



OCCUPATIONAL THERAPY IN FORENSIC PSYCHIATRY

Role Development and Schizophrenia

VICTORIA P. SCHINDLER, PhD, OTR

Victoria P. Schindler, PhD, OTR

Occupational Therapy in Forensic Psychiatry: Role Development and Schizophrenia

Occupational Therapy in Forensic Psychiatry: Role Development and Schizophrenia has been co-published simultaneously as *Occupational Therapy in Mental Health*, Volume 20, Numbers 3/4 2004.

*Pre-publication
REVIEWS,
COMMENTARIES,
EVALUATIONS . . .*

“**D**R. SCHINDLER HAS ANSWERED OUR PROFESSION’S CALL for more evidence-based practice by using both basic and applied scientific inquiry to investigate how individuals diagnosed with schizophrenia can develop meaningful life roles while in a maximum-security psychiatric facility. Her findings clearly demonstrate the value of focusing intervention on helping clients pursue meaningful occupations through role development, rather than simply focusing on individual components of treatment.”

Laurie Knis-Matthews, OT, MA
Assistant Professor, Kean University

*More pre-publication
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“EXCELLENT. . . . A BRILLIANT, COMPASSIONATE, HUMANISTIC APPROACH. . . . Provides an excellent framework for assisting individuals diagnosed with schizophrenia to acquire personally relevant, valued social roles beyond that of patient. In true holistic form Dr. Schindler's Role Development guideline provides clear guidance for staff training and supervision that can help transform mental health service delivery from an illness- to wellness-based model of care. The training and supervision guidelines can benefit both paraprofessional and professional level staff and can be used in both restrictive and community-based settings.”

**Margaret Swarbrick, OT,
CPRP, MA**

*Associate Director,
Collaborative Support Programs
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Department of Psychiatric
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School of Health Related Professions
University of Medicine and Dentistry
of New Jersey*

“CLEARLY DEFINES TREATMENT INTERVENTIONS AND MAKES IT EASY TO DEVELOP EFFECTIVE CLINICAL APPROACHES The case studies paint a precise picture of how role development is implemented. As an art therapist, I utilized role development and found it very helpful in my daily clinical practice. My clients have benefited by developing task skills they needed for the ‘art’ part of therapy and interpersonal skills needed to establish a therapeutic alliance. Don’t let the title of this book deceive you. Healthcare providers of various backgrounds will benefit from reading this book.”

Carol Pletnick, LPC, ATR-BC, MA

*Art Therapist
Ann Klein Forensic Center
West Trenton, New Jersey*



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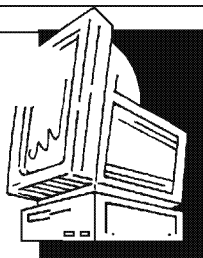
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Occupational Therapy in Forensic Psychiatry: Role Development and Schizophrenia

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Preface

This volume, *Occupational Therapy in Forensic Psychiatry: Role Development and Schizophrenia*, includes a description of a set of guidelines for clinical practice, Role Development, a research study that assessed the effectiveness of this set of guidelines, and practical information and resources for therapists to implement this set of guidelines with their clients.

Role Development is based on the concept of social roles. Social roles are the foundation of all social behaviors. Individuals learn social roles, such as worker, family member, and friend, throughout their lives, and roles can be learned in a functional or dysfunctional manner (Parsons, 1951). Effective role functioning requires a repertoire of task and interpersonal skills.

The learning of effective roles and skills can be disrupted in individuals diagnosed with a schizophrenic disorder. Commonly available treatment, such as medication and activity programs, may alleviate symptoms and promote improvement for these individuals, but may not address the development of social roles or skills. Additional treatment methods are required to develop roles and skills (Lehman & Steinwachs, 1998). One such method is treatment based on a set of guidelines for clinical practice (Mosey, 1996).

Role Development (Schindler, 2002), a set of guidelines for clinical practice, provides direction for health care practitioners to assist individuals diagnosed with schizophrenic disorders to learn social roles and the task and interpersonal skills associated with these roles.

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The research problem in this study was to ascertain if individuals diagnosed with schizophrenic disorders demonstrated greater improvement in task and interpersonal skills and social roles when involved in the Role Development program in comparison to a multi-departmental activity program. A pretest-posttest design with repeated measures follow-up at four, eight, and 12 weeks was used. Three rating scales and one self-perception checklist were used as data collection instruments. Participants were 84 adult males, diagnosed with a schizophrenic disorder, and confined to a maximum-security psychiatric facility. Eighteen rehabilitation staff members were trained in Role Development, and they provided this intervention to participants in the experimental group.

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, ANCOVA, MANCOVA, and repeated measures ANOVA were conducted. Data analysis indicated that participants in the Role Development program showed statistically significant improvement in the development of task skills, interpersonal skills, and role functioning, especially at four weeks of treatment, in comparison to participants in the multi-departmental activity program. Qualitative data from staff focus groups and patient interviews supported the findings.

Case studies are provided to demonstrate application of Role Development to individuals diagnosed with schizophrenia. Finally, a description of Role Development and forms to facilitate the practical use of this set of guidelines have been included.

Chapter 1

Introduction: Social Roles and Schizophrenia in Forensic Psychiatry

INTRODUCTION

Paul is a single, 20-year-old male, of Italian and African American descent. He was incarcerated following an altercation with his father and at the jail appeared to be responding to internal stimuli. Paul had resided with his parents and younger brother and sister ages 19 and 15 respectively. Both parents worked at a factory.

Paul completed the 11th grade at a Technical Institute and was a few months into 12th grade when he started to become withdrawn, isolative and paranoid. He refused to attend school and became more reclusive at home. In a short time he quit school and did not earn a high school diploma or a GED. He had one job as a busboy at a chain restaurant, but he quickly became suspicious of others and was absent from work. After only a few weeks he was fired for absenteeism. He began to argue with his parents more as their frustration with him grew.

Paul's family denied any history of alcohol or substance abuse or mental illness or legal problems. Paul denied any history of physical or sexual abuse. Paul also denied any history of substance abuse. He stated

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that he had tried alcohol but denied using it on a regular basis. He denied blackouts and denied using marijuana, cocaine, heroin, or other drugs. Records suggest that he might have used marijuana in the past but he denied such use. He had never been referred to, or treated in, a drug rehabilitation facility.

Paul had difficulty believing that he may have symptoms of schizophrenia. He repeatedly stated his belief that he does not need to take medications. He reported that the medication has no impact on him, stating, "I feel the same with medication as without medication." In addition to the growing problems Paul was experiencing at home, Paul also stated he didn't have any friends or anyone with whom he could confide or talk.

Paul reported that his current legal problems resulted from an "argument" with his father. He stated that he was lying on the couch with his eyes closed, and his father was talking to him about getting a job and not lying around the house. Reportedly, his father threw a book at him, and "I started yelling at him." His mother and brother apparently tried to break up the fight. The police were called, arrested Paul, and charged him with harassment. Records indicate that such altercations have occurred in the past.

Paul's family and the police subsequently dropped all charges. However, Paul's family did not want him to return home. They stated he could only return home when he was settled in a job.

Young men who are Paul's age typically have several coexisting roles such as student, worker, friend, son, brother, and boyfriend, significant other or spouse. However, Paul had none of these roles. He had quit high school and did not have a GED, was unsuccessful at the only short-term job he had held, had no friends nor a significant other, and was becoming increasingly distanced and uncomfortable as a family member. In fact, an argument with his father resulted in Paul's arrest and commitment to a forensic hospital. For a young man who would typically have several roles indicating a developing, fulfilling life, Paul's current roles were limited to patient and inmate. The symptoms of schizophrenia not only invaded Paul with frightening, paranoid, and unreal thoughts, but also robbed him of his ability to function normally in roles typical of young men his age.

Roles are patterns of behavior and the foundation of all social behavior (Parsons, 1951a), and they are commonly referred to as social roles (Barbour & Moreno, 1980; Blume, Green, Joanning, & Quinn, 1994; Karmel, 1970; Ruddock, 1976; Wapner & Craig-Bray, 1992). Social roles have also been defined as a combination of behaviors, functions, privi-

leges, and responsibilities that are socially defined and expected of an individual in a particular position in society (Wolfensberger, 2000). Social roles are not roles one plays in the theater or personality roles, such as that of a leader or a follower, but life roles that are the foundation of our relationships with our families, friends, work, and community. Some social roles are spouse, community member, student, and friend (Kielhofner, 1985, 1995; Mosey, 1986). Such roles are potent because we attach considerable importance to them (Anthony & Liberman, 1986; Durkheim, 1938; Pearlin, 1983). These roles are also basic to all interactions and relate to all areas of human experience including family life, activities of daily living, school/work, and play/leisure/recreation (Kielhofner, 1995; Mosey, 1986). Enacting roles that are important and meaningful to us produces contentment, joy, and satisfaction (Csikszentmihalyi & Csikszentmihalyi, 1988; Mead, 1964; Sarbin & Scheibe, 1983).

Individuals learn social roles throughout their lives in a developmental manner and normally act out a number of different roles at the same time. These roles can vary in priority at different times in the life cycle (Ruddock, 1976; Sarbin & Scheibe, 1983). For example, a 35-year-old man may have active roles of a husband, father, son, brother, worker, and basketball coach for his daughter's team. The role of basketball coach may be dropped if his daughter loses interest in the game. Although the thought of juggling simultaneous roles may spark overwhelming feelings of frustration, individuals with a variety of roles in their repertoire are often better able to function in society because they can deal with a wide range of situations (Stephan & Stephan, 1990; Thoits, 1983).

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 a role successfully and consistently. For example, the role of parent can be developed in a way that is supportive and nurturing to a child or in a way that is harmful or neglectful. Roles are generally beneficial to society. However, an individual can also learn a role that is considered deviant, such as that of a criminal (Karmel, 1970; Parsons, 1951a; Wolfensberger, 2000).

To enact a role effectively, individuals need a repertoire of task and interpersonal skills, and these skills are the foundation of roles (Black, 1976; Liberman et al., 1993; Mosey, 1986; Versluis, 1980). Task skills that are basic to roles include paying attention, following directions, and solving problems related to a task. Interpersonal skills include initiating and sustaining a conversation and expressing one's thoughts and feelings. For example, a restaurant cook needs to be able to follow direc-

tions for various recipes, interact with peers, and relate to supervisors appropriately. When task and interpersonal skills are learned in a functional manner, learning is hierarchical, and the learning of basic skills precedes the learning of complex skills. For example, one must be willing to engage in a task prior to being able to follow the directions associated with that task. However, just like social roles, task and interpersonal skills can be learned in a dysfunctional manner, or not at all (Mosey, 1986).

The development of roles can be disrupted in individuals diagnosed with a mental illness. The more disabling the mental illness, the more it affects the learning of and ability to sustain social roles (Anthony, 1993; Parsons, 1951b; Pearlin, 1983; Shannon, 1972; Wessen, 1965; Wolfensberger, 2000). One of the most severe types of mental illness is the schizophrenic disorders. Schizophrenic disorders are classified as a group of psychotic disorders that cause a major disturbance of personality. This disturbance takes the form of positive symptoms (i.e., primary symptoms), such as delusions and hallucinations, and negative symptoms (i.e., secondary symptoms), such as apathy, withdrawal, and avolition (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders-IV [DSM-IV]*, 1994; Straube & Oades, 1992; World Health Organization [WHO], 1978).

Schizophrenia involves dysfunction in one or more major areas such as interpersonal relations, work or education, or self-care (*DSM-IV*, 1994, p. 277). The overwhelming effects of the sequelae of schizophrenia can clearly affect an individual's ability to learn or carry out social roles. Individuals diagnosed with schizophrenic disorders are often limited by their symptoms in their ability to function as a parent, lover, shopper, or friend, or engage in other roles that would be meaningful to someone of their age or gender. Social roles are either never developed or are withdrawn or severed. Wolfensberger (2000) describes individuals with severe mental illness as persons who often do not have a single positive role involving an enduring unpaid relationship.

To complicate matters further, some of the few remaining roles enacted by individuals diagnosed with schizophrenic disorders are viewed as dysfunctional by society. One of these roles is that of patient. This role can be viewed as dysfunctional because it involves a pattern of passive, dependent behavior as opposed to active, independent behavior (Parsons, 1951b; Pearlin, 1983; Wessen, 1965; Wolfensberger, 2000). In addition, individuals diagnosed with schizophrenic disorders often have deficits in learning and/or maintaining the task and interpersonal skills necessary to enact positive, socially acceptable roles. These basic skill deficits are manifested in areas such as personal hygiene, money management, eating habits, cook-

ing skills, use of public transportation, and use of leisure time (Broekema, Danz, & Schloemer, 1975; Liberman et al., 1993; Mann et al., 1993).

For individuals diagnosed with schizophrenic disorders, commonly available treatment such as medication and activity programs may alleviate symptoms and promote involvement in activity and social interactions. However, activity programs may not address the development of social roles or the specific skills that are nested in these roles. Additional treatment methods are required to develop these skills and roles (Lehman & Steinwachs, 1998). One such method is treatment based on a set of guidelines for clinical practice. Sets of guidelines for practice describe the assessment and intervention methods necessary to promote change within a specific theoretical foundation. Staff trained in the use of a set of guidelines for practice are then able to use their skills and knowledge to facilitate positive growth and change in their clients (Mosey, 1996).

Role Development (see Chapter 3) (Schindler, 2002), a set of guidelines for clinical practice, has been developed to provide direction for health care practitioners in assisting individuals diagnosed with schizophrenic disorders to learn social roles and their underlying task and interpersonal skills. As with all sets of guidelines for practice, Role Development links theory to practice and consists of four parts: theoretical base, function-dysfunction continuums, behaviors indicative of function and dysfunction, and methods to promote positive change. The theoretical base of Role Development focuses on an individual's need to learn and feel competent and successful in social roles. It describes how learning takes place, the learning of typical and atypical roles, and the therapeutic tools that assist in the process of learning roles. The continuums and the behaviors indicative of function and dysfunction address skills (task and interpersonal) and roles (worker, student, group member, friend). The postulates to promote positive change are the specific ways to design the intervention to engage the client in the development of roles (Kielhofner, 1985, 1995; Mosey, 1986, 1996).

The primary source for Role Development is Role Acquisition, a frame of reference developed by Mosey (1986). Role Acquisition was developed in 1986 and used with individuals diagnosed with psychiatric illnesses—particularly with individuals residing in the community or anticipating a return to the community in the near future (Mosey, 1986, p. 450).

In contrast, this study was implemented in a maximum-security psychiatric facility. Individuals hospitalized in this type of facility often have fewer and less independent roles than others of their age and gender (Parsons, 1951b; Pearlin, 1983; Sarbin & Scheibe, 1983; Wessen, 1965). Some of these individuals have been hospitalized or incarcerated

for much of their adult lives, whereas others have lived in community environments plagued with abuse, neglect, alcohol, and illicit drugs. As a result, many of these individuals have not developed constructive social roles; others have developed social roles but no longer perform them. The development of roles needs to begin at a level lower than that described in Role Acquisition. Therefore, to better meet the needs of the patients in this study, the Role Acquisition frame of reference was modified, resulting in Role Development.

Role Acquisition was modified in several ways. The theoretical base of Role Acquisition consisted primarily of Mosey's original work. This was expanded upon in Role Development to include some of the seminal literature on role theory (Durkheim, 1938; Mead, 1964; Merton, 1957; Parsons, 1951a; Sarbin, 1954), social learning theory (Bandura, 1977), and skill development (Anthony, 1993; Fidler, 1969; Liberman et al., 1993). Additionally, the function-dysfunction continuums in Role Acquisition addressed task and interpersonal skills on an equal level with roles and included the areas of activities of daily living, play/leisure/recreation, and family interaction. In Role Development, task and interpersonal skills are nested within roles. In the maximum-security psychiatric facility in which this study was implemented, patients are not allowed access to some of the types of settings associated with activities of daily living, play/leisure/recreation, and family interaction (e.g., one's own home, community recreational facilities). Therefore, Role Development does not address activities of daily living or family interaction, and has incorporated some of the aspects of play/leisure/recreation into the role of friend. Also, Role Development has included the role of group member.

For the individuals involved in this study, the road to developing constructive social roles, and the tasks and interpersonal skills nested within these roles, may be a long one. First, in institutions such as the one in this study, the number and type of roles one can develop is restricted (Sarbin & Scheibe, 1983). This study addressed roles that are attainable in this setting such as student, worker, friend, and group member. Also, because the roles of individuals in this setting may have been severely limited in the past, learning of roles, and the skills associated with these roles, may be slower and take longer to develop. Lastly, for a variety of legal reasons, individuals hospitalized in a maximum-security setting have varying lengths of stay. Some individuals may stay in the setting for only a few weeks, whereas others may stay for several years. Usually, less can be practiced and learned in weeks than in years. Although this must be considered, it is important that the learning process is initiated. Therapeutic interventions should not be ignored or excused due to short-term hos-

pitalizations or more complex needs of the individuals requiring services (Stuve & Menditto, 1999). With these factors in mind, the following problem statement and hypotheses were developed.

PROBLEM STATEMENT

The rationale for this study is that health care practitioners need to provide meaningful, relevant interventions, and empirical information regarding the effectiveness of these interventions, to clients receiving health care services and the payers of these services. The purpose of this study was to examine the effectiveness of an intervention, Role Development, on the development of task and interpersonal skills and social roles in adults diagnosed with schizophrenic disorders. Because there is no empirical information on this set of guidelines for practice, this study was the first step in examining the effectiveness of Role Development as a frame of reference or guideline for practice.

HYPOTHESES

Adults diagnosed with schizophrenic disorders demonstrate greater improvement in task skills (as evidenced by a statistically significant improvement in scores on the Task Skills Scale) when involved in an individualized intervention based on Role Development in comparison to participation in a multidepartmental activity program.

Adults diagnosed with schizophrenic disorders demonstrate greater improvement in interpersonal skills (as evidenced by a statistically significant improvement in scores on the Interpersonal Skills Scale) when involved in an individualized intervention based on Role Development in comparison to participation in a multidepartmental activity program.

Adults diagnosed with schizophrenic disorders develop more social roles (as evidenced by a statistically significant improvement in scores on the Role Functioning Scale and a greater number of roles on the Role Checklist) when involved in an individualized intervention based on Role Development in comparison to participation in a multidepartmental activity program.

The longer an individual participates in treatment based on Role Development, the greater will be the difference between his scores on the three scales (Task Skills Scale, Interpersonal Skills Scale and Role Functioning Scale) and those of persons participating in a multidepartmental activity program.

DEFINITIONS

Role Development Program is an intervention based on a theoretical set of guidelines for practice that addresses the development of meaningful social roles and the skills that are the foundation of these roles. It is an individualized intervention in which staff and client work collaboratively to identify and develop the client's social roles, such as worker, student, friend, and group member, and the task and interpersonal skills associated with these roles. When the Role Development Program is implemented by a variety of rehabilitation staff members, it provides a common link and theoretical foundation on which to base intervention (Kielhofner, 1985; Mosey, 1986; Schindler, 2002). Role Development Program is defined operationally as the set of guidelines for practice used to address the development of social roles and the task and interpersonal skills associated with these roles (see Chapter 3).

Social Roles are life roles that are the foundation of our relationships with our families, work, and community, such as worker, group member, student, and friend (Mosey, 1986; Wolfensberger, 2000). Social roles are defined operationally as the score an individual receives on the adapted Role Functioning Scale (Goodman, Sewell, Cooley, & Leavitt, 1993) and the roles an individual chooses to address on the adapted Role Checklist (Oakley, 1981).

Task Skills are physical and cognitive abilities used to manipulate the nonhuman environment (Mosey, 1986, p. 451). Task skills are defined operationally as the score an individual receives on the Task Skills Scale (Mosey, 1986, pp. 322 & 453) during the performance of structured activities.

Interpersonal Skills are verbal and non-verbal abilities used to interact in dyadic and group situations. Interpersonal skills are defined operationally as the score an individual receives on the Interpersonal Skills Scale (Mosey, 1986, pp. 324 & 454; Rogers, Sciarappa, & Anthony, 1991) during interaction with others in the course of structured activities.

The Comparison Group consists of two subgroups: *Multi-departmental Activity Program* is a non-individualized, therapeutic intervention designed to encourage the productive use of time and socialization in a group setting. Individuals in this program are scheduled to participate in leisure, education, and work-oriented activity groups. Intervention is group-oriented and is *not* structured to address the development of individual social roles or the specific skills that are nested in these roles. There is no common link or theoretical foundation among staff using this intervention. The Multidepartmental Activity Program is the routine activity-based program implemented in this facility prior to this

study. *Multi-departmental Activity Program* is defined operationally as the four one-hour programs comprising a patient's daily program schedule in the maximum-security facility in which this study occurred (Clark et al., 1997).

Multi-departmental Activity Program with Individual Attention is the same activity program described above with the addition of a weekly 15-minute individual social session between staff and the individual. The purpose of this social session is to give individual attention to the patient in the form of social conversation. Individuals in this program are also scheduled to participate in leisure, education, and work-oriented activity groups. *Multi-departmental Activity Program with Individual Attention* is defined operationally as the four one-hour programs comprising a patient's daily program schedule with the weekly 15-minute social session in the maximum-security facility in which this study will occur (Clark et al., 1997).

Schizophrenic Disorders are a group of disorders characterized by positive symptoms (i.e., primary symptoms) such as delusions, hallucinations, disorganized speech and grossly disorganized or catatonic behavior, and negative symptoms (i.e., secondary symptoms) such as affective flattening, avolition, and alogia, causing a deterioration in social and occupational functioning for a duration of at least six months (DSM-IV-R, 2000; Straube & Oades, 1992; World Health Organization [WHO], 1978). Schizophrenic Disorders are defined operationally as those disorders listed in the DSM-IV Axis I diagnosis of the client's hospital record as Schizophrenia, undifferentiated type; Schizophrenia, residual type; Schizophrenia, catatonic type; Schizophrenia, paranoid type; and Schizoaffective disorder.

Statistically Significant. For clarification, the use of the term "statistically significant" throughout this journal defines a statistically significant result at $p < .05$.

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