**Extended report:**

**Social Cognition and Interaction Training (SCIT) for Adults with Psychotic Disorders: A Feasibility Study in Finland**

Greta Voutilainen and Tiina Kouhia

*Social Services and Health Care, City of Helsinki, Finland*

David L. Roberts

*University of Texas Health Science Center, San Antonio, USA*

Jorma Oksanen

*Helsinki University Hospital and Helsinki University, Finland*

Correspondence to Greta Voutilainen, Social Services and Health Care, City of Helsinki - Aurora Hospital, P.O. Box 6800, Helsinki 00099, Finland. E-mail: greta.voutilainen@gmail.com

**Abstract**

**Background:** Social Cognition and Interaction Training (SCIT) is a psychosocial treatment designed to improve social functioning in schizophrenia by improving social cognition. Positive results have been reported from several studies mainly from the USA, but more studies are needed to determine the feasibility of SCIT in different cultural contexts. **Aims:** The objective of this study was to evaluate the feasibility and acceptability of the Finnish translation of SCIT in Finland. **Method:** This was an uncontrolled, within-group study. Thirty-three patients with psychotic disorders participated in SCIT groups and also received the standard services provided at their respective care facilities. We measured participant attendance, attrition and responses on feedback surveys. Participants also completed measures of emotion perception, Theory of Mind (ToM), attributional bias and metacognitive overconfidence both before and after SCIT. **Results:** The attendance rate was high, attrition was low, and the patients expressed satisfaction with SCIT. Preliminary efficacy analyses showed a statistically significant pre- to post-test improvement in emotion perception and ToM, but not attributional bias or overconfidence. **Conclusions:** SCIT is feasible and well accepted and may remediate social cognitive dysfunction in people with psychotic disorders in Finland.

**Introduction**

Schizophrenia is a chronic disorder causing major deterioration in an individual’s ability to attain employment, independent living and adequate social relationships. Social cognition, commonly described as “the mental operations underlying social interactions” (Brothers, 1990, pg. 28), has been shown to be an important predictor of social functioning (Couture, Penn & Roberts, 2006; Fett et al., 2011; Mancuso, Horan, Kern & Green, 2011) and may act as a mediator between basic neurocognition and functional outcome (Schmidt, Mueller & Roder, 2011). The most recognized domains of social cognition include emotion perception, Theory of Mind (ToM) and attributional style, and patients with schizophrenia have been shown to have abnormalities in these domains (Penn, Sanna & Roberts, 2008). Training people with schizophrenia in these social cognitive skills may be a feasible way to improve their social functioning.

Several targeted interventions for social cognition have been published, some focusing on improving the recognition of facial expressions, others on more broad-based objectives (Kurtz & Richardson, 2012). Social Cognition and Interaction Training (SCIT) is a broad-based manualized group treatment that targets dysfunctional social cognitive processes in schizophrenia, including problems with emotion perception and ToM, metacognitive overconfidence (the tendency to overvalue the accuracy of one’s judgments, as occurs in Jumping to Conclusions) and biased social attributions (Roberts & Penn, 2009). Positive effects on these social cognitive domains and also social skill have been reported in studies from the USA, China, England, Spain and Israel (Combs, Adams et al., 2007; Penn, Roberts, Combs & Sterne, 2007; Roberts & Penn, 2009; Roberts, Penn, Labate, Margolis & Sterne, 2010; Wang et al, 2013; Lahera et al, 2013; Hasson-Ohayon, Mashiach-Eizenberg, Avidian, Roberts & Roe, 2014; Taylor et al, 2015; although see Parker, Foley, Walker, & Dark, 2013). More studies on feasibility and acceptability of SCIT in different cultural contexts are still needed.

The objective of this study was to evaluate the feasibility and acceptability of a Finnish translation of SCIT with Finnish patients. Second, we collected social cognitive outcome data as a preliminary assessment of the potential efficacy of SCIT in this population.

**Methods**

Participants

Participants comprised both in- and outpatients from Aurora Hospital, Helsinki, Finland, whose chart diagnosis was psychotic disorder. Inpatients were from rehabilitation wards, outpatients were mainly from a supported housing program, and all were in stable condition. SCIT was offered as a regular clinical group, and more patients expressed interest than could be accommodated. Social cognition measures were administered to interested patients and a subset of 40 were selected for SCIT participation based on poor test performance or clear social dysfunction as evaluated by clinician observation. These 40 patients were offered research participation and 33 consented to participate in the current study. During the study intervention period, some patients proceeded from rehabilitation wards to supported housing or back home.

Procedures

All participants were fully explained the procedures of the study. The study was accepted by the Ethical boards of Helsinki University Central Hospital and City of Helsinki Health Services. The authors assert that all procedures contributing to this work comply with the ethical standards of the relevant national and institutional committees on human experimentation and with the Helsinki Declaration of 1975, as revised in 2008.

All the study patients received the SCIT intervention in addition to standard care. SCIT groups were delivered for 5-6 patients at a time by a pair of clinicians who were trained to use SCIT by the developers of the intervention. Group leaders were psychologists and occupational therapists. Groups were provided once or twice per week for 22-24 sessions. Participants completed measures of social cognition both before and after SCIT intervention. Measures were administered by clinical psychologists some of who also provided the SCIT groups.

The SCIT Intervention

The SCIT manual was translated to Finnish by clinical psychologists and psychiatrists, and the audio-visual material was reproduced in Finnish by local theater school students. Minor modifications were made to the manual and stimuli for language and cultural appropriateness.

All patients had practice partners, mostly clinical nurses, who helped them to practice SCIT skills between group sessions. The nurses were not present in the group sessions. The main focus of each SCIT session was explained briefly via email to practice partners and their main role was to ask the patient about the group and provide help with weekly SCIT homework if the patient wanted. Therefore the amount of influence the nurses had was quite variable. Homework assignments were paper-and-pencil exercises drawn from the SCIT manual.

Measures

After the SCIT intervention, written anonymous feedback was collected with a questionnaire. Items included statements such as “The SCIT exercises and homework were clear and understandable.”, “The SCIT group was useful to me.”, “The SCIT group helped me to better understand social situations.” and “The SCIT group helped me to better understand other people.” Participants rated each item on a scale from 1 (completely disagree) to 4 (completely agree). The questionnaire also included a section for informal written feedback. The anonymous feedback was collected from all patients who attended SCIT groups and therefore because of practical reasons we could not separate the feedback that was from the study patients who gave written consent.

After the SCIT intervention and the post measurements we also arranged individual interviews, where the patient, practice partner and the group leaders discussed the patients’ and practice partners’ individual impressions of the group.

Emotion perception was measured with the Facial Emotion Identification Task (FEIT) (Kerr and Neale, 1993) which consists of 19 pictures of faces expressing six different emotions. ToM was measured with the Hinting Task (Corcoran, Mercer & Frith, 1995) which consists of ten short vignettes involving two people in conversation. The task is to infer what one person is implying indirectly. Attributional bias was measured with the Ambiguous Intentions Hostility Questionnaire-Ambiguous items (AIHQ-A) (Combs, Penn, Wicher & Waldheter, 2007). The AIHQ-A consists of five second-person vignettes of social situations with negative outcomes of ambiguous causality. The participant is asked what he or she thinks is the cause of the outcome, how much he or she would blame the other person in the vignette and what he or she would do in response. We used this subscale only because it is the most sensitive to social cognitive bias (Combs, Penn, Wicher & Waldheter, 2007) and there is a precedent in the literature for using the subscale only in studies of SCIT (Combs, Adams et al., 2007). In addition to these measures, we used the Social Cognition Screening Questionnaire (SCSQ). The SCSQ is a newer instrument consisting of ten short stories that are read to the participant. It measures broad-based social cognitive accuracy (including subscales for ToM, schematic inference and verbal memory) and two social cognitive biases, attributional bias and metacognitive overconfidence (the tendency to overvalue the accuracy of one’s judgments, as occurs in Jumping to Conclusions). All the measures were translated into Finnish and backtranslated to ensure accuracy.

**Data analysis**

For feasibility data, descriptive statistics (sums, means, standard deviations) were computed and participants’ feedback on the group was examined for themes. For outcome data, changes in total scores for the FEIT, Hinting Task, and the subscales of AIHQ-A and SCSQ were analysed separately using paired samples t-tests in IBM SPSS Statistics version 21.

**Results**

Of the 33 participants, two had their data excluded due to a sudden and dramatic deterioration in their clinical condition. The deterioration was clinically concluded to be unrelated to SCIT and these patients did not considerably differ from the rest of the study population. Eighteen of the final participants were males and thirteen females, all were native Finnish and the age range was 18-56 years (mean 31 years). Seven participants had the clinical diagnosis of ICD-10 F29 Unspecified nonorganic psychosis, seventeen had F20.3 Undifferentiated schizophrenia, six had F20.0 Paranoid schizophrenia and one had F25.1 Schizoaffective disorder, depressive type. At the start of the study participation approximately 2/3 of the participants were inpatients at rehabilitation wards and 1/3 were outpatients. Of the outpatients all except one were from supported housing.

The mean attendance rate in the study population was 94.76% (sd=5.36; range 82.6% - 100%). Regarding attrition, no research participants dropped out of the SCIT group. Fifteen patients returned the anonymous feedback form. Typical comments in the written feedback section include, “Thanks for a great group!”, “The content of the SCIT-group was versatile and good. Getting homework to do was a good thing. The facilitators knew how to explain the things in an understandable manner.” and “SCIT-group was a nice place to study different social situations.” On structured feedback items, participants indicate that they found SCIT exercises and homework to be clear and understandable (mean=3,33), that the SCIT group was useful to them (mean=3,13) and that the SCIT group helped them to better understand social situations (mean=3,13) and other people (mean=3,2). In the individual interviews after the intervention many participants requested an ongoing group to continue working on social cognition skills and also practice partners gave positive feedback about SCIT.

Results of paired-samples t-tests of outcome measures are displayed in table 1. Analyses showed a statistically significant pre- to post-test improvement on the FEIT and the Hinting Task. For the AIHQ-A, change in the Hostility Bias scale was not significant, the Blame Composite score approached significance with an increase following SCIT, and the Aggression Bias score also showed a trend towards increased scores.

**Table 1.** Paired samples *t*-tests of social cognition measures before and after SCIT

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Measure | Before SCIT  mean | Before SCIT  *SD* | After SCIT mean | After SCIT  *SD* | Paired samples mean | Paired samples *SD* | Paired samples *t* | *df* | *p* |
| FEIT | 11.484 | 2.885 | 13.710 | 3.237 | 2.226 | 2.929 | 4.23 | 30 | <.001 |
| Hinting task | 14.548 | 3.472 | 15.548 | 3.053 | 1.000 | 2.517 | 2.21 | 30 | .035 |
| SCSQ accuracy | 23.633 | 2.930 | 23.967 | 3.459 | .333 | 3.437 | .53 | 29 | .599 |
| SCSQ hostility bias | 1.400 | 1.037 | 1.533 | 1.042 | .133 | 1.306 | .56 | 29 | .580 |
| SCSQ over-confidence bias | 1.469 | .799 | 1.222 | .843 | -.247 | 1.041 | -1.30 | 29 | .203 |
| AIHQ-A hostility bias | 1.903 | .620 | 1.855 | .552 | -.047 | .656 | -.39 | 29 | .700 |
| AIHQ-A blame composite | 2.610 | .850 | 2.747 | .635 | .166 | .510 | 1.78 | 29 | .085 |
| AIHQ-A aggression bias | 1.670 | .325 | 1.800 | .414 | .147 | .419 | 1.92 | 29 | .065 |

*Notes:* Possible scores in FEIT range from 0 to 19 with higher scores indicating better functioning.

Possible scores in Hinting Task range from 0 to 20 with higher scores indicating better functioning.

Possible scores in SCSQ accuracy scale range from 0 to 30 with higher scores indicating better functioning.

Possible scores in SCSQ hostility bias scale range from 0 to 5 with higher scores indicating lower functioning.

Possible scores in SCSQ overconfidence bias scale range from 0 to 3 with higher scores indicating lower functioning.

Possible scores in AIHQ-A hostility bias and aggression bias subscales range from 1 to 5 with higher scores indicating lower functioning.

Possible scores in AIHQ-A blame composite range from 1 to 5.33 with higher scores indicating lower functioning.

Two of the 31 participants had missing data, one in SCSQ and the other in AIHQ-A, and had to be excluded from these two segments of analysis respectively.

**Discussion**

Our results support the feasibility of our translated SCIT intervention and its acceptability to patients. Based on the high interest in participating in SCIT and the high group attendance rate in participants, the motivation to work with social cognitive problems was quite high in our patient population. The patients’ and practice partners’ experiences with SCIT seemed to be very positive according to anonymous written feedback and individual interviews after the intervention. Based on patient requests, six of the study patients who were still at the rehabilitation wards or supported housing in spring 2013 participated in a SCIT continuation group consisting of 13 sessions (75 minutes/session).

This uncontrolled study also provided initial evidence that SCIT may improve emotion perception and Theory of Mind. These results are consistent with previous research (Combs, Adams et al., 2007, Wang et al., 2013). Regarding hostile attributional bias, the results were interesting. In previous research some studies have found significant improvements in attributional biases (Combs, Adams et al., 2007), but some have not (Roberts & Penn, 2009). We found that the AIHQ-A Blame composite and the Aggression bias increased at a statistical trend level, although the aim of SCIT is to decrease the tendency to blame others and act aggressively. It is notable that the average scores in these bias scales were quite low in our participants both before and after SCIT (Combs, Penn, Wicher & Waldheter, 2007). This apparent floor effect may be due to participants “faking good” (van de Mortel, 2008; Roberts & Penn, 2009) in order to appear non-aggressive or non-paranoid. It also could indicate actual low levels of bias in this sample, which would be consistent with the finding that hostility bias is only present in a subset of schizophrenia patients (Bentall, Corcoran, Howard, Blackwood & Kinderman, 2001). On the SCSQ, analyses showed null results across broad-based social cognitive accuracy, hostility bias, and overconfidence bias. It is possible that the SCSQ’s high demand on verbal memory could explain the lack of impact of SCIT treatment on patients’ SCSQ performance. However, this is unlikely because only one participant at pre-test and one at post-test met the cut-off score of 6 on the SCSQ verbal memory scale indicating that poor performance was driven primarily by verbal memory deficits. As the SCSQ is a new measure with uncertain psychometric properties, it is unclear whether the current null result is due to the limitations of the measure or to real null effects of SCIT on aspects of social cognition measured by the SCSQ.

A strength of this study is that it was conducted in real-world mental health treatment settings, including both longer-stay wards and supported housing. The limitations include lack of a control group, small study size and no use of measures of symptoms.

**Conclusions**

SCIT seems to be a feasible and well-accepted intervention with the potential to remediate social cognitive dysfunction in people with severe psychotic disorders and Finnish cultural background.

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