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SOCIAL COMPETENCE IN SCHIZOPHERENICS, NEUROTIC DEPRESSIVES AND NORMALS

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SUMMARY

The purpose of this investigation is the assesment of social competence in schizophrenics, neurotic depressives and normals. Social competence has been viewed according to the dimension given by Argyle (1969). Twenty subjects were studied in each group. The California Test of Personality was used to assess social competence in terms of personal and social adjustment. Extraversion and dominance were measured using the second order factors II and IV of the 16 P.F. Questionnaire. Based on an interview schedule, the subjects were evaluated by a significant other on their social competence and role taking ability, as seen premorbidly and at present. Statistical analysis showed that the normals differ significantly (0.01) from the clinical groups, i.e. they show better social competence. Correlation was high only for the neurotic depressive group for social competence, chi. square values were not significant for any group but useful trends were observed. The results have been discussed in the light of the social skills model of Argyle and Kendon (1967).

Introduction

Mental health professionals have become increasingly aware that mental disorders have interpersonal as well as biological origins, that many of the symptoms are in the sphere of interaction and that various kinds of social interaction can be useful (Argyle 1969). This awareness has led to work in the area of social competence also interchangeably called social skills. The areas worked on are —

1. Assessment of Social Competence:— Zigler and Phillips (1961) examined social competence in relation to psychopathology as measured by demographic variables. Phillips (1978) and Beckfield and Mcfall (1982) used inventories of social relationship items to measure competence. Levenson and Gottman (1978) used self report measure of skills in social situations. The use of role play by Bellack et al (1979), video tape recordings by Conger and Farrel (1981) are some of the other measures used in this area.

2. Clinical Studies:— Social competence as a prognosis predictor in schizophrenics has been reported by Zigler and Phillips (1962), Lewine et al (1980) and Brady (1984). Poor social skills and clinical depression have been widely studied by Libet and Lewinsohn (1973), Phillips (1978), Lewinsohn et al (1980). The response of neurotics in social interactions have been examined by Trower (1980) and Halford and Foddy (1982).

Training for social competence has been extensively studied by Argyle (1969) in the areas of motivations, perception, response pattern, self confidence and self presentation. He has also updated the techniques to meet the developments in social psychology (Argyle 1984).

The significance of studying social competence lies in understanding the etiology, clinical presentation, management possibilities and in predicting the prognosis of mentally ill individual. Social competence here has been studied as reflected in adjustment and mediated by personality variables in normal and clinical conditions.

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The operational definition of social competence that is considered for this study is Argyle's (1969) description of the term. According to him, "when considering the term social competence, there is an assumption that some people are better at dealing with social situations in general than others are". There is a possibility that there may be a general factor of social competence, but he discusses competence in terms of a profile of specific abilities: Extraversion, Dominance, Poise, Rewardingness, Perceptual sensitivity, Role taking ability and Interaction skills.

With this background, the present study was planned with the following aims:

1. To study social competence (social skills) and its deficits in normal and clinical conditions respectively, in terms of total adjustment.
2. To study the relationship between personality and social competence interms of its Extraversion Introversion and DominanceSubmission Components.

In addition, the schizophrenics, neurotic depressives and normals have also been evaluated with regard to their role performance, based on a brief interview schedule.

Material and Methods

20 Schizophrenics and 20 neurotic depressives (diagnosed according to ICD9) formed the experimental group, while 20 normals formed the controls. Age range was 18–45 years. Minimum of 7 years of education was required. Duration of illness for clinical groups was taken from a minimum of 6 months to maximum of 3 years. Clinical sample was obtained from the outpatient department of NIMHANS, Bangalore. Individuals with no previous psychiatric consultation constituted the normal sample. The method of sampling for normals was purposive, taken from the general population in the community. Frequency matching was done for the samples in the clinical and control group.

Measures

1. California Test of Personality (C.T.P.): The 1953 revision by Thorpe, Clarke and Tiegs was used to assess personal and social adjustment which serve as a comprehensive tool for total adjustment.

2. 16 P.F. Questionnaire 'C' Form, Cattel (1956): It's modified version (Kameshwari 1977) was used to study the next aim in terms of the two second order factors II (Extraversion-Introversion) and IV (Dominance-Submission).

3. A brief interview schedule was used to elicit demographic details and the subject's role taking ability by interviewing a significant other.

4. Another interview schedule was used to elicit brief information about the social competence of the subject as viewed by the significant other.

The above two schedules were prepared by the authors, as there were no direct tools available for measurement of premorbid competence.

Procedure

The test were administered individually to each subject. Firstly the demographic details were collected. Next the California Test of Personality and 16 P.F. Questionnaire were administered to the subject and the responses noted. The significant other person accompanying the subject was interviewed, about his/her evaluation of the subjects' competence and role taking ability in the past and in the present. For the normal subjects, the significant others were interviewed with regard to their behaviour in the past 3 years.

Table 1
Mean, S.D. and F ratio of the 3 groups on CTP

Scales	Schizophrenics Mean	S.D.	Neurotic Depressives@ Mean	S.D.	Normals Mean	S.D.	F ratio
Total adjustment	92.55	(17.26)**	89.80	(16.35)**	118.6	(18.41)	16.75**
1. **Personal Adjustment**	44.30	(13.29)**	39.30	(9.57)**	61.20	(10.20)	21.14**
A. Self Reliance	7.45	(2.06)**	6.10	(2.24)**	9.35	2.23)	11.20**
B. Sense of personal worth	7.85	(3.07)**	6.90	(2.79)*	10.10	(2.99)	6.20**
C. Sense of personal freedom	8.90	(2.92)NS	8.95	(2.80)NS	8.95	(2.80)	.0000816 NS
D. Feeling of belonging	7.45	(2.06)**	7.40	(3.14)**	10.90	(3.03)	10.16**
E. Withdrawing tendencies (Freedom from)	6.15	(3.92)**	4.70	(2.66)**	10.30	(2.69)	17.05**
F. Nervous symptoms (Freedom from)	6.70	(3.69)**	5.10	(3.28)*	10.75	(3.81)	13.11**
2. **Social Adjustment**	47.75	(7.93)**	50.80	(8.06)*	57.40	(11.23)	6.22**
A. Social standards	8.55	(1.99)NS	10.00	(2.13)NS	9.30	(2.39)	2.23NS
B. Social Skills	6.50	(2.70)**	6.50	(2.42)**	9.55	(2.19)	10.37**
C. Antisocial tendencies (Freedom from)	8.15	(3.42)NS	9.55	(3.12)NS	9.40	(3.10)	1.13NS
D. Family relations	8.95	(2.68)**	9.00	(3.06)*	11.10	(2.97)	3.71*
E. Occupational relations	8.25	(1.99)NS	8.10	(3.31)NS	9.10	(3.08)	0.72NS
F. Community relations	7.85	(1.89)NS	7.40	(2.46)NS	8.96	(3.05)	2.01NS

@ The two clinical groups did not differ significantly with each other in any area.

* Significantly different from normal group at .05 level.

** Significantly different from normal group at .01 level.

Scoring was done manually using scoring keys, by standard procedures for CTP and 16 P.F. Questionaire. The interview schedules were scored as 0, 1 based on the absence and presence respectively of the phenomena and the totals were calculated.

Results and Discussion

The first aim was examined by comparing the subjects' scores on the scales and subscales of CTP by using ANOVA wherever the results were found significant, 't' test was done.

The analysis shows that normals have significantly better total adjustment than the clinical groups. The normals have significantly better personal adjustment. They are more self reliant, have a sense of personal worth, feeling of belonging, they are free from withdrawing tendencies and from nervous symptoms. In their social adjustment they show better social skills and family relation.

Thus the clinical groups show lack of personal and social security. Argyle (1969) has also brought out reduced self confidence, increased social anxiety, isolation, withdrawal and guardedness in depressives and schizophrenics. Others supporting the finding of personal maladjustment are Zigler and Phillips (1962), Phillips (1978), Beiser et al (1981), Halford and Foddy (1982).

In social relations disturbed family relations with pathological family interaction and poor social skills have been reported by Argyle (1969). Other studies with similar findings are of Libet and Lewinsohn (1973), Phillips (1978) and Lewine et al (1980).

Table 2
Correlation between total adjustment scores (CTP) Extraversion (16 P.F.) and Dominance (16 P.F.)

Group	Extraversion	Dominance
Schizophrenics	−0.262	0.205
Neurotic Depressives	0.665	0.039
Normals	0.357	−0.392

To study the next two aims the total adjustment scores on CTP were correlated with Factors II and IV of 16 P.F.

The above scores show negative correlation between competence and extraversion for schizophrenics and a high positive correlation for depressives and low positive correlation for normals. Thus the schizophrenics show proneness towards introversion, being aloof, not desiring to mix with people. This leads to poor social competence and maladjustment. The depressives show low adjustment scores and introversion. Argyle (1969) reports social anxiety as a possible inhibiting factor. The normals in the study show outgoing behaviour and skills of establishing and maintaining interpersonal contacts, which enhances adjustment.

Correlation for the scores of neurotic depressives is lower and negative than either schizophrenic or normal group for Dominance. The schizophrenics are seen to be more dominant, which goes against Argyle's (1969) findings, while the neurotic depressives are submissive. The normals in the study, however, do not lack in the dominance component of social competence.

The social competence of the subjects before and after illness, as evaluated by the significant others on an interview schedule was analyzed using Chi-squares.

Table 3
Mean number of social competence items in the past and present, their Chi-square values, for the 3 groups.

Group	Score Past	Score Present	df	Chi-square	
Schizophrenics	14.8	9.6	1	2.34	NS
Neurotic depressives	16.15	14.05	1	2.97	NS
Normals	22.35	22.35	1	0	

NS = Not Significant at 0.05 level.

The results do not bring out significant differences from the past to the present social competence for the 3 groups. Though the quantitative data in terms of X^2does not bring out the significance, the qualitative analyses shows useful trends. Interview items of social competence (compiled by the authors) show the schizophrenics as being non assertive, unable to make and keep friends, to take decisions, lacking tact, poise and spontaneity in personal experience. The depressives score low in making friendships, assertiveness and initiation. They are easily upset, tense, indecisive with a negative view of self. The normals in the study not only show higher competence, they also show stability from the past to the present.

The role taking ability of the subjects in the sphere of home, education and occupation was compared using percentages.

Argyle (1969) has considered the ability to adapt the one's role expectations as a measure of social competence. The schizophrenics show lower premorbid ability in Home and Occupational areas. There is a decline in these two as well as in educational area from the past to the present. The neurotic depressives also show a decline but have better ability than the schuzophrenics. Thus role taking ability is poorer in clinical groups as against the normals.

Table 4

Role taking ability of the 3 groups, in the past and present, in terms of percentages of items present, for the 3 aroas.

Group	Home		Education		Occupation	
	Past	Present	Past	Present	Past	Present
Schizophrenics	81.25	39.59	71.43	23.81	64.47	39.47
Neurotic depressives	90.19	56.86	60.00	42.86	81.25	70.83
Normals	100.00	95.00	78.57	78.57	96.66	97.77

The findings of this study have been interpreted in the light of the socialskills model of Argyle and Kendon (1967). The clinical groups show poor social competence. They do not take interest in people and lack personal worth. Their perceptual sensitivity is decreased because they tend to view themselves and others negatively. Even if perception is adequate, the next task is decision making. But, as they lack confidence in themselves, they are not self relient and this prevents them from effective decision making. The next step is to perform an act based on the decision taken. But the patients are hampered by their submissive nature, withdrawal and preoccupation with nervous symptoms. Finally, in the process of interaction, one examines one's performance and learns from it. But the clinical groups. because of their withdrawal, may fail to respond to consequences. They tend to evaluate their performance negatively, which leads to further devaluation and results in greater withdrawal.

Conclusion

The present investigation was carried out to assess discrepancies in social competence in clinical and normal groups. From the results, it is observed that normals show greater social adjustment. Their extravertive and dominant approach in social interactions contribute to better social skills. Poor social competence and poor role taking ability in the patients is also perceived by their significant others, both before and after the illness. These deficit have a potential for restoration through social skills training, psychotherapy and family counselling.

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