Bibliotherapy in Practice

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I WOULD LIKE TO SHARE the results of experience gained in a patients' library program centered around the concept of bibliotherapy—the use of selected reading materials as a therapeutic tool. This particular program at Danvers State Hospital in Massachusetts, as far as I know, is the only such patients' library partially funded by federal funds distributed through the state Division of Library Extension. This does not mean such a library would not be possible under other arrangements. Indeed, a cooperative effort with groups such as the local public library, a college library interested in mental health, nursing homes dealing with deinstitutionalized mental patients, and community mental health centers could aid in the development of a bibliotherapy program. At this time, when patients are being released into the community in great numbers, it would seem most appropriate to promote such liaisons with community facilities. No one should be discouraged from beginning a bibliotherapy program because of lack of funds. A modest program could be started with a small amount of money. If there are funds for a more elaborate program, an effort should be made to have the patients enjoy a library with books, journals and other materials specifically chosen for their application to the bibliotherapy program, staffed by a permanent full-time librarian, and available to all the patients in the hospital.

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This paper will not go into the theory and historical background of bibliotherapy, nor its various classifications and definitions. For those interested in reading along those lines, I would highly recommend two new books by Rhea Joyce Rubin[1] and an older book by Eleanor Frances Brown[2] as well as the October 1962 issue of *Library Trends*[3] devoted to bibliotherapy. Instead, I will talk about my experiences in the field for fifteen years.

Because of my interest in bibliotherapy, I applied for, and received in 1976, a $20,000 Title I grant from the Massachusetts Bureau of Library Extension. The purpose of the grant was to expand the patients' library at Danvers into a model program for a state hospital where bibliotherapy would be an important part of the total patients' library program. Under the terms of the grant, the hospital administration was to provide one additional permanent full-time position in the patients' library and a mental health assistant one day a week on each unit to work with library programs. My position became supervisor of both the medical and patients' libraries.

Bibliotherapy in a Mental Hospital Setting

The head of the occupational therapy department and I started holding bibliotherapy sessions in 1965. We found it desirable to develop our own resource material, mainly because we found that much of the material listed as suitable for use with mental patients was much too lengthy, and proved to be far beyond our patients' intellectual as well as emotional capabilities. The attention span of most of the patients is very limited, and any chosen work has to be very brief. Poems such as Robert Frost's "The Road not Taken" (20 lines) and "Lodger" (6 lines), and "I'm Nobody, Who are You" (4 lines) by Emily Dickinson are examples of poems we used successfully. These poems are simple, easy to understand, elicit many different interpretations and feelings, and express emotions the patients can relate to. A large state mental hospital provides a rather unusual setting, by its very nature a rather negative environment, and the population is quite unlike that of most psychiatric units in veterans' hospitals and that of private psychiatric hospitals.

All mental patients, sooner or later during their hospital course, are given diagnostic labels. Because the labeling is such a pervasive part of the patient's hospitalization as well as the patient-staff relationship, it is very important that the bibliotherapist try to remain apart from this practice. He/she should make a special effort to personalize the relationship with the group members, to come to know them as individuals, and to try not to make judgments based only on case histories.

Bibliotherapy with a group of chronic institutionalized patients concentrates primarily on improving the quality of their lives. Any other goal would really be quite unrealistic, considering their length of hospitalization and degree of deterioration. Very simple poems, such as those found in the magazine *Ideals*,[4] are good. For example, we used one called "Coloring the Margarzine" which described the time when margarzine was snow-white and came with a little red button of coloring material that had to be mixed in. This poem elicited many similar reminiscences and, for a while, there was laughter and sharing of an earlier and happier time of life for them.

I have often overheard the patients speak of "their group" with some trace of pride and self-importance in their voice. The members of the group share some common thread in their backgrounds that can be used to draw them together. By consulting their case histories, one would find something the members had in common, such as once living on a farm, coming from the same or adjoining towns, being of the same ethnic descent, being the same age, or remembering similar interests in their younger years. We always made sure they greeted each other by name and shook hands, and that any similarities of background were brought out to foster group interaction.

Some mental health personnel have established what are called "therapeutic communities" on hospital wards. One of the aspects of such a community is that the patients work together for a common goal. Mental patients do not cooperate easily in this way. Most patients remain apart and isolated from each other, even on a crowded ward. In bibliotherapy groups, they individually might attempt to get the leader's attention, but conversational repartee with each other is seldom seen.

The Librarian as Bibliotherapist

The librarian/bibliotherapist and his/her sessions in the library can provide a respite, an oasis from ward turmoil and routine. The library provides a link with the community from which the patient came and to which, it is hoped, he/she will return.

It is of paramount importance that all bibliotherapy sessions be held in the library and not on the ward. Meeting on the ward proved a dismal failure because of constant interruptions, unpleasant physical surroundings, and mainly because of the difference in the patients' behavior in a ward setting. We found patients responded appropriately to the atmosphere of the library and were able to repress much of their

abnormal behavior in contrast to their "acting out" on the ward. Patients generally have much more control of their behavior than they are given credit for. Paranoid patients, for example, learn very quickly that once they are discharged from the hospital they had better keep quiet about their paranoid ideas, because verbalization of these ideas will usually mean a return to the hospital. We also found that patients taken on outings outside the hospital are often able to behave according to the circumstances in which they find themselves. Even patients who hallucinate and talk back to imaginary voices in the hospital will remark, when cautioned about this, "My goodness, you don't hallucinate on a public bus."

From observation of people attempting bibliotherapy groups, two qualities stand out; without either one of these, any success in really helping people with their problems is at best very superficial. First and foremost, you must really value people as individuals and as human beings, with the result that you feel strongly motivated to help them. It is surprising how many people form groups for all the wrong reasons—prestige, to please or impress someone in authority, or because it is expected in their job descriptions. Patients intuitively know whether or not the therapist is genuinely interested in them. Taking on a group implies a serious responsibility on the part of the therapist. There is a commitment not only to the routine of having a group (preparing the proper setting, preparing the materials, recording group statistics, etc.), but especially to maintaining the trust and reliance that the group members, it is hoped, come to have in the therapist. You want to avoid adding yet another disappointment in interpersonal relationships to their long list of previous failures. If the bibliotherapist is genuinely interested and motivated, the patients will sense this and appreciate his or her efforts on their behalf, and this will help overcome any defficiencies in technique.

The second essential quality is the ability to communicate. People in general tend to evaluate statements made by others from their own frame of reference. To use a very simple example: if a group is forming and one of the patients should announce with some feeling that the library is filthy and he is not going to stay, the bibliotherapist would not respond by becoming defensive about the library, but instead realize that the patient is ill at ease about being there—probably overcome with anxiety about attending the group if it is his first time. The response, "You feel uncomfortable being here," should show understanding and concern for his feelings. Mental patients often say things that, if taken at face value, would put one immediately on the defensive. It is necessary

to listen with understanding to see what lies behind the statements, to see their point of view, to imagine how it feels to be in their position.

Another aspect of the communication skills necessary is the ability to read nonverbal clues. For example, a depressed patient may verbalize that he feels fine. On observation, you may see a patient whose facial tone is slack and dejected, whose movements are slowed and restricted, who might remain in the same position for long periods of time, physically slumps, and responds to questions as if all speech were a burden and a chore. Obviously, these nonverbal clues point to a possibly dangerously depressed person. Your ability to sense this will enable you to alert the staff.

Types of Bibliotherapy Groups

Because different ages and categories of patients respond to very different kinds of approaches and techniques, we found it best to divide our groups into sessions for schizophrenic, geriatric and adolescent patients. Each group consisted of from five to eight patients and included both sexes. Groups met twice weekly as a rule, and each session lasted approximately one hour.

There are certain basic personality traits one finds in patients with a schizophrenic illness. First and foremost, the problem of loneliness and alienation is at the heart of schizophrenia. Usually the loneliness and isolation were present long before the patient became psychotic. Some therapists have greater success than others in dealing with this group, and I believe one really must want to work with these people to be successful in helping them. There are other characteristics which should be of interest to the bibliotherapist. Schizophrenic patients have a great anxiety about closeness or touching. This is in contrast to other groups, where physical contact is deliberately sought. Schizophrenic patients display an ambivalence about practically everything. They can become almost immobilized as a result of any indecision. Their indecision also affects their group attendance—a conflict between a desire to join the group and the wish for social withdrawal. They tend to display a single-mindedness about their particular beliefs. A therapist will have to be on guard less he/she find the therapist/patient roles reversed. An intelligent, well-educated patient can be very convincing when espousing a philosophical view or religious belief. The therapist sometimes has to remind himself or herself who the patient is.

I hope it is understood that bibliotherapy is not possible with frankly psychotic patients whose behavior is too disruptive to handle in

a group setting. No one can lead a discussion when someone in the group is shouting, or arguing, or pacing up and down, or "acting out" in general. Should such behavior suddenly erupt during a session, it is best to call the ward attendant and have the patient returned to the hospital unit. To talk calmly and sensibly to such patients requires special skills, and is more likely to succeed on an individual basis.

With all patients, but particularly with schizophrenic patients, it is important to build trust and confidence by being sincere and honest, by maintaining your commitments to the group, by avoiding what is referred to as a "double-bind" type of communication. If some of their behavior makes you anxious or fearful, share this with them. They will appreciate your honesty, because they will have become aware of your feelings, anyway. I think it is vitally important to these patients, especially since they will have to deal with people in the community on their release, to know how their behavior affects their relationships with other people. This is not to say they will modify their behavior, but at least they will come to appreciate and understand other peoples' reactions to them. Biographies and autobiographies of individuals who also felt alienated are helpful to patients. We used excerpts from Perle Epstein's book *Individuals All,*[5] which includes biographies of Thoreau, Dickinson and Whitman. In groups where sports were of interest, we used biographies of sports figures such as *Fear Strikes Out,*[6] the story of Jim Piersall's (the Boston baseball player) mental illness. For adolescent groups we used biographies of rock stars. With the doctors' approval, we even used *I Never Promised You a Rose Garden,*[7] the story of a woman's schizophrenic illness, for certain patients. We used psychodrama with some success to deal with the issues of how, by their behavior, the patient may generate fear, hostility and anxiety in the community. It also proved very useful in discussing job interview situations, dating behavior, dressing appropriately, and many other social situations.

Most of the geriatric groups we conducted were made up of patients who were being readied to leave the hospital as a result of the current mandate to release patients. Some had been hospitalized practically all their adult lives, some were institutionalized (in all implications of that word), some were "burnt-out" schizophrenics, some were former alcoholics, and a few were mentally deficient as well as psychotic. Most of them were past being acutely psychotic, but had many residual mental symptoms. They all had in common a great deal of fear and anxiety about leaving the hospital, the only home most of them had known. Our bibliotherapy groups had the express purpose of relieving some of

this anxiety and trying to improve the quality of the patients' lives wherever they might move—to nursing homes, other hospitals or into the community.

In my geriatic groups I used a great deal of touching and many remotivation techniques. Touch, after all, is a basic method of communication, more poweful and more honest than words. I found that just holding the hands of someone in the group who was upset would help to calm and quiet them. We sat in a very close circle, which made touching easy, and also made it easier for patients to keep their attention on what was being said. Calling them by name, introducing them to each other, shaking hands, finding something to compliment them about—a neat, clean appearance, an attractive hairdo, etc., also helps in working with geriatric patients. Recorded material—music, talking books, etc.—are not useful unless the goal is to put them to sleep. Telling a story or creating a poem in the bibliotherapist's own words, so the group can watch his/her face and see the feelings generated by the material reflected there—this is what works best. The bibliotherapist should wear bright, attractive clothing, be enthusiastic, and show that he/she is happy to be with them. It is also helpful with this type of group to have a little warm-up exercise, even if it is just moving arms or legs to music at the beginning of the session. They have a tendency to escape into sleep, and the medication most of these older patients take also makes them sleepy. The brief activity helps to keep them alert. (Sleepiness proved to be such a problem that we did a whole session on the subject of sleep—what it meant to them, as well as human and animal patterns of sleep.)

In our special group of patients about to be moved to other hospitals, nursing homes, or community settings, we held a series of discussions about the hospital as they remembered it in the old custodial system, when the superintendent was considered "big daddy." Most of these older patients knew the superintendent personally, and upon his arrival in the morning, he had quite a waiting line of patients to greet him and talk to him about their specific problems. Through our discussion sessions, the patients were able to see that the hospital as they had known it was gone, and that the coming changes might be to their benefit. In some cases we were able to inform them that there would be bibliotherapy groups in the nursing homes for them to attend. For material we used current articles from newspapers regarding community centers, community support (or lack of it), and the whole changing mental health picture and what it might mean to them. All of these long-term, older patients had much to contribute to these discussions

about the hospital. The staff became very interested in their early reminiscences about the hospital and feelings about leaving their home.

The whole series was very successful. It enhanced the patient's self-esteem to feel that he/she had something to contribute that was interesting and valuable to other people. Like everyone, these patients needed to feel they were still useful members of society. We even tape-recorded some of their memories, and made the tapes part of the hospital history collection.

A very different group was the adolescents. At the hospital there was a special unit made up of adolescents who would ordinarily have been sent to a state hospital for the criminally insane for lack of a more suitable setting. This ward was experimental and was used to avoid the practice of confining adolescent delinquents with hardened criminals. It was a closed ward, and the ratio of attendants to patients was high.

At first we had quite a problem establishing any kind of rapport with these young people. Most of them demonstratd a lot of delinquent behavior, and tended to act out in a very hostile way. Like most adolescents, they resented authority figures, and tended to ridicule efforts to hold a bibliotherapy group. We found, however, that they had one love in common, and that was music—usually rock and roll. We finally formed a very successful group using this music as our bibliotherapy discussion material. Together we explored the lives of some of the rock and roll heroes, and surprisingly found that some of these stars had backgrounds similar to those of our patients. Some of the lyrics provided amazingly appropriate material for discussion. For example, many fruitful meetings were built around the lyrics to "I Am A Rock" by Simon and Garfunkel:

A Winter's day
In a deep and dark December
I am alone
Gazing from my window
To the streets below
On a freshly fallen, silent, shrouded snow
I am a rock, I am an island

I've seen walls
A fortress steep and mighty
That none may penetrate
I have no need of friendship
Friendship causes pain
It's laughter and it's loving I disdain
I am a rock, I am an island

Don't talk of love, well
I've heard the word before
It's sleeping in my memory
I won't disturb the slumber
Of feelings that have died
If I never loved, I never would have cried
I am a rock, I am a island

I have my books
And my poetry to protect me
I am shielded in my armor
Hiding in my room
Safe within my room
I touch no one and no one touches me
I am a rock, I am an island

And the rock feels no pain
And an island never cries.[8]

I think these words speak to all of us, and to those young people who came from emotionally impoverished backgrounds, the words were especially poignant. Not all of them were able to verbalize their feelings. Some were encouraged to sketch or draw images the words evoked, and this was useful as a nonverbal form of communication, just as important as gestures, posture, facial expression, or tone of voice. The patients were then encouraged to discover for themselves the meaning of their drawings.

We also found psychodrama combined with bibliotherapy helpful with this group. We tried the technique of role reversal to enable them to see their behavior from the receiving end. For example, in a father-son conflict, the patient would play the father and an attendant, the son. Also, just as we did with the schizophrenic patients, psychodrama was adapted as a way of developing social skills. A very practical application, and one in which all these young people were interested, was the development of a repertoire which would result in getting a date and behaving adequately.

Bibliotherapy Material

I have deliberately not been very specific about materials used for various groups, because I find this a very personal matter. I have often, on request, recommended a particular poem or story that has proven helpful to me, only to discover it did not work well for someone else. My guiding principle in selecting material is, first of all, does it address whatever goal I have in mind for the group? and, second, do I like it

enough to be enthusiastic about presenting it to others? I feel each bibliotherapist has to develop his/her own resource material.

Much of the literature recommended for bibliotherapy use we found to be beyond the comprehension of these patients, and always much too lengthy. It takes extensive personal involvement by the therapist to keep patients' attention. Short poems, such as those found in anthologies of old-time familiar poetry, were well received and patients could relate to them easily. Any nostalgic type of poem or story, provided it was very short, was good, and invariably stirred some faraway memory of their earlier, pre-hospital days.

Another area of concern is the whole issue of psychotropic medications. A large majority of patients, once discharged, stop taking their prescribed drugs without consulting anyone. It is possible to deal with this in the bibliotherapy setting. The hospital pharmacist can be invited to participate, and information and literature can be made available. The soon-to-be-discharged patient can be made aware of the importance of being in touch with the signs and symptoms of impending illness—such as sleeplessness, anxiety, hostility, deterioration of personal hygiene, etc.—in time to forestall a full-blown psychosis, just as someone with a physical illness stays alert for physical symptoms that indicate it is time to consult a physician. It seems very practical to spend time on these aspects which will determine whether the patient is going to be able to live in the community or will have to remain hospitalized. In the past it was not considered desirable to discuss medication problems with the patient, but now, when in some cases the patient has a right to refuse medication, it becomes doubly important that the patient know what is involved. Most hospitals have a medical library which can be a fruitful source of material for the bibliotherapist. Every patient has a curiosity about his or her illness. Just as many general hospitals have patient education programs so that their patients can learn how to live with diabetes, heart disease, etc., so mental patients can also profit from the same type of education, and these programs are being established.

Training for Bibliotherapy

As far as I know, there are no training programs for bibliotherapists in Massachusetts. Indeed, superintendents and mental health professionals, as well as local librarians, were usually unfamiliar with the term, many associating it with some kind of bible-study group. Among state hospital librarians, there was more exposure to literature about bibliotherapy, and those of us who were interested read all we could

about it and educated ourselves. We, in turn, introduced and explained the concept to our superintendents and other hospital staff. Those librarians who formed patient groups and developed a technique did so because of a strong desire to become more involved with patients in a helping relationship, as well as a belief in the influence of literature on people's lives.

Currently, however, there is a growing concern here in Massachusetts about all forms of psychotherapy. Everyone is jumping on the therapy bandwagon, and there is an ever-expanding list of kinds of therapy offered by a variety of people, some trained and some just self-appointed. So many therapies are offered that soon there will have to be some sort of control, supervision and proof of effectiveness of these different techniques (including bibliotherapy) and of the people who use them. It has been suggested that librarians who are untrained and inexperienced but who want to become involved in bibliotherapy refrain from calling themselves "therapists" conducting "bibliotherapy," but instead conduct a "library hour" until they have gained knowledge and experience or completed a recognized training program. There is such a program at St. Elizabeth's Hospital in Washington, D.C.

Looking to the Future

In Massachusetts, deinstitutionalization and the development of community facilities for the mentally ill have taken place simultaneously, with controversial results. Mental patients have been sent into communities that were not prepared to receive them and had little understanding of how to respond to them. With many former mental patients now visiting local libraries, many doing this as a result of favorable experience with the library within the institution, this seems an opportune time to develop some sort of cooperative effort with community libraries. The goal would be to make the transition period easier not only for the ex-patients, but also for the community receiving them.

We found the local public library very interested in our bibliotherapy program. They are one of the few public libraries actually doing work in bibliotherapy and conducting groups for children. They were most cooperative in other ways as well—welcoming visits by our patients, supplying needed materials, and sharing their music collections. Some of the hospital patients proved very talented artistically, and the local library welcomed paintings and sketches as a part of their art rental program. All the paintings were displayed in the library. These

were enventually sold, and the patients received money, but more importantly, they gained self-confidence with the realization that others liked their paintings enough to display them in their homes. Local library pesonnel were interested in attending our bibliotherapy sessions; unfortunately, we were not able to receive permission to allow this, as it was considered a violation of the patients' right to privacy. I retired before this kind of mutual interest could be developed, but a growing cooperation between the hospital and the local library to foster mental health education for the general public is another desirable goal. As more and more patients are discharged into the community and share community resources, this need will become more urgent.

Nursing homes are fast becoming the new institutions for the mentally ill. When and if bibliotherapy becomes recognized as a legitimate therapy with licensed therapists, bibliotherapists could be hired to work in nursing homes and community mental health centers, just as other therapists are now. However, the prospects are not bright. As state hospitals close or are phased out, institutional libraries will disappear, and along with them, the very few librarians who are knowledgeable and interested in bibliotherapy.

It would seem that public libraries will be the environment in which bibliotherapy will develop in the future. The factor contributing most to this development will be the need to deal with, and to understand, the new neighbor in our midst—the ex-mental patient.

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