SOCIAL SKILLS DEFICITS ASSOCIATED WITH DEPRESSION

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ABSTRACT. This article reviews the empirical evidence of impaired social skills associated with depression. Conceptualizations of social skills are examined followed by evidence from self-report, observer-rating, and behavioral assessments of depressed people’s social skills. Evidence of social skills deficits in children with depression and in people with bipolar disorder is also examined. The effectiveness of social skills training as a treatment of depression is evaluated. Three different theoretical relationships between disrupted social skills and depression are described and evaluated, including poor social skills as a cause of depression, depression as a cause of poor social skills, and poor social skills as a vulnerability factor in the development of depression. Currently, there is some evidence to support each of these conceptualizations, as the relationship between poor social skills and depression can take a variety of forms. © 2000 Elsevier Science Ltd.

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DEPRESSION IS A pervasive mental health problem with heterogeneous etiological origins. Cases of depression can be explained by biological (Mendlewicz, 1985; Stokes, 1987), environmental and life stress (Lloyd, 1980a, 1980b), and cognitive (Abramson, Metalsky, & Alloy, 1989) factors, to name but a few of the scientifically documented causal origins of this disorder. Several decades of research on interpersonal aspects of depression (Coyle, 1976a, 1976b; Lewinsohn 1974a, 1975; Segrin & Abramson, 1994) have clearly situated interpersonal problems on this list of associated features that simply must be considered in order to gain a full understanding of the cause and course of depression.

As the result of a temporal artifact in the social sciences, interpersonal approaches to depression were rather slow to develop, gain acceptance, and generate empirical support. Just as scientists were developing interpersonal theories of depression in the
1970s, they were being eclipsed by the cognitive and biological approaches that were beginning to dominate the field at that time. Fueled by the larger cognitive revolution in the social sciences, and the seduction of being able to explain depression in purely biological terms, along with the equally seductive hope of being able to treat it simply with pharmacological agents, cognitive and biological theories of depression rapidly reached in-vogue status.

The ultimate survival and shelf-life of interpersonal theories of depression was undoubtedly sustained by the compelling empirical evidence that continues to amass. This evidence consistently indicates that the psychological problem of depression and the social problem of disturbed interpersonal relationships and communication are inextricably entwined. Without question, one of the dominant, if not the dominant interpersonal theory of depression is Coyne’s (1976a, 1976b) interactional model. Coyne argued that the interpersonal behavior of depressed people eventually elicits rejection from others. This model has been very influential in focusing attention on the interpersonal responses of others to the problem of depression, and thorough reviews of this literature are available elsewhere (Coyne, 1990; Coyne, Burchill, & Stiles, 1990; Coyne, Kahn, & Gotlib, 1987; Marcus & Nardone, 1992; McCann, 1990; Segrin & Dillard, 1992).

At the same time that Coyne’s interactional model of depression was being developed and studied, Lewinsohn was refining his behavioral theory of depression (Lewinsohn, 1974a, 1974b, 1975; Libet & Lewinsohn, 1973; Youngren & Lewinsohn, 1980). A key postulate of Lewinsohn’s behavioral theory is that people with depression often lack social skills. These diminished social skills make it difficult to obtain positive reinforcement from the social world in which the depressed person lives, hence the resultant depression. This article will trace the theoretical development of Lewinsohn’s social skills deficit hypothesis, briefly review conceptualizations of social skills, examine the empirical evidence suggestive of impairments in social skills among people with depression, evaluate the effectiveness of social skills training as a treatment for depression, and finally outline several theoretical relationships between depression and poor social skills.

THE SOCIAL SKILLS DEFICIT HYPOTHESIS

The idea that poor social skills play a role in the development of depression can be traced back to an early article by Lewinsohn and his colleagues in which the authors argued that “social skill, defined as the emission of behaviors which are positively reinforced by others, is seen as an area of deficit especially important in the development of depressive behaviors” (Lewinsohn, Weinstein, & Shaw, 1969, p. 232). The authors go on to state that “since most people in the depressed person’s environment (and eventually even his family) find these behaviors aversive, they will avoid him as much as possible, thus decreasing his rate of positive reinforcement and further accentuating his depression” (Lewinsohn et al., 1969, p. 232).

Lewinsohn went on to develop these ideas into a full-blown behavioral theory of depression (Lewinsohn, 1974a, 1974b, 1975). Here again, social skills deficits were viewed as an important antecedent to depression. Lewinsohn (1975) noted that this behavioral theory differed from previous behavioral theories of depression in the “assumption of a causal relationship between low rate of positive reinforcement and the feeling of dysphoria; in its emphasis on the maintenance of depressive behaviors by
the social environment; and in its emphasis on lack of social skill as one of the antecedents (to) a low positive reinforcement rate” (p. 31). This behavioral theory elevated poor social skills to causal status in depressive disorders in stating that they lead to low rates of positive reinforcement from the social environment, which in turn leads to depression. Early tests of the theory provided consistent evidence indicating that people with depression exhibited problems with socially skilled behavior (Lewinsohn, Mischel, Chaplin, & Barton, 1980; Libet & Lewinsohn, 1973; Younggren & Lewinsohn, 1980).

For some time after the appearance of the behavioral theory, Lewinsohn’s work continued to emphasize poor social skills in the causal path leading to depression (e.g., Lewinsohn & Hoberman, 1982), while noting that most of the evidence to date was correlational and thus in need of longitudinal investigation (Lewinsohn, Teri, & Hoberman, 1983). The behavioral theory underwent modification in the mid-1980s by integrating cognitive and interpersonal variables together in the same theory (Lewinsohn, Hoberman, Teri, & Hautzinger, 1985). Of particular note is the change in the hypothesized relationship between social skills and depression: “many of the social skills deficits shown by depressed individuals are secondary to being depressed” (Lewinsohn et al., 1985, p. 348). At this time, poor social skills were viewed more as a consequence than cause of depression. Finally, Lewinsohn himself began to question the social skills deficit hypothesis. In his review of the relevant evidence to date, he lamented “the methods involved are very labor-intensive, and without attempting a careful review of this literature, the results may be said to have been disappointing. In general, the findings have not gone beyond showing that depressives are less active, smile less, maintain less eye contact, report more discomfort in social interaction, and rate themselves as less socially skillful” (Lewinsohn & Rohde, 1987, p. 252). He added that “the results are not easy to summarize, and part of the problem is that there are ambiguities and often serious disagreements about the definition and operationalization of ‘social skills’ that have not been sufficiently addressed” (Lewinsohn & Rohde, 1987, p. 254).

Indeed, research on the assessment of social skills in distressed populations is extremely labor-intensive, and to this day there are still serious disagreements about how to conceptualize and operationalize social skills. Nevertheless, the large body of evidence that does exist, produced by a variety of methods in a variety of populations, indicates that disrupted social skills are indeed a problem for at least some people with depression.

**CONCEPTUALIZATIONS OF SOCIAL SKILLS**

Before reviewing the empirical evidence on social skills and depression, it would be instructive to briefly examine some of the conceptualizations of social skills that appear in the literature. A prerequisite to discovering whether depressed people exhibit problems with social skills is to first establish, with at least some clarity, what social skills are.

**Issues of Definition**

First and foremost, readers should be aware that the concept of “social skills” is also referenced with a number of related terms that include: interpersonal skill, interpersonal
competence, social competence, and communication competence. Many authors use these terms interchangeably. Some have tried to differentiate social skills, from, for example, social competence. However, such attempted distinctions have never been widely recognized in the literature.

Conceptual definitions of social skills have ranged from “the ability to maximize the rate of positive reinforcement and minimize the strength of punishment from others” (Libet & Lewinsohn, 1973, p. 311) and the “ability to express feelings or to communicate interests and desires to others” (Liberman, King, DeRisi, & McCann, 1975, p. 1), to “the ability to express both positive and negative feelings in the interpersonal context without suffering consequent loss of social reinforcement” (Hersen & Bellack, 1977, p. 512).

One can reasonably distill most of the definitions of social skills (and their associated aliases) to the ability to interact with other people in a way that is both appropriate and effective (Segrin, 1992; Spitzberg & Cupach, 1985, 1989). Appropriateness indicates that the actor’s behavior does not violate social norms, values, or expectations—that is, it is not viewed negatively by others. Effectiveness indicates that the actor’s behavior achieves or accomplishes his or her intended goal(s) in that interaction.

This conceptualization, and the operationalizations and assessments of social skills that stem from it, has an important implication for those who work with people afflicted with depression. It is often assumed that one’s behavior is reflective of his or her ability. Consequently, the ability to perform socially is often inferred from a person’s behavioral performance. However, it is prudent to consider that sometimes people may not behave or perform with all of their ability. Without sufficient motivation, even a person of good ability may not come across as very skilled.

This issue has far more than just semantic implications when dealing with the social skills of people with depression. Depression is a problem that severely reduces motivation, and this reduced motivation often impacts and impairs sociability. Upon observing the socially “unskilled” behavior of a depressed person, it may not be clear whether this is the result of the person’s lack of capacity to behave in a socially appropriate and effective fashion, or whether it is because the person is unmotivated, anxious, guilty, or fearful as a result of their depression. To date, this important issue has not been brought to a comfortable resolution in the social skills literature. Perhaps the most effective approach to addressing this problem involves triangulation: assessing social skills from multiple perspectives that counterbalance each other’s strengths and weaknesses.

Conceptual Models

There are two major conceptual models that are followed, at least implicitly, by most who study social skills (McFall, 1982). The first is the trait model that treats social skills as a fairly stable and enduring personality trait. Riggio’s model, which states that good social skills entail encoding, decoding, and control abilities in emotionality and sociability, is a good example of this approach (Riggio, 1986, 1992; Riggio & Zimmermann, 1991). This model is associated with the use of self-report, personality-type inventories (e.g., Buhrmester, Furman, Wittenberg, & Reis, 1988; Riggio, 1986, 1989). Such approaches have yielded results indicating that people with good trait social skills have high self-esteem and empathy, for example (e.g., Riggio, Throckmorton, & DePaola, 1990; Riggio, Tucker, & Coffaro, 1989).
The second conceptual model is the molecular model that examines situation-specific behaviors in social contexts. For example, Arkowitz, Lichtenstein, McGovern, and Hines (1975) had male subjects interact with a female confederate for 10 minutes. They assessed subjects’ social skills through measuring their eye contact, smiles, head nods, talk duration, and so on. When populations with suspected problems with social skills are assessed in this way, results typically show that they talk, gaze, smile, etc. significantly less than control subjects.

There are many different methods of assessing social skills (e.g., Becker & Heimberg, 1988; Bellack, 1979a, 1979b). Debate over the validity of self-report trait-like assessments versus molecular behavioral indicators represents a false dilemma. Both are useful and valid indices, despite the fact that they do not always corroborate each other. In addition, these are not entirely competing points of view, but rather different levels of analysis. Ultimately, the sum of the molecular behavioral indicators of social skills should be predictive of the more global indicators of social skills, assuming that the “correct” indicators are measured, and that a sufficient number are assessed (see Segrin, 1998 for an empirical analysis of this issue).

To use Curran and Moriotto’s (1980) analogy, social skills are complex and multidimensional, like baseball skills. These include offensive skills that can be represented by indices of hitting and running, and defensive skills indexed by catching and throwing. The list could also include global indicators, such as being recognized as a “good” player by fans and coaches. Similarly, social skills involve many categories and subcategories of communicative phenomena. A wide range of these categories and approaches is represented in the research on social skills and depression.

**EMPIRICAL EVIDENCE OF SOCIAL SKILLS DEFICITS ASSOCIATED WITH DEPRESSION SELF-REPORTS OF SOCIAL SKILLS**

One of the most common and straightforward ways of measuring social skills is through self-report inventories. These have the advantage of assessing feelings and tendencies over a wide range of often unobservable social behaviors and situations. People with depression consistently evaluate their own social skills more negatively than nondepressed people do (e.g., Cole, Lazarick, & Howard, 1987; Lewinsohn et al., 1980; Meyer & Hokanson, 1985; Segrin & Dillard, 1993; Vanger, 1987; Youngren & Lewinsohn, 1980). This pattern appears when both state (e.g., Dow & Craighead, 1987; Edison & Adams, 1992) and trait (e.g., Gotlib, 1982) operationalizations of social skills are employed.

Students of depression are unlikely to be surprised by the finding that depressed people evaluate their social skills negatively. Depressed people evaluate themselves negatively on a number of different variables, not just their social skills. Some studies that have used triangulation in the operationalization of social skills indicated differences between depressed and nondepressed subjects in self-reports of social skills, but not on behavioral indicators (e.g., Dow & Craighead, 1987; Ducharme & Bachelor, 1993; Segrin & Dillard, 1993). Consequently, it has been suggested that depressed people’s negative views of their social skills may be pursuant to a more generalized negative self-evaluation bias (cf. Gotlib, 1983; Grabow & Burkhart, 1986). While self-ratings of social skills are undoubtedly contaminated by this bias, depressed people’s general tendency to evaluate themselves negatively does not fully account for the often-noted self-reported social skills deficits associated with the disorder (Dykman,
Horowitz, Abramson, & Usher, 1991). Dykman et al. (1991) convincingly demonstrated that depressed people's negative evaluations of their social skills are an amalgamation of both negative schematic processing biases, and actual performance deficits. Furthermore, results from observer ratings and behavioral indicators of social skills are also suggestive of deficits associated with depression.

A related issue to emerge in the literature on depressed people’s evaluations of their own social skills concerns their agreement with observers. Although depressed people are often judged by others as having poorer social skills than nondepressed people, the depressed people’s judgements are in closer agreement with observers' judgments (Edison & Adams, 1992; Lewinsohn et al., 1980). In the Lewinsohn et al. (1980) study, nondepressed people actually overestimated their social skills relative to observers who also made judgments of the subjects’ social skills. This pattern is consistent with the depressive realism effect (Alloy & Abramson, 1979, 1988).

Results of a 1990 meta-analysis of the depression-social skills literature indicated effect sizes of $r = .30–.61$ for the differences between depressed and nondepressed people’s ratings of their own social skills (Segrin, 1990). Using confirmatory factor analysis, Cole et al. (1987) demonstrated that most studies have traditionally underestimated the strength of this effect. When correcting for measurement error the effect for the depressed-nondepressed difference in self-reported social skills can be as high as $r = .85$.

**Partner- and Observer-Ratings of Social Skills**

When observers or conversational partners are asked to evaluate depressed people’s social skills they often give them lower ratings relative to nondepressed controls (Dalley, Bolocofsky, & Karlin, 1994; Edison & Adams, 1992; Lewinsohn et al., 1980; McNamara & Hackett, 1986; Segrin, 1992). However, interpretation of these findings must be tempered by some notable instances where observer’s ratings did not discriminate between the two groups (e.g., Ducharme & Bachelor, 1993; Gotlib & Meltzer, 1987; Haley, 1985). When summed across multiple studies, the effect for depressed-nondepressed differences on partner- or observer-ratings of their social skills is $r = .22$ (Segrin, 1990), considerably weaker than that associated with self-reports.

**Behavioral Indicators of Social Skills**

**Paralinguistic behaviors.** Paralinguistic behaviors involve the noncontent portion of human speech, such as rate, volume, pitch, and pause duration. People use and vary these behaviors to give their discourse interest and liveliness. Numerous studies indicate that people with depression do not use paralinguistic behaviors with the same degree of “skill” as nondepressed people. Studies of the temporal aspects of paralanguage indicate that people who are depressed speak more slowly (Pope, Blass, Siegman, & Raher, 1970; Siegman, 1987; Weintraub & Aronson, 1967; Youngren & Lewinsohn, 1980), speak less (Breznitz & Sherman, 1987; Edison & Adams, 1992; Ellgring, Wagner, & Clarke, 1980; Fossi, Faravelli, & Paoli, 1984; Hinchliffe, Lancashire, & Roberts, 1971a; Williams, Barlow, & Agras, 1972), exhibit longer pauses (Ellgring & Scherer, 1996), and take longer to respond to the speech behaviors of others (Breznitz & Sherman, 1987; Mandal, Srivastava, & Singh, 1990; Talavera, Saiz-Ruiz, & Garcia-Toro, 1994) than nondepressed people do. In fact pause duration is so powerfully linked to depression, that some have argued that it can be taken as an indicator of an individual’s degree of depression (Greden & Carroll, 1980; Hardy, Jouvent,
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Widlocher, 1984; Hoffman, Gonze, & Mendlewicz, 1985; Szabadi, Bradshaw, & O’Bes-son, 1976; Teasdale, Fogarty, & Williams, 1980).

Investigations of speech production indicate that people with depression generally speak with less volume (Darby, Simmons, & Berger, 1984; Gotlib, 1982), and more si-
lences (Greden, Albala, Smokler, Gardner, & Carroll, 1981; Natale, 1977a; Nilsonne, 1988; Pope et al., 1970; Rutter & Stephenson, 1972; Vanger, Summerfield, Rosen, & Watson, 1992), and hesitancies than nondepressed persons. When prompted by a
topic, people with depression have more difficulty producing speech than nonde-
pressed controls (Calev, Nigal, & Chazan, 1989).

Vocal fundamental frequency (f₀), subjectively perceived as pitch, is closely tied to
the experience of emotion. There is evidence to suggest that people with depression
speak in a monotonous tone (i.e., diminished f₀ variability) and with a lower pitch
than nondepressed persons (Darby et al., 1984; Kuny & Stassen, 1993; Nilsonne, 1988;
Talavera et al., 1994; see Scherer, 1987 for review). The voices of depressed people are
often perceived by others as sad and/or tense (Tolkmitt, Helfrich, Standke, &
Scherer, 1982). In one investigation there was a greater presence of spirantization in
voice samples of depressed elderly patients versus nondepressed elderly controls
(Flint, Black, Campbell-Taylor, Gailey, & Levinton, 1993). Spirantization is the pres-
ence of voice-related noise during what would normally be total closure of the vocal
tract.

Studies on subjective perceptions of the voices of depressed speakers show that they
are rated as less clear in their communication (Lewinsohn et al., 1980) and more diffi-
cult to hear and understand than nondepressed speakers (Dow & Craighed, 1987).
In one particular investigation, depressed subjects were asked to speak about a happy,
sad, and angry experience they had (Levin, Hall, Knight, & Alpert, 1985). The vocal
qualities of the depressed persons did not differentiate between happy and angry expe-
riences. Levin et al. (1985) concluded that it was only sad affect that depressed people
communicate effectively and appropriately through their voices. Depressed people ap-
pear to be very “skilled” at communicating sadness and despair paralinguistically. How-
ever, they may be less concerned about cultural display rules that often proscribe the
outward display of such emotional states. Alternatively, depressed people may be un-
able to mask their negative affect paralinguistically, since vocal cues such as pitch,
speech rate, and intonation, are difficult to consciously control.

Speech content. Studies of speech content and depression have generally focused on
topics and themes that emerge in the discourse of people with depression. In one
such investigation, Hautzinger, Linden, and Hoffman (1982) had distressed married
couples talk to each other in the lab about eight different topics. In half of the couples
there was a partner suffering from a clinically significant depressive episode. The cou-
uples with a depressed partner were more likely than the nondepressed couples to ver-
bally express dysphoric feelings, negative well-being, talk more about well-being, ask
questions about well-being, and in the case of the depressed partner, engage in nega-
tive self-evaluation. Depressed spouses have also reported being more verbally aggres-
sive and less constructive in problem-solving, a view corroborated by their spouses,
when engaged in marital interaction (Kahn, Coyne, & Margolin, 1985, see also Segrin

When depressed students were asked to get acquainted with another student for 15
minutes, they emitted fewer statements that reflected a positive appraisal of their part-
ner, and made more directly negative statements than their nondepressed peers (Got-
lib & Robinson, 1982). Similar findings of negative verbal content among depressed speakers were obtained in studies of stranger interactions (Coyne, 1976b), unstructured interviews (Hinchliffe, Lancashire, & Roberts, 1971b), 10-minute monologues (Weintraub & Aronson, 1967), telephone conversations with confidantes (Belsher & Costello, 1991), and psychotherapy sessions (Weissman & Klerman, 1973). Likewise, Blumberg and Hokanson (1983) demonstrated that depressed individuals communicate self-devaluation, sadness, and general negativity to their interpersonal partners.

It now appears that negative verbal content is especially pronounced in interactions between depressed people and intimate others (Hautzinger et al., 1982; Ruscher & Gotlib, 1988). Segrin and Flora (1998) coded the linguistic behavior of depressed and nondepressed students discussing the “events of the day” for 7 minutes with either a friend or a stranger. An interaction between depression and relationship with partner indicated that the depressed speakers withheld their negativity when talking with strangers, but were more inclined to introduce negative topics into the conversation (e.g., criticize, disagree, negative self-disclosure) when talking with a friend.

On a related point, negative self-disclosures appear more generally to be a problem area for depressive speech behaviors (Gibbons, 1987; Gurtman, 1987; Jacobson & Anderson, 1982). People with depression emit negative statements about the self at a higher rate than their nondepressed counterparts (Jacobson & Anderson, 1982). In addition, depressed subjects in this study were more inclined to emit unsolicited self-disclosures, and were more likely to self-disclose following a partner self-disclosure, than were the nondepressed subjects. This indicates that depressed subjects not only self-disclose more than their nondepressed counterparts, but that their timing of these disclosures is often inappropriate and the content is often negative. This finding is noteworthy in that self-disclosures have been shown to be a key ingredient in the rejection of depressed persons by others (Gurtman, 1987).

Not only do people with depression exhibit more negative verbal content behaviorally, they also appear more inclined to evaluate such topics of conversation as more appropriate than nondepressed people. In an examination of depressed people’s views of topics for self-disclosure, Kuiper and McCabe (1985) gave depressed and nondepressed respondents 30 different items from Jourard and Lasakow’s (1958) scale of self-disclosure. The scale includes items such as work, money, personality, body, and opinions. A panel of judges labeled items as positive if they thought that they would feel comfortable or good discussing it with another person, and that a positive social interaction would follow in the pursuit of the topic. Items labeled negative were those that judges thought would make them unhappy, uncomfortable, and lead to negative social interaction. As might be expected, the depressed subjects rated the negative topics as more appropriate for discussion than the nondepressed subjects. There were no group differences for the positive topics (see also Breznitz, 1992).

**Facial expression.** Human beings use facial expression, both consciously and unconsciously, to send information to others about their emotional state and attitudes. Most available evidence indicates that depressed people are less facially animated than nondepressed people, except when it comes to conveying sadness through the face. This trend is evident in two studies conducted by Schwartz and his colleagues (Schwartz, Fair, Salt, Mandel, & Klerman, 1976a, 1976b), in which participants were connected to electromyographic (EMG) electrodes that measure subtle facial activity in the form of electrical discharge produced by muscle movements. In the first investigation, depressed subjects evidenced an attenuated EMG response while trying to imagine
happy situations and images, and an exaggerated reaction (relative to controls) while trying to imagine sad situations and feelings. In a second and similar investigation, both depressed subjects and nondepressed controls evidenced similar abilities to self-regulate a happy facial state when requested to do so, however, when no instructions were offered, the controls spontaneously assumed a happy expression while the depressed subjects showed no evidence of a happy expression (cf. Oliveau & Willmuth, 1979; Schwartz et al., 1978).

In a related investigation, depressed and nondepressed people had their facial expressions recorded while having their hand and arm immersed in ice water (Ganchrow, Steiner, Kleiner, & Edelstein, 1978). Under this physical pain condition, there were no differences between the two groups. However, at rest the depressed group had a higher incidence of corrugated brow, squinting or closed eyes, turned-down mouth, and were more frequently judged as looking “depressed.” Correlations between depressed mood and corrugator (brow region) EMG activity have also been noted by other investigators (Greden, Genero, Price, Feinberg, & Levine, 1986; Teasdale & Bancroft, 1977), including Jones and Pansa (1979), who found depressed patients less likely to have their brows raised than controls. Other inquiries revealed differences as a function of depression in mouth position (Waxer, 1974), facial expressions of pleasantness and arousal (Youngren & Lewinsohn, 1980), smiles (Ellgring, 1986; Williams et al., 1972), expressions of anger (Brenbaum, 1992), and facial expressions of happiness, sadness, fear, surprise, and interest (less in the depressed group; Fossi et al., 1984).

To determine how well judges could read the nonverbal expressions of depressed people, Prkachin and his associates videotaped clinically depressed women as they viewed a series of interesting pictures, heard loud sounds, or were presented with nothing (Prkachin, Craig, Papageorgis, & Reith, 1977). Judges then had to guess which of the three conditions each stimulus person was in based on the videotaped record. Depressed people proved to be significantly more difficult to accurately judge than their nondepressed peers.

Generally, depressed people exhibit diminished animation of involuntary facial expression of emotion (Gaebel & Wolwer, 1992). As their emotional state improves, increases in smiles and general facial activity become evident (Ellgring, 1986). Although results clearly converge to suggest a deficit in the encoding of facial expressions, depression shows no such association with performance on decoding tasks. When asked to decode emotional facial expressions, depressed individuals perform similarly to the nondepressed (Gaebel & Wolwer, 1992; Rubinow & Post, 1992). This finding is consistent with a larger body of literature indicating few impairments in social perception or decoding associated with depression (e.g., Segrin, 1993a).

**Gaze.** Gaze is an important indicator of interest and attention in conversation and is an important component of social skill (Cherulnik, Neely, Flanagan, & Zachau, 1978). Numerous interaction analysis studies indicate that depressed persons engage in less eye contact with others than nondepressed interactants (Dow & Craighead, 1987; Ellgring et al., 1980; Fossi et al., 1984; Hinchliffe, Lancashire, & Roberts, 1970, 1971b; Jones & Pansa, 1979; Kazdin, Sherick, Esveldt-Dawson, & Rancurello, 1985; Natale, 1977b; Segrin, 1992; Waxer, 1974; Youngren & Lewinsohn, 1980). Rutter and Stephenson (1972) discovered an interaction between depression and presence or absence of speech, such that depressed subjects were less likely than controls to be looking while speaking. As looking while speaking is a behavior associated with confidence
and status (Exline, Ellyson, & Long, 1975), it is likely that depressed people’s negative feelings about themselves precipitate this gaze avoidance.

Most studies that have documented negative associations between depression and eye contact with others have provided subjects with a topic to discuss or instructions for a role play interaction (e.g., Edison & Adams, 1992; Gotlib, 1982; Shean & Heefner, 1995). These subjects almost always had knowledge that they were being observed and/or videotaped. Segrin (1992) demonstrated that the differences in eye contact between depressed and nondepressed people are much more dramatic in unstructured situations with unobtrusive recording and observation, versus the more standard laboratory interactions. Consequently, many past studies may have provided a rather conservative estimate of just how little depressed people make eye contact with others in their daily interactions.

Posture and gesture. People’s postures and their use of gesture can indicate interest, boredom, agreement, disagreement, attitudes, and emotional states (Bull, 1987). Some researchers have noted certain patterns or tendencies in gesture and posture that are associated with the experience of depression (Dittmann, 1987; Ekman & Friesen, 1974; Miller, Ranelli, & Levine, 1977). For example, depressed patients have been observed to engage in significantly less gesturing and head-nodding than controls (Fossi et al., 1984). Similarly, depressed children appear to have a diminished tendency to use illustrators, which are gestures that accompany speech (Kazdin et al., 1985). Ekman and Friesen (1972) found that the tendency to use illustrators increased dramatically in depressed individuals as symptoms lifted (see also Ekman & Friesen, 1974).

Depressed subjects have been noted to engage in more body contact (self-touching, including rubbing and scratching) while at rest, and when presented with a number of different stimuli, than nondepressed subjects (Jones & Pansa, 1979; Ranelli & Miller, 1981). Depressed individuals are also more likely to hold their head in a downward position than nondepressed persons (Waxer, 1974). It appears that the tendency for depressed people to engage in head movements indicative of eagerness (e.g., head nods indicating “yes” and minimal head shakes indicating “no”) is much greater when interacting with strangers that with close friends (Hale, Jansen, Bouhuys, Jenner, & van den Hoofdakker, 1997). This finding is reminiscent of those for depressive language use in which depressed people appear more inclined to withhold their negativity from strangers.

Most of depressed persons’ tendencies in the use of posture and gesture are the same cues that indicate sadness, anxiety, and disinterest. Since this pattern has been absent in some samples (e.g., Gotlib, 1982; Segrin, 1992; Youngren & Lewinsohn, 1980) tentativeness is warranted until these findings are better replicated.

Childhood Depression and Social Skills

Thus far, all of the reviewed evidence linking poor social skills with depression has come from studies of adults with depression. However, there is a substantial body of evidence indicating that poor social skills are also common among depressed children. These are important in indicating that the relationship between depression and poor social skills is fundamental and may occur developmentally before the more complex and subtle adult social behaviors become part of one’s repertoire.

Empirical investigations of social skills deficits and childhood depression closely parallel those of adults in both method and results. For example, when asked to rate their own social skills, depressed children generally produce lower scores than their nonde-
pressed counterparts (e.g., Blechman, McEnroe, Carella, & Audette, 1986; Chan, 1997; Dalley et al., 1994; Hops, Lewinsohn, Andrews, & Roberts, 1990; Spirito, Hart, Overholser, & Halverson, 1990). Problems with social skills among depressed children also appear to be evident to observers, be they teachers (Dalley et al., 1994; Shah & Morgan, 1996) peers (Kennedy, Spence, & Hensley, 1989), or parents (Hamilton, Asarnow, & Tompson, 1997; Wierzbicki & McCabe, 1988) of the depressed child. Even student raters who observed brief parent–child interactions noted problems with social skills among more depressed children (Fauber, Forehand, Long, Burke, & Faust, 1987).

Researchers have also operationalized children’s social skills through behavioral assessments. For example, during two 6-minute periods of free play in the presence of other children, depressed children were observed to be alone more often, initiate fewer interactions, and to emit more negative and aggressive behaviors than nondepressed children (Altmann & Gotlib, 1988). Others have documented significant relationships between childhood depression and longer response latencies, more frowning, and less smiling in interview situations (Kazdin et al., 1985).

In a rare investigation into children’s decoding skills, Nowicki and Carton (1997) had children take an extensive audiovisual test of nonverbal decoding ability. Results indicated a rather robust association between poor decoding skills and depression for boys, but not for girls. Replication of this finding has important implications for understanding the continuity of the depression-social skills relationship between children and adults, as such decoding deficits are rarely seen among depressed adults.

Regardless of the performance on decoding tasks, it is clear that the encoding aspects of social skills deficits that are observed in depressed adults appear in parallel form among depressed children. Even in the less developed and complex social behavioral repertoire of children, disruptions in social skills are already evident among those who are depressed. Poor social skills are not a phenomenon associated only with adult depression.

**Bipolar Depression and Social Skills**

Research on social skills and depression has been focused largely on individuals with major depression, or those in a depressive or dysphoric episode. Far less is known about potential social skills deficits associated with bipolar disorder. In a rare examination of bipolar patients in a manic phase, Eckholdt and Lenzenweger (1990) compared the social competence of patients representing several diagnostic categories. Their results indicated that people with bipolar disorder had better social competence than those with schizophrenia, but worse social competence than a group of nonpsychotic patients with mixed diagnoses.

The heightened activity level and gregariousness that are associated with manic episodes might suggest improvements in the social skills of bipolar patients, at least during such phases. However, as Eckholdt and Lenzenweger’s (1990) study suggests, bipolar patients may still have difficulty with social skills. Just as too little eye contact and too little talking may be indicative of poor social skills, too much talking and too much eye contact can be equally inappropriate and ineffective (Trower, Bryant, & Argyle, 1978). Accordingly, bipolar patients have exhibited longer phonation times than either unipolar patients or nonaffective controls while reading a standard passage (Greden & Carroll, 1980), and in another investigation exhibited more gross body movement over a 24-hour period than nondepressed controls (Wehr, Muscettola, & Goodwin, 1980). Bartels, Mueser, and Miles (1997) recently discovered that bipolar patients reported social skills that were less impaired than those of schizophrenic pa-
tients, but not significantly different from a depressed comparison group. It is possible that the social behavior of people with bipolar disorder oscillates between the kind of diminished behavioral involvement that is commonly associated with depressive episodes, and overly excessive and intense social behavior that can similarly leave a negative impression on others.

**ASSESSMENT OF DEPRESSION RELEVANT SOCIAL SKILLS IN CLINICAL SETTINGS**

Traditionally, assessment and diagnosis of depression has focused on affective, cognitive, and somatic symptoms. However, as evidence continues to amass, some are beginning to suggest that an analysis of interpersonal symptoms and problematic social behaviors are a valuable addition to these traditional focal points (Rehm, 1988). Many of the studies of nonverbal behaviors associated with depression were not focused on social skills per se, but rather the assessment of depressive symptoms.

Certain social behavior problems may be so powerfully linked to depression that they might serve as an effective gauge of the severity of patients’ depression. For example, slowed speech rate, excessively long pauses and silences, diminished vocal pitch, diminished gestures, sad facial expression, and reduced eye contact all exhibit fairly strong associations with depression, and are sensitive to the severity of the depressive state.

Many of these behavior problems are evident to the naked eye or ear. However, when human beings communicate with each other, they send and receive dozens if not hundreds of microscopic behaviors simultaneously. It is for this reason that researchers often employ recording devices, such as audio- and videotapes (and more sophisticated techniques, such as facial EMG and computer-assisted motor telemetry recordings). These recordings allow for a careful analysis of individual behaviors in what would otherwise be an overwhelming stream of social behavior.

At a more macroscopic level, people with depression often tend to exhibit inhibition in initiating new relationships and interactions with others, problems in expressing themselves clearly to others, inappropriately and excessively self-disclosing information, especially if it is negatively toned, to others, and sometimes being overly negative and perhaps even hostile around other people. Some of these social skills deficits are again evident to the naked eye, often after only brief interactions with the depressed person (see, e.g., Coyne, 1976b). On the other hand, other problems, such as excessive self-disclosure to others, may not be as evident in clinical settings, simply because that kind of behavior is often called for in clinical settings. For problems such as these, assessments from informants, such as spouses, peers, parents, and teachers, are often useful. In addition, several excellent self-report instruments, such as the Social Skills Inventory (Riggio, 1986), the Interpersonal Competence Questionnaire (Buhrmester et al., 1988), and the Conversational Skills Rating Scale (Spitzberg & Hurt, 1987) are available to assess general tendencies in social situations as well as respondents’ own perceptions of their strengths and weaknesses in interpersonal contexts (see Spitzberg & Cupach, 1989 for an extensive review of self-report instruments).

**SOCIAL SKILLS TRAINING THERAPY FOR DEPRESSION**

In recognition of the pervasive association between problems with social skills and depression, a number of therapeutic regimes for the treatment of depression emphasize training in social skills. Although a thorough review of this literature is beyond the
scope of this article, and is available elsewhere (e.g., Becker, Heimberg, & Bellack, 1987; Hersen, 1979; Jackson, Moss, & Solinski, 1985; Williams, 1986), it is instructive to at least briefly consider the components and effectiveness of this form of treatment for depression.

As Jackson et al. (1985) note, social skills training is predicated on the assumption that there is a lack on knowledge and skills for appropriate behavior in social settings. Social skills training is actually a generic term that refers to a number of more specific forms of training in things like assertion skills, conversational interaction skills, dating skills, and job-interviewing skills. The approaches to training these skills can include instruction, modeling, rehearsal, role playing, and homework assignments outside of the therapy setting (Becker et al., 1987; Trower, 1995).

In an extensive program of research, Hersen and Bellack and their associates documented effectiveness of social skills training as a treatment for depression (e.g., Hersen, Bellack, & Himmelhoch, 1980; Wells, Hersen, Bellack, & Himmelhoch, 1979). Their treatment regime involved 12 weekly sessions ranging from 60 to 90 minutes. These training sessions focused on skills appropriate for interactions with family, friends, co-workers, and strangers. Participants were given instructions, role-playing tasks, feedback, modeling, and positive reinforcement from the therapist. Careful attention was given to the molecular details of social interactions, with discussions of appropriate verbal responses, proper use of eye contact, gestures, smiles, vocal tone, and so on. Ultimately patients were asked to practice their newly learned skills in the natural environment. Results indicated that participants exhibited clear improvements in their social skills, along with improvements in self-reported depression that were still evident at 3- and 6-month follow-ups (Hersen et al., 1980).

What is particularly attractive about the training regime employed in these investigations is the attention to microscopic components as well as more molar aspects of social skills. As noted earlier, depressed people often have problems with the effective use of many molecular behaviors, such as eye contact, gestures, response latencies, vocal pitch variety, speech rate, and facial animation. For many people, appropriate use of these behaviors is guided by knowledge that is largely tacit. For some people, such knowledge was never acquired, and direct instruction on these basic aspects of social conversational skills is essential in order to proceed with more higher order, goals such as doing well on a job interview or getting a date. Accordingly, some of the more effective treatments give instructions on, model, and reinforce these basic aspects of effective and appropriate social behavior (Becker et al., 1987; Bellack, Hersen, & Himmelhoch, 1996).

Upon establishing social skills training as an effective treatment for depression, researchers set out to evaluate its efficacy relative to other treatments for the disorder. For example, Zeiss, Lewinsohn, and Munoz (1979) compared social skills training to pleasant activities and cognitive psychotherapy. Subjects in the social skills training condition showed improvements in social activity, comfort in social interactions, comfort with assertion, and received higher social skills ratings from observers and peers. Perhaps more importantly, their depression decreased significantly over the course of the study. However, the pleasant activities and cognitive therapies were similarly effective in reducing depressive symptoms.

Other comparisons of social skills training to different forms of therapy have yielded similar results but with some positive side effects of the social skills training. In a pair of studies, social skills training was contrasted with pharmacotherapy and psychotherapy (Bellack, Hersen, & Himmelhoch, 1981, 1983). The depressed participants in these
studies exhibited improvements in their condition regardless of therapy. However, by the end of the study, those who received social skills training had the highest scores on measures of interpersonal skills, and were most similar to nondepressed controls on those skills (Bellack et al., 1983). There was also an unanticipated effect of a low drop-out rate among those who participated in the social skills training. Participants who were given social skills training plus antidepressant medication had almost half the drop-out rate of those on antidepressant medication alone; those on social skills training plus a placebo had almost one quarter the drop-out rate of those in the pharmacotherapy-only condition (Bellack et al., 1981). Results of these and other comparison studies (e.g., Fine, Forth, Gilbert, & Haley, 1991; Miller, Norman, Keitner, Bishop, & Dow, 1989) indicate that social skills training is at least as effective as other commonly employed therapies for treatment of depression.

The demonstrated efficacy of social skills training as a therapy for depression does not prove that poor social skills necessarily play a role in the etiology of depression. However, such findings are at least consistent with that hypothesis. The fact that a more or less randomly selected group of patients with depression can be administered a social skills training program and exhibit significant improvements in their depressive symptoms is testimony to the power of effective social behavior in improving and maintaining a positive psychological state.

**THEORETICAL RELATIONSHIPS BETWEEN SOCIAL SKILLS AND DEPRESSION**

Barnett and Gotlib (1988) published a very thorough analysis of the psychosocial antecedents, concomitants, and consequences of depression. At that time, they concluded that there were no existing studies with the methodological criteria (e.g., longitudinal, path analytic, etc.) for determining the exact nature of the relationship between social skills and depression. Since that time, a number of studies have been published with designs that speak to the temporal ordering of the relationship between social skills deficits and depression.

**Social Skills Deficits as a Cause of Depression**

In its original form, Lewinsohn’s (1974a, 1975) behavioral theory of depression postulated that poor social skills are direct antecedents to the experience of depression. Lewinsohn reasoned that people with poor social skills would not be able to obtain positive reinforcements from their social environment, and would be similarly unable to prevent the occurrence of punishing events from others. Such reasoning was elaborated by Segrin and Abramson (1994), who characterized it as the “social skills-stress hypothesis.” Support for this hypothesis and, hence, Lewinsohn’s rationale for the relationship between poor social skills and depression, is clearly evident from a recent 1-year prospective study indicating that people with poor social skills experience more chronic interpersonal stressors (Herzberg et al., 1998).

Virtually all of the studies reviewed earlier examined covariation between depression and social skills. It is generally clear from these studies that depression is associated with decrements in social skills across a variety of different operationalizations of the social skills construct (Segrin, 1990). Although consistent with Lewinsohn’s (1975) social skills deficit hypothesis, these studies do not establish a clear temporal ordering of poor social skills first, followed by depression, as implied in the behavioral theory.
In the past 10 years, several longitudinal studies have appeared, testing this exact hypothesis. Unfortunately, these tests have yielded mixed results. For example, Wierzbicki and his associates conducted three longitudinal studies with children and college students examining the relationship between social skills and depressive symptoms (Wierzbicki, 1984; Wierzbicki & McCabe, 1988, study 1 and study 2). Both social skills and depressive symptoms were operationalized with self-report inventories. In all cases, social skills at time 1 were found to predict changes in depression over 1- to 2-month intervals, such that lower social skills scores at time 1 predicted a worsening of depressive symptoms. These results are clearly consistent with Lewinsohn’s (1975) social skills deficit hypothesis of depression.

Although the above-mentioned studies suggest that poor social skills are an antecedent to depression, a number of other longitudinal studies produced no such support for this hypothesis. Other longitudinal investigations using diagnostic interviews for the assessment of depression (Hokanson, Rubert, Welker, Hollander, & Hedeen, 1989; Lewinsohn et al., 1994), multiple indicators of social skills (Segrin, 1996), longer interwave time intervals of 4 to 12 months (Hokanson et al., 1989; Lewinsohn et al., 1994; Segrin, 1993b, 1996), very large samples (Lewinsohn, Hoberman, & Rosenbaum, 1988; Lewinsohn et al., 1994), and three waves of assessment (Segrin, 1999) have not been able to establish poor social skills as a predictor of subsequent worsening of depression. Overall, among the 12 or so longitudinal studies that have examined the relationship between poor social skills and depression, the majority are not consistent with the hypothesis that situates social skills deficits as an antecedent to depression.

Cole conducted a series of large sample cross-sectional studies that used path analysis to test the social skills deficit hypothesis. In one investigation (Cole & Milstead, 1989), there was no significant path leading from social skills to depression. In the other (Cole, Martin, Powers, & Truglio, 1996), this path was significant for a group of sixth graders but not third graders.

Taken as a whole, there is not much compelling empirical support for the idea that poor social skills are direct causal antecedents to the experience of depression. On the other hand, there are some studies—more than what would be expected by chance alone—that have produced results consistent with this hypothesis. Synthesis of these findings is further complicated by the radically differing operationalizations of social skills and depression employed by researchers who set out to test the hypothesis.

Social Skills Deficits as a Consequent of Depression

The relatively consistent concomitant covariation between social skills and depression, but inconsistent prospective main effects for social skills in predicting subsequent depression, suggests that relationships other than that proposed by the social skills deficit hypothesis should be explored. One reasonable possibility that has begun to garner some empirical attention is the hypothesis that an episode of depression might be a sufficient cause of poor social skills. This might better account for the covariation between depression and social skills, than the hypothesis that states that poor social skills cause depression, and was actually proposed by Lewinsohn at one point in time (Lewinsohn et al., 1985).

The condition of depression is defined by a collection of symptoms, many of which have immediate implications for the production of skilled social behavior. For example, depression is generally accompanied by a number of psychomotor symptoms that
entail slowed and delayed motor behaviors (Sobin & Sackeim, 1997; Williams et al., 1972). These psychomotor tendencies include slowed speech, long response latencies, diminished eye contact, and increased nervous gesturing (i.e., adaptors or body-focused gestures). These are the exact same behaviors that are considered indicative or poor social skills. The difficulty in concentration, feelings of worthlessness, and social withdrawal that are common to depression could clearly also disrupt social behavior and the desire to interact with other people.

The idea that a state of depression is sufficient to disrupt some of the behaviors that are indicative of social skills is consistent with results from a mood induction study conducted by Natale (1977b). In this study, students read a series of depressed, elated, or neutral statements as part of the Velton mood induction technique. Those in the depressed mood induction condition scored significantly lower in subsequent gaze frequency and duration than those in the neutral statement control group. Similar results were produced in a study of speech behaviors (Natale, 1977a).

To date, several empirical studies have been conducted to examine the hypothesis that depression at one point in time will predict decrements in social skills at a later point in time. In a test of the scar hypothesis (that people are permanently changed by an episode of depression), Rohde, Lewinsohn, and Seeley (1990) demonstrated that self-rated social skills of once-depressed people remain lower than those of never-depressed controls, even 1 to 2 years after the depressive episode had lifted. However, two longitudinal studies conducted by Segrin did not replicate this finding (Segrin, 1993a, 1993b, 1999), although these studies did not include clinical cases of depression. Here again, Cole’s path analytic studies can also be used to assess this hypothesis. Unfortunately, one investigation with university students indicated a significant path from depression to lowered social skills (Cole & Milstead, 1989), while the other study with third and sixth grade students produced a weak and nonsignificant path from time 1 depression to time 2 social skills, controlling for time 1 social skills.

The hypothesis that depression leads to lowered social skills has only been tested in a few studies, and has been met with mixed findings. Again, there is more support for the hypothesis than what one would expect by chance alone. On the other hand, notable exceptions are evident and suggest a need for further consideration of other potential relationships between depression and disrupted social skills.

Social Skills Deficits as a Vulnerability Factor in the Development of Depression

If social skills deficits are not a consistent antecedent to the experience of depression, and if depression does not consistently produce decrements in social skills, are these two phenomena simply concomitants? It has been suggested recently that poor social skills may be a distal contributory cause, or vulnerability factor, in the development of depression (Segrin, 1996; Segrin & Flora, in press; Vanger, 1987). Such a relationship could account for some of the mixed findings from past research.

In the tradition of diathesis-stress models of psychopathology, Segrin proposed that poor social skills might serve as a diathesis in development of depression (Segrin, 1996; Segrin & Flora, in press). It is possible that some people with poor social skills who might live alone in an isolated area, or work by themselves in a laboratory, for example, may be satisfied with the state of their lives, and not experience the kinds of stressors and cognitions that may precipitate depression. It is only those people who have poor social skills and experience events and outcomes that they perceive as stressful who are predicted to develop depressive symptoms. It is, therefore, the combina-
tion of poor social skills and negative life events that are thought to produce depressive distress. The reasoning behind this model is that people with good social skills can marshal the kind and quantity of social support that will be effective for coping with the stressful events. On the other hand, people with poor social skills are expected to (a) experience more stressors, and (b) be less able to secure assistance and social support for dealing with those stressors when they do occur.

In a preliminary examination of this social skills deficit vulnerability model, Segrin (1996) conducted a two-wave panel study to test the social skills by stressful life events interaction in predicting changes in depressive symptoms over the course of 4 months. This study did not yield results that are supportive of the social skills deficit vulnerability model. However, most student participants in this investigation were not undergoing many stressful life events.

In a follow-up study, Segrin and Flora (in press) secured a sample of people undergoing stressful life events: incoming college freshmen who had moved at least 200 miles from their hometown to come to school. These students were assessed at the very end of their senior year in high school, and once again at the end of their first semester of college. Results indicated that the relationship between stressful life events and depression was strongest among those with the poorest social skills. On the other hand, those with high social skills scores exhibited a relationship near 0 between stressful life events and depression. In other words, poor social skills made people vulnerable to the development of depression when faced with stressors, while good social skills produced a prophylactic effect in the face of stressors.

A similar investigation by Cummins (1990) followed a sample of students over a period of 1 month. Although Cummins did not measure social skills directly, he used a measure of social insecurity that has items that are very similar to many self-report social skills measures. Data from this study also suggested that those with lower social skills at time 1 were more vulnerable to depression at time 2 if they experienced stressful events during the course of the study.

While support for the social skills deficit vulnerability model is still tentative and in need of much more evaluation, its tenants provide a logical explanation for the mixed findings in many of the past studies on social skills and depression. Social skills on their own should not always produce strong prospective main effects for predicting depression. Only when combined with stressful life events during the course of the study.

Potential Moderators of the Social Skills-Depression Relationship

In addition to the possibilities raised above, there is reason to suspect that the relationship between poor social skills and depression can be influenced by a number of additional variables that might specify when the relationship will hold. Consideration of these variables may help to explain the sometimes inconsistent results in the literature, as well as predict when problematic social skills will contribute to the experience of depression.

First, several studies of children provide evidence consistent with the model of poor social skills as an antecedent to depression (i.e., Cole et al., 1996; Wierzbicki & McCabe, 1988 study 1 and study 2; but see Lewinsohn et al., 1994), whereas this same hypothesis has not received as much support in studies of adults as noted above. Perhaps social skills deficits play a more substantial role in the development of early onset cases of depression that occur in childhood or adolescence versus those that occur
later in life. Failure to establish rewarding social relationships may be especially devastating for younger people who are just starting to expand their social networks and who have less developed coping strategies at their disposal.

Second, social skills might be more predictive of relapse than first onset cases of the disorder. In the schizophrenia literature, certain communication difficulties are now recognized as more predictive of the course rather than onset of the disorder (Miklowitz, 1994). Similarly, poor social skills might predispose depressed people to relapse, more than predict their initial onset (Zeiss & Lewinsohn, 1988).

Third, poor social skills may play a different role in primary versus secondary cases of depression. In many cases, depression follows from another mental disorder, such as schizophrenia, substance abuse, or anxiety. The mechanisms by which poor social skills contribute to depression might be inoperative (or potentially hyperactive) in cases of depression that are secondary to other problems. This points to the importance of examining other potential mental health problems that the depressed person might be experiencing when attempting to assess the exact role of potential social skills deficits in the disorder.

Summary of the Relationship Between Depression and Social Skills

A considerable degree of equivocality exists in the literature on social skills and depression. However, two conclusions are clearly evident. First, social skills are unquestionably concomitants to depression. When people are in a depressive state, they often exhibit what appear to be poor social skills, relative to nondepressed people. The question of whether impaired social skills are a proximal cause or symptom of depression, or a nonsufficient distal cause (i.e., vulnerability factor) need not be approached in an “either/or” fashion. Some evidence has appeared to support all of these conceptual relationships. This points to the obvious conclusion that the relationship between depression and social skills is multiformed. For some people with chronically poor social skills, depression may ensue, as proposed by Lewinsohn’s (1974a, 1975) behavioral theory. For others, the experience of depression may produce temporary corruption of effective and appropriate social behavior. For still others, problematic social skills may be a vulnerability factor that gets transformed into full-blown distress in the face of significant stressors.

Second, poor social skills are clearly not specific to depression. It is a well-documented fact that people with schizophrenia (Harrow, Westermeyer, Silverstein, Strauss, & Cohler, 1986), anxiety (Pope, Seigman, & Blass, 1970), and alcoholism (Monti, Corriveau, & Zwick, 1981) all exhibit problems with social skills. As Garber and Hollon (1991) aptly noted, a variable may be nonspecific but still causal if it is one of several multiple interacting causes of a disorder. This is consistent with the social skills deficit vulnerability hypothesis. However, the nonspecificity of poor social skills to depression definitely rules out any potential deterministic relationship between having problems with social skills and experiencing depression.

CONCLUSION

An important, but often overlooked interpersonal aspect of depression is the role of poor social skills in the development and course of the disorder. Poor social skills invariably are associated with difficulty when interacting, establishing, and maintaining satisfy-
ing relationships with other people. It is apparent that problematic social skills are concomitants of depression. Such evidence has emerged from studies that have used a wide range of assessment protocols, operationalizations of social skills, and examinations of communication behaviors. There is limited evidence to suggest that in some cases poor social skills may cause depression, and in some cases they may be symptomatic of depression. Tests of both of these possibilities have been met with an abundance of null results however. Perhaps those approaches that consider the interaction between social skills and other exogenous variables, such as negative life events, hold more promise for predicting cases of depression. In any case, a complete understanding of the interpersonal aspects of depression, and depression more generally, is not possible without a careful examination of the social skills of those afflicted with this psychosocial problem.

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