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Abstract

There are various quantitative studies have been conducted both nationally as well as internationally that revealed the effectiveness of social skills training in schizophrenia. However, very few qualitative studies have been conducted to measure the relevance of social skills training in schizophrenia. The present study investigated the effectiveness of six months social skills training program with 5 inpatients chronic schizophrenia, conducted for one and half an hour in a week. Employing phenomenological approach, psychosocial assessment was done on the basis of interviews, observations, role-plays, and work assignments, which was analyzed using Stevick-Colaizzi-Keen Method of phenomenology. The social skills training resulted in decreasing social anxiety and enhancing social functioning as maintaining personal hygiene, significant gain in adherence to medications, making request, expressing feeling, and sorting out problematic issues that sustained up to 18 months following intervention. It has been effective in changing the patient's behaviors and boosted their capacity to confront problematic situations, but weaker effects were found for auditory hallucination in one of the patients.

Keywords

Schizophrenia, Social Skills Training, Social Functioning, Role Play, Qualitative Research

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Efficacy of Social Skills Training for the Persons with Chronic Schizophrenia

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There are various quantitative studies have been conducted both nationally as well as internationally that revealed the effectiveness of social skills training in schizophrenia. However, very few qualitative studies have been conducted to measure the relevance of social skills training in schizophrenia. The present study investigated the effectiveness of six months social skills training program with 5 inpatients chronic schizophrenia, conducted for one and half an hour in a week. Employing phenomenological approach, psychosocial assessment was done on the basis of interviews, observations, role-plays, and work assignments, which was analyzed using Stevick-Colaizzi-Keen Method of phenomenology. The social skills training resulted in decreasing social anxiety and enhancing social functioning as maintaining personal hygiene, significant gain in adherence to medications, making request, expressing feeling, and sorting out problematic issues that sustained up to 18 months following intervention. It has been effective in changing the patient's behaviors and boosted their capacity to confront problematic situations, but weaker effects were found for auditory hallucination in one of the patients. Keywords: Schizophrenia, Social Skills Training, Social Functioning, Role Play, Qualitative Research

Schizophrenia is a heterogeneous psychiatric disorder includes three clinical syndromes as *reality distortion* (inability to change cognitive sets, resulting in fixed beliefs and misinterpretation of internal stimuli), *disorganization* (is a failure to maintain a cognitive set, leading to distraction and disorganized thinking) and *psychomotor poverty syndrome* (a failure to initiate a cognitive set, leading to mental poverty and apathy; Sadock & Sadock, 2000). The severe impairment in the major areas of social functioning such as work, interpersonal relations or self-care is acknowledged a hallmark of schizophrenia. Evidenced revealed that these patients usually face social dysfunction in various aspects such as social withdrawal, occupational disturbances, did not utilized leisure activities, problem in adjustment with near and dear one, are related to poor psychosocial functioning among the persons with schizophrenia (Mueser, Bellack, Douglas, & Morrison, 1991). It is agreed that social skills is the ability to interact with other people in a way that is both appropriate and effective (Segrin, 2000; Spitzberg & Cupach, 1989).

Chronic mental illness is characterized by chronic deficits in personal and social functioning. In addition to that, the chronically mentally ill individuals also have to deal with the pernicious and negative attitude of the society in the forms of stereotypes, stigma and prejudices. These factors put together to make them "one of the most needy and disadvantaged groups of society" (Shadish, Lurgio, & Lewis, 1989, p. 7). A literature stated that persons with schizophrenia often realized self-stigma due to societal reaction, which consequently decreasing the quality of life (Kumar et al., 2012). Besides this, even family members considered them as burden (Suri et al., 2012). Therefore, it is the fundamental need

to enhance the social functioning of patients so that their family could not recognize them as a burden. In fact, chronicity is determined primarily by duration and disability rather than by diagnosis (Kay & Tasman, 2006). Schizophrenia is a severe psychiatric illness, afflicting more than 1% of the population worldwide (National Institute of Mental Health, 2009). It usually has an onset in late adolescence or early adulthood, and tends to have an episodic course punctuated by symptom exacerbations requiring brief hospitalization throughout the lifetime (Mueser, 1998).

The social skills training is attempted to restore the patient's ability to function in their community. It includes medical, psychological and social treatment so that they could increase social interaction, become independent, and encourage vocational performance (Cook et al., 1996). The increase cases of dumping of psychiatric patients in the government run psychiatric institutes definitely affected both patients as well as hospitals in terms of quality care in India. The proliferation of population 1.21 billion (Bose, 2011) along with increased cases of mental disorders in India took heavy toll on government expenditure. In India, in a population of nearly one billion people, there are an estimated four million people with schizophrenia, with different degrees of impact on some 25 million family members. The proportion of health budget to GDP is 5.2%. The country spends 0.83% of the total health budget on mental health (WHO, 2001). In terms of resources, India has 0.25 beds per 10,000 populations (0.2 in mental hospital and 0.05 in general hospitals). There are 0.2 psychiatrists per 100,000 populations (WHO-AIMS, 2006). This would mean a dramatic increase in demand for treatments targeting the needs of patients with schizophrenia. The truth revealed that long-stay patients often show "Social Breakdown Syndrome" (Zusman, 1966), characterized by apathy, loss of interest, over conformity, over submissiveness, deterioration in personal habits, lack of individuality, lack of concern for the future, over dependency, a resigned acceptance of things as they are and a tendency to resist change (Bhaskaran & Dhawan, 1974), is seen to a greater or lesser degree in patients of schizophrenia who have been continuously in the hospital for 2 years or longer (Bhaskaran & Dhawan, 1974). Social skill has been important part of psychosocial rehabilitation of the long-stay patients in the psychiatric hospital.

The large number of researches in India and abroad stated that the effectiveness of social skills training among the patients of schizophrenia depend on the type and frequency of treatment sessions and it also linked with the immediate environment that affect psychosocial functioning of the patients (Kopelowicz, Liberman, & Zarate, 2006). Social skills training are used to enable individuals to learn specific skills that are missing or those that will compensate for the missing ones. Social skills training improved ability to acquire and sustainability of specific social skills (Benton & Schroeder, 1990); it improved social functioning activities significantly more frequently as compared to the patients in treatment as usual (Granholm et al., 2005).

Method

Whether psychiatric patients regard his experiences in a mental hospital setting has been positive or negative depends upon hospital milieu. Understanding the patient's experiences is not only relevant, but critical in understanding "why" and "how" a therapeutic intervention is or is not effective. Here researchers have tried to identify the factors that impede the social functioning of the inpatients. It was not necessary to explore merely the psychosocial factors, but to make an effective psychosocial intervention compatible with patients and their environment. Providing patients an opportunity to voice and explain their experiences requires a phenomenological approach that is designed to capture the live experiences of the patients. Consequently, this study employed a phenomenological approach

to explore patient's problematic experiences in the hospital set up. The general question of this study was: how do psychiatric patients, who were deserted by their family, realize experiences of psychiatric illness and how has that experiences impacted their lives?

Phenomenology is a qualitative study which concerns itself with the nature of the phenomena for the participants, in this case social skills training. This research is a qualitative phenomenological study into the lived experiences of the persons with psychiatric illness and their acquisitions of social skills training in the group. One-on-one interviews were conducted to explore the problematic experiences of each participant. In addition to this, participants were also involved in the group interviews to explore the psychosocial factors that affect the social functioning of the participants. The personal and interactive nature of each group interview reflects the social constructivist worldwide (Creswell, 2009; Mertens, 2009). Social constructivists hold assumptions that persons seek understandings of the world in which they live and work (Creswell, 2009).

Phenomenological approach is a qualitative research that centers on comprehending a concept or a phenomenon. It illustrates the significance of the lived experiences of more than one person and explores the structures of consciousness in human experiences (Polkinghorne, 1998). Husserl (1970) emphasized that it is a world of experience or the life world as it is lived, felt, and understood by human beings. This study employed scientific method of phenomenal analysis described by Moustakas (1994) as a *Modification of the Stevick-Colaizzi-Keen Method*. This method of organizing and analyzing data was applied to interviews with participants who were being given social skills training program.

The present study illustrated a holistic inquiry of the complex pattern of social dysfunctions for the persons with chronic schizophrenia. Patients were involved in the phenomenological understanding on the general meaning of simultaneous effects of the social skills and vocational training for enhancing psychosocial functioning among them. The purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence (Van Manen, 1990). This description consists of "what" they experienced and "how" they experienced it (Moustakas, 1994).

Phenomenology is not only a description, but it is also seen as an interpretative process in which the social scientist makes an interpretation of the meaning of the lived experiences (Van Manen, 1990). Here the social researcher "mediates" between different meanings of a particular phenomenon. He describes research as oriented toward lived experience (phenomenology) and interpreting the "texts" of life (hermeneutics). Further, the method allows the researcher to keep the "voice" of the participants in the research without abstracting their viewpoint out through analysis.

Participants

The five male persons with chronic schizophrenia, Mr. W., Mr. S., Mr. N., Mr. B., & Mr. P. (The name of the patients were changed to ensure the confidentiality) purposively selected from one of the ward of the Ranchi Institute of Neuro-Psychiatry & Allied Sciences (RINPAS), Kanke, Ranchi, Jharkhand, India. They were diagnosed as schizophrenia according to International Statistical Classification of Diseases and Related Health Problems-10th Revision (World Health Organization, 1990).

Data Collection

This study was a one group-pretest-posttest psychosocial treatment of the chronic schizophrenia. It includes comprehensive social skills training to the patients for six months once in a week. The data was collected through various qualitative techniques: in-depth

interviews, role play observations, empirical observation of behavior in the ward and at work sites, work assignments, and formal interaction with participants. It is the blind qualitative assessment of social functioning, positive and negative symptoms and cognitive insight. Besides this, patients were also assessed through the rating scale at two different times: at baseline and at the end of six months, by using Social Adaptive Functioning Evaluation (SAFE) in order to evaluate the process of changes throughout treatment (Fig. 3 & 3.1). The role plays and empirical observation of the patients during treatment sessions also provided information about the amount of therapy needed to achieve meaningful change in the participants. They were also observed at their respective work sites, patient's library as well as in the wards by respective in-charge.

Qualitative Assessment of Psycho-social Functioning for the Persons with Schizophrenia in the Group - Developed by Author(s)

There are seven steps were prepared taking in to account the need of the persons with psychiatric problem in the socio cultural environment of the India. In India, there are multi cultural communities resides which have multiples requirement. So, taking in to the consideration about the need of the persons suffering from psychiatric illness, a seven steps qualitative assessment of psychosocial functioning for the persons with psychiatric illness in the group were prepared. These steps are:

Step 1: Assessment of Problematic Experiences

In this step, patient's behaviors were assessed. Detailed information was elicited from patient through in-depth interviews. Participants were cooperative and maintained partial eye contact. They were involved in the interactions process by putting various related questions.

Therapist: Could you describe your daily routine?

Patients: We awoke in the morning, took breakfast, medicine and then either we sit alone or wander here and there. There was no work in the ward.

Therapist: Is there any other things you usually do in the ward?

Patients: If we feel good went for rehabilitation center but we did not work there. Supervisor used to say complete your work within a stipulated time and did not allow to rest.

Therapist: How did you spend your spare time?

Patients: We did not have work; we see television and wander here and there.

Observation by ward nurses: Ward nurses told the therapist that "usually these patients did not interact with others, they took meal and medicines and either sleep or sit alone." Earlier they went rehabilitation center for work but supervisor often complained that they did not work here and did not take interest in the work allotted to them and wander here and there and at the time of lunch they went ward. Besides this, they did not come regularly here. Even they did not greet to anyone.

Step 2: Clarification of Problematic Experiences

Patients were assessed whether they know nature, course and prognosis of psychiatric illness- schizophrenia. The importance of social skills training was also elicited from the

patients. They hardly knew about the schizophrenia and its relationship with social skills. They hardly interacted with other fellow members.

Step 3: Assessment of Motivational Level

Patients were motivated to take part in-group treatment so that they could live life in the community without ridicule. They were inculcated during interview that it would create independence in you and would get self-confidence.

Observation: It was observed during multiple of interview sessions that patients were showing hesitations during interaction process. They were highly motivated to participate in the treatment sessions. Finally, patients became prepared to participate in the social skills training program. They were in the third stage of motivation: Decision and agreed to participate in the group treatment.

Step 4: Analysis of Social Support

During pre-morbid, patients used to perform their daily routines and functions adequately. As patients narrated that their condition had started deteriorating due to frequent hospitalization and usually did not take interest in any social activities. As time passes, become passive and gradually their interaction became decrease even with their roommates. Patients verbatim, *“we usually, saw only people suffering from psychiatric illness in the ward. Nobody even talked to us in a good manner. Sometimes, guard or ward attendants beat and humiliate us.”* *“We did not get adequate social support either from family member or staffs of the hospital.”* Unfortunately, their family members did not come to see him after admission at the hospital. Hospital administration had tried to locate their address but did not succeed.

Step 5: Assessment of Impulse Control

Patients were very passive. Even they did not demand extra clothes from ward staffs after bath. They did not request for help, sat alone and not interacted with others. At the baseline assessment, patients were having impoverishment of emotional expression and feeling. They appeared to have wooden expression, as less than normally expected. Even there is no apparent smile on the face. Sits quietly during interview and shows few spontaneous movements. Do not use his body as in aid in expressing his ideas, through such means as hand gestures, sitting forward in his chair without maintaining eye contact. They avoid looking at others and stair into a corner of the room when interview was being in process.

Besides this, they did not speak coherently and some of the questions may left unanswered and take longer time to reply questions than normally expected; were unable to mobilize themselves to initiate or persist in completing many different kinds of tasks. Maintain poor personal hygiene and did not take interest in recreational activities; relatively restricted in their relationship with friends and peers. They usually tried to avoid interactions with others and wander away while in the middle of interview. Participants were motivated to participate actively in the group through sharing their experiences.

Step 6: Assessment of Social Engagement and Social Appropriateness

Patient's social relationship with colleagues, ward staffs, mental health professionals and other persons were elicited. During psychosocial assessment at baseline (before

treatment), they did not concentrate upon the things were asked. They usually look at other most of the time, did not maintained appropriate distance while talking. Sometime they become too close or some time too distant. Usually, patients were facing problem to speak to unknown person; often, felt hesitation to initiate conversation with others; became unable to express their positive as well as negative feeling to fellows or ward staffs, and lack social skills to resolve the problematic experiences. They often, quarreled, fight, and sometimes use abusive languages on a little bit issues. They rarely, had friends in the hospital ward, and usually not interacted with the others and did not ask for help even difficult situations.

Step 7: Analysis of the Immediate Social and Physical Milieu

Patients were belonging to state Bihar and Jharkhand, India. They were belonging to joint family, from both lower and middle socio economic status; speak Hindi language, from agricultural background. The surrounding environments of the patients were gardenized with different color of flowers, having arrangement of cemented sit where patients used to sit, have several plants like mango, guava, jackfruit, berries, and others greenery where patients enjoyed it. It is full of greenery around the hospital wards and a hygienic condition was maintained.

Measure

Social Adaptive Functioning Evaluation (Harvey et al., 1997)

The social adaptive functioning evaluation (SAFE) was originally developed to use with geriatric psychiatric clients (Harvey et al., 1997). The SAFE scale has been adapted for use with people of all ages who have experienced severe functioning problems related to schizophrenia. It is especially helpful in inpatient and long –term residential settings. The scale contains 19 different items, such as “bathing and grooming,” “clothing and dressing,” “money management,” and “conversational skill.”

Procedure

The content of the social skills training program was developed by the researcher after a thorough review of literatures (Bellack, 2004; Liberman, DeRisi, & Mueser, 1989). The basic structure of the sessions was prepared by taking in to the account the need of the patients in Indian set up and facilities available in the hospital. After the assessment of the patients in the group, contents of the sessions were prepared. The group intervention was carried out for six months once in a week for one and half hour along with regular providing opportunity them to practice learned skills. Social skills training were given to the patients according to the established and prepared structure of the sessions.

The goal of the social skills training was to involve patients in such a way that they could spend their life as independent as expected in normal conditions. The structures of the sessions are depicted in the intervention packages (Table 1). After establishing rationale, the different steps of the skills were demonstrated through role plays. Immediately after the social skill had been demonstrated by the therapist, patients were engaged in a role play of the same skill. The purpose of this role play was to give patients an opportunity to practice the skill they had just observed and learned. Following completion of the role play, therapist elicited positive feedback from group members and provided additional feedback for specific components of the skill which were performed well. Then after corrective feedback was provided in the form of suggestions for how the patient could do the skill more effectively in

the next time. Effort had always been reinforced. There were following strategy employed for teaching social skills such as modeling, role play rehearsal, feedback, shaping, reinforcement and additional role playing. Besides this, coaching (providing verbal prompts) and prompting (providing hand signals) were used during role plays that can help patients improve their performance.

Patients were taught one skill in a session and same skills were repeated twice in the next session. After inculcating the skills, patients were sent to rehabilitation center and library so that they could practice learned skills in real life situations. Their behaviors were observed by the respective in-charge such as ward nurses and staff, supervisor at work place, and library in-charge.

Ethical Aspects

An official approval was obtained from the competent authority, Director, Ranchi Institute of Neuro-Psychiatry and Allied Sciences (RINPAS) Kanke, Ranchi, Jharkhand, India, to conduct this study. The study procedures were approved by the ethical committee of the RINPAS, Ranchi, India. It was delineated and informed to all subjects that they have the right to not participate in the study at any time. Informed consent was obtained from all eligible participants who agreed to participate in the study.

Intervention Packages

Table 1. Social Skills Training for Schizophrenia: Sessions and its Contents

Sessions	Objective	Strategies	Process	Duration (Approx.)
1 & 2	Rationale of the social skills training.	Sharing of experiences, awareness, clarification	Figure drawn on chart, clarification,	1:30 hour
3, 4, & 5	Consciousness raising	Sharing of experiences, awareness regarding stages of behavior change,	Patients were inculcated nature, course, and prognosis of schizophrenia and components of recovery.	1:30 hour
6, 7, & 8	Inculcation of bathing, dressing, and grooming skills	Demonstrations of skills before the patients. Then after patients were involved.	First therapist demonstrated in front of patients step by step, then after patients were given opportunities to do same activities in the session.	1:30 hour
9, 10, & 11,	Initiation, maintaining and termination of conversation skills	Steps developed by the therapist to inculcate conversation skills were demonstrated before the patients.	Patients were tried to inculcate conversation skills in the real life situations.	1:30 hour
12, 13, & 14	Inculcation of skills "Listening to other"	Involving patients by assigning different roles that to be played at the session.	Role play, clarification, prompting, rehearsal, observation, Clapping,	1:30 hour
15, 16, & 17	Inculcation of skills "Making request"	Involving patients by assigning different roles that to be played at the session.	Role play, clarification, prompting, rehearsal, observation, Clapping,	1:30 hour
18, 19, & 20	Inculcation of skills "Expressing	Involving patients by assigning different roles that	Role play, clarification, prompting, rehearsal,	1:30 hour

	negative feeling”	to be played at the session.	observation, Clapping,	
21, 22, & 23	Inculcation of skills “Problem solving skills”	Involving patients by assigning different roles that to be played at the session.	Role play, clarification, prompting, rehearsal, observation, Clapping,	1:30 hour
24, 25 & 26	Inculcation of skills “Health maintenance skills”	Involving patients by assigning different roles that to be played at the session.	Role play, clarification, prompting, rehearsal, observation, Clapping,	1:30 hour
27 & 28	Review and termination	Orientation, summarization, discussion of long-term goals, and follow up.	The participants will be involved to review the overall sessions, its pros and cons, and discuss long-term goals and follow up.	1:30 hour

Results

Socio Demographic and Clinical Characteristics of the Participants

They belong to age range of 30-45 years, of which two patients were in the age group 30-35 years and three patients were 36-45 years. All of the patients were male, of which two were single and three were married; belongs to religion Hindu. Three patients belong to lower socio economic status and two were middle socio economic status. Regarding education, two patients were educated up to secondary and one patient higher secondary, and remaining two patients were drop out in class 8th. They were staying in hospital for last five years. The clinical profile of the patients indicated that there were five patients whose duration of illness was for last 10 years, and their illness started within the age range of 20-25 years (Table 2).

Table 2. Socio-Demographic and Clinical Characteristics of the Participants

Variables	Patients Group		N (%)
	Schizophrenia N=5		
Age	30-35 years	2	40%
	36-45 years	3	60%
Sex	Male	5	100%
	Female	00	0.0
Marital status	Single	2	40%
	Married	3	60%
Education	Below High school	2	40%
	High school	2	40%
	Intermediate (Higher secondary)	1	20%
Religion	Hindu	5	100%
	Others	00	0.0
Socio economic status	Lower	3	60%
	Middle	2	40%
	Upper	00	0.0
Duration of stay	Below 5 years	3	60%
	Above 5 years	2	40%
Age of onset	20-25 years	3	60%
	26 years and above	2	40%

Duration of illness	Less than 10 years	4	80%
	More than 10 years	1	20%

The Pre Morbid Job / Occupation of the Participants

Patients were skilled in multiple of aptitude like making threads, gardening, weaving, book binding, and operate computer. The pre-morbid occupation of the patients was agriculture and doing household work (Table 3).

Table 3. Pre-Morbid Occupation of the Participants

Variables	Patients Group		N (%)
	Schizophrenia N=5		
Aptitude	Making threads	1	20%
	Gardening	1	20%
	Weaving	1	20%
	Book binding	1	20%
	Computer operator	1	20%
Pre morbid occupation	Agriculture	3	60%
	House hold work	1	20%
	Service/ business	1	20%

Analysis of Raw Data

Raw data of each session was analyzed using scientific method of phenomenological analysis described by Moustakas (1994) as a *Modification of the Stevick-Colaizzi-Keen Method*, in terms of textural description, structural description, textural-structural description and composite textural-structural description of the participants. The *first two sessions* were devoted to create *rationale for the skills training* among participants.

Rationale for the Skills Training Program

Textural Description

In first two sessions, group participants were involved to explore the relevance of social skills training in their day-to-day life. When talked about social skills training, group had responded like “*one must talk in good manner; we must not fight; we should not cheat and must become an honest person.*” Participants was tried to facilitate to explore the relevant questions such as why they have had hesitation to express feeling to others. Why you people have had some nervousness to initiate conversation with strange person? Why did you not demand clothes from ward attendants? Why they had just realized hesitation to talk to doctor? Why would you not be able to enjoy own life as per the expectation of the society? Patient’s verbatim as “*We have been hospitalized for years. Individuals did not interact with us. There is no society in the ward and we are isolated from mainstream.*”

Structural Description

Patients described diverse circumstances wherein they felt abandoned by the family members and betrayed by the society. Eventually, participants came to identify this perception as being judge and labeled by society as these people incapable of fulfilling

expectation of the society. It was exacerbated their family's inability to provide them time, love and affection required for them to make adequate progress. Participants described that *"lack of social support, abandoned by family, long term hospitalization, lack of social environment in the ward, cut off from mainstream"* are the crucial one that aggravated their problem.

Although patients narrated about that one must talk in good manner, not to fight, and maintain cleanness, they usually did not interact with others, either they sat alone or wander here and there. Even they were not attending group meeting conducted every day. They usually faced difficulty to express their feeling to doctor, did not demanding even clothes from ward attendants. Often, patients used to blame others that no one interacts with us. Regarding hospital environment, participants stated that there is no society exists here. This reflected that to which quantity they had been aggrieved to self. Their motivation level was low. The first two sessions, were devoted about to inculcate the significance of skills training in the life of an individual.

The rationale of social skills training was narrated to the participants. While discussing skill *"listening to other"* participants was tried to give some clues about whenever someone is in a conversation with you, it is important to show the other person that you are listening, that you are paying attention. Making a request in a polite way, however, is usually less stressful and is more likely to lead to the request being met. One should not make request by oblige or order that you shall have to fulfill my need. Sometimes people feel shy about starting a conversation, maintaining conversation which allows people to learn more about each other's feelings and whether they may have more in common to talk about. Like this, people can also express their unpleasant feeling as anger, sadness, concern and worry. People *"express their unpleasant feelings"* can help to prevent arguments and more bad feelings. Yet another skill such as *"Making a complaint"* usually works best if you also suggest a solution and also responding it politely. Besides this, problem-solving skills are another unique skill that must be learned by the individuals.

Textural-Structural Description

The rationale for the make use of social skills training in schizophrenia is based on numerous theoretical and experimental resources. Strengthening the social skills and social competence of persons with schizophrenia can, along with other services, soothe and compensate for the undesirable effects of cognitive deficits, stressful situations, and social maladjustment. It provides protection against stress triggering factors and, improves quality of life, interpersonal support, resilience and social affiliations. When individuals with schizophrenia have been inculcated with social skills to deals with stressful situations and daily hassles, they are more efficient in solving problematic experiences and barriers in their daily lives. Consequently, stress triggering factors less likely to affects the lives of the schizophrenia. Furthermore, the shielding results of social skills training also facilitate individuals alleviate their illness, improve adherence to medications and psychosocial treatment and promote progress toward recovery.

Social skills training if carried out with structured designed, intensity, culture specific module, patiently, and adequate time, have been shown to improve the personal competencies among the individuals with schizophrenia, thereby soothing their pre morbid lack of social skills. Social skills training serves as a common denominator for becoming an active participants in controlling one's illness, overcoming obstacles to achieve personal goals and mobilizing social support (Kopelowicz, Liberman, & Zarate, 2006). Social skills training expand a patient's participation as a partner in making informed treatment decision is through its demonstration and teaching of skills before the participants. For example, when patient

learn how to use medication, they are more in control of their illness, experience greater responsibility for their treatment, and achieve insight in to their illness (Day et al., 2005).

Consciousness Raising for the Participants

Conscious raising, meant participants acquire awareness about themselves and the nature of the conduct, they did in day to day life. Because participants may have been previously unaware of the adverse impacts of the maladaptive behavior learning more about it and its effects will help them make better informed decisions (Velasquez, Maurer, Crouch, & DiClemente, 2001).

Textural Description

In the 3rd, 4th, and 5th session, patients were shared their problematic experiences about illness. The individual experiences were recorded as Mr. B. realized some voices coming in his ear. Mr. P. still heard some voices. Mr. W. verbatim “I did not enjoy any work, I could not enjoy as other patients did, I remain isolated and became sad.” While speaking very slowly, Mr. W. verbatim “I did not enjoy any work, I could not enjoy as other patients did, and I used to remain sad.” Mr. S. verbatim: “I did not talk to others due to fears, my neighbors used to say look, a ‘*mad person*’ was coming.” Mr. N.’s verbatim “My family was responsible for that, they frequently quarreled on little bit issues. I was hospitalized for the same.”

In addition to this, patients were tried to create consciousness about the relevance of psychosocial treatment through a diagrammatic representation of *combined effects of medications and psychosocial treatments in psychiatric illness* (Figure 1).

Therapist: What did you understand from this chart (Figure 1)?

Patients: (Simultaneously), it means; only medicines cannot reduce our problems, we would get better improvement from both medicines as well as psychosocial treatments.

Therapist: What would you get benefit from combined treatment of medicines and psychosocial treatment?

Patients: While getting psychiatric medicines patients would realize improvement in symptoms only; we will get strength, become independence, people respect us, and converse nicely when going through comprehensive psychosocial treatment.

Structural Description

The experiences of the patients reflected about multiple of the factors that are associated with aggravating their illness. Conducting social skills training along with family members can directly affects the family interaction pattern, and problem solving that, in turn, results in reductions in the stress triggering emotional aspects of the patients and their family. Psychosocial treatment appears an effective process for alleviating the effects of psychotic experiences, improving patient’s social functioning, and reduce family stress, when combine it with proper and adequate doses of pharmacological treatment by the highly experienced mental health professionals.

Patients usually suffer more with the side effects of the medicines, which consequently lead multiple of problems like continuous saliva coming out from mouth, remain isolated, sitting silently in the session without interacting with others, and social

withdrawal. The empirical finding of the researches demonstrated that the combined use of psychosocial treatment together with medicinal treatment produces the best clinical results in the treatment of schizophrenia. Often, patients remain alienated from the combined treatment at the same time, especially in the Indian context. Furthermore, patients became an object in the mental hospital as well as in the community, without progressing toward recovery, what we termed it as “*objectification of the patients.*”

Textural –Structural Description

Although antipsychotics have been shown to be effective for the treatment of acute psychosis and the prevention of relapse for persons suffering from schizophrenia, the majority of the persons with schizophrenia, even those who benefit from medication, continue to have disabling residual symptoms and impaired social functioning and will most likely experience a relapse despite medication adherence (Bustillo, Lauriello, Horan, & Keith, 2001). Therefore, it is essential to integrate empirically validated psychosocial treatments into the standard of care for persons with schizophrenia.

Failure to intake of medicines impedes both short and long term stabilization in domains of especially symptomatology, interpersonal relationships, hospitalized again and again, violent activities and poor quality of life. However, a multiple of barriers often patients had to face, even to take regular medicines as prescribed. An example of a patient’s barrier is meager illness management skills. Providing skills training have been shown to improve adherence to medication treatment as well as follow up. The aim of this session about to made patients enable to comprehend the relevance of psychosocial treatment together with medicinal treatment to enhance their recovery process (Figure 1 & 2; Figure 1 was presented before the participants in the form of chart to create awareness about the combined effects of medications and psychosocial treatments for persons with Schizophrenia). Since mental health recovery is a journey of healing and transformation enabling a person with a psychiatric illness to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

Figure 1. Combined Effects of Medications and Psychosocial Treatments in Psychiatric Illness

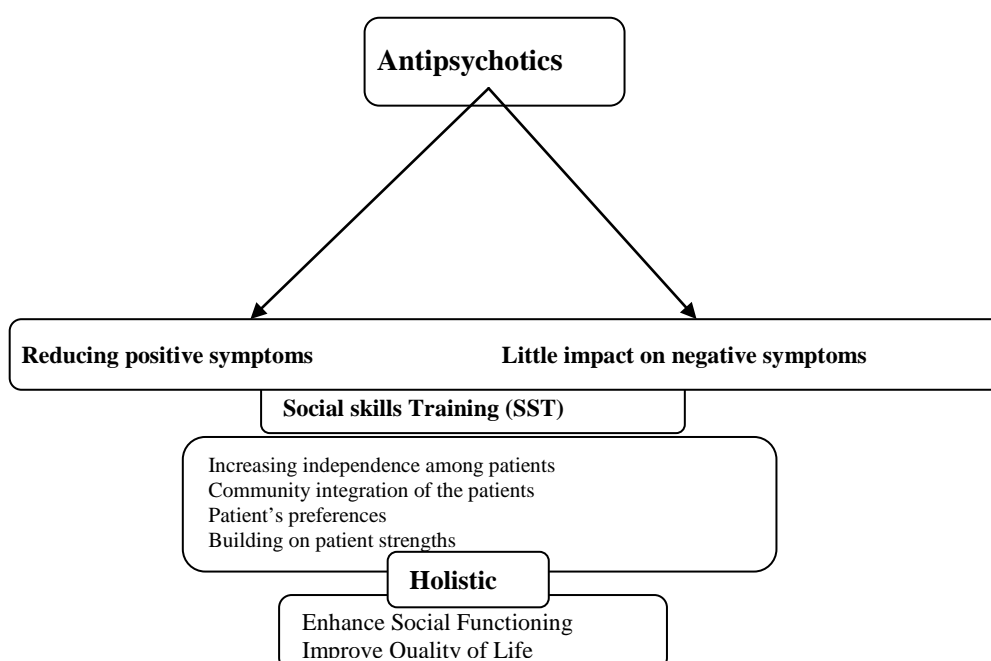
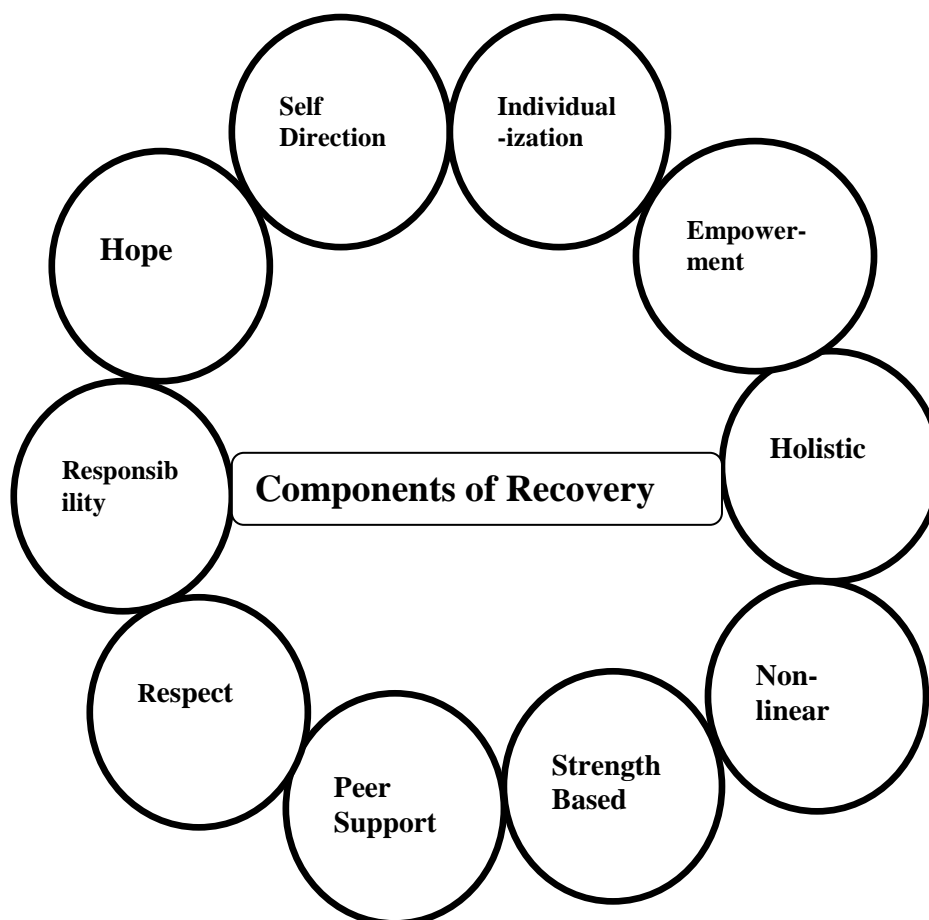


Figure 2. Components of Recovery (Young, 2006)

Instilling Bathing, Dressing, and Grooming Skills to the Participants

It is significant for every individual to maintain his or her personal hygiene himself. Taking bath, maintaining his grooming, able to dress himself without help, chooses clothes appropriate for the season, enable them to be competent about to take care independently.

Textural Description

In the 6th, 7th, and 8th sessions, patients were facilitated to create knowledge about to maintain personal hygiene as bathing, dressing and grooming. Patients were given dresses according to season, comb, soaps and oil. They were made aware about relevance of each item, given to them. It was also demonstrated before the patients that dresses, you had to wear, comb for hair combing, oil for massage, and soaps for bathing and cleaning of body and washing clothes. Then after, they were given choice to choose clothes appropriate to the season.

Observation: It was observed that three patients had chosen appropriate clothes, and other available things but two patients remain stand there. These two patients had chosen only clothes and not other things. Again, two patients were told to pick up things that you need. They had, finally, chosen the things.

Therapist: Why did you choose these things?

Patients: You had told us that pick up the things available here.

Therapist: Why did I tell you to pick up these things?

Mr. B.: We will maintain personal hygiene.

Mr. P.: Comb is used for grooming hair.

Mr. W.: We wear dress, massage oil, and comb hair.

Mr. S.: Clothes are used for covering body.

Mr. N.: No response.

Observation: Patients were facilitated to make effort to use the things provided to them during sessions. Three patients were responding well but two patients were not using things given to him.

Clarification: The mistakes done by the patients were corrected in the repeated session. And again they were demonstrated about the use of soap, clothes, comb, and oil in the next repeated sessions.

Observation: After the clarifying the mistakes, patients did well in the sessions.

Therapist: It is very important to maintain personal hygiene and keeps his area neat and help staff in maintenance activities in the hospital ward.

Structural Description

It has been very significant for every person to have good looking. Unfortunately, patients with schizophrenia shows multiple of problem as did not caring about himself or herself, sometimes worn torn clothes, poor oral hygiene, unusual and eccentric style of hair arrangement. They need extensive assistance in dressing and grooming. Skills training provided about to correct these deficits had been successful in initiating activities of grooming and clothing among participants. The basic social adoptive functions such as bathing and grooming, clothing and dressing, neatness and maintenance were taught through educational session. They learned basic information about psychiatric illness, importance of personal hygiene as takes bath daily, groomed hair, cleaning teeth, changing clothes, and maintaining cleanness of surrounding, facilitated patients to be more responsive in daily routine care. In this session patients were involved in a very interactive style, elicited the experiences of the patients and asked questions frequently to check on understanding.

Textural-Structural Description

In the beginning of this session, patients usually did mistake in wearing clothes. Patients need some assistance to dress up. They sometimes may dress in odd combinations of clothes or seasonally inappropriate clothing. Although patients dress themselves without assistance, but sometimes he appears sloppy as worn torn clothes, buttons or zippers are open. After 6th months of social treatment, it has appeared to have patients becoming enabled in maintaining personal hygiene. They bathe and grooms without prompting and assistance. Occasionally, they need to be reminded to complete oral hygiene, bathe, or comb his hair but when prompted, corrected theses problems. They also became able to dress themselves without help. If given a choice they often, choose clothes appropriate for season from among his possessions. Patients may realize when his clothes need to be cleaned. They regularly uses comb to maintain his basic grooming.

Conversation Skills: Initiating, Maintaining and Termination of Interaction

Textural Description

In the session 9th, 10th, and 11th, participants were facilitated to initiate, maintain, and terminate interaction in an appropriate way. They were instructed in the group that whenever you need to talk with other you need to remember following things as:

1. Maintain eye contact with to which you were to start interaction.
2. Maintain appropriate distance, not too close or too distant, according to social norms of the society.
3. Salute him or her according to your cultural norms.
4. Ask questions related to the conversations.
5. Give proper attention upon what other person are saying. If you did not understand what conveyer had given you message, request him or her to repeat same things again. If you feel comfortable, go ahead during interaction.
6. Not to terminate interaction accidently. Before terminating conversation, give explanation to him or her about to terminate. For example, well, I had to go rehabilitation center for work or I had to go library. I had to attend social skills training session.
7. Say, thanks, and goodbye.

Like above steps of social skills, the specific steps were followed for conversation skill. In teaching the skills, specific situations were given that was to be taught through role play and corrective feedback.

Structural Description

The specific situations were demonstrated before the patients. On the basis of above steps, developed by the authors, patients were facilitated to engage in the real life situations as recreational (game sessions), live events organized by the hospital administration like patient's picnic day, annual sports day, independence and republic day celebration, foundation day celebration, ongoing Indian festivals (Durgapuja, Deepawali, Holi) so that their social engagement could be improved. This was the ongoing process over a period of intervention. During the session patients felt comfortable and talked to other members. It was arranged with the help of ward nurses, and other staffs of the hospital.

Observation: It was observed whenever patients were involved in the real life events, they felt happiness. During sport day, they also tried to compete with others and won the game and receive some gifts from the organizer committee.

Besides this, participants were regularly sending at rehabilitation center where they were asked to converse work supervisor. Patients were introduced with work supervisor.

Observation: It was observed that three patients were interacting well according to instructions given to them but two patients were not taking much interest (looking down, speak few words) during interaction with work supervisor. Again these two patients were tried to inculcate the things, they

were to maintain during interaction. After clarification, their interaction was improving gradually. Patients were kept under observation in the working hour at rehabilitation center. And on the basis of shortcoming, again they were continuing clarified in the next session.

Textural-Structural Description

The role play tests of simulated social interaction made enable to patients about to initiate conversation. The patient converses with others in a socially appropriate, skilled manner with good eye contact and voice loudness. Frequently, patients started maintaining appropriate distance during interaction and sustaining it for up to 8-10 minutes. Patients performed their role adequately when evaluated at the end six months. They often, maintained eye contact and adequate social distance during social interactions; started expressing positive and negative feeling adequately after six of the intervention. Besides this, clinical patients used to ask for help positively and easily started communication with treatment team by asking question related to health also. Now they were not hesitating to share their problem with treatment team.

Listening Skills: Becoming Active Listeners

Textural Description

In the 12th, 13th, and 14th sessions, patients were assisted to instill a social skill “*Listening to others*” through role play demonstration. The scene to use in the role plays was “*listening to ward nurse who had been talking about daily activities.*” For this, patients were allocated different role as one person (Mr. W.) would take the role of ward nurse, and remaining persons listened the things conveyed by the ward nurse (Mr. W.). The nurse explained the activity schedule which was to be followed by patients in the ward. First, the therapist demonstrated the role play before the group members and explained the things they were to be followed. The treatment session was as:

Therapist: Mr. W., did you able to play your role?

Mr. W.: Nodding head only,

Therapist: Mr. W., did you able to speak on activity schedules in the ward?

Mr. W.: Yes (Very slowly), Good morning, (with folded hand). Now, I would explain them about daily routine that will be carried out in the ward -----
(Not spoken further)

Therapist: What Mr. W. wanted to say; he wanted to introduced group that what we have to do daily in the ward. Is it right, Mr. W.?

Mr. W.: (Very slow), yes. Please, listen carefully. We had to awake 6’O clock in the morning; became fresh, brush your teeth and do daily bath; then took breakfast and medicine; -----(not spoken further).

Therapist: Very good, Mr. W. He had explained lot of things. One clapping for him (patients made clapping for him. Little bit smile on the face of Mr. W.). Mr. W. can you complete your sentence? You can do it; you have a potential, do it without hesitation.

Therapist observation: All of the patients involved in the clapping but no smiling on face except Mr. W.

Mr. W.: We had to attend group meeting from 9:30 AM. -10:30AM.; then after we shall have to go for work at the rehabilitation center, and return to ward at 12:30PM-1PM. for lunch.

Observation: One of the patients was looking down, another one was taking nap and two patients were listening things. It was told the patient who was looking down, you came and stand along with Mr. W. He did it. Those who were taking nap told him to drink water and walk for 2 minute and then after attend the session.

Mr. W.: We will go on bed after lunch; at 3:00PM go to library and read some books or paper according to interest; -----(Not spoken further).

Observation: All of the patients were listening things, what Mr. W. narrated. Mr. Wakil was feeling tiredness and said it was enough for today.

Therapist: Can I complete the remaining things, what Mr. Wakil had left it?

Patients: (Simultaneously), Yes,

Therapist: You will stay at library till 5.00PM and you would get your tea break there and after that return to the ward and do some enjoyable activities. By 7:00PM took dinner and medicine and finally go for sleep. Now was it Okay?

Patients: Yes. What should we do, now?

Therapist: You people tell us, where to go? We had discussed here. Anybody can speak except Mr. W. Try to recall the things.

Mr. N.: Now, we should go to rehabilitation centre for respective work.

Therapist: Can we have one clapping for Mr. N.?

Observation: All of the patients make sound clapping for Mr. N., (smiling on face). Mr. W. was standing, had a little bit smile on face and remaining patient had just made clapping without smiling.

Structural Description

The structural description of the session was to infuse listening skill to the patients in the group, called as participatory group. Participatory group meant to say that group participants were given equal opportunities to express their views through play role to a specific situation given to them as “*listening to ward sister who had been talking about daily activities.*” The proper role allocation provided patient an opportunity to express their skills before the group and therapist. One of the patients was given the role of narrator who tried his level best to explain about the daily routine to the group. In meantime of the session, narrator did not speak further. While making his confidence high, he again started to speak on daily routine and completed it with the help of therapist.

In the mean time of the session, it was observed that one of the patients was taking nap and another patient was looking down. The problematic experiences of the patients were taken into account, by motivating them to attend the session with paying attention on what was tried to inculcate in you. The work assignment given to patients did it in real life situations. The given situations reviewed in the next repeated session, clarified and provided feedback to them. The work assignment was in the form of role plays such as:

- a) Listening to Ward nurses who had been talking about the rules of the ward; and
- b) Listening to supervisor telling you about work activities at rehabilitation center.

Textural-Structural Description

In this session, patients were facilitated to participate in the skill “listening to others.” Usually, patients were sending along with ward attendant at their respective work sites. Participatory role play was demonstrated before the patients about how they would utilize their day to day life. This session was structured for the patients to comprehend the things narrated to him, analyze it and ultimately use their competency as an active listener. It is usually noticed that schizophrenic patients did not able to comprehend the things adequately and did not take interest in ongoing interaction, even after much effort taken by the therapist. They either respond only few things or become mute, and finally abandoned talk. It may lead to blocking of interaction. The focus of this participatory session was to involve patients in such a way that they could not realize uncomfortable during interaction process. Their confidence level was always tried to boost up. For example, whenever patients leave sentences without completing it, therapist tried to boost their confidence by saying as “*You may now have a potential to do it; do it without hesitation.*”

In addition to this, making sound clapping for the patients and involving patients in some recreational activities were the ongoing processes of the sessions. Here, in this participatory session listening skill was inculcated through explaining the daily routine activities which were to be followed in the ward. It also covered about to maintaining personal hygiene like becoming fresh, brushing teeth, bathing and changing clothes.

Making Requests: Skill to Ask for Help Politely

Textural Description

In the *session 15th, 16th, and 17th*, a social skill “*Making request*” provided to the patients. Scene to be used in the role play: “*You demanded clothes from ward sister after bath.*” In India, ward sister is called as sister. In this session, the relevance of making request was tried to inculcate among patients.

Therapist: Well, suppose you (patients) had bath but did not have clothes to wear. Wrapped small wet towel around waist, you had to demand clothes to ward nurse. For this, it was demonstrated different roles before the patients. The role allocated to them as Mr. S. (make request); Mr. P. (ward nurse or sister who would listen the request); and remaining patients had carefully observed the role play.

Mr. S. (Making request for Clothes): With folded arms. Good morning sister (Mr. P.).

Mr. P. (Ward nurse or sister, would listen the request): Good morning. How were you?

Mr. S.: (With folded hand) I am fine. Sister, I did not have extra clothes to wear after bath. I just took bath, so please, give me clothes.

Mr. P.: Well, come along with me. But keep in mind; you had to keep cloths safe. Clean your clothes daily and if need arise you can demand extra clothes without hesitation.

Mr. S.: All right sister. Thank you, sister.

Therapist: How this role play would help to *role plays observers* (Mr. B., Mr. W., & Mr. N.)?

Mr. B.: (Became stand). I would use it in my daily routine.

Mr. W.: I will use it in ward and at workplace.

Mr. S.: I shall also use it in daily life.

Observation: Patients made a sound clapping and shown smile. Roles play observers were carefully observing each step of skill. They maintained eye contact with role player and sometimes with therapist and felt comfortable.

Structural Description

A “request making skill” instilled to the participants in the group, by giving role “about demand clothes from ward sister after bath.” The patient's interactions with others are well mannered and polite. Even in emotionally charged situations they usually conduct themselves in a thoughtful and considerate fashion. The patient shows appropriate respect and concern for others' feelings in his interactions, even during emotionally charged conflicts.

Textural-Structural Description

Ward sister had tried to mould the patients about to shows appropriate respects and concerns for other's feelings in his interaction, even during difficult situations. She had influenced them about to keep clothes neat and clean. Furthermore, she motivated to patients that “*you could demand extra clothes without hesitation.*” It is usually happened with the patients that their voices were declined by others. Often, staff members did not give importance to them, even in ward. However, it is the bitter facts that voices of the psychiatric patients were not taken into the account. We can make the patients as competent as others in all aspects. The main emphasis of this session was to inculcate skill to the patients so that they became stronger, independent and boost their confidence level irrespective of the circumstances. The work assignment provided them, reviewed in the next session. The situations used in role play are

- a) Seek permission from supervisor to go outside from the rehabilitation center;
- b) You want to have television in the dining room.

Expressing Negative Feelings without Arguments with Others

Textural Description

In the *session 18th, 19th, and 20th*, patients were demonstrated to “expressing negative feeling” through scene to be used in the role play: “*Your room mate left dirty clothes in the living room.*”

Therapist: Suppose your roommate left dirty clothes in the living room and you are very upset about this. How could you resolve like this situation? Each patient was involved to express their view regarding this. The answer of each patient was taken in to consideration.

Mr. S.: I would throw his clothes out.

Mr. P.: I would complain to ward nurses.

Mr. B.: (With angry), I would tell him that took away your clothes from this room. It smelled very bad.

Mr. N.: No response.

Mr. W.: There were still dirty clothes in my room. Nobody was bothered to keep it aside.

Therapist: We would play different roles and performed it: Mr. N. (complaint); Mr. B. (left dirty clothes in the room); Mr. W. (ward nurse or sister who would listen the problem); and remaining patients shall carefully observe the role play. We can solve this problem in two ways either complaint must talk directly and politely to those who left dirty clothes in the room or complain to ward nurse (in India ward nurse is called as sister).

Mr. N. (Complaint): (With folded arm), Mr. B. your clothes smelled very badly, you must either clean or gives it to laundry.

Mr. B. (left dirty clothes in the room). Ok, when laundry man would come I would give him for clean.

Observation: Both of the patients were speaking politely but in slow speech. Two patients who were observing the role play was looking at each steps.

Therapist: You can also solve this problem by complaining to ward nurse.

Mr. N. (Complaint): With folded arm, good morning sister (Mr. W. playing the role of Nurse). Mr. B. had kept dirty clothes in the room. It smelled very bad. Please do your level best to keep clothes out of room.

Mr. W. (Ward nurse or sister): Well, called to Mr. B.

Mr. B.: Yes sister.

Mr. W.: Mr. N. had complained against you about leaving dirty clothes in the room.

Mr. B.: Sister, I had kept it in a corner of the room.

Mr. W.: Where should we keep dirty clothes?

Mr. B.: Sister, we should give it to laundry for clean. I am going to give dirty clothes to laundry.

Mr. W.: We should not spread dirty things around us. It leads to infections; we must maintain hygiene situation in the room.

Mr. B.: Sorry sister, I would not repeat such mistakes from now.

Structural Description

In present session, patients were facilitated to express unpleasant feeling toward others. Participants tried to explore the possible answer of question as “*Your room mate left dirty clothes in the living room*” in the group. The possible solution of the group was as “I would throw clothes out.” Another patient verbatim was “I would tell him that took away your bad smelling clothes from this room.” Furthermore, another patient was very upset by saying “*there were still dirty clothes in my room. Nobody was bothered to keep it aside.*”

During observation, patients express their feeling politely but in slow speech, appeared that they have low self confidence in expressing things. Complaint (Mr. N) in this session expresses his feeling toward nurse (Mr. W) with folded hand against Mr. B. who scattered dirty clothes in the living room. Here ward nurse tried to facilitate the patients about to inculcate what were disadvantages of scattering dirty clothes inside living room. The same situations of the role play were

- a) A psychiatrist did not attend you when you approached;
- b) Ward nurses did not respond you when you demanded new clothes while bathing.

The same role plays were reviewed in the next session.

Textural-Structural Description

The patients comprehended the hospital social order and roles and are able to ask for specific services from appropriate staff members in a socially skillful manner. They regularly accomplished the goals daily routine. The patient did not shows inappropriate regard for others' feelings, (e.g., during a conflict) during the course of skills training. When prompted, the patient can demonstrate more appropriate respect. When the patient is given feedback about his behavior, much more improvements are possible. The patients became aware of how others may feel about what they say. The patients both initiate social interactions with others on a regular basis and is responsive to interactions initiated by others. Social interactions are extended to longer periods of time as more than 8-10 minutes. It has been the major achievement of the social skills program.

Problem Solving Skills: Enabling Participants to Sort out Problematic Experiences

Problems are part of everyday life. People usually find themselves confronted by difficult situations. A situation became a problem if the individuals have no effective coping response immediately available to handle it. When participants success in problem solving, their self efficacy is increased.

Textural Description

In the 21st, 22nd, and 23rd sessions, it was strived to provide “*Problem solving skills*” to the participants. Equipping participants with problem solving skills assists them to think through situations and plan the steps to take rather than responding solely based on their emotions, feelings, or instincts.

Therapist: Well, were you able to execute skills in their daily activities, learned in the past sessions?

Patients: Skills inculcated to us, we employed in the ward, at work sites and library. Now, we did not have fear from Doctor.

Therapist: You, Mr. P., what happened to you? Why were you unhappy?

Mr. P.: Today's, one of the patients had poured down my tea.

Therapist: Then, what you did?

Mr. P.: Initially, I thought, I should beat him but just, I thought that I must ask him, why he had poured down my tea?

I told him, say sorry for that. (Irritated voice)

Then he replied, pardon me; I committed mistake. Then, I did hug him.

Therapist: Who had seen this incident? Whether Mr. P. did it?

Mr. B. and Other patients: (Simultaneously), Mr. P. had done this.

Therapist: One clapping for Mr. P.

Patients: (Those who present there). Patients made a sound clapping.

Observation: Patients were listening to things carefully with maintaining eye contact. Other patients had also appreciated Mr. P. for such a nice solution. It was smiling upon patient's face.

Therapist: Today, we were to learn how to solve a problem as Mr. P. had solved it.

The scene was used in the role play: “*Suppose you (son) want to go market to purchase clothes. Just your mother came and told, today we will go to relative's home and*

you have to be with me."For this, we had to play a role: Mr. W. (play a role of son); & Mr. N. (play role of Mother) and remaining patients will become an observers.

Mr. W. (play role of son): Today, I was planning to go market to purchase clothes.

Mr. N. (play role of mother). No, today we will go to grandmother's house.

Mr. W.: No mother, I would go to market.

Mr. N.: No my son, grandmother was very ill and sick. Hence, we should go to see her condition.

Mr. W.: Mother, was it very essential?

Mr. N.: What did you think?

Mr. W.: We must go to grandmother's house.

Mr. N.: Nice son

Therapist: It meant, those work which was more significant, we must give priority. A clapping should be made for both role players as well as for observers.

Patients: (Simultaneously), patients made sound clapping with smile on face.

Observation: Both of the patients Mr. W. & Mr. N. had played respective role of son and mother nicely. The observers were watching each step carefully.

Structural Description

Effective Problem solving strategies should a part of everyone's program for sobriety. A great effort provided to participants has shown effectiveness in sorting out daily problem. There are following steps were followed to introduce problem solving skills to the participants:

1. Identification of the problematic experiences.
2. Creation of possible alternative solutions to the problem (*brainstorming*).
3. Evaluation of its pros and cons of each alternative solution according to your immediate requirement.
4. Choose one best alternative solution
5. Implementation of the best chosen possible solution.
6. Evaluation of effectiveness of the implemented solution.
7. Review progress towards solving the goal and do additional problem solving if required.

In brainstorming participants note down as many possible solutions as they can think of without judging or eliminating options. They became enable to generate possible solutions for the specific problem and were implementing in their daily life. The homework assignment reviewed in the next repeated sessions:

- a) Your doctor told you that you would have to stay in the hospital for another two months;
- b) You and ward nurses had different opinions about what type of cloths you need.

Textural-Structural Description

In beginning of the sessions, one of the patients Mr. P. had narrated how he did try to resolve the problematic experiences as “pouring down of tea by one of the fellow members of the patient.” He had generated possible best alternative solution as “either should I beat him or finding reasons (why fellow member had poured down my tea?)” And he became successful in resolving problem without any argument with him. His fellow members also cooperated with him by “saying sorry and accepted the mistake” done by him.

A wide variety of different problems and goals were addressed at this stage of the treatment. For example, ward activities, dealing with problematic, looking for job at work site and kitchen are all problems which have been resolved or achieved through problem solving skills in the course of treatment. This study shown that structured and participatory session have been major impact in instilling the things among the patients, which are not possible only through face to face interaction. They show significant improvement in the areas of resolution of conflicts without argument.

Health Maintenance Skills: Cooperation with Treatment

This session was devoted to make competent participants ask health related questions to treatment team. They should understand the benefits and risks of the treatment.

Textural Description

In the 24th, 25th, and 26th sessions, health maintenance skill was inculcated among patients through demonstrating a particular role play: “*You are having problem in sleeping and ask your doctor if he or she can prescribe any medication to help.*”

Therapist: Patients had to play a role: Mr. S. (doctor), Mr. N. (Patient), Mr. W. (psychiatric social worker) and remaining patients would keep observing the situations.

Mr. N. (Play the role of Patient): (With folded arm). Good morning, doctor.

Mr. S. (Play the role of Doctor): Very good morning, How are you?

Mr. N.: I am in problem. I could not sleep at night. Can you help me?

Mr. S.: Yes, I would help you. You are being given prescribed medicines. Now, I cannot increase your doses. Why were you not sleeping at night?

Mr. N.: There are different thought comes in my mind. It disturbed me, which lead to unpleasant feeling.

Mr. S.: I will be referring you to Psychiatric social worker and narrate your problem to him.

Mr. N.: (With folded hand), May I come in sir?

Mr. W. (Played a role of Psychiatric social worker): Come in, sat down. How were you?

Mr. N.: I will not be feeling well. I could not sleep at night; multiple of irrational feeling came in mind.

Mr. W.: Do not think so, that disturbed you. Try to distract yourself from such irrational thoughts. Take deep breathing and deep breath out for 30 minutes whenever such thought comes and also do backward counting from hundred. You must also share your problem to fellow members, which release most of problematic experiences.

Observation: Patients were playing their respective role as confident as not earlier. The role play observer were very quiet and listening the thing properly with maintaining eye contact. The role players had performed their role adequately.

Therapist: How this role play would help to role play observers (Mr. B., & Mr. P.)?

Mr. B.: Now, I will be discussing each problem to doctor.

Mr. P.: I would share my problem to ward sister and doctor.

Therapist: You should also share your problems to doctor and other mental health professionals such as psychiatric social worker, clinical psychologist, psychiatrist and psychiatric nurses.

Structural Description

Patients have been encouraged to manage one's health care. It was given emphasis about an understanding of their illness and the medication that they are taking. The focus of the session was to make patients competent so that they could ask questions about health related concerns and also complaining about medication side effects and reporting pain and other physical symptoms. The patients fully cooperated with the treatment program. They understand the benefits and the risks of the treatment, and are active participants in their treatment (e.g., they requested to change medicines, discussing their problem to mental health professionals). They became enable to report adverse effects from medication doctor. They usually accepted the suggestions provided to them.

Textural-Structural Description

It is also crucial to understand why a doctor has prescribed a certain medication for us and how to take that medication properly. It is equally important to feel that the medication is being helpful. When participants have questions about the medications they are taking, they consulted to the psychiatrist and tried to explore the importance of medications, and its side effects. Since, not every medicine is perfect. Each medication comes with side effects, some more severe than others, and everyone responds to medication differently. A medication that causes little to no side effects in one person may cause severe side effects in another. Results showed considerable gains in information stipulated in the health maintenance skills and relatively high level of skill attainment among patients. Work assignment performed before the doctor, supervised by the therapist. The situations given to the patients were:

- a) *You noticed that you have been gaining weight since intake of medications and want to talk to the doctor about it*
- b) *Your psychiatrist/physician just changed your medication dose, and you want to know how it will affect you.* The work assignment was reviewed in the next repeated sessions.

Reviewing of the Overall Sessions

Textural Description

In the *session 27th and 28th*, overall sessions were reviewed about what were taught in the past sessions?

Therapist: We had learned lot of things in the past multiple of sessions and also did work at rehabilitation center. Now, it was necessary to terminate sessions because what we had planned, had been achieved. We would terminate social skills training in the next session. But you continuously would go to occupational therapy department for their respective work. Had we achieved our target? What we had learned in last six months?

Patients: (Simultaneously), we had learned bunch of things about schizophrenia, its factors, recovery process, and skills. Initially, we had a hesitation to talk with others, now we can confront anyone, even then can talk to hospital director. We had also enjoyed different role play assigned to us.

Therapist: Would you sustain these skills in their day to day life?

Patients: (Simultaneously), Yes. We, use it at work site, ward and library.

Therapist: You must appreciate other's performance and designed such a skills program at ward for other patients also.

Observation: Patients were very cheerful. The smiling was on their face. All of the patients were participated.

Structural Description

The last session devoted for reviewing overall sessions. Here participants were informed that it was the last session and whatsoever, goal was planned, it had been achieved. Now, patients became so competent and strong psychologically, even to put any questions and reply any questions to others. Participants became enabling also to design such a skills program for other patients in the ward according to their level best.

Textural-Structural Description

The last twenty eighth sessions was reviewed from beginning. It was inculcated among the patients that although, it was the last session of the social skills training but it would be continuing as you would be regularly go to rehabilitation center for their respective works. They had sustained social skills in their day to day life.

Composite Textural-Structural Description

It is the universal description of the experiences representing the group as a whole. Social skills' training has been employed to improve the social skills and psychosocial functioning for persons with schizophrenia. Patients were instilled social skills through role play along with corrective feedback and psycho-education in the subsequent sessions. An analysis of the participant's description of their experiences revealed the experiences as a thematic structure composed of lacking of social skills in multiple of areas bathing, dressing, and grooming; initiation, maintenance and termination of conversation skills; making request, listening to others, expressing negative feeling; problem solving and health maintenance skills. Analysis of the participant's descriptions defined the following substructure as those which contributed to the process of social skills training impacting the level of patients' engagement:

Amplification of Prejudice and Stigma

Schizophrenia patients struggled early on with a perception of not being capable of meeting the expected role in the ward. They were not able to maximize social expectation. In

the first two sessions, participants explored about the relevance of social skills training in their daily live. Participants identified that they are being labeled by society as incapable people, not fulfilling the role allocated to them. This attributed them to become more vulnerable. This perception of the people led them negative evaluation of the person as tainted or discredited on the basis of attributes such as mental illness, drug misuse, racial or physical disability (Goffman, 1963). Although, it is generally known that persons with schizophrenia may behave abnormally during the acute phase of their illness, is not occurred always, when patients in remission or complete recovery. This abnormal behavior may cause them to be labeled as *unstable, violent, unpredictable, strange, incompetent or unproductive*. What was relevant in the Indian context, the public perceptions that persons with mental illness may cause harm erratically to others.

Prejudice is to be considered as the conformity with negative stereotypes to whom were being prejudiced (“it is right that people with psychiatric illness are incompetent or unproductive!”) which leads to an emotional reaction (“I realized that all the incompetent mentally ill persons are useless!”) Discrimination is the behavioral consequences of the prejudice (Crocker, Major, & Steele, 1998), for example, I tried to avoid incompetent psychiatric patients because they are useless.

For example, one of the family members shared to me that “*mentally ill persons should not have right to live in the community as their behavior was unpredictable, may create trouble for the family members or neighbors. So, they should be abandoned in the mental hospital.*” This reflected that public remains largely uninformed about the prognosis and courses of schizophrenia and they considered persons with mental illness lose their mind permanently. It is not the truth that patients with mental illness may lose their mind completely. They can live their life in the community if provided immense love, care and support to them. It is universally accepted opinion by the scientific community that if persons with mentally ill given chances to maximize their competence building, their recovery became fast. It would not be beneficial only to patients and their family but create productivity to the Nation’s exchequer and also reduces the burden on hospitals. Literature suggested that schizophrenic patients frequently realized stigma due to societal reaction, which accordingly decreased their quality of life (Kumar et al., 2012). It highlighted that the persons with schizophrenia must instill strength and dignity of their self through the social skills training so that they could live their life in the community without self stigma and fear. Therefore recovery can be defined as “*Recovery is a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness...*” (Anthony, 1993, p. 11).

Managing Illness to Reduce Frequent Relapse

A further factor associated to the treatment of schizophrenia is negative impact on the patient’s interpersonal relationships are side effects of prescribed medicines as extra pyramidal symptoms, gaining weight, and continuing salivation. Adequate psychosocial treatment involving participants in treatment to enjoy its benefits, should involve holistic plan for treatment and rehabilitation, taking account of the problematic experiences of schizophrenic patients often face inside and outside of the psychiatric institutes, in their daily lives. The comprehensive health maintenance skills made them competent to discuss their problem with mental health professionals. Results on all measures of medication compliance showed significant gains in adherence to medications. Patients became competent to ask

health related questions and also complaining about side effects of the medicines to treating doctor.

Problem Solving Proficiency

Problem solving skill narrated by Mr. P. has been greatly benefitted to other patients also. The way, he tried to resolve the problematic experience as “*pouring down of tea by one of the fellow members of the patient*” was interesting. For instances, initially, patient think about to beat fellow member, who poured down his morning tea; in the mean time, he tried to explore the reason, why such fellow did so. The steps of problem solving skill often patients followed it, has been delineated in the participatory group activities. They became able to consider multiple of possible solutions to a problem. It was noticed in the beginning of intervention sessions that although patient was competent to explore possible alternative solutions, became unable to implement it because they were not looking each alternative solutions in its own context of pros and cons, giving equal weigh to all possible solutions. It had improved gradually by providing them opportunity to face real life situations during the course of treatment.

Capacity Building: Increasing Competency of the Patients

It was apparent that at baseline assessment patients usually did not take interest in work allocated to them; and spending their time either sitting alone or wander here and there. It has been the grand outcome of this study that the uses of role play in the skills training made patients enable about to improve their relationship with fellow members regularly participated in group meeting and maintain their personal hygiene, became more efficient in handling these issues easily. They bring drastic changes in maintaining daily routine care, wearing appropriate dress, combing hairs, and maintaining appropriate distance. An observation being made by work supervisor stated that patients became enabling to maintain attendance regularly, improved quality of work, making interaction even with strange person. Although, there was not much improvement was noticed in their appearance, sometimes worn dirty clothes but when reminded about this, they changed their clothes. Ward nurses also keep observing to the patients delineated that they maintaining personal hygiene and daily routine care; politely requested for help if any need arise and started sharing problem to treating team.

Sustaining Interaction: Maintaining Hope and Positive Expectation

Regarding conversation skills and expressing positive feeling, the present study indicated the significant improvement at baseline-6months. It signified that the patients became enabling to initiates and maintains conversation for longer periods (8-10 minutes) and also able to express positive feeling to others; asking questions with treatment team about medication, side effects of medicine, and ask for help politely. Goldsmith and McFall (1975) found that in a 5-minute conversation with a male stranger, trained patients were rated significantly higher in skill and comfort; in addition, the trained patients successfully completed more tasks than the other patients.

Impacting on Positive and Negative Symptoms of the Patients

One of patients were realizing auditory hallucination,complained that they heard voices talking with one another but what was being talking it is not clear to them. Patient

verbatim “*voices did not disturb me, I went rehabilitation center and work there; did work in ward and kitchen, and read books in patient’s library but voices did not hinder me in carrying out daily routine.*” It is clear from the above statements that despite being of auditory hallucination, patient does his daily routine. This study indicated that there was no significant improvement in the domain of auditory hallucination of positive symptoms during the course of intervention. What was the level of auditory hallucination at baseline; it was same at the end of six months. What we referred it as an “***encapsulated auditory hallucination.***”

Regarding delusion, one of the patients complained about persecutory and somatic delusion at baseline. Patient’s verbatim that “*I realized that someone was trying to harm me, and also conspired against me.* One another patient stated that “*Usually, I felt that rod has been placed in my leg that is why I could not stand properly as normal individual.*” The delusions of the patient were tried to minimize by providing psycho-education together with social skills training in the subsequent sessions.

Patient: I am saying that rod had been placed in one of my leg. You are not taking my problem genuinely.

Observation: The patient realized resistant that it is the rod has been placed in his legs.

Therapist: Multiple of medical reports indicated that there is no rod present inside your leg. It is your false belief about that. One should not consider in that way. Think on rational basis.

In Psycho-educational session, patient was given extra booster session to comprehensive inculcation of rational thought that your legs did not have fractured or there is no operative (surgical) sign on legs, then how could you say that rod has been placed in the legs. You must try to stand as normal person do it and did not bring in mind that if you stand, it would give pain to your leg. The false belief impregnated in the mind of the patient remain intact for the first three months of the intervention, as there was no improvement in the thought process during that period. Patient realized improvement during the evaluation at end of the treatment.

Regarding persecutory ideas, patient was tried to facilitate that what was thinking it is not appropriate and it was his irrational thought.

Therapist: The colleague to whom, you were blaming, he is your best friends, helped to you when need arise, provide clothes and also assist you in maintain daily routine care. The false believe you hold was not correct. In both cases, patients noticed improvement at the end of the treatment.

Negative Symptoms

The present study indicated that there was significant improvement found at end of six months of social skills training. Their emotional expression was as normal as expected. Sat comfortably and used his hand and other body part as an aid in expressing his ideas during social skills sessions. They started taking active role during conversation and speak coherently for longer time while maintaining eye contact. As for as possible, they were able to give answer to the questions except in few cases. Their personal hygiene gradually improved, bathing daily, changing clothes, pay attention to grooming and hygiene as expected. Maintaining daily routine care, to wash their clothes, bath daily, care for hair, and clean teeth. The live experiences of the patients made them enable to face even difficult situation adequately. Now, they did not have hesitation to start interaction with others and

making friendship. Provided opportunities to take active part in recreational activities led patients to enhance their social engagement with others.

This study stated that there were significant improvements in the negative and positive symptoms except auditory hallucination in one of the patients, during the course of social treatment. A research indicated that patients experienced a significantly larger improvement in both negative and positive symptoms through the integrated treatment along with social skills training (Thorupa et al., 2005). Negative symptoms influence the patients' abilities to maintain their social functioning and to create social networks (Macdonald, Hayes, & Baglioni, 2000), since aspects like asociality, anhedonia and apathy all contribute to isolation and introvert behaviour. Social skills training have been a significant effect on a cluster of negative symptoms, including poor rapport, social avoidance, poor flow of conversation, and emotional withdrawal (Dobson, McDougall, Blusheiken, & Aldous, 1995), moderate average effect size on improving negative symptoms, which are strongly associated with impaired psychosocial functioning in schizophrenia (Mueser, Bellack, Morrison, & Wixted, 1990; Sayers, Curran, & Mueser, 1996).

Figure 3. Patient's Evaluation in Social Functioning on Social Adaptive Functioning Evaluation (SAFE) during the Course of Treatment.

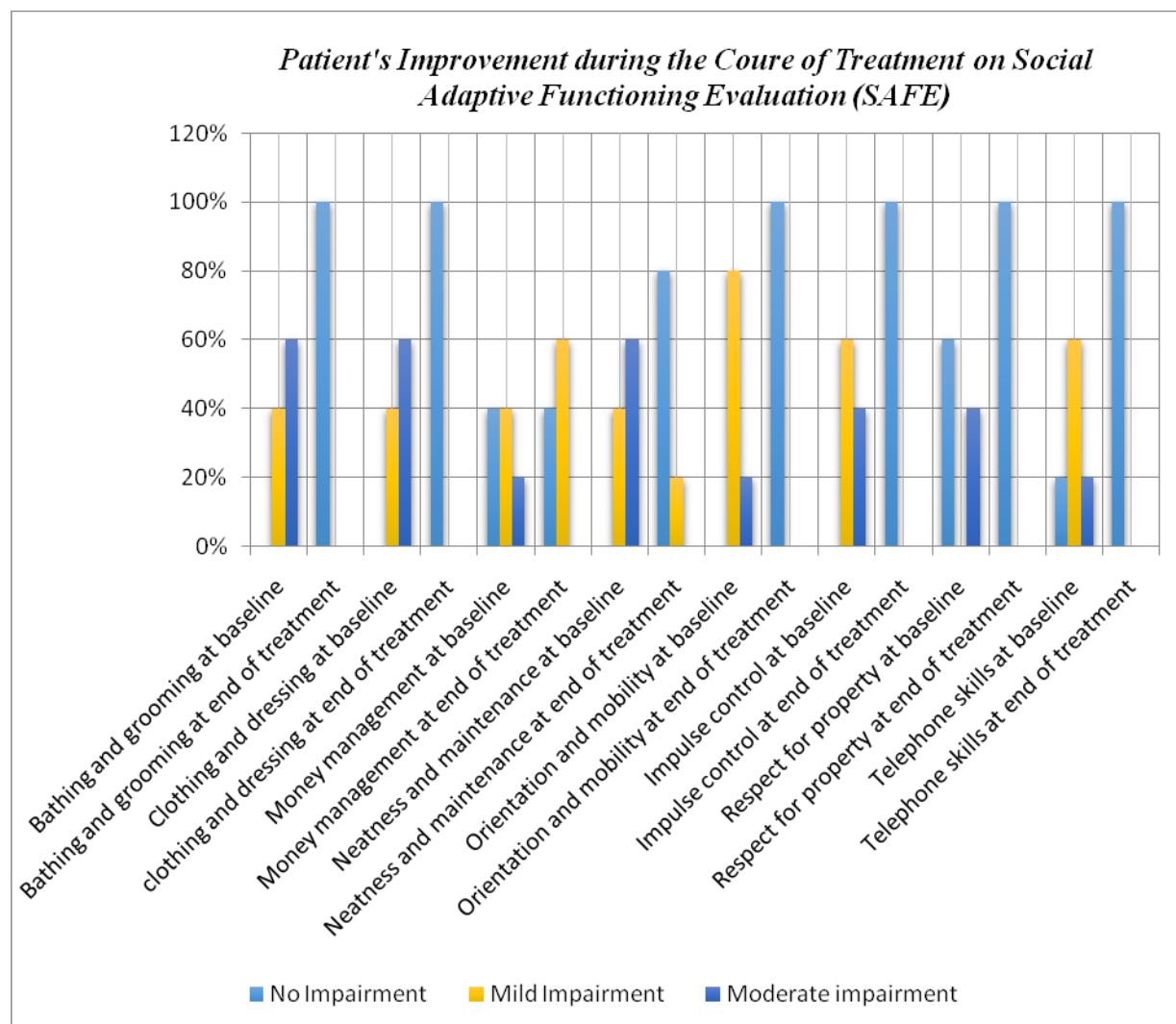
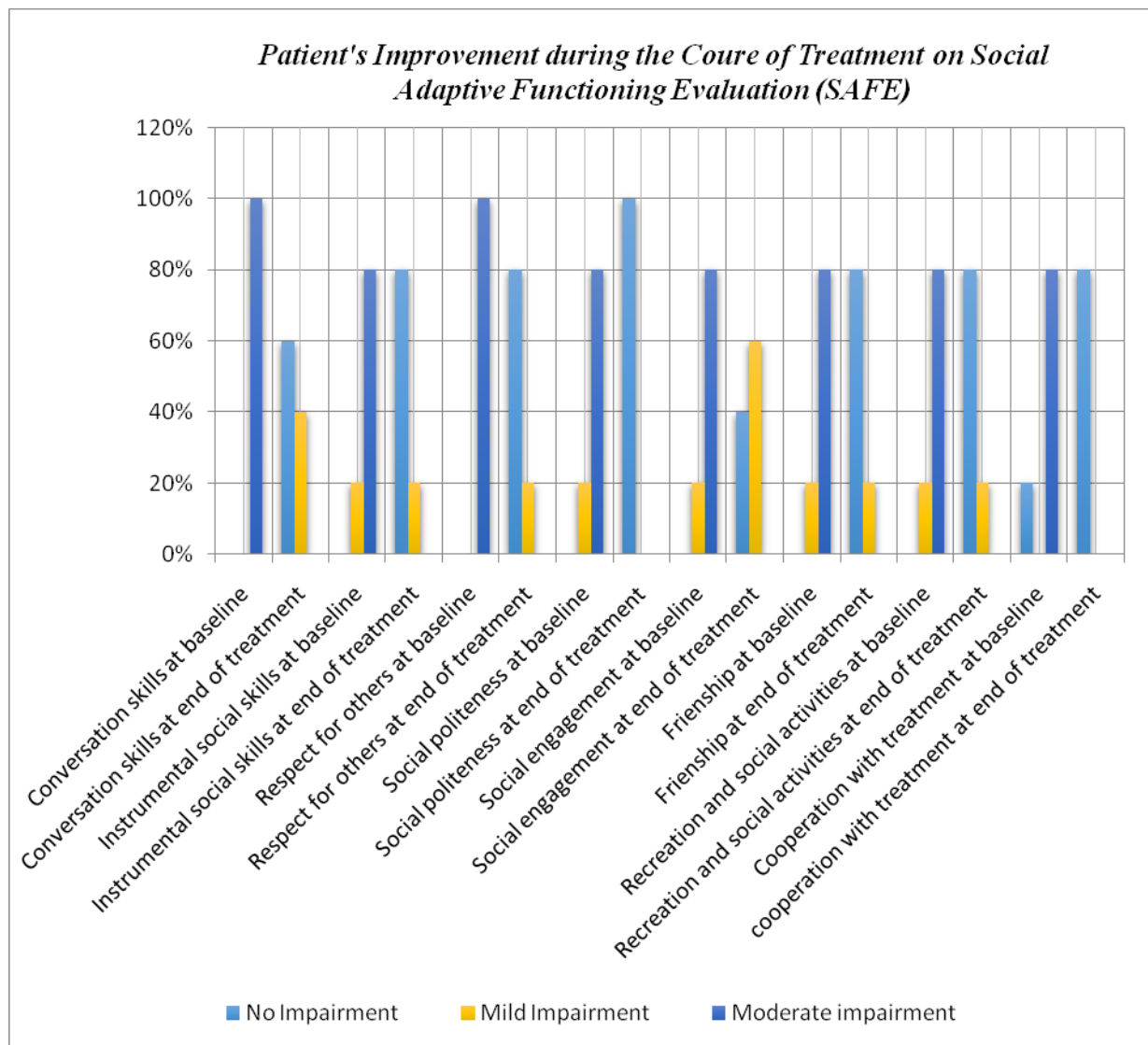


Figure 3.1 Patient’s Evaluation in Social Functioning on Social Adaptive Functioning Evaluation (SAFE) during the Course of Treatment.



Discussion

Schizophrenia is foremost public health crisis which claims massive personal, social, psychological and economic costs worldwide. It meant to affect individual self, socially, psychologically, and financially. It does not leave an aggrieved individual to spend their remaining life with dignity in the community, due to various allegations labeled to them by the society. This overall evaluation of the consequences of alienation which make them social and psychological vulnerable is very disheartening. Social skills have been expressed as those specific response competencies necessary for efficient social performance. The overall effectiveness of social skills training program and its result can be comprehended through examining each session together with Figure 3 & 3.1.

The current study attempted to establish how multiple of skills deficit can be corrected with comprehensive social skills training for the person with chronic schizophrenia. It is the known facts that social dysfunction is a core of the schizophrenia patients. They hardly involved in the social activities such as interactions with others, making eye contact, expressing their positive and negative feeling, requesting for help. They became unable to

deal with the day to day life and it is believed to be source of stress among patients, it might lead to relapse and poor quality of life (Addington, Penn, Woods, Addington, & Perkins, 2008). It is utmost necessary to inculcate social skills together with real life exposure. Result support the notion that different skills techniques employed with this study had shown effective in enhancing the psychosocial functioning for the persons with schizophrenia. There are marked improvements in psychosocial functioning among the patients even persistence of auditory hallucination in one of the patients.

Social Adaptive Functioning

Participatory group interaction had facilitated patients about to explore rationale for social skills training. In first two sessions, they tried to investigate in depth about the relevance of skills in the life of an individual. The revelation of basic social skills to the patients made them a habit to use the basic things such as clothes, comb, oil, and others basic requirement. It sustained over a period of 18 months after completing the social skill program. Educational sessions rendered to inculcate information about psychiatric illness, importance of personal hygiene and stress vulnerability model of schizophrenia. A very interactive style of intervention enabled patients to make a holistic understanding about their illness. It boosted recovery process of the patients on decreasing symptoms and preventing relapse. A study conducted by Kopelowicz, Wallace, and Zarate (1998) found that patients who received basic information about schizophrenia and its treatment, developing after care plan, dealing with stress learn more of the targeted information and social skills than who received occupational therapy. Social skills training showed better independent skills and lower the levels of distress in schizophrenic patients with persistent symptoms (Lieberman et al., 1998).

Over a period of 6 months of social treatment, they were in better position to manage his wealth, became competent in taking care of personal possessions, making friendship and engaging in social activities, making simple addition and subtraction. Literature suggested that social skills training conducted for 6 months had shown significant improvement in personal possessions, more skilled food preparation, and improved money management for schizophrenia patients that were sustained up to 18 months after completing the intervention (Lieberman et al., 1998). The sheer enjoyment of experiencing the social and game activities maintained participant's attention rather than a winning condition. By this means, they move from one psychological state to another or to imagine or feel something different which awakened a sense of curiosity. The study conducted by Lazzaro (2004) stated that playing game provides soothing effect on the individual's mind. It changes the internal state of the individuals during and after play. Playing games inspires creativity in the development and application of strategies. It rewards the player with feedback on progress and success (Ekman, 2003).

Social skills training has been largely benefited to patients in the domains of increasing interactions, engaging in social activities, expressing feeling to others. In addition to this, their quality of work improved. Patients had started participated in social activities such as interaction with colleagues, supervisor at worksites, nurses and other staffs of the ward. Thara and Sreenivasan (1998) had found same result as significant improvement in the domains of under activity, social withdrawal, participation in the family, and work performance in patients undergoing vocational rehabilitation. Ajimol (2001) have noted a higher degree of overall functioning and reduced symptoms in rehabilitated patients compared to those not vocationally rehabilitated.

They became efficient to easily communicate with treatment team by asking health related questions. Besides this, they made them enable to express positive and negative

feeling adequately during the course of treatment. The similar result found that patients trained in social skills felt comfortable to initiate conversation and maintain it for up to 8-10 minute and completed more tasks (Goldsmith & McFall, 1975). They also became proficient in resolving the problematic experiences. Research stated that there are significant improvements on the Independent Living Scale specifically for the problem solving on chronic inpatient schizophrenia (Medalia, Revheim, & Casey, 2001). Skills training that target both communication and problem-solving skills in combination yield the most impressive results (Bedell, Hunter, & Corrigan, 1997). Patients receiving social skills training showed greater skill acquisition and generalization, did not realize adjustment problem in the community, and fewer relapses and re-hospitalizations compared to patients receiving holistic health therapy (Wallace & Liberman, 1985). Spaulding, Reed, Sullivan, Richardson, and Weiler (1999) conducted social skills training program on chronic schizophrenia for six months had shown significant improvements in several measures of neuro-cognition, positive symptoms and social skills.

Social skills training provided to chronic schizophrenia have had significant impact on the patient's capacity to work and participate in the ward activities. Social skills approach assists chronic schizophrenia to learn new skills (Tsang & Pearson, 2001). Enhanced independent living skills have been associated with the increase of cognitive functions (Delahunty, Morice, & Frost, 1993; Penades et al., 2003). In addition to this, present study also affirmed that patients became proficient to sort out any problematic situations. They had shown significant improvement in the areas of resolution of conflicts without argument. The problem solving skills has been very effective to resolve problematic experiences among persons with psychiatric illness (Kumar & Singh, 2014).

Social Skills Impacting Positive and Negative Symptoms

Patients had also shown significant improvement negative symptoms such as verbal and non verbal communication and expression of feeling. There is various researches find similar result as Thorupa et al. (2005), stated that patients experienced a larger improvement in both positive and negative symptoms through the integrated treatment along with social skills training. Social skills training have been a significant effect on the negative symptoms, including poor rapport, social avoidance, poor flow of conversation, and emotional withdrawal (Dobson et al., 1995). It had an average effect size on improving negative symptoms, which are strongly associated with impaired psychosocial functioning in schizophrenia (Mueser, Bellack, Morrison, & Wixted, 1990; Sayers, Curran, & Mueser, 1996). Social skills training showed significantly greater improvement at follow up on daily living skills and negative symptoms than the clients who received treatment as usual, but did not differ in positive or other symptoms (Patterson et al., 2003). A narrative review of randomized controlled trials for schizophrenia indicated that there are evidenced that clients learn and retain new social skills and improve social functioning during the course of treatment (Smith, Bellack, & Liberman, 1996).

In conclusion, the results of the study substantiated that social skills training has been very useful in enhancing social functioning of schizophrenic patients. The skills taught were retained over a considerable period of time, without substantial degradation in the skills. Hence, this research stipulated that patients with chronic schizophrenia can learn and execute the basic social skills needed to live independently, learn and work in the given community. It shows the effectiveness of the comprehensive social skills training programs.

Limitations

The limitations of the present study are as follows: the sample size was small; lack of control group; only male chronic schizophrenia was included in the present study. The study is totally hospital based.

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