A Portfolio of Research Work

Including an Investigation of The Experiences of Individuals with Psychosis in Group Social Skills Training

by
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In order to ensure the confidentiality and anonymity of all research participants, pseudonyms have been used throughout the portfolio, and any identifying information has been changed or omitted.
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Abstract

This is a portfolio of research work that was completed during my three years of training on the PsychD in Psychotherapeutic and Counselling Psychology at the University of Surrey. It includes a literature review and two qualitative research studies. The literature review offers a critical perspective on the available literature on social skills training for individuals living with psychosis. The first research study uses interpretative phenomenological analysis (IPA) as a methodology to understand client experiences within group social skills training. The second study employs thematic analysis (TA) to explore therapist perspectives on their role in social skills training for individuals with psychosis.
Introduction

This dossier comprises a literature review and two empirical studies employing qualitative methods. The literature review examines the psychosocial model of social skills training (SST) for psychosis with a specific focus on underpinning epistemological assumptions. The positivist basis and objectivist methodology in the research and practice of SST may be a useful way of understanding and addressing the phenomenon of social difficulties, but can also pose barriers to a more holistic approach. I believe that communication is a complex relational process that does not lend itself readily to quantification. This may reflect the complexity of the social world, and perhaps creates the need to rethink how we conceptualise human communication and define competence in communication, and how we can help the client interact effectively in different social contexts.

In the literature review, it is pointed out that the study of social difficulties in psychosis from an existential-phenomenological perspective has been largely overlooked in the development of SST. There seems to be an active effort to address the problems of generalisation and maintenance of targeted social skills from a positivist perspective, but little attention has been paid, for example, to evidence from the field of phenomenological psychiatry linking social difficulties to impaired embodiment and intersubjectivity. Although I found the process of doing this literature review intellectually rewarding, I also experienced conflict due to irreconcilable worldviews. Thus, for the purpose of analysis, I decided to divide the report into two main sections. The first part sets the context by providing the positivist framework for the theory and empirical research on SST. The following section focuses on an existential-phenomenological critique of the existing theory and practice, and offers ideas that can potentially enhance the model. It is my view that each approach by itself is insufficient for a holistic vision. Therefore, I attempt to show how existential phenomenology can supplement the therapy in such a way that can potentially provide a new approach to social difficulties in the context of psychosis. The review highlighted the need for research that moves beyond taken-for-granted assumptions and focuses on understanding the subjective experiences of individuals participating in SST. Bringing to the fore the experiences of clients from their own perspective, while reflecting on how interpretations and personal meanings are placed on findings, seemed timely given
perhaps the need to re-evaluate the therapy in light of new evidence. I thought that taking a different angle on current thought might add an important dimension to research that could inform, support or challenge the existing theory and practice of SST.

In the second year, I employed Interpretative Phenomenological Analysis (IPA) as a methodology to explore how clients experience SST in the context of a group. I was particularly interested in exploring what it is like for clients to be trained in a particular mode of relating and how the therapy impacts the self and the individual’s social world. I was interested in the meanings clients attach to those experiences that could potentially highlight the perceived effectiveness and relevance of the therapy in everyday life. Participants’ experiences varied, however, findings revealed that the therapy affected the individual on several levels of relating (self in relation to self; self in relation to other; self in relation to society). There were significant barriers to the transfer of skill knowledge in natural settings and, in most cases, the skills learned in the group were not generalised. In some cases, a perceived discrepancy existed between the social world of the group and the real social world. Overall, I believe that the findings of this study opened up possibilities for future research. Questions were raised regarding the need for a partly structured approach that would allow the exploration of relational dilemmas, conflicts and concerns that may serve as impediments to skills generalisation.

Doing phenomenological research was a most stimulating and invigorating experience. I found that the relationship I formed with research participants reflected the relationship I formed with clients at my clinical placement. There was a special quality to this relationship, characterised by embodied relational dialogue and a mutual effect of process on both members of the dyad, which affected, in turn, how the research proceeded and what data emerged. There was a sense of uncertainty and it was as if a word, a gesture or a look could turn things around and lead us to explore a different aspect of the topic in relation to their personal and social world. I remember feeling restless at the end of the encounter with each research participant. What if we had made a different choice? What if we had taken another path? I think that this quality is missing from the process of quantitative research where the researcher stands at a safe distance and has a more personal relationship with the data (objects) than participants (human beings).

In the process of doing IPA, I learned how clients experienced SST and had the opportunity to think about the potential implications of this, including the role of
therapists working within this model of practice. My review had exposed a gap in the literature, from a relational perspective, concerning the therapeutic process in SST and the relationship between the client and therapist. This made me wonder about how practitioners view their role within SST, as this understanding could potentially influence the outcome of therapy. I thought that this inquiry is particularly relevant to us (counselling psychologists) at this time because professional, social and political changes are taking place and the trend is towards certainty, control, simplicity and efficiency. This trend is represented by an emphasis on psychometrics, protocols and manualised approaches to therapy that arguably limits the unfolding of subjectivity and the intersubjective space for curiosity, openness, reflection and questioning of existing ways of being in the world.

In the third year of my training, I used Thematic Analysis to examine practitioners’ understandings of their role in SST. I was interested practitioners’ subjective views and meanings that would allow me to understand what happens between members of the therapeutic dyad or system (in the case of group therapy). I aimed to explore the action of SST from practitioners’ perspective; how they use the model and how they relate to their clients and manage difficulties. The findings of this study indicated that practitioners’ view of social functioning differed significantly from the way the model conceptualises it. More specifically, participants seemed to view social functioning as flexible and primarily context-dependent. There was a sense that they served as gatekeepers who facilitated the flow of information from the social world to clients, offering an account of the wider social reality in which social skills are used and relationships between people develop. The therapeutic process did not reflect just an educational approach. It was a relational and flexible practice that facilitated exploration without drifting from the purpose and structure of the therapy. A finding of particular interest was that participants drew from their own knowledge base and used their clinical judgement to compensate for gaps of the model pertaining, for example, to conflict management in group work. Similarly to my IPA study, this study raised questions about the current theory and practice of SST, opened up possibilities for further research and pointed to a need for a change of paradigm.

I found the experience of the research process of this study very interesting because, in my view, it represented a search for understanding and truth focused on subjective experience, and highlighted the uniqueness of context. By using a qualitative
method and a different epistemological approach in a field dominated by quantitative methods and a positivist philosophy, I felt I was making an effort that allowed greater perspective. Also, by the end of the study, I came to appreciate more the uncertainty of the process, reflected perhaps in the number of questions my three-year research endeavour raised. This may connect to a growing ability to be open to experiences that force me to consider different ways of being, and to hold uncertainty in my practice. I feel passionate about our profession’s commitment to recognising and celebrating differences, as it is through taking a different direction in research that I have broadened my vision and feel in a better position to serve my clients. Even salmons swim against the stream sometimes, despite the resistance of the water and for good reason. Similarly, through my research I feel that I have appreciated and embraced diversity, engaged with uncertainty and connected with a great source of energy for me.
Year 1 Literature Review

Social Skills Training for Psychosis: An Existential-Phenomenological Critique of the Research Literature

Abstract

Social skills training (SST) includes learning activities involving behavioural techniques that aim to help individuals living with psychosis develop skills for improved social functioning in their lives. A large body of positivist/post-positivist research supports the effectiveness of the therapy. When SST is linked to the phase of psychosis, has a shorter duration and focuses on specific skill areas, clients may benefit more. However, there are no qualitative studies to date that have explored the effectiveness of SST and its relevance to recovery from psychosis from clients’ perspective. Important questions also remain regarding the degree to which clients retain and transfer social skills to natural settings. The present review aims to unpack associated theoretical and methodological problems, rooted in a naturalist ontological framework and modernist epistemological assumptions. A critical evaluation of the therapeutic model is offered from the standpoint of existential phenomenology. Implications for practice and ideas for future research are considered.

Key words: Social skills training, psychosis, social competence, existential phenomenology
Introduction

Individuals with psychosis have been reported to face many challenges in their striving to manage acute psychotic episodes, cope with daily activities, fit in socially, and preserve a good quality of life (e.g. Bellack & Mueser, 1993). The loss of social bonds is characteristic in their lives and has been reported by these individuals to be a devastating experience (Wagner, Torres-Gonzalez, Geidel, & King, 2011), as they tend to experience loneliness and difficulty building and maintaining intimacy in their few relationships (Jablensky et. al., 1999). Due to the loss of social connections being omnipresent in the lives of individuals living with psychosis, it is therefore imperative to elucidate the various dimensions of this phenomenon. What is it that leads to a sense of social competence? What brings about a feeling of being effective in social interactions? Social skills, researchers have suggested, have a great deal to do with it.

The definition of social skills involves behaviours to communicate our emotions to others in order to achieve personal goals and meet our affiliative needs (the need for interpersonal contact, social support and companionship) and instrumental needs (the need for tangible and material support) (Liberman, 2008). Individuals with psychosis are perceived by the psychiatric community to present with inadequate social skills compared to individuals without the diagnosis, and this issue has attracted a lot of attention. In fact, a positivist study that used a role-play test found that approximately 50% of people with a diagnosis of schizophrenia are socially unskilled compared to normal controls, and that only 11% fall within the normal range of repeated social skills assessments (Mueser, Bellack, Douglas, & Morrison, 1991). Being socially unskilled, from a positivist viewpoint, implies internal dysfunction and is attributed to social skills ‘deficits’ that are thought to persist even in the absence of acute psychotic or negative symptoms (e.g. Bellack, Morrison, Wixted, & Mueser, 1990; Bustillo, Lauriello, Horan, & Keith, 2001).

The notion of the existence of social deficits is used to explain social difficulties in psychosis, based on the predominant diagnostic classification system of mental disorders (DSM-5) (American Psychiatric Association, 2013). This reductionist understanding that describes human distress in terms of psychopathology is rooted in medical naturalism. The worldview of medical naturalism splits mental health from physical health and holds that mental disorders (in this case,
Schizophrenia spectrum disorders are naturally occurring pathological entities that exist independent of our observations (Brown, 2002; Pilgrim, 2007). From a positivist view grounded in realist ontology, this pathological reality is driven by natural laws and can be broken down into measurable parts.

Such assumptions bear important implications in the practice of psychological therapy for individuals with psychotic experiences and social difficulties. Social skills training (SST) (Bellack, Mueser, Gingerich, & Agresta, 2004; Liberman, DeRisi, & Mueser, 1989) is a model that was developed on the basis of the above ontological and epistemological foundations to address social deficits by teaching social skills and improving social functioning. Therapy for social difficulties is deemed particularly important given the ineffectiveness of first- and second-generation antipsychotic medications for social deficits (Buchanan et al., 2010). When the literature on the effectiveness of SST is reviewed, there is an evident focus on categorical distinctions and systematic explanations from empirical investigations. Research evaluating the effectiveness of SST has employed solely quantitative methods yielding quantifiable outcomes and there is a notable absence of qualitative research.

Although the efforts aiming for empirical knowledge on the model of SST have been useful, they have been limited, potentially due to the inherently interpersonal phenomenology of these difficulties. For example, it is currently unknown how the clinical effectiveness of SST is achieved on an individual experiential level and how the problem of skills generalisation (i.e. the degree to which a skill is applied in a new situation) can be thoroughly addressed. Also, an investigation from an existential-phenomenological perspective is missing from the literature. The current paper posits that reflections from existential phenomenology can help refine, revise and improve the psychosocial model of SST. This position is based on the philosophy of counselling psychology (CoP), which is grounded in philosophical relativism and recognises the existence of multiple and equally valid realities constructed through subjective and sociocultural meanings that can never be entirely understood (Ponterotto, 2005; Woolfe, Strawbridge, Douglas, & Dryden, 2010). From a CoP perspective, behaviours that are indicative of internal pathology are both functional and adaptive (Golsworthy, 2004). Thus, we need to use approaches to understanding that can highlight meanings and contexts in which those behaviours take place and allow us to assess our interventions.
Insights from existential phenomenology can help us understand alterations in the structure of interpersonal experience that occur in psychosis. The term ‘existential phenomenology’ refers to a philosophical approach that includes ideas with interrelated themes. Phenomenology rejects objective scientific conceptions that split the human being into distinct psychological and physical components (the Cartesian mind and body dualism), and is involved with description and interpretation of the being-in-the-world (Heidegger, 1953/2010). A central concern of the current paper is the way in which human beings are situated in a world that matters (Heidegger, 1953/2010), a world in which we intentionally pursue things of interest and value that offer a certain experience. Pursuing a social goal for example can turn out to be exciting and rewarding and/or threatening and disturbing in some way. Several writers have suggested that psychosis can be understood in terms of alterations in one’s sense of belonging, interpersonal experience and the ability to pursue possibilities in the world (e.g.Binswanger, 1956/2012; Laing, 1960/2010). I intend to show the relevance of such ideas to the understanding of social difficulties in psychosis, and their application in therapy.

The purpose of the present paper is threefold. First, to review the theory and critically evaluate the positivist and post-positivist empirical research on SST that uses objective outcome measures. Findings from this type of research are presented to hopefully illuminate key problems in the design and implementation of SST. Second, to provide an existential-phenomenological critique of the theory and practice of SST, and suggest how an existential-phenomenological approach can enhance the particular therapeutic model. Third, to consider the implications for practice in general and specifically to the field of CoP. The diagnostic label ‘schizophrenia’ is replaced by the concept ‘psychosis’ to denote experiences that lie on a continuum as opposed to being distinct clinical entities.

**Positivist and post-positivist empirical research findings on SST**

Social skills deficits

Social skills deficits may exist prior to the onset of the disorder. Some individuals never learned social skills and shyness traits may partly account for this phenomenon, as individuals with psychosis have been found to be more socially
inhibited before they develop symptoms than non-psychotic individuals (Goldberg & Smidt, 2001). Shyness and decreased sociability traits are believed to predispose a person to developing social anxiety, leading to fear and avoidance of social interaction, and social dysfunction, involving limited social skills and social competence. Poor premorbid social functioning with little or no involvement in social and sexual relationships prior to the onset of symptoms has been found to predict poor social functioning after the development of psychosis (Pratt, Mueser, Smith, & Lu, 2005). Thus, human characteristics like introversion are seen as pathological and indicative of internal malfunction. An assumption is created within a perceived objective reality according to which a set of normal behaviours exist prescribing how much anxiety one should feel in social situations and sexual encounters.

Another group of individuals are believed to be socially skilled prior to developing psychosis but lose their ability to perform skilfully in social situations sometime after. Deterioration of social life is considered one of the first signs and may long precede psychotic symptoms (Haefner et. al., 2003). Taken together, these finding are consistent with the current dominant model for the aetiology of ‘schizophrenia’ – a polygenetic and multifactorial model that emphasises the role of dopamine dysregulation, neurodevelopmental damage, environmental factors, and a gene-environment interplay in symptomatology (for a full account, see van OS & Kapur, 2009). Deficits in social skills develop presumably as a result of genetic and neurobiological vulnerability (Schiffman et. al., 2004). The conclusion drawn is that in spite of premorbid social functioning, both groups of individuals present with social skills deficits (e.g. Bellack & Mueser, 1993) that need to become the target of work within therapeutic practice. The aim, therefore, is to fix what is broken.

Social skills training

Social communication involves the transmission of information via a three-stage process: (a) social perception, (b) social problem solving and decision-making, and (c) expressiveness (Liberman, 2008; Bellack, 2004). To be described as socially skilled, one needs to be able to consider time and contextual factors, perceive environmental cues, analyse and integrate information and have a repertoire of appropriate responses available for use (Bellack et. al., 2004; Corrigan, Mueser, Bond, Drake, & Solomon, 2008; Liberman, et. al., 1989; Liberman, 2008). When social
communication leads to favourable and relevant social outcomes for a person, it indicates social competence (also termed social intelligence). Not being socially skilled is considered to be enough evidence to indicate lack of social competence.

SST is a structured behavioural therapy that follows a sequence of steps and uses psychotherapeutic techniques based on social learning theory (Bellack et. al., 2004). SST can be offered on a one-to-one basis or in a group format, and is used for individuals in inpatient and outpatient settings although therapy effects tend to be more positive in outpatient settings (Corrigan, 1991). Social learning theory holds that people learn social behaviours through observation, imitation, modelling, and naturally occurring consequences of their actions (Bandura, 1969). The theory recognises mediating cognitive factors and emphasises self-efficacy, that is, the belief that one is capable of performing in a way that allows the achievement of goals (Bandura, 1977).

Self-efficacy has been suggested as a mediating variable in the relationship between coping skills and successful emotional adjustment. Individuals with positive self-efficacy beliefs are thought to be more likely to set higher goals, pursue these goals and attribute failure to insufficient effort (Bandura, 1977). Those having negative self-efficacy beliefs are regarded as more likely to have low expectations, imagine failure scenarios, and attribute their failures to personal ability (Bandura, 1982, 1993). A theoretical model referring to self-efficacy in psychosis (Liberman et. al., 1986) suggests that self-efficacy is related to social skills and competence and that this relationship is mediated by the efforts a person makes to use their skills. One implication of this model is that people need to have both social skills and positive self-efficacy beliefs to be able to function effectively in social situations. This essentially means that the success of SST is thought to depend on good use of therapeutic techniques and the client’s perceptions of their ability to achieve social goals.

As a social learning theory intervention, SST recognises environmental and behavioural influences and the mediating role of cognitive factors affecting how one processes information from the environment (Nangle, Hansen, Erdley, & Norton, 2010). SST uses five principles of social learning theory: reinforcement, modelling, shaping, overlearning and generalisation (Bellack et. al., 2004). Reinforcement refers to increased frequency of behaviour when it is followed by a positive consequence or
removal of an aversive stimulus (Ferster & Skinner, 1957). For example, an individual may be positively reinforced to use social skills when they receive praise from the therapist or group members (Bellack et. al., 2004). However, it could be argued that receiving praise might be experienced as patronising, depending on the individual and their sociocultural context. An example of negative reinforcement might be the case of a client’s use of skills being associated with a decrease in their sense of social isolation.

Reinforcement alone is inadequate in cases where individuals have never learned social skills (Nangle et. al., 2010), thus, modelling is considered an absolute necessity. Modelling refers to learning whereby a person learns social skills by observing others (Bellack, 2004). This principle is thought to exert a strong influence on the development of personal competence beliefs. A model’s failure to engage in competent behaviour can have a negative influence on an observer’s self-efficacy perceptions when the model is judged to have similar ability (Pajares, 1997). If the model’s ability is judged as superior, then failure to perform the behaviour may not have a negative effect on an observer’s self-efficacy beliefs. For this reason, modelling of social skills is always performed by the therapist first and then by other participants, if applied in a group setting.

Shaping involves reinforcement of successive steps that approximate the target behaviour (Skinner, 1958). In SST, the target social skills are complex, and so they are broken down into easier skills that are taught one at a time. Shaping of the target behaviour occurs gradually over time through reinforcement of even the slightest positive change. Overlearning refers to repeated practice of skills to the extent that they become part of the person’s natural behavioural repertoire. Opportunities to practise the skills in role-plays are provided in and outside therapy as part of homework assignments to promote skills maintenance and generalisation (Liberman, et. al., 1989). Basic components of SST include expressive skills (verbal, non-verbal, and paralinguistic behaviours), social perception skills, interactive behaviours, assertiveness skills, independent living skills, and medication management and issues pertaining to the communication between mental health service users and providers. In the UK, SST is regarded more relevant for individuals with problems in the social domain (NICE, 2013).
Outcome measures and effectiveness of SST

Outcome measures traditionally used in assessing the effectiveness of SST are psychopathology measures such as the severity of psychiatric symptoms, relapse, and the rehospitalisation rate of individuals with psychosis. Some studies (e.g. Hayes, Halford, & Varghese, 1995) and reviews of studies (e.g. Penn & Mueser, 1996) report a positive effect of SST on this type of measures. More often however, a lack of or modest effect on these outcome measures has been reported (e.g. Pfammater, Junghan, & Brenner, 2006; Bustillo et. al., 2001; Pilling et. al., 2002). Improvement and durability of positive effects on relapse rate is regarded uncertain even when SST is combined with other psychosocial therapies (Hogarty et. al., 1991).

A common outcome measure used in SST research is community functioning. It has not yet been clarified what it precisely involves (Bellack et. al., 2007). Several factors have been suggested; for example, role functioning, defined as the ability to cope with expectations associated with socially defined roles (e.g. partner, parent, caretaker, student, employee) (Corrigan et. al., 2008). Other factors include clinical symptoms (Bradshaw & Brekke, 1999; Katschnig, 2000), independent living, social relationships, employment (Eklund & Hannson, 2007), age, duration of acute symptoms and hospitalisation, tardive dyskinesia (Browne et. al., 1996), and social stigma associated with the diagnostic label of schizophrenia (Katschnig, 2000). Tardive dyskinesia is an adverse side effect of antipsychotic agents presenting as involuntary muscle movements (Andreasen & Black, 2001).

Social functioning is another construct of interest in the relevant research. Its definition of overlaps with that of community functioning and involves role functioning, the number of social relationships, and the quality and depth achieved in social relationships (Corrigan et. al., 2008). Improvements in social skills have been found to co-vary with improvements in social functioning (Halford & Hayes, 1991); therefore, social functioning is frequently used as an objective outcome measure. Results of randomized controlled trials (RCTs) of SST assessing social functioning, community functioning, and quality of life are mixed. In general, SST may have better effects when coupled with psychopharmacological therapy and family therapy (Hayes et. al., 1995; Valencia, Rascon, Juarez, & Murow, 2007), cognitive behavioural therapy (Granholm et. al., 2005), integrated psychological therapy (Spaulding, Reed, Sullivan, Richardson, & Weiler, 1999) or virtual reality technology for role-playing
Virtual technology may enhance the positive effects of traditional SST and overcome the problem of skills generalisation, but the suitability of its application in psychosis has not been thoroughly investigated. The emergence of positive symptoms during task performance is noted in 3 out of a total of 33 studies included in a systematic review, where virtual reality was used in the assessment or psychosocial rehabilitation of individuals with psychosis (Macedo, Marques, & Queirós, 2015). This response can be regarded as evidence for the need for further research in order to establish the safety of its use.

Meta-analytic reviews of RCTs using comparisons against both standard care and active interventions have not consistently found a positive effect on these outcomes (Pilling et. al., 2002). However, many studies (e.g. Patterson et. al., 2006), reviews of studies (e.g. Heinssen, Liberman, & Kopelowicz, 2000) and meta-analytic reviews of RCTs (e.g. Kurtz & Mueser, 2008) agree that SST is an effective practice when it is combined with pharmacological therapy. Behavioural skills may be maintained over time, improving community functioning and social functioning for individuals with symptoms ranging from mild to severe, including older persons (Bartels et. al., 2004; Patterson et. al., 2006). It is important to mention here some of the limitations of RCTs and meta-analyses because the choice of method can influence results. The exclusion of studies reporting negative findings may lead to an over-estimation of size effects reported in meta-analyses. Also, it is often unclear which variables, or whether an interaction of these, influence size effects. Research participants typically do not represent the population of individuals with psychosis as a whole. For example, individuals with co-morbid psychological problems tend to be excluded from RCTs thus results may not apply more generally. A further problem with RCTs worth mentioning is that they do not provide answers to pertinent questions about individuals’ experiences or the process of therapeutic change (Persons & Silberschatz, 1998).

Until now, a reductionist-positivist approach of science has provided one side of the story and has left questions unanswered concerning clients’ experiences of therapy (e.g. ‘What does it mean to participate in a SST group?’ and ‘How can I be in the group?’), the problems of skills generalisation and maintenance, and the process of therapy. Qualitative methods acknowledge the importance of personal narratives in
recovery from psychosis (Roe & Lysaker, 2012) and the co-construction and negotiation of meaning in knowledge (Yardley, 2000). A pluralist epistemology characterised by creative synthesis of the positivist/postpositivist paradigm and the constructivist/interpretivist paradigm may do more justice to the full exploration of therapeutic effectiveness (Goss & Mearns, 1997) of SST. By creatively combining existing findings of the nomothetic approach using quantitative methods and those of an idiographic approach using qualitative methods, new possibilities could be created. Qualitative studies could potentially interpret or illuminate quantitative research findings and provide fresh insights and relevant targets for behaviour change among clients who opt in for SST.

Summary and evaluation of positivist/post-positivist research on SST

In general, the use of a skills approach to social competence appears to have several strengths. Descriptions of social skills involving gestures, expressions and bodily movements are based on observations of people judged as good models (Liberman et. al., 1989). Thus, it is relatively easy to define and target specific behaviours, and create a basis of assessment and intervention. However, there are also a number of weaknesses. Different methods of selecting social behaviours have led to disagreements on criteria as well as diversity and overlap in conceptual definitions of constructs. Methodologies, assessment instruments and population samples vary significantly among studies. This type of diversity as well as differences in SST programmes makes the comparison between studies and communication in the scientific and academic communities difficult. Additionally, most studies do not include long-term follow-up outcomes and cannot indicate whether lasting changes have been achieved.

Having these potential limitations in mind, the following conclusions can be drawn. In general, positive effects may be more likely for specific skill areas, rather than changes in community functioning (Kurtz et. al., 2008). Further, SST with a shorter duration (weeks) and of less intensity may have better effects than training with a longer duration and of greater intensity. Skills are reportedly maintained for up to one year after the end of therapy (e.g. Eckman et. al., 1992). The number of techniques used does not seem to impact therapy effectiveness (Benton & Schroeder, 1990), but tapping a restricted range of social skills may be more effective than
targeting a broad range of skills (Kurtz et. al., 2008). In terms of individual characteristics, age has been associated with a good response to therapy, with younger individuals having significantly better improvement.

Generalisation strategies and follow-up booster sessions of decreasing frequency are an important part of SST to increase the probability of skills maintenance and transferability. The degree to which skills generalisation is possible is currently unknown. Kopelowicz et. al. (2006) suggest that the more similar the training and natural environments, the higher the chances that the skills will be used in everyday life. The transfer of social skills in the community may be more likely when extra measures are taken, for example, behavioural trapping, booster sessions, case management with or without in vivo training (Tauber, Wallace, & Lecompte, 2000; Glynn et. al., 2002; Liberman, Glynn, Blair, Ross, & Marder, 2002), and involvement of family members (Kopelowicz, Zarate, Gonzalez Smith, Mintz, & Liberman, 2003).

**An existential-phenomenological critique of SST**

The previous section demonstrated theoretical and methodological issues involved in SST for psychosis. These issues potentially reflect an epistemological cul-de-sac and in the next section, an existential-phenomenological lens is offered that might help clarify the understanding of such issues, and provide the means to challenge the existing approach.

**Psychosis from an existential-phenomenological perspective**

From the vantage point of existential phenomenology, psychosis is not an entity but a lived experience. Laing’s (1960/2010) existential-phenomenological perspective views psychotic problems as disorganisation and failure to achieve self-integration. Without a solid and strong sense of self and personal identity, the psychotic person is thought to experience a basic ontological insecurity – an absence of trust in their own and others’ permanence, essence and realness. Heidegger (1953/2010), however, claims that human beings are always in relation with others and inseparable from their social context. Thus, in the face of danger that threatens the psychotic person’s existence, posed by love, relatedness, or even the very existence of
another person, a split between the mind and body may occur to cope with an impossible reality to live in, resulting in a disembodied existence (Laing, 1960/2010). Stanghellini (2004) and Fuchs (2005) argue that in psychosis the body does not constitute the basis of experience or form a means of communication with the world determining how one perceives and interprets things. Instead, the world is viewed from a distance, motivation is decreased and action is unintentional.

Laing (1960/2010) argued that in psychosis, the body becomes another object in the world, a separate part of the self, characterised by autonomous and compulsive actions. By abandoning bodily experiences, maintaining a disembodied existence and creating a mental world that is not shared with others, there is a sense that freedom is protected and identity is preserved. However, detachment from the lived body implies a loss of self and vice versa (de Haan & Fuchs, 2010). The person’s lived experience may consequently become an exaggerated form of living in what Sartre (1943/2003) called ‘bad faith’ through extensive imitation of others and compliance with real or imagined wishes as well as standards purely for reasons of survival (Laing, 1960/2010). Living in bad faith means that one denies oneself of the freedom to choose for fear of potential consequences, and remains unaware of the multitude of other choices that are available.

In addition to alterations in subjectivity, corporeality and mode of being-in-the-world, disturbances in temporality and intentionality have also been noted. According to Heidegger (1953/2010), human beings are defined by their projects, aims, actions and future goals. They are always acting on some future possibility based on values, and they are always in the process of becoming, linked to temporality. In psychosis however, the experience of time is described by Stanghellini et. al. (2016) as fragmented. Time freezes to avoid feelings of insecurity and any kind of potentially destabilising change (Binswanger, 1956/2012; Fuchs, 2007). Each moment is experienced as disconnected from the previous and the following one, and the capacity to integrate single moments in a meaningful and coherent way is lost (Stanghellini et. al., 2016), as is the ability to intentionally direct oneself towards projects (Minkowski, 1927/2012; Fuchs, 2005). I will next examine the above ideas in an evaluation of the model of SST. My analysis will focus on complexity and causality, and the existential notions of autonomy, relatedness, freedom and responsibility.
Complexity

Social learning theory emphasises the interaction between behaviour and environment and has contributed significantly to our understanding of the development, maintenance and modification of social behaviour, but is limited in the multiplicity of phenomena that it covers (Ryckman, 2004). Its popularity can be attributed to the amount of empirical evidence in the scientific community, however, it appears to lack comprehensiveness, as it accounts for isolated factors and fails to present a holistic view of the individual as a person existing in a sociocultural context and facing problems in coping with complex relational experiences. Such would be, for example, intimacy in interpersonal relationships (Jablensky et al., 1999) and existential needs for meaning, self-integrity, freedom, love and acceptance (Wagner & King, 2005) – domains that psychosis touches and are reported by affected individuals as relevant for their lives.

As a behavioural therapy, SST is guided by a natural scientific epistemology that is based on the positivist and post-positivist paradigms and views subject and object as separate (Ponterotto, 2005). It follows a nomothetic perspective on human beings and research applies objective procedures and methods to investigate observable behaviours that then become the focus of therapy (Langle & Kriz, 2012). Epistemological claims about the intervention’s benefits have been justified and proven for the discovery of true knowledge that applies to all individuals, and the uniqueness of the individual is inevitably lost. A Cartesian analysis of the world cannot grasp the primary sense and mode of a being-in-the-world (Heidegger, 1953/2010) nor can it address psychotic experience, the lived meaning of psychosis (Keller, 2008) and its impact on the personal sense of existence, essence and identity.

One of the defining aspects of SST as a behavioural therapy is its focus on observable behaviours dependent on associated social stimuli and immediate consequences. The psychosis is not addressed however, and social behaviours are broken down into interrelated yet independent component skills (Bellack et al., 2004). As a result, learning may be of a fragmented experience since psychotic and social experiences are viewed as separate. The existential-phenomenological paradigm argues that the understanding of phenomena can only occur in the context in which they are embedded (Heidegger, 1953/2010). The full meaning of human existence can
only be seen in the context of individual social circumstances and in terms of intentionality of the self in the world (Keller, 2008). The same social behaviour may serve a variety of functions for different individuals or in different conditions, and people may also differ in the significance they attach to social goals. Ontologically, social experience cannot be viewed in a vacuum thus any attempt to break down a person’s existence to a set of independent components is doomed to failure. There can be no distinction between the intrapsychic world and the interpersonal world (Heidegger, 1953/2010), as human beings are neither autonomous nor self-contained, but always situated in the world with others. This requires an understanding of a social person in their entirety and description of the totality of their social actions, which can be missed by focusing on single behaviours (i.e. social skills).

Still another problem with the efforts to break down complicated human experience into a set of fixed components is the significant heterogeneity in symptoms and cognitive functioning that is observed among individuals with psychosis (Seaton, Goldstein, & Allen, 2001; Ritsner, 2011). This diversity confirms the existence of many psychotic worlds (Jaspers, 1959/2012) and may, by extension, include social difficulties, making it questionable whether these can be universally categorised into deficits. From an existential-phenomenological vantage point, heterogeneity implies uniqueness and it is neither pathological nor unexpected and problematic. Uniqueness cannot be described nomothetically and requires an idiographic approach to description of the individual’s personal circumstances, difficulties, meanings and values (Langle & Kriz, 2012). This connects closely with a therapeutic approach that focuses on the client’s subjective experiences to clarify the widest social realm of possibilities in which their existence occurs. SST, however, deals with only a small part of the client’s social world due to the active learning that leaves little space for discussion, in line with the recommendations of Bellack et. al. (2004) and Liberman et. al. (1989). Consequently, interpersonal relationships are only glimpsed via role-plays where the individual acts out a social role (e.g. the role of a friend or partner) in real or made-up interpersonal scenarios.

Causality

SST is a modernist model of practice and as such is informed by assumptions of a pathological underlying cause of dysfunction, with the individual being treated
for their deficits as the locus of pathology (Milton, Craven, & Coyle, 2010). Social deficits are viewed as an entity that interferes with the individual’s ability to form and maintain intimate relationships and fulfil social roles. Some of the contextual factors that have been associated with the loss of social skills based on quantitative findings include chronic institutionalisation, a non-supportive social system, limited availability of community recreational sources and opportunities for supported employment, unemployment, and the presence of stigmatising attitudes and discriminatory behaviours (Bellack, 2004; Corrigan et. al., 2008). These factors are inevitably given a more peripheral role because psychosis is constructed as predominantly biological in nature (Crowe, 2000). Its expression is thought to be triggered almost automatically by stressful events or psychological trauma as if the person were carrying an internally a ticking bio-bomb, which, under certain circumstances could leave them flawed, dysfunctional, and deficient in skills and abilities. Consequently, a large body of research showing the importance of the role of contextual factors in the aetiology of psychosis and the impact on relatedness is neglected (Read, Mosher, & Bentall, 2013; Shah, Mizrahi & McKenzie, 2011). The recognition of traumatic events as causally involved in the development of psychosis or resulting from psychosis reveals a far more complex story (NICE, 2014). In cases where there is no history of early trauma, cumulative adverse experiences have been implicated in the emergence of psychotic symptoms (Shevlin, Houston, Dorahy, & Adamson, 2008).

Causality relating to the absence of social skills has been broken down to specific factors within the modernist paradigm. One of the assumptions is that the interaction between biological and environmental factors causes the ‘disorder’ and ‘deficits’ lead to impaired social skills, although the term ‘associated’ is preferred over ‘caused’ possibly to abstain from absolute epistemological certainties which are nevertheless implied. The person is seen as a closed system, a sum of parts that are observable and measurable (Aho, 2008), and social competence is a learned ability of the individual, rather than a lived phenomenon that emerges from relational interaction between people. Causation cannot be a relational process within a mechanistic epistemological framework (Brown, 2002), thus, there is no need for knowledge of the person’s lived experience and the meaning placed upon it. Human experience is objectified and explained by breaking down causality in the hope,
perhaps, that complexity can become manageable. The split between body and mind is omnipresent in the theory of SST.

The structure of intentionality in psychosis offers an alternative to the understanding of negative symptoms (Keller, 2008) that have been associated with the development of social skills deficits (Mueser, Bellack, Morrison, & Wixted, 1990). Although the person with psychosis maintains a disembodied existence, from an existential-phenomenological perspective, there is an embodied intentionality of a fragile self, characterised by internal tensions and struggles relating to existential anxiety (Keller, 2008). The individual with psychosis embodies the profile of a person with no motivation to engage in social interaction, no initiative or interest for goals, and who derives no or little pleasure from activities (Davidson, Stayner, & Haglund, 1998). These negative features affect lived experience, with the person shifting between feeling different from others and socially withdrawing (Keller, 2008; McDonald, Sauer, Howie, & Albinston 2005). This is supported by findings of a qualitative study employing focus groups that individuals with psychosis isolate themselves when they fear to lose important others’ love and support (Wagner & King, 2005). From this fundamentally relational perspective, social deficits are regarded as impairments of intersubjectivity impeding intuition and the ability to socially attune to others (Stanghellini & Ballerini, 2002).

In the process of understanding the being-in-the-world we must contemplate time, as it is only in terms of temporality that existence can be understood (Heidegger, 1953/2010). Inherent in the biomedical model is an assumption that time is experienced in a linear process, moving from past to present and future. However, from an existential-phenomenological perspective, life is fluid and human beings are in constant change, with their existence unfolding (Merleau-Ponty, 1962/2002). From this viewpoint, it makes sense that our social competence changes depending on the context and personal/social circumstances requiring us to adapt accordingly. Based on the idea that subjective reality is experienced multidimensionally across time, we always carry the past, contain the present and anticipate the future (Heidegger, 1953/2010). In this process, one may feel more or less socially competent depending on the demands of the experience and interaction, which reflects the fluidity of human existence. The loss of social skills may be an inevitable phenomenon, in the view that things are not static. Based on the positivist epistemology that has traditionally formed
the basis of research on SST, social skills can be maintained for up to one year (Eckman et. al., 1992). This claim is a clear example of time assumed to be unilinear, which justifies, perhaps, the existence of social deficits. Kopelowicz et. al. (1998) recommend booster sessions for better generalisation of skills, and this reveals an assumption that this type of learning is impermanent due to the nature of psychosis, rather than possible inadequacies of the model that arguably undermine its effectiveness. Indeed, May, Angel and Ellenberger (2004) highlight the risk of creating monotony of language across time, potentially yielding the feeling of a string of similar days and disrupting the sense of time and continuity.

Autonomy

The existential-phenomenological perspective regards human beings as meaning-making creatures in the face of the absurdity of life (Sartre, 1943/2003), in consistence with the quest for and finding of meaning that can bring happiness and make struggles worthwhile (Camus, 1942, 2005). This approach cautions against efforts aiming to reduce experience to pathology and argues for strengthening a person’s agency in the world (Davidson, Staeheli, Stayner & Sells, 2004). The notion of recovery challenges the traditional views of psychiatry and refers to creating new meaning and living a personally fulfilling life beyond psychiatric symptoms (Anthony, 1993; Deegan, 1988; Leete, 1989). The task of SST is to promote autonomy whereby the person can develop a repertoire of interpersonal responses to achieve relevant social goals hence it is included in recovery programmes because it is perceived to be helpful in empowering individuals (Liberman, 2008). On closer view, this seems like a contradiction because high structure in therapy can strip the client of personal power, autonomy and agency. The SST therapist, after all, is leading (Bellack et. al., 2004; Liberman et. al., 1989) and asking or encouraging the client to be different. This is consistent with the finding of a qualitative study using content analysis that individuals with psychosis experience important others to be overprotective and regard them as not having faith in their abilities (Wagner et. al., 2011). Participants also reported relapsing due to what they perceive as lack of stimulation and motivation (Wagner et. al., 2011). Little stimulation can lead the person to despair and learned helplessness – a state where one lacks the social skills to interact with others or the willingness to take care of oneself (Bentall, 2004). At the
other end of the spectrum, over-protectiveness and high structure can equally damage a person. The paradox for practitioners in SST may be that to help the client change their passive stance to the world, they themselves become, perhaps, too active. Similarly, there might be an over-focus on the use of skills for the client to connect as opposed to helping them achieve some balance between connectedness and autonomy.

According to individuals with psychosis, mainstream therapy approaches over-focus on experiences and needs related to symptomatology and can suppress behaviour, thoughts and feelings that deviate from the norm (Wagner et. al., 2011). This qualitative research finding may be somewhat consistent with the philosophy of SST. It starts with an assessment of social behaviours that objectively stand out from the ordinary and seeks to replace them, perhaps, with normative social behaviours. During the training, individuals are offered an opportunity to take initiative when they are requested to provide feedback to other group members involved in role-plays. Even then, however, there seem to be limits placed on autonomy, as the feedback needs to be specific to the skills in which they are trained and any expression of spontaneity and creativity may be discouraged. From this it follows that there may be a bias towards creating a particular type of social person. Practitioners may unintentionally swamp their clients’ autonomy and encourage imitation and impersonation, thereby reinforcing the expression of what may be considered as another form of a ‘false’ self (Laing, 1960/2010), involving conformity to social norms.

The epistemological debate as to whether individuals with psychosis are a reliable source of information further adds to the paradox of autonomy and empowerment. The use of informant-rating assessment tools of social functioning in empirical studies assessing the effectiveness of SST has been popular, however, caution has been raised over its potential unreliability. Individuals with psychosis have been characterised as unable to accurately observe their behaviour due to cognitive impairment, low insight, comorbid depressive symptoms and individual characteristics (Harvey, Velligan, & Bellack, 2007). They have therefore been excluded from positivist/post-positivist research studies on SST for reasons of pathology and deficiency.
Freedom and responsibility

According to Heidegger (1953/2010), human beings find themselves in situations that they might not have chosen for themselves. Sartre highlights the responsibility of becoming aware of our situation, whatever that may be, which allows us to live authentically (Daigle, 2011). This responsibility is intricately linked with and not separable from the freedom to choose how to respond to situations (Yalom, 1980). In fact, Sartre (1943/2003) goes so far as to say that “we are our choice and...to be is to choose ourselves” (p. 328), thus, there is no freedom without choice.

As mentioned above, the lack of adequate social skills is described as social skills deficits, indicating that there is impairment in the functional capacity of individuals in the social world. Deficits represent an obstacle between the person and others and provide structure in the subjective experience of social functioning and isolation. Forcing rigid preconceived categories upon a person can victimise and disempower them (Larsson & Loewenthal, 2011). It can also restrict, perhaps, their freedom because it introduces an external frame of reference, an explanatory system that prevents the person from constructing their own meaning of their social experiences. Meanwhile, practitioners can make pathological assumptions that ignore the meaningfulness of psychotic experience (Bentall, 2004; Dillon, 2012), which obscures their ability to see the real person behind the diagnosis (Cotton & Loewenthal, 2011). Yalom (1980) referred to mental ‘illness’ being experienced as an external force that denies freedom and responsibility awareness. Similarly, in SST, the medical discourse can discourage clients and practitioners from assuming their share of responsibility for the outcome of therapy, and can potentially offer an excuse for responsibility avoidance (e.g. ‘It is not me but rather the social deficits’).

Viewing a person as deficient can promote stigmatising attitudes that are perceived by individuals with psychosis as a major obstacle in their personal development and ability to maintain interpersonal relationships (Wagner et. al., 2011). Thus, it could be argued that in SST, the modelling of the desired social behaviour in the group creates stigma and power differential. The need for the therapist’s relational way of being to be judged as superior (Pajares, 1997) in therapy may promote a one-size-fits-all attitude, neglecting individual and contextual factors that may be key to long-term change. Learning through modelling of social behaviour may indeed be essential when one never had the opportunity to learn social skills, but it is a method
that is consistently used regardless of individual personal and contextual characteristics.

SST aims to increase the individual’s social skills and ability to cope with a variety of interpersonal situations. The implementation of therapy is tied to a specific time and place, involving role-playing of made up or real interpersonal situations from the person’s life as a strategy to increase the likelihood for skills generalisation to occur (Liberman et. al., 1989). Bellack et. al. (2004) advise against the use of dialogue as a way to induce change in the client’s social ability, and use the example of learning to play the piano or tennis to highlight this point: “A piano or tennis instructor does not bring a group of students together to talk about striking the piano keys or the tennis ball and discuss how the students feel about it” (p.186). It is therefore possible that choosing social skills role-play scenarios and practice situations for homework completion is the only time where the client is allowed the freedom to choose. From an existential-phenomenological perspective, it could be argued that there is a dynamic process linked to all activities of daily living. Our relationship with music or sports might be in flux and uncertain in the same way that relationships between people are. Thus, the absence of dialogue and the emphasis placed on instrumental techniques in SST could truncate the dimensions of social experience and foreclose the exploration of self-efficacy beliefs and outcome expectations associated with social skills practice.

Relatedness

From an existential-phenomenological perspective, “being alone is a deficient mode of being-with” (Heidegger, 1953/2010, p.117). From this fundamentally relational stance, communication is part of relationships between people embedded in social systems and communication difficulties reflect relational problems. The process in SST however promotes a mechanistic understanding of communication, where the sender and the receiver engage in a reciprocal exchange of messages (Liberman, 1989, 2008). The self and the other can be viewed as two objects that function independently; one object sends a message and one object receives this message, processes it, and sends back another message responding to the demand placed. Communication is fragmented, broken down into a three-stage process, with each stage requiring a set of independent component skills, and the person is reduced into
the role of sender or receiver of information. Consequently, the kind of relationship is created that Levinas (961/1998) spoke about – a relationship where the subjectivity of the other (and perhaps of the self) is objectified and not appreciated, and little meaning can be extracted from the interaction.

Laing (1960/2010) believed that in the relationship with the psychotic person, it is common for practitioners to become the target of aggressive communication due to the psychotic fear of subjectivity being impinged upon. A manual-based therapy may serve to protect practitioners from this type of communication and create pseudo-safety, but it can also fill the in-between space and preclude being open to whatever emerges (Cayne & Loewenthal, 2011). By filling the space in therapy and allowing no room for doubt or uncertainty, the process may become predictable. This is not to suggest that therapy should have no structure and that the process must become unpredictable, as this might be overwhelming for someone experiencing ontological insecurity. Rather, it may be that a social world needs to be co-created within the realm of the relationship between the client and the therapist (and perhaps other group members) that is only partially defined in a semi-structured therapy in the hope that something new can emerge. This way, the client may find alternatives through challenges, paradoxes and contradictions that can prompt shifts in meaning, lived experience and social behaviour.

**Implications for practice**

The scenario posed by the biomedical and behavioural models pose profound difficulties for counselling psychologists and practitioners taking a postmodern approach to practice. The field of CoP has a humanistic value base, recognises the importance of the therapeutic relationship (Woolfe et. al., 2010) and appreciates meaning making as essentially relational (Manafi, 2010). The relationship between therapist and client as a key aspect of effective therapy is supported by evidence in the literature regardless of therapeutic approach (Cooper, 2008), and manual-based therapies form no exception to this (Wilson, 1998). The therapeutic relationship is currently neglected in the theory of SST and needs to be accounted for. The reason for this is that the development of a positive therapeutic relationship is a requirement of
all psychological therapies in the context of psychosis (NICE, 2013). In light of these arguments and the available evidence, it is perhaps surprising that little attention has been given to the therapeutic relationship in SST. Adhering too closely to a manualised approach can potentially foreclose avenues of exploration of social difficulties that can be targeted with skills training procedures. Additionally, the mechanistic representation of social communication in the model of SST may reflect a fixed relationship that involves division between the self and others in the role of sender/receiver, rather than a dynamic relationship between people embedded in sociocultural systems. This conceptualisation is at odds with the stance of CoP that privileges the relationality of human existence (Manafi, 2010) and the phenomenology of subjective experience over fixed viewpoints (Milton et. al., 2010). It might be that the meaning of the social dimension of existence can only be established within a confiding relationship in which the SST therapist assumes a ‘being with’ attitude – an attentive and gradual way of entering another person’s world (Spinelli, 2007).

Although CoP focuses on ‘being with’ and SST focuses on ‘doing to’, these attitudes can be considered together (Corrie & Milton, 2000), alternating, depending on the client’s needs at a particular moment. At present, the ‘doing to’ attitude appears to be overrepresented in SST and it remains to be seen whether more space needs to be allowed for what cannot be expressed in social skills behaviour.

A dilemma that also arises from engaging with the model of SST involves pathological assumptions that ignore socially and cultural constructed forces that hold up the variety of human experience to an illusory normal standard. CoP is positioned within contrasting epistemologies, and rejects diagnostic labels, notions of pathology (Larsson, Brooks, & Loewenthal, 2012) and binary oppositions (Manafi, 2010) such as normal/abnormal and functional/dysfunctional that dominate the theory of SST. Conversing critically with behavioural science is thus required at this stage, as a change of paradigm may be necessary. From a behavioural point of view, this is reflected in two important issues, social skills maintenance and generalisation to real-life settings. Attempts to overcome these through the use of computerised technology may be a useful scientific investigation but, nonetheless, turns away from human beings as the focus of attention.

A change in paradigm can be achieved through the development of new theories revising fundamental concepts (Kuhn, 1996), or perhaps integration with
existing therapeutic models. The debate for a shift in the behavioural tradition to incorporate humanistic principles and existential ideas has been going on for some time (Schneider & Langle, 2012), however, the countervailing force of standardisation and manualisation may be stronger. In the case of behavioural therapies like SST that are based on a more mechanistic model of human being, the onset of dialogue with the existential-phenomenological approach may allow for a deeper view of social functioning. Through therapeutic integration, SST could potentially take a place among third-wave psychological therapies. For example, acceptance and commitment therapy (ACT) for psychosis (Bach & Hayes, 2002) retains a behavioural orientation and takes into account existential-phenomenological concepts of meaning, intentionality, agency and embodied awareness (Ramsey-Wade, 2015). Similarly, existential-phenomenological insights into a person’s complex social world within the experience of psychosis could potentially open the way to alternative pathways of exploration and teaching in SST. If behaviour is what existential writers call ‘existence’ (McDowell, 1975), then verbal, non-verbal and paralinguistic skills may indeed reveal intentionality and embodied action in the social world.
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What might it be like for individuals with psychosis to participate in group social skills training? An interpretative phenomenological analysis

Abstract

Social skills training (SST) for psychosis is a psychosocial therapy that aims to teach social skills through the use of learning activities that are based on behavioural principles. A large body of positivist/empirical research supports the efficacy of the particular therapy, however, to date, no qualitative research has been conducted to ascertain the relevance, acceptability and efficacy from service users’ perspective. The aim of this study was to explore the experiences of group SST of participants with a diagnosis of a schizophrenia spectrum disorder. Semi-structured interviews were carried out in order to explore subjective experiences in and outside the group. Interpretative Phenomenological Analysis was used to analyse interview transcripts from eight participants. Two main themes emerged from the analysis: (a) Effects of SST, and (b) Barriers to skills generalisation and suggestions for improvement. Findings suggest that participants experienced the therapy as acceptable, but perhaps only partially effective and relevant to their social world. Implications for practice within a phenomenological and counselling psychology framework are discussed.
Introduction

Social skills training (SST) (Bellack, Mueser, Gingerich & Agresta, 2004; Liberman, DeRisi, & Mueser, 1989) is a first-line psychosocial therapy for psychosis (NICE, 2014) that aims to improve individuals’ social functioning by teaching social skills. SST is structured and uses psychotherapeutic techniques based on social learning theory (Bandura, 1969), which posits that people learn social behaviours through observation, imitation, modelling, and from naturally occurring consequences of their own actions. The therapy has been extensively researched and a modernist, positivist/post-positivist epistemological perspective dominates the field with a focus on categorical distinctions and systematic explanations from empirical investigations (Ntoutsia, 2014, unpublished). From examining studies within the modernist paradigm, it is apparent that there is significant diversity and overlap in conceptual definitions of constructs related to social skills, methodology, assessment instruments, population samples and SST programmes. This makes it difficult to make universal claims about the therapeutic effectiveness and efficacy of SST, which is essential according to the realist view of the world upon which this epistemology is based. The lack of agreement makes the comparison between studies and communication in the academic and scientific communities difficult, and may create uncertainty. Also, the absence of an open and critical discussion about existing methodological and theoretical tensions as reflected in research prevents the exploration of differences and has potentially led to confusion in the field.

Despite the difficulties in making universal claims about the beneficial effects of SST, researchers using quantitative methods conclude that SST is an effective psychosocial therapy and that positive effects tend to be more evident for specific skill areas rather than changes in the clinical presentation of symptoms and functioning in the community (e.g., Kurtz & Mueser, 2008). However, there are still pertinent questions about individuals’ experience of the training, its perceived effectiveness and relevance to their life, and if in fact generalisation of training effects occurs. This raises an important dilemma of whether we have the best possible understanding or just a partial view that does not do justice to the phenomenon at hand. Knowledge from quantitative research is undoubtedly useful, but accounts for isolated factors thus it is not sufficient for an understanding of an individual’s holistic experience.
Service users’ views and experiences are crucial to service research and planning (Macran Ross, Hardy, & Shapiro, 1999) and qualitative research methods may be better suited than quantitative methods for their understanding. This is due to the descriptive and exploratory nature of qualitative research, the focus on lived experience and meaning, the reduced distance between researcher and participants (Hodgetts & Wright, 2007), and the explicit reflexive links to the researcher’s theoretical/epistemological assumptions, personal biases and prejudices. In keeping with the ethics of the psychology profession and in order to understand if and how SST induces change, we need to start from service users’ experiences. To my knowledge, no previous research attempts have been made to understand participants’ experiences of SST through the use of qualitative methods. The present study set out to investigate first-person narratives to complement the theory and practice of SST in a way that taps into the primary sense and mode of the psychotic person’s social world.

Views on the disruption of social life and SST in schizophrenia

The predominant diagnostic classification system of mental disorders (DSM-5) (APA, 2013) explains the phenomenon of loss of relationships in psychosis in terms of social ‘dysfunction’, i.e., a compromised ability to function in different social roles and develop satisfactory social relationships (Corrigan, Mueser, Bond, Drake, & Solomon, 2008). This ability is linked to the presence of social ‘deficits’, that is, deficiencies in social competence – the achievement of personally relevant social goals in daily living (Liberman, 2008). Mueser et. al. (1991) found that approximately 50% of individuals with a diagnosis of schizophrenia were socially unskilled compared to normal controls, and only 11% fell within the normal range of repeated social skills assessments using role-playing. Quantitative studies conclude that individuals with this type of mental health problem have difficulties in face perception, facial affect recognition (Mueser et. al., 1996; Mueser, Penn, Blanchard, & Bellack, 1997) and vocal affect recognition (Hooker & Park, 2002). Studies also show an impaired Theory of Mind – the ability to recognise that others may have different intentions and beliefs, and to make assumptions about these (Badgaiyan, 2009; Bruene, 2005). Overall, the underlying assumption of the notion of social dysfunction appears to be that relational problems arise because of a malfunctioning
brain, which may be unrelated to how one lives, thinks and feels. This renders early intervention necessary to fix what is perceived to be wrong with a person.

As a behavioural therapy, SST is guided by such prevailing medical discourse and modernist ideas. From this viewpoint, learning social skills can help a person compensate for social deficits and social ‘disability’ can be prevented. The picture is further complicated by the presence of factors like residual cognitive impairments and psychiatric symptoms, but a linear, direct and one-sided causal explanation is nonetheless offered that focuses on the person with a context-less ‘disorder’. Consequently, the impact of contextual factors (e.g. abuse, neglect, violence and poverty) on relatedness is ignored, despite arguments to the contrary (Read, Mosher, & Bentall, 2013). Psychotic and social experiences remain separate and the detrimental effect of psychotic experiences on the self in relation to others is not accounted for. Taken together, these introduce the risk that the learning experience in SST may be insufficient and fragmented. It could also be argued that the experience and social knowledge gained in therapy may not fit with an individual’s subjective experience of the social world.

In contrast, a phenomenological understanding of human existence presupposes that human beings are inseparable from their social context (Heidegger, 1953/2010). From this perspective, ‘social deficits’ in psychosis are seen as impairments of intersubjectivity, which is considered to be the basis of common sense that allows us to understand things intuitively, and to socially attune to others and take things for granted (Stanghellini & Ballerini, 2002; Stanghellini, 2004). The body becomes an object and does not influence how one perceives and interprets things, thus, the world is viewed from a distance, motivation is decreased and action is not experienced as intentional (Stanghellini, 2009, Fuchs, 2005). Additionally, the inability to remember or attend to the sequence and content of verbal exchanges in psychosis can interfere with speech or action and lead to distortions of awareness, loss of spontaneity and diminished affect expression (Sass & Parnas, 2003). Perception of time is also disrupted to the point that time can freeze to avoid change and feelings of insecurity (Binswanger, 1956/2012; Fuchs, 2007). In light of this evidence, it is imperative to explore whether the skills taught and the social knowledge acquired in SST can make up for some of the disruption in intentionality and intersubjectivity,
serving as a kind of bridge between the person and their family, the community and society.

The need for further understanding

The present study aims to open up the space for subjective experience to unfold, give a voice to a silenced minority group, and facilitate the dialogue between diverse epistemological approaches by exploring the experiences of SST of individuals with psychosis in an outpatient setting in Greece. The research questions are: How do individuals with psychosis experience group SST? What is it like to be trained in a particular mode of relating and how does the therapy impact the self and social relationships? Research objectives include (a) to describe and clarify participants’ experiences in a way that emphasises subjective meaning; (b) to understand the perceived effectiveness, acceptability and relevance of the therapy in their everyday life; (c) to illuminate barriers to the transfer of skill knowledge in real-life settings.

Methodology

Interpretative Phenomenological Analysis (IPA) (Smith, 2004) was used as a methodology to explore participants’ lived experiences. IPA is embedded in a relativist ontology that maintains that there is no single and objective truth bound by order and laws. Instead, there are multiple subjective truths/realities evolving from subjectivity and existing behind motivation, thoughts, action and interpretations about the self and the world (Krauss, 2005; Willig, 2013). The world is experienced by human beings in particular contexts and at different times in various ways, thus, no general statements can be made about the nature of the world. A derivative of this fundamental ontological position is that knowledge depends on and varies according to the context in which the data is collected and interpreted (Madill, Jordan, & Shirley, 2000). Based on Madill’s et. al. (2000) conceptualisation of epistemological positions, phenomenology lies between realism and relativism and emphasises an attempt to grasp phenomena as they appear to consciousness, and to capture life as it is lived (Moran, 2000).
The choice of the particular methodology was guided by recognition of the importance of the connectedness of human beings with the physical and social environment, and the embodied perception and subjective meaning of phenomena within an individual’s life-world (Ashworth, 2009; Finlay, 2009; van Manen, 2014). An epistemological approach grounded in the philosophical tradition of phenomenology is in harmony with the epistemological stance of counselling psychology (CoP) that views human nature as relational and embodied (Manafi, 2010). It was hypothesised that IPA could provide evidence that would satisfy the purpose of the study and answer the research questions posed, as it maintains an idiographic focus and therefore, it was expected that particular variations in experience would not be lost. The focus is on how individuals with psychosis experience and make sense of SST in a group setting, and how they use the skills they learn in the context of their everyday life. IPA was used to capture the unfolding and complexity of different facets of group activity and participants’ social life from a first-person perspective, examining and interpreting each case before proceeding to making more general claims.

Participants and recruitment

A total of eight participants were recruited from a psychosocial rehabilitation day centre in Athens, Greece, by purposive sampling. The day centre is a therapeutic milieu for people with serious and chronic mental health issues aged from 18 to 65 years living in the community. To be eligible for the study, participants needed to have a diagnosis of schizophrenia spectrum disorder and SST participation experience in the last year with attendance of more than half of total group sessions. Individuals were excluded from participation in the study if they had experienced acute psychotic symptoms in the last month or there was evidence of intellectual disability, comorbid alcohol or substance dependence issues. This decision was made to reduce the complexity of the phenomenon under study.

A written informed consent from the scientific director of the day centre (Appendix A) was received and a screening took place to assess which individuals met study criteria. Potential research participants were recruited through contact with mental health professionals working at the day centre and a meeting with the researcher was scheduled where they had the opportunity to learn and raise questions
about the research. A written description of research procedures (Appendix A) was also given. Potential research participants had one week to decide whether they would like to enrol in the study. Upon return of the signed consent form, they were deemed eligible to take part.

The study sample included 4 men and 4 women with an age range of 34 to 57 years and a mean age of 44.92 years. Seven met DSM-V diagnostic criteria for schizophrenia and one for schizoaffective disorder. Participants had a mean illness duration of 17.67 years. Four had 0 to 1 psychiatric hospitalisations in their lifetime and four had 2 to 4 hospitalisations. All were of Greek ethnic origin; five resided with their family and three in a group home facility in the community. None of them was or had ever been married but two were involved in a romantic relationship. None was employed at the time of the study. Rehabilitation programmes and participation in psychological therapies varied considerably from person to person. No participant chose to withdraw from the study.

Design

Qualitative data were obtained through in-depth individual semi-structured interviews, a flexible tool suitable for IPA analysis (Smith, 2015). Interviews were recorded for later transcription to gain a verbatim account for data analysis and took the form of a phenomenological enquiry by adopting an open and curious stance and using open questions phrased in an appropriate way to prompt participants’ descriptions of perceptions, experiences and reflections. Cues were used to enable participants to speak in an uninterrupted way. The interview schedule (Appendix C) was developed with the goal of exploring participants’ subjective experience of SST and questions attempted to clarify and expand on their holistic experience in terms of how they were impacted and transformed by the training. Strict adherence to the interview schedule was avoided but it was made sure that the conversation did not move too far away from the area of interest (Smith, 2015). Counselling skills were used within interviews to help participants understand their experiences without losing sight of the topic (Coyle & Wright, 1996).

The interviews lasted between 25 and 60 minutes and took place in a professional office of the day centre, a private space and familiar surrounding for
participants where therapeutic and non-therapeutic groups take place. Some time was spent before the interviews to build rapport and trust and following the interviews, the recording device was switched off and a brief discussion took place to understand participants’ experiences of the interview and identify any changes that needed to be made. Reflection on the process and the feedback ensured consistency and suitability of the number and type of questions asked. Emphasis was placed on non-verbal and paralinguistic communication aspects in the process of applying the hermeneutic method, as these aspects also reflect human meaning (Langdridge, 2007).

Ethical considerations

Individuals with psychosis constitute a vulnerable population, thus, informed decisions were made throughout the process, based on the principle of non-maleficence and the Code of Human Research Ethics (BPS, 2010) to ensure ethical research practice. Ethical approval by the Hellenic Data Protection Authority and the University of Surrey Faculty Ethics Committee was obtained prior to commencing the research study (Appendix B).

Participants were informed about research aims, procedures and participation anticipated outcomes, and they were asked to assess any risk from participation showing respect for their autonomy (BPS, 2010). More specifically, they were informed about the reasons to audio record interviews, their rights to confidentiality and anonymity, and what would happen to the data. Participants were encouraged to ask questions about the study at various points before and after obtaining written informed consent and the opportunity to withdraw was reiterated at each stage. Informed consent was a continuous process rather than an action reduced to a signature. This may have helped shift power and control from the researcher to participants, reduce the power differential inherent in the research process and roles, and facilitate the process of disclosure (Karnielli-Miller, Strier, & Pesach, 2009).

Participants were informed that they would determine the pace of the interview, and could take a break or stop the process and withdraw from the study in the case of experiencing distress without needing to provide a reason. An experienced member of the clinical team would be available on site to offer support if needed. Participants were informed that they had the right to withdraw even retrospectively and to require that their data be destroyed. It was emphasised that this decision would
not affect their clinical care in any way. A dilemma related to dual roles/relationships emerged over my past clinical experience at the particular day centre. Two research participants had participated in a SST group co-facilitated by myself for a period of approximately 2 months. This raised concern regarding whether their consent was true and intended and how the dynamic between us could affect the study. Working within the reflective scientist-practitioner model (Lane & Corrie, 2006) created awareness of the factors contributing to the asymmetrical power in the researcher-participant relationship and the dilemmas relating to potential conflicts of interest in achieving research objectives.

I discussed the tension that emerged between my role as a researcher and my past experience as a practitioner with a mental health professional at the day centre to receive support and reflect on decisions that would lead to greater effectiveness and ethical accountability. During the interviews with my former clients, we discussed the conflict arising from my role as an insider and a researcher, the different factors involved in the power equation (researcher, participants and the broader mental health community) and the potential impact on research findings. In the process of practicing research openness, it was acknowledged that our familiarity potentially contributed to building trust and promoted a smooth interview flow. On the other hand, our previous therapeutic encounter ran the risk of creating pressure on them to respond to my questions in a particular way. It is possible that my former clients were motivated by an overriding desire to please an authority figure, or to influence their care by controlling the information they provided. My lived experience of their previous SST group participation also added an extra layer of interpretation, enacting a triple hermeneutic. My role as a researcher was clarified, the expression of participants’ feelings was allowed, boundaries were set, and confidentiality and associated limits were outlined. The research supervisor and the University of Surrey Faculty Ethics Committee were informed about the situation.

A journal was kept during data collection, recording reactions, ideas and insights with regard to potential ethical issues and themes that warranted further exploration. Although time during the interviews was given to allow participants to reflect, it was hypothesised that long silences might cause emotional discomfort or distress, and were broken. The decision was based on my belief that psychotic existence is characterised by internal struggles and tensions that can be easily
triggered and lead to intense anxiety. A commitment was made to schedule a debriefing after the end of the study as a sign of acknowledgment of participants’ contribution to the research and respect for their rights.

Analytic procedure

Data were transcribed verbatim, translated from Greek to English language and analysed and interpreted systematically according to IPA guidelines (Smith et. al., 2009; Smith & Eatough, 2007). Extra care was taken to ensure that the distance between participants’ experienced meanings and interpreted meanings was as close as possible, as is recommended in the literature (Polkinghorne, 2007). To achieve this, transcript translation became a particularly time-consuming process and different English-text versions were considered to stay as true to the original texts as possible. I personally carried out this interpretative act, respecting the anonymity and confidentiality of participants, but the choice of certain words and concepts was discussed and negotiated with a third party – a bilingual Greek/English speaker and mental health professional. The cooperative exchange helped me bind threads of meaning together, whilst being mindful of cultural parameters, but the second translator inevitably became part of the decision-making process of cultural meanings and knowledge production.

Lived experience may have been different in participants’ first language, as it is through language that we understand our existence (Heidegger, 1953/2010), thus, it is recognised that experiential subtleties may have been lost in the process of transfer of meaning. What complicates things even more is that the context in which participants’ words were used following translation is different from their cultural and linguistic context (Temple & Koterba, 2009).

Each transcript was read and re-read many times to attend to the content of the experience whilst listening to the audio recording to capture the emotional tone of what was said. Key parts of transcripts were marked with a highlighter pen to indicate interesting or relevant ideas in the corpus of data. Descriptive, linguistic and conceptual comments were noted in the right margin of each transcript to identify how participants talked about, understood, and felt about an issue (see Appendix D for an example). These comments represented initial thoughts that would potentially prove helpful later on, as they could highlight patterns, inconsistencies or contradictions in
participants’ verbal reports. The process was repeated several times to ensure a thorough analysis of each transcript.

Themes were noted on the left margin of each transcript (Appendix D), summarising the initial descriptive and interpretative notes and exploring interconnections and patterns between them. At this point, my theoretical knowledge about the SST model was brought forward. Initial notes and ideas were transformed into themes using psychological theoretical concepts, keeping the research questions and participants’ words in mind. This carried the risk of introducing bias in the theme selection process (Brocki & Wearden, 2006) thus themes were checked against the transcripts to ensure they were grounded in the data. The same process was repeated and all themes were colour-coded, typed on strips of paper and spread out on the floor. This facilitated the process of drawing out patterns and relationships among themes that were perhaps not obvious.

Super-ordinate themes were formed by means of abstraction, where connections among emergent themes were noted, and themes were grouped together based on patterns identified across cases. Patterns highlighted similarities and differences between participants. Some emergent themes became super-ordinate themes by drawing related themes. The process was selective and certain themes were dropped due to difficulty standing on their own or due to a poor fit with the emerging structure that reflected the research objectives. Superordinate theme labels conveyed the conceptual nature of the themes contained in these clusters of narrative. A table was produced (see Table 2, Appendix E) with each superordinate theme and the themes that comprise it. Key words from participants’ accounts were included to show a clear connection between superordinate themes, themes and the original text, and to create a convincing narrative.

Identification of and clustering of themes is where I became very aware of my role and influence in the research analytic process. This part of the analysis required considerable openness, reflexivity and engagement with uncertainty. The effects of my interpretations on subjectivity and meanings were inevitable. My motivations caused me knowingly or unknowingly to focus on aspects of the texts that I found of greatest interest and relevance, and my knowledge and ideas became evident in my attempts to capture the essence of the texts by using specific thematic labels. The research supervisor was involved after the interpretation and initial analysis to
enhance the credibility of the study by offering an alternative interpretative perspective. Member checking was not completed, as it could have placed additional demands on participants’ time, energy and emotional well-being. This compromises the credibility of the study because it is not possible to know the extent to which the analysis captures what participants wanted to communicate.

Findings

The data analysis yielded two super-ordinate themes that capture a variety of patterns in participants’ experiences. Themes are outlined in Table 1, and are developed and illustrated by transcript excerpts below.

Table 1  
Summary of themes

<table>
<thead>
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<th>Super-ordinate themes</th>
<th>Subordinate themes</th>
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<td>2. Barriers to skills generalisation and suggestions for improvement</td>
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1. Effects of social skills training
This theme emerged from participants’ reflections on the impact of social skills practice. It represents an account of what changes occurred and how these took place over time. For some, these changes took place only in the group, whereas for others the changes spilled over to other contexts. The changes were in how they viewed their self, how they viewed their self in relation to others, and how they perceived others to view them. The process of change is unfolded next.
1.1 *Understanding the self through role-playing*

Three participants described a process of personal development and growth through observing others or participating in behavioural role-playing in the group. Stelios\(^1\) emphasised the element of learning through struggle by engaging in role-playing:

*They discuss a topic let’s say, and this person tries to provide the correct answer on the particular topic in a particular question. And through that I think that he struggles and learns things (Stelios).*

Stelios’ account indicates that the effort invested to achieve the learning outcome is experienced as satisfying and fulfilling because in the end, knowledge is gained and his sense of self grows. He seems to concretise the phenomenon of communication by making sense of it cognitively rather than knowing it in his own being and getting an embodied experience from the inside out. His account reflects a reductionistic thinking and a discourse that there is a right and wrong way of communicating with people. This understanding assumes that there is one truth instead of different perspectives of the phenomenon of human communication and variations of openness to being in relation with others. Observing others perceived to be successful in performing a skill in a role play was described by Nemos as a stressful but also positive experience, which transformed his belief that he is capable of performing in a way that will enable him to achieve his goal. He described a sense of doubt about his ability to perform before engaging in the role-play exercise, and a sense of relief after successful skill performance:

*Every time I have to engage in role-playing, I feel anxious and get stressed...Then I watch the other people engaging in a role play and it raises my spirits...If others can do it then so can I (Nemos).*

Nemos’ account suggests that he tends to compare himself to others in the group and knows what having the experience of role-playing will do for him. This creates emotional arousal that is followed by the desire to take a risk within the context of the role-playing task:

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\(^1\) Pseudonyms have been used to protect the identity of participants.
When I engage in role-playing, my spirit is raised...because I can say ‘There I’ve done it, no problem, I can cope with the demands of the role play’. Before engaging in it I have some doubts, but after doing it I immediately feel okay (Nemos).

As in Stelios’ account, there is evidence of engagement with the role-playing activity and a sense that the goal is worth the effort, as something important is gained in the end. Unlike Stelios however, Nemos takes a risk and shifts the boundary between risk and safety, moving between the fear that he will fail and the desire to succeed. He seems to experience tension as he manages the balance between risk and safety, control and loss of control, fear and excitement. One way of understanding this participant’s experience is through the felt sense of the inescapable uncertainty within our fundamental interconnectedness with others that may underline the process of social skills learning. The anxiety that emerges in the prospect of being subjected to the look of others before experiencing oneself in a more positive way seems to be both inevitable and necessary. For Nemos, participating in role-playing suggests embarking on a paradoxical process of self-transformation involving challenge and opportunity, ambiguity, tension, change, and finally, liberation. Mia captures the essence of relational uncertainty by noting how a most intimate part of her self was exposed as she engaged in role-playing and became aware of herself being observed by other members of the group:

I feel that, not exactly that I am being watched by others, not that I expose myself, but something like that maybe. There are some group members observing me...I expose a piece of myself (Mia).

She described feeling anxious but finding the inner courage to persist and moving forward by learning to tackle a challenge in a new way, going beyond her limits and becoming something else:

I believe that the exposure actually helps you...it helps you become more social, it is good and the fact that I try to go beyond my limits, overcome my anxiety (Mia).

Mia’s narrative provides evidence of a dynamic engagement with boundaries and existential tension. Through participating in role-playing, there is a sense that she
moves between the risk of being seen by others and the safety of remaining hidden, and the certainty and uncertainty of relatedness. Mia negotiates and manages the tension that emerges from these complementary and opposing elements and when the task comes to an end, she relieves herself of anxiety. The learning experience is deep and it is not the skills she practiced that changed her but the way she feels she has changed, as if seeing her self with fresh eyes.

1.2 Changes in the self and the world
Some participants expressed that social skills practice resulted in a change in how they viewed themselves and their social world. Pepi for example, talked about the beneficial changes she experienced, including an increased awareness of her intrapersonal world, greater control over feelings and self-confidence, and an increase in the number and quality of her interpersonal relationships:

*I would get angry whereas now I’ve noticed that I don’t get angry, I stand up and leave and discuss the negative feelings later...And I express the positive feelings at that moment, whereas before I was keeping them inside... (It’s good) to have greater control, self-confidence and be heard by others, whereas before I don’t know if the other was paying attention to me...more people from the group want to hang out with me (Pepi).*

Thus, Pepi attempted to reach out to others long before her participation in SST, but was not able to engage with the world the way she wanted to. She suggested that knowledge about social skills strengthened the certainty that she felt about her abilities. There is a sense that in the group, she managed to understand how she could be with others in a way that makes her feel wanted and listened to. Learning to communicate differently, that is, reaching a kind of fixed, absolute truth about human communication somehow dissolved the obstacles between her self and others. She appeared to gain a sense of certainty of relatedness, which, for her, made the world more predictable:

*I would do it my way without knowing how the conversation would evolve, whereas now they teach us more correct ways, how to communicate better in society (Pepi).*
Here again, this account suggests that there is a right and wrong way of relating with others, and knowing the difference between the two is experienced as satisfying because for Pepi, it opens the gates to the social world. A dualistic experience of the world is implied therefore, revealing a need to adopt a widely accepted objectivist view of communication in order to be able to be part of something bigger than the self. Accepting and embracing an objectivist philosophical perspective suggests reducing communication to specific and simple, though perhaps less flexible forms of dialogue and non-verbal behaviour. It seems that in Pepi’s case, success in applying social skills is something to benefit not only herself but also her family:

In the past we were fighting and the skills helped me be more social with my father, stop fighting (with him), use better words, talk to him more rationally, more appropriately and we reconciled with each other (Pepi).

Similarly to her earlier account, there is evidence of dualism here, represented by reference to what is rational and what is suggested to be irrational, implying tension. This tension is resolved through the use of social skills, which creates unity, as indicated by Pepi’s reconciliation with a loved one. Read together, the above excerpts suggest that communication through the use of social skills relieves the uncertainty and anxiety contained in being in relation with each other in an encounter. On the other hand, reductionism means the end of new possibilities that are dependent on circumstances and intentionality permitting openness to being in relation. Stelios noted that some of the most important things he learned in the group were how to perceive and interpret non-verbal behaviour and initiate contact in different social situations:

This group helped me in social behaviour… If you see someone slouching and you look at him and he doesn’t look back at you, you shouldn’t attempt to sell something to that person or ask him for information as this person may be thinking about something, or is in a rush, or other things may be going on… We look at this person in the eyes first so that we can see whether he pays attention to us… (Stelios).

Thus, through participation in SST, he is able to obtain a clearer view of others and read body language to reveal an underlying truth. This will then resolve the dilemma of whether to attempt to relate to others or not, as it gives information about the
possibility of rejection. Nemos described how he managed to challenge his doctor’s belief about him after he learned assertiveness skills in the group, though not as much as he would have liked. This indicates an act of establishing autonomy and freedom:

*I hadn’t realised that the doctor had written these things about me... I mean it (i.e. the use of social skills) is a way to challenge an expert, a doctor, in a polite way, without creating a conflict... I haven’t challenged my doctor on his view yet. I’ve certainly told him, “Doctor, what you write about me isn’t quite true”... The fact that I pointed it out to him really mattered to me (Nemos).*

He noted that in the beginning, the possibility of confronting his doctor created a fear of becoming rejected, or controlled and restrained, but his fear did not materialise:

*I overcame my own fear... that I would have to find a different doctor, or that they would take me to the doctors as a patient... I had this anxiety that something might happen, but in the end nothing happened (Nemos).*

This account mirrors a power issue and suggests that Nemos’ fear of being overpowered by another person who is in a position of authority led to ultimately going along with the other’s view despite disagreeing fundamentally with it. This may involve a sacrifice of something that is of personal value and comes at a cost. He described how he eventually managed to challenge his doctor with the help of a psychologist at the day centre with whom he was working closely in individual therapy:

*She said, ‘Doing this takes guts’. I took it to heart and thought to myself, ‘Why not?’ and I said it (Nemos).*

Thus, the process of change for participants appears to be driven by inner tension, willingness and ability to take risks in the social world, moving beyond isolation and insecurity. Nemos’ narrative, however, suggests that when the stakes are high, the knowledge of social skills is not enough and the threat of relatedness may be tackled by means of genuine dialogue in the context of therapy that gives rise to novel insights and self-understandings. The application of social skills thus can be facilitated by expression of subjective meanings attached to experiences and emotional words that clarify the feelings associated with those experiences. This type of exploration in the
presence of the other may place the self in relation to intentionality and personal values that are to be protected.

1.3 Social skills as a means to fulfil the need for acceptance
Some participants reflected on how they are perceived by the world as they practise social skills and how they use social skills to be socially accepted. Stelios expressed a view that the learning he gained in the group afforded him the opportunity to become re-integrated in society by using skills and managing social situations effectively:

*When you’re among a group of particular people every day, you use...a different lingo...However, when you’re in a social setting, say at the workplace...There you should know how to use social skills (Stelios).*

For Stelios, social skills may represent the rules of the game of social interaction. If one does not know the rules, one cannot play and is automatically excluded from important areas of everyday life. However, for some participants discussing this proved to be an emotionally difficult and a complicated task. For example, Pepi referred to an incident where she interacted with a person whom she perceived to be afraid that ‘schizophrenia’ is contagious the way that a cold or flu is:

*The moment I told her that I am ill, she put her tissue on her face and stopped talking to me (Pepi).*

Pepi’s account implies a dichotomy between health and illness, and suggests that the diagnosis of schizophrenia and associated stigmatising attitudes serve as a major obstacle to relatedness regardless of individual social competence. She described a need to be understood and accepted by mainstream society, fuelled by a sense of unfairness due to her perceptions and experiences of mental health stigma:

*They are not giving us the attention we would want. Even on television, whenever someone does something, they blame it on mental health issues. I would like for people to understand us, not reject us. What happened to us is not our fault, others hear voices, others are afraid to take a walk, others are being watched, others...have lost their parents and are afraid and get sick...and take their medication and then I don’t know why people behave like that, it is not our fault (Pepi).*
In contrast to Stelios, it seems that although Pepi valued the knowledge she had gained in the group and its positive effects on her life, it still was not enough for her to feel accepted and integrated into society. She divided the world into two distinct groups (‘us’ and ‘them’) and described a negative bias towards her own group. Her account suggests that psychosis can trigger misunderstandings that cannot be resolved through the use of social skills. When that happens, Pepi’s experience is that the world is cruel and rejecting. Eugene expressed confusion about his place on the presumed spectrum that stretches from mental ‘illness’ at one end to well-being at the other. This feeling was shaped by people’s attitudes towards him. He spoke of and rejected psychiatric diagnoses, giving primacy to subjective experience:

*I basically don’t know where I belong... Some treat me as if I am sick and some treat me as if I am well, which confuses me to a degree. Anyone can say whatever one wants, what does it mean? The point is how you feel. They are labels basically... It doesn’t mean anything* (Eugene).

For Eugene, the confusion in regards to other people’s behaviour leads to self-identity confusion and a need for self-definition. Not being able to provide a rational explanation for this confusion creates despair or anger, and leads to rejection of diagnostic categories. Pepi’s and Eugene’s excerpts point to an interrelationship between self and other that gives rise to dissonance and contradictory views when mediated by cultural stereotypes, placing limitations upon experience. For these participants, there seemed to be an element of distance after encountering experiences of otherness and marginalisation, as if choosing to opt out from being-with. This disengagement is thus reflective of Cartesian dichotomies and objectification of otherness, and reveals assumptions of superiority and inferiority that lead to splitting and opposition, and prohibit a sense of at-homeness.

2. Barriers to skills generalisation and suggestions for improvement

This theme describes perceived aspects that prevented participants from transferring the social skills they learned in the group to everyday life settings. Some of the difficulties with skills generalisation were internalised and seen as a product of the mind and some were externalised and seen either as the product of relational
dynamics or a problem of the social microcosm of the SST group. The theme also offers participants’ ideas of ways to improve the therapy.

2.1 Cognitive and psychological aspects and relational dynamics
Overall, participants identified a number of factors that they considered to prevent them from practising social skills beyond the training setting. Participants saw the lack of skill transfer largely as a personal failing. For example, Mia noted how anxiety is an important self-imposed obstacle in communicating with others, which she linked to personality traits and psychosis:

*In my daily life there is anxiety about interacting with other people but I believe it is a more personal matter, the group is not responsible for this...The anxiety I experience about interacting with others is a matter of character and my condition.*

*I am not so talkative nor sociable and perhaps I find it hard sometimes to express myself, if someone doesn’t address me I won’t talk...In general I am experiencing some difficulties with human contact... (Mia).*

Her account indicates that the self, psychosis and anxiety cannot be separated and difficulties with relatedness need to be considered in light of this complexity. Exploring this further, Mia revealed that anxiety defines her existence in social contexts. She reported that anxiety blocks her in social situations and then she finds it difficult to use the skills she has learned in the group. She appeared to take responsibility for this and expressed feelings of sadness:

*If I didn’t experience the anxiety that surrounds me when I interact with other people I believe that social skills would be helpful... I get anxious and I get blocked and I feel sad...It’s a pity that I let it overwhelm me and I can’t be functional (Mia).*

Mia’s anxiety increases to such an extent that she loses control and skill knowledge, which leads to sadness and a negative perception of self. Although the role of psychosis was acknowledged in her previous account, the blame is now fully internalised, contributing to a feeling of emotional isolation with traces of compassion for her situation. Similarly, Violet held the view that personality traits affect her ability to apply conflict management skills in difficult social situations. This participant perceived her upbringing to be partly responsible for this and in particular,
the dynamics in her relationship with her mother, who, according to Violet, was overprotective and overinvolved. This left her feeling unable to cope with situations where she became the target of mistreatment, and guilty for rejecting people that her mother did not approve of:

_When people pick on me I find it difficult to defend myself. I am built this way, it is my character and I also think my upbringing. My mom would take me away from people she didn’t want me to hang out with… and take me somewhere else. So I have this difficulty, I can’t easily handle a situation where someone picks on me and defend myself…. She would say, “My child isn’t picking on anyone, why are they picking on her? … She should go with people who love her”. But as I was growing up I thought to myself, ‘Isn’t it a shame to reject people who ask me to hang out with them just because my mother doesn’t like them?’ (Violet)._ 

It seems that Violet moved from being the one treated unfairly and potentially feeling rejected to being the rejecting one until she was in a position to question her mother’s practices. She takes an ontological position that implies that personality confronts us as an external fact that is fixed from the past and beyond our influence. She described retreating from conflict when she felt she became the recipient of verbal aggression to the point of “torturing” herself. By maintaining a reflexive relation to her body, she described the mind as an object that stops functioning as intended, blocking herself like Mia:

_I back off when there’s conflict… I torture myself when others speak badly to me. There’s something wrong, my mind gets stuck and I can’t do anything about it (Violet)._ 

This account suggests that once Violet experiences her mind as having stopped functioning, she loses control and it is as if her whole existence freezes. Two participants explicitly noted their memory difficulties as an obstacle in applying the skills learned in the group. Nemos expressed the view that successful application of social skills involves following the steps of the skills religiously, and he attributed the difficulty to apply them to a perceived impairment of memory:

_I think that I am not the type of person… who remembers something easily… to practise a skill and learn it, remember it word for word… Perhaps my memory doesn’t work very well… (Nemos)._
There is a sense that Nemos has unrealistically high standards, as indicated by his need to recall the skills verbatim, thereby setting himself up to fail and then taking the blame for it. He spoke of the challenge of self-motivation and relying on external support to be able to achieve things, a strategy he developed from an early age:

*I was like this ever since I was a child...I needed a crutch to be able to do something...my parents’ opinion, the neighbours’ opinion...to achieve things, I can’t easily motivate myself (Nemos).*

Nemos has been sinking into an exaggerated dependence on others ever since he was a child, suggesting that the world was emptied of meaning and he lacked a clear sense of purpose and direction. The toll this took on his existence was a loss of his individuality. He associated the challenge he faces with his experiences of the school learning process and evaluation system, as well as an excessive focus on outcome as opposed to process. Nemos argued that, as a result, he does not use the skills out of fear of failure and his own self-criticism:

*It’s like in school where we used to learn things by heart. This has stuck on my mind... In the end I focus on evaluation and not on the skill...If I manage to practise the skill well, what will supposedly happen?...Nothing will happen, it is just on my mind... (Nemos).*

Although he recognises and challenges his dispositional stance toward the process of learning, there is a sense that this remains fixed and unaffected, as if any change would be experienced as threatening or destabilising to the existing system of security. In contrast, Maria attributed equal importance to her memory difficulties and her psychological state at the moment of skills practice, but she identified her volatile temperament as the reason for forgetting the skills. She appeared to experience anger in response to problems in her everyday life as an uncontrollable emotion:

*Most times I can’t because I forget what I have to say or I am irritated, I am not psychologically well and I am not in that position. Sometimes...I forget how to talk, how to behave, I am pretty intense, I am volatile but I don’t want to, it just comes to me because of the problems that exist, the situations I am in (Maria).*
Maria seems to experience anger as binding and disruptive to the flow of communication to the extent that control is unattainable and removed from the self and behaviour deviates from the social norm. This participant equated social skills with good manners and socially acceptable behaviour, and her perceived poor performance in social situations had an impact on her self-concept:

*I forget... I talk the way I think is right and maybe it’s my mistake to misbehave, forget the social skill and sometimes be polite and other times be aggressive (Maria).*

Maria’s account suggests a struggle between conformity that is represented by the application of good manners and opposition to it, as evidenced by the presence of aggression. Despite the varying accounts within this subtheme, participants’ lived experience did not start from an a priori fact of being with others. This particular mode of existence implies lack of a relational identity developing through negotiation and dynamic communication and interaction with others. It further suggests taken-for-granted certainties about oneself and difficulty with openness and movement in the process of becoming.

### 2.2 The struggle between an authority figure’s perspective and the personal perspective

Three participants explored the meaning of someone else having superior knowledge about social behaviour. Nemos discussed how he already used a particular social skill that was part of the SST programme. He emphasised the importance of social skills being validated by the science of psychology, but also expressed a desire to do things in his own way:

*It’s not the same to actually see it on paper...to know that it’s valid because it’s written somewhere. That’s different from thinking it’s good without knowing it from somewhere.
I believe it’s important because it’s written somewhere...it’s kind of scientific...it’s not just my view, it’s also psychology’s perspective...
I prefer to go by the song, ‘My Way’ by Frank Sinatra that inspires me to do things on my own but anyway, every time I have to do things, they should be written somewhere (Nemos).*
This account reflects tension between being driven by a sense of personal agency and lack of a sense of control or a feeling of having a personal role in things. There is also evidence of intolerance of uncertainty and a tendency to adopt fixed ideas to defend against anxiety. It is as if scientific knowledge provides the context from which personal experience unfolds. Maria on the other hand spoke of having an authentic dialogue in personal therapy with a psychologist at the day centre. This participant felt she could not discuss personal issues in the SST group, where she had to engage in a specific and predetermined set of activities:

_I discuss personal issues with Mrs Ellie and she advises me, she asks me what’s wrong, how I am, she asks me. She knows. In the group we mostly do role-playing and learn about how to engage in conversation (Maria)._ 

Maria’s account reflects a sense of being seen by an other, but perhaps also embracing the other’s opinion as indicated by the pronouncement, ‘She knows’. It seems that Maria has a real and vibrant communication with her therapist, but there is also a sense that in the SST group she exists behind a social mask that is based on common values of society embodied in norms. However, Eugene had a different understanding of this. He challenged the primacy of the training programme and the existence of an authority figure in the face of a mental health research professional who wrote the SST manual and who knows better:

_There are no guarantees. No one can tell you that this is the Bible. It is not the Bible._
_We are all being judged...He has written nothing and what does it mean that he has written this? (Eugene)._ 

This participant found it difficult to apply conflict resolution skills, which he perceived as prescribing a particular set of affective responses in communicating with another person:

_That is the most difficult of all, i.e. to look at the person and speak calmly and firmly and explain to him the problem...because there is rage, there is annoyance, there is sadness and there is joy. You can’t always be calm and have the look of a cow and talk to a person saying always ‘yes’ (Eugene)._
Eugene’s narrative reflects anger, possibly from fear of his existence losing its personal quality and uniqueness, becoming a mere copy of socially accepted ways of being. He expressed a desire to communicate through verbal, non-verbal and paralinguistic features in his own unique way, depending on how he feels in the moment, thus adopting an ontological stance that allows for free will and freedom of expression:

*I want to be able to use my own tone of voice. It may be very aggressive, it may be very calm...depending on my psychological state (Eugene).*

He described how he raised his concerns in the group and challenged the group facilitator reacting angrily towards him. His rebellious response was received defensively, leaving him with anger and self-doubt as indicated by his identification with the image of a mentally ‘ill’ person, a person he perceived to be less functioning than a ‘healthy’ person:

*I have quarrelled many times with John, who runs the group...and I have also shouted at him. I say, “What are you talking about now? Can these things happen?” John said, “Eugene is expressing a disagreement about the session and places an atomic bomb at the foundation of the group”...I react, seeing what is written in here, the way it is written... This is where I had disagreed, I remember. Who said that this is this way?... I may not be an example of a healthy person but who says a healthy person can do these things? Does the other have to do it just because we ask for something in a polite way? ... I may ask for a glass of water in a polite way and they won’t bring me one (Eugene).*

There is a sense that by accepting the unwritten rules of social communication, Eugene would risk losing his sparkle and individuality, and that the use of social skills would stifle his natural way of being with others. His account also raises a dualistic distinction between what is ‘normal’ and what is ‘abnormal’ that fills him with confusion and shakes his self-confidence as is also suggested in a comment in an earlier extract. Social skills use is almost identified within participants’ accounts as a means to achieve group membership and a threat to the role of a unique, self-directed, independent individual. The absence of a solid relational grounding in the experience of the group can be interpreted as reflecting a sense of ontological strangeness that
made the skills knowledge intimidating and the feeling of a sense of belonging difficult for them.

2.3 The fit between the group and external realities
Many participants identified a mismatch between the social reality of the group and the world of relations to people. A feature that echoed across most participants was an appreciation of the difficulties involved in real-life social situations. Mia identified herself as an introvert and reported finding the steps of the skills helpful in her communication in the group but not in the social world where communication generates a conscious stream of anxiety:

Generally speaking I am not very talkative so these skills help me function. Outside the group there is anxiety but I try to communicate. I don’t think of the steps but I try to talk as much as I can (Mia).

She seems to fight back against anxiety and insecurity in an effort to establish a social grounding. Valias spoke of the construction of an inauthentic world of engagement and connectivity that led to acceptance in the group and highlighted that in real life there is disagreement and risk of rejection. This participant suggested that using social skills to follow through with requests cannot protect one from conflict and disappointment, and he argued in favour of a more assertive attitude in dealing with disputes:

There is a great discrepancy between the things we learn here and life. Things are tough out there. You need to take the bull by the horns right from the start. It’s just like in the movies...like a movie with a script... If you try to do this out there, you are going to be rejected...because there is disagreement out there. Here, we might make up with each other but actually, in real life this will turn out to be a complete disaster (Valias).

For Valias, the group seems to represent unnaturally stable and perfectly symmetrical relationships, whereas his experience is that relationships are awry and messy. He also highlights a fundamental dimension of interpersonal relationships; namely, dominance versus subordination. Maria also questioned the link between the group and external
realities, feeling that there was no room for anger in the group, as in her mind expressing anger would constitute inappropriate behaviour.

*There is no relationship between what happens inside the group and the (day) centre. In the group we don’t have any disagreements. We also talk about other stuff but mainly we talk about how to behave (Maria).*

Maria and Valias’ accounts suggest that they experience the group as an artificial version of social reality where everything must be kept nice and comfortable. It seems that for these participants, conflict and expression of feelings of anger have no place in the group the way it is structured at the moment. This scepticism towards the therapy is shared by Eugene, who commented on the predictability of responses in role-play scenes for social skills practice in the group. He used an example of a social interaction in the real world to illustrate the inauthentic quality of the dialogue in role-play scenes based on the steps of the skills, and challenged the notion that the group reality can be translated into concrete world reality:

*Role-playing is helpful but the responses you get are as expected... It’s either negative or positive... the people I know and I am surrounded by do not react in this way.
It was a dialogue that was different from the ones we have here. I knew what I had to tell this girl...If I had applied the social skills and talked to her the way we talk in here, I think she would have responded in a verbally aggressive manner (Eugene).*

Regardless of whether the obstacles to skill transfer were portrayed as internal or external, participants experienced them as unsurpassable, beyond control and personal effort. Only one participant, Eugene, took responsibility and immersed himself in an exploration of truth, but he appears to somewhat disown his aggression that pervades most aspects of his accounts. Some of the discrepancy experienced in relatedness between the group reality and the external social world can be attributed to difficulty adapting one’s social frame of reference in the direction of conformity. It is also possible that participants’ lived experience represents difficulty in engaging with an objectivist portrayal of communication in which self-other interactions occur in ways obviously predicted and forced.
2.4 A different outlook on the training

Some participants suggested ways in which social skills training can be improved. Nemos expressed the view that further support was needed to foster flexible thinking and overcome self-imposed barriers that swamp his spontaneous expression:

*I believe that it could give general guidelines… One could be that…you should have first thoughts for second thoughts to go away…that what comes to mind first is the best. If I try to…apply a social skill in every situation, I think this is rather masochistic…Every time I say to myself, ‘Say it in your own words and whatever happens, happens’* (Nemos).

This account suggests that Nemos would like some help with developing his capacity for free play with the social skills in order not to become overly dependent on the intellectual side of his existence. Valias, on the other hand, suggested a modification of the training programme by using an alternative scene in the role play when teaching conflict management skills, this time without using the steps of the skills that serve to de-escalate anger and hostility:

*Let’s bring real people in the group and see what happens. “Why did you hang the laundry in my courtyard? I can’t go outside” and so on… At that point there will be a mix-up. There is no savoir vivre in these situations. We should bring two housewives in the group…They are going to pull each other’s hair!* (Valias).

It seems that for Valias, SST does not address the complexity of our bonds with the social world, particularly those situations in which we try to impose our will on others and dominate them in the process of achieving our goals. Finally, Eugene proposed a flexible and individualised approach in SST that tailors skills for individual needs and characteristics:

*I would like to know that someone who suffers from schizoaffective disorder that creates these symptoms and based on the social skills that you are trained in, you can be helped in this and that area, assuming you apply them in your way and try to own them…to learn social skills because they can be helpful in a sort of general way doesn’t make sense* (Eugene).
In this section there is a clear need for guidance towards personal development and better living, and a desire to extend the limits and widen the horizons of the SST group in a way that reflects external reality more accurately. Nemos, Valias and Eugene remind us that they participate in a relational process – a process of joint action with the therapist in the group and people in the social world. Like any other human interaction, communication appears to be a process of dialectical construction of meaning and self/other discovery, suggesting the need for relational skills.

**Discussion**

Effectiveness of SST

Most participants in this study reported positive effects from participation in the SST group and for some, these appeared to extend beyond the therapy setting. Participants identified different ways in which the training had helped them and some noted a change in the number and quality of social relationships, which allowed for re-integration in society and an increase in self-esteem. These findings are in agreement with previous findings of quantitative research suggesting that improvements in social skills are associated with an increase in social functioning and self-esteem (e.g., Dilk & Bond, 1996; Kurtz & Mueser, 2008; Ji-Min, Sukhee, Eun-Kyung, & Chul-Kweon, 2007). Participants also reported an increase in the ability to perceive and interpret cues in social situations, which supports the idea of a positive relationship existing between social skills, social perception and social functioning (Couture, Penn, & Roberts, 2006).

Several participants reported a change in the self as a result of engaging in role-playing. They described a process of overcoming self-imposed obstacles and transcending the self through personal effort and observational learning of successful social interaction. This finding relates closely to a basic application of social learning theory (Bandura, 1969) pertaining to the acquisition of social skills through the use of modelling and other modes of observational learning. There is also support for previous findings suggesting that modelling exerts a strong influence on the development of self-efficacy beliefs (Pajares, 1997). The findings of this study, however, show that benefits from role-playing go beyond what is prescribed by the
behavioural paradigm. Participation in role-playing provided an opportunity to engage in self-reflection, develop a contextual perspective and believe in oneself enough to initiate intentional action. This is in line with the view that the social dimension cannot be flattened to include primarily intrapersonal aspects, as it is mainly determined by personal values, goals and beliefs (Stanghellini & Ballerini, 2002).

There was some evidence that role-playing facilitated change through exposure before the gaze of another. From an existential-phenomenological perspective, being seen by another requires an intentional understanding that involves awareness of the body and the surrounding, determines feeling states and opens up a world of possibilities (Sartre, 1943/2003). The way the therapy is set up, there is no space for discussion about bodily awareness, internal states and perceptions of alteration of the self in relation to awareness of an other person, as conversation is recommended against (Bellack, 2004). Discussion in the group mainly serves the purpose of giving positive and corrective feedback on the quality of behaviours exhibited in role-play exercises (Bellack et. al., 2004; Liberman et. al., 1989). Internal states may be talked about but only insofar as they affect performance of skilled behaviours (Goldstein, Sprafkin, & Gershwa, 1976). This means that if the role-play is performed in a way that indicates successful acquisition of a social behaviour, then internal states need not be explored. Indeed, this may prevent access to an important source of learning that promotes bodily agency and intentional action – aspects that are perceived to be critical preconditions for developing an intersubjective sense of self from a existential-phenomenological standpoint (Fuchs, 2005; Stanghellini & Ballerini, 2002; Stangellini, 2009). On the other hand, observational learning followed by group discussion that aims to facilitate awareness of bodily feelings, personal strengths and vulnerabilities may lead to a sense of possibilities in the group and, by extension, the social world. This, in turn, may help reduce anxiety, depersonalisation, uncertainty and ambiguity in social interactions, and may increase motivation for intentional action and personal agency.

The findings of the present study reveal that the use of social skills may not protect individuals from experiences of societal rejection and feelings of stigma. Important aspects of this experience were confusion about self-identity, a sense of unfairness and anger, as well as a need to be understood and accepted, in line with previous research on subjective experiences of stigma (Schulze & Angermeyer, 2003).
It is important to note that only one research participant in this study highlighted the importance of subjective experience and rejected psychiatric diagnosis. Seeing the world through the lens of subjectivity, understanding human distress and moving beyond the concept of psychopathology are views embraced by CoP (Milton, Craven, & Coyle, 2010). Overall, findings suggest that the concepts of psychopathology and well-being need to be addressed in the group or therapeutic effectiveness may be reduced. It is argued that the concept of well-being needs to be sketched in a multifaceted and contextual way that includes the everyday unfolding life, the tension created by the shift between familiarity, unfamiliarity and a primordial and groundless state where one risks losing oneself in others (Heidegger, 1953/2010), and the unique ways to manage this tension. From this starting point, stigmatising and discriminating attitudes can be challenged, thereby potentially increasing the level of involvement with the therapy and the possibility of skills use in everyday life.

Findings also suggest that group members may not transfer social skills to natural settings when there is a fear of going against a perceived authority figure. This supports the premise that the parameters of the social situation affect skill practice (Bellack, 2004). However, in one particular case, it was the participant’s involvement in personal therapy and his capacity to make use of the therapeutic relationship that determined the outcome, which supports the link between the construct of therapeutic alliance and a positive outcome (Cooper, 2008). Not fully considering the social context in which group members interact may stand in the way of recognising and working through important dilemmas and conflicts that serve as an obstacle to the use of skills. This highlights the need for research to explore the value of creating a safe, containing and reflective space where awareness of interpersonal dilemmas becomes possible.

Social skills generalisation

Participants identified specific obstacles that prevented them from applying the social skills they learned in therapy. These included mental health issues, personality traits, perceived impairment of memory, feelings of anger and low frustration tolerance. Other obstacles were low self-motivation and an external locus of evaluation (Rogers, 1961), i.e. a lack of a sense of control and an ability to recognise one’s personal role in events. There is evidence from positivist research arguing for a
positive relationship between social functioning and verbal and working memory (Addington & Addington, 1999; Smith, Hull, Goodman, Hedayat-Harris, Willson, Israel, & Munich, 1999). This perspective introduces the need for structure and repetition for skill acquisition to occur. From a phenomenological point of view, lack of integration of information from working memory, attention and prefrontal executive functions leads to a disruption in the sense of time and continuity (Fuchs, 2007). This perspective points to a need to synthesise relevant information from group members’ past and present, and combine it with a unique view of the future to create a narrative thread. The value of such an opportunity may be an understanding of actions and ways in which skills can be used to reach a valued state of being with others despite difficulties encountered.

Some participants touched on the role of the social world and linked family and school experiences and the effect of educational evaluation to the ability to use social skills. Overprotectiveness and over-involvement from important others is a common experience among individuals living with psychosis (Wagner et. al., 2011), and it was identified as having an adverse effect on skill transfer and social functioning. The paradox here is that the high level of structure in SST can be viewed as a form of overprotection. Thus, future research could seek to identify the necessary conditions of therapy for group members to be able to claim more space in the social world.

Interestingly, participants seemed to have fixed ideas about their social competence and accepted a dualistic dichotomy between social competence and incompetence. This finding parallels the positivist perspective that views individuals with psychosis as low in social competence and social skills (Bellack & Mueser, 1993; Liberman, 2008; Mueser et. al., 1991), and perhaps suggests a static narrative. According to this narrative, the relationship between social competence and social skills is predetermined and unchangeable. To some extent the finding also echoes the phenomenological view that the sense of time is disturbed in psychosis (Binswanger, 1956/2012; Fuchs, 2007). Inherent to the model of SST is an assumption that time is experienced in a linear process, implying that beliefs of personal ability and effective use of social skills can lead to positive social outcomes under specific circumstances, in line with the positivist theoretical perspective (Liberman et. al., 1986). However, from an existential-phenomenological perspective, life is fluid and human beings are
in constant change with their existence unfolding (Merleau-Ponty, 1962/2002). Thus, it is only natural that social competence will fluctuate in time, as existence is experienced differently at different times (Cohn, 1997). It follows that failure to acknowledge this possibility can lead to perceptions of personal inadequacy. This translates to a real need to challenge fixed understandings of social competence and to offer an alternative conceptualisation of time as cyclical, rather than linear, with the present moment always containing the past and anticipating the future (Heidegger, 1953/2010). This idea may be experienced as liberating because it allows for an understanding of human beings always being in the process of becoming and learning from their mistakes in the context of their social relationships.

A related obstacle to skills generalisation reported by participants in this study was the tension created by the dilemma of either embracing an authority figure’s perspective or following one’s own convictions about how to behave in a social setting. For some participants, following the steps of the skills as prescribed by the training programme seemed to be the only choice and skill practice took place strictly in the therapeutic setting. The exception was one participant who challenged the primacy of the training programme and the authority of mental health research professionals, and expressed a desire to communicate in his own way. It seems reasonable to conclude that the degree of structure in SST undermined skill transferability across contexts. From an existential-phenomenological perspective, uniqueness is neither pathological nor problematic (Cohn, 1997) and it is not necessary to force an individual’s social responses into predefined categories. It is possible that the high level of structure in therapy stripped participants of personal power and autonomy in the process of replacing social behaviours that stand out from the ordinary with normative social behaviours for the sake of fitting in.

Several participants identified a mismatch between the group reality and external reality, making it difficult for them to transfer their skill knowledge. The difference between the two realities mainly revolved around conflict and associated feelings of disappointment, anger and anxiety. Some participants’ subjective experience was that there was absence of conflict and expression of negative feelings in the group, which agrees with the finding of previous research that individuals with psychosis perceive the main function of therapy to be the suppression of behaviour, thoughts and feelings that deviate from the norm (Wagner et. al., 2011). An important
point that emerges is that structure may protect practitioners from aggression, but it can also create a kind of pseudo-reality that bears little resemblance to a world where rejection and emotional pain is commonplace.

Suggestions for therapy improvement

Some participants made suggestions for improvement of the SST model, including the provision of further support for one to be able to trust oneself more and achieve a more spontaneous expression in interpersonal communication. This mirrors the phenomenological view of psychosis in terms of alterations in self-consciousness and subjectivity (e.g. Sass & Parnas, 2003; Parnas & Handset, 2003). The experience of ontological insecurity in the absence of a solid sense of self and trust in one’s own essence (Laing, 1960/2010) may be reflected in the difficulty to generalise social skills to new social situations or settings. On the other hand, a stable and secure identity may denote a need to know oneself through relating to others (Stanghellini & Lysaker, 2007) in the context of skills training.

Another recommendation was to include conflict and aggression in role-playing in a way that accurately represents external reality. Acknowledging the existence of aggression and engaging with it may be necessary given the view that conflict is a natural part of group interaction and development (Yalom & Leszcz, 2005). Alternatively, the group reality could fail to correspond to clients’ experiences in the social world and such an occurrence could limit the effectiveness of therapy. Group facilitators may need to engage in their own personal process to be able to deal with aggression – an insight that is supported by phenomenological research studies (e.g. Fletcher & Milton, 2005).

Finally, there was a suggestion for the training to be tailored to individuals’ needs, based on their characteristics and personal circumstances. This translates to a need for SST group facilitators to look for the unique; unique stories, personal strengths, vulnerabilities and needs so that group members can navigate their unique world of relationships within the safety of the group’s social microcosm (Yalom & Leszcz, 2005).
Conclusion

The findings of the present study suggest that participants considered SST to be an acceptable but partly relevant and effective therapy. There appears to be support for a semi-structured approach to SST that would allow for exploration of relational concerns, conflicts and dilemmas that serve as obstacles to skills generalisation. Findings also suggest a need for a paradigm shift toward integration of behavioural principles and phenomenological understandings, moving away from medical discourse and offering a view of psychotic existence that takes subjective meaning and intentionality into account.

Limitations of study and suggestions for future research

This was a preliminary study, the findings of which cannot be generalised because the lived experiences of participants in this study are considered to be unique. In some cases, comments were brief and concrete and speech was circumstantial requiring a more active stance by the researcher, which is in contrast with the phenomenological attitude. There could be a sample selection bias, as my two former clients may have felt pressure to give favourable responses in the interviews due to my presence. An independent interviewer may have generated a different set of responses. Our previous therapeutic encounter may have also imposed a skewed interpretation of their experience of the SST group.

Adding to the limitations of the present study, it was not possible to achieve an in-depth understanding of every participant’s subjective experience, translation posed challenges in transferring meaning and member checks were not performed. The lack of member checks following data analysis arguably reduces the credibility of the study. Further qualitative research focusing on narratives or other types of qualitative data is needed to examine SST. A tentative overall conclusion is that it is time to take stock, look ahead and change direction by using qualitative research evidence for the design and implementation of a new therapy for social difficulties in psychosis. Therapeutic effectiveness can be evaluated using a quantitative research method.
References


Appendix A
Letter to the scientific director

My name is Paraskevi Ntoutsia and I am a trainee counselling psychologist at the University of Surrey, UK. I am doing a research project as part of my psychology doctorate in Psychotherapeutic and Counselling Psychology on the experiences of social skills training in individuals with a disorder in the schizophrenia spectrum. The study aims to utilise participants’ accounts to identify the implications of their experiences for future therapy protocols. I would like to invite the members of the (name of) day centre to participate in this study.

The duration of the study will be approximately one week. With your consent, I intend to interview 4 to 10 members of the day centre who have participated in group SST. The interviews will last up to 60 minutes and will involve questions about their experiences of SST and how the training affects their social relationships, if it does. Before participants are recruited, they will be briefed verbally and in writing on the nature and aims of the study, what participation entails, and their rights to confidentiality and anonymity. They will also be informed about the use of a recording device, provided with the opportunity to ask questions and asked for written consent.

All data will remain confidential via coding, secure data storage and anonymous reporting. To enable potential follow-up interviews, individual data will initially be coded with a number and the document with the numbers will be destroyed once there’s no need for it. After the end of the study, data will be kept for 10 years, in line with the University of Surrey, UK Code on Good Research Practice.

Please feel free to contact me (e-mail: p.ntoutsia@surrey.ac.uk) or my supervisors, Dr Dora Brown (tel. 0044 1483683979, e-mail: dora.brown@surrey.ac.uk) and Dr Riccardo Draghi-Lorenz (email: r.draghi-lorenz@surrey.ac.uk) should you require further information.
Thank you for your time.
I (Title and name of Director in BLOCK CAPITALS)..............................................................
confirm that I have read the above and allow Miss Paraskevi Ntoutsia to conduct research at the (name and address of) mental health day centre.

Signed:

........................................................................................................................................

Date:

........................................................................................................................................
Participant Information Sheet

My name is Paraskevi Ntoutsia and I am a doctoral student/trainee counselling psychologist at the University of Surrey in the UK. I would like to invite you to take part in a research project. Before you decide you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

What is the purpose of the study?
This study is carried out with the purpose of exploring what it is / has been like for you to participate in a social skills training group and how the training has affected your social relationships.

Do I have to take part?
No, you do not. Your participation in this study is entirely voluntary thus it is up to you to decide whether you want to take part or not. If you decide to participate, you are free to leave the study at any time without giving a reason. This means that you can stop the interview at any time or decide at the end of the interview that you do not want what you have told me to be used in the study. This will not affect your clinical care in any way and what you have told me will remain strictly confidential, meaning that it will not be shared with anyone, including staff members.

What will happen to me if I take part?
You will be asked questions as part of an interview and your answers will be audio recorded. I will follow ethical research practice and the information you give will remain confidential, meaning that your name and answers will only be accessible to me. I may use quotes in my research report to highlight key findings but names and personal details will be removed to protect your identity. Personal data will be managed in line with the UK Data Protection Act 1998. The information you give will be stored in a password-protected file in a secure server located in the University of Surrey, UK premises. Research data will be kept for 10 years, in line with the University of Surrey, UK Code on Good Research Practice.
What are the risks of taking part?
No serious risks are anticipated from taking part in the study. If you experience any distress or problem answering to the questions, we can pause and you can discuss your concerns with me or a member of staff.

What are the benefits of taking part?
Your answers will help me come draw some conclusions about SST. This knowledge can be used to improve the content and way of conduct of the training in the future to best help you and the other members of the day centre who will participate in the training. Your answers may also promote knowledge in the area of mental health and you may find the experience of participation in the study rewarding, as you will have the opportunity to voice your opinions, expectations, wishes, and concerns in relation to the training.

Will I be informed of the results of the study?
The results of the study will be available to you after the end of the study. We can schedule a meeting for all interested members at the day centre in May 2015 and inform you of research findings.

Complaints and concerns:
Please feel free to raise any questions you may have to me at any point, during or after the end of the study. Any complaint or concerns about any aspect of the study will be addressed. Please contact me (Miss Paraskevi Ntoutsia, Principal Investigator, e-mail: p.ntoutsia@surrey.ac.uk), my supervisors (Dr Dora Brown, tel. 0044 1483 683979, e-mail: dora.brown@surrey.ac.uk, and Dr Riccardo Draghi-Lorenz, e-mail: r.draghi-lorenz@surrey.ac.uk), or an independent contact person (Miss Joy Kokkalis, e-mail: j.kokkalis@surrey.ac.uk).

This study has been reviewed and received a favourable ethical opinion by the University of Surrey, UK Ethics Committee.

Feel free to take your time to decide whether or not you would like to take part in the study. Thank you for your time.
Consent Form

• I, the undersigned, voluntarily agree to take part in the study on the experiences of social skills training among individuals with psychosis.

• I have read and understood the Information Sheet (Version 3, 13/02/15) provided. I have been given a full explanation by the investigator of the nature, location and likely duration of the study, and of what will be expected to do. I have been advised about any discomfort and possible ill effects on my health and well-being which may result. I have been given the opportunity to ask questions on all aspects of this study and have understood the advice and information given as a result. I have also been given the opportunity to be informed about research results after the end of the study.

• I agree with the instructions given to me during the study and to co-operate fully with the investigator. I shall inform her immediately if I suffer any deterioration of any kind in my health or well-being, or experience any unexpected or unusual symptoms.

• I understand that I will be audio recorded during the interview and I give my permission for this.

• I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the UK Data Protection Act (1998).

• I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

• I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS): .................................
Signed: ..................................................................................
Date: ..................................................................................

Name of witness (BLOCK CAPITALS):..............................
Signed: ..................................................................................
Date: ..................................................................................
Debriefing Statement

I would like to thank you all for taking the time to participate in this study. I will inform you about the results of the study in a group meeting that we will schedule at a time of convenience. During the meeting, you will have the chance to raise questions however, if you have any questions or concerns at this or anytime during the study, or if my instructions are not clear enough, please feel free to come and talk to me about it. You can also talk to me if you have second thoughts for your interview to be used in the final report of the study. I am available to you for anything you may need.
Miss Paraskevi Ntoutsia  
School of Psychology  
Faculty of Arts and Human Sciences

05 March 2015

Dear Miss Ntoutsia

UEC ref: EC/2014/156/FAHS  
Study Title: The experiences of social skills training in individuals with a diagnosis of a disorder in the schizophrenia spectrum.

On behalf of the Ethics Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the submitted protocol and supporting documentation.

Date of confirmation of ethical opinion: 05 March 2015

The final list of documents reviewed by the Committee is as follows:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethics Application Form</td>
<td>Sub.</td>
<td>17 Feb 2015</td>
</tr>
<tr>
<td>Protocol</td>
<td>3</td>
<td>13 Feb 2015</td>
</tr>
<tr>
<td>Covering letter from researcher in response to queries from the UEC and RIGO, sent 05 Feb 2015</td>
<td>3</td>
<td>13 Feb 2015</td>
</tr>
<tr>
<td>Interview Schedule</td>
<td>3</td>
<td>13 Feb 2015</td>
</tr>
<tr>
<td>Letter from the Family Association for Mental Health confirming researcher is permitted to conduct research at the site</td>
<td>3</td>
<td>14 Jan 2015</td>
</tr>
<tr>
<td>Letter to Director</td>
<td>3</td>
<td>13 Feb 2015</td>
</tr>
<tr>
<td>Consent Form</td>
<td>3</td>
<td>13 Feb 2015</td>
</tr>
<tr>
<td>Participant Information Sheet</td>
<td>3</td>
<td>13 Feb 2015</td>
</tr>
<tr>
<td>Debriefing statement</td>
<td>3</td>
<td>13 Feb 2015</td>
</tr>
<tr>
<td>Risk Assessment</td>
<td>3</td>
<td>13 Feb 2015</td>
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<tr>
<td>Clinical Research Insurance Proforma</td>
<td>3</td>
<td>13 Feb 2015</td>
</tr>
<tr>
<td>Clinical Research Insurance Certificate</td>
<td>3</td>
<td>29 Jul 2014</td>
</tr>
</tbody>
</table>

Please note that the Hellenic Data Protection Authority approval form is not included because it contains personal information about the researcher. It can be made available upon request to either the researcher or the University of Surrey Ethics Committee.
Appendix C
Interview Schedule

1. Can you tell me about your experiences in the SST group?
2. What exactly did/do you do in the group?
3. Would you recommend the training to a friend? If so, for what reason?
4. What impact, if any, does participation in the group have on your social life? (Prompts: family; friends; acquaintances)
5. Can you describe anything else outside the SST group that helped, or did not help, with practising the social skills that you learn in the group? (Prompts: other group; other activity; the social clubhouse of the day centre)
Appendix D

Example Interview Transcript (first two pages are available for view)
followed by an Example of Initial Coding

The participant and I talked a little bit about the research and other things and then he started to share his experience of the therapy. I kindly ask him to hold on a moment so that I can turn on the recorder.

I = Interviewer, P = Participant

I1: Okay, I am listening…
P1: The four social skills that are…

(Pause 7 seconds)
I2: You were saying that what you remember from the group is…
P2: We are doing whatever it is we’re doing with the groups and we have a good time but afterwards sometimes I forget what we’ve done, for example the rules. The rules that I remember well are the four basic social skills; I listen carefully, I ask for something politely, I express negative emotions and I express positive emotions. This is what I remember from the social skills training group and the rest are sub-modules of the two basic…four basic skills.
I3: And what exactly do you do in the group?
P3: In the group we focus, let’s say, on one skill at a time… each time we learn a skill that is different from the previous one and we engage in role-playing...meaning...um... I express a positive feeling towards you...we go on stage...two people are sitting side by side and we say...me for example...I start by saying what it was that made me feel bad...that you didn’t call me on the phone for example or that you didn’t...that...and I tell him...you know...that ok, I’ll make sure to fix this and... This is how role-playing works.
I4: Would you recommend this group to a friend?
P4: Yes, of course.
I5: Why is that?
P5: I believe that this group relieves your stress...that is it gives you...it provides you with key ways to behave in certain situations...let’s say, that happen to you in life, it
provides you with key positive ways and if one has good memory ability, which is absolutely necessary I believe…it’s necessary…anyway, it’s good to have it to be able to do certain things that one believes one cannot do…I believe that new doors are opened for that person.

I6: Is that what you think? That it has opened new doors for you? You were talking about stress earlier…that the group helps you manage your anxiety under certain circumstances… Could you give me an example?

P6: There’s a skill…a role-play about how to meet people…let’s say, how to make an acquaintance…and it involved steps, let’s say, one, two, three…how was it exactly? I’ve written it down because we also have these handouts… (He turns to the handouts he has in front of him trying to find the answer).

I7: It’s okay…The thing is…I am not really interested in what the steps of the skill are but rather, I am interested in your own experience…I mean can you give me an example where you found it helpful…because earlier you said that what you learn in the group can open new paths for you or help you with stress and…you mentioned the situation of making an acquaintance so…has the social skills helped you in any way in that area?

P7: What I’ve learned is mostly these four basic skills, i.e., how to ask for something in a polite way, how to ask for something, how to express positive feelings, how to express negative feelings and…this is what I remember.

I8: Would it be possible to give me an example from your life?

P8: Um…to tell you the truth I haven’t used any of the skills elsewhere…other than this place.

I9: And what do you think the reason for that is?

P9: I think that I am not the type of person who can memorise well…that is, someone who remembers something easily…meaning, to practise a skill and learn it, remember it word for word…I can remember a social event but not very well…I have this issue. Perhaps my memory doesn’t work very well…and I can’t remember exactly the social skill thus I can’t transfer it outside…in society.

I10: Do you think that you ought to remember the steps exactly in order to use it?

P10: I think not…that it’s not necessary… You just need to remember some basic…basic…key ways, let’s say. Yes, that’s it.

I11: And what are these key ways for you?
### Example of Coding Procedure

<table>
<thead>
<tr>
<th>Validation of social skills</th>
<th>The scientific versus the personal; evidence-based knowledge versus experience</th>
<th>Scientific knowledge provides the context in which personal experience unfolds</th>
<th>Negotiating the tension between control and loss of control</th>
<th>Performance anxiety associated with role-playing: Taking courage from shared experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>P21: I did but I hadn’t seen it written somewhere outside. It’s not the same thing to actually see it on paper and to know that it’s valid…to know that it’s valid because it’s written somewhere. That’s different from thinking it’s good without knowing it from elsewhere.</td>
<td>I22: What’s the difference? What does it mean to you that you can see it in the manual? To know that it’s good to do it because it’s in there?</td>
<td>P22: I believe it’s important because it’s written somewhere, I believe that it’s…it’s kind of scientific…It’s a scientific view, let’s say…It’s not just my view, it’s also psychology’s perspective that supports this view on the particular issue.</td>
<td>I23: And for you…How important is this perspective, the perspective of the scientific community?</td>
<td>P24: With the addition of the other thing…of the scientific view let’s say.</td>
</tr>
<tr>
<td>Validation of social skills is experienced as positive</td>
<td>Foregrounding of social skills is based on scientific knowledge</td>
<td>Personal view is valued. Self-doubting tone. Allowing self to be shaped by evidence-based knowledge (i.e. others’ ideas), which may be worth more than the personal view</td>
<td>The manual provides evidence that behaviour is good. Seeking confirmation</td>
<td>Feeling anxious about role-playing. Self-doubt. Mood is lifted after watching others perform successfully</td>
</tr>
<tr>
<td>I24: Ok, so you are saying that you want to follow your own way…</td>
<td>I25: What you’re saying is very interesting. Can you tell me more about it? I mean, what is it that makes you to find so important the…?</td>
<td>P25: That psychology’s view supports it as well?</td>
<td>(Interruption due to a phone ringing)</td>
<td></td>
</tr>
<tr>
<td>P26: Now… You asked me something that I’ve forgotten.</td>
<td>I27: Right. We were talking about psychology’s viewpoint, the perspective of the scientific community…and you were saying how important it is for you…</td>
<td>I26: Yes.</td>
<td>(Inaudible word)</td>
<td></td>
</tr>
<tr>
<td>P27: To be documented somewhere… It shouldn’t just be my own assumption but someone else’s too…To be said by someone who knows certain things, I believe. And because I am the type of person who likes to offer compliments, generally speaking, I believe that this has helped me a lot….</td>
<td>P28: Is there any experience from the group that you recall…that made some kind of impression to you or….</td>
<td>I28: I like it a lot when the guys… (Inaudible word) in role-playing because every time I have to engage in role-playing, I feel anxious and get stressed…I am thinking for example, ‘Will I make it? I don’t know what I’m going to say’. Then I watch the other people engage in a role-play and it raises my spirits. It’s not that hard; if others can do it, then so can I. Would you like me to tell you about the compliment in specific or talk in general?</td>
<td>(Inaudible word)</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix E

**Final List of Themes**

<table>
<thead>
<tr>
<th>Summary of themes</th>
<th>Examples from participants’ accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Effects of social skills training</strong></td>
<td></td>
</tr>
<tr>
<td>1.1 Understanding the self through role-playing</td>
<td>Exposure helps (Mia)</td>
</tr>
<tr>
<td></td>
<td>Go beyond my limits (Mia)</td>
</tr>
<tr>
<td></td>
<td>To learn how to manage myself (Pepi)</td>
</tr>
<tr>
<td></td>
<td>We learn from the roles we play (Pepi)</td>
</tr>
<tr>
<td></td>
<td>If others can do it then so can I (Nemos)</td>
</tr>
<tr>
<td></td>
<td>Struggles and learns things (Stelios)</td>
</tr>
<tr>
<td>1.2 Changes in the self and the world</td>
<td>More confident in social situations (Violet)</td>
</tr>
<tr>
<td></td>
<td>I can say ‘no’ to others (Violet)</td>
</tr>
<tr>
<td></td>
<td>To challenge an expert (Nemos)</td>
</tr>
<tr>
<td></td>
<td>I overcame my fear (Nemos)</td>
</tr>
<tr>
<td></td>
<td>Greater control, self-confidence (Pepi)</td>
</tr>
<tr>
<td></td>
<td>More people want to hang out with me (Pepi)</td>
</tr>
<tr>
<td></td>
<td>We reconciled with each other (Pepi)</td>
</tr>
<tr>
<td></td>
<td>Helped me in social behaviour (Stelios)</td>
</tr>
<tr>
<td>1.3 Social skills as a means to fulfil the need for acceptance</td>
<td>I don’t know where I belong (Eugene)</td>
</tr>
<tr>
<td></td>
<td>They are not giving us the attention we would want (Pepi)</td>
</tr>
<tr>
<td></td>
<td>We need to be calm in order to live in this society (Pepi)</td>
</tr>
<tr>
<td></td>
<td>At the workplace...you should know how to use social skills (Stelios)</td>
</tr>
<tr>
<td></td>
<td>I love people more than myself (Violet)</td>
</tr>
<tr>
<td><strong>2. Barriers to skills generalisation and suggestions for improvement</strong></td>
<td></td>
</tr>
<tr>
<td>2.1 Cognitive and psychological aspects and relational dynamics</td>
<td>Anxiety...is a matter of character and my condition (Mia)</td>
</tr>
<tr>
<td></td>
<td>Difficulties with human contact (Mia)</td>
</tr>
<tr>
<td></td>
<td>I am intense...volatile (Maria)</td>
</tr>
<tr>
<td></td>
<td>My memory doesn’t work very well (Nemos)</td>
</tr>
<tr>
<td></td>
<td>It is my character and...my upbringing (Violet)</td>
</tr>
<tr>
<td></td>
<td>My mind gets stuck (Violet)</td>
</tr>
<tr>
<td>2.2 The struggle between an authority figure’s perspective and the personal perspective</td>
<td>Mrs Ellie...She Knows (Maria)</td>
</tr>
<tr>
<td></td>
<td>To know it is valid because it is written somewhere (Nemos)</td>
</tr>
<tr>
<td></td>
<td>I prefer to go by the song ‘My Way’ (Nemos)</td>
</tr>
<tr>
<td></td>
<td>My aunt would insist not to hang out with this girl (Violet)</td>
</tr>
<tr>
<td></td>
<td>It is not the Bible (Eugene)</td>
</tr>
<tr>
<td></td>
<td>Who said that this is this way? (Eugene)</td>
</tr>
<tr>
<td>2.3 The fit between the group and external realities</td>
<td>These skills help me function. Outside the group...I don’t think of the steps (Mia)</td>
</tr>
<tr>
<td></td>
<td>This is how a person learns to function in the community (Pepi)</td>
</tr>
<tr>
<td></td>
<td>No relation between what happens inside the</td>
</tr>
</tbody>
</table>
2.4 A different outlook on the training

To learn social skills...in a sort of general way
doesn’t make sense (Eugene)
It would give general guidelines (Nemos)
Let’s bring real people in the group (Valias)

group and the (day) centre (Maria)
People...do not react in this way (Eugene)
Discrepancy between the things we learn here
and life (Valias)
Practitioners’ understandings of their role in social skills training for individuals with psychosis: A thematic analysis

Abstract

Social difficulties in psychosis have been conceptualised from a positivist perspective as a phenomenon resulting from internal dysfunction. Social skills training (SST) developed within the ontological framework of the medical model to make up for social deficits by teaching social skills through the use of techniques based on behavioural and social learning principles. In this study, I consider social functioning within the model of SST and argue that it is based on a limited, de-contextualised and pathological understanding. The aim was to explore practitioners’ understandings of their role in SST. Drawing on semi-structured interviews with 8 practitioners, this study attempts to fill a gap in the literature in an area that has been neglected experientially. Thematic Analysis was used to analyse transcripts and two main themes emerged relating to core therapeutic tasks, and attitudes and qualities of the therapist. Findings suggest that participants attempted to provide their clients with understandings contained within a broader relational matrix, and to offer a dialogical learning experience that acknowledges uncertainty and ontological insecurity. Implications for practice and clients’ recovery process are discussed, particularly with reference to existential-phenomenological understandings.

Key words: Psychosis, social difficulties, social skills training
Introduction

Social skills training (SST) in schizophrenia (Bellack, Mueser, Gingerich, & Agresta, 2004; Liberman, DeRisi, & Mueser, 1989) is a structured psychosocial therapy deriving from behavioural and social learning traditions. It involves teaching social skills utilising role-play with scripts largely based on interpersonal situations from clients’ lives (Liberman, Kopelowicz, & Silverstein, 2004). There are different variations of SST depending on clients’ needs and the focus of therapy; however, most include modelling of social skills, coaching during role-plays and positive reinforcement for approximations to the desired behavioural responses. Clients are also given homework assignments to facilitate the generalisation of skills outside therapy. The aim is to minimise the effects of the significant loss of interpersonal relationships in psychosis, and to improve individuals’ ability to initiate and maintain relationships and function in their different social roles (Corrigan, Mueser, Bond, Drake, & Solomon, 2008; NICE, 2014). From a medical model perspective, this phenomenon is termed as social ‘dysfunction’ caused by social ‘deficits’ (DSM-5, APA, 2013). The epistemological roots of the medical model are firmly grounded within medical naturalism that holds a mechanistic worldview (Pilgrim, 2007; Brown, 2002). It assumes a split between mental and physical health and positions mental disorders as naturally occurring phenomena that can be objectively measured.

Psychosocial rehabilitation efforts began at a time of deinstitutionalization in the 1960s when individuals returned to the community and the social rules and conventions they had learned in institutions were insufficient or of little use (Corrigan et. al., 2008). There was a need for individuals to understand and follow the social norms that govern social interactions among non-psychotic individuals to re-enter community social life. The transfer from psychiatric institutions to community care had a big impact on the provision of care (Wolkon, Karmen, & Tanaka, 1971), as there was a shift in the philosophy of what constitutes good care from a medical model to a rehabilitation model that, however, remain closely aligned.

Engaging with a therapeutic model that is centred on the idea of treating social deficits as the locus of pathology has important implications for practice from the vantage point of counselling psychology (CoP). CoP is rooted in philosophical relativism that recognises the existence of multiple equally valid realities influenced
by subjective experience and context that can only be imperfectly understood (Ponterotto, 2005; Woolfe, Strawbridge, Douglas, & Dryden, 2010). Dualistic dichotomies are rejected (Manafi, 2010) (e.g. social function/dysfunction, high functioning/low functioning) and subjectivity and lived experience are placed at the heart of therapeutic practice (Martinelli, 2010; Ponterotto, 2005). The existential-phenomenological philosophy and humanistic value base that underpins CoP practice conceptualises human beings as autonomous yet inherently relational, and takes a holistic, non-pathological view of human beings that focuses on well-being (Woolfe et. al., 2010). When considering the ontology and epistemology of CoP and SST, a gap emerges that creates uncertainty and tension around therapeutic practice, as this medical and positivist discourse dominates the formulation of social difficulties within the context of psychosis. The tension arises from taking a holistic, contextualised view of clients and prioritising subjectivity within a social world that is conceptualised as an entity somewhat independent of subjective experience.

The aim of this study is to provide insights from CoP that will extend practitioners’ understanding of how to engage with the SST model. This exploration is important because SST is an established therapy for social difficulties in psychosis that has been translated and culturally adapted by countries across the world (Liberman, 2007). Reflection upon engagement with SST offered by practitioners and clients can help to refine, elaborate and revise the model. As a counselling psychology trainee who embraces the values and the multifaceted ontology and epistemology of CoP, I view psychosis as a form of human distress that is best represented on a continuum as opposed to discrete categories. I believe in relational forms of understanding psychological distress in people that go beyond the intrapersonal to include interpersonal and collective dimensions. On this basis, I suggest that social communication is both a complex and situated phenomenon, and discuss the potential impact of interacting with a modernist model of practice that entails a mechanistic vision of social difficulties. In doing so, I employ insights from existential phenomenology – a broad philosophical approach that is centred around existential themes (e.g. freedom, temporality and possibility) and is shared by a number of philosophers despite conceptual differences (Dreyfus & Wrathall, 2006).
SST as a remedy for social dysfunction

Social functioning has been defined as role functioning and the number, quality and depth of social relationships (Corrigan et. al., 2008). It follows that when a person with psychosis has difficulty in any of these areas, it is perceived to be an indication of social dysfunction and social deficits. This brings up a potential criticism similar to that levelled against realist representations of schizophrenia as a mental disorder or illness (Aho, 2008; Bentall, 2004; Read, 2013). The construction of social dysfunction, embedded in a medical model of health care underpinned by positivism, exists as a kind of object with a fixed essence that signals social deficits resulting from mental disorder. A social deficit as an inner experience of inadequacy is quantitatively and qualitatively different from the norm and thus ontologically different from consensus reality. Social fearfulness and individual characteristics like shyness and introversion become pathological and important indicators of social dysfunction (Goldberg & Schmidt, 2001) within this consensus reality that matches an unquestioned and therefore presumed objective reality about the existence of internal social dysfunction.

Social communication from a modernist perspective is based on the premise that a sender and a receiver convey information to each other (Liberman, 2008). The self and the other become two objects that function independently; one object sends a message making a demand and one object receives it, processes information and sends back a message responding to the demand. In this mechanistic representation of social communication, relationship is division between the self and others and communication is fragmented, as it is broken down into a three-stage process, with each stage requiring a set of independent component skills (Bellack et. al., 2004; Liberman et. al., 1989). Accurate social perception is understood to involve recognition of emotion, social cues, norms and expectations (Corrigan et. al., 2008), but the impact of society and culture on the individual and the individual’s efforts to make sense of this impact are neglected. Consequently, the uniqueness and complexity of social communication is unlikely to emerge and its nuances are bound to be lost.

From an existential-phenomenological perspective, difficulties in the social realm develop from a disruption of how individuals with psychosis find themselves in the world. The body does not constitute the basis of experience that determines how
one perceives and interprets the world (Fuchs, 2005; Laing, 1960/2010; Stanghellini, 2004) but is experienced as an object, thus, one cannot orientate oneself in the world of things and possibilities created through intentional action. The other is also experienced as an object and is a threat to one’s sense of self that Laing (1960/2010) referred to as ‘ontological insecurity’ (p. 39), a state of unfamiliarity, vulnerability and overwhelming anxiety. The sufferer’s response to this threat is to sit on the side-lines, observe the social world from a distance, feel unmotivated and engage in action that lacks purpose. Being-in-the-world-with-others however is regarded to be the primary mode of our existence (Heidegger, 1953/2010) and from this fundamental relational stance vis-à-vis the world, it follows that social communication reflects relationships between people embedded within social systems. By extension, communication problems reflect difficulties in the context of the relational matrix and reducing a person to an object means that the subjectivity of the other cannot be appreciated in a face-to-face human encounter (Levinas, 1961/1998).

The danger that emerges with the modernist view of social communication and skills training is the development of an extreme variant of a social mask (Laing, 1960/2010) that reflects conformity to social norms. A non-psychotic individual can potentially abandon this inauthentic self, but a psychotic individual is likely to fail because of the altered bodily experience, the loss of self (de Haan & Fuchs, 2010), and the associated detachment from the world with others. Within this framework of understanding, social functioning transforms into a lived social experience and an intentional stance towards the world. If we adhere to the social deficit discourse and understanding, it makes intuitive sense that the meaning, function or dilemma behind intentionality could be misidentified or lost, and that social stigma similar to that associated with the diagnosis (Corrigan et. al., 2008) could impair chances of recovery.

The impact on practice

Following from the above, the development of a model of practice that is based on a theoretical framework of social functioning that does not prioritise subjective experience or is defined in relational terms is problematic. This raises questions about the way practitioners use a model that implies pathology on the part of the client, expertise and power on the part of the therapist, and portrays social communication in a fragmented
way, broken down into a set of skills. The absence of experiential evidence could lead practitioners to over-rely on techniques, lose sight of clients and their individual needs, and shut off potential areas of exploration (of intentionality, context and meaning). The model could be delivered as a quick-fix solution to communication problems, complex relational difficulties or internal pathology. The emphasis on active learning leaves little space for discussion, as Bellack (2004) and Liberman et. al. (1989) recommend, and thus could easily be misinterpreted. An inflexible approach to therapy can create tension between ethics, values and professional contexts in counselling psychologists and any practitioners who embrace a postmodern approach to knowledge and practice.

In 2015, I investigated clients’ lived experiences of group SST (Ntoutsia, 2015, unpublished) using Interpretative Phenomenological Analysis (Smith, 2004), and found that although clients reported benefits from therapy, some experienced a discrepancy between the realities of the social world and the therapy world. Interestingly, important personal and interpersonal dilemmas that served as obstacles to skills generalisation were not discussed in the group. The world of therapy from clients’ perspective revealed in this study contradicts the positivist view, as it involves dynamic and meaningful processes between the client and the therapist. The phenomenological reality of these individuals supports the argument that therapist-related factors and the therapeutic relationship need to be considered to promote social skills generalisation in real-life settings (Marholin & Touchette, 1979; Scott, Himadi, & Keane, 1983).

Aims of present research

The gap identified in the literature leaves room for investigation into practitioners’ engagement with clients within this modernist model of practice and discourse, and their understanding of their role beyond the use of social learning strategies. Practitioners’ perceptions are important to examine as they have been found to contribute to the shaping of the therapeutic outcome (Beutler et. al., 2004) and may play a role in skills generalisation. The present study aims to make a contribution to the field of CoP and the relevant literature by exploring practitioners’ understandings of their role and the therapeutic process in SST. In contrast to the positivist view, practitioners’ engagement with the model is not regarded as cut off
from external influences in a closed system thus attention was paid to the interaction between human agency and social context.

This inquiry is relevant to counselling psychologists and other mental health professionals who wish to increase their understanding of their role in delivering a structured, evidence-based therapy in a way that shifts the focus from what happens within people to what happens between people in context. The evidence generated can be used to promote therapy development, thereby creating more options in the delivery of SST within community mental health settings, improving service user satisfaction and involvement and facilitating their recovery. Moving away from objectivity and quantification to an engagement with subjective experience and qualitative interpretation can extend the focus of research on SST. The overall guiding research question of the study was: ‘How do practitioners view their role in SST when working with individuals with psychosis?’ To answer this question, a qualitative research method was used for an in-depth exploration of first-person accounts allowing contextualised understandings to emerge.

**Epistemological position**

A critical realist/contextualist epistemological framework was adopted that recognises the existence of a physical reality, a world that exists independently of our perceptions and theories, but emphasises a process of co-creation that has subjective meaning making and interpretation at its centre (Willig, 2013). This position accepts that our perceptions about the social world depend partly on our beliefs and expectations (Madill, Jordan, & Shirley, 2000). It also allows the examination of theoretical concepts and applied models in the context of the social/historical conditions that these developed (Pilgrim & Bentall, 1999). Since practitioners’ understandings of their role may be scaffolded by discourses (psychological/social/political) that constrain or facilitate their practice, it is essential to locate their accounts in practices within context. This includes the immediate context of therapy and the broader social and cultural context in which meaning is created.
In line with the aims of this study and the research question, a qualitative research design embracing an experiential approach (Braun & Clarke, 2013) was employed focusing on subjective meaning and experience to obtain a rich and comprehensive picture of the world of SST from practitioners’ perspective. The research design is grounded on a critical realist and contextualist approach that focuses on an understanding of reality that is co-created, intersubjective and therefore open to multiple interpretations (Coyle, 2015). It follows that knowledge about events, actions and social processes becomes possible by going beyond participants’ realities and making interpretations about a reality that exists independently (Willig, 2012). I was interested in mapping participants’ subjective views and meanings to understand what happens between members of the therapeutic dyad (or between the therapist and group members), what practitioners actually do, how they relate to clients, and how they structure therapy and manage difficulties. Exploration was situated within the larger social and cultural forces that informed micro-level exchanges between therapists and clients.

**Method**

Participants and recruitment

The study took place in the UK and in Greece where I have worked and have knowledge of social systems. I recruited participants with experience working with psychosis in community mental health settings by means of convenience sampling and snowballing through my social networks and the initial group of participants. Contact via email was made with community NHS mental health services, UK mental health charities, and mental health services and lead organisations offering accredited CBT training courses in Greece. The email was sent to service managers and contacts within other organisations and included an outline of the project and a request for circulation. After expressing initial interest, participants were provided with an information sheet explaining the purpose of the study, a consent form and a background information questionnaire (see Appendix A). Upon return of the signed form, a date for the interview was arranged. The interviews with participants in the UK were conducted either at their workplace or via Skype. Interviews with participants in Greece took place over Skype due to time constraints and financial limitations.
The final study sample included eight therapists in total, three men and five women. Two participants were trainees with clinical experience ranging between 2 years and 5 years, and six had clinical experience between 2 years and 10 years. One participant was a clinical psychologist, three participants were counselling psychologists, and two were professional psychologists and psychoanalytic/psychodynamic psychotherapists. Four participants were English, three were Greek, and one was of English and Greek origin. All of the therapists had experience with individual SST, and six had experience with group training. Table 1 provides participant information with names altered for confidentiality reasons.

Table 1
Participant demographics

<table>
<thead>
<tr>
<th>Pseudonym</th>
<th>Gender</th>
<th>Years since qualifying</th>
<th>Professional Setting</th>
<th>Therapeutic Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alex</td>
<td>Male</td>
<td>6</td>
<td>Day centre</td>
<td>Group Psychoanalytic</td>
</tr>
<tr>
<td>Sue</td>
<td>Female</td>
<td>10</td>
<td>Psychosis research unit</td>
<td>CBT &amp; Systemic</td>
</tr>
<tr>
<td>Artemis</td>
<td>Female</td>
<td>9</td>
<td>Residential service</td>
<td>Integrative</td>
</tr>
<tr>
<td>Kate</td>
<td>Female</td>
<td>2.5</td>
<td>Psychosis recovery service</td>
<td>Pluralistic</td>
</tr>
<tr>
<td>John</td>
<td>Male</td>
<td>Trainee</td>
<td>Residential &amp; Day centre</td>
<td>Group Psychoanalytic</td>
</tr>
<tr>
<td>Paul</td>
<td>Male</td>
<td>Trainee</td>
<td>Early intervention service</td>
<td>Integrative</td>
</tr>
<tr>
<td>Helen</td>
<td>Female</td>
<td>2</td>
<td>Day centre</td>
<td>Psychodynamic</td>
</tr>
<tr>
<td>Jemma</td>
<td>Female</td>
<td>2</td>
<td>Psychosis recovery service</td>
<td>Integrative</td>
</tr>
</tbody>
</table>

Design

Semi-structured interviews were used to allow participants to offer an account of issues of personal importance to them (Smith, Harré, & Langenhove, 1995). Within the critical realist paradigm, semi-structured interviews are an appropriate method of data collection that can reveal rich information about participants’ reality, and the social conditions and structural processes that underlie actions and events (Healy & Perry, 2000). Meanings and understandings were co-created through interaction between participants and myself (Mason, 2002), and were guided by the questions in the interview schedule (see Appendix B).

The interview schedule was developed through identifying the main areas of inquiry in appropriate sequence and constructing open-ended, non-leading questions relating to these areas. As data gathering proceeded, the interview schedule was revised to include questions that addressed views about social context expressed by participants in the
early interviews. The interviews lasted between 60 and 90 minutes and were audio recorded. Prior to recording, participants were given the opportunity to ask questions about the study, and at the end of the interview they were encouraged to feedback their experience of the interviewing process.

Analytic procedure

Thematic Analysis (TA) (Braun & Clarke, 2006) was chosen as a suitable method to address the research question by identifying themes (patterns of meaning across the entire data set) within therapists’ understandings that represent beliefs and realities. Thematic Analysis is not tied to any theoretical position and is therefore flexible towards epistemological approaches, including critical realism (Clarke, Braun, & Hayfield, 2015). It maintains a focus on patterned meaning, rather than idiographic focus, and was used to generate data that could shed light on interactions between practitioners’ perceptions about their own experiences, perceptions about their clients’ experiences, and ways in which the social context affected the meanings assigned to these experiences.

The analysis was primarily grounded in the data (inductive approach) to allow for predominant themes to emerge, offering a rich description and reflection of the content of the data as is recommended for under-researched areas (Braun & Clarke, 2006). Codes (labels of meaning) were assigned to single segments of data and constituted the building blocks from which themes were constructed. Coding was not made to fit into preconceived options to limit imposition of a priori assumptions and allow themes to emerge from the data. It is recognised nonetheless that my engagement with participants and the data was influenced by my theoretical and epistemological assumptions that have developed over a long period of involvement with different aspects of the topic. A descriptive form of analysis was used, in line with the critical realist epistemological framework, aiming to stay close to the story of the data and participants’ explicit meanings. The analysis also included some interpretative elements to account for the significance of patterns and broader meanings and implications (Braun and Clarke, 2013; Clarke et. al., 2015). The themes identified were coded primarily at a semantic level, with the analytic process progressing from description to interpretation and creation of relationships and patterned meanings revealing personal significance and impact.

The analysis followed the steps outlined by Braun and Clarke (2006). The audio-recordings were transcribed verbatim and the data from interviews with 3 Greek
Participants were translated into English (see Appendix C for an example). Translating transcripts from Greek to English made it difficult for me to reflect the true meanings of participants’ realities despite my efforts to stay as close as possible to the meanings intended. Language is tied to time, context, and history (Willig, 2012) thus in the process of translation, meanings may have been inevitably lost or unintentionally added by me. This threatened the trustworthiness of the research and raised a need for a reflexive exploration of how I addressed challenges. The participant of two ethnic backgrounds gave the interview in English and so translation was not required.

Reading and re-reading the transcripts facilitated familiarisation with the data and initial codes were noted (see Appendix D). Data were then coded across the entire data set working on each transcript separately and a common list of all codes was developed. Initial themes (see Appendix E) were created by colour coding the list of codes from the entire data set to highlight potential patterns and looking for supporting data from transcripts. Prevalence of themes was counted in terms of the number of participants within the data set who gave a patterned response. The same process was repeated, this time by cutting strips of paper and spreading codes out on the floor in search of patterns and relationships (see Appendix F). Themes were then reviewed and either collapsed into each other or formed separate themes and subthemes, and their names were refined resulting in the final set of themes and subthemes. Some codes were discarded from the analysis, as they were insufficiently supported to form themes and could not form subthemes due to a lack of fit with the other themes. Care was taken to ensure that there was a clear distinction between themes and meaningful coherence was maintained. The outcome of the refinement process is presented in the thematic map that can be found in Appendix G. The data set was then reviewed in relation to the story revealed by the thematic map to ensure a good match between the themes and the data (see Table 2, Appendix H), and to check if any important data within the themes had been missed. My input in the research process was considered by contemplating alternative interpretations, and by reflecting on personal experiences, values and assumptions that may have affected the data interpretation. My supervisor was involved from the start of the analytic process and provided credibility checks by giving alternative perspectives on interpretations. An opportunity for member checks (Barbour, 2001) was offered for a critical evaluation of my interpretations.
Ethical considerations

The study was conducted in accordance to the University of Surrey Ethical Guidelines for Teaching and Research and the Code of Human Research Ethics (BPS, 2010). University fast track ethical approval was sought and obtained (see Appendix I) as the risk was considered to be no more serious than potential discomfort. The likelihood of harm was minimised by obtaining informed consent from participants (see Appendix A), making study procedures transparent and giving participants the opportunity to withdraw from the study at any time without giving any reason. The use of online interviewing raised concerns about data security and participant disclosure (Deakin & Wakefield, 2013), thus, participants were made aware that the interview would be recorded and the Dictaphone was shown and referred to during the interview. Participants were also informed that they had the right to withdraw even retrospectively and require that their data be destroyed. On the other hand, benefits of taking part in the study were considered to be the opportunity to voice personal views on the topic, and to influence practices within mental health care that could benefit service users.

The dignity and autonomy of participants was respected by obtaining valid consent in writing and maintaining anonymity and confidentiality through secure data storage in a password-protected electronic folder. Priority to participants’ views was given and leading questions were avoided during the interview (BPS, 2010). Interpretation of findings remained ethical by clarifying and elaborating the meanings associated with participants’ accounts, and by making my intentions and interpretative understandings explicit (Willig, 2012; Steffen, 2015). Participants were offered the opportunity to critically comment on research findings before research report submission and a commitment was made to debrief participants after the end of the study, acknowledging their contribution and respecting their rights. Efforts were made to ensure sound research design and execution, and achieve research utility by linking findings to the existing literature, and by taking into account my supervisor’s views on the research method and procedures. The relational focus of the study and the context-dependent nature of the research data may serve to promote a qualitative thinking (Braun & Clarke, 2013) about the topic that is currently absent.
Findings

Two main themes were identified from the analysis, as outlined in Table 3. A description of the themes will be presented first, followed by interpretive points illustrated by representative excerpts from coded transcripts. Data has been edited and […] indicates that some detail has been removed for space, clarity and confidentiality reasons.

Table 3

<table>
<thead>
<tr>
<th>Themes and Subthemes</th>
<th>Subordinate themes</th>
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</thead>
<tbody>
<tr>
<td>Themes</td>
<td>Subordinate themes</td>
</tr>
<tr>
<td>1. SST in action: Core therapeutic tasks</td>
<td>1.1 Creating a therapy culture in which safe and energetic interactions can take place</td>
</tr>
<tr>
<td></td>
<td>1.2 Recognising and deterring forces that threaten group cohesion</td>
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<td></td>
<td>1.3 Facilitating awareness of self in context</td>
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<td>1.4 Building on existing skills and empowering the client</td>
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<td></td>
<td>1.5 Keeping the hope alive and focusing on change</td>
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<td></td>
<td>1.6 Managing external pressures</td>
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<tr>
<td>2. Qualities and attitudes of a SST Therapist</td>
<td>2.1 Embracing a phenomenological attitude</td>
</tr>
<tr>
<td></td>
<td>2.2 Maintaining flexibility in delivering therapy</td>
</tr>
</tbody>
</table>

1. SST in action: Core therapeutic tasks

Participants varied in their thinking about the therapeutic process in SST beyond the application of behavioural techniques. Most distinguished between their practices in group therapy and individual therapy and focused more on one or the other, which suggests that the actual context in which SST takes place was significant for participants. Despite the diversity of views, there were commonalities in the data around creating a group shaped by social norms and managing interpersonal forces that threaten group cohesion and effectiveness. From this start point, participants commented on needing to enhance existing skills, rather than attempt to change their clients, and promote their understanding of being in interaction with others. Contextually, this awareness stresses the meaningfulness of clients’ life histories and interpersonal relationships, and acknowledges the existence of social pressures. Participants suggested their work is influenced by external forces (economic and social), and discussed what they think about these pressures and how they
manage the tension that springs from the challenge. Furthermore, participants emphasised hope as an energy or catalyst of change that they feel clients often lack, and thus they need to create or maintain. These key similarities are highlighted below.

1.1 Creating a therapy culture in which safe and energetic interactions can take place

The majority of participants spoke of the importance of creating a therapy culture that encourages and supports members. The group setting provides the context as a physical reality for interactions to take place. Within this reality, participants described unwritten behavioural rules or social norms that need to be established in the beginning of therapy and govern the behaviour of group members. Of note is that these rules are not contained in the SST manual.

*You need to establish a set of rules [...] we will not interrupt each other [...] Everyone will have an opportunity to speak [...] It’s okay to take a break or leave the group [...] Boundaries provide structure for the process [...] members can feel safe and supported (Jemma).*

Jemma highlighted the importance of boundaries about communication so that group members know what is expected of them. The establishment of clear boundaries makes it safe for members to interact with each other and casts the therapeutic process as containing. The possibility of an exit on the part of the client is not framed as unhealthy or problematic. Helen also spoke about the importance of respectful interaction within the group and Alex presented it as a skill that needs to be developed:

*You need to explain what the group is about, which solves the problem of freedom of expression...that, yes, you can talk, but you need to stay on the topic [...] you can say that you are angry...that you are annoyed, but not swear (Helen).*

*Group participation is in itself a skill that is imprinted...if it’s a positive experience [...] (The group) is already a living laboratory for the application of what you do as a social skill lesson, and a first positive experience of application of those skills [...] always, though, having first set some very*
specific rules about staying on a particular topic and not offending others (Alex).

Alex suggested that group members learn to respond in a patterned way with barely any conscious thought. It seems that the development of rules is critical to ensure acceptable social behaviour in the group as a first skill that will facilitate the learning of other skills. These participants’ use of language is revealing; Alex and Helen constructed unacceptable behaviour in negative terms whereas Jemma phrased her comments in a more positive way. In a broad sense, these participants’ language may reflect cultural traditions of understanding and communicating. Direct, second-person address (‘you’) can be found across the entire data set, indicating perhaps a stronger sense of responsibility for an activity in a particular social and cultural context. Artemis highlighted the importance of confidentiality to reinforce the norm that self-disclosure is safe, and she touched on the challenges brought to the fore by the setting in which therapeutic practice takes place:

*It’s difficult when you are working at a residential home. Staff members know all the information about the residents. It is very important to help them feel safe by telling them that the information will not leave the room* (Artemis).

Artemis made a direct contrast between the relational experiences offered by the group to the experience of the residential setting where it may not be safe for clients to disclose personal information. She made a clear distinction between in-group and out-of-group behaviour, represented as maintaining confidentiality and understood as developing safety and trust within the group for the work of therapy to commence.

1.2 Recognising and deterring forces that threaten group cohesion

The need to identify and tackle challenges to the group was present in accounts. Participants spoke of challenges they have encountered for which they lacked guidance from the SST protocol. For example, John expressed a dilemma about how to handle a conflict between two group members:

*That was something I found difficult…to what extent I would allow it and what form I would give it […] Role-playing was taking place but I was not*
supervising it; I was part of it [...] I let it finish so that we could discuss it (John).

Evident in his account is that the therapist needs to decide when to interrupt the conflict. John described a sense of lack of control following a breakdown in communication between two group members. He vividly illustrated how his role in the group changed from being an active group facilitator to being a passive role-play participant. The conflict was seen as a real life role-play and there is a sense that the therapist’s task is to use the role-play material in the service of growth by tying it to the skills taught in the group. Alex raised a different issue that could potentially lead to hostility and conflict in the group:

*Listening and reflecting on their own experience is a connection to the group, but if you let it happen without any control [...] if you don’t somehow bring them back to the group, then it will serve as disconnection from the group (Alex).*

Alex contrasted between productive and counterproductive free expression. He concluded that one of the therapist’s tasks is to allow free expression of experiences within definable boundaries and to enable the client to maintain a sense of connection to the group, though he did not specify how. This could be interpreted as an active search for something that links the client to the group or creates an attachment. The possible forms of conflict were an issue raised by Helen:

*The challenges encountered in the group often arise from group dynamics; whether the client is allowed to speak [...] or there is an understanding that it is all the therapist’s job and his attention is all that matters [...] You can’t treat it as a problem of the individual, there needs to be a group culture that we can do something about it…an understanding that we can resolve issues (Helen).*

Of note is how Helen illuminated the approach to responding to problems that are believed to threaten group cohesion and how these need to be treated as group issues. Her argument is seemingly underpinned by an assumption that problem-solving skills
need to be applied by all group members to build connectedness and cohesion. Helen again highlighted group dynamics:

*You always need to keep in mind what the group may want [...] Standing up and trying out a skill whilst being watched can stir up a lot of anxiety...‘I will be judged’... ‘I am being watched’... So, you turn to the member and say that we are a group... and in a group you also pay attention to the group climate and the relationships that you have besides the training aspect (Helen).*

Here the group is conceptualised as a separate entity with needs to be met before training in social skills can take place. The activity of role-playing is represented as intimately tied to an experiential, embodied context and the solution to the individual’s problem (performance anxiety) emerges from connectedness to the group. Role-playing thus represents adherence to social norms in addition to social skills practice, and it is suggested that an investment in the maintenance of the bond between group members needs to be explicitly addressed. Failing to identify and attend to clients’ underlying needs may lead to ‘disruption’ (Jemma) in the group and clients are likely to miss out on important interpersonal learning:

*If someone competes with others for the therapist’s attention [...] it needs to be indirectly addressed so that the client can work on their way of relating to others (Jemma).*

This comment highlights a consistent pattern across the data set, which is the representation of the group as a physical space where clients have the opportunity to cultivate their relational way of being.

1.3 *Facilitating awareness of self in context*
This subtheme intends to capture a construction of the reality of SST as relational in nature. Social skills knowledge is construed in terms of the self in relationship, so it’s more of a co-constructed entity shaped by individuals in relation, as well as between people and with social systems. It represents relational self-awareness that comes from various sources, for example, interaction between a voice hearer and their voices, interaction with people in therapy or the immediate social environment, and
interaction with society:

*Looking at whether they tend to be more aggressive or passive and thinking about power and closeness and control within their relationships [...] getting them to think about how they interact within their relationships but then more broadly how that is often mirrored in their relationship with their voices (Sue).*

Sue highlighted dilemmas emerging as clients relate to others, reflected in relationships with voices. Insight about repetitive patterns of relating and acceptance of polarities (e.g. proximity versus separateness) needs to be involved to enhance social functioning, as evidenced in her account. Paul on the other hand commented on learning manifesting in an interpersonal context in which SST takes place:

*He is sitting in the room with me, he is making eye contact and in other situations he isn’t. What is going through his mind? (Paul).*

Similarly, John noticed how a member turned to an older and more experienced member in the group and said ‘*what he couldn’t say to his father*,’ who was role-played by the co-facilitator. In both accounts, the reality of the external world is explicitly contrasted with the reality of the therapy world in which social skills practice has a safer quality, suggesting that social skills performance is primarily context-dependent. More specifically, behaviour rehearsal seems to be influenced by characteristics of the environment such as age and status of the recipient of the communication. Understanding the context of social skills practice thus becomes a key ingredient in SST and, for Alex, this includes self and other awareness:

*The other is different and may have a different opinion from us. Our goal is to ask for what we want and to communicate with the other, rather than just do it. I don’t know if this intention is understood (Alex).*

Alex alluded to the importance of intersubjective communication as a goal in itself and the development of tolerance for others with different views. Participants also felt that tolerance needs to be extended to those who may have a limited understanding of the needs of individuals living with psychosis:
I always advise them to start small. They need to choose a non-threatening situation to practise the skill for homework…a friendly person […] Rejection can be very painful when you have a history of multiple rejections […] If you get rejected, you will either take it personally or the skill doesn’t work (Jemma).

The psychotic individual experiences great anxiety […] a rejecting look or one’s silence could cause them something…without even applying the social skills (Alex).

The psychotic individual will not be assertive, he will not insist…he will never speak again, he will withdraw […] Part of the training is to talk about what things are like out there…that this is what public services are like and the reality in Greece […] You can’t just say, ‘They are bad and they don’t listen to me, so I won’t go’ (Helen).

You know that the psychiatrist will see them for five minutes. He will open the door and start writing the prescription without looking at them or saying anything more than, ‘How are you? Are you okay?’ before continue writing […] You may need to explain the situation at public hospitals […] The reality is that many doctors see 50 patients one after another (Helen).

These extracts highlight the detrimental consequences of the possibility of rejection, and the distress experienced by individuals with psychosis in the case of non-facilitative environmental input that hinders the application of social skills. Some responsibility for social skills performance thus shifts from the individual to society, that is, it becomes relational. The cultural and social context in which communication takes place is portrayed as having a decisive impact on a person’s response to him/herself, the social skills and the social world. It is suggested that when faced with the possibility of rejection, the individual with psychosis has three options that lead to social withdrawal and lack of social skills generalisation across environments: rejecting the self, rejecting the world, or rejecting the social skills. Helen’s use of the word ‘patient’ reflects a realist medical narrative of the Western tradition that emphasises genetic factors as the main determinants of human behaviour.

Alex commented on the meaning of this shared responsibility to ensure promotion of social skills generalisation in the community:
By placing greater emphasis on the context and mental health professionals’ attitude toward patients – because we can’t possibly talk about the whole society, can we? – I think that the ability to generalise and stabilise the skills they acquire will be greater (Alex).

In the above extract there is a sense that work needs to be done towards creating a more humane society. This includes developing more effective services, with mental health professionals increasing their knowledge of SST, the particular needs of individuals with psychosis and the critical role they can play in skills generalisation. The use of the word ‘patient’ reflects a realist medical discourse and a judgment made by a knowledgeable objective professional.

1.4 Building on existing skills and empowering the client

In addition to the emphasis placed on securing or holding secure some ground for therapy as the basis for an optimal therapeutic experience, participants commented on their role in relation to the actual skills training. They focused on developing clients’ strengths, as opposed to concentrating on deficits/weaknesses, and spinning struggles into challenges. They spoke about ‘thinking more in terms of what the person is doing well’ (Paul). Direct phrases referring to actively looking for strengths and helping clients ‘recognise them’ (Sue) were present, and this was described as a ‘resilience-based approach’ (Sue). For example, Kate said to a client:

You did really well there. What do you think about that? Maybe we could tweak that a little bit (Kate).

Evident in these examples is the notion that clients learn best when they are involved in an active process where they need to develop critical thinking apart from behavioural skills. The therapist attempts to move the client from a passive learning process to an active one, address a knowledge gap and promote change. Helen explicated that focusing on clients’ strengths means ‘trying to bring them closer to their actual behaviour’ and ‘improving what the client has, not changing them entirely’. She linked this effort to a ‘greater chance that the knowledge will remain’, whereas John contrasted it to a deficits-based approach:
If we always place the client in the position of a trainee, [...] it’s as if [...] we undermine their effort to be autonomous because we keep reminding them of what they don’t know [...] There needs to be more room for expression of the more adult part (of the client) (John).

John presented the position of a trainee in a negative light: as someone who does not know enough and has an insufficient degree of autonomy. This sense of reality seems to be disempowering and adheres closely to the representation of a mental health delivery system that discourages independence and autonomy through professionally led therapeutic groups that focus on social skills deficiencies. Furthermore, there was consensus that the uniqueness each client brings matters:

Even the fact that a patient was able to participate in role-playing, despite finding it difficult and regardless of whether they managed to do it well or not [...] (What is to) reinforce is that if they try something, they might achieve it without it being necessarily perfect or fully complete [...] I tried to focus on their own way (Alex).

People express themselves in different ways. You need to know your client and be mindful of how they communicate with others. Some people use more words than others [...] Some people mix up the order of the steps or can’t recall steps...What’s important is that the message is clear and that you keep reinforcing the good elements (Jemma).

Such comments provide examples of how individual difference and uniqueness need to be understood and valued. Alex and Jemma emphasised the personal qualities of the client that are unique to an interpersonal encounter involving structured learning through social skills. And, in making this emphasis they stressed the role of the therapist. The therapist is depicted responsible for creating a context in which clients can learn and own the skills by becoming aware of their active and unique contribution to skills application.

1.5 Keeping the hope alive and actively encouraging change

Some participants described providing hope in addition to positive reinforcement. It was discussed as ‘improving their self-esteem and self-worth’ and ‘building resilience’ (Sue), ‘making the effort worthwhile’ (Jemma) and constituting an
important part of the therapeutic work:

> I think part of our role is holding onto that hope for the client [...] Do you say to yourself, ’Well done!’? [...] I will be quite effusive about that so I hope they can internalise it (Kate).

> A therapist in that kind of environment is a bit of a cheerleader (Artemis).

Artemis used to work as a counselling psychologist in a residential health care facility in Greece, a country where families tend to play a major role in the care of their relatives living with psychosis. She alluded to the lack of family support and the degree of difficulties experienced that makes having hope particularly important in clients’ recovery process. This view is echoed by Sue:

> We don’t want people to be in therapy forever. It is about passing skills to people and getting them to run with them [...] Thinking of the self as hero [...] thinking about the journey that people had and the experiences that they’ve had, and the ability to recognise that in spite of all those things that have happened to them...and I suppose, yeah, bits of narrative that they’ve tended to hear [...] about loss and deficit...but it’s actually more positive than that...it’s actually, ’You have come through this’ (Sue).

Sue referred to the power of engaging with the client’s narrative. The ‘hero’ and ‘journey’ metaphors imply that the client is a purposeful protagonist engaged in the difficult process of adapting to and overcoming life challenges associated with psychosis, and moving beyond stories about deficit and loss that have been historically assigned to them by the medical profession. Hope is thus represented as both necessary and important, and is intimately tied to the client’s narrative.

1.6 Managing external pressures

English participants spoke about service pressures that they experience and perceive to be in conflict with the primary therapeutic purpose for their work that places the client at the centre. This was felt to be an important contributor to the way in which they perceived their role in SST. Some participants reported that the experience of support (or lack of it) in applied clinical work partly determines their ability to manage the demands placed by their service:
I am in a quite lucky position because I have a fantastic supervisor who allows me to work in the way I like to work [...] There is definitely a service pressure on making people recover and then discharge them. I tend to ignore that frankly because in the end, the client is my priority [...] I listen to what the client says they want (Kate).

It’s a bit confusing because the goals of the intervention need to match the goals and needs of the client as closely as possible [...] but there might not be sufficient time to address or follow up on important things (Jemma).

These extracts highlight the role conflict that can occur from juggling service constraints with optimal care provision by prioritising clients’ needs and following their pace. The source of this conflict is a dilemma presented at two extremes of relating to the client and relating to the service. The presence of support seemed to have a beneficial effect on these participants. Paul on the other hand, reported how he experienced his supervisor’s response to this dilemma as unsupportive.

The client would set their goal but the service would set a different level of goal [...] some kind of functional activity [...] I don’t know how honest I can be in supervision (Paul).

Paul acknowledged a disjuncture between what he does and what he should be able to do, that is, be transparent in the relationship with his supervisor rather than unwillingly engage in acts of service sabotage to respect client priority. Sue commented on the freedom of practice in an unconventional clinical setting, which allows her to meet the client in the way she wants, rather than a way that fits with organisational requirements:

When we are trying to meet the client where they want to be met...so, it’s psychologically, physically...and I try working with what they bring, which [...] feels quite liberating in many ways to not have the constraints that you would otherwise have maybe in a conventional clinic setting (Sue).

The above extracts suggest that SST is not offered in a vacuum; there is an implicit negotiation between clients and society through NHS service provision, with therapists acting as mediators. The role of the therapist as a mediator is framed as
usual and perhaps forced, but the professional context and the presence of support through supervision matter in terms of the impact that this role has on the therapist.

2. Qualities and attitudes of a SST therapist
This theme is intended to include elements of the therapist’s unscripted communication toward the client. The value of an interpersonally sensitive and humanistic approach was emphasised across the data set. This approach aims at being responsive to clients’ needs and reactions to enhance the learning of social skills. Participants gave accounts of how effective therapy requires therapists to move beyond adherence to the nuts and bolts of a therapy manual to include a relationship that can serve as a prototype of other interpersonal relationships in the client’s social world. Some participants also referred to flexibility in their application of the SST model.

2.1 Embracing a phenomenological attitude
There were varied views on the specific skills that are involved in a successful social encounter between the therapist and the client, highlighting perhaps the complexity of this relationship. Assumptions that reflective practice and a phenomenological attitude, characterised by non-judgment, empathy, curiosity, acceptance, genuineness and presence, constitute key elements of the dyadic communication underpinned much of these views:

A lot of clients come in and assume that you are going to be another person that’s going to judge them, [...] give them a label, [...] tell them that there is something wrong with them. Actually [...] you are just trying to understand what they are going through (Kate).

Every interaction is between two people. Part of the normalisation process was helping her see that it’s okay if someone is a bit rude back; it could be worth reflecting why they might have been rude back (Kate).

Have a foot in their world. Imagine what it’s like to look outwards from inside the world...be kind and curious (Paul).

I’ll listen to it (the dilemma) [...] If it’s something very personal I’ll listen to it, I’ll understand its importance, but I’ll also signpost them [...] I’ll explain that
this is not the place to discuss it [...] It is an admission that your needs can’t be met right now (Helen).

The overall sense conveyed in these accounts is that the therapist recognises the emotional nuances in the client’s communication and reflects this understanding with sensitive accuracy and a threefold aim in mind: (a) to help the client improve their social perceptiveness, (b) to offer a safe holding environment and indirectly influence self-stigmatising attitudes, and (c) to promote the client’s contextual understanding (e.g. of how our needs are met by different people at different times and in different places) by increasing sensitivity to social norms. The high degree of variability in participants’ accounts reflects the being of the therapist, the therapist’s presence (rather than any specific behaviour), including willingness to be guided by the client and psychological flexibility. The therapist’s communication to the client seemed to be more or less direct as the following contrasting accounts illustrate:

They need to identify how they are feeling, how the other is feeling...and come up with an appropriate response. This can be difficult even for anyone, but it’s harder for people with psychosis [...] Just be patient and explore it for a moment [...] I often ask, ‘How does it feel in your body?’ (Jemma).

Versus…

(Artemis said to a client:) ‘You look sad and you are crying now. What are you thinking? [...] That sounds very difficult. That sounds like it feels sad. Are you sad?’

And…

We engage in sports or fun activities once a week. It is something that helps a lot because [...] I am not the one teaching something. I am a member of their team. I play basketball with them and we have an equal role (John).

Of interest is how perception of emotions is facilitated through mirroring (evident in Artemis’ account) or embodied learning (evident in Jemma’s account) that is not typically a part of SST. Also, it would seem that for John, a challenge that the therapist faces in a structured therapy group is to reduce the inherent power differential in the therapeutic relationship. The way this can be achieved varies according to the context of communication. His account offers an example of how it
may be easier for the therapist to find a way to decrease the power differential in a residential setting in which communication can be woven into everyday life and community activities. This supports earlier extracts highlighting how context as a physical entity is important to clients’ learning.

2.2 Maintaining flexibility in delivering therapy

The need to achieve a ‘balance between structure and flexibility’ (Jemma) was reported by some participants who discussed how they tend to tailor the therapy to meet the unique needs of each client. For example, Kate spoke about a behavioural experiment she devised with her client to tackle a safety behaviour (wearing sunglasses when talking to people) before moving to assertiveness skills training. Reflecting on this, Kate stated that…

Sometimes clients benefit from a very structured approach, sometimes they don’t. It really depends on the individual client […] I do tweak it to fit with the client’s needs (Kate).

This view is shared by Sue:

See how people are managing that day […] prioritise what’s important for them […] and perhaps shorten the sessions, chunk information […] You can have […] a structure of how a session would be, but what goes on within that session is hopefully reciprocal, it is not didactic (Sue).

One gets the sense that participants express uncertainty about how a session will proceed despite having a structure in mind. Structure seems to be influenced by two factors: the client’s state on a particular day and their special needs. It was via one participant that I was able to get a sense of the implications of the therapist not improvising as the context unfolds:

If the group […] is focused more on the manual but this resulted in group members feeling that they cannot actively participate or introduce something of their own and exchange something with the other members, then group participation will probably end up being a negative experience of social skills…where most of them may have felt oppressed or inadequate because they couldn’t perform the skills well in the group […] the group experience reinforces what you teach them…(Alex).
Thus, committing oneself to the manual was perceived as a barrier to housing experiences that are positively reinforcing. This account suggests that therapists who do not abandon the authority of the manual and the behavioural school of thought may provide their clients with a negative social experience. Clients, in turn, may not seek further relational contact or transfer knowledge and skills outside the therapeutic setting.

**Discussion**

This study aimed to explore how practitioners make sense of their role in SST beyond the use of social learning strategies. Looking at the themes that emerged, the world of therapy from participants’ perspective seemed to be a representation of clients’ lives in the context of their relationships. Participants made efforts to understand the context in which social skills were used and the circumstances in which clients found themselves in order to facilitate skills learning and generalisation. This potentially highlights the context-dependent and flexible nature of social functioning and competence. The starting point of therapy was a person embedded within a network of relationships, and the impact of society was acknowledged as clients attempted to engage in social behaviours. A picture thus emerges in which social competence arises from interactions between individuals rather than being located in the individual as a trait or ability. This framework marks a shift from the experience of being immersed in the project of social skills application to awareness of one’s capacity to relate to others in the context of this project. It also constitutes a point of departure from the views of Bellack et. al. (2004) and Liberman (2007) who emphasise the ability to communicate internal states (feelings, interests and desires) through the use of social skills. Overall, findings in this study indicate that SST offers a glimpse into clients’ social realm of existence and salient opportunities for goal-directed, skilful action that could potentially help restore the loss of intentionality and the intersubjective capacity in psychosis that Blankenburg (1968/2012) and Stanghellini & Ballerini (2002) spoke about.

Participants believed that their clients’ primary modes of relating to others in terms of relational poles had to be understood by looking at how people behave in
different contexts, including their relationships with voices. This finding is in line with the growing evidence that the relationships that hearers develop with their voices mirror relationships within the social world (Hayward, Berry, & Ashton, 2011; Sorrell, Hayward, & Meddings, 2010). It also suggests that practitioners need to be guided by the client’s relational being, rather than an objectification of social experience. In the present study, participants explored subjectivity as a social phenomenon, in line with Stanghellini & Ballerini’s argument (2002). They framed communication failure from a relational and contextual perspective, attributed a large share of responsibility to society and culture, and offered a social explanation for the commonly observed lack of social skills generalisation. This could offer a way for the reflective-scientist practitioner to conceptualise social communication not as just a joint product between the individual and the social world, but as a fluid and situated phenomenon in the context of meaning and relationships with people and complex systems.

As part of creating a bridge to the client’s social world, it was suggested that the therapist may have a gatekeeping role, transmitting information from the world outside therapy to clients, and offering an account of the wider social reality in which skills are used and social relations are developed. This finding supports the view that the acts of perceiving, thinking and acting that constitute intentionality are disconnected in psychosis (Fuchs, 2007; Sass, Parnas, & Zahavi, 2011). Indeed, practitioners’ gatekeeping role might facilitate the process of integrating moments from the client’s social world, potentially enabling them to intentionally move in the direction of social goals with more spontaneity. The finding is also in contrast to the positivist view that information from the social world needs to be broken down (i.e. time and context factors and social cues need to be analysed) and subsequently synthesised to form a coherent narrative that can lead to socially skilful behaviour (Bellack et. al., 2004; Liberman et. al., 1989).

In the case of group SST, participants presented the group as a community that offers opportunities for clients to learn how to be with others. Group participation was a rehearsal for relationships outside therapy and a climate was cultivated where the subjectivity of the other was respected. Participants in this study used the group to tap into the benefits of group process that Yalom and Leszcz (2005) discuss, by turning it into a therapeutic tool that facilitates interpersonal awareness and identiﬁes
maladaptive relational patterns. In this respect, present findings do not provide support for the assumption of Bellack et. al. (2004) that SST is strictly an “educational, skills building procedure” (p. 186) that does not necessarily involve “conversation” or include “self-exploration”. In fact, group relating through language allowed for skill-building opportunities that might otherwise not have been possible.

Referring to the task of preparing clients for social skills training to commence, participants stressed the importance of providing clear guidelines relating to the ‘how’ of group participation. This was meant to reduce anxiety that stems from uncertainty, and to create a space of safety, trust and confidence in the interactions that would follow. There was perhaps a sense of participants needing to manage the interplay and tensions between the individual and the group to achieve a fluid process in which clients are in touch with their subjective experiences and way of being in the group. The way, therefore, in which practitioners can manage interactional group processes pertaining to SST opens up a new area of investigation.

The group seemed to take priority over the individual in the presence of interpersonal conflict, and in the absence of guidelines for constructive conflict management participants relied on their clinical judgment. These findings highlight an important gap in the literature, given that it might be difficult to eliminate conflict from the group (Yalom & Leszcz, 2005) without creating a favoured reality that fails to match clients’ experiences in the social world (Ntoutsia, 2015, unpublished). Participants in this study generally used conflict in the service of clients’ growth, and relational understanding and connectedness was thought to precede resolution to intrapersonal problems. Participation in unplanned and unscripted role-playing was seen as an opportunity for the development of social skills learning. What interestingly emerged from the data is that the SST therapist may not be excluded from this learning process. One must nonetheless lose one’s role and associated status, authority and power, and intentionally immerse oneself in the client’s social world to provide something of value.

All participants valued the therapeutic relationship over technique irrespective of their training background and most attempted to reduce the power associated with their professional role, and to close the distance created in the name of expertise. This reflects and extends the assumption that practitioners need to build a good therapeutic alliance in SST by finding ways to challenge the traditional professional-client
relationship (Liberman, 2008) prescribed by the medical model. Tailoring therapy to meet individual needs was identified as the basis for the development of a positive experience. This was in turn interpreted as facilitating skills acquisition and generalisation, which agrees with empirical evidence from positivist research, although generalisation of new behaviours is noted to be more likely when the therapeutic and natural environments are similar (Kopelowicz, Liberman, & Zarate, 2006). Additionally, it seems that my findings disagree with the view of the ‘expert’ therapist suggested by the theory of SST and point to a different understanding of the therapist’s role. From participants’ perspective such a role includes openness and ability to engage in relational dialogue that can highlight clients’ social dilemmas (e.g. of trust in relationships), which could serve as barriers and impede intentional use of social skills. This may require that the therapist refrain from filling the in-between space with something already known, and explore possibility from intersubjective experiences (Cayne & Loewenthal, 2011) to allow social dilemmas and conflicts to arise.

In the context of SST theory, role-play informs the therapist of clients’ difficulties with social skills, which point to weak areas of social performance in real life (Liberman et. al., 1989; Bellack et. al., 2004). The therapist then focuses on areas of improvement linked to personally meaningful goals. The focus on social skills deficits was perceived as disempowering by participants in this study, who instead paid attention to clients’ unique strengths and abilities relative to their goals. This suggests that the emphasis is misplaced on social deficiencies, reflecting mental health services’ historical focus on pathology (Cromby, Harper and Reavey, 2013). It also stands in direct contrast to the recovery-orientated mental health practice that emphasises individual values and strengths (Deegan, 1993), and the existential-phenomenological framework for understanding alterations in social experience and opportunities to restore social connection. It is therefore argued that recovery-focused practice in mental health cannot accept the flattening of social competence by restricting it to an ability to understand and conform to contextual norms, placing subjective meaning in the background.

English participants reflected on dynamics of power and powerlessness that affected their practice as they mediated between clients and society (represented by mental health services). The negotiation that participants engaged in had a practical
and context-specific quality, as there were material and institutional constraints involved. There was a sense, however, that participants lacked commitment to act according to service policies when their humanistic values were challenged. From a CoP perspective, the clash between identity and practice within NHS settings and the resulting dissonance that occurs is understandable given our ethical responsibility as reflective-scientist-practitioners (BPS, 2014) to question ‘grand narratives’ and commit to clients’ ‘little narratives’ (Milton, Craven, & Coyle, 2010). This kind of reflection was notably absent from Greek participants’ accounts. A possible explanation of this difference is the absence of imposition in the form of national guidelines that shape the decision-making process in health care provision and reflect the prevalence of the medical model.

The responses of people in the social world were reported to impede clients’ efforts to transfer social skills across everyday life settings. For example, mental health professionals in Greece were perceived as having little knowledge of SST, despite being the first point of reference for issues pertaining to mental health. This is in line with a finding from positivist empirical research that social skills generalisation can be enhanced by involving others to support clients’ learning and ability to use social skills (Tauber, Wallace, & Lecompte, 2000). The current study expands upon this finding by suggesting that social skills generalisation may be a matter of social change. Increasing knowledge about social skills among mental health professionals through training and supervision might improve clients’ ability to generalise social skills in novel situations, but is merely one aspect of this change. Taken together, these findings echo a holistic notion of recovery in health care provision that advocates social transformation and cautions against a polarised view that presents recovery as a process of symptom reduction and functional improvement (Jacobson, 2001; Jacobson & Greenley, 2001; Read & Dillon, 2013). This broader conceptualisation emphasises social attitudes and conditions, policies and practices associated with trauma and psychosis (Read, Mosher, & Bentall, 2013; NICE, 2014), in contrast to the small and peripheral role assigned to these factors by the theoretical and epistemological frameworks that guide the practice of SST.

There was a general powerful impression from participants’ accounts of what an autonomous client might be like, indicating that the role of the SST therapist is moving from a sole emphasis on social skills training towards an emphasis on use of
empowerment with the aim of enhancing clients’ resilience. It was suggested that this way, clients might be better equipped to cope with the possibility of rejection in relationships that could leave them in a state of ontological insecurity (Laing, 1960/2010), reflected in the absence of trust in their ability to apply social skills. One implication of this might be that practitioners need to take an active role in empowering the client to utilise and develop their personal assets and social skills competency.

Hope was perceived as significant in the way that helps the client acknowledge loss, commit to change and resist pathologising narratives of psychiatry. This echoes the findings of qualitative studies that hope is an important part of recovery to overcome “despair” (Ridgway, 2001) and “stuckness” (Young & Ensing, 1999), and to help one empower and redefine oneself. Similarly, in this study, it was the belief that clients can achieve something that was primarily positively reinforced, and mastering the social skills taught was viewed as less important. Mental health professionals are granted a special role in facilitating hope for recovery from psychosis through their work (Hobbs & Baker, 2012; NICE, 2014). This role seems to be consistent with the coaching approach to building on clients’ existing social skills (Bellack et. al., 2004; Liberman et. al., 1989). One implication of the behavioural/functional model however is that notions like hope are rather incompatible, as one uses behavioural techniques solely to bring about change. The theory of SST seems insufficiently broad to allow for the conceptualisation of recovery and the instillation of hope as relational, active and meaningful processes. For this purpose, a much broader view of human distress may be required to allow for an understanding of the social determinants of losing hope, and individually attributed meanings.

Participants’ views of hope as part of their clients’ recovery reflected a sense that subjective reality needs to be understood in a multidimensional way. For the person living with psychosis, who may not be situated in the context of activity guided by personal goals and projects (Fuchs, 2007), the notion of hope becomes particularly salient. It may be that hope is a stronger component of recovery from psychosis if clients have knowledge of the fact that social skills can be lost and regained. This latter possibility is in contrast to the naturalist truth that associates reduced social competence to internal dysfunction (Mueser, Bellack, Morrison, & Wixted, 1990) and
clients’ fixed ideas and negative perceptions about their own social competence (Ntoutsia, 2015, unpublished). It may therefore be essential that practitioners are open and attuned to the nuances of clients’ experiences, and rekindle hope in their ability to engage in goal-directed social behaviour.

Limitations

Recognising the context-dependent construction of meaning inherent to my epistemological and methodological approach, it is expected that different participant accounts would be provided in a different context. The diversity in participant characteristics (age, gender, training background, clinical experience) is thought to contribute to the richness of the qualitative data obtained. Braun and Clarke’s (2013) recommendation regarding the sample size of the project was followed, but cultural diversity could be considered a limitation given the number of participants representing each group. A larger sample may be required to demonstrate patterns of context-dependent realities whilst ensuring that the richness and depth of the data is not sacrificed. Finally, the translation process posed challenges in transferring meaning, although effort was made to stay true to the original texts. It is also possible that my previous involvement with SST may have influenced the analysis. The data could have been analysed differently by a researcher who had no experience with the particular therapeutic model.

Conclusion

The findings of this study foreground the relational and contextual nature of the practice of SST, and reinforce the need to reframe the pathological conceptualisation of social difficulties in psychosis. The theory of SST currently exists at an individual level and neglects the complexity of contextual realities that shape socially skilful behaviour. The findings of this study indicate that social difficulties in psychosis and the therapeutic practices employed in SST cannot be divorced from contextual understandings. Social skills generalisation may partly depend on these understandings and further research is needed to investigate this link. More qualitative studies are required to expand on the knowledge generated by this study, inform theory and help refine the model of SST, as this is an area that has been significantly neglected experientially.
References


Sorrell, E., Hayward, M., & Meddings, S. (2010). Interpersonal processes and auditory hallucinations: A study of the association between relating to voices


My name is Evi Ntoutsia and I am a third year doctoral student in Psychotherapeutic and Counselling Psychology at the University of Surrey, UK. The research I have chosen to undertake is on social skills training (SST) for psychosis. More specifically, I am interested in exploring how practitioners view the role of the SST therapist in individual therapy and/or within the context of a group. To the best of my knowledge, there is currently no research in this area. I feel that a study of this nature will highlight the role of SST therapists beyond the use of behavioural techniques, and possibly also the experience of role tensions and dilemmas with the aim of offering insight into the theory of the model and maximising the benefits that clients derive from this type of therapy.

I would like to invite you to take part in this research project. Before you decide, you need to understand why the research is being done and what it will involve for you. Please take the time to read the following information.

What will be involved?

The study will involve an individual interview lasting approximately 60 minutes. The interview will take place at a location of your choice and a time of convenience. You will be asked questions and your answers will be audio recorded. The questions I will be asking during the interview are about your own views, understandings, experiences and feelings of working with the particular model within your work with individuals experiencing psychosis.

What will happen to the results?

I will be transcribing the recordings for the purpose of this study. I will follow ethical research practice and the information you give will remain confidential. I may use quotes in my research report to highlight key findings but your name and personal details will be removed to protect your identity. The information you provide me with will be stored in a password-protected file on a password-protected laptop. Research data will be kept for 10 years, in line with the University of Surrey, UK Code on Good Research Practice.

Who will have access to the information?

Only my supervisor and myself will have access to the recorded interviews. The research report will be made public once I have submitted it to be marked but as already mentioned, all identifying information will be anonymised.

Do I have to take part in the study?

No. You do not have to participate and if you decide to participate, you are free to leave the study at any time without providing a reason. This means that you can stop
the interview at any time or decide at the end of or after the interview that you do not want what you have told me to be used in the study. In this case, the data will be destroyed.

*What are the benefits of taking part?*

Your answers will help me draw conclusions about SST. This knowledge can be used to fill the gap in the relevant literature, and to improve the content and way of conduct of SST so as to best help individuals with psychotic experiences and difficulties in the social realm. You may find the experience of participation in the study rewarding, as you will have the opportunity to voice your opinions and concerns in relation to the particular psychosocial therapy.

*What are the risks of taking part?*

No serious risks are anticipated from taking part in the study. If you experience any distress in the process of answering any of the questions, we can pause and discuss it or stop the interview entirely should you wish.

*Will I be informed of the findings of the study?*

You will be offered the opportunity to check the analysis of findings before submission and determine whether it reflects your accounts of views and experiences. Your feedback would be very helpful as the analysis would then be adapted accordingly. Please note that after research report submission and marking, the report may be put forward for publishing, meaning that it could be read by anyone.

*Opportunity to raise complaints and concerns:*

Please feel free to raise any questions you may have to me at any point, during or after the end of the study. For any complaint or concern about any aspect of the study, please contact me (Miss Paraskevi Ntoutsia, principal investigator, tel. 07955062380, e-mail: p.ntoutsia@surrey.ac.uk) or my supervisor (Dr Elena Manafi, tel. 01483 683637, email: e.manafi@surrey.ac.uk).

This study has been reviewed and received a favourable ethical opinion by the University of Surrey, UK Ethics Committee.

Feel free to take your time to decide whether or not you would like to take part in the study.

Thank you for your time.
Consent Form

- I, the undersigned, voluntarily agree to take part in the study on practitioners’ role in social skills training for individuals with psychosis.

- I have read and understood the Information Sheet provided. I have been given a full explanation by the investigator of the nature, location and likely duration of the study, and of what will be expected to do. I have been advised about any potential distress and possible ill-effects on my well-being which may result. I have been given the opportunity to ask questions on all aspects of this study and have understood the advice and information given as a result. I have also been given the opportunity to give feedback on data analysis and to be informed about research results after the end of the study.

- I agree with the instructions given to me during the study and to co-operate fully with the investigator. I shall inform her immediately if I suffer any deterioration of any kind in my health or well-being.

- I understand that I will be audio recorded during the interview and I give my permission for this.

- I understand that all personal data relating to volunteers is held and processed in the strictest confidence, and in accordance with the UK Data Protection Act (1998). I agree that I will not seek to restrict the use of the results of the study on the understanding that my anonymity is preserved.

- I understand that I am free to withdraw from the study at any time without needing to justify my decision and without prejudice.

- I confirm that I have read and understood the above and freely consent to participating in this study. I have been given adequate time to consider my participation and agree to comply with the instructions and restrictions of the study.

Name of volunteer (BLOCK CAPITALS): ...........................................

Signed: .................................................................................................

Date: ......................................................................................................

Name of researcher (BLOCK CAPITALS): .................................

Signed: .................................................................................................

Date: ......................................................................................................
Demographics Questionnaire

Practitioners’ understandings of their role in social skills training when working with individuals with psychosis: A thematic analysis

Background Information

1. What is your gender? *(Please tick)*
   
   Male   Female

2. What is your date of birth?

3. To which ethnic group would you say you belong to? *(Please tick)*
   
   Bangladeshi
   Black (African)
   Black (Carribean)
   Black (Other)
   Chinese
   Indian
   Pakistani
   White
   Other *(Please specify)*

4. What is the country of your residence?

5. What is your highest educational qualification? *(Please tick)*
   
   GCSE(s)/O-level(s)/CSE(s)
   A-level(s)/AS-level(s)
   Diploma (HND, SRN etc.)
   Degree
   Postgraduate Degree/Diploma

6. If you are accredited, please indicate the professional body that has accredited you. *(Please tick)*
   
   BPS Division of Clinical Psychology
   BPS Division of Counselling Psychology
United Kingdom Council for Psychotherapy
British Association for Counselling
Other (Please specify)…………………………………………………………

7. What is the length of time since your accreditation?

8. What is your main current occupation?

9. What other work do you undertake? (Please tick)

   Teaching
   Private practice
   Supervision
   Consultation
   Research
   Management
   Other (Please specify)…………………………………………………………

10. If you work within an organisational setting, what is your rank within the organisation? (Please tick)

    Honorary Therapist
    Junior Therapist
    Senior Therapist
    Head of Service
    Other (Please specify)…………………………………………………………

11. What is your therapeutic orientation? (Please tick)

    Cognitive-Behavioural
    Psychoanalytic/Psychodynamic
    Humanistic
    Existential-Phenomenological
    Systemic
    Integrative/eclectic
    Other (Please specify)…………………………………………………………
Appendix B
Interview Schedule

Can you tell me about your relationship to the model of SST within your work with individuals with psychosis?

What is it like working with the particular model? How does it fit with your theoretical orientation/training background?

What is your understanding of the therapeutic process in SST?

What are the things you found challenging working with this model? What were the obstacles you encountered? In your opinion, how can these obstacles be overcome?

Can you think of a time when you found it hard to cope in the SST group? What did you do? What happened in the end?

How do you perceive the experience of therapy to be for your clients? What is your sense of the benefits of this therapy, if you feel there are any?

Do you have any suggestions for the academic community or the mental health system that might be useful for professionals using the particular model in their work with individuals with this type of difficulties?

Is awareness of the societal context in which social re-integration takes place important to consider in social skills training?
Appendix C

Example Transcript (first two pages are displayed)

R = Researcher, P = Participant

R1: Okay. I have turned on the recorder now. We can start? Good. I don’t know where to place it. I don’t know where is the speaker is. Anyway…
P1: What is it? Is it a laptop that you have? What is it?
R2: Yes, it’s a laptop. I don’t have a desktop.
P2: Okay.
R3: Okay. Um… could you tell me about your relationship with the therapeutic model of social skills training (SST) in the context of your work with people with psychotic experiences?
P3: Well… in general? What shall I tell you about it?
R4: What is your relationship… that is, when have you… in what context have you…
P4: I started to think about this model and use it while I was working in a residential setting…but I applied it more systematically in the context of a day centre for patients in the community, most of whom did not live in residential care. It was at a time when I was trying to find a more organised and concrete way of training in skills. Initially, this concerned independent living skills... how you can do this training in a more systematic way, and then, after reviewing the literature I realised that it can be done for many more things and much more conditions. This is how I came to involve myself in this.
R5: Okay, and when you say independent living skills... let’s say, have you also used it…well, for what skills exactly?
P5: This initially had to do with skills applied at the hostel... how to train someone to take care of themselves, look after his space, use possibilities in the community e.g. public transport, services, do shopping for things. I was thinking of a way to do this training in a more systematic way.
R6: Okay…
P6: Yes, it was more about self-care and independent living issues initially. Something that was already taking place and there was concern about doing it more systematically.
R7: Um, and then…have you also used it for skills like communication…you know, basic communication skills, problem solving (skills)...

P7: To a large extent, this was the basis for all the other skills, i.e. basic communication skills that need to be learned so that you can move on to training of other skills. These constitute the basis of communication for the patient when he uses a skill and it facilitates our communication with the patient…so, it is the way you train for the rest of the skills. As a therapist, you need to use them and train the other to use them…to understand them so that you can move on to the next (skill).

R8: Okay ... and the day centre? Again, I am assuming that you mean group therapy?

P8: In group therapy ... yes, in a group context.

R9: What type of skills did you focus on there?

P9: The goal was initially to train (people) in basic communication skills that could be applied in all circumstances, and I also thought about what group members needed…what they encounter in life, what problems they might be having... and to extend (the training) to other (skills)… things that would come up or anger management issues that they all have... These had to do with the relationship with their doctor or relationship issues with the opposite sex that concerned them. We also tried to integrate…how shall I put it… important issues that included many skills e.g. (how to stay on) the topic of conversation… how to have a conversation etc. The basic communication skills were the basis and then, depending on what the group asked for and efforts on our part to identify what the patient would likely encounter in everyday life… we developed a programme for the entire year. This is more or less how (things happened).

R10: Okay, so you had in mind the group members’ needs and then you developed a programme in a way that you could…

P10: The needs of the members the way they expressed them and the way I could understand them based on things I knew about their lives … their daily lives... what they might be facing.... The aim was for them to be trained in skills they would need to use... A large....information about this could also be obtained through observation of the patients outside the group in the social clubhouse (of the day centre)...or what difficulties they might be facing… so that you can also make some suggestions for skills that you think they could work on… that you have seen they may be finding hard.
### Appendix D

#### Example of Initial Codes

| P28: I think that in the training the therapeutic process involves two things. The first one is the climate created within the group and there it is important that one knows within a... that one knows how a group can operate and to the extent that it is done that it is a pleasant and positive experience for participants, and the second part has to do with how the information to be learnt will be given. When the information is addressed to psychotics, I believe what I said earlier...that it must be simply expressed and it must be to a great extent adapted to what they can already do in a way. I think that the combination of these two things is the best because I think that social skills are to a large extent reinforced by a positive learning experience. That is, group participation is in itself a skill that is imprinted...if it is a positive experience. That is, the fact that I managed to participate in this group, to communicate and interact is a social skill that is learned, and it is a first significant, positive experience in the issue on which exactly training is carried out. So, how you will handle the group, to what extent you will allow free expression of certain thoughts, feelings, opinions on what is going on inside the group and how it is going on...is already a living laboratory for the application of what you do as a social skill lesson, and a first positive experience of application of those skills. Maybe this completes the answer to the previous question... that if the way in which the group will be created focuses more on the manual, with an anxiety to apply those things, not to omit anything... but this resulted in the people participating feeling that they cannot actively participate or that they cannot introduce something of their own and exchange something with the other members... then group participation will probably end up being a negative experience of social skills... where most of them may have felt oppressed or inadequate because they couldn’t perform the skills well in the group. That is, the first part is that you train them and teach them, and the second part is to what extent the group experience reinforces what you teach them also as an actual experience. | The therapeutic process: Develop a positive group climate  
Knowledge of group functioning  
Creating a positive group experience  
Information in simple language  
Information adapted to the client  
Good fit with individual abilities  
The positive group experience as a reinforcer  
Group participation is a skill  
Communication + interaction = positive group participation  
Mastering the art of group therapy  
Freedom of expression within limits  
Focusing on content and process  
The group as a ‘living laboratory’  
Exposure to real life social situations  
Exposure to social skills  
Following the manual with rigidity  
The client is more important  
Acknowledgement and appreciation of the client’s input  
Giving priority to the manual can cause harm to the client  
Psychological harm  
SST is more than training in skills  
Group experience as a reinforcer of skills |
Appendix E

Initial Themes

Assessment
Observation of client’s needs
Knowledge of difficulties facilitated by context

Group therapy climate
Group rules and norms
Boundaries
Expression
Safety and respect
Client’s needs comes first, structure comes second

External pressures
Authority implied by the biomedical model
Reality defined by service resources
The clash with client’s reality
The client knows best
Resisting service pressures

Use of authentic self
Normalisation
Validation
Immediacy
Authentic interaction
Therapist as role model

Change
Historical vs present focus of therapy
Therapist and client working as a team
Therapist as ‘cheerleader’
Client as ‘hero’
Building resilience
Building hope

Being mindful of self and other
The client exists in a sociocultural context
Relationships in therapy
Relationships with voices
Relationships with people outside therapy
Linking relationships
The power of the facilitating environment

Empowering the client
Recognising strength and stamina
Autonomy and personal responsibility
Building on existing abilities
Reinforcing the effort regardless of outcome

**Therapist’s way of being with the client**
Optimism
Acceptance
Empathy
Kindness and curiosity
Non-judgmental attitude
Patience
Reducing power

**Flexibility in relation to use of technique**
One size does not fit all
Fitting the model to the person
Deviating from the plan
Complexity leads to model adaptation
Inflexible approach might result in negative experience

**Experimentation**
Expression of thoughts/feelings/needs
Client as scientist
Therapist as guide

**Handling challenges**
Attention
Hostile communication
Therapist’s uncertainty
Focus on process
Linking to group
Linking to skills

**Consulting to the client**
Knowledge of wider social reality
Possibility of rejection
Radical acceptance of reality
Therapist as mediator
Appendix F
In Search of Themes
Appendix G
Thematic Map

SST in action: Core therapeutic tasks

- Creating a therapy culture in which safe and energetic interactions can take place
- Managing external pressures
- Keeping the hope alive and focusing on change
- Building on existing skills and empowering the client
- Facilitating awareness of self in context
- Recognising and deterring forces that threaten group cohesion

Qualities and attitudes of a SST Therapist

- Maintaining flexibility in delivering therapy
- Embracing a phenomenological attitude
### Appendix H

#### Reviewing Final Themes

**Table 2**

<table>
<thead>
<tr>
<th>Themes and Subthemes</th>
<th>Examples from participants’ accounts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. SST in action: Core therapeutic tasks</strong></td>
<td><strong>1.1 Creating a therapy culture in which safe and energetic interactions can take place</strong>&lt;br&gt;You need to establish a set of rules (Jemma)&lt;br&gt;Staying on a particular topic and not offending others (Alex)&lt;br&gt;Help them feel safe (Artemis)&lt;br&gt;You need to explain what the group is about (Helen)</td>
</tr>
<tr>
<td><strong>1.2 Recognising and deterring forces that threaten group cohesion</strong></td>
<td>The challenges...often arise from group dynamics (Helen)&lt;br&gt;You also pay attention to the group climate (Helen)&lt;br&gt;Role-playing was taking place but I was not supervising it (John)&lt;br&gt;If someone competes with others for the therapist’s attention (Jemma)&lt;br&gt;If you let it happen without any control...it will serve as disconnection (Alex)</td>
</tr>
<tr>
<td><strong>1.3 Facilitating awareness of self in context</strong></td>
<td>Talk about what things are like out there (Helen)&lt;br&gt;You may need to explain the situation at public hospitals (Helen)&lt;br&gt;The other is different and may have a different opinion (Alex)&lt;br&gt;Rejection can be very painful when you have a history of multiple rejections (Jemma)&lt;br&gt;How they interact within their relationships...is often mirrored in their relationship with their voices (Sue)</td>
</tr>
<tr>
<td><strong>1.4 Building on existing skills and empowering the client</strong></td>
<td>There needs to be more room for their more adult parts to be expressed (John)&lt;br&gt;I tried to focus on their own way (Alex)&lt;br&gt;What's important is that the message is clear and that you keep reinforcing the good elements (Jemma)&lt;br&gt;You did really well there. What do you think about that? (Kate)</td>
</tr>
<tr>
<td><strong>1.5 Keeping the hope alive and focusing on change</strong></td>
<td>You have come through this (Sue)&lt;br&gt;Holding onto that hope for the client (Kate)</td>
</tr>
</tbody>
</table>
1.6 Managing external pressures

There might not be sufficient time to address important things (Jemma)
I don’t know how honest I can be in supervision (Paul)
There is definitely a service pressure on making people recover (Kate)
Liberating…to not have the constraints that you would otherwise have…in a conventional clinic setting (Sue)

2. Qualities and attitudes of a SST therapist

2.1 Embracing a phenomenological attitude

I’ll listen to it (the dilemma) (Helen)
Have a foot in their world (Paul)
Just be patient and explore it for a moment (Jemma)
That sounds like it feels sad. ‘Are you sad?’ (Artemis)
You are just trying to understand what they are going through (Kate)
I am a member of their team (John)

2.2 Maintaining flexibility in delivering therapy

Perhaps shorten the sessions, chunk information (Sue)
If the group […] is focused more on the manual…then group participation will probably end up being a negative experience (Alex)
I do tweak it to fit with the client’s needs (Kate)
Appendix I
Ethical Approval

Ethics Study Application Form and checklist Ref: FT-PSY-234-16 - Confirmation to proceed
Earl JE Mrs (FHMS Faculty Admin)
To:
Ntoutsia P Miss (PG/R - Psychology)
Cc:
Manafi E Dr (Psychology)

Tue 05/01/2016 11:07

Dear Evi

Thank you for submitting your ethics study application form, checklist and summary to the Faculty of Health and Medical Sciences Ethics Committee via the Fast Track procedure. I am pleased to confirm that your project, as stated in your application, does not raise any issues that would necessitate a full review and you are therefore able to proceed with your research. However one point to note is that any information sheets handed or sent to participants should be on university letterhead, with the logo etc.

Please keep your original application, checklist form and summary with the reference given above together with a copy of this email, as no copies are kept by the ethics committee.

If there are any significant changes to your project which require further scrutiny, please contact the Ethics Committee before proceeding with your Project.

Many thanks and Happy New Year to you too!

Best wishes
Julie

Julie Earl
Administrator Faculty of Health and Medical Sciences Ethics Committee
Duke of Kent Building (16DK03)
University of Surrey
Tel: 01483 689175
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PLEASE NOTE: I am now based in FHMS (16DK03). My working hours remain the same and are 9-5.30, (5.00 in vacation), Tues, Wed and Thurs.

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