kissing is sanctioned within families and between lovers, but not between casual acquaintances or in the office. Direct expression of anger is more acceptable within families and toward referees at sporting events than toward an employer. The socially skilled individual must know when, where, and in what form different behaviors are sanctioned. Thus, social skill involves the ability to perceive and analyze subtle cues that define the situation as well as the presence of a repertoire of appropriate responses.

Second, social competence involves the maximization of reinforcement. Marriage, friendship, sexual gratification, employment, service (e.g., in stores, restaurants), and personal rights are all powerful sources of reinforcement that hinge on social skills. The unskilled individual is apt to fail in most or all of these spheres and, consequently, experience anxiety, frustration, and isolation, all of which are especially problematic for people with schizophrenia. Thus, social skills deficits may increase the risk of relapse, whereas enhanced social competence may decrease that risk.

Social Skills and Social Behavior

The following discussion elaborates the elements of the social skills model depicted in Table 1.1. First, interpersonal behavior is based on a distinct set of *skills.* The term *skill* is used to emphasize that social competence is based on a set of *learned* performance abilities, rather than traits, needs, or other intrapsychic processes. Conversely, poor social behavior is often the result of social skills deficits. Basic aspects of social behavior are learned in

TABLE 1.1. Social Skills Model

1. Social competence is based on a set of component response skills.
2. These skills are learned or learnable.
3. Social dysfunction results when:
   a. The requisite behaviors are not in the person's behavioral repertoire.
   b. The requisite behaviors are not used at the appropriate time.
   c. The person performs socially inappropriate behaviors.
4. Social dysfunction can be rectified by skills training.

childhood, while more complex behavioral repertoires, such as dating and job interview skills, are acquired in adolescence and young adulthood. It appears as if some elements of social competence, such as the facial expression of affect, are not learned, but are genetically "hard wired" at birth. Nevertheless, research suggests that virtually all social behaviors are *learnable;* that is, they can be modified by experience or training.

As indicated in Table 1.1, social dysfunction results from three circumstances: when the individual does not know how to perform appropriately, when he or she does not use skills in his or her repertoire when they are called for, or when appropriate behavior is undermined by socially inappropriate behavior. The first of these circumstances is especially common in schizophrenia. Individuals with schizophrenia fail to learn appropriate social behaviors for three reasons. First, children who otherwise seem normal but who later develop schizophrenia in adulthood seem to have subtle attention deficits in childhood. These deficits interfere with the development of appropriate social relationships and the acquisition of social skills. Second, schizophrenia often strikes first in late adolescence or young adulthood, a critical period for mastery of adult social roles and skills, such as dating and sexual behaviors, work-related skills, and the ability to form and maintain adult relationships.

Many individuals with schizophrenia gradually develop isolated lives, punctuated by lengthy periods in psychiatric hospitals or in community residences. Such events remove clients from their normal peer group, provide few opportunities to engage in age-appropriate social roles, and limit social contacts to mental health staff and other severely ill clients. Under such circumstances, clients do not have an opportunity to acquire and practice appropriate adult roles. Moreover, skills mastered earlier in life may be lost because of disuse or lack of reinforcement by the environment.

Other Factors That Affect Social Functioning

Why might a person not use behaviors that are still in his or her repertoire, as suggested by item 3b in Table 1.1? As indicated in Table 1.2, a number of factors can be expected to influence social behavior in schizophrenia in addition to social skills per se (Bellack & Mueser, 1993).

Psychotic Symptoms

It should not be surprising that an individual hearing highly intrusive voices, or feeling jeopardized by malevolent forces, would be unable to focus on social interactions. Clients

TABLE 1.2. Factors Affecting Social Performance

1. Psychotic symptoms
2. Motivational factors
   - Goals
   - Expectancies for success and failure
3. Affective states
   - Anxiety
   - Depression
4. Environmental factors
   - Lack of reinforcement for efforts
   - Lack of resources
   - Social isolation
5. Neurobiological factors
   - Information-processing deficits
   - Negative symptoms
   - Medication side effects

can be expected to have difficulty fulfilling social roles and behaving in a socially appropriate manner at the height of acute exacerbations.

However, research indicates that clients with schizophrenia have marked deficits in social competence even when psychotic symptoms are under control; conversely, many clients can learn more effective ways of interacting even when they have persistent symptoms. Psychotic symptoms may have a limiting effect on social performance, but they do not explain the bulk of social disability in this population.

Motivational Factors

Many individuals with schizophrenia actively avoid social interactions and appear to have little motivation to develop social relationships. Several factors seem to be involved in this pattern. First, most chronic clients have a history of social failure, rejection, and criticism. As a result, they learn that it may be safer to minimize social interactions than to risk further failure or censure. Second, most clients are engaged in a lifelong struggle to find an equilibrium in which they can control their symptoms, limit their experience of negative affect, and maintain the best possible quality of life. Although at one level they may desire to have improved social relationships and undertake more demanding social roles, venturing out into the social environment may pose an unmanageable threat.

Affective States

As indicated earlier, social interaction is often very anxiety provoking to individuals with schizophrenia which leads to avoidance. Moreover, clients frequently seek to escape from social interactions initiated by others. Research from our laboratory has shown that clients are particularly sensitive to conflict and criticism and will withdraw from potential conflict situations even when they are being taken advantage of or unjustly accused of things they have not done (Bellack, Mueser, Wade, Sayers, & Morrison, 1992).

Environmental Factors

Three aspects of the environment often make it difficult for clients with schizophrenia to use their social skills effectively. First, as their skills tend to be limited, their performance is often odd or imperfect in some way. Unfortunately, many people are not tolerant of idiosyncrasies or social errors and tend to be unsympathetic, impatient, or overtly critical. As a result, clients are not reinforced for their efforts and, in some circumstances, may receive a critical or hostile response. Hence, they tend to become wary of engaging in social interactions.

Second, many clients are unemployed and live in harsh economic circumstances. They do not have the resources to participate in social recreational activities that they might otherwise be able to succeed in and enjoy. Finally, many clients are isolated and do not have good social networks. The illness is stigmatizing, leading others to avoid them. In addition, repeated exacerbations and periods in the hospital disrupt relationships and gradually remove clients from the social environment. Friendships generally develop from the workplace or school, hobbies, volunteer activities, child rearing, and other activities that individuals with schizophrenia often do not participate in. As a result, social contacts for many clients are limited to other clients, mental health staff, and/or family members.

Neurobiological Factors

Several significant neurobiological factors affect social behavior in schizophrenia. The illness is characterized by significant deficits in information processing: the multiple abilities necessary for thinking, learning, and remembering (Green, Kern, Braff, & Mintz, 2000). People with schizophrenia tend to have a variety of problems with attention. They cannot process information as rapidly as others. They have difficulty discriminating important from unimportant stimuli, such as what the interpersonal partner is saying versus voices coming from another conversation or the TV. They have problems with concentrating, focusing attention, sustaining attention over time, or focusing in difficult conditions such as when under stress or when presented with a highly complex task. Thus, they may have great difficulty in attending to what someone is saying if the person speaks rapidly or presents a lot of complex information, if there are distractions (e.g., other conversations going on in the background), if the other person is angry and increasing their level of stress or anxiety, or if the person is providing confusing cues (e.g., subtlety or sarcasm).

Clients with schizophrenia also frequently have problems with memory, especially with short-term verbal memory (e.g., what someone said or told them to do) (Mueser, Bellack, Douglas, & Wade, 1991) and working memory (e.g., ability to retain information *on line* while making a decision or solving a problem). The problem does not seem to be one of forgetting as much as difficulty in initial learning or accessing information that has been learned (e.g., as when you cannot remember a name). Individuals with schizophrenia often seem forgetful or distracted, and they may be accused of not paying attention or not caring about important things. In fact, the real problem may be that the information is not presented in a way that adjusts for their attention problems (e.g., slowly, clearly, and with repetition) or that they simply cannot remember what they did hear unless they are provided with reminders or prompts.

A third important information-processing deficit involves higher-level or complex information processing. People with schizophrenia have trouble in problem solving, in part because they have difficulty in drawing abstractions or deducing relationships between events. A related problem involves the ability to draw connections between current and past experience. Whether it is because they cannot recall past experience, cannot determine when past experience is relevant, or because they simply cannot integrate the diverse processes of memory, attention, and analysis of multiple pieces of information, these individuals have difficulty in learning from experience. They also are unable to effectively organize mental efforts, such as initiating and maintaining a plan of action. As a result, their reasoning and problem solving often seem to be disorganized or even random.

These various problems are not extreme, such as the memory impairment in Alzheimer's disease, but they can nevertheless disrupt social behavior and the ability to fulfill social roles. The fact that these deficits cause significant problems without their being very noticeable to other people sometimes adds to their negative effects, as family members and others in contact with such clients often get frustrated and angry with them when they fail to respond or do things that they appeared to understand (e.g., requests for favors, directions for taking medications). As indicated earlier, disability is often mistaken for laziness, disrespect, and other undesirable personal attributes.

Another significant neurobiological constraint is negative symptoms (Andreasen, 1982). *Positive symptoms*, such as hallucination and delusions, are things that clients experience that normal individuals do not. *Negative symptoms* are things that are deficient as compared with normal levels of functioning. Many persons with schizophrenia suffer from a variety of such deficits, including avolition and anergia, a generalized lack of motivation, energy, and initiative; anhedonia, an inability to experience pleasure and positive emotions; and alogia, a relative inability to generate conversation.

Negative symptoms may result from significant depression or social isolation or from excessive doses of antipsychotic medication. In other cases, they reflect a symptom constellation referred to as the *deficit state*, which appears to be a fundamental biological component of the illness. In either case, these symptoms deprive the patient of the motivation and energy to participate in social activity or to enjoy interactions with others. This symptom constellation is one of the most pernicious aspects of the illness and is also the least responsive to medication.

Components of Social Skills

As specified earlier, social competence is based on a distinct set of component skills (Morrison, 1990). These components can be roughly divided into two broad sets: expressive skills and receptive skills. Table 1.3 provides a list of the most important skills for schizophrenia, including some additional skills that reflect the reciprocal nature of social interaction.

Expressive Skills

There are three groups or categories of expressive behaviors that contribute to the quality of social performance: verbal behaviors, paralinguistic behaviors, and nonverbal behaviors. *Verbal behavior* refers to what we say: the form, structure, content, and amount of words we

TABLE 1.3. Components of Social Skills

Expressive behaviors
Speech content
Paralinguistic features
Voice volume
Speech rate
Pitch
Intonation
Nonverbal behaviors
Eye contact (gaze)
Posture
Facial expression
Proximics
Kinesics
Receptive behaviors (social perception)
Attention to and interpretation of relevant cues
Emotion recognition
Interactive behaviors
Response timing
Use of social reinforcers
Turn taking
Situational factors
Social "intelligence" (knowledge of social mores and demands of the specific situation)

emit. Socially skilled individuals are easy to understand. They use vocabulary and sentence structure that are sensible to their audience. Conversely, many clients with schizophrenia are difficult to follow, in part because they use language in an odd or confusing manner. They may use common words to mean something very idiosyncratic, use neologisms (words that are not real words), or use sentence structure that omits key elements (e.g., conjunctions), making it difficult for the listener to discern the meaning of what is being said. Moreover, many persons with schizophrenia have a paucity of relevant and interesting things to say. They often do not work or go to school, they do not read newspapers or attend to current events, and they live relatively restricted lives. Hence, even if they have the desire to converse, they may not have a repertoire of things to talk about. Their conversation may also be dominated by their personal concerns, such as bizarre physical symptoms or delusions.

The manner in which one speaks and presents oneself may be as important as what one says. The term *paralinguistic* refers to characteristics of the voice during speech, including volume, pace, and intonation and pitch. Speech that is very fast is difficult to understand; speech that is very soft may be difficult to hear; speech that is very slow, very loud, or monotonic (as in monotonous) is unpleasant to listen to. High-pitched (e.g., shrill) voices may also be annoying, especially as the volume increases. Speech dysfluencies (e.g., "uh" or "um," stutters) and lengthy pauses may also make it difficult or unpleasant for the listener. These voice and speech characteristics are important for interpreting meaning, as well as for the listener's interest and enjoyment. For example, pace, volume, and intonation are especially important in communicating affect or emotion. Flattened tone, slow pace, and low

volume often reflect boredom, depression, or fatigue, but they may also signal a romantic intention (e.g., a slow, deep, sultry voice quality). Loud volume (e.g., raising one's voice) is associated with anger. Rapid pace and high pitch can reflect excitement or fear. Changes in these characteristics are also important in signaling meaning and feelings. For example, increasing loudness can be used to emphasize a point. Schizophrenia, especially the deficit syndrome, is frequently marked by a relatively monotonic voice quality and slow rate of speech that are unpleasant for the listener and hard to interpret. Conversely, excited states can result in pressured, high-pitched speech that is very difficult to follow.

Nonverbal behavior also affects one's interpersonal impact. Facial expression is, perhaps, the primary cue to emotional state: smiling, frowning, grimacing, glowering, and other expressions are substantially reflexive correlates of our mood and feelings. Subtle changes in the muscles around the mouth and eyes signal annoyance, curiosity, surprise, pleasure, or any number of other emotional reactions to what the speaker is saying or doing. The eyes have often been regarded as the primary "window to the soul." Good eye contact is associated with strength, authority, anger, and truthfulness. Lovers will look deeply into each other's eyes. Conversely, "shifty" eyes or avoidance of eye contact is thought to reflect anxiety, discomfort, or dishonesty. Wide-open eyes and dilated pupils can signal heightened interest or fear, whereas narrowed eyes and contracted pupils are associated with suspiciousness, annoyance, or anger. The eyes also play an important role in the flow of conversation. Typically, the speaker looks directly toward the listener's eyes, and the listener moves his or her gaze around the speaker's face. When the speaker is ready to pause and shift the floor to the listener, he or she breaks off eye contact; similarly, the listener wanting to speak tries to catch the speaker's eye to signal the desire for a floor shift. Individuals with schizophrenia tend to be gaze-avoidant. They are uncomfortable in social situations and seem to be especially sensitive to maintaining eye contact. Of course, clients with paranoia may exhibit an unblinking stare that makes the listener uncomfortable or even fearful.

Posture may denote feelings, interest, and authority. A relaxed posture signals comfort, whereas muscular tension (e.g., balled fist, pursed lips, forward lean) signifies arousal or tension. Similarly, leaning forward while speaking or listening is associated with interest and attention, whereas leaning away may reflect fear or distaste. The latter stance is characteristic of many clients with schizophrenia, who are uncomfortable in social interactions.

Proximics, a related behavioral category, refers to the distance between people during their interactions. There are fairly clear, albeit unwritten, cultural rules for the comfortable and appropriate distance between two people during conversations. The acceptable distances vary according to the nature of the relationship and gender, as well as across cultures. For example, familial and romantic relationships allow closer contact than is permitted between employer and employee, especially when they are of opposite sex.

Strangers or casual acquaintances are expected to remain farther apart than friends, although the acceptable distances shorten in crowded subway cars or elevators. A male patient who got as close to a female staff member in an office or on the ward as in a crowded elevator would be perceived as threatening and displaying inappropriate behavior; conversely, if the same staff member approached him to take his blood pressure, the interaction would be entirely acceptable. As previously indicated, many clients with schizophrenia are uncomfortable in close interpersonal situations and maintain inappropriately large in-

terpersonal distances. Some clients with paranoia may be sufficiently threatened as to act out when their "personal space" is violated.

These diverse behavioral elements identified here are each important by themselves, but their impact and interpretation are generally a function of their relationship to one another. When the different components are consistent with one another, they serve to reinforce the speaker's message, as when someone says, "I am angry," in a loud and slow voice, makes direct eye contact with the listener, and has a tense posture with balled fist, clenched teeth, and a forward lean. Conversely, when someone says, "I'm not afraid of you," in a rapid and tremulous voice, avoids eye contact, trembles, and leans backward, the verbal content must be interpreted in light of these inconsistent paralinguistic and nonverbal cues.

Receptive Skills

Regardless of an individual's ability to emit socially skillful responses, he or she cannot be effective without accurate perception of the social situation. The socially skillful individual attends to the interpersonal partner, analyzes the situation, and knows when, where, and how to structure his or her response. This combination of attention, analysis, and knowledge is generally referred to as *social perception*. Not surprisingly, individuals with schizophrenia are thought to have particular difficulty in this area. First, as previously discussed, they have significant difficulties with attention. Effective social perception requires the person to detect a rapidly changing series of facial expressions, verbal content with shifting intonation, and subtle gestural and postural changes. Individuals with schizophrenia may not be able to pick up all of the relevant cues provided by a partner. In addition, accurate interpretation of these various cues requires the individual to integrate the diverse pieces of information, remember them, be able to integrate current information with previous experience (e.g., does Susan express anger directly, or does she do it indirectly by talking more slowly, looking slightly tense, and calling you "John" instead of "Johnny"?), and abstract the crux of the communication by differentiating important and unimportant details. These are all capacities that are limited in schizophrenia.

In addition, it has been suggested that clients with schizophrenia have a specific deficit in the ability to perceive emotions, especially negative emotions such as anger and sadness (Bellack, Blanchard, & Mueser, 1996). This difficulty is thought to be the result of a specific neurological impairment, akin to receptive aphasia for language or agnosia that prevents the interpretation of visual images. The data on this point are somewhat inconsistent, but the clinician should be attuned to the possibility that an individual client who has difficulty interpreting other people's feelings may have a specific, inherited deficit that interferes with the decoding of affect cues.

Social skills depend on the effective use of the constellation of specific elements discussed earlier, but they are not the simple sum of these molecular behaviors. Rather, the ability to communicate and interact effectively is the result of the smooth integration of these behaviors over time, along with ancillary characteristics such as grooming and hygiene. In essence, the whole is greater than the sum of the parts. Moreover, as discussed in the context of our definition of social skill, social behavior is situationally specific. Each situation presents special demands and constraints, and many situations have specific rules

that must be mastered. For example, dealing with a high-pressure car salesman may require a false bravado and less candor than is desirable in most other situations. Similarly, effective performance on a job interview demands a style of behavior that would be very difficult to maintain in everyday interactions and would not be appropriate in informal interactions with peers. We refer to these discrete areas of skill as *behavioral repertoires*.

Skills training programs involve development of curricula to teach one or more of these repertoires, depending on the needs of the specific group of clients and the amount of time available. This issue is elaborated in subsequent chapters; Part II provides an extensive set of such curricula. For illustrative purposes, in the rest of this chapter we highlight a few repertoires that we have found to be particularly important for clients with schizophrenia: (1) conversational skills, (2) social perception skills, and (3) skills relevant to special problem situations. Remediation strategies for these repertoires are discussed in subsequent chapters.

Conversational Skills

The ability to initiate, maintain, and terminate a conversation is central to almost every social interaction. Conversational skill is not simply the ability to engage in repartee at cocktail parties, but the basic medium of communication for interactions as simple as asking directions, ordering in a restaurant, and saying "Thank you" for a simple favor. Conversational skills involve verbal and nonverbal responses employed in (1) starting conversations, (2) maintaining conversations, and (3) ending conversations.

A relatively circumscribed repertoire of specific verbal responses can be sufficient for starting and ending most conversations. Responses for initiation include (1) simple greetings, such as "Hi" and "Good morning"; (2) facilitating remarks and open-ended questions, such as "How are you today?" "I haven't seen you in a while, what's new?" "Isn't today a beautiful [miserable] day?" and "Did you listen to the ball game yesterday?" and (3) remarks for entering ongoing conversations, such as "Mind if I join you?" and "Are you talking about the game [show, etc.] last night?" Ending a conversation or leaving a group is frequently an awkward process, and many clients with schizophrenia either leave abruptly or continue ad infinitum. Concluding statements include "I have to go; see you later," "What time is it? I have to meet someone," and "It was nice talking with you. See you tomorrow." Of course, social perception skills (see the next section) are required to ensure that entry and exit are smooth and appropriately timed.

A somewhat more complex set of skills is required to maintain a conversation effectively and to promote satisfactory and reinforcing relationships. A basic requirement is the ability to ask appropriate questions that facilitate a response by the interpersonal partner and/or secure relevant information. The socially skilled individual generally has two types of questioning strategies at his or her disposal. Open-ended questions serve primarily as response facilitators. Examples include "How are you doing?" "What's new?" "What did you think of the game [show, meeting, etc.] yesterday?" and "Do you really think so?" Frequently, the questioner is less interested in the specific answer to such questions than in the general conversation that follows. Specific information is more effectively secured by closed-ended questions, such as: "What was the score of the game yesterday?" "What did you eat last night?" and "Would you like to go downstairs for

lunch now?" The individual must also be able to differentiate these two types of questions when they are directed at him or her so as to make an appropriate response. Consider the following reply to the greeting "Hi, what have you been doing?": "Well, I bought a pack of cigarettes this morning, then I went to my group, then I had a hamburger for lunch, and I just went to the bathroom." Although this response might ordinarily be ascribed to a schizophrenia patient's concreteness, it could more profitably be viewed as a manifestation of social skill deficit.

Another factor that is critical for maintaining interactions is periodic reinforcement of the interpersonal partner. Brief interactions can be effectively enacted with an exchange of greetings and/or information, but these minimal responses are not sufficient to maintain longer interactions or to facilitate the development of continuing relationships. Conversational reinforcers include statements of agreement (e.g., "Yeah, you're right," "I agree with you"), approval ("That's a good idea," "I never thought of that, you re right"). Simple verbal facilitators such as "Yeh," "Uh-huh," and "Mm-hmm" have also been shown to have significant reinforcing value. The quality of social interactions is also improved by the appropriate use of social amenities such as "Please," "Thank you," and "Excuse me." The experienced clinician will likely be aware of both the relative infrequency with which most clients with schizophrenia emit either reinforcement of amenities and the rather sterile nature of their conversational style.

There are a number of nonverbal response elements that substantially contribute to socially skillful behavior:

1. Eye contact should be maintained intermittently, interspersed by gazing in the direction of the partner. Both constant eye contact (i.e., staring) and the absence of eye contact are generally inappropriate.
2. Voice volume should approximate a "conversational" level, neither too loud nor too low.
3. Voice tone should not be monotonic, but should include inflection to communicate emphasis, affect, and so on.
4. Response latency to input from the interpersonal partner should generally be brief (see also the discussion of timing in the next section). Mediators such as "Let me think about that" and "Hmm" can be employed when a response must be contemplated.
5. Speech rate should coincide with normative conversational style.
6. Speech dysfluencies should be at a minimum.
7. Physical gestures such as head nods, hand movements (for emphasis), and forward leaning all add to the qualitative impact of the communication.
8. Smiles, frowns, and other facial gestures should be employed in conjunction with verbal content.
9. Physical distance should be maintained according to preferred social norms.
10. Posture should be relaxed, rather than wooden.

These response elements undoubtedly have differential importance in different situations. At present, there are no clear data on their comparative contributions to social effectiveness or on the relative importance of the nonverbal and verbal response components.

However, it seems likely that they combine to create a gestalt impression and that anomalous performance of any of the nonverbal elements (e.g., staring, extremely low voice volume) would have deleterious effects on social interactions.

Social Perception Skills

Good conversational behavior also requires effective social perception skills. The most relevant social perception skills for clients with schizophrenia fall into five general categories: (1) listening, (2) getting clarification, (3) relevance, (4) timing, and (5) identifying emotions.

Listening or attending to the interpersonal partner is the most fundamental requirement for accurate social perception. Many clients with schizophrenia exhibit poor interpersonal behavior precisely because their focus of attention is primarily internal and only intermittently and selectively directed outward. Consequently, they fail to secure sufficient accurate information to make an appropriate response and they cannot emit social facilitators or reinforcers.

Even if the individual is an adept listener, he or she will periodically tune out for brief periods and/or occasionally be confused or uncertain about the message being communicated. The skillful individual can identify this confusion and will seek *clarification.* Failure either to perceive confusion or to resolve it frequently results in a breakdown of the subsequent communication process and the emission of inappropriate responses. Clarification can be secured with such statements as "Excuse me, but I didn't hear that," "I don't understand, and I'm not sure what you mean (what you're asking, etc.)." A related and somewhat more subtle skill is perception of confusion on the part of the interpersonal partner. Confusion is often communicated by quizzical or vacant looks, which may include cocking the head to the side, furrowing of forehead and eyebrows, contraction of the pupils, and cessation of social reinforcers (e.g., head nods and "mm-hmms"). By perceiving the partner's confusion, the skillful individual can avoid noncommunicative rambling.

In order to be appropriate, a response must be *relevant* to the conversation as a whole, as well as to the immediately preceding communication. Persons with schizophrenia are frequently seen to be irrelevant in their persistent references to personal problems and family members. Determining relevance is primarily a function of listening to and analysis of the communications. However, relevance can also be increased by self-censoring, such that certain content areas or discrete responses are not emitted in certain types of interactions (or conversely, are allowed only in certain interactions). For example, complaints about ill health, references to idiosyncratic experiences (e.g., hallucinations), and discussion of toileting and sexual behavior are customarily inappropriate other than in conversations with health service providers, family, and close friends.

Timing involves performance of responses at appropriate points in an interaction, as well as with appropriate latency. Effective social interaction involves ebb and flow, including both rapid exchanges and silences. Certain activities and emotional states (e.g., grief) also affect social appropriateness.

The content of the conversation and social norms are the primary determinants of appropriate timing, and thus knowledge of social rules is essential for proper timing. Poor timing is exemplified by interruptions, long latencies to simple closed-ended questions, or

leaving an interaction before some resolution is reached (e.g., ignoring requests for delay such as "Let me finish this first" or "Let me think about that").

The final aspect of social perception involves accurate *perception of emotion.* Emotion is frequently communicated by a subtle combination of verbal and nonverbal cues (most people are not sufficiently assertive to communicate their emotions with clear, direct statements). Given that the emotional status of the interpersonal partner is a critical factor in determining an appropriate response, the socially skilled individual must be able to read emotional cues. Minimally, this entails perceiving changes in the nature of the partner's behavior; however, discrimination of emotional states is also necessary. In addition, the skillful individual is able to identify his or her own emotional states, transmit them accurately, and analyze their cause. Such personal perception and analysis enhance accurate communication and are necessary for effective resolution of conflict and distress.

Additional Problem Situations

An individual possessing the full range of conversational and perceptual skills described earlier will be effective in most social situations. However, some interactions are especially difficult to complete because they are anxiety provoking or stressful, because they require great subtlety and nuance, or because they are infrequently encountered. Although an exhaustive list of such situations cannot be supplied, there are a number of situations that we have found to be problematic for a great proportion of clients with schizophrenia.

Assertiveness Skills

One of the most frequently encountered deficits is lack of skill in appropriate assertion. There are generally considered to be two forms of assertion. Hostile or negative assertion involves the expression of negative feelings, standing up for one's rights, and refusing unreasonable demands. Examples of appropriate negative assertion include returning food (in a restaurant) or merchandise that is unsatisfactory or damaged, standing up to an authority figure (police officer, employer, teacher) who is treating you unfairly or inappropriately, requesting an intruder to get to the back of a line or wait his or her turn at a store counter, and expressing justified anger or annoyance to a repairman who has done faulty work or caused unreasonable delay. Commendatory or positive assertion consists of expression of positive emotions: affection, approval, appreciation, and agreement. This includes, for example, warmly thanking a friend for doing a favor, kissing a spouse and verbalizing affectionate feelings, telling a friend (or employee, child, etc.) that he or she has done a really good job, and complimenting someone on his or her appearance or improvement, and so on.

Individuals with schizophrenia tend to avoid or escape from situations in which they may be criticized or in which there may be conflict. The result is that they are frequently taken advantage of. In addition, they often face increased criticism from frustrated family members or mental health staff for failing to deal directly with difficult issues. Appropriate assertiveness is one of the most critical skills for clients with schizophrenia to learn in order to avoid and reduce distress and avoid mistreatment. Positive assertion is similarly impor-

tant for them to be able to develop and sustain friendships. Assertiveness skills, along with conversational skills, are the most common focus of skill training programs.

Heterosocial Skills

In addition to the general conversational and perceptual skills described earlier, there are a variety of special demands and social norms that pertain to dating, romantic, or sexual interactions. Comparable skills are needed by clients who wish to develop same-sex romantic and sexual relationships.

Grooming, cleanliness, social amenities, social reinforcement, and positive assertion are of special importance. Age-appropriate, as well as culturally appropriate, dating etiquette (e.g., telephone calls, planning, and engaging in social activities) must be observed. Finally, the individual must have information about sexual functioning, be somewhat sophisticated about how to make and respond to sexual overtures, and know how to perform sexually to maximize pleasure and minimize discomfort. In addition, all clients need to learn about safe-sex practices, including the use of condoms and how to avoid or resist unwanted or dangerous sexual encounters.

Assertion skills targeted on condom use and saying "No" are especially important for female clients, who are particularly vulnerable to manipulation and abuse by male acquaintances. Education about HIV and AIDS should be a standard part of any skills curriculum with clients who are sexually active or may otherwise be at risk.

Independent Living Skills

Although many clients are unable to compete for employment or even to hold jobs in sheltered workshop settings, *job interview skills* are needed by those who are able to look for work. These skills include how to present oneself positively; how to answer questions about experience and abilities; how to ask questions about salary, working conditions, and so forth; and such associated behaviors as grooming, punctuality, and the like. Dealing with one's psychiatric history and long periods of unemployment is particularly important.

Clients need to be taught what information *not* to disclose about their history and symptoms, as well as what should be disclosed and how to disclose this information in the most positive light possible. Many clients experience difficulty in making *satisfactory living arrangements*. Issues here include how to find an apartment, how to speak with a landlord (e.g., what to ask, how to discuss rent), how to make arrangements with a roommate (e.g., sharing rent and chores, visitors), and how to interact with neighbors. A related set of topics, which may or may not be appropriate for social skills training, involves activities of daily living (ADLs), including cooking and grocery shopping, managing money, and using public transportation. Although such training is often covered in vocational rehabilitation, the social skills training technology is particularly effective for teaching these nonsocial skills.

Medication Management

A critical factor in poor posthospitalization adjustment and relapse is failure to follow the prescribed medication regimen. It is our contention that an important factor in this regard

is faulty communication between the client and the health service provider. Thus, the client may not effectively communicate about side effects and inconsistent usage or may fail to comprehend the physician's treatment plan or the need to continue with medication.

We believe that interacting with health service personnel is a specific social skill and that treatment compliance can be increased if clients are able to communicate their concerns, reactions, expectations, and desires effectively.

These various behaviors, referred to as *medication management skills*, include education about medication, its importance, side effects, and so forth, as well as specific conversational and assertiveness skills needed to discuss questions and concerns effectively with physicians and nursing staff (Eckman et al., 1992).

SUMMARY

This chapter has provided an introduction and overview of the social skills model. We defined social skills and gave a detailed description of the elements of social behavior. Expressive skills include verbal behavior, paralinguistic behavior, and nonverbal behavior. Receptive skills, referred to as social perception, refer to the ability to attend to and interpret the cues provided by an interpersonal partner. We also discussed factors that interfere with appropriate social behavior and prevent clients from using skills in their repertoires, including significant deficits in information processing, positive and negative symptoms, motivation and affect, and environmental constraints. Finally, we described some of the basic repertoires that constitute effective social performance, including conversational skills, assertiveness, and skills needed in special situations, such as sexual skills and job interview skills. This material was designed to provide an orientation to the rest of the book, which discusses the assessment and treatment of social skill deficits. As the reader will see, the basic building blocks and constraints to effective performance introduced in this chapter are referred to in every subsequent chapter in the volume.

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