Social Skills Training for Schizophrenic Patients

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Abstract

Recently, several mental hospitals have implemented social skills training for schizophrenic patients. It has been shown that the level of social functioning in mentally ill patients is directly related to social competence (Beidel, 1981). Improved social competence could help these patients develop and interact more in society. Summaries from several schizophrenic patients participating in social skills training at Richmond State Hospital are included. These summaries are personal and should not be used as evidence or generalizations of schizophrenics or social skills training.

Social Skills Training for Schizophrenic Patients

Schizophrenia is a term used to describe a complex, and extremely puzzling condition, the most chronic and disabling of the major mental illnesses. This disorder is complex and may actually be several disorders acting together. It is estimated that three million Americans will develop schizophrenia is their lives, and that about 100,00 schizophrenics are in the public mental hospitals on any given day. Currently, 20 million suffer from this disorder in the world (Bellack, 1989).

Various symptoms of schizophrenia which can act alone or in combination include: hyperactivity, delusions, anxiety, hallucinations, cognitive disorganization, suspiciousness, apathy, depression, social withdrawal, and intellectual impairment (Bertram, 1992). These symptoms cause many schizophrenics to be stereotyped by society as dangerous, "crazy", or "totally out of it". These labels are dangerous to recovery because the recovering schizophrenic needs to be treated normally by others to resume a normal lifestyle.

No direct cause has been found for schizophrenia, although many correlations have been discussed. It has been shown that there is a deficiency of the dopamine neurotransmitter. Several concordance rates have also been established. The genetic contribution of immediate family is ten percent, whereas concordance of non-relatives is one percent. Twin studies have shown that monozygotic twins have a 20 to 40 percent genetic component, whereas dizygotic twins only have a 7 to 12 percent

influence (Curran, 1984). Schizophrenia may have a genetic factor which possibly could be inherited. Once found, society would face the ethical decisions of altering or aborting the fetus, but first the government must support this research that can lead to a cause or cure for schizophrenia.

Although this disorder may not be as prevalent as some diseases, such as cancer, its effects can be devastating to many. Since the cause of schizophrenia is unclear, much research is needed before those affected can be cured. In spite of this, there have been a few success stories which give us hope.

" Social skills training is a structured approach, aimed at teaching the skills necessary for the effective interactions in interpersonal situations " (Berdel, 1981, p.3). It has been proven to be effective in increasing the social competence of chronic mental patients, specifically schizophrenic patients (Liberman, 1985, p.396). Therefore, social skills training could help these patients recover and become integrated back into society. As an individual becomes more socially skilled, that person may become less anxious, less depressed, feel less inadequate and more confident in social situations. By acquiring social competence, the patient should be capable of influencing his or her own environment and attaining personal goals which are major factors in successful community adjustments.

Social skills training includes both verbal and non-verbal communication. Although each is singularly important, it is the combination of these elements that creates the overall impression

of social skill. At times the elements may contradict each other. For example, a patient may insist he is feeling relaxed while his fixed stare and rigid posture indicates he is curious. The therapist must be familiar with various components included in social skills and evaluate the patient's performance in each area. Although social skill is situation-specific, there are certain elements that should be included for successful interactions.

The therapist should not ignore interpersonal style or judge the performance based on what the therapist would say in such a situation. Rather, the therapist's evaluation is based on the inclusion of the basic social skill elements and the patient's ability to secure positive reinforcement from the environment with such a response. The inclusion of elements of interpersonal style are acceptable as long as they add to rather than detract from the overall performance.

According to Beidel (1981), there are four categories or components of social skill. The first category expressive features, " refers to the manner in which a response is expressed " (p. 4). This includes speech content, paralinguistic elements, such as voice volume, pace, pitch, and tone, non-verbal behavior such as proxemics, kinesics, eye contact and facial expression, and interactive balance or response timing.

The second category is receptive features which are also known as social perception skills. The basic components include attention, decoding, and knowledge of context factors and

cultural mores. Special repertoires, the third category, refers " complex sets of skills which are tied to specific contexts " (p. 5). These include assertiveness, social interactions, job interview skill, etc.

Associated factors represents those factors which, although not primary components of social skill, still affect an individual's performance in a social situation. This fourth component includes cognitive factors such as goals, expectancies, and values, and affects such as anxiety, depression, and anger.

" Structure, support, and focusing on the here and now" are three principles that social skills training follows (Plante, 1989, p.7). These are the most critical components for effective psychotherapy. Overall, social skills training is a useful program to help schizophrenic patients cope. With improved skills in dealing with others, these patients are more likely to maintain satisfying relationships as well as enhance their chances of obtaining and maintaining employment. " Recent studies have shown that social skills training are viewed as more undergone, social skills training are viewed as more socially adept by individuals in the community " (Liberman, 1985, p. 402).

During the summer of 1992, I worked at Richmond State Hospital with schizophrenic patients. I conducted two separate social skills training sessions in which I primarily worked with the lower functioning patients. The sessions met two times a week for six weeks. I have enclosed summaries of several patient's progress throughout the sessions. The criteria for

inclusion in social skills training included the following:

1. Must be referred and have a specified behavior to be addressed through S.S.T.
2. Be able to respond appropriately when asked for name, date of birth and current date.
3. Be able to use and understand simple sentences.
4. Listen to others for 3 to 5 minutes without interruption.
5. Follow simple 3-step instructions.
6. Interact in small group setting without talking to self, pacing, provoking others, yelling, or exhibiting other acting-out behavior.
7. Accept goal of improving one's interacting with others and the expression of personal feelings such as anger, fear, happiness or sadness.

During the first meeting, students are asked to state their name, their date of birth, and to tell something about themselves. If they cannot follow these steps, they are usually excluded from the group.

Most of my patients were able to progress readily through the training scenes with significant decrease in "errors" as they practiced. We used data collection sheets following the format presented by Liberman. The group started with a passing greeting in which we, the "instructors", gave the patients pass or fail marks for eye contact, giving a friendly greeting and for using appropriate gestures. Next, the patients introduced themselves and shook hands with each other. Some other topics included giving and receiving compliments, apologizing, initiating conversations, maintaining conversations, making requests, turning down requests, responding to social invitations, responding to the feelings of others, and handling problematic social situations. Enclosed is a copy of the evaluation form we used for this training (See Appendix A).

It took the entire six weeks to finish all topics. In my opinion, the patients needed more time to develop these skills. We discussed each topic, but could have developed the skills more. In the first social skills session I conducted, there were seven patients. Within the first week, Mrs. Crowley, the coordinator, promoted one of the patients to the advanced class. It was interesting to watch the patients develop. By the end of the summer, Jay*, from the lower class, would stop me while I was walking across grounds and have a perfectly "normal" conversation. It made me feel good to realize that I helped him gain this ability to communicate with others.

Not all of the patients were as successful as Jay. Susan*, another patient, did very well in class, but could not extend her knowledge outside of the session. When I visited her on her ward, she could day "hi", but she did not maintain a conversation.

Overall, I learned many things from my internship at Richmond State Hospital. It was an invaluable experience in which I gained insight about the mental health system and schizophrenic patients.

Although a schizophrenic may not meet all of the criteria to be considered a "normal person" I believe that a schizophrenic is still a person and should be treated as such. Every patient I

* The names of patients have been changed to insure confidentiality.

worked with this summer was unique, but beyond all reasonable doubt, had potential. By this, I mean, all were capable of expressing emotions, all were aware of their existence, and several had strong possibilities of getting better. I definitely feel that social skills can help in this recovery and should be implemented in all state hospitals.

Several patients have controlled this disorder and returned to normal lives. For example, Dr. Fred Frese, a psychologist and head of a state mental institution, was a schizophrenic patient for several years in another mental hospital. If no one had helped him and supported him, he now would not be working to help others. Even though social skills training is only a small step, it is a beginning. Once patients are able to communicate better, we as a society may be better able to help them. Someday research could help schizophrenics integrate back into society to function and live normally.

JAY

Although I did not have much time to work with Jay on a one-to-one basis, I did watch his social skills improve. Jay is an older black man that seems to have a hearing problem. He continuously says, "huh?" when asked any questions. He participated in the lower functioning social skills group. Even though he refused to participate many times, I could see a difference in his skill. He always paid attention to what was going on in the class whether he participated or not.

Jay was 45 minutes late for the first session that I attended. At first he refused to participate in the exercises, but finally I persuaded him to try. We were working on apologies, as described in the data collection sheet, and he said that he did not have anything to apologize for. During this exercise, the patient is told to face the other person and keep eye contact. We explained to the students that they should also say, " I'm sorry " and specify what he or she is apologizing for. Furthermore, the person should offer to make up in some way. After I started focusing my attention on him, he gave in and participated in the exercises. He completed all of the exercises with success, always remembering to give an explanation for the fault. Once he tried the exercise, we realized that he understood everything, but did not want to participate.

Jay did not show up for the next social skills session, and refused to talk at the one after that. He would not say anything. He did pay attention when we were explaining the exercises, though. Jay did a complete turn around for the following session. He walked in the room in good spirits and openly participated in conversation with us. He was very talkative and continuously made jokes. We were working on extending social invitations, Jay was able to keep eye contact, and supply all of the specifics such as time, place and cost. He completed every exercise correctly and even told other patients how to do it the right way. During the final session, he refused to talk again.

I passed Jay on grounds a few weeks after the training ended. He stopped me and talked for about 20 minutes. He asked me where I went to school and then told me that he had once lived in Muncie. His records indicate that he did actually live in Muncie for several years. We also talked about the social skills training. I asked him to participate in the second group, but he told me that he did not want to because it was too easy. Finally, I had to return to the Psychology building. He used all of the proper skill demonstrated in class. He greeted me, maintained the conversation, and ended the conversation appropriately. I was very impressed with his social skill. I believe that he was put in the lower functioning class because of his hearing problem, and did not find it challenging, so he refused to participate.

SUSAN

Susan is an older woman in her 60's that retorts to physical complaints or accusations of unfair treatment. She has a low tolerance for frustration and becomes easily upset and verbally aggressive. She also self-abuses and returns to child-like states when faced with difficult situations. I went to Susan's ward to observe her before she joined the second group of social skills training. I had never seen her before, but when I walked in, she looked at me and said, "You're here for me." Next she walked over to the other patients and ignored me the rest of the time I stayed there.

On the first day of training, Susan came in late and was very disruptive. She wanted attention. We were telling our names, birthdates, and something about ourselves, and she wanted to talk the entire time. When it was her turn, she kept talking about how she liked the new ward that she was moved to and how she was going to make fudge that night. She was extremely impatient when others tried to talk and I had to continuously ask her to be quiet.

I started the second session by asking everyone to introduce himself or herself. While they introduced themselves, we instructed them to maintain eye contact, offer a hand, and state their name. Susan said her name and what ward she was from, but then rambled on about various topics. She also had a difficult time remembering other patient's names and she would not look at the person that she was talking to. While I was explaining the agenda for the session, Susan interrupted me several times and said that she was sorry for hurting so many people and that she wanted to be friends. When I asked her what she would say if she passed a friend on grounds, she replied that she would just walk by and not say anything. She told me that if she passed a stranger, she would say, "Hi stranger, I want to be your friend." After I explained the proper way to introduce yourself to someone, Susan completed the exercise with ease. She kept good eye contact, used proper tone of voice, shook hands, and said her name. By the end of the hour, she was completing all of the exercises successfully, but continued to talk about other things,

such as getting an apartment.

Susan did an excellent job at paying attention at the next session. She did not interrupt and usually only talked when it was her turn. She told me that she was tired, so that could possibly be part of the reason she was so calm. She was able to properly introduce herself again, as well as complete the new exercises which included giving compliments. During this exercise, the student is asked to have appropriate eye contact, say thank you, and explain why they are giving the compliment.

When Susan arrived for the next session, she told us that everyone was mad at her from her ward. She claimed that she did not know why, but that no one would talk to her. She said that she said "hi" to a ward attendant and he did not acknowledge her. Susan said the attendant was talking to a patient's mother at the time. I tried to explain that just because someone does not talk does not necessarily mean that person is mad. She could not understand this concept. Susan seems to think like a five year old child. She constantly needs attention and whines if she does not get it. During this class, we reviewed greetings, introductions, and compliments. Susan participated in all of the exercises, but when finished she would start whining about how everyone was mad at her. This lasted for the entire hour, even though we tried to get her to stop.

At the following session, Susan could not properly extend a social invitation. This exercise includes maintaining eye contact, giving details about the invitation, answering relevant

questions, and providing specific information such as the date, place, and cost. She could not remember important facts such as when, what time, where, and how to get there. By the end of class, she had improved considerably. Susan brought a letter that she had written to a ward attendant. It was an apology for last week. She wrote that she wanted to be his friend. The handwriting looked like a little kid's writing. Some letters were big, others were tiny, and she did not leave space between words.

Susan was much happier at the next class. She kept asking for popcorn throughout the session. She knew exactly what a compliment, and apology and an invitation was. An apology should include an explanation for the apology, as well as an offer to make up for the wrong-doing. She did well on the exercises, but rambled about unrelated topics. For example, when she was inviting another patient to go shopping, she started talking about how she would leave her children with a babysitter. She also kept talking about her husband, eventhough records indicate that she has never been married. She also continuously told us that she was happy to be in the class and how we all were her friends.

Susan talked more than usual during the next session. She told us that her father used to pick her up in a polka dot and striped station wagon. When we asked her to be quiet, she would not say anything for about three minutes, then would start again right where she left off. Susan did not show up the following

session.

At the last session, Susan was very cooperative. She did not talk about unrelated topics as usual. However, she did state, "I'm glad to be here...Mary is my friend, and George, Sherrie Rabe, and LeAnne Cole..." She did not interrupt anyone and she completed all of the review exercises correctly. At the end, she told us that a ward attendant was her husband. Apparently, this particular ward attendant is nice to her, so she has developed an attachment. She has a tendency to attach herself unconditionally to anyone that is nice to her. She acts like a young child that needs security.

I visited Susan several times after the sessions ended, but she did not use the skills from class. She continued to be disruptive and very difficult to talk to on the ward. It seems like she has the potential, but cannot understand how to apply the skills to daily life.

KEVIN*

Kevin is a middle-aged man, that has difficulty focusing attention. He speaks to voices and has many grandiose ideas. He was recommended for this class so he could improve his interactions and control his mumbling.

On the first day, Kevin could not follow the directions to

* The names of patients have been changed to insure confidentiality.

say his name, what ward he resided on, and something about himself. He just sat in his chair and did not respond the entire afternoon. During the next social skills session, Kevin mumbled to himself the entire time. He kept repeating that he was the devil. When I asked Kevin to complete an exercise, he just looked at me and laughed. When Susan, another patient, introduced herself to him, he only mumbled and we could not understand him. I asked him to speak up and he laughed at me. Kevin did not participate in any other exercises, he just sat in his chair and mumbled about being the devil. Charlie Springer, a behavioral clinician, told me that we may have to exclude Kevin from the group because he is too psychotic and he will be frustrating to work with.

Kevin still mumbled about the devil and other things at the next session. He did not volunteer to participate in giving compliments and when asked to, he mumbled some words that we could not understand. It seems like he has created and is speaking his own language. Kevin has a twin brother that also stays at Richmond State Hospital. He uses his twin brother's name many times in conversation. Once during the hour, we were able to get Kevin to tell us his name and introduce himself.

Kevin was a few minutes late for the following class. He did participate in the exercises with George, another patient. He was able to complete the exercises, but had trouble with a non-greeting. He continued to mumble throughout the session. Again, he talked about the devil. When we were able to hold his

attention and instruct him what to do, he could complete the exercises. Once while we were going over a compliment, he said my name three times to get my attention. He then asked me some question that we could not understand. At the end, when we asked him to tell us everyone's name, he could not remember any. He called me Kathy. I looked at him and asked him what he said. He proceeded to tell me that my name was Sherrie. When I said, "Good, that is right," he just laughed.

At the beginning of the next session, only Kevin showed up. We talked to him for about ten minutes. He was much more receptive on a one-to-one basis. After we asked him to speak up, we could understand some of what he was saying. He makes jokes a lot. When we asked him to tell us everyone's name, he replied, "Pete and Repeat." It was nice to have a semi-normal conversation with him. After the other patients showed up, he returned to mumbling to himself and did not participate in extending social invitations.

Kevin did not show up for the next session and refused to participate in the session following that. He would repeat what we said, but could not do the exercise on his own. He was late to the next session, but his awareness improved. He only mentioned the devil once during the entire hour. He also talked so that we could understand him. He properly introduced himself to another patient. Once, we asked him to speak up and five minutes later he told us to speak up! When we went over apologies, Kevin refused to participate. He said that it was a

pretend situation and he does not pretend. At the end of the hour, he accidently hit my arm. He looked at me, touched my arm, and said that he was sorry. This shows that he does know how to act, but he becomes psychotic and is unable to complete the exercises.

During the final session, Kevin did not participate in the review exercises, but he was extremely interested in my geology book that I brought. He pointed to a picture and asked me what kind of rock it was. After I told him, he stared at it for awhile. He also asked me why certain sentences were highlighted. I told him that those were the important points, and he asked, "What does it say?" I read the sentence and he shook his head. Throughout the session, he and I looked at the book and he pointed to pictures that he liked. Before he left, he put his arm around my shoulder and smiled. Eventhough Kevin did not progress well in class, it was interesting to have him there.

All three of these patients described have unique qualities and attributes that would make them an asset to society. Although they did not all achieve significant improvements, there is hope for each individual. New research could provide a combination of new medications or treatments that could enable them to function better in society. If we can provide an opportunity for these patients, as well as others, to enhance their social skills, eventually they could incorporate these into their daily lives while recovering.

References

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Appendix A

WELCOME TO SOCIAL SKILLS TRAINING

This course will help you improve the way you deal with people -- to carry on conversations, understand what others want of you, and let people know what you want. This will make you more comfortable with other people at the Hospital and in the community. You can get what you want more often, and avoid being talked into doing things that you don't want to do.

What Will We Learn?

We'll work on many of the simple things that help good communication: how to choose the right words; how loud or soft your voice is; how to look at others when you are talking with them; how to manage your posture and gestures; how to start conversations and keep them going.
Also, we'll work on ways to manage difficult situations, ask more clearly for what you want, deal with criticism, and avoid being taken advantage of.

What Do We Do in Class?

Everything that we do in class is aimed at working out ways of solving problems with other people. We will spend most of our time practicing how to deal with actual social situations. Staff will coach you to help you deal with the practice sessions, and will give you praise and encouragement for your improvements.
To help you cross the gap between the classroom and the "real world," you'll have the chance to use some of your new skills outside the classroom when we visit a mall or a restaurant.

If you have any questions about Social Skills Training, be sure to ask us. We hope that you will enjoy the class, and that it improves your life.

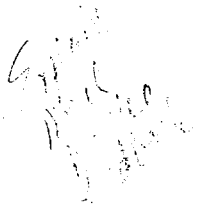
Topics Covered

Greetings
Introductions
Giving and Receiving Compliments
Apologizing
Starting a Conversation
Maintaining a Conversation
Making Requests
Turning Down Requests
Extending Social Invitations
Responding to Social Invitations
Responding to Feelings of Others
Handling a Problematic Social Situation
Ignoring a Troublesome Person
Asking for Help to Resolve a Difficult Situation

SUMMARY DATA COLLECTION SHEET

Name: _____

Greetings						
Introducing Self						
Giving (Receiving) Compliments						
Apologizing						
Starting Conversation						
Maintaining Conversation						
Making Requests						
Turning Down Requests						
Extending Social Invitations						
Responding to Social Invitations						
Responding to Feelings of Others						
Handling Problematic Social Situation						
Ignoring a Troublesome Person						
Asking for Help to Resolve Situation						



SOCIAL SKILLS DATA COLLECTION SHEET

Name: _____

Passing Greeting						
Looks at other person, eye contact						
Gives short, friendly greeting						
Appropriate gesture (wave,etc) or none						
Non-Greeting						
Walks by other person without eye contact, greeting or gesture						
Introducing Self						
Looks at other person, eye contact						
Offers hand without touching						
Short greeting, gives name						
Giving, Receiving Compliments						
Faces other person, keeps eye contact						
Says "Thanks" or comliments other						
Describes what is being rewarded						
Apologizing						
Faces other person, keeps eye contact						
Says "I'm sorry," specifies for what						
Gives explanation for fault						
Offers to make up						
Initiating Conversation						
Faces other person, makes eye contact						
Introduces topic (statement or question)						
Appropriate voice volume and tone						
Maintaining Conversation						
Faces other person, makes eye contact						
Refers to other person's comments						
Introduces a topic						
Exchange of 3+ statements/questions						
Appropriate voice volume and tone						
Making Requests						
Faces other person, keeps eye contact						
Asks other person to do something, gives general details						
Answers relevant questions of other by repeating or expanding instuctions						
If request accepted, expresses thanks						
If request declined, says "Okay," states intention to find someone else						

SOCIAL SKILLS DATA COLLECTION SHEET

Name: _____

Turning Down Requests						
Faces other person, keeps eye contact						
Says "No," gives reason calmly						
If other person repeats request, repeats refusal once						
Avoids arguing, avoids aggressive gestures						
Extending Social Invitations						
Faces other person, keeps eye contact						
Extends invitation, gives some details						
Answers relevant questions						
If accepted, provides specifics (time, place, cost)						
If declined, expresses polite regret						
Responding to Social Invitations						
Faces other person, keeps eye contact						
Asks for clarification of details						
Expresses appreciation for invitation						
Accepts or declines politely						
Responding to the Feelings of Others						
Faces other person, keeps eye contact						
Makes statement/ expresses own feeling/ asks question referring to other's feelings						
Suggests way of dealing with problem						
Handling Problematic Social Situations						
Faces other person, keeps eye contact						
States or clarifies problem by asking other person involved in problem what they think in calm, steady voice						
Expresses opinion in calm, steady voice						
Responds to other's comments calmly (avoids restating already expressed opinion)						
Suggests ways of dealing with problem calmly, after letting other respond to previous statements						
Avoids aggressive gestures						

SOCIAL SKILLS DATA COLLECTION SHEET

Name: _____

Ignoring a Troublesome Person						
Faces other person, keeps eye contact						
Express opinion in calm, steady voice (relevant to annoying behavior)						
Asks other person to stop annoying behavior in calm, steady voice						
Stops verbal, physical contact with other person if they continue annoying behavior						

Asking for Help to Resolve Problematic Social Situation						
Faces other person, keeps eye contact						
Asks relevant person to help discuss or solve problematic situation						
If other person agrees to help, states problematic person or situation						
If other person declines to help, says "Okay," states intention to find someone else to help with problem						