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Role Development Applied to Art Therapy Treatment of an Artist Diagnosed with Schizophrenia

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Abstract

Role Development is a theory-based, individualized intervention developed for health care practitioners, including art therapists, to assist individuals diagnosed with schizophrenia to learn roles and their underlying task and interpersonal skills. The role of artist is particularly suited to this intervention. This paper describes the role development model and methods for implementation, two evidenced-based research studies examining the effectiveness of Role Development, and the application of role development to art therapy. A case study specifically describing the process of role development in art therapy treatment is provided.

Introduction

The purpose of this paper is to describe the application of role development to the practice of art therapy and results as discussed in the context of a case study. To provide the reader with a foundation, the role development model will be described and studies assessing its efficacy will be summarized.

Roles are the foundation of all social behavior. Commonly referred to as social roles, they underlie life-long relationships with families, friends, work, and community. Some social roles are worker, community member, student, and hobbyist. The role of artist can be incorporated into a variety of roles including those mentioned. Enacting roles that are important and meaningful to the individual produces contentment, joy, and satisfaction (Kielhofner, 2002; Mosey, 1986; Parsons, 1951; Wolfensberger, 2000).

Roles can be learned in a functional or dysfunctional manner. An individual can be highly adept at performing many aspects of a role or can be lacking in skills or motivation to perform one successfully and consistently. To enact a role effectively, individuals need a repertoire of task and interpersonal skills, because these are the foundation of roles (Liberman, Wallace, Blackwell, Eckman, Vaccaro, & Kuehnel, 1993; Mosey, 1986). The development of roles can be disrupted in individuals diagnosed with mental illness. The more disabling the mental illness, the more it affects the learning of and ability to sustain social roles (Anthony, 1993; Wolfensberger, 2000). One of the most severe types of mental illness is schizophrenia (American Psychiatric Association, 2000). Individuals diagnosed with schizophrenia often have deficits in learning and/or maintaining the task and interpersonal skills necessary to enact positive, socially acceptable roles (Anzai, Yoneda, & Kumagai, 2002; Liberman et al., 1993; Mann, Tandon, Butler, Boyd, Eisner, & Lewis, 1993; Torres, Mendez, & Merino, 2002).

For individuals diagnosed with schizophrenia, commonly available treatment such as medication and activity programs alleviate symptoms and promote involvement in activity and social interactions. However, these types of treatment may not address the development of social roles or the specific skills that are needed in these roles. Additional treatment methods with demonstrated effectiveness are required (Lehman & Steinwachs, 1998; Roy-Byrne, Sherbourne, & Craske, 2003). One such method provides a theoretical framework and clinical guidelines necessary to facilitate positive growth and change in their clients (Mosey, 1996).

Role development (Schindler, 2004b) guidelines for clinical practice have been developed to provide direction for health care practitioners to assist individuals diagnosed with schizophrenia to learn social roles, their underlying task, and interpersonal skills. The role development (Schindler, 2004b) model is a theory-based, individualized intervention in which staff and client work collaboratively to identify and develop the client's social roles and the skills associated with these roles. When role development is implemented by rehabilitation staff and art therapists, it provides a common link and theoretical foundation on which to base intervention (Kielhofner, 2002; Mosey, 1986; Schindler, 2004b).

Role Development

The primary frame of reference for the role development model is role acquisition (Mosey, (1986); secondary sources include role theory (Durkheim, 1938; Mead, 1964; Merton, 1957; Parsons, 1951; Sarbin, 1954), social learning theory (Bandura, 1977), and skill development (Anthony, 1993; Fidler, 1969; Kielhofner, 2002; Liberman, et al., 1993).

To implement role development, the therapist follows guidelines briefly summarized as follows: First, the therapist conducts an initial interview with the client to deter-

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mine the roles and skills the client would like to address. The therapist and the client discuss the types of activities and interactions in which the client could participate in order to develop the task and interpersonal skills that comprise the desired role. Then, the therapist observes the client in group sessions and assesses for skills and roles based on both the observation and interview. Next, the therapist develops a treatment plan in collaboration with the client. At least weekly, and more often if necessary, the therapist and the client meet to discuss the client's progress with the treatment intervention and develop a plan for the following week. The therapist documents a weekly progress report based on this meeting. Modifications to the treatment plan are made accordingly. A training manual is available which fully describes role development and its application (Schindler, 2004b).

Previous Research

Two research studies have been conducted on the role development model to date. A larger-scale study was conducted at a maximum-security psychiatric facility (Schindler, 2004a; 2004b). A study incorporating multiple single subject case studies was conducted at a community mental health center. Both studies will be briefly summarized.

Study A: Research Conducted at a Maximum-Security Psychiatric Facility

The purpose of this study (Schindler, 2004a; 2004b) was to examine if adults diagnosed with schizophrenia who resided in a forensic setting demonstrated improved task and interpersonal skills and social roles when involved in an individualized intervention based on role development compared to an intervention based on a multidepartmental activity program. Developing the role of artist was one of the social roles available to the clients.

Method

Participants

Client participants were adult males, 18-55 years of age, who were diagnosed with schizophrenia and receiving antipsychotic medication. A total of 84 clients were admitted to the study with 42 participants each in the experimental and comparison groups. No participants withdrew from the study. Eighteen rehabilitation department staff participated in the role development training and implementation, including two art therapists. Training occurred over 10 weeks for a total of 15.5 hours.

Procedures

The study used a repeated measures pretest-posttest design with an experimental group (role development program) and a comparison group (multidepartmental activity program). Quantitative and qualitative measures were used to collect data. Participants in both groups were assessed with four instruments upon admission to the study and at 4, 8, and 12 weeks of participation in the study: The Role Functioning Scale (Goodman, Sewell, Cooley, & Leavitt, 1993); the Task Skills Scale and the Interpersonal Skills Scale (Mosey, 1986; Rogers, Sciarappa, & Anthony, 1991) and the Role Checklist (Oakley, 1981). Independent raters, blind to the purpose of the study, conducted the initial and repeated measures of functioning. Qualitative measures included client interviews and staff focus groups.

The comparison group participated in the existing multidepartmental activity program (MAP) routinely offered by the facility. The multidepartmental activity program is a non-individualized therapeutic intervention designed to encourage the productive use of time and socialization in a group setting (Clark et al., 1997). The experimental intervention, role development, was a new treatment and an enhancement of the existing multidepartmental activity program. Once the experimental group began, staff was monitored bi-weekly for fidelity to the intervention via completion of fidelity checklists by the staff and the principal investigator.

Results

Data analysis included quantitative and qualitative results. There were no demographic differences between participants in the experimental and comparison groups. Within-group tests, between group tests, analysis of covariance (ANCOVA), multivariate analysis of covariance (MANCOVA), and repeated measures ANOVA were conducted. Data analysis indicated that participants in the role development program showed statistically significant improvement ($p < .05$) in the development of task skills, interpersonal skills, and role functioning, especially at four weeks of treatment, in comparison to participants in the multidepartmental activity program. Qualitative data from staff focus groups and patient interviews supported the findings. A complete description of this study can be found in Schindler (2004b).

Study B: Research Conducted at a Community Mental Health Center

Purpose of the Study

The purpose of this study was to examine if adults diagnosed with severe and persistent mental illness who attended a community mental health center demonstrated improved task and interpersonal skills and social roles when involved in role development. The study, currently under review for publication, used a single-subject case-study design with pretest and posttest follow-up at eight weeks (Campbell & Stanley, 1963; Portney, & Watkins, 2000). Qualitative interview questions at pretest and posttest were used to supplement quantitative findings. This design was selected to continue the assessment of role development in a different setting (i.e., outpatient setting) and with a more focused view on the process involved in role and skill development. Master's level students conducted the treatment

intervention and participated in weekly supervision to maintain fidelity to the treatment intervention.

Participants

Client participants were six men and four women who were diagnosed with a severe and persistent mental illness. The same assessments used in the previous study were used as pretest and posttest measures in this study. Results of the Wilcoxon Signed Ranks Test demonstrated a statistically significant improvement in role functioning (p = .02) and interpersonal skills (p = .029) and task skills (p = .05).

Application of Role Development to Art Therapy

Art therapists can successfully utilize role development for clinical art therapy practice. Role development in art therapy becomes the vehicle for therapeutic change as the client develops task skills required for art making and interpersonal skills needed to establish a therapeutic relationship with the art therapist.

Role development requires that the art therapist and the client collaborate in their efforts for the beneficial outcome of the client. Empowerment of the client is enhanced by such effort. A positive self-identity can be developed as the client begins to have small success in regaining roles and skills.

The following case study was conducted at a maximum-security psychiatric facility and illustrates how role development was effectively used in combination with art therapy techniques with a mentally ill offender. In general, this population is isolated from their lives in the community and faced with the challenge of learning how to survive in their new community of confinement. Within a confined environment, art therapy has been found to foster personal growth and development (Day & Onorato, 1997; Hall, 1997; Ursprung, 1997). Mentally ill offenders need appropriate therapeutic interventions to help them regain a productive life even while in prison (Sigurdson, 2000). The combination of art therapy and role development provided the motivation for the following individual to re-engage in the social, interpersonal and task skills needed to develop various roles (including that of artist), reconnecting him with his outside community of family and friends, and helping him to survive in his current confined community.

Case Study

Client History

The client, who will be referred to as B to preserve anonymity, was a 35-year-old man diagnosed with Schizophrenia, Paranoid type, compounded with a history of alcohol abuse. B was previously found Not Guilty by Reason of Insanity for murder charges and was being treated at a state hospital. While at this facility, B, unprovoked, assaulted a physician causing significant bodily harm. He was charged with Aggravated Assault and admitted to a forensic facility. Initial evaluation of B's mental status found him to be psychotic with paranoid delusions despite receiving an adequate dose of antipsychotic medication. This was B's fifth admission to the forensic facility.

Limited personal and family history was obtained from B upon admission due to his extreme hostility and paranoia. It is known that B was not married. He had a high school diploma and served three years in the United States Army, honorably discharged. He was employed as a cook for one year, installation installer for two years and occasionally as a land surveyor in his father's business. His parents were divorced and both were supportive of B, visiting him every other weekend while he was hospitalized. In the past, B had some minor involvement with the law while under the influence of alcohol.

Initial Assessment

Upon initial assessment, B was observed as sleeping or reading books during art therapy sessions. He stated that he was not interested in doing artwork but did not want to leave the art therapy group. B was introduced to the concept of roles and role skills. He agreed to participate in the role development program and together we completed an interview and role checklist that identified activities and interactions for B to engage in while in art therapy. B stated that he liked art and had been in an art therapy group in another hospital.

Course of Treatment/Application of Role Development

At the time of the case study, B attended the rehabilitation program five days a week. During participation in the case study, B received art therapy services for approximately five hours a week for 12 weeks.

The first week, B worked directly with the art therapist on developing a specific plan on how to work on tasks and interpersonal skills within the role of artist. B needed much prompting to engage in tasks and always stated that he was too tired to participate. He agreed to work on task skills by completing one drawing per group session before he read his book or slept. This task skill was chosen to help B regain interest in the creative art process and to have success performing tasks at his level of concentration. B had minimal to no interactions with others during group sessions and he would respond briefly when social conversations were initiated by others. The art therapist modeled interpersonal skills for B in the first week by initiating daily conversations with him and reinforcing any verbal or nonverbal responses. The art therapist planned to gradually increase the complexity of this skill by encouraging B to initiate social conversations with at least one peer per group session over the next several weeks.

The art therapist met with B to discuss his progress after one week. B displayed progress in task skills by demonstrating a willingness to engage in art tasks. He completed three drawings the first week. He displayed no progress in his interpersonal skills as he made minimal responses to conversations initiated by the art therapist and

did not initiate conversations with his peers. B was uncomfortable communicating his thoughts to others and isolated himself by avoiding interactions with peers.

During weeks two and three, B agreed to continue working on task skills by completing one drawing per session. He identified an interest in drawing animals and began creating one drawing per group session. The art therapist continued to initiate daily conversation and reinforced all responses made by B. In an effort to help B with his level of comfort in communicating his thoughts with others in the group, the art therapist began to show his completed drawings to the other group members and asked the group to provide B with feedback regarding his completed projects. Peers provided B with positive feedback regarding his artwork. Their positive attitude toward his nonverbal creations helped B to gain confidence in verbally expressing his thoughts and interests to others in the group. B displayed progress in his interpersonal skills over these two weeks and was able to identify that talking with the art therapist helped him to be successful in working on his interpersonal skills.

In his fourth and fifth weeks, B continued to make progress in task and interpersonal skills as he created one drawing per day and began to initiate spontaneous conversations with the art therapist. With this success, B was willing to work further on the role of artist. B agreed to have two pieces of his artwork framed and displayed at the Creative Arts Therapies Hill Day Conference in Washington, DC sponsored by the American Art Therapy Association (AATA). He was given the option of having his artwork returned to him or donated to the AATA or to a member of Congress. B opted to have his artwork donated to a member of Congress. He also was offered the recognition of becoming "Artist of the Month" in which his artwork would be displayed in the lobby of the hospital for one month. He worked with the art therapist in framing his artwork for display in the hospital lobby. B's parents visited him on weekends and praised him for his successful role as "Artist of the Month." He then realized that his productive use of time in the art room opened a door to another life role, that of family member. The positive recognition of his artistic skills by his parents seemed to have given B the confidence to continue to work on the role of family member even though he was hospitalized and separated from his family.

During the sixth week, B and the art therapist discussed his new skills and role accomplishments. Together, B and the art therapist planned to continue working on his roles of artist and family member. To expand his role as artist, B took on the role of art student. The art therapist instructed B on how to use various art supplies, as all previous drawings had been completed with felt-tipped markers and white drawing paper. B expressed an interest in learning how to do block printing and participated in the role of art student learning block printing techniques. It was B's idea to use these techniques to create greeting cards for his family and friends, further expanding his newly regained role of family member (and friend).

Through weeks seven, eight and nine, B displayed positive progress in his task and interpersonal skills. He initiated art tasks and displayed an eagerness to learn new art techniques and engage in group sessions. He was more verbal in the art therapy groups as he was initiating and sustaining conversations with the art therapist and his peers. His level of concentration also improved as B was now able to focus his attention on art tasks for the duration of the group session. It was during this time that B learned that two congressmen from his home state accepted his artwork donated at the Creative Arts Therapies Hill Day Conference. One of the congressmen posted a picture on his website accepting B's artwork (Figure 1). B informed his parents of this accomplishment and his mother was thrilled to be able to access this website, seeing her son's artwork on the Internet. The peers in B's art therapy group also recognized him for this accomplishment. The photographs of congressmen accepting B's artwork were framed and hung in the art therapy room.

Figure 1 Left to right (then) United States Senator accepting B's artwork in 2001 from Donna Betts (then) AATA Capitol Hill Exhibition Curator and Jenna Michalik (then) AATA GAC Federal Liaison.

In the final three weeks of B's participation in the role development program, he continued to engage in positive and productive activity in art therapy. He identified new art activities and performed these tasks independently. B asked his mother for a list of addresses of his family and friends and sent his block printed cards to these people. He volunteered to create various holiday decorations and gave these decorations to other staff members at the hospital. B was now exhibiting comfort in his roles as group member, family member and friend. He continued to expand his role as art student by experimenting with paint, a medium he had never used. He offered to complete a mural that was started by another patient. This mural is now hanging in the staff's lunchroom (Figure 2).

The role development model proved to be effective in helping B address treatment issues. His participation in this program allowed him to be actively involved in his treatment planning. Through the course of this program, his interest in the art therapy process was stimulated. His participation in role development and in art therapy improved

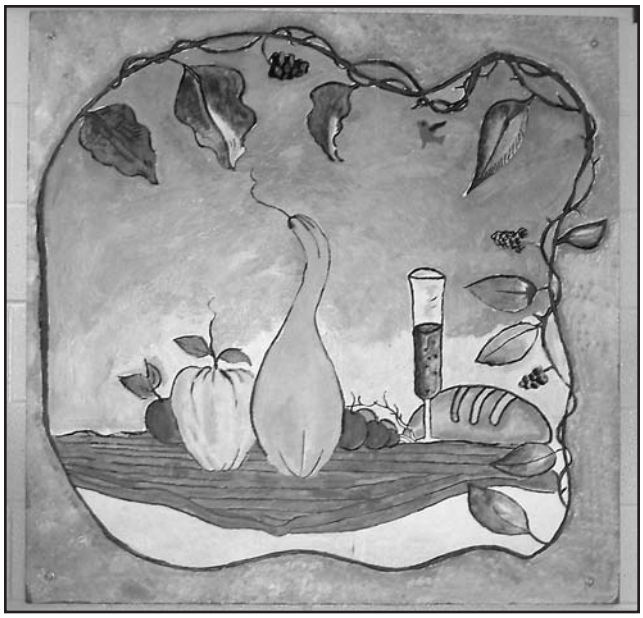

Figure 2 Mural completed by B

his relationships with family, friends, peers, staff members and the community. He developed social, interpersonal, and task skills that he might apply to future life situations.

Limitations

Case study design has inherent limitations. It is possible that B's progress was due to the individual attention he was receiving from the therapist. However, the quantitative research studies described earlier support the premise of the model which is that individuals will gain meaningful task and skills development that underlie the role. The treatment process with B illustrated the process used in both previous studies.

Implications

There are important implications for role development. Individuals diagnosed with schizophrenia, especially those committed to a forensic facility, often are not offered comprehensive rehabilitation treatment. This paper suggests that individuals living with multiple disabling factors, such as a long psychiatric history, legal charges, and low levels of education, can develop skills and roles, particularly the role of artist. The necessity of simultaneous pharmatherapy and psychosocial treatments has been identified (Lehman & Steinwachs, 1998). The improvement of individuals participating in role development demonstrates that despite complicating life factors and residual effects of a severe mental illness, individuals are willing and able to develop skills and meaningful roles, including the role of artist.

Conclusions

The role development model is not a complex, complicated nor difficult intervention. It is based on some very simple, common principles of collaboration and the creation of meaningful roles for the client. Used in collaboration with other multidisciplinary treatments, it is effective in promoting positive change and improved quality of life for individuals diagnosed with schizophrenia.

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