Summary. Aim. Currently substantial evidence exists about Theory of Mind (ToM) impairment in subjects affected by chronic and first episode schizophrenia. In particular, in order to enhance the validity of our construct, we used in this study classical false beliefs tasks and advanced theory of mind tasks, together with the application of structural equation model, in order to examine whether we are using ToM tasks with good psychometric properties. The main goal of the present study was to examine ToM deficits in a large sample including subjects suffering from chronic schizophrenia, first episode of schizophrenia and normal controls, by observing in the same task the relationship with symptomatological gravity, neurocognition and social function.

Materials and methods. A sample of 178 patients with chronic schizophrenia, a sample of 49 subjects with a first episode of psychosis and 484 healthy controls participated to this study. Measures of social cognition included task of false belief and advanced theory of mind task.

Results. No significant differences were found on ToM tasks between subjects affected by chronic and first episode schizophrenia. Social cognition showed in both groups a strong correlation with negative symptoms and social function, but did not evidence any relationship with neurocognition.

Conclusion. ToM deficits exist in subjects suffering from chronic and first episode schizophrenia. These impairments do not seem to be a consequence of illness condition, they are likely to be state-independent and appear to be the most important cognitive mediator of social functioning in both groups.

Key words: theory of mind, schizophrenia, first episode, neurocognition, symptoms and social function.
INTRODUCTION

Theory of Mind (ToM) is a cognitive capacity to represent one’s own and other persons’ mental states, for instance, in terms of thinking, believing, or pretending. The term was first used by the primatologists and psychologists Premack and Woodruff, who wondered whether the chimpanzee had a ToM (1). In human people, ToM indicates a competence used in everyday life during social interaction with other people.

Impaired ToM has been described in a variety of neuropsychiatric disorders and the most extensive ToM studies have been carried out in autistic spectrum disorders (2), in chronic schizophrenia (3) and in recent onset, but also in adult patients with frontal lobe damage (4,5).

Many tests applied in schizophrenia and aimed at examining ToM competences were developed to test young children’s ability to infer mental states of other individuals (6).

The classic false beliefs tasks as Sally and Anne Test (7) involves the experimental creation of a situation in which a tested person has to distinguish his/her own knowledge that an object has been hidden by one character (Anne) in the absence of another person (Sally) from the knowledge of other characters involved (Figure 1).

The crucial issue is the place where Sally would look for the object when she comes back: the place where it was before she left the scene, or the place where it has been moved by Anne.

Figure 1. Relationships between the factors referred to as theory of mind I and II level.
New evidence in theory of mind deficits in subjects with chronic schizophrenia and first episode

the false beliefs tasks cannot satisfactorily be resolved in experimental laboratory “offline” test conditions.

Usually, in clinical practice, it is important to reduce as much as possible the time of examination, and it would also be very useful to use a task which could be administered in the clinical practice, which could examine ToM in subjects affected by schizophrenia and which already exists in literature.

Some studies report different tasks used to examine ToM in adults. In particular Happe (13), tested subjects with Asperger Syndrome by using an “advanced” theory-of-mind task. This task involved story comprehension, where the key questions concerned either a character’s mental state or physical events. She found that even competent persons suffering from autism showed more difficulties with mental state stories than did matched controls, and that they used fewer and more inappropriate mental state terms than the control group in their explication of the reason why the character behaved as they did.

Some authors later replicated to this finding by using a modified version of the story battery with individuals with Asperger Syndrome (14,15) and other authors used this task in a patients with frontal lobes lesions (4,16).

In recent years some authors reported similar ToM disorders both in subjects affected by schizophrenia and in patients with brain damage (17-19).

Patients with frontal lobe lesions, in fact, have been described as presenting diminished social cognition competences similar to schizophrenic subjects (4,16).

The aim of the present study is to examine theory of mind competences in a large sample of subjects affected by chronic schizophrenia and a sample with a recent onset of schizophrenia spectrum psychosis using two tasks to assess a first and second order false belief tasks by Happe (13) and compare their performances in same task.

We used a task just present in literature and easy to perform also in clinical practice. However, it has never been deeply tested so far the structure of advanced theory of mind test, in order to examine whether the task really examine theory of mind.

Moreover, in order to enhance the validity of the construct, we used also classical false beliefs tasks, which allow us to explore whether the task really examines ToM, and is therefore a good measure of mentalizing abilities and we applied structural equation model to examine whether we were using ToM tasks properly from a psychometric point of view.

Finally, the relationship between ToM and clinical variables, such as symptoms and social function, have also been explored.

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**MATERIALS AND METHODS**

Two groups of subjects suffering from schizophrenia participated to the study.

The first group was composed of 178 people affected by chronic schizophrenia (124 males and 54 females), diagnosed according to DSM-IV-R (20) criteria.

Subjects were in-patients of the Day Hospital (DH) service of the University of L’Aquila Psychiatry Department from January 2000 to January 2009.

The average age was 34,5 years (sd 8,4), the average years of schooling 11,54 (sd 2,7).

All the subjects gave informed consent to the participation in symptoms assessment for therapeutic management in DH.

Every subjects’ assessment took place when clinically stable within a month from the day of admission to DH and establishment/confirmation of diagnosis. 98% was treated with maintenance atypical antipsychotic drugs. The mean daily dose was 210,3 (sd 143,67) mg/equivalents of chlorpromazine (21). We classified this group as “remitted” according the criterion used by Krabbendam (22).

The second group was composed of 49 first episode (FE) subjects affected by schizophrenia (33 males, 16 females) whose mean age was 26,8 years (sd 6,4), the average years of schooling 10,8 (sd 2,8). None of them showed any concurrent medical condition at the time of the assessment. This was defined “first episode” group and consisted of patients who had been diagnosed with an interval of 3 months from first diagnosis (i.e., at time of first hospitalization or presentation to the services).

All patients were free of other medical conditions or substance abuse. The majority of the FE sample was single (88%) and lived at home (78%). In terms of education 34% attended some years of high school education, 18% had completed high school, 34% had some post-graduate training and 14% was graduated. Diagnoses for these patients included schizophrenia, schizoaffective disorder and schizophreniform disorder.

All subjects were in-patients consecutively admitted to the SMILE Services. The SMILE (Service for Monitoring and early Intervention against psychoLogical and mEntal suffering in young people) is a service composed of a multidisciplinary team (senior psychiatrist, resident psychiatrists, child neuropsychiatrist, neuropsychologist, psychiatric rehabilitation technician) inside the Outpatients Department of the San Salvatore Hospital, L’Aquila, Italy.

Diagnoses of both groups were completed at baseline. DSM-IV-TR diagnoses of schizophrenia or schizoaffective disorder based on the Structured Clinical Interview for DSM-IV- Patient Edition (SCID) (23) before being confirmed through a consensus meeting attended by at least two senior psychiatrists. 67% was treated with maintenance atypical antipsychotic drugs whose mean daily dose was 98,3 (sd 95,76) Mg/Equivalents of Chlorpromazine (24). The mean IQ level was assessed through Raven’s Progressive Matrices Scale (1938).
Subjects were compared to two control normal samples. The first group was composed of 386 (71 males, 53 females) subjects taken from students who matched with FE group for age and education.

The second group was composed of 96 (51 males, 45 females) subjects selected from normal Italian population, who matched with subjects suffering from chronic schizophrenia for age and education. Socio-demographic and clinical details are reported in Table 1.

**Psychopathology measures**

The severity of psychopathology was assessed with the following instruments:

Brief Psychiatric Rating Scale-24 in its Italian version. Each symptom on the 24-item scale was rated on a scale from 1 to 7 (1= absence of symptom; 7= very severe symptom). The key score was composed by the total points gathered throughout the complete scale. 6 symptom clusters were evidenced as following, after performing a factor analysis on the BPRS scores on a larger sample composed of 225 psychiatric patients: Disorganised cluster, including items 12 (Bizarre behaviour), 13 (Self-neglect), 14 (Disorientation), 15 (Conceptual disorganisation); Negative affect cluster, including items 16 (Blunted affect), 17 (emotional withdrawal), 18 (Motor retardation); Positive symptoms cluster, including 9 (Suspiciousness), 10 (Hallucinations), 11 (Unusual content of thoughts); Mania cluster, including items 7 (Mood elevation), 8 (Grandiosity), 21 (Excitement), 23 (Motion hyperactivity); Depression cluster 3 (Depression), 4 (Suicidality), 5 (Guilty) and Anxiety cluster 1(somatic concern), 2 (anxiety).

**Social function**

The VADO Personal and Social Functioning Scale (FPS) consists in a modified version of the Social and Occupational Functioning Assessment Scale (SOFAS) (25). As with the SOFAS, the FPS scores range from 100 (excellent functioning) to 1 (extremely severe impairment with risk for survival). The instructions for scoring the 10 points within each level are very detailed. The rater is instructed to take into account four main areas: work and/or socially useful activities; family, personal and social relationships; self-care; aggressive and destructive behaviours. Suicide risk is considered in the score as much as suicidal ruminations may interfere with social-functioning. The FPS requires a brief and simple training, that is described in the VADO manual. The FPS can be easily scored by rehabilitation workers, including those with a limited psychiatric experience. It is, therefore, an very useful tool to assess severity and outcome in routine practice.

**Neuropsychological assessment**

All subjects were administered a Phonemic Verbal Fluency Test and verbal reasoning test. All participants completed a comprehensive battery of neuropsychological test. The different raw scores were converted into T-scores (Mean: 50; SD: 10) and, in order to make all scores comparable, we applied appropriate norms for age and educational level outlined in the manual covering each test. The neurocognitive assessment was carried out through the following instruments: Estimated IQ: Raven Progressive matrices; Working Memory: forward and backward Digit Span; Psychomotor Speed: Trail Making Test-A (TMT-A);

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**Table 1. Clinical and socio-demographic features of participants**

<table>
<thead>
<tr>
<th></th>
<th>Chronic schizophrenics</th>
<th>Recent onset schizophrenics</th>
<th>T Students</th>
<th>CL 95%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>34.57 (8.4)</td>
<td>26.4 (7.56)</td>
<td>7.872; p&lt;0.000</td>
<td>8.14-13.367</td>
</tr>
<tr>
<td>Years of education</td>
<td>11.54 (2.7)</td>
<td>12.6 (2.4)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Intellectual level</td>
<td>76.9 (34.9)</td>
<td>79.7 (12.9)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Duration of illness (years)</td>
<td>10.9 (2.9)</td>
<td>1.01 (0.5)</td>
<td>9.320; p&lt;0.000</td>
<td>7.77-11.94</td>
</tr>
<tr>
<td>FPS</td>
<td>45.5 (16.5)</td>
<td>39.1 (15.8)</td>
<td>2.35; p&lt;0.019</td>
<td>1.09-11.06</td>
</tr>
<tr>
<td>BPRS totale score</td>
<td>47.5 (14.7)</td>
<td>63.79 (16)</td>
<td>6.55; p&lt;0.000</td>
<td>21.147-11.369</td>
</tr>
<tr>
<td>Positive cluster</td>
<td>9.7 (4.7)</td>
<td>13.6 (4.4)</td>
<td>7.68; p&lt;0.000</td>
<td>7.34-4.34</td>
</tr>
<tr>
<td>Negative cluster</td>
<td>6.5 (3.2)</td>
<td>7.2 (3.2)</td>
<td>2.91; p&lt;0.000</td>
<td>.549-2.674</td>
</tr>
<tr>
<td>Disorg. cluster</td>
<td>16.06 (7.35)</td>
<td>21.6 (14.6)</td>
<td>8.06; p&lt;0.000</td>
<td>12.6-7.6</td>
</tr>
<tr>
<td>Mania cluster</td>
<td>4.4 (6.5)</td>
<td>5.1 (3.4)</td>
<td>10.49; p&lt;0.000</td>
<td>5.66-3.87</td>
</tr>
<tr>
<td>Depression cluster</td>
<td>5.6 (2.4)</td>
<td>4.8 (1.8)</td>
<td>3.23; p&lt;0.000</td>
<td>.409-1.978</td>
</tr>
<tr>
<td>Anxiety cluster</td>
<td>5.1 (2.3)</td>
<td>5.4 (2.3)</td>
<td>4.47; p&lt;0.000</td>
<td>.943-2.43</td>
</tr>
</tbody>
</table>

Value are means, standard deviations are in parenthesis.
New evidence in theory of mind deficits in subjects with chronic schizophrenia and first episode

RESULTS

In the first phase of the study we analyze the sociodemographic and clinical details of our sample; as a second step, we examined the factorial structure of advanced ToM task through a structural equation model. Finally we examined the differences between 3 groups in all measures.

Sociodemographic and clinical details

We performed One Way Anova to analyse differences in age and education in all groups.

Our results showed statistically significant differences in age (F 3,542=8.6, p<.000) and education (F 3,542=2.917, p<.018).

Post hoc (Bonferroni methods) analysis evidenced that subjects suffering from chronic schizophrenia differ for age both from recent onset patients (mean differences=.949, p<0.000) and young healthy controls (age mean differences=.529, p<0.000) and that recent onset subjects differ both from chronic subjects (mean differences=.949, p<0.000) and from chronic healthy controls (mean differences=.949, p<0.000).

With regard to education, Post hoc analysis (Bonferroni methods) evidenced that subjects affected by chron-
ic schizophrenia and recent onset schizophrenia patients differ from young healthy controls (age mean differences=.185, p<0.000) and from patients with chronic schizophrenia (mean differences=.261, p<0.000).

We performed t-test in order to analyze differences in duration of illness, IQ level and clinical measures between recent onset and chronic schizophrenia. There were significant differences between the groups in BPRS total score (t 200=2.76, p<.006, recent onset <of chronic Subjects with schizophrenia) and in Positive Cluster (t 200=4.46, p<.000, recent onset <of chronic Subjects with schizophrenia). Clinical results are reported on Table 1.

To have a better comprehension of the relationship between the variable on advanced theory of mind scale, we used a structural equation model. This statistical approach allows to explain how the variables of the present scales are related to each other, through the computation of quantitative and goodness of fit.

In fact we analaze SEM with the strength of the correlational links between the plausibility of causal factors hypothesized. Through the use of models and can see if the scale that we used actually looks at the ability of mind reading in a manner similar to the false belief task.

In order to evaluate the comprehension adaptation statistical fitness of our model we considered the following indices of fit: 2 (and the respective degrees of liberty, df), Goodness of Fit Index (GFI) (27), Adjusted Goodness of Fit Index (AGFI) (27,28), Comparative Fit Index (CFI) (29), Nonnormed Fit Index (NNFI) (30), Root-Mean-Square Error of Approximation (RMSEA) (31), GFI, AGFI, CFI and NNFI are indexes varying between 0 and 1 which express the level of adaptation, the better the closer they approach level 1. RMSEA, instead, indicates a good adaptation when results are less than 0.06 (32).

The pattern of relationships between the factors referred to as ToM I and II level is shown graphically in Figure 1.

In this model we calculated for each item values of saturation (λ) and respective errors of variance (θ). The optimal solution obtained from the item analysis are reported in Table 2. As it is possible to observe our model shows perfect solution allows to confirm the relation between all the items in the Advanced level and the two false belief tasks used showed that all factors used in the model belong to a single theoretical construct.

### Advanced ToM scale

The comparison between subjects affected by chronic and recent onset schizophrenia and all controls showed statistically significant differences in total score of ToM scale task (F 3,658=40.500, p<.000).

**Post hoc** (Bonferroni methods) comparisons showed that chronic schizophrenic group’s performance differed significantly from both normal samples performances (old normal sample: mean differences=-1.92; p<0.000; young normal sample: mean differences=-2.56; p<0.000; effect size d=1.32; r=0.55) but not from recent onset group; comparisons showed also that recent onset group’s performance differed significantly from those of both normal samples (old normal sample: mean differences=-1.76, p<0.000; young normal sample: mean differences=-2.40, p<0.000 effect size d=1.02; r=0.45) but not from subjects suffering from chronic schizophrenia (Table 3).

### First-order false belief tasks

**False-belief test question**: groups differed significantly on the non-parametric Kruskall-Wallis test: 2(3) = 212.604, df=3 p < 0.000). **Post hoc** (Bonferroni methods) comparisons showed that chronic schizophrenic group’s performance differed significantly from both normal samples performances (old normal sample: mean differences=-.798, p<.000; young normal sample: mean differences=-.891, p<.000) but not from recent onset group; comparisons showed also that recent group’s performance differed significantly from those of both normal samples (old normal sample: mean differences=-1.76, p<0.000; young normal sample: mean differences=-.875, p<.000) but not from recent onset group; comparisons showed also that recent group’s performance differed significantly from those of both normal samples (old normal sample: mean differences=-1.76, p<0.000; young normal sample: mean differences=-.875, p<.000; effect size d=1.32; r=0.55) but not from subjects affected by chronic schizophrenia.

**Fact questions**: the percentage of correct scores revealed no significant overall differences between groups.

**Memory questions**: the percentage of correct scores showed no significant group differences (Table 3, Figure 2a).

### Second order theory of mind

**False-belief test question**: groups differed significantly: Kruskall-Wallis 2(3) = 138,317, df=3, p = 0.000). **Post hoc** (Bonferroni methods) comparisons showed that chronic schizophrenic group’s performance dif-

---

**Table 2. Advanced ToM and index of fit**

<table>
<thead>
<tr>
<th>MODEL</th>
<th>ITEM</th>
<th>Chi2</th>
<th>gl</th>
<th>GFI</th>
<th>AGFI</th>
<th>RMSEA</th>
<th>RMSEA 90%</th>
<th>CFI</th>
<th>NFI</th>
<th>NNFI</th>
<th>AIC (model)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Theory of mind</td>
<td>13</td>
<td>158.61</td>
<td>65</td>
<td>.95</td>
<td>.93</td>
<td>.056</td>
<td>.045 -.067</td>
<td>.90</td>
<td>.84</td>
<td>.88</td>
<td>210.61</td>
</tr>
</tbody>
</table>

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Table 3. Performances of all participants to the study in experimental tasks

<table>
<thead>
<tr>
<th></th>
<th>Schizophrenic subjects</th>
<th>Matched Healthy controls</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Chronic</td>
<td>Recent onset</td>
</tr>
<tr>
<td>Advanced ToM Scale</td>
<td>6.7 (4.1)</td>
<td>7.8 (4.4)</td>
</tr>
<tr>
<td>First order Theory of Mind</td>
<td>37.6/62.3</td>
<td>38.3/61.7</td>
</tr>
<tr>
<td>(% correct/ % uncorrect)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second order Theory of Mind</td>
<td>32/68</td>
<td>25.5/74.5</td>
</tr>
<tr>
<td>(% correct/ % uncorrect)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FERED significantly from both normal samples performances (old normal sample: mean differences= -.798, p<0.000; young normal sample: mean differences=-.892, p<0.000) but not from recent onset group; comparisons showed also that recent onset group’s performance differed significantly from those of both normal samples (old normal sample: mean differences= -.875, p<0.000; young normal sample: mean differences=-.891, p<0.000) but not from subjects suffering from chronic schizophrenia.

Fact questions: the percentage of correct scores revealed no significant overall difference between groups. Memory questions The percentage of correct scores showed no significant group differences (Table 3, Figure 2b).

Correlation with symptoms, neurocognitive and social function measures

A Pearson’s bivariate correlation analysis was conducted to compare the scores obtained on advanced ToM task scale total score and other measures used. The analysis showed an inverse correlation between advanced ToM tasks show a lower level of negative cluster in BPRS in patients with chronic schizophrenia and in recent onset subjects: the higher the score achieved in total score of Tom Advanced, the lower the negative symptomatology both in chronic and in recent onset schizophrenia patients. On the other hand, we obtained a correlation between scores at ToM tasks and social function measured with FPS scale: the lower the ability to understand other people’s beliefs, the lower the global social function. Finally we obtained a good correlation between advanced ToM score order false beliefs task in chronic (r=.236;p<0.000) in recent onset (r=.278;p<0.000) and in all normal controls (r=.202;p<0.000). The results are reported in Table 4.

DISCUSSION

This study examined ToM skills in a group of subjects affected by chronic schizophrenia and a group of patients who experienced the first episode of this disease.

We applied a structural equation model in order to examine the psychometric properties of the Advanced ToM scale. A careful study provides the guarantee to obtain reliable measures of what is observed.

Structural equation models (27) consent a better management of the complex phenomena we are observing. Structural equation models allow in fact to test a precise factorial hypothesis throughout the presence/ab-

![Figure 2A](image1.png)

Figure 2A. Results on First order ToM stories in all groups. The figure show the percentages of correct/uncorrect response in ToM tasks.

![Figure 2B](image2.png)

Figure 2B. Results on Second order ToM stories in all groups. The figure show the percentages of correct/uncorrect response in ToM tasks.
Table 4. Correlation in chronic schizophrenics subgroup between advanced ToM total score with first and second order false beliefs tasks, symptoms, neurocognition and social function

<table>
<thead>
<tr>
<th></th>
<th>Chronic schizophrenics</th>
<th>Recent onset schizophrenics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Negative cluster</td>
<td>-.334*</td>
<td>-.383**</td>
</tr>
<tr>
<td>Verbal reasoning</td>
<td>-.062</td>
<td>-.058</td>
</tr>
<tr>
<td>Verbal Fluency</td>
<td>-.095</td>
<td></td>
</tr>
<tr>
<td>IQ level</td>
<td>-.121</td>
<td>.047</td>
</tr>
<tr>
<td>False beliefs First order</td>
<td>.236*</td>
<td>.278*</td>
</tr>
<tr>
<td>False beliefs Second order</td>
<td>.213*</td>
<td>.234*</td>
</tr>
<tr>
<td>Social function (FPS total score)</td>
<td>-.337*</td>
<td>-.380**</td>
</tr>
</tbody>
</table>

*p<.05; ** p<.000

In our research we compare performances in a large group of very stable schizophrenic patients to the performances of a first episode schizophrenia group in a same task of ToM. In literature very few studies in fact that examine both groups in a same ToM task, including moreover a very large normal sample at the same time.

Interestingly, the first episode group’s mean performance in this study nearly matched the mean scores obtained in previous studies conducted on a more chronically affected group (33,43,46).

This similarity between the two populations seems to indicate that in case of schizophrenia, illness chronicity may not exacerbate social cognitive deficits, although only longitudinal studies of a number of first episode situations could provide a more definitive answer in this regard. This represents another interesting result in our correlation between negative symptomatology on both groups.

It is evident that ToM impairment is more severe in the acute phase of schizophrenia, and differences in symptom characteristics of the various studies may therefore contribute to the heterogeneity of the reported findings.
However, our results suggest that ToM impairments in schizophrenia persist even after the remission of acute psychosis. These results suggest that there is a trait related to ToM impairment in schizophrenia, because ToM abilities deficits are not influenced by symptoms since our sample was in remission.

This result contradicts theoretical positions of Frith (47) and Hardy-Bayle (48). Frith’s concept of ToM deficit in schizophrenia suggests a state related impairment. This model proposed that psychotic symptoms in schizophrenia may be explained by mentalising impairment. Consistent with this model, several studies by Frith and his colleagues showed intact ToM performances in remitted patients. While the model of Hardy-Bayle suggests an association of ToM impairment with another symptom dimension of schizophrenia (disorganized thought), it also considers ToM deficit as a characteristic state of schizophrenia. However, other findings demonstrating ToM impairment in remitted patients and in people at genetic risk of schizophrenia support the notion that ToM dysfunction may be a characteristic trait of schizophrenia.

Results of metaanalysis of Bora (8) and results of Sprong (43) are also consistent with this opinion.

The present study exceeds the limitation of other studies in which insufficient power due to small sample size was able to explain only some results.

Definition of remission is clearly important for a proper interpretation of the findings since residual positive and persistent negative symptoms are commonly observed in recent onset and in stable subjects affected by schizophrenia.

The finding related to the absence of the effect of IQ level on ToM impairment in schizophrenia is an important result. In our study we did not observe any correlation and these results suggested that cognitive deficits and IQ could not explain the ToM impairment in both groups suffering from schizophrenia. We also obtained a correlation between ToM and social function in both groups: few studies have directly investigated the relationship between ToM deficits and social functioning (49) in schizophrenia (46, 50).

At the same time, the impact of mental state decoding tasks on social dysfunction has also not yet been investigated. In this study, our results showed the relationship between ToM deficits and social functioning in subjects affected by chronic and first episode schizophrenia.

It is then possible to conclude that mental state decoding skills appear to be the most important cognitive mediator of social functioning in both groups.

REFERENCES


