SOCIAL SKILLS TRAINING

Developed by

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What is social skills training?

Social skills training aims to help individuals with serious and persistent mental disabilities to "perform those physical, emotional, social, vocational, familial, problem-solving, and intellectual skills needed to live, learn and work in the community with the least amount of support from agents of the helping professions" (Anthony, 1979). Social skills training is used to enable individuals to learn specific skills that are missing or those that will compensate for the missing ones.

The basis of social skills training is derived from social learning theory (Bandura, 1969) and operant conditioning (Libeman, 1972), techniques that have been tried and tested effective for the full range of human learning and behavior therapy. In particular, the principles underlying social skills training emphasize the importance of setting clear expectations with specific instructions, coaching the individual through the use of frequent prompts, using modeling or vicarious identification, engaging individuals in role playing or behavioral rehearsal, and offering abundant positive feedback or reinforcement for small improvements in social behavior.

Because generalization or transfer of the skills from the learning or clinical setting to each person's real life is "where the rubber hits the road", trainers give assignments to participants in skills training to practice the skills acquired in the training situation to the home, workplace, community or other natural environment. Social skills training also includes teaching accurate social perception, including the norms, rules and expectations of others with whom the person will be interacting. Being able to recognize reliably the emotional expressions shown by others during social interactions is one example of the social perception goals inherent in social skills training.

The simplicity of such techniques as instructions, coaching, demonstrations, practice and homework assignments belies the challenges of the training process. The cognitive impairments that many people experience who suffer from serious and persistent mental disorders severely constrict their ability to learn, remember, and adapt new skills to their own environment (Liberman, Nuechterlein & Wallace, 1982). To overcome individuals' learning disabilities, the skills to be learned must be presented slowly, repetitively, and consistently. The participants in social skills training should be asked to repeat back what has been presented and to demonstrate in role plays that they have absorbed the material which has been taught. To counteract memory impairments, skills are presented in small chunks punctuated with numerous reviews and frequent positive reinforcement.

In addition to conducting social skills training with individual patients in groups or individually, the same methods have been shown to be useful and highly effective in teaching family members to improve their relationships. This is extremely important because the emotional temperature in the home, whether it be with natural family or surrogate family as is the case with residential care homes, can be the most important determinant of outcome---for better or for worse. When family members learn how to communicate with each and to use those communication skills for everyday problem-solving, their coping markedly improves in dealing with the stress of managing a serious mental disorder and its consequences. The application of skills training techniques to family services has been the most widely validated method of psychosocial intervention for reducing stress-related relapse (Falloon et al., 1999).

What are the reasons for using social skills training?

Serious and persistent mental disabilities are often accompanied by widespread deficits in skills required for friendships, family life, work, school, dealing with agencies, and getting one's needs met in the full range of life situations. In addition to the cognitive and symptomatic impairments that interfere with the use of skills that may have been learned earlier in life, many individuals with schizophrenia and related disorders have never learned the interpersonal skills required for adult functioning. This is because serious mental illnesses begin in adolescence and early adulthood before individuals have had the time and opportunities to acquire instrumental and affiliative skills.

Individuals with serious and persistent mental disorders typically have long-standing deficits in their performance of even the most basic social roles. They are often socially isolated, unemployed, with poor personal hygiene, unable to manage money, and in general lack the skills to live independently. These impairments and disabilities are often untouched by psychotropic drugs. The latter can suppress symptoms and signs of a mental disorder (as long as they are taken), but no one has ever learned new skills by taking a pill. Treatments in psychiatry tend to be modality-specific; that is, medications are efficacious with symptoms and relapse reduction while social skills training is effective in teaching people how to live (Liberman et al., 1994). Thus, treatment must be *biobehavioral* with a sound integration of pharmacological with psychosocial services.

What evidence supports the value of social skills training?

A large body of research supports the efficacy of social skills training for schizophrenia and other serious and persistent mental disorders (Wallace et al., 1980; Halford & Hayes, 1991; Heinssen et al., 2000; Kopelowicz, Liberman &

Zarate, 2002; Liberman, Kopelowicz & Smith, 1999; Benton & Schroeder, 1990; Corrigan, 1991; Dilk & Bond, 1996; Mueser et al. 1997; Mojtabai et al., 1998; Mueser & Bond, 2000). Skills training has been well documented as the technique of choice for helping individuals with serious and persistent mental disorders to *acquire* skills, *durably maintain* the skills, and successfully *transfer the skills to everyday life* (Liberman et al., 1994; Liberman et al., 1998; Marder et al., 1996; Glynn et al., 2002; Liberman et al., 2002). In recent years, the generalization of skills from the training environment to the person's natural living environment has been particularly emphasized (Heinssen et al., 2000; Liberman & Fuller, 2000).

Effectiveness of skills training demands that trainers be competent and faithful in using the technology of teaching. Thus, competent skills trainers use active teaching methods such as didactic instruction, modeling, behavior rehearsal, coaching of desired responses, corrective feedback, contingent social reinforcement, and homework assignments to facilitate the acquisition of new competencies. To counteract schizophrenia patients' attentional, memory, and abstraction impairments, learning material is presented slowly and repetitively in small segments that contain opportunities for numerous reviews and positive reinforcement (Liberman et al. 1993).

Evidence for the efficacy of social skills training has accumulated for the following outcome dimensions: acquisition, durability, and utilization of the skills in real life; improvements in social functioning; reductions in relapse rates and hospitalization; and enhanced quality of life. There are more than 40 randomized controlled trials or controlled empirical evaluations documenting the efficacy of social skills training (Kopelowicz & Liberman, 1998).

From the patients' perspective, quality of life is enhanced. They are provided with a sense of personal effectiveness and a wider range of realistic choices among social, vocational, recreational, and community living situations which they can adequately cope with and enjoy. By learning skills to achieve their own personally relevant goals in life, individuals with serious mental disorders are empowered to function more autonomously from mental health professionals. Thus, skills training clearly belongs squarely within the broad framework, ideology and therapeutic philosophy of psychiatric rehabilitation (Liberman, 1992).

What types of individuals (patients, clients, consumers) can benefit from social skills training?

Since social skills training aims at improving our communication of feelings and needs, as well as the quality of our relationships, everyone can

benefit from this approach. However, the goals must be tailored to fit the priorities and personal preferences of each individual and the methods must also be modified somewhat to ensure that the learning disabilities present can be overcome.

Common goals that people have achieved in Social Skills Training include making friends, starting conversations, asking for help from a professional person, succeeding at a job interview, solving family problems, improving a marriage or friendship, coping with criticism and anger, and getting discharged from the hospital.

What about people with schizophrenia who are very regressed, incoherent and distractible so they cannot sustain attention to the training situation and process?

Skills training requires that individuals be reasonably well stabilized on their medications, be able to follow instructions and pay attention to the training process. Because of the attentional requirements of the training, this modality is not suitable for floridly and acutely symptomatic individuals nor for those with persistent high levels of thought disorder and distractibility.

How can one tailor or fit social skills training to the personal goals of an individual and how can a practitioner effectively elicit the personal goals of an individual when the person states that "I have no goals."?

The term *goal* need not be used initially if it is too overwhelming for the patient. Help the individual to define his or her desired life roles by inquiring, "What would you like to be to be different in your life?" or "What are your current dissatisfactions in your daily life?" or "How might your life be more satisfying to you- what kinds of changes would you like to make in your routine or daily life?" Assist the individual to move from grandiose and unrealistic fantasies to articulating the more proximal and immediate, realistic changes and steps that must be accomplished before the longer-term goals can be reached.

How can a practitioner assist the individual in prioritizing his/hers goals?

List all of the patient's goals preferably in a visual manner. Next assist the individual in assessing each goal for its relevance, its importance and its feasibility. It may be necessary to spend time discussing the meanings of relevance, importance and feasibility. Review each goal individually until it becomes clear which goal should be prioritized. The goals should be endorsed by the individual, family, caregivers and responsible clinicians.

Some situations involving person-to-person communication make better goals for social skills training than others. Goals should be attainable, specific, incorporate functional positive behaviors, consistent with patient's rights and responsibilities and chosen by the patient. It is best to choose goals that are relevant to the patient's current life situation and that are behaviors that occur frequently and can be practiced often.

Are there any standardized social skills training programs that fit the needs and personal goals of many individuals so that training can be done more efficiently?

Many individuals with serious and persistent mental disorders, such as schizophrenia, have endured deficits in conversation skills, ability to initiate and maintain recreation for leisure, difficulties in managing their own medications, abusing substances such as alcohol or stimulants, and not knowing what to do when warning signs of relapse appear. For these individuals , semi-standardized educational programs or modules have been developed which can benefit many persons.

Titles of current modules available:

- Medication management
- Symptom management
- Substance abuse management
- Recreation for leisure
- Basic conversation skills
- Interpersonal problem solving
- Workplace fundamentals
- Community re-entry
- Involving families in services for the seriously mentally ill
- Friendship and intimacy

Who can be effective as a social skills trainer? What disciplines? What competencies? What kinds of learning experiences?

All disciplines in the mental health, counseling and rehabilitation professions have the ability to gain competence and confidence as a trainer of social skills. The best way to gain competence is through direct exposure and experience. This can often be arranged by serving as a co-therapist to a more experienced and competent colleague who then serves as a role model and instructor. A text may also be helpful:

Social Skills Training for Psychiatric Patients-by Robert Paul Liberman, William J. DeRisi, and Kim T. Mueser; New York, Pergamon Press, 1989.

Please see resource section for further recommendations on books and videos.

What are the advantages of conducting social skills training in groups compared with individuals.

- A group, with its ready availability of social interaction among members, provides multiple, naturalistic, and spontaneous opportunities for practicing skills.

- The group arena offers a forum for the therapist to frequently assess patients informally exhibiting their social skills, reflecting progress in training.

- Reinforcement of learned skills is amplified by peer feedback, in addition to therapist feedback, and may be more credible than feedback from the therapist.

- Modeling options are multiplied by availability of peers who can provide more realistic and congruent models for a patient than a therapist.

- Patients can serve as "buddies" for each other in facilitating the completion of homework assignments.

- Motivation to persevere in skills training is enhanced by the presence of more advanced, "veteran" patients whose progress can encourage beginners.

- Orientation and favorable expectations for new patients can be given by "veterans".

- Group cohesion magnifies the positive influence on symptomatic relief that derives from the therapeutic relationship between patient and therapist.

- Social and performance anxiety can be desensitized when anxious patients observe other group members participate with positive emotions and reinforcement for effort and progress.

- Group training is more efficient than individual training as 4-8 patients can be led by a single therapist.

Should group skills training be done by cohorts of patients who start and finish a group together as a unit? What if someone wants to join a group already in progress? Are open or closed groups preferable?

It is not necessary to do groups by cohorts. Given most staffing situations combined with patient needs for skills training it is not possible to have a closed group, nor is it in everyone's best interest. When a patient is deemed appropriate for group participation, he/she should be enrolled. When a new patient starts the group it is a good time for the veterans of the group to take on co-leading roles, by orienting the newcomer and providing positive expectations for the group.

Can social skills training be offered to families?

Skills training can be offered to the family unit and in some cases it is preferable to have family members present. One of the advantages of this is that the people closest to the individual can see for themselves where the deficits lie and how they can promote use of skills learned. Input from the family is also helpful to the trainer in understanding how the skills are being generalized.

How long is a typical social skills training session?

A typical group training sessions lasts between 45 and 90 minutes and can be conducted as infrequently as once a week or as often as once a day. Patients suffering from chronic psychiatric illnesses, such as schizophrenia, major depression, bipolar illness, and severe personality disorders, require more intensive social skills training because of the duration and extent of their social disabilities and cognitive and attentional deficits; in fact frequent training sessions and between session practices are necessary for severely impaired individuals.

Are there cultural factors that should be taken into account?

A patient's cultural background is a significant factor in determining the treatment plan and how skills training will be conducted. Taking cultural concerns seriously can increase the likelihood that the individual will be successful with skills training. Culture is more than just the language used, it will play an important role in determining the outcome expectancies of treatment. It is important to note that in many cultures it is the expectation for mentally ill adult children to live in the family home, whereas Anglo-Americans place great emphasis on the mentally ill living independently.

How do you overcome resistance to social skills training? For example, what can a clinician do if a person refuses to do role playing?

The best cure for resistance is to prevent it. How a person is invited to join the group is critical. A rationale should be provided. The referring clinician should be primed to give prospective patients some favorable orientation in

advance of the referral. The whole idea is to build favorable, but realistic expectations.

As for role playing, liveliness and spontaneity are key on the part of the therapist. Be sure to project acceptance, tolerance and optimism. Display warmth and enthusiasm toward reluctant patients. It is helpful to begin with the most enthusiastic patients. After the role-play, call on the reluctant patients to provide feedback to their peers. Then ask them to demonstrate what they mean. Initially it may be necessary to allow reluctant patients to take secondary roles or remain in their seats.

How can you help people who are anxious and nervous in front of other people are reluctant to participate in a group?

Modeling for the resistant patient can be helpful. The clinician can "double" for the patient who is reluctant to rehearse a scene. By doubling or providing an auxiliary ego, some of the pressure for initiating or processing an interpersonal problem can be taken off the resistant patient who can repeat, verbatim, the phrases spoken by the "double."

Another use of modeling is to have the patient observe the therapist taking the patient's role and then asking the patient to criticize, revise, or elaborate on the therapist's performance. This gives the patient a chance to learn vicariously through observing the therapist and to become task involved. With very anxious and inhibited patients, it may be necessary to allow the patient to watch others engage in behavioral rehearsal for a session or two before prompting active participation on the patient's part.

What can the trainer do when a participant in a social skills group becomes disruptive?

As with any other situation where you are trying to motivate a patient into doing something that he or she doesn't want to do, never let the situation escalate into a power struggle. Maintain the normal expectation of every patient performing at every session, but present alternatives rather than just restate the rule. Ignore inappropriate and interfering behaviors. Be sure to give the patient positive feedback for specific verbal and nonverbal behavioral skills.

How do you know that a person is making progress in skills training?

After each role play reassess the individual's "receiving" and "processing" skills by asking the patient : What did the other person say? What was the other person feeling? What were your short term goals? What were your long term goals? Did you obtain your goals? What other alternatives could

you use in this situation? Would one of these alternatives help you reach your goals?

A record of the patient's in vivo homework assignments should be kept. What percentage of the assignments are being completed? Are there certain types of assignments for example, initiating phone calls or socializing in groups that are more difficult for the patient to complete? The short term goals should progressively become more challenging leading up to the long term goal. In a series of over 70 patients with serious and persistent mental disorders who participated in weekly social skills training sessions, goal attainment was seen in almost 80 percent of the cases. Assessing goal attainment is the most practical method of assessing the impact of social skills training.

Other assessment methods include role play tests, interviews, questionnaires and naturalistic but simulated situational tests. Two particularly useful assessment tools are the *Client's Assessment of Strengths, Interests and Goals* (CASIG) and the *Independent Living Skills Survey* (ILSS). The CASIG enables clinicians to perform comprehensive assessments, tapping personal goals of individuals, deficits in social and independent living skills, symptoms, attitudes toward and compliance with medication, and quality of life (Wallace et al., 2001). The clinician can use CASIG to develop an individualized treatment plan for the client and then, by re-administering the CASIG every 2-6 months, to monitor progress in treatment. Based on the information gleaned from repeat assessments, changes can be made in the person's goals and/or treatment plan (Kopelowicz et al., 1997). The CASIG also permits evaluations of outcome of treatment for a person or an entire program, when the information from all clients is aggregated across the program, unit or facility. CASIG is extraordinarily "user friendly" with high functioning patients with schizophrenia demonstrating excellent reliability in administering the interview to fellow patients (Lecomte et al., 1999).

The ILSS is one of the components of the more comprehensive CASIG and it assesses twelve dimensions of importance to social skills trainers: management of personal possessions, appearance and clothing, personal hygiene, money management, use of transportation, leisure time activities, friendships and acquaintances, food preparation, eating, job seeking, job maintenance and health maintenance (Wallace et al., 2001). There are versions for the patient (self-report) and for those who know the patient (informant). Cross-comparisons of the information obtained through the two types of inquiries often leads to important findings relevant to treatment planning, such as when the patient reports not having any problems with money management but a relative indicates that the patient has repeatedly given away money, fails to budget or uses funds to purchase illicit drugs.

When can a person "graduate" or complete skills training? Are there different levels of skills training?

Since skills training needs to be adapted to fit he personal goals and phase of a person's disorder, a participant can begin the process by learning how to manage his or her mental illness. There are semi-standardized modules or curricula for this, such as the **Medication Management, Symptom Management, Substance Abuse Management,** and **Community Re-Entry Modules.** Once a person with a stress-related, relapsing form of mental disorder gets into a more stable phase of his or her disorder and is collaborating effectively with treaters on medications, training can shift to personal goals related to the individual's adjustment to the community. At this time, it would be suitable to consider training in such areas as **Recreation for leisure, Street Smarts, Basic Conversation, Involving Families in Services,** and **Friendship & Intimacy.** In this fashion, a person can make stepwise progress in social skills training as he or she goes down the pathway toward recovery.

How can you individualize social skills training? Can individualization of training be done while the person is participating in a group?

Skills training can be individualized, with goals for improving personal effectiveness derived from each person's long-term and personalized aspirations for role functioning. Although each group member has these unique self expectations, many of the components and skills needed to be learned are shared. Therefore, each group member is working on their own personal treatment plan and at the same time is benefiting from group interaction, opportunities for observing and learning from others, and positive and corrective feedback from the group members and therapist.

What are some examples of how social skills training helps individuals achieve their personal goals in life?

The following three vignettes give examples of how broad personal goals are used as guideposts for selecting the very specific educational objectives which serve as the session-by-session goals for training. Each specific objective or goal is functionally related to the broader, long-term goal---a kind of stepping stone to reaching one's important life goals. Educational objectives selected for skills training are also operationalized by making the interpersonal situation clear and realistic by asking the client to specify *what, with whom, where* and *when* the action will be taking place. This degree of specificity also helps to bridge the gap between the role played scenes and the completion of the assignment in the person's real life setting.

Jim is 38 year old, unemployed and divorced male whose social life had been restricted by 20 years of chronic, disorganized schizophrenia. He resides in a guest house with an older brother on his family's property. He has a nine year old daughter who does not live with him but who he visits once per month. He attends a weekly medication management group at which his clozapine is monitored. He has considerable distractibility, loose associations and meandering, circumstantial speech, but is very motivated to improve his life by getting more income through part-time work. Jim has successfully participated in volunteer work activities and was volunteering once per week in a botanical garden when he joined the social skills training group. He attends the group regularly and has gradually learned to focus his thoughts and goals, give accurate feedback to others, and to complete his community assignments between sessions.

During Jim's first few sessions in the social skills group, he identified the following long term, personal goals: 1) to improve his family relationships, specifically those with his father and brothers and 2) find and maintain competitive, part-time employment that would not jeopardize his Supplemental Security Income but would give him more discretionary funds each week.

The following are in vivo assignments Joey worked on to achieve these goals:

1) Make a positive request of his father to attend church on Sunday with his family
2) Call the Venice Skills Center to get information on job training opportunities
3) Make a positive request to use his brother's washer/dryer
4) Call the community mental health program regarding his eligibility to take the high school equivalency course and exam.
5) Ask his supervisor to increase his hours at his volunteer job at the botanical garden.
6) Update brothers on progress toward working and thank them for their support.
7) Ask volunteer supervisor for feedback on the quality of his work and how he might improve.
8) Go to local supported work program and inquire about available jobs.
9) Ask volunteer supervisor for letter of recommendation for prospective employers.
10) Attend orientation meeting at supported employment program.
11) Offer to get his Dad a snack while the latter is watching television
12) Call Kim at the supported employment program to get a start date for the janitorial job secured by the supported employment program.
13) Print a work record on an index card to remind him to sign in at work
14) Call social security office to have payee changed to self.
15) Thank Marcel, the foreman of the supported work program, for the job lead and inform him of progress on the job.

Janet is 28 year old and single who has a nine year history of schizoaffective disorder. She had done well academically and completed two years of college at a select university prior to becoming ill. She lives with her parents who are supportive both emotionally and financially. Her parents have encouraged her to participate more actively outside the family circle, but until joining the social skills group, her

conventional treatments were unsuccessful in motivating her or reducing her social anxiety. The entire family are practicing Orthodox Jews for whom religious rituals at home and in the synagogue are very important.

When she joined the social skills group, Janet identified the following, two long term goals: 1) to develop relationships with peers outside of her family 2) Reduce the dependent quality of her family ties so she would be able to experience more reciprocal, balanced, adult-to-adult relationships with her parents and siblings. Prior to joining the group she had been discharged from a Partial Hospital Program where she exhibited extreme social isolation, low self-esteem and poverty of speech. She is seen in a local schizophrenia clinic for maintenance medication but has refused other psychosocial services.

The following are examples of conversational and social outreach assignments completed by Jane as steps toward attaining her long-term, personally relevant goals:

1) Introduce self to store manager at Whole Foods
2) Call Santa Monica College to get schedule of classes
3) Call disabled students office at College to get information about services
4) Call synagogue to inquire about singles groups and recreational classes
5) Compliment the Rabbi on his sermon after the Friday evening service
6) Call a former friend, Allison, and set up a date to go to the gym they both belong to.
7) At a family reunion, tell her brother how much she misses him
8) Call owner of an art school and join a ceramics class
9) Ask an open-ended question of at least two other participants at the ceramics class
10) Give her sister an update on her progress and thank her for her support and confidence
11) Suggest that she and her Mom spend an afternoon together at the museum and initiate at least three conversations with museum officials about the art collection
12) Have a brief conversation on a relevant topic with other students in her flower arranging class
13) Introduce self to at least 2 new congregants at a synagogue event
14) Report to Dad how her confidence has grown with the development of her outside activities and socializing.
15) Invite a peer from the social skills group to go out together for dinner and conversation. Find out more about the person than you previously knew.

Florence, 47 years old and single, lives in her own apartment associated with a psychosocial rehabilitation program in the Los Angeles area. Her first episode of psychosis occurred during her early 20's but she has had continuous and active biobehavioral treatment only for the past five years. After a florid relapse of her chronic, undifferentiated schizophrenia five years ago, she transitioned from inpatient to partial hospital care and then returned home to live with her aged father. Shortly after discharge from the partial hospital, she joined the social skills training group.

In the group, Florence set as her initial goal, finding a place to live apart from her father. She practiced in the group making contact with various psychosocial programs that offered housing and placed her name on numerous waiting lists. She also secured a Section 8 housing voucher from the Department of Housing and Urban Development, after role playing the interview required for application. Increasingly, she learned how to advocate for her own needs and tapered down her contacts with the case manager from the local mental health center. Within the past two years she moved out of her father's home and has been successfully maintaining herself in an apartment without any supervision.

During her many years of living with her father, they had frequent arguments and he distanced himself from her emotionally to reduce his own stress. Her sister also became alienated from Florence and no longer spoke with her. The impoverishment of her family relations depressed her but participation in the group refocused her efforts along constructive goal setting. Prior to her illness, Florence had developed and enjoyed skillfulness in sewing. After saving money, she purchased a sewing machine and found that sewing came back to her quickly. With her growing independence, she re-set her personal goals for social skills training to include (1) increasing her socialization and friendships with peers; and (2) improving her relationship with her father and sister.

The community-based assignments that Susan has completed to progress toward her new long-term goals are:

1) Introducing herself at a party sponsored by a psychosocial self-help club.
2) Making small talk with another member of the self-help club at a picnic.
3) Making a phone call to a quilting school to get information about registering.
4) Traveling to the quilting school and registering for a class.
5) Attending the1st session of the quilting class and introducing herself to at least two other students in the class.
6) Inviting one student with whom she got acquainted to have coffee together after class.
7) Negotiating with her psychiatrist about switching from a conventional to a novel antipsychotic medication to minimize Parkinsonian side effects.
8) Presenting her father with a vest that she sewed for him.
9) Expressing regret to her father over their years of emotional distance and telling him how much she appreciated his assistance to her over the years of her illness.
10) Inviting her father to come to her apartment to watch one of his favorite TV programs.
11) Inviting her father to her apartment for lunch.
12) Making a positive request of her father for a loan to help her pay for a vacation trip to Mexico which was sponsored by her self-help club.
13) Asking another member of the club Linda to join her for lunch an inexpensive restaurant.
14) During a visit to her father's home, offering to fix him a snack and get him a drink.
15) Phoning her sister to let her know how much better she was doing in her life.
16) Asking her sister if she could briefly visit to show her photos from her vacation in Mexico.

17) Phoning her father to inquire how he was doing and to tell him what she had done that week.
18) Putting her name in nomination to be a facilitator of a social group sponsored by the self-help club.
19) Thanking the members of the self-help club for electing her facilitator of one of the social groups.
20) Using open ended questions to encourage members of the group to describe their recent activities.

As can be seen from the above examples of community-based, real-life asignments, the leader or therapist of a social skills training group helps participants to select weekly goals that are attainable, feasible and compatible with their rights and responsibilities as well as the rights and responsibilities of others with whom they will be interacting. Another criterion for selecting a goal is to give precedence to interactions that are frequently occurring and are likely to take place or be orchestrated during the week interval between group sessions. Finally, assignments are more likely to be completed when they are in the domain of the individual's valued, personal goals and desires for change in their life.

What assessment tools can be used to determine the personal goals of an individual or the phase of a person's mental disorder to help decide on the level or approach to use in skills training?

There are several tools that can be used to assess the person's symptomatic and functional state and identify the particular goals or phase of disorder that a person may be experiencing. For example, the **Brief Psychiatric Rating Scale** or **Beck Depression Inventory** can identify symptoms of a mental illness that may indicate that a person is in the acute or stabilizing phase and may benefit from training in disease management. Functional assessment tools include the **Client's Assessment of Strengths, Interests and Goals (CASIG), Independent Living Skills Survey (ILSS),** and **Inventory of Social & Living Skills (ISLS)** which are all available through *Psychiatric Rehabilitation Consultants* at its web site, www.psychrehab.com (Wallace et al., 2000)

How can a clinician promote generalization of skills training from the training setting into the participants' everyday lives?

Facilitating generalization of skills training can be done through repeated practice and overlearning. Be sure to select specific, attainable, and functional goals for "homework" assignments. Provide positive feedback for successful transfer of skills to "real life". Prompt the individual to use self-evaluation and self-reinforcement. Fade the structure and frequency of the skills training. By

advocating with caregivers and significant others, one can "program" the natural environment for generalization.

How durable are skills taught through skills training methods and what can be done to make them more durable?

The durability of skills depends on the opportunities to practice those skills and to receive encouragement and reinforcement as they use the skills in everyday life. Skills can be generalized to non-treatment environments and to other areas of functioning. Booster sessions can promote retention. Family members and other natural caregivers or supporters can be trained to help promote durability and generalization of skills learned in the clinic, private office, mental health center, or psychosocial self-help program (Liberman et al., 2002; Tauber et al., 2000).

PROFESSIONAL RESOURCES for USE by LEADERS or THERAPISTS in SOCIAL SKILLS TRAINING

Bellack AS, Mueser KT, Gingerich S, Agresta J (1997) ***Social Skills Training for Schizophrenia: A Step-by-Step Guide.*** New York, Guilford Publishing Co.

Corrigan PW, Mackain SJ, Liberman RP (1994) Skills training modules: A strategy for dissemination and utilization of a rehabilitation innovation. In Rothman J, Thomas J (Eds) ***Intervention Research***, Chicago: Haworth, pp 317-352.

Kopelowicz A, Liberman RP (1994) Self-management approaches for seriously mentally ill persons. ***Directions in Psychiatry*** 14:1-8. Available from *Psychiatric Rehabilitation Consultants,* PO Box 2867, Camarillo CA 93011-2867. (805) 484-5663 (Tel) 805-463-0735 (Fax). <www.psychrehab.com>

Liberman RP (1992) ***Handbook of Psychiatric Rehabilitation,*** New York, Macmillan. Available from *Psychiatric Rehabilitation Consultants,* PO Box 2867, Camarillo CA 93011-2867. (805) 484-5663 (Tel) 805-484-0735 (Fax) www.psychrehab.com

Liberman RP (1988) ***Psychiatric Rehabilitation of Chronic Mental Patients.*** Washington DC: American Psychiatric Publishing Co. Available from American Psychiatric Publishing Inc., 1400 K Street NW, Washington DC 20005.

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