The Arts in Psychotherapy 50 (2016) 91–100

Contents lists available at ScienceDirect

The Arts in Psychotherapy

Research article

Drama therapy to empower patients with schizophrenia: Is justice possible?

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ARTICLE INFO

Article history:
Received 17 March 2014
Received in revised form 20 May 2016
Accepted 3 June 2016
Available online 6 June 2016

Keywords:
Drama therapy
Transitional space
Empowerment
Recovery
Group therapy
Cultural similarities

ABSTRACT

This article develops an empowerment model for treating individuals with schizophrenia, exploring developmental transformations drama therapy techniques. The author contrasts the dominant medical model of schizophrenia treatment, which primarily seeks symptom control, with the emerging recovery model of schizophrenia treatment, which is focused on empowering patients. The author then builds a theoretical framework for an empowering drama therapy, rooted in Winnicott's notion of transitional space and Johnson's developmental transformations. These clinical precepts are synthesized with the social justice theories of Rawls and Flax, Boal's political theatre, and the absurdist "Before the Law" parable of Kafka. Two case examples of an empowering developmental transformations drama therapy are presented, exploring clinical sessions with schizophrenic patients in two different cultures. Emphasis is placed on key techniques: "pre-empting"; "transformation to the here and now"; and "therapist as subject." The article concludes by suggesting types of research that can test the potential of an empowering drama therapy to fit within the medical model.

Individuals diagnosed with schizophrenia are among the most disempowered and stigmatized members of society (Wahl, 2012; Ngui, et al., 2010). Due to the severity of the disease and the limitations of pharmacological treatments they all too frequently carry a negative prognosis. This article will explore how drama therapy can empower these individuals, assisting their recovery and reintegration into society. Drama therapy techniques in which the drama therapist becomes the patient's "play object" and encourages patients to play higher-status roles can promote insight and help patients to become more active participants in their recovery.

This paper develops a model of drama therapy in which the drama therapist assists the patient in confronting the stigma associated with his or her status as a patient. It draws together the psychoanalytic theory of Winnicott and Flax, the developmental transformations drama therapy techniques of Johnson, the political philosophy of Rawls, the political theatre work of Boal, recent clinical research on treatment outcomes, and case examples from drama therapy sessions with chronic schizophrenic patients in the United States and the Czech Republic. The thesis of the article is that drama therapy, which takes place in the playspace mutually created by drama therapist and patient, can become a locus of justice, encouraging the patient to re-engage with society.

1. Challenges and opportunities In the treatment of schizophrenia

1.1. The prevalence and limitations of the medical model

Many mental health practitioners and researchers view schizophrenia primarily in genetic, biological, or neurological terms without reference to social causation (Insel, 2010). Consequently, in the "medical model," treatment often focuses on the symptoms of the disease and "containing" persons with mental illness, as opposed to working with them as complete human beings responding to a social milieu. In fact, the main – and sometimes only – treatment for schizophrenia is psychotropic medication (Kane & Correll, 2010). Many psychiatric facilities practice mental-health triage, diagnosing quickly, then racing to stabilize and discharge their patients (Berger and Vuckovic, 1994). "There is also pressure to 'shoot with the big guns' immediately, such as. . using high doses of medications in an effort to get a rapid clinical response" (Lewin & Sharfstein, 1990; p. 123). Fleck (1995) observed that in contemporary psychiatry, precise descriptive classification is the

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http://dx.doi.org/10.1016/j.aip.2016.06.001
0197-4556/

main purpose of the clinical enterprise. "The patient as a sick person was replaced by the patient as a container of symptoms to be subdued" (p. 196). Even after discharge, patients' lives are typically managed in the community just as they were inside institutions, with treatment often limited to symptom containment via medication.

Although psychotropic medication – on which many billions of dollars are spent globally every year – can be useful in reducing the positive symptoms of schizophrenia, it frequently causes severe side effects, most notably involuntary movements and metabolic changes (Tollefson, Beasley, Tamura, Tran, & Potvin, 1997). Further, as demonstrated in the landmark longitudinal studies known as CATIE (Lieberman et al., 2005) and CUtLASS (Jones et al., 2006), even the current generation of antipsychotic medications may fail to help schizophrenic patients. Also, these medications have been shown to be ineffective in the cognitive rehabilitation of individuals with schizophrenia (Hurford, Kalkstein, & Hurford, 2011). Although for many years, pharmaceutical companies have dominated the treatment of schizophrenia due to their large marketing and research budgets, alternative treatment approaches have emerged to address the limitations of the medical model.

1.2. Empowering psychiatric patients through the recovery model

In the last few years, disability and mental health rights advocates have helped craft an array of treaties, national laws and organizations that have, at least on paper, advanced the rights of individuals with mental illness. In particular, as of February 2016, 162 countries had become parties to the Convention on the Rights of People with Disabilities (CRPD), the purpose of which is "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity." (CRPD, Art. 1.) The CRPD protects the rights of people with disabilities to equal recognition under the law (Art. 12), access to justice (Art. 13), and to live in the community with choices equal to others (Art. 19.).

In the United States (which has signed but not yet ratified the CRPD), an array of laws protect the rights of persons with mental illness and prohibit discrimination against them. Under the Americans with Disabilities Act (ADA), the government must provide services to qualified patients with disabilities in the most integrated setting appropriate to their needs. ADA, 42 U.S.C. § 12132 (1990). In the case of *Olmstead v. L.C.*, 527 U.S. 581 (1999), the United States Supreme Court found a right to community treatment under the ADA, pursuant to which states are required to explore treatments less restrictive than long-term hospitalization. In 1990, the same year the ADA was enacted, the United States Supreme Court held that "[t]he forcible injection of medication into a non-consenting person's body represents a substantial interference with that person's liberty." *Washington v. Harper*, 494 U.S. 210, 229 (1990). The Protection and Advocacy for Individuals with Mental Illness Act (PAIMI), 42 U.S.C. § 10801, mandates that each state confer upon an agency the authority to pursue legal, administrative and other appropriate remedies to ensure the protection of individuals with mental illness. Finally, mental health parity laws have been enacted at the federal and state levels, requiring health insurers to cover mental health treatment in the same manner as medical treatment, Mental Health Parity and Addiction Equity Act, 42 U.S.C. § 300gg-26, and these laws are being vigorously enforced, particularly in New York State.

As the rights of mental health patients have expanded, a new psychosocial model has begun to emerge, backed by scientific research. The hypothesis that psychiatric disorders may be exacerbated by external influences such as traumatic events (Mack 1994) is supported by neurological research that suggests that disempowerment and the long-term experience of "social defeat" may increase the risk for schizophrenia (Gevonden et al., 2014; Luhrmann, 2007; Selten and Cantor-Graae, 2005; Selten, van der Ven, Rutten, & Cantor-Graae, 2014).

These political and scientific developments support the recovery model, which posits that the main goals of mental health treatment should increase patients' ability to function in the community, empowering them and improving their overall quality of life (Frese, Knight, & Saks, 2009). Researchers have operationally defined the recovery model concepts, such as empowerment and self-stigma (the prejudice that people with mental illness turn against themselves), and studied how these factors influence treatment outcomes. (Rogers, Chamberlin, Ellison, & Crean, 1997). These studies have shown that patients' experiences with serious mental illness, the service system, and social stigma often undermine their sense of self-efficacy, control, and independence (Coursey, Keller, & Farrell, 1995). Moreover, a perception of empowerment on the part of the patient, which is manifested through perceptions of therapist permission and ability to say critical things in therapy, has been shown to be an indicator of better mental health and is associated with shorter hospital stays. (Coursey et al., 1995).

> The characteristic clients most desired in a therapist was friendliness. It is not clear whether these clients were referring to characteristics such as warmth and acceptance, a collaborative/egalitarian rather than authoritarian style, empathic resonance, engagement rather than detachment, or other specific attributes of their therapists. All these qualities have extensive empirical support for enhancing therapeutic effectiveness in schizophrenia and other disorders. (p. 297)

Recovery-oriented care is characterized by shared decision making. In other words, the person in treatment should have the greatest role possible in collaborating with the provider to define the goals of treatment and plan for ways to reach these goals (Silverstein and Bellack, 2008).

A review of research conducted by Cavelti, Kvrgic, Beck, Kossowsky, and Vauth (2012) concluded that personal (as opposed to merely clinical) recovery from schizophrenia – which includes components such as finding hope for the future, taking control of one's life, and empowerment – is indeed possible and can be measured.

Self-stigma, which is defined as internalization of negative stereotypes about schizophrenia and self-blame (Corrigan, Larson, & Rusch, 2009) and is common and sometimes severe among people with schizophrenia, can be significantly reduced by empowering patients (Brohan, Elgie, Sartorius, & Thornicroft, 2010). Because an avoidant coping style erodes self-efficacy and empowerment, schizophrenia treatment should focus on anticipated stigma to improve recovery (Vauth, Kleim, Wirtz, & Corrigan, 2007). Following a recovery approach in mental health services by focusing on internalized stigma reduction also has the potential to reduce depression in patients with schizophrenia and thus improve their quality of life (Sibitz et al., 2011). Patients who reported that they experienced less coercion were more satisfied with their treatment, and thus less at risk of involuntary readmissions to hospital (Katsakou et al., 2010), and patient satisfaction with treatment is correlated with fewer hospital readmissions and fewer days readmitted (Druss, Rosenheck, & Stolar, 1999).

The mental health system frequently forces patients to give up their power and relate to the world only through their illnesses, reinforcing the experience of social defeat. In *Asylums* (1961), Goffman described role dispossession, a state in which individuals can no longer identify with roles other than that of pariah or outcast. To counter this tendency, researchers have called for the development of techniques that empower patients to reframe their life