Efficacy of Social Skills Training in Schizophrenia: A Nursing Review

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Abstract

Background: Social skills training, a psychological approach, is used to ameliorate the deficits in social skills among patients with a severe mental illness. For the efficacy of social skills training in schizophrenia, the literature in other core psychiatric disciplines (i.e. psychology, psychiatry, etc) indicates some conflicting evidences and a limited quality of evidence in psychiatric nursing. With the exemption of a few individual nursing studies, no systematic review is available to date in psychiatric nursing literature. This systematic review of literature was undertaken to explore the efficacy of social skills training in schizophrenia.

Methods: Relevant studies on the topic were searched both in the electronic databases and manual sources. Twenty nine experimental studies among adult patients with a diagnosis of schizophrenia were included. The author critically reviewed them for their methodological quality and narratives of main findings.

Results: Several studies had indicated that social skills training interventions significantly increase the participants’ knowledge of text and performance about taught skills, improve their social adjustment and decrease their negative symptoms that are associated with social dysfunctions. The existing nursing studies had shown the efficacy of basic conversational and assertiveness skills training in terms of improvement into participants’ conversational, interactional and assertiveness abilities and reduction of their social anxiety, negative symptoms and increasing of their self-esteem.

Conclusions: Social skill training is a practicable therapeutic nursing intervention and should be implemented in routine care.

Keywords: nursing; psychiatric nursing; review; schizophrenia; social skills; social skills training.

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Introduction

Schizophrenia, a severe and disabling brain disorder, is affecting 1% of the general population. Social dysfunction is a hallmark of schizophrenia and a major constituent of burden on the individual and their family. Social dysfunction is characterised by deficits in general social functioning and several social skills. Social skills are the specific abilities that enable an individual to perform a task competently in social situations.

People with schizophrenia have marked deficits in social skills because either they have never learnt them or they have lost them in the course of a severe mental illness (SMI). The deficits in core social skills (i.e. conversational, interpersonal relationship and assertiveness) present in various forms, such as: lack of spontaneity or clarity in conversation and inappropriate style of social interaction and relationship with others. Individuals with a marked deficit in social skills find it difficult to establish and maintain social relationships and fulfill ascribed social roles. They may also find it difficult to meet their needs, to adjust and live a stable social life in the community.

Social Skills Training

During the 1960s and early 1970s, social skill training (SST) emerged as an educational and clinical modality for improving social behaviour or performance of people with a mental disability. SST, a psychological approach, utilises a number of behavioural principles and techniques, such as: problem or skill specification, direct instructions, modeling, role-plays, behavioural rehearsal, coaching, feedback, verbal reinforcements and home assignment. In SST, complex social behaviours are broken down into smaller sets of discrete behavioural elements so they can be easily learnt in a systematic and progressive way through structured training sessions. Basic to any teaching programme, SST involves planning and implementation of step-by-step training curriculum in didactic sessions.

In mental health, SST is used as a primary or supplementary intervention under the umbrella of psychosocial rehabilitation to ameliorate deficits in social skills in patients with SMI. It is a well established treatment and rehabilitation strategy for patients with schizophrenia, especially in the United States of America.

R.P. Liberman and colleagues at the University of California, Los Angeles (UCLA) systematically tailored SST into social and independent living skills (SILS) modules on a number of rehabilitation topics namely medication management, early detection and self-management of symptoms, coping with life stresses, grooming and hygiene, interpersonal problem solving and conversation. Since SILS modules were first introduced, they have been translated into twenty three languages and implemented in more than thirty countries. Any mental health professional that has graduate level qualifications and experience in treating and caring for psychiatric patients is able to implement these modules.

Like other mental health care professionals, psychiatric nurses are in an excellent position to assess social skills deficit and to implement appropriate intervention because they are having a greater degree of contact with their patients and primary knowledge and concern of the patient’s disability. A recent policy document emphasizes the role of the registered psychiatric nurse to implement a range of evidence-based psychosocial interventions to assist service users to recognise their strengths and to develop strategies to facilitate service users to avail of community supports and resources. For the compliance of such local policy, nurses should implement SST with service users as an evidence-based intervention.

For the efficacy of SST in schizophrenia, the literature in other core psychiatric disciplines (i.e. psychology, psychiatry, etc) indicates some conflicting evidences and a limited quality of evidence in psychiatric nursing. With the exemption of a few individual nursing studies, no systematic review is available to date in psychiatric nursing literature. This systematic review of literature was undertaken to answer, whether the SST an effective intervention for adult patients with schizophrenia.

Methods

In order to reduce potential bias in the selection of relevant intervention studies regarding efficacy of SST in schizophrenia, a number of pre-defined inclusion and exclusion criteria were set. The set inclusion criteria were as follows: a primary study that was conducted with a randomised controlled trial or controlled trial or
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quasi-experimental design among middle-age adult/older patients with a diagnosis of schizophrenia or schizophrenia spectrum disorder i.e. schizoaffective disorder, schizophreniform and delusional disorder (by any means of diagnosis) and was published in the period covering January 1991 to October 2013 in the English language (full-text). Whereas, the set exclusion criteria were as follows: a primary study that was carried out with a descriptive or case study design, a secondary study (i.e. narrative review, systematic review or meta-analysis), a study that had participants other than middle-age adult/older patients, a study in which participants had a diagnosis other than a schizophrenia or schizophrenia spectrum disorder and a study that was reported out of the period from January 1991 to October 2013 and in a non-English language.

To gain an understanding regarding the efficacy of SST for patients with schizophrenia, the author performed a systematic search of literature mainly from electronic databases (i.e. PubMed, Ovid, Medline, CINAHL Plus and ProQuest). While conducting electronic database searches, different key words or phrases were entered into search engines either singly or in combination. Examples of these key words or phrases are as follows: social skills training [title] AND schizophrenia [text word], effects of social skills training [title/abstract] AND schizophrenia [title], social skills training [title/abstract] OR cognitive-behavioural social skills training [title/abstract] AND schizophrenia [text word], social skills training [title] AND nursing [text word] etc. Mapping of search was done based on the inclusion and exclusion criteria. Additionally, the general search engines on the internet such as ‘Google’ and ‘Google Scholar’ were used. Some relevant studies were also searched manually in the Journals and further studies gleaned within reference lists.

From the comprehensive search results, the author screened the specific and relevant material on the topic. In total, thirty four studies including eight nursing studies were considered as relevant for the efficacy of SST in adult patients with schizophrenia or schizophrenia spectrum disorder. While considering the inclusion and exclusion criteria of this review, a study of other core psychiatric disciplines and 3 nursing studies were excluded as they didn’t meet the inclusion criteria. Therefore, 29 published studies including five nursing studies were included in this review.

All included studies were critically appraised and reviewed for their methodological aspects and their findings. Qualitative-narratives of main findings were extracted in matrix tables.

Results

The search results indicate that a majority of published studies on the efficacy of SST in the literature are of other core psychiatric disciplines. The majority of these included studies were either randomised controlled trials or controlled trials (See Table 1). Although some of the trials were small scale involving relatively small sample sizes.

SST interventions were varying especially in the included studies of other core psychiatric disciplines. They were implemented either in a traditional format or cognitive format. The traditional type of SST interventions were namely: conversational skills training, assertive skills training, effective social interactions or interpersonal relationship training, independent living skills training and skills training of finding a new job. Several recent studies on SST in other core psychiatric disciplines had incorporated some cognitive techniques such as cognitive remediation, cognitive behavioural therapy, neurocognitive training, and attention training.

On the other hand, search results have indicated relatively limited studies in psychiatric nursing discipline (See Table 2). Most of these included nursing studies were small scale and quasi-experimental in nature. However, the overall design of a study is appearing good as it had utilised multi-stage measurements, randomisation and compared group.

In the majority of included nursing studies, the conversational and assertiveness skills training were frequently implemented common nursing interventions in basic format. However, a study had used an additional problem-solving format. In most nursing studies, the SST curriculum was implemented in didactic group sessions at hospital in-patient settings with a small group of 5–8 participants. The duration of session was ranged from 60 to 70 min with a frequency of 2 or 3 sessions per week for a period covering 4–8 weeks.
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Table 1. Included studies of other core psychiatric disciplines (i.e. psychiatry, psychology, etc) regarding efficacy of SST in adult patients with a schizophrenia or schizophrenia spectrum disorder.

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Participants(n)</th>
<th>Treatment</th>
<th>Duration</th>
<th>Comparison</th>
<th>Outcome variable(s) indices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Controlled study[13]</td>
<td>1991</td>
<td>103</td>
<td>SST approach plus supportive therapy</td>
<td>52 Weeks</td>
<td>Supportive therapy</td>
<td>No relapse, effects were generally favored at 2 years.</td>
</tr>
<tr>
<td>Randomised control trial[13]</td>
<td>1992</td>
<td>41</td>
<td>A modularized training in self-management skills</td>
<td></td>
<td>Supportive group psychotherapy</td>
<td>A significant gain was observed in each of the areas taught. The skills learned during training were retained without significant erosion over a 1-year follow-up period.</td>
</tr>
<tr>
<td>Controlled trial[20]</td>
<td>1992</td>
<td>108</td>
<td>SST modules</td>
<td>13 Weeks</td>
<td>Social milieu</td>
<td>Social skills were significantly improved and maintained during a 1-year follow-up.</td>
</tr>
<tr>
<td>Randomised control trial[12]</td>
<td>1995</td>
<td>Exp. = 15; Cont.=13</td>
<td>Basic SST</td>
<td>9 Weeks</td>
<td>Social milieu</td>
<td>Social skills were significantly improved and maintained during a 1-year follow-up.</td>
</tr>
<tr>
<td>Randomisation control /compare trial[22]</td>
<td>1995</td>
<td>63</td>
<td>SST</td>
<td>18 Weeks</td>
<td>Discussion group</td>
<td>Greater increase in targeted social skills, but no change on measures of community functioning, quality of life and positive symptoms.</td>
</tr>
<tr>
<td>Randomised control trial[23]</td>
<td>1996</td>
<td>80</td>
<td>SST modules</td>
<td>24–78 Weeks</td>
<td>Supportive group therapy</td>
<td>A significant improvement was seen in social skills and certain measures of social adjustment.</td>
</tr>
<tr>
<td>Randomised control trial[24]</td>
<td>1998</td>
<td>Exp. = 28; Cont.=31</td>
<td>Community Re-entry Programme Total eight days</td>
<td>4 Four times in a week</td>
<td>Occupational therapy</td>
<td>A significant improvement in patients’ knowledge and performance of the skills taught in the sessions, and increase attendance at aftercare appointments.</td>
</tr>
<tr>
<td>Randomised control trial[26]</td>
<td>2001</td>
<td>Exp. = 56; Cont.=41</td>
<td>Basic SST</td>
<td></td>
<td>Finding and keeping a job</td>
<td>A significant improvement was seen on the ability of participants to obtain and maintain a job.</td>
</tr>
<tr>
<td>Controlled trial[27]</td>
<td>2002</td>
<td>32</td>
<td>Community Re-entry Module, eighteen 1 hour session</td>
<td></td>
<td>Occupational rehabilitation</td>
<td>A significant increase in knowledge and skills. At one-year follow-up, the knowledge and skill levels had eroded somewhat, but still significantly higher than levels at baseline.</td>
</tr>
<tr>
<td>Multi-center Clinical trial[28]</td>
<td>2002</td>
<td>73</td>
<td>Specific SST programme</td>
<td>24 Weeks</td>
<td>Traditional SST</td>
<td>Higher symptoms reduction for the experimental group, but significantly greater improvements in some cognitive variables for the control group.</td>
</tr>
<tr>
<td>Randomised control trial[29]</td>
<td>2005</td>
<td>Exp. = 37; Cont.=39</td>
<td>Cognitive-behavioural social skills training (CBSST)</td>
<td>24 Weeks</td>
<td>Treatment As Usual</td>
<td>Significantly greater cognitive insight, indicating more objectivity in reappraising psychotic symptoms, and greater skill mastery.</td>
</tr>
<tr>
<td>Randomised control trial[30]</td>
<td>2005</td>
<td>Exp. = 16; Cont.=16</td>
<td>A programme of cognitive behaviour</td>
<td></td>
<td>SST plus psycho-education</td>
<td>Significantly better acquisition of social skills and decrease in negative coping behaviour.</td>
</tr>
<tr>
<td>Randomised control trial[31]</td>
<td>2005</td>
<td>Exp. = 17; Cont.=18</td>
<td>A workplace fundamentals supplemented by SST</td>
<td>36 Weeks</td>
<td>Treatment As Usual</td>
<td>A significant improvement in knowledge of workplace fundamentals at the nine-month follow-up.</td>
</tr>
<tr>
<td>Randomised control trial[32]</td>
<td>2006</td>
<td>Exp. = 32; Cont.=32</td>
<td>UCLA’ Social and independent living skills programme</td>
<td>6 Months</td>
<td></td>
<td>A significant decrease in the scores of Positive and Negative Syndrome Scale (PANSS) was observed.</td>
</tr>
<tr>
<td>Randomised control trial[33]</td>
<td>2005</td>
<td>Exp. = 18; Cont.=18</td>
<td>SST</td>
<td>8 Weeks</td>
<td>Supportive group discussion</td>
<td>No significant improvement was found in symptoms or social functioning, after completion of either SST or supportive group discussion. The relapse rate was similar across two groups.</td>
</tr>
<tr>
<td>Randomised control trial[34]</td>
<td>2006</td>
<td>Exp. = 124; Cont.=116</td>
<td>Functional Adaptation Skills Training (FAST)</td>
<td>24 Weeks</td>
<td>Attention Control (AC)</td>
<td>A significant improvement in everyday living skills, social skills, but not medication management skills.</td>
</tr>
<tr>
<td>Randomised control trial[35]</td>
<td>2007</td>
<td>Exp. = 43; Cont.=39</td>
<td>Psycho-social skills training (PSST) plus family therapy</td>
<td>48 Weeks</td>
<td>Treatment As Usual</td>
<td>A significant improvement in symptoms, psychosocial and global functioning. Also lower relapse, rehospitalisation and drop-out rates. A higher level compliance with anti-psychotics medication and adherence.</td>
</tr>
<tr>
<td>Randomised control trial[36]</td>
<td>2007</td>
<td>Exp. = 49; Cont.=45</td>
<td>Community Re-entry module (CRM)</td>
<td>4 Weeks</td>
<td>Psycho-education</td>
<td>A significant improvement in social functioning, insight and psychiatric symptoms. Also significantly higher the re-employment rate and lower relapse and re-hospitalisation rates.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Participants(n)</th>
<th>Treatment</th>
<th>Duration</th>
<th>Comparison</th>
<th>Outcome variable(s) indices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multi-site Randomised control trial</td>
<td>2009</td>
<td>Exp.= 47 Cont.=35</td>
<td>Basic conversational skills module (BCSM) plus Attention shaping (AS)</td>
<td>17 Weeks</td>
<td>Standard format of BCSM</td>
<td>Significantly more attentiveness in group sessions and higher level of skill acquisition. Moreover, significant relationship was found between changes in attentiveness and amount of skills acquired.</td>
</tr>
<tr>
<td>Randomised control trial</td>
<td>2010</td>
<td>Exp. = 90 Cont.=93</td>
<td>Helping Older People Experience Success (HOPES) includes intensive skills training</td>
<td>1 year</td>
<td>Treatment As Usual</td>
<td>Significant improvement in performance measures of social skills, psychosocial and community functioning, negative symptoms, and self-efficacy, with effect size in moderate range.</td>
</tr>
<tr>
<td>Randomised control trial</td>
<td>2010</td>
<td>Exp. = 30 Cont.=30</td>
<td>Social skills and neurocognitive individualised training (SSAINT)</td>
<td>6 Months</td>
<td>Structured leisure activities</td>
<td>Increase personal and social functioning, but no change in psychopathology and cognitive outcome indices.</td>
</tr>
<tr>
<td>Controlled trial</td>
<td>2011</td>
<td>Exp. = 35 Cont.=38</td>
<td>A rehabilitation programme of eight modules on psychosocial skills</td>
<td>4–12 Weeks</td>
<td>Treatment As Usual</td>
<td>Significantly better improvement over the course of the programme on all measures. The rehabilitation programme is effective in addressing psychosocial deficits.</td>
</tr>
<tr>
<td>Randomised control trial</td>
<td>2011</td>
<td>Exp. = 46 Cont.=45</td>
<td>SST with virtual reality</td>
<td>5 Weeks</td>
<td>SST with traditional role-playing</td>
<td>A significant improvement in conversational skills and assertiveness, but less in non-verbal skills.</td>
</tr>
</tbody>
</table>

SST – Social skills training, Exp. – Experimental group, Cont. – Control group.

Table 2. Included psychiatric nursing studies regarding efficacy of SST in adult patients with a schizophrenia or schizophrenia spectrum disorder.

<table>
<thead>
<tr>
<th>Study</th>
<th>Year</th>
<th>Participants(n)</th>
<th>Treatment</th>
<th>Comparison</th>
<th>Outcome Variable(s) indices</th>
</tr>
</thead>
<tbody>
<tr>
<td>Longitudinal design with randomisation</td>
<td>2003</td>
<td>Exp. = 35 Cont.= 43</td>
<td>Training in conversation and assertive skills, each session last up to 60 minutes and two sessions per week during 4 weeks</td>
<td>Routine nursing care at inpatient psychiatric ward</td>
<td>A significant improvement observed in conversational and assertive skills at intra-treatment, post treatment, and follow-up.</td>
</tr>
<tr>
<td>Quasi-experimental design with non-equivalent control group</td>
<td>2007</td>
<td>Exp. = 34 Cont.= 32</td>
<td>Training in conversation, relationship, assertiveness skill and problem-solving, Total 16 sessions each may last up to 60-70 minutes and two per week during 8 weeks</td>
<td>Routine inpatient nursing care at inpatient psychiatric ward</td>
<td>A significant improvement in conversational skills, assertive skills, interpersonal skills and in their self-esteem but no difference in the problem-solving skills of both groups.</td>
</tr>
<tr>
<td>Controlled design with Randomisation in experimental group</td>
<td>2011</td>
<td>Exp. = 32 Cont.= 30</td>
<td>Assertive skills training, Total 10 sessions, each for 60 minutes at every second day during 4 weeks</td>
<td>The usual routine care at inpatient psychiatric ward</td>
<td>No significant difference was observed in scores of assertive skills between experimental group and control group.</td>
</tr>
<tr>
<td>Controlled design with randomisation only in treatment group</td>
<td>2012</td>
<td>Exp. = 20 Cont.= 20</td>
<td>Training sessions in conversation and assertiveness skills, each may last up to 45-60 minutes and two sessions per week during 6 weeks</td>
<td>The usual routine care at inpatient psychiatric ward</td>
<td>Participants in experimental group improved significantly in psycho-social skills.</td>
</tr>
<tr>
<td>Controlled design with randomization</td>
<td>2013</td>
<td>Exp. = 15 Cont.= 15</td>
<td>Training in conversational skills, Total 15 sessions</td>
<td>The usual routine care at inpatient psychiatric ward</td>
<td>A significant increase was found in the scores of conversational skills of the experimental group after training.</td>
</tr>
</tbody>
</table>

**Note:** The studies listed are based on Diagnostic and Statistical Manual IV. However, two studies were involved a single gender, respectively male or female. The average age of participants was ranging from 18.5 to 41 years.
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and their education profile was usually at secondary level. The majority of them were unmarried and unemployed. The average duration of their illness was 12 years.

Findings of previous studies showed that SST was effective, particularly in terms of a significant acquisition and performance of taught skills during a classroom or clinic training setting and generalisation of learned social skills beyond training setting. In addition, findings of several studies indicated a significant improvement in social adjustment, independent living skills, community after care, social functioning, insight and a significant reduction in symptoms, relapse and re-hospitalisation rate. Several nursing studies have shown the efficacy of conversational and assertiveness skills training in terms of a significant improvement in three sub-categories of targeted social skills i.e. conversational skills, interpersonal relationship skills and assertiveness skills except one study that had reported no significant difference in scores of assertive skills between the experimental group and control group. Additionally, the conversational and assertiveness skills training had significantly reduced the general psychopathology, positive and negative syndrome (symptoms) and interaction anxiousness and it had significantly increased the self-esteem of participants in the experimental group.

Discussion

In this qualitative-narrative review, the author found a number of randomised control trials and controlled trials in support for the efficacy of SST for schizophrenia, especially in published literature of other core psychiatric disciplines. The findings in terms of a significant gain in the text knowledge and performance of targeted social skills are consistent with findings of previous reviews in published literature of other core psychiatric disciplines. The existing nursing studies that examined the efficacy of conversational and assertive skills training had consistently reported a significant improvement in the human interaction abilities of participants and their findings are consistent with findings of studies in other disciplines.

It is clear and evident from a number of reviewed studies that participants with schizophrenia had significantly acquired the targeted social skills as a result of SST interventions. Several previous studies in other core psychiatric disciplines had supported the generalisation of social skills beyond the training setting. However, two reviews reported scant regarding effectiveness of SST in this outcome. Some researchers have suggested that simultaneously creating the opportunities, encouragement and reinforcement could amplify the generalisation of skills to the natural environment and a more extended treatment to maintain the social skills.

A body of research in schizophrenia revealed that impairment in cognitive functions is predictive of lower work status, deficits in social skills and a poor response to psychosocial skills training. The social cognition particularly plays a significant role in the execution of a variety of social skills and overall social functioning. Therefore, the traditional or classic form of SST has been recently augmented with cognitive techniques such as cognitive remediation, cognitive behaviour therapy and social cognitive training because the cognitive therapy format may contribute in faster skill acquisition and greater mastery of skills. None of included nursing studies focused on cognitive aspect of SST with patients with schizophrenia.

SST can improve patients’ social adjustment and capacity for independent living, this has been supported by a recent meta-analysis in terms of improving functional outcomes like social adjustment and independent living. SST was effective in improving psychosocial and global functioning of participants with schizophrenia. The greatest improvements in social outcomes occurred particularly when SST was combined with active pharmacological supplements. In contrast, Pilling and colleagues had reported no clear evidence for the benefits of SST on the global adjustment, social functioning and quality of life. However, Mueser and Penn were pointed out that the ‘empirical basis for these conclusions is insufficient’. They further commented on Pilling and colleagues’ work that review of the research literature on SST was both ill-informed and misleading as there was insufficient inclusion of randomised control trials in examining the effects of SST for social functioning.

As mentioned earlier, most nursing studies focused on improving participants’ conversational and interaction abilities, but none of these primarily examined the

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impact of SST as a nursing intervention on social adjustment or social functioning. The ultimate aim of any psychosocial intervention for patients with SMI is to improve their social functioning and quality of life. SST equips the necessary skills among patients with schizophrenia so that they cope better with the day-to-day demands of independent living in the community and it slightly improves social functioning. Patients’ social skills are an accurate reflection of their social functioning and well being. According to Couture and colleagues, ‘social functioning is a phrase, used to apply to self-or other report of interpersonal behaviours, behaviour in community settings, skills of independent living, ratings of social skill in laboratory settings, and ratings of problem-solving skills’. Therefore, it may be supposed that a significant improvement in social functioning may be expected through SST interventions as seen in relation to improvement in social skills.

The UCLA’s community re-entry module (CRM) was specifically designed to teach individuals with SMI at acute inpatient settings how to develop their own comprehensive community aftercare. None of the nursing studies have examined the efficacy of CRM, but some studies showed the efficacy of CRM in improving subject’s knowledge and performance of skills and social functioning. SST was beneficial at helping patients with schizophrenia in finding and keeping a job but one study reported that the supplementary skills training did not improve work outcomes for clients.

Patients with chronic schizophrenia suffer with negative symptoms such as social isolation, lack of motivation, apathy and loss of enjoyment. Finding a nursing study showed that SST significantly reduce both positive and negative syndrome (symptoms) in participants with schizophrenia. These findings are consistent with findings of some other studies. However, Bustillo and colleagues concluded that SST has no effect on psychopathology. A recent meta-analysis revealed that SST has moderate ‘average effect size’ on improving negative symptoms which were strongly associated with impaired psychosocial functioning in schizophrenia.

None of the included nursing studies focused on the impact of SST intervention on decreasing relapse and re-hospitalisation among participants with schizophrenia. Although 2 studies of other core psychiatric disciplines reported significant lower relapse and re-hospitalisation rate in the experimental group but other studies and reviews were reported no clear evidence regarding the benefits of SST in decreasing the rate of relapse or re-hospitalisation.

Self-esteem is widely used as an outcome variable in studies of psychiatric rehabilitation, based on the assumption that improved functional status leads to higher self-esteem. One of the underlying assumptions of the stress-vulnerability model is that people who have poor social and coping skills appear anxious and less confident in social situations. SST reduces the distress and difficulty in social situations and consequently, it enhances social performance and self-esteem.

Conclusions

Previous research work demonstrated the efficacy and usefulness of SST interventions for patients with schizophrenia. Therefore, these kind of SST interventions should be implemented in routine care combined with other elements of comprehensive care and treatment i.e. medication and other psychosocial therapies. Psychiatric / Mental health nurses may implement SST as a nursing intervention either independently or as a joint venture with other mental health care professionals. A structured SST intervention has the same key steps as the nursing process (i.e. assessment, planning, implementation and evaluation) so it can be easily integrated to the nursing care process. In designing and implementing SST as a nursing intervention with small group of patients, the individual patient’s characteristics, impairments and needs should be taken into account. SST should be ideally commenced in hospital in-patient settings and should be continued without interruption in the community. Future nursing interventions would be focused to incorporate a cognitive format. The nursing role as social skills trainer needs to be developed through facilitating short-term workshops.

The existing nursing studies indicate that SST is a viable therapeutic nursing intervention for patients with schizophrenia. However, existing nursing studies were small scale and quasi-experimental; therefore generalisation of findings from those studies should be done with caution and this warrants further research with a larger sample size and rigorous research method. Although this nursing review provides a broad overview of
relevant information tempered by critical appraisal of relevant SST studies, particularly of existing nursing studies, but this review restricts itself to summarising the findings narratively and exclusion of relevant publications within the non-English language. It had also failed to include mathematical calculation or graphic presentation of findings which could be possible to compile from homogeneous controlled studies. Future systematic reviews should include meta-analyses of nursing studies for more precise and reliable results regarding efficacy of SST as nursing interventions.

**Disclosure**

There are no conflicts of interest.

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