

REVIEW ARTICLE

Social skills training in psychiatry

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Abstract

Communication skills are important to overall well-being, for creating positive interpersonal atmosphere and for solving interpersonal problems. Many patients suffering with various psychiatric disorders suffer from either a state-dependent decrease of social skills or lifelong deficits of such skills. Patients with social skills deficits such as problems with communication with others people, social withdrawal, problems with activities of daily living should be offered to social skills training. Social skills training are set of systematic techniques and strategies useful for teaching interpersonal skills that are based in social learning theory. It is a widely used treatment of a range of psychiatric disorders that include schizophrenia, affective disorders, anxiety disorders, social phobia, attention deficit hyperactivity disorder, dependence, sexual dysfunctions. The key elements of these interventions include behaviorally based instructions, modeling, corrective feedback, and contingent social reinforcement. Clinic-based skills training should be supplemented with practice *in vivo* and training in the patient's day-to-day environment.

INTRODUCTION

Good human relations require a complex set of skills, including understanding, empathy, self-disclosure, reciprocity, respect for another's opinion, making compromises, appropriate modulation of self-disclosure and speak about emotions, the tempered ability to yield on some occasions and to set limits at other times, the natural use of social reinforcers, and the capacity to express anger and resolve conflicts in a constructive manner (Hersen *et al* 1984). Many patients suffering with various psychiatric disorders that include schizophrenia, affective disorders, social phobia, alcohol and drug dependence, attention deficit hyperactivity disorder, sexual dysfunctions and others suffer from either a state-dependent decrease of social skills or lifelong deficits of such skills (Friedman *et al* 2008).

Social skills training are set of systematic techniques and strategies useful for teaching interpersonal skills that are based in social learning theory (Solomon & Cullen 2008). Social skills training is a collection of strategies aimed to improving the quality of patient's interpersonal communication and relationships and may help them to more effectively obtain social support in time of distress (Segrin 2008). A several reviews show that social skills training can be effective in increasing patients' social skills and at reducing their psychiatric symptoms (Corrigan 1991; Taylor 1996; Kopelowicz *et al* 2006). Social skill training is best appropriate for the patients who are experiencing psychosocial problems that is at least partly caused or exacerbated by interpersonal difficulties, such as a trouble initiating new relationships, lack of close friends, strained relationships with coworkers, mari-

tal distress, frequent quarrels, difficulties with reaction to critique, to say no, to express own wishes or feelings etc. Social skills training can be an useful adjunct to other therapeutic approaches when the psychosocial problem has collateral high impact on patients' interpersonal relationships. For example, an individual with alcohol dependence is likely to experience complicated interpersonal relationships, regardless of what "caused" dependence. It is a widely used treatment of a range of psychiatric disorders that include schizophrenia (Heinssen *et al* 2000; Granholm *et al* 2007; Kurtz & Mueser 2008), affective disorders (Bellack *et al* 1983), anxiety disorders (Taylor 1996), attention deficit hyperactivity disorder (Gol & Jarus 2005; Frankel *et al* 1997), dependence (Monti & O'Leary 1999). It involves the ability to communicate with other people in a fashion that is both appropriate and effective.

- a. Appropriateness indicates that the interaction does not violate social and relational norms.
- b. Effectiveness indicates that the communication leads to achieving patient's goals in social situations.

Social skill training is based on a structured learning-orientated approach to the building of skills important to the individual and the demands of patient environment (Cunningham *et al* 2003). Social skills training can take a variety of specific forms that can be tailored to the specific patients' populations and to the concrete needs of the patient. Initially, much of the training focused solely on behavioral skills, but now includes perceptual, cognitive and emotional regulation skills as well (Solomon & Cullen 2008). The setting in which social skills training is used is broad, from mental hospitals and outpatient clinic or community-based services to the actual locations in which the skill that are being taught will be used.

SOCIAL DYSFUNCTION

Socially skilled communications are a complex aggregation of declarative and procedural understanding, knowledge, motivation, ability to select among various behavioral response possibilities, and the ability to express a particular social behavior (Segrin 2008). Social skills include (Prasko 1996):

- a. verbal response skills (e.g., the ability to start a conversation, or to say "no" when needed),
- b. paralinguistic skills (e.g., use of appropriate voice volume and intonation), and
- c. nonverbal skills (e.g., appropriate use of gaze, hand gestures, and facial expressions).

Ineffective social behavior is often the result of social skill deficits or inhibition of social skill due to anxiety of adverse affective state (Prasko *et al* 1995). Social skills deficits can increase the likelihood of experiencing stressful life events as well as "turn of" family members and other sources of social support that may help to buffer people against stress. Some basic components of social competence, such as the perception of facial expressions of affect, are probably genetically determined. Nevertheless the majority of social behaviors can be modified by experience. Many elemental aspects of social skill, such as sharing, turn taking, basic conversation skills are learned in childhood, whereas more complex behavioral repertoires, such dating and job interview skills, are generally acquired in adolescence and young adulthood. Social competence is based on 3 component skills (Drake & Bellack 2005):

1. social perception, or receiving skills;
2. social cognition, or processing skills; and
3. behavioral response or expressive skills.

Social perception is the ability to accurately decode social inputs. This includes accurate detection of nonverbal and preverbal affect cues, such as facial expression and nuances of voice, tempo, gesture, and body posture, as well as verbal content and contextual information (Solomon & Cullen 2008). *Social cognition* involves effective analysis of the social stimulus, cognitive reconstruction, integration of current information with historical information, interpretation, and cognitive planning of an effective response. This domain is also referred as a social problem solving (Prasko 1996). *Behavioral response* or expressive skills include the ability to generate effective verbal content, speak with appropriate paralinguistic characteristics, and use suitable nonverbal behaviors, such as facial expression, gestures, and posture. Optimal social behavior requires the subtle integration of these 3 component processes so as to reach the demands of the concrete social situation. Effective social behavior also involves more macrolevel response skills, including turn taking and providing of social reinforcement. Social dysfunction is hypothesized to be result from 3 circumstances (Drake & Bellack 2005):

1. skill deficit – person does not know how to perform appropriately;
2. skill inhibition – person does not use skills in their repertoire when they are called for;
3. skill blockade – appropriate behavior is undermined by socially inappropriate behavior.

Tab. 1. Purpose of social skills training.

• Improvement of social skills
• Increased self-esteem
• Improved problem solving
• Regulation of emotions
• Increased tolerance to stress & frustration
• Increased self-respect & self-esteem
• Changes in cognitive processes
• Focus at personal rights & personal goals

SOCIAL SKILLS TRAINING

The fundamental principles for teaching social skills were developed in the 1970s, and have not changed substantially from these years. Based on social learning principles, social skill training stresses the importance of behavioral rehearsal and training of skills (Prasko 1996; Drake & Bellack 2005). Complex social skills, such as creating friends and dating, are first broken down into discrete little steps or component elements. For example, initiating conversations requires first smiling, eye contact, gaining the other person's attention via introductory remarks, asking general questions, following up with specific questions, and sharing information with first-person statements. Nonverbal and paralinguistic behaviors are similarly segmented as verbal skills. Patients are first taught to perform the elements and then gradually learn to smoothly combine them through shaping and reinforcement of successive approximations.

The most important approach of social skills training is role playing of simulated situations. The trainer first presents instructions on how to perform particular skill and then models the behaviors to show how it is performed (Prasko *et al* 1995). After identifying an important social situation in which the skill might be used, the patient engages in role play with the trainer. The trainer and the group next provide feedback and positive reinforcement, which are followed by suggestions for how the response can be improved. The cycle of role play followed by feedback and reinforcement is repeated until the patient can perform adequately (Drake & Bellack 2005).

Training is typically carried out in small groups (six to ten patients), in which case patients each practice role playing for three to four trials and provide feedback and reinforcement to each other (Drake & Bellack 2005; Prasko *et al* 2011). Teaching is tailoring to the individual patient according to his/her needs and possibilities – for example, a highly impaired patient of the group might simply practice saying no to a simple request, whereas a less cognitively impaired patient might learn to negotiate and compromise. Once deciding on the targeted behavior to be taught, complex behaviors are broken down into several behavioral elements, and the patient is trained for each element employing various techniques (Solomon & Cullen 2008). Trainers first put elementary instructions to patients about how the behavior is to be performed, then they model appropriate behavior in a simulated dialog, and then they engage patients in role playing of simulated social encounters as a tool for practicing new skills (Prasko *et al* 1995). When the patient can manage basic elements, then gradually the elements are taught to be combined. The leader of the group rewards by social reinforcement each role played response and shapes improved performance.

Social skills programs can be organized into modules, such as conversation, family discussion skills, job

interview skills, assertion skills, medication management skills (how to communicate with health care providers), dating skills etc (Linehan 1993a,b; Reed 1994; Prasko *et al* 1995; Prasko 1996; Scott & Colom 2005). Each session has a concrete focus such as how to initiate conversation with strangers and how to refuse an unreasonable request. Trainers work more like coaches than traditional psychotherapists. Duration of social skills training can range from four to eight sessions for a very circumscribed program, such as safe sex skills or job seeking to 6 months to 2 years for a comprehensive program including conversation skills, assertiveness, making friends, soliciting help, and dealing with problems in group living situations (Lieberman 1987). Training sessions are typically held one to five times per week. In case of difficult patient with cognitive deficits (like schizophrenia) training is structured so as to minimize demand on neurocognitive capacity (Lieberman *et al* 2002). Extensive use is made of audiovisual aides, data projector, with instructions presented in handouts or brochures, patients' workbooks, and on flip charts of white boards, as well as delivered orally. Material is presented in brief units, there is frequent repetitions and summarizations, and patients are required to verbalize instructions and express plans (what the person wants to say) before engaging in role play.

SOCIAL SKILLS TRAINING IN VARIOUS DISORDERS

The social skills training must be tailored to specific problems typical for different patients' population and concretized to each patient's problems and aims.

Adjustment disorders

One of the typical stressors which triggers an adjustment disorder is relationship problems (Katzman & Tomori 2005). One of the most important targets is to teach patient how to effectively communicate in problematic situations which triggered his or her distress. There are mostly relations with significant others (partner, parents, children, siblings) or relation at workplace (Prasko *et al* 1995). The identification of the problematic patterns of maladaptive communication is important first, help to understand how they contribute with distress and create new more assertive and adaptive style.

Social phobia

According to the social skills deficit theory, patients with social anxiety disorder lack important communication skills to interact effectively with others (Cahill & Foa 2005). They often have not acquired many adolescents' social skills (Jacob & Pelham 2005). Often, the interpersonal anxiety and lack of self-confidence that go hand in hand with social skills deficits lessen in response to successful mastery of targeted assignments (Friedman *et al* 2008). Patients with social phobia experience fewer

interpersonal rewards and more punishments, leading them to avoid interpersonal interactions when possible, thereby further limiting their ability to acquire effective social skills. In fact, their social defensive behaviors (e.g. escaping from social situations, making brief statements, using silent voice, avoiding of eye contact, and minimizing self-disclosure) increase the probability of the rejection that they fear (Jacob & Pelham 2005). In the absence of effective social skills the punitive interactions with others only help to strengthen the worries of negative evaluation. Optimal treatment for social phobia would provide explicit training to help patients acquire and use appropriate social skills and thereby reverse the negative cycle (Prasko *et al* 2006).

Over the past 15 years, behavioral, cognitive, and cognitive behavioral procedures (primarily exposure and cognitive reconstruction based treatments) have been found effective in the treatment of social phobia. Cognitive behavioral therapy (CBT) is typically a time limited psychosocial intervention, administered either in individual or group settings, that has demonstrated clear efficacy for the treatment of SAD (Heimberg & Jester 1995; Heimberg 2002). Typical components of CBT include psychoeducation, somatic management techniques such as muscle relaxation, in vivo and imaginal exposure, video feedback, cognitive restructuring, and social skills training (Heimberg & Jester 1995; Gould *et al* 1997; Vyskocilova *et al* 2011). Members in group CBT program have the opportunity to try out and practice basic social skills which they can use later in their natural environment (Prasko *et al* 2006).

Social skill training is designed to help patients suffering with social phobia to become more socially competent when they interact with others (Vyskocilova *et al* 2011). Treatment strategies may include modeling (i.e., the therapist demonstrates a more effective alternative approach), role playing, behavioral rehearsal, corrective feedback, social reinforcement, and specific homework assignments (McCabe & Antony 2008). Wlazlo *et al.* (1990) compared social skills training to exposure therapy conducted either individually or in groups. All three treatments led to significant improvements and there were no differences between treatments.

Sexual dysfunctions

Worries and fear of sexual failure are the part of most sexual dysfunctions and the part of general fear of failure. They have been associated with decreased ability to express feelings, wishes, and to assert itself. The useful strategy can be to train these patients in social skills, such as asking for favor, expressing own wishes, speaking about love and sexual themes, sharing positive and negative feeling, rejection of inappropriate claims of the other etc. Among the communication skills needed in these group of patients are (Prasko & Trojan 2001):

- *The ability to communicate about sexual desires and needs* – this skill allows partners to understand each other's wishes and needs and been

able to communicate without shame, excessive restraint while gently and tactfully.

- *The ability to create favorable conditions for lovemaking* – tuning is an essential part of lovemaking. Many people overlook this skill because they believe that the spirit to lovemaking comes or not comes without any afford because people feel it. The truth is that people's mood have a big influence and we have possibility to create fine mood. Tuning to lovemaking may be important especially for women. It means to break free from worries and other tasks, speak about nice things and think to the pleasantness. This skill requires ability to create a positive mood and atmosphere, making compliments and self disclosures; gentle touching, chatting about how look forward to lovemaking etc. Positive communication is a major component provides tuning for lovemaking.
- *The ability to encourage partner* – sexual dysfunction are frequently in connection with silence or with critique with both increase feeling of inferiority. Encouragement and reinforcement is what both partners needs. The rewards could be done and important before act (e.g. by saying him/her about our wishes, we are looking forward to touches with him/her etc.), during lovemaking (e.g. how we like what partner do), and also after making love (e.g. how nice it was). There could be used the words, gestures, huddled, gifts in the encouragement. Encouragement is "contagious" and the other person typically reciprocally encourage back.
- *The ability to comfortably stay with the partner after lovemaking* – after lovemaking is the time of increased intimacy and sharing. It is time when people have a chance to be very open to each other. After spending a delightful time together it is possibility to express the mutual proximity, gently care about partner, touch him/her, rest together. Time after lovemaking can be just as beautiful as lovemaking itself. Pair can create the atmosphere of two deep lovers, gentle friends, time of common understanding and meeting.

Borderline personality disorder

The hallmarks of borderline personality disorder are pervasive and excessive instability of affects, self-image, and interpersonal relationship, as well as marked impulsivity (Svrakic & Cloninger 2005). Typical features also include dramatic efforts to avoid real or imagined abandonment, intensive and unstable interpersonal relationships with alternating between idealization and devaluation (Linehan 1993a). Physical and sexual abuse, neglect, hostile conflict, abandonment and early parental loss or separations are more common in childhood histories of these patients. There are many

different interpersonal problems in patients with borderline personality disorder like serious dysfunctional interpersonal behaviors (examples: choosing or staying with physically, sexually, and/or emotionally abusive partners; excessive contact with abusive relatives; ending relationships prematurely; making other people feel so uncomfortable that few friends are possible; incapacitating shyness or fear of social disapproval); Employment- or school-related dysfunctional behaviors (examples: quitting jobs or school prematurely; inability to look for or find a job; fear of going to school or getting needed vocational training; difficulties in doing job or school-related work; inappropriate career choices; getting fired or failing in school excessively).

Dialectical behaviour therapy was developed by Marsha Linehan, a clinical psychologist, to address the treatment needs of individuals with a diagnosis of borderline personality disorder and a history of parasuicidal behaviour (Linehan 1993a,b). Linehan's original randomized controlled trial demonstrated efficacy for this form of therapy compared with treatment as usual in reducing the frequency of parasuicidal behaviour, in retaining patients in therapy and in reducing in-patient bed-days (Linehan *et al* 1991). The components of standard out-patient dialectical behaviour therapy are once-weekly individual psychotherapy, coordinated with a weekly skills training group and telephone consultations between sessions with the primary therapist with the aim of preventing emergencies by providing skills coaching and/or relationship repair with the therapist (Verhaeul *et al* 2003). The fourth component is a weekly consultation session for the therapy team members to ensure adherence to the model and to keep them motivated in the face of the difficulties that arise in the treatment of individuals with borderline personality disorder (Blennerhassett & O'Raghallaigh 2005). It is not clear at present how the individual elements of the therapy contribute to treatment outcome. The addition of a dialectical behaviour therapy skills training group to non-dialectical individual therapy has not been shown to be of benefit (Linehan 1993a). An ability to regulate affect expression in some social situations may seem completely absent in other situations. In many instances, borderline individuals exhibit very good interpersonal skills and are often good at assisting others in dealing with their own problems in living; yet they cannot apply these same skills to their own lives. Inadequate interpersonal skills both result in interpersonal stress and preclude solving many of life's problems. An equally inadequate social support network (the invalidating environment) may contribute to the inability to control negative environmental events; it also further weakens the person's chances to develop needed capabilities.

The skills are broken down into four types (Linehan 1993b): (1) those that increase interpersonal effectiveness in conflict situations, and thus show promise in decreasing environmental stimuli associated with nega-

tive emotions; (2) strategies culled from the behavioral treatment literature on affective disorders (depression, anxiety, fear, anger) and posttraumatic stress, which increase self-regulation of unwanted emotions in the face of actual or perceived negative emotional stimuli; (3) skills for tolerating emotional distress until changes are forthcoming; and (4) skills adapted from Eastern (Zen) meditation techniques, such as mindfulness practice, which increase the ability to experience emotions and avoid emotional inhibition.

Teaching mindfulness and distress tolerance skills is balanced by teaching skills in emotional control and interpersonal effectiveness in conflict situations. Social effectiveness, however, requires two complementary behavioral-expressive skills: (1) skills in producing automatic responses to situations encountered habitually; and (2) skills in producing novel responses or a combination of responses when the situation calls for them.

The interpersonal response patterns taught in DBT are very similar to those taught in assertiveness and interpersonal problem-solving classes. They include effective strategies for asking for what one needs, saying no, and coping with interpersonal conflicts. „Effectiveness“ here means obtaining the changes one wants, keeping the relationship, and keeping one's self-respect. Any well-developed interpersonal training program could be substituted for the DBT package (Linehan 1993b). The problems arise in the application of these skills to the situations that the patients encounter. They may be able to describe effective behavioral sequences when discussing another person encountering a problematic situation, but may be completely incapable of generating or carrying out a similar behavioral sequence when analyzing their own situation. Usually, the problem is that both belief patterns and uncontrollable affective responses are inhibiting the application of social skills.

Behavioral mistake that borderline individuals often make is premature termination of relationships. This probably results from difficulties in all of the target areas. Problems in affect tolerance make it difficult to tolerate the fears, anxieties, or frustrations that are typical in conflict situations. Problems in affect regulation lead to inability to decrease chronic anger or frustration; inadequate self-regulation and interpersonal problem-solving skills make it difficult to turn potential relationship conflicts into positive encounters. Borderline individuals frequently vacillate between avoidance of conflict and intense confrontation. The therapists should assist the patients in learning to apply specific interpersonal problem-solving, social, and assertiveness skills to modify aversive environments and develop effective relationships (Linehan 1993a). There are a number of ways in which the therapist can model skilled behavior. In-session role playing can be used to demonstrate appropriate interpersonal behavior. When events between the patient and therapist arise that are similar to situations the patient encoun-

ters in her natural environment, the therapist can model handling such situations in effective ways. The therapist can also use self-talk (speaking aloud) to model coping self-statements, self-instructions, or restructuring of problematic expectations and beliefs. If interpersonal effectiveness is the focus, the problem can be framed as related to interpersonal actions (Linehan 1993b). Generally, events become „problems“ because they are associated with aversive emotional responses; one solution might be for the patient to change her emotional response to the situation. An effective response might be cast in terms of mindfulness skills. The ability to apply any of the behavioral skills to any problematic situation is at once important and very difficult. Therapists must themselves know the behavioral skills inside and out, and be able to think about them quickly during a crises.

Affective disorders

Research has shown that adolescent's avoidant coping styles are at risk for developing a depressive disorder (Calvete *et al* 2010; Herman-Stabl *et al* 1995). Patients with depression often experience a lack of social reinforcement because a lack of social skills and social skills training has been found to be efficacious for depression (Bellack *et al* 1983). Thereby assertivity is part of therapeutic packages in preventing and treatment programs for depression (Bellack *et al* 1981; Elkin *et al* 1989; Last *et al* 1985; Reed 1994; Tak *et al* 2012; Sherril & Kovacs 2002). At the first study in this area Bellack *et al.* (1984) compared four treatments for unipolar depression: amitriptyline, social skills training plus amitriptyline, social skills training plus placebo, and psychotherapy plus placebo. The four treatments were not significantly different from one another. Each treatment produced significant changes in symptomatology and social functioning. The social skills plus placebo treatment has less drop outs than groups with amitriptyline. The main aim in social skills training in depression is the improvement of assertivity skills:

- improving positive assertivity (compliments, empathy, confirmation, asking for kindness);
- saying “no”;
- reaction to the critique;
- conflict resolution.

The social skills training could be also powerful strategy in the treatment of bipolar disorders (Lam *et al* 2009; Scott & Colom 2005; Scott *et al* 2007; Soares-Weiser *et al* 2007; Zaretsky *et al* 2007). Main aim is decreasing of emotional expressivity in the family.

Schizophrenia

Once an acute psychotic episode has subsided, psychosocial therapy and living and vocational skills training may be recommended. Drug maintenance treatment is usually prescribed to prevent further episodes. Literature searches identified randomized controlled trials of four types of psychological interventions: family

intervention, CBT, social skills training and cognitive remediation (Pilling *et al* 2002a). Social skills training is package of psychological techniques with considerable face validity for the treatment of negative symptoms of schizophrenia and their consequences. Consistent with its foundation in the social learning literature, many of the early empirical investigations in the field were small case studies using multiple baseline designs, (Bellack *et al* 1984) but now many controlled trials incorporating the gold standards (Foa & Meadows 1997) of experimental design (Glynn *et al* 2002; Marder *et al* 1996, Mueser & Penn 2004) (eg, randomization, blind assessors, manualized interventions, fidelity ratings, intent-to-treat analyses, etc) have been published. According the first meta-analysis (Pilling *et al* 2002b) there was no clear evidence for any benefits of social skills training on relapse rate, global adjustment, social functioning, quality of life or treatment compliance. But the later meta-analysis of 22 studies including 1,521 patients (Kurtz & Mueser 2008) authors showed mean effect size for content-mastery exams ($d=1.20$), a moderate mean effect size for performance-based measures of social and daily living skills ($d=0.52$), moderate mean effect sizes for community functioning ($d=0.52$) and negative symptoms ($d=0.40$), and small mean effect sizes for other symptoms ($d=0.15$) and relapse ($d=0.23$). These results support the efficacy of social skills training for improving psychosocial functioning in schizophrenia. The last meta-analysis of 19 studies consisting of 692 clients were aggregated from relevant databases (Kurtz & Richardson 2012). Outcome measures were organized according to whether they were social cognitive tests proximal to the intervention or whether they represented measures of treatment generalization (symptoms, observer-rated community, and institutional function). For measures of generalization, weighted effect-size analysis revealed that there were moderate-large effect on total symptoms ($d=0.68$) and observer-rated community and institutional function ($d=0.78$). Effects of social cognitive training programs on positive and negative symptoms of schizophrenia were no significant.

The content of the earliest applications of social skills training programs tended to be formulation and driven by the clinicians' agendas, but more recent implementations highlight the importance of teaching unique social skills that can be used in the service of meeting the specific goals of the participant. Thus, if one person wants to find a romantic partner, many of the social skills taught will concern dating skills, while if another person wants to get or keep a job the social skill curriculum will be focused on the skills necessary for that enterprise.

An integral part of psychoeducation of schizophrenic patients and their families are behavioral techniques aimed to help with stress management, elimination of communication traps in the family leading to over-emotionalism and also training in early

detection of signs of impending deterioration in mental state (McFarlane *et al* 1995; Kissling 1994; Anderson *et al* 1980; McFarlane 2002). This usually includes some social skills training for the patients and information about the disease and the management of expressed emotions for the relatives. As a result of the early age of onset, its relapsing nature, and persistence of many clinical features, schizophrenia can potentially disrupt the smooth acquisition and evolution of skills essential for developing mature interpersonal relationships, occupational competence, and independent living (Prasko *et al* 2011). Social skills training is based on a structured learning-orientated approach to the acquisition of skills relevant to the individual and the demands of his/her environment.

Social dysfunction is a defining characteristic of schizophrenia that is semi-independent of other domains of the illness (Lenzenweger *et al* 1991; Heinsen *et al* 2000). As a consequence of the early age of onset, relapsing nature, and persistence of many symptoms, schizophrenia can potentially disrupt fluent acquisition and development of skills essential for mature interpersonal relationships, occupational competence, and independent living (Cunningham Owens & Johnstone 2003). Social skill deficits are widespread, although not ever-present in patients with schizophrenia and tend to be relative stable over time. In large number of patients, deficits in social competence persist despite antipsychotic treatment. Patients with the schizophrenia have difficulty fulfilling social roles, such as worker, partner, spouse, and friend. They have difficulty recognize their needs when social interaction is required (Prasko *et al* 2011). Social dysfunction is semi-independent of symptomatology and plays an important role in the course and outcome of the illness (Granholm *et al* 2007). Cognitive dysfunction is a relatively universal feature of schizophrenia and is associated with deficits in social cognition, including social perception and social problem solving (Kopelowicz *et al* 2006). Particularly relevant are difficulties with the integration of contextual information, or the ability to see the importance of previous experience to current events and use experience to guide future behavior (Drake & Bellack 2005). Social skills deficits are resistant to treatment with antipsychotics, including new-generation of medication.

The main reason that people with schizophrenia do not learn key social skill is that children who later develop schizophrenia in adulthood have been found to have subtle attention deficits in childhood that may interfere with the development of social relationships and the acquisition of basic social skills (Drake & Bellack 2005). Also 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, the ability to form and maintain adult relationships, and work-related skills. In addition many patients gradually develop isolated lives

punctuated by periods in psychiatric hospitals or community residences. These events remove patients from their "normal" peer group, provide few opportunities to engage in age appropriate social roles, and limit social contacts to psychiatric staff and other severely ill patients. Under such conditions patients suffering with psychoses do not have the opportunity to acquire and practice appropriate adult roles. In addition, skills mastered earlier in life may be lost due to disuse or lack of reinforcement by the environment during periods of chronic disorder (Prasko *et al* 2011).

Because social and interpersonal skills are generally deficient in schizophrenic patients, social skills training aims to help the patient develop more appropriate behaviour. Research has shown that social skills training can significantly enhance social functioning, but probably has little effect on risk of relapse. Models involving family therapy have received greater prominence. They are especially important since they have a direct impact on relapse rate. Learning to minimize criticism and emotional overinvolvement will help to decrease the patient's level of stress, reducing the risk of relapse. Multiple-family groups may work even better than single-family interventions.

Social skills training for schizophrenia patients cover basic conversational skills, community living skills, assertiveness skills, interpersonal problem solving, conflict management skills, friendship and dating skills, work and vocational skills, illness self-management, substance abuse management and medication management skills. Each module is composed of skill areas. The skill areas are taught in exercises with demonstration videos, role-playing and problem solving exercises and in-vivo homework assignment (Gray *et al* 2004). Each of these skills has several components. For example, assertiveness skills include making requests, refusing requests, making complaints, responding to complaints, expressing unpleasant feeling, asking for information, making apologies, letting someone know that they are afraid, and refusing alcohol and street drugs (Cunningham Owens & Johnstone 2003; Jacob & Pelham 2005). Each component involves several specific and concrete steps. For example, conflict management includes skills in negotiating, compromising, tactful disagreeing, responding to untrue accusations, and leaving overly stressful situations (Prasko 1996). A situation in which conflict management skills be used is when the patient and a friend decide to go to a movie and their choice of movie differs. Besides reducing anxiety social skills training also improve level of social activity and foster new social contacts.

The improvement of social skills is connected with decrease in the patient's life stress and also with decrease in psychotic symptoms and increase in life quality. Basic social skills trained are (Lieberman 1987; Prasko *et al* 2011):

- correct perception and understanding of information

- communication of positive information (compliments, awards)
- the initiation, continuation and closing short interview
- expression of negative emotions appropriately
- self-assertion (defending their own rights, reject unauthorized requests)
- ability to find a compromise

Negotiating and compromising, for example, involves the following steps (Jacob and Pelham 2005): (a) explain one's viewpoint briefly; (b) listen to the other person's viewpoint; (c) repeat of the other person's viewpoint; (d) suggest a compromise.

Teaching a circumscribed skill usually takes 4–8 sessions, while a more comprehensive skill may take anywhere from 6 months to 2 years. Training sessions frequently occur 2–3 times per week (Bellack 2004). After social skills are learned, they can also be lost during some time (Jacob & Pelham 2005). This is particularly true for patients with schizophrenia. The average mean time for losing learned social skills is two years. New retraining of social skills is need. This process of losing social skills during the time is connecting with the negative symptoms of the disorder. The negative symptoms of schizophrenia essentially involve social skills deficit. The negative symptoms in schizophrenia constitute behavioral deficits that go beyond difficulties with assertiveness. These patients have inadequate expressive behaviors and inappropriate stimulus control of their social behavior.

Unfortunately, social skill training is difficult to evaluate. While some studies have focused on rehearsal of activities of daily living, other concentrate on communication and conversational skills, and although some view improvement in symptoms as the underlying goal, for others the benefit lies with cognitive ability

(Cunningham Owens & Johnstone 2003). Blindness of assessments is a major problem. While individual studies have found improvements in assertiveness, general social competence, and even speed of discharge, with benefits extending to a widened social network and that generalize, Cochrane review failed to find conclusive evidence of benefit (Robertson *et al* 1998). Bellack (2004) reviewed 12 meta-analytic and narrative reviews of social skills training and concluded that social skills training does not reduce or prevent relapse; but does improve targeted behavioral skills; seems to have a positive impact on social role functioning, although results are inconsistent in this regard; and improves patient's sense of self-efficacy with targeted social situations after training. The approach is most effective when it is embedded in a broad, comprehensive rehabilitation program (Kopelowicz *et al* 2006). Social and community functioning improve when the trained skills are relevant for the patient's daily life, and the environment perceives and reinforces the changed behavior. Long-term training has to be provided for positive effects (Bellack 2004). Overall, social skills training have been shown to be effective in the acquisition and maintenance of skills and their transfer to community life (Lieberman *et al* 2002). Combining psychoeducation and skills training is effective in improving communication among family members and, consequently, reducing environmental stresses (Solomon & Cullen 2008; Prasko *et al* 2011).

STYLES OF COMMUNICATION

After explaining basic styles in communication (passive, aggressive, passive-aggressive, manipulative and assertive) there is important the therapist discuss with the patient when he/she uses each communication style, and what the consequences were. If the patient is unable

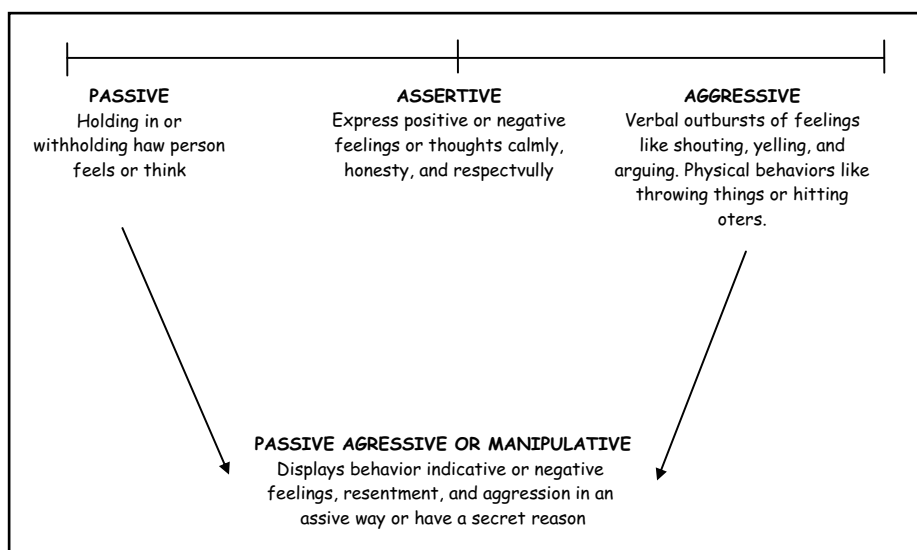


Fig. 1. The communication continuum (adapted according Mohr 2010).

to generate times when he/she used a type of communication, therapist might also have him/her identify his/his experience when other people have used these types of communication. After discussing different styles in more detail, therapist asks the patient to try to think of which style he/she uses most often. Some patients may be precisely informed in the styles they use under difficult circumstances. But most of patients may use different communication styles under different circumstances. They use other style of communication at work, other with partner, other with parents, other with friends etc.

Passive communication puts the respect for the rights and needs of others above person's own. People with this style tend to keep their thoughts and opinions to themselves. They are likely to say nothing when somebody bothers them. They may also have difficulty identifying and saying what they need or want. *Aggressive communication* puts person's rights above those of the listener. It means that person tends to focus on "getting his/her way" or "having hem/her say" rather than respecting the concerns of the other person or helping them understand his/her concerns. *Passive-aggressive communication* is sometime used when person is angry and wants to be aggressive, but also wants to avoid direct conflict. This means person do something that will cause irritation in the other person, but in a way that leaves a plausible excuse. Common examples are being late and making people wait, not following through on things he/she promises to do etc. This type of communication can be particularly destructive because it aggravates the other person, while also shutting down avenues toward resolution. Neither person's needs nor the needs of the other party are respected when communicating in a passive-aggressive manner. *Manipulative communication* is indirect, follow up secret and mainly egoistic target (Prasko 1995). The manipulative person is aggressive indirectly a wants to control others secretly. *Assertive communication* is a more balanced and adaptive way of communicating. It balances respect for both person and the listener. It considers needs for both sides. Assertive communication allows person to express his/her needs or wants, but acknowledges that the other person's needs or wants may be different.

Many patients will express concern that their behavior is too passive or too aggressive. Therapist have to explain that communication styles exist on a continuum from passive to aggressive with assertive communication falling in the middle. Both passive-aggressive communication and manipulative communication are a combination of passive and aggressive styles, and do not fall on the continuum.

HOW TO TRAIN SOCIAL SKILLS

First step is to evaluate the types of communication problems the patient believes has to. This step can include very general questions about what types of com-

munications are not easy, difficult or that the patient avoids. After general description it is useful to have a concrete picture, how it looks like. If he has problem to say other people "no", and if yes, under which circumstances? Has he the problem to initiate conversation with other person/persons? For therapist is important to collect description of recent situations including:

- a. the type of situation;
- b. patient's thoughts or images before any discussion and afterward;
- c. typical behavior including safety and avoidant behavior and thoughts facilitate these behaviors and accompany;
- d. the consequences of the behavior.

Sometimes patients can further aggravate communication problems, sometime dissimulate them (e.g. patients with social phobia because of shame), and in many cases patients don't know, they have communication problems but when they describe, what happen in relations, the communication problems are visible.

Methods used in social skills training include modeling, role playing, chaining, corrective feedback, and feedback reinforcement. Skills are typically taught in groups with two trainers, one directs session and the other role plays (Solomon & Cullen 2008). But session can also be conducted on an individual basis or with family members of other social network members, as these individuals can help to encourage and reinforce the use of the skill (Kopelowicz *et al* 2006).

COMPONENTS OF SOCIAL SKILLS TRAINING

There are several components of social skills training, which are typically firstly trained separately. Typical first step is learning of active listening and expressing the understanding. Therapist informs the patient that active listening and expressing are the main components of an effective communication. If one person in a conversation or discussion is not listening or speaking clearly the communication breaks down. Active listening contains:

- a. focusing on understanding what the other person is saying;
- b. making sure that the patient accurately understands what the other person has said;
- c. letting the other person know that patient have understood what he/she has said.

In summarizing, therapist tells the patients that when listening actively, people make sure that they accurately understand the other person while letting the person know what we understand (Mohr 2010). There are a variety of different techniques the people can use to let the other person know that they have heard and understood what he/she has said. One way is to paraphrase and repeat back what the other person has said to ensure that we understand it correctly and

Tab. 2. Assertivity skills.

TYPE OF SKILLS	EXAMPLES OF TYPICAL SKILLS
Empathic skills	listening, body signals and other non-verbal uhhmm, reassuring, paraphrasing, summarizing
Conversation	choosing theme, starting, giving information, questioning, using partners information, self-opening, reinforcing the partner
Positive assertion	compliments, shearing, asking for kindness, self-opening
Negative assertion	persistence, critique, solving the problems and conflict resolution, self-protective skills

let the other person know that we have understood. Therapist explains that active listening is a skill that can be applied to many different situations. It can:

- be an important component of letting others know that patient cares about them;
- be used in situations in which there is a high potential for conflict;
- defuse potentially difficult interactions by allowing patient to step back before reacting.

Therapist emphasizes that if we really listen to what other person has to say, we are more likely to respond with compassion and empathy, even when disagreeing or saying no.

One variant of social skills training include assertiveness training or communication skills training. Assertiveness training was first used in behavior therapy to counter condition social anxiety. Assertiveness is defined as follows: Assertive behavior enables a person to act in his or her own best interest, to stand up for herself or himself without undue anxiety, to express honest feelings comfortably, and to exercise personal rights without denying the rights of others (Jacob & Pelham 2005). The target of standing up for oneself overlaps with that for aggressive behaviors, but aggressive behaviors deprive others, of their rights, whereas assertive behaviors reflect a spirit of cooperation in which the rights of both parties are respected. .

Two typical types of interpersonal situations frequently call for assertive behaviors, setting limits of pushy friends or relatives and commercial situations, such as countering a sales pitch or being persistent when returning defective merchandise. Increasing attention is given to context, that is, what would be assertive behavior in this situation depends on circumstances.

The communication skills of summarizing, reflecting, validating, and using I statements and eye contact are important in the context of positive assertivity.

Responsiveness, self-disclosure, warm engagement, and genuineness are the four basic reciprocal communication strategies. Reciprocity is important in any good interpersonal relationship. It is particularly important within an intimate relationship,

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