Bibliotherapy and Psychotherapy

EDWIN F. ALSTON, M.D.

THIS PAPER HAS TO DO WITH the possible uses and values of bibliotherapy in the treatment of emotional and mental illness. The discussion will be introduced with brief considerations of personality development, psychopathology, concepts of mental and emotional health, and psychotherapy from standpoints of goals, principles, techniques, and problems. We shall also want to review the rationale for thinking of bibliotherapy in connection with the treatment of the mentally ill. Such a background is necessary before we can see clearly the possible roles of bibliotherapy in the present treatment of psychological disorders.

The development of a human personality is an extremely complicated process. Here we shall not attempt to describe the details; rather we shall emphasize the diversity of factors that are involved in the growth and development of a human personality. At birth the individual exists largely as a potential. His very survival is dependent upon those who care for him; his future development is shaped first by the start they give him and subsequently by all of the experiences which he has on his way to adulthood. Physically and psychologically the individual will go through different phases of growth and development.[1, 2] In each phase different needs and activities are prepotent. For instance, in the earliest months, eating, eliminating, and sleeping are dominant activities. Subsequently different periods are characterized by the special prominence of learning to walk, talk, control sphincters. As the years go by, at different stages, the individual will be especially involved in developing the nature of his relationships with people, of acquiring basic knowledge and skills. His sexual interest, curiosity, and activity will go through complex phases of development.

Dr. Alston is Visting Lecturer in Psychology, University of California, Berkeley (1961-1962); Consultant in Psychiatry, Letterman Army Hospital; and Clinical Instructor in Psychiatry, University of California Medical School.

For optimal physical development, the individual requires adequate food, shelter, clothing, sleep, exercise, and protection from adverse elements such as disease. Likewise, for psychological development, there are basic requirements: adequate contacts with people, example and instruction, help from others, and independent activity. However, it is not sufficient simply to list the needs and activities essential for growth and development. The quality, intensity, timing, order of prominence, sequence, and associated experiences all relative to his stage of development will be important factors in determining the formation of the individual's personality structure. The point to be emphasized here is that orderly growth and development is not assured by any means, but rather is dependent upon a great number of variables. The successes and failures, the gratifications and frustrations which the individual meets in each stage of development will determine how well he is prepared to handle subsequent stages. Anywhere along the line, the individual may become stuck or fixed either because of failure or because of excessive gratification.

The outcome of growth and development in the human being usually leaves much to be desired. There is always some psychopathology. This fact is easy to understand when one considers the complex processes of growth already referred to. Specific deficiencies occurring in the growth process may be very subtle and not directly observable. They are likely to occur throughout the course of development despite the wisest efforts and best intentions of everyone concerned. These deficiencies will be manifest in the failure to develop the capacity for global integration of the personality. A chain is no stronger than its weakest link. In order for one to evaluate the integrity and health of a personality, it is necessary to consider its weakness and dissociations as well as its strengths. The inevitability of psychopathology may be clearly seen in terms of an analogy cited by Salter: "Parents, and everyone else, are doing the best they know, but just as there is only one way for a wrist watch to run correctly, and hundreds of ways for it to get out of order, so is there only one way for children to be psychologically sound and a multitude of ways for them to develop psychological troubles. Consequently, probability is against mental health, all of which is deplorable, but quite patent." [3]

Psychopathology may be described in terms of "disability, distress, and dread," to use the terms of Whitehorn [4] or "stupidity, misery, and symptoms," to quote Dollard and Miller.[5] It is manifest in physical complaints, mood disturbances, defects in motivation, unrealistic self

attitudes, disturbances in relationships with other people, or diminished capacity for gratification. Anxiety and tension of mild or great degree and reactions to them are present in all psychopathology. Psychopathology can be viewed as unstable, fragmented, fixed, and maladaptive personality structure. The essence of psychological illness is conflict or disassociation of various tendencies within the individual and conflict between the individual and the world outside himself. It can be conceptualized as incomplete development or as regression resulting from undue stress or lack of essential maintenance. It appears in all degrees of severity from that of personality structure which is extremely disorganized and conflicted to that which is barely evident. The most severe and disabling disorders are usually seen in psychoses; less crippling are the neuroses, as a rule; and least noticeable is the psychopathology occurring in so-called normals. When one considers the multiple ingredients that go into the development of the human personality, it is not difficult to understand that some psychopathology is present in every one. No one is perfect.

Because psychopathology is seen in palpable reality while mental health is more of a concept and cannot be demonstrated for all to see, psychopathology is easier to see, define, and understand than is mental health. Ideas of mental health will differ from one person to another. It has been conceptualized in a variety of ways. It can be defined in terms of freedom from symptoms, or as statistical normality; it is sometimes thought of as being related to a sense of well being. Jahoda [6] has summarized a number of dimensions referred to by most writers on the subject as criteria for evaluating mental health. These include capacities for self-awareness, self-actualization, integration, autonomy, reality perception, and reality mastery.

Having referred to some of the qualities of psychopathology and a few of the concepts of mental health, we can recognize that the possible goals of psychotherapy are numerous and varied. The goals may be very explicit, or they may be very vague; they may be modest or extremely ambitious. The goal in any particular therapeutic program will, of course, depend upon considerations of time and money. In addition, the goal in therapy will be determined by the patient's psychopathology, psychological mindedness, motivation, age, intelligence, behavior and affect states; the goal will also be influenced by the therapist's experience, skill, philosophy, and various personal factors. Some categories of goals are (1) custodial care, (2) long-term support, (3) relief of symptomatology, (4) management through situ-

ational stress, (5) recovery of premorbid personality state, and (6) total reconstruction of the personality through the development of insight and reeducation. The goal, of course, will determine the form of treatment to be applied.

Psychotherapy involves, above all, a relationship between the therapist and the patient (or group of patients). Important categories of influence in all therapies include the therapist's personal impact (direct and transference) upon the patient and the approach to and content of the material dealt with. Within limits, what is said is of secondary importance to the interest, integrity, authority, and confidence which the patient sees in the therapist. In other words, the intense experience of a developing interpersonal relationship, perhaps very different from any other that the patient has known, seems to be the *sine qua non* of progress in therapy.[7] This is evident in the fact that skillful therapists of diverse theoretical orientations employing widely different approaches seem to secure comparable results.

Depending upon the goal of therapy, the character and content of treatment can assume various forms. Therapy may be primarily reinforcement and support. This form means that the therapist will listen to the patient's problems, give him reassurance and support, and offer occasional advice or suggestions. This form of therapy is sometimes indicated in situations of acute stress or in cases where the patient is so fragile that this is all that he can tolerate. Otherwise this form of therapy is likely to be insipid and endless. If and when it is terminated, the patient is probably no better off than he was when he started. Another form of therapy has to do with reeducation and training. Here the therapist acts as something of a pedagog and attempts to impart new attitudes and skills to the patient. The trouble with it is that it may leave untouched or even enhance the opposing trends within the patient. This is a sort of patch work, and yet it may have a real value when there is not the need, indication, or realistic possibility of an all-out reconstructive effort. The third major form of psychotherapy is so-called deep therapy or insight therapy, represented primarily by psychoanalysis. Here the emphasis is upon a process devoted to the patient's actually *experiencing* the fullest possible knowledge of himself. This is hardly possible except in an appropriate relationship to another person, since it is all but inevitable that every person is going to have blind spots with respect to himself. It is a profoundly pertinent observation that "the problem of

self-analysis is the counter-transference." Exhaustive self-knowledge is an essential condition for total personality synthesis when some trends of feelings, thoughts, and actions have failed to become incorporated into a global personality structure or have become dissociated from one another. It is not until the individual becomes capable of a wholeness within himself that he can achieve an occasional oneness with the world and some of the people outside himself with maximal chances for effectiveness and gratification with them.

Irrespective of the form of psychotherapy, there are a number of therapeutic instruments which may be used.[8] In various forms, they will be used with different combinations, emphasis, and purpose. Therapeutic instruments may be used either for "curative" effect or for "technical" purposes in service of the total therapeutic process. Common to all psychotherapy is *respectful listening* to the patient's description of his problems, feelings, thoughts, and behavior. Such attention, of course, is essential not only to understanding the patient, but also to establishing contact with the patient. For the patient, the very act of attempting to communicate with another person about matters of personal concern may help him toward greater clarity and psychological expansion by improving his powers of association, discrimination, and synthesis. The description of personal experience in public language may provide him with some leverage against inner fixations. The feeling that another person has listened, understood, and tolerated may diminish the patient's sense of loneliness and isolation. Thus, listening without any other intervention may itself have considerable therapeutic value.

A second type of therapeutic intervention is that of *suggestion* which in a broad sense includes advice, counseling, guidance, instruction. It can be said that the effect of suggestion is always present in any therapeutic relationship whether or not it is recognized or used directly as such. Suggestion of a general character is more likely to have enduring value than concrete specific suggestion. The latter is likely to have a deceptive value in providing an immediate solution while neglecting increase of the patient's spontaneity and self-sufficiency. Two major dangers of suggestion include introducing something foreign to the patient's personality (making even more difficult the task of synthesis) and increasing the patient's dependency.

Manipulation involves nonverbal or indirect handling of the patient's problems. It may involve manipulating aspects of the milieu in which the patient lives; it may be directed specifically toward the

patient. In manipulation the patient is relatively passive and the therapist is more active. As a therapeutic vehicle, it shares some of the values and limitations of suggestion.

Clarification has to do with restructuring the material offered by the patient. In clarification per se there is little emphasis upon "digging" more deeply but more upon dealing with what is at hand in terms of comparison, discrimination, and organization.

Interpretation is directed toward bringing into awareness a conscious knowledge of feelings, ideas, wishes, or memories which have been repressed and split off from consciousness. By bringing repressed material into awareness, interpretation offers the first step by which repressed material can be blended or fused with other contents of consciousness. If successful, interpretation leads alternately to a greater unity of the personality. Interpretation, of course, is inferential, based upon the therapist's general information and experience and his knowledge of the patient. It is subject to error in form, content, and timing, and in this sense it has some of the liabilities of suggestion and manipulation. One difficulty with interpretation resides in the fact that the same mechanisms responsible for repression in the first place will also stand against the return of the repressed material into consciousness. For this reason, attention has to be directed first toward the repressing mechanisms, the patient's defenses and resistances. When repressed material is successfully brought into consciousness, there will be a resulting anxiety which, if severe, may again evoke the repressing forces or lead to acting out. Accordingly it is necessary to anticipate the amount of anxiety the patient can tolerate and to make interpretations in such a way as to avoid crippling anxiety.

In psychoanalysis one uses all of the therapeutic instruments referred to above. Interpretation, however, is the ultimate vehicle of psychoanalysis, and all of the other instruments are used not for their curative value so much as for leading up to and otherwise serving the process of interpretation. By contrast to psychoanalysis, Rogers' client centered therapy [9] places major emphasis upon reflection and clarification, minimizing the other techinques. More eclectic therapies will use all of the therapeutic instruments for curative as well as technical value.[10] It should be said that when suggestion and manipulation are used for curative purposes, the field becomes clouded and the opportunity for clear, effective interpretation is minimized.

In addition to the use of the therapeutic instruments mentioned above in psychotherapy proper, adjunctive activities may be prescribed. These include occupational therapy, art therapy, music therapy, bibliotherapy, etc. Ordinarily such activities are not prescribed for the patient in psychoanalysis. Rather, efforts are largely confined to interpretative activity, and otherwise the patient is left to his own devices. The adjunctive therapies are utilized largely to provide the patient with interest, activity, outlets, structure; to develop new attitudes and skills; and to occupy the patient's time. They are used mostly with hospitalized patients.

Having considered the therapeutic devices used by the therapist, one may refer to the role of the patient in the therapeutic process. In a broad sense, the patient must think, feel, and act. In the therapy he must give and receive, and he must put into action the understanding, skills, and attitudes which he has developed. It is not enough for the patient and therapist to be talking in the same room. Each must strive for a meaningful encounter with the other. The patient must be able to postpone gratification, to endure frustration and tension which are inevitable accompaniments of growth and development. If he has to leave the field of therapy because of inevitable frustration and anxiety, he will obviously forsake any possibility of benefit from it. As stated above, it is not sufficient for the patient to acquire new knowledge, understanding, and attitudes. To obtain a firm grasp and value he must be able to apply these acquisitions in daily living.[11] The patient has to be prepared to tolerate initial ineptness, failure, and adverse reactions and to persist until he has developed mastery, effectiveness, and gratification.

Psychotherapy, old as humanity itself, is nevertheless relatively stagnant as an art and science. In all the centuries of human history, few really important advances have been made. Psychoanalysis is a major exception to this statement, but even so, it has to be said that there simply are not innovations in psychoanalysis whose breadth and magnitude and effectiveness compare with innovations in other fields of medicine, education, art, and science. Failure of development probably has to do with the intensity of feeling that human beings have about the behavior of human beings, a feeling that constitutes a powerful resistance to experimentation and change. Major problems and challenges facing psychotherapy have to do with the effectiveness and breadth of application.

With respect to effectiveness there are not only problems of in-

creasing effectiveness, but also problems of defining and evaluating effectiveness. Psychoanalysis, client centered therapy, hypnotherapy, "eclectic" psychotherapy, reciprocal inhibition therapy, experimental therapy, personal construct therapy, assertion-structured therapy, Gestalt therapy, and the other therapies too numerous to mention here,[12] make their claims for success but have to admit their failures and inability really to predict the probability of success. There is no way yet really to evaluate success. No therapy today helps as much as must be possible. For comparable time and effort there may not be much real difference between one approach and another. The chances are that improvements or innovations in psychotherapy necessary to bring about significant measurable changes in effectiveness will have to be really drastic in nature. There is also little doubt that drastic innovations, if and when they are made, will meet with the same—or greater—abhorrence and opposition that originally confronted psychoanalysis and still does to some extent. Psychotherapy probably remains relatively ineffective because it is still limited to half measures. The breadth of applicability of psychotherapy, at present, is probably a secondary matter. If a really effective psychotherapy is ever developed, then will be the time to devise the means of making it more widely applicable. As it stands, the current psychotherapies are for the most part expensive and time consuming. Therapists are few in relationship to the needs. And the existing therapies are of little value for the most disturbed patients; they have their greatest value for those whose need is least.

There are many reasons for thinking that bibliotherapy might be of some value in the treatment of patients with psychological disturbances.[13, 14] Throughout centuries of history, the written word has acquired an increasing, fantastic time- and space-binding significance for man. Man, in papers, pamphlets, and books, has recorded something, at least, about every conceivable aspect of his existence—his interests, aspirations, and activities. For information, instruction, inspiration, understanding, and entertainment, an individual today need not rely only upon his own life experience nor upon that of those immediately around him. In the poetry, fiction, or non-fiction of the world, a person can find broad coverage of the individual human situation in all times and places; he has immediate access to the recorded feelings, knowledge, ideas, desires, and activities of all kinds of men and women. In the world literature there is plenty to meet every need and taste. It is easily and widely available, to every-

one, at relatively little cost. A helpful or favorite book, unlike a passing conversation, relationship, or experience, can be referred to time and again in the full and original form it had for the reader. The written word, which one can take or leave, is not as intrusive as the spoken word, nor is the written word likely to have been as associated with demands and prohibitions and other anxiety-provoking experiences as the spoken word.[15] Accordingly, many people can approach a book with minimal defensiveness and maximal accessibility. For many people, the written word has an exceptional authority and authenticity. Finally, in actuality, many if not most literate people can mention at least one or two books which have affected them profoundly, opening up new vistas, new directions for growth and development.

A striking example of the extent to which people in general look to books and pamphlets for help with personal problems is seen in the experience of the Metropolitan Life Insurance Company over the last decade with its educational pamphlets. Since 1947, this company has been issuing booklets on various aspects of physical and emotional illness. The response of the public gives an indication not only of the need and demand for help with personal problems but also of the interest and hope invested in the written word. In a personal communication, George M. Wheatley, Medical Director, writes:

Perhaps some indication of the interest in our booklets relating to mental health can be gauged by the following figures. For example, from 1958 to 1961, our booklet, *6 to 8—Years of Discovery,* was requested by 1,689,514 persons; there were 906,450 requests for *Nine to Twelve* in 1961; 6,640,190 requests for *Understanding Your Young Child* from 1947 to 1961; 4,277,150 requests for *Understanding Your Teen-Ager* from 1953 to 1961; 3,500,000 requests for *Emotions and Physical Health* from 1954 to 1961 and 2,200,000 requests for *Stress and What It Means to You* from 1958 to 1961. We have had numerous letters from individuals, PTA's, child study groups, physicians and others, telling us how useful our materials are to them, and how glad they are to receive them.[16]

Dr. Wheatley also makes reference to a film: "Since its release in 1956, our film on mental health, *Mr. Finley's Feelings,* has had a total attendance of 21,215,128. The purpose of the film was to stimulate questions and comments and provoke an exchange of ideas about the ways of meeting stress situations and handling day to day relationships with people. Through the response we have had, as well as the

requests for further reading materials, we feel confident that *Mr. Finley's Feelings* is fulfilling its purpose." [16] Hardly any statement could exemplify more clearly the extent to which people look to written material for help in the solution of personal problems and concerns, the tremendous demand for such help, and the response that occurs when specific universal problems are discussed and the material is made easily and widely available.

Some people, perhaps quite a few people, are profoundly influenced by books where they find not only amusement and instruction but also understanding and inspiration. This basic fact lends hope to the idea that books may be useful in the treatment of psychiatric patients. But the matter is not as simple as it seems. While it is undoubtedly true that a few people can and do find in books a powerful stimulus for problem solving and further development, a probable fact is that most people are not so deeply affected. Some people simply do not read; others do not get much out of what they read.

As discussed above, really significant change in a person requires not simply a powerful incitement, but the incitement must be of appropriate form and content and has to develop in a proper order from initial contact to a peak of significance. It is difficult to imagine how such a process can be organized primarily around the reading of books. Books are not written with the individual patient in mind, and certainly no book will completely fit any one patient. By its very nature, the patient's psychological illness may preclude his discrimination between what applies to him and what does not; and his psychological illness may make it impossible for him to integrate effectively into his own particular situation what he has learned and felt. Activity is an absolutely essential condition to growth. Reading without active, critical participation and application can hardly be expected to have any significant effect. Finally, there is no book that can possibly substitute completely for a vital, give-and-take exchange between two people. Unless such a relationship is somewhere in the background, whole libraries of books will be of no avail. For those of us who are interested in bibliotherapy, it may be well to keep these reservations in mind, lest we be carried so far away by our enthusiasm that we seek more than it has to offer and derive from it less than what is possible.

The various purposes for which reading can be used by the patient and the physician have been treated quite extensively in the literature.[13, 14, 17-25] It is relevant to summarize some of them here. Ob-

viously books may be of value for information and instruction, as guides in the development of new skills. Often patients will find courage to enter therapy or discuss a particular problem after reading about it. Occasionally a patient will be able to discuss something that he has read when he cannot at the moment talk about the same matter as it applies directly to himself. Thus, the discussion of a book is sometimes helpful as an introduction to more personal topics. Books may be used to help the patient obtain greater insight into his problems or to acquire language and ideas with which to communicate his problems.

They may help the patient focus attention outside himself and to find new interests. The reading of books may assist the patient in the processes of socialization by providing him something which he can share and talk about with other people. Often people can find new directions and attitudes in books. The knowledge to be acquired from books that other people have similar problems may give the patient greater courage to face his own problems, and a lesser sense of isolation and loneliness. Finally, although too much should not be made of it, there is the therapeutic value of relaxation and diversion to be found in books. Books may be and often are used for escape purposes, but this use should not cause us to overlook the possibilities of having our worries, concerns, and problems too much with us. Books may be used by the patient to take his mind off his problems for a bit so that he can eventually return to them with refreshed and new points of view.

Patients may derive from reading some definite therapeutic gains such as those listed above, but reading and its results may also become deterrents to therapeutic progress. It is possible to acquire erroneous information and misunderstanding from books. Reading may be used as a way of avoiding the personal issues of therapy or of achieving further withdrawal and isolation. False hopes and expectations may be engendered, or the patient may be discouraged, or depressive trends may be enhanced. In response to reading, the patient may attempt to use ideas and facts that do not apply to him. Some patients become overwhelmed or especially anxious from reading. Obsessive-compulsive tendencies may be enhanced. In short, reading may become a resistance to therapy, especially if the reading is not accompanied by appropriate critical discussion. Some writers on bibliotherapy suggest general contraindications to some types of reading for patients belonging to certain diagnostic categories. For in-

stance, remarks are sometimes made about what a depressed or obsessive-compulsive patient should be allowed to read or prevented from reading. While these may be some fairly useful rules of thumb, one might also question any prescription of reading based upon Kraeplinian diagnostic categories. The indications and contraindications for bibliotherapy and the material recommended should be based upon an estimate of what the patient needs for therapeutic purposes at the moment and upon expectations of how he will use and respond to the material being considered.

The therapist may use the patient's interest and responsiveness to books in several different ways. He may use reports that the patient makes about his reading to further analyze and understand the patient. By and large, in insight therapy, it is seldom that a book is actually prescribed for a patient. The emphasis is more upon the patient's learning directly and specifically about himself. But when the patient reports that he has read a particular book, valuable insights may develop from analyzing his choice, what he got out of the book, his responses, etc. Whereas books are seldom prescribed in analytic therapy, probably most analytic therapists are quite attentive to what the patient reports about his reading and his attempt to relate this to other material which the patient is producing. In analysis as well as in other forms of therapy, the patient very often refers to his reading and very often reports having gained from it.[13] A quick review of this writer's patients now in therapy shows that about seventeen out of twenty-one patients have not only reported their reading of books, but have also made assertions about increased understanding, new points of view, etc. Also in analytic therapy, there is often a tendency on the part of the patient to choose and discuss books as a way of avoiding more direct discussion of himself. However, even this tendency can be used for the purposes of therapy when it can be pointed out that the patient is reading to divert himself from the work of analysis and when attempts can be made to infer what the patient is trying to avoid.

Reading of books, pamphlets, and articles can also be definitely prescribed for the patient. In such an instance, of course, the therapist as a rule will have a definite purpose in mind, tailored to the individual at the time he makes the prescription. He will probably encourage the patient to discuss what he has read and examine the ways in which this applies to the patient's situation. This essentially is the use that has been made of bibliotherapy in the two cases reported

by Schneck,[26] and in "Objective Psychotherapy" described by Karpman.[27] Prescribed reading may be for any of the therapeutic purposes outlined above and may make use of fiction or nonfiction. When the therapist prescribes a book in this way, he should not only know what he is attempting to accomplish, but he should also be fairly sure of what is in the book in order to know that it is suited to his purpose. Very probably, any therapist who intends to recommend books should have in mind a small number which he can use for definite purposes and which he himself can know quite thoroughly. It is probably a futile gesture for the therapist to recommend books when he does not have a relatively fresh and recent knowledge. No one can keep fully in mind a large number of books sufficient for therapeutic purposes, and a busy therapist will seldom have time to examine many books for their therapeutic potentiality. A therapist who intends to make extensive systematic use of bibliotherapy would be well advised, therefore, not only to have his own list of well known reliable books but also to have the collaboration of someone such as a librarian who is able to pay more attention to books for therapeutic purposes.

There is another manner in which bibliotherapy can be employed. There is the possibility of designing a course of therapy using books as the principal focus and starting point of therapy and discussion. Powell, Stone, and Frank[28] experimented with having patients in two groups, one therapeutic and the other for discussion of a prescribed reading list. (They chose *Declaration of Independence,* Benedict's *Patterns of Culture,* Epictetus' *Discourse,* Farrell's *Young Lonigan,* Wolfe's *Look Homeward Angel,* Augustine's *Confessions,* and Plato's *Republic.*) They found that their therapy and reading groups offered different opportunities to different patients. In some patients the reading may afford a means of diminishing anxiety, of increasing self-esteem to the point of being able to function more freely in the therapeutic group. They also found that a given patient's success in either the therapeutic or reading group significantly enhanced his ability to make full use of the other group.

Wilson[29] has reported on a single case for whom twelve books were selected and prescribed over a period of more than two years. Several prolonged conferences and about eight report conferences were held with the patient. In the report conferences, the discussions were centered primarily around what the patient had read and how it pertained to him. At the end of each conference, after a book had

been prescribed, it was left up to the patient as to when the next meeting would occur. There were intervals of many months between conferences. Wilson had the patient tested before and after the course of bibliotherapy and concluded that the patient had made substantial gains. The patient reported being satisfied with what he had achieved. Wilson feels that such bibliotherapy is useful when time is at a premium and is more especially useful in problems of attitude.

Reading material has also been put to use in "remotivation," a technique developed by Dorothy Hoskins Smith, and widely used in State and Veterans Administration Hospitals.[30, 31] Training and demonstration of this technique across the country have been supported by a grant from Smith, Kline, and French Laboratories and sponsored by the American Psychiatric Association. The technique consists of twelve meetings of patients under the leadership of a trained remotivation therapist. After the therapist has helped to create an "atmosphere of acceptance" the next step consists of reading a poem. A basic concept underlying the technique is that even very withdrawn people can be aroused into talking about subjects outside their emotional tensions. However, "definitely barred are sex and marriage problems, financial worries, racial questions, and matters concerning religion and politics."[30] A poem or other piece of literature presenting rhythm and evocative images of perception and motion is likely to attract the attention of withdrawn people and provide the nucleus around which more nearly normal conversations can be developed in the group. Having awakened interest in the patients by reading of literature, the remotivation sessions continue with stages referred to as "sharing the world we live in," "appreciation of the work of the world," "the climate of appreciation." These different steps have to do with the introduction into group discussion of different subjects having concrete interest chosen for variety, the elicitation of personal interests from patients, and eventually the expressions of thanks to the patients for their participation. It is said that "a mere series of 12 group conversations about such objective topics as fishing, railroads, cotton, rock gardens, or cooking, conducted in an atmosphere of friendliness and approval, can give mental patients a strong thrust toward recovery."[32]

Obviously, the use of bibliotherapy in private practice is going to be very much different from that which is possible in a hospital setting. Only rarely in private practice will there be the possibility of a

sufficiently close working relationship between the therapist and a librarian to provide the basis for a team approach to bibliotherapy. It is questionable whether or not such a team approach would justify the difficulties of setting it up, especially if it required preference over other therapeutic approaches. If a private therapist were to set up a course of therapy with bibliotherapy as the central point of departure, as in the work of Wilson, he might well request consultations with a librarian and other experts to develop an appropriate reading list. For the most part, however, the main use to be made of bibliotherapy by therapists in private practice will probably continue to be examination of the patient's various reactions to books which he reports having read. It will undoubtedly include occasional suggestions on the part of the therapist that a patient read some special book. The basis of the selection here will probably be books that are quite familiar to the therapist and which he feels will be of help to the patient at the moment in furthering the course of his understanding and therapy.

In the hospital setting there is, of course, opportunity for a much closer working relationship between the therapist and librarian, and the facilities are often such that more extensive use can be made of bibliotherapy.[33, 34] The physician and librarian can collaborate in the development of reading programs for any given patient, and they can confer with one another about their observations for evaluation and for determination of the succeeding steps. The physician and librarian will each have his own contributions to make to such a program. The physician may impart to the librarian something about what he hopes to achieve by prescribed reading for a patient. It may be helpful to the librarian if the therapist can summarize some of the patient's basic psychological mechanisms and indicate the type of books and subject matter that he has in mind for the patient. The physician may also wish to indicate what would be contraindicated for the patient in his therapy. The physician will doubtless want to follow up on his recommendations with discussions and observations of the patient's reactions. The librarian will probably want to have available a relatively limited list of books which might be used more frequently in bibliotherapy and a readily available knowledge of the contents, plots, problems treated, etc. From these the librarian should be able to make recommendations that would fulfill the physician's prescriptions. The librarian's interest and enthusiasm can be an ad-

ditional and very important personal contact for the patient, and his observations about the conduct and reactions of the patient may be of considerable value to the therapist.

In summary, books may be of great value for some patients. With others, bibliotherapy is simply not going to be applicable, or there will be other preferred adjunctive measures. Bibliotherapy is likely to be more useful in psychotherapy oriented toward support re-education and training, and of much less value in analytic or insight therapies. It may be that a relatively systematic program of bibliotherapy along the lines indicated by Wilson, Karpman, and others can be developed to have some positive but limited value for some patients. This is an area for further investigation and development, although perhaps not one of top priority. Short of such a procedure, bibliotherapy is always likely to be adjunctive in nature to a broader program of therapy, and being adjunctive it may not be susceptible to standardization and precise evaluation. The use of bibliotherapy will always be more helpful for some than for others. To some it is doubtful that a highly standardized, precise form of generally applicable bibliotherapy can ever be developed. On the other hand, for any given therapist-patient situation, there may be times when the examination of a patient's reactions to a book or the recommendation that a patient read a book will be of real value in the overall program. This will probably have to remain an individual affair of the moment dependent upon the patient and the therapist. It is probable that bibliotherapy will remain a science and an art as applicable to the individual patient rather than to the patient population. Some therapists will always make more use of books than others; some patients will respond more to books than others. There are times that contact or understanding may be accomplished by way of a book as the vehicle. The science and art of bibilotherapy will be the matching of the therapist, patient, moment, and content, where a book is likely to be of more value than anything else.

References

1. Fenichel, Otto. *The Psychoanalytic Theory of Neurosis.* New York, W. W. Norton and Company, 1945, pp. 33-117.

2. Erickson, Erik H. *Childhood and Society.* 1st ed. New York, W. W. Norton and Company, 1950.

3. Salter, Andrew. *Conditioned Reflex Therapy.* New York, Capricorn Books, 1961, p. 40.

4. Whitehorn, John C. "Goals of Psychotherapy." *In* Eli Rubinstein and Morris B. Paroff, eds. *Research in Psychotherapy.* Washington, D.C., American Psychological Association, 1959.

5. Dollard, John, and Miller, Neal E. *Personality and Psychotherapy.* New York, McGraw-Hill Book Company, 1950.

6. Jahoda, Marie. *Current Concepts of Positive Mental Health.* New York, Basic Books, 1958.

7. Frank, Jerome. *Persuasion and Healing, A Comparative Study of Psychotherapy.* Baltimore, The Johns Hopkins Press, 1961.

8. Bibring, Eduard. "Psychoanalysis and the Dynamic Psychotherapies," *Journal of American Psychiatric Association,* 2:745-771, 1954.

9. Rogers, Carl R. *Client Centered Therapy: Its Current Practice, Implications, and Theory.* Boston, Houghton-Mifflin, 1951.

10. Thorne, Frederick C. *Principles of Personality Counseling.* Brandon, Vt., Journal of Clinical Psychology, 1950.

11. Wheelis, Allen. "The Place of Action in Personality Change," *Psychiatry,* 13:135-148, 1950.

12. Harper, Robert. *Psychoanalysis and Psychotherapy; 36 Systems.* Englewood Cliffs, N.J., Prentice-Hall, 1959.

13. Menninger, William C. "Bibliotherapy," *Bulletin of the Menninger Clinic,* 1:263-274, Nov. 1937.

14. Schneck, Jerome M. "Bibliotherapy and Hospital Library Activities for Neuropsychiatric Patients: A Review of the Literature with Comments on Trends," *Psychiatry,* 8:207-228, May 1945.

15. Alston, Edwin F. "Psychoanalytic Psychotherapy Conducted by Correspondence," *International Journal of Psychoanalysis,* 38:32-50, 1957.

16. Wheatley, George M. Medical Director, Metropolitan Life Insurance Company, Personal Communication, March 27, 1962.

17. Appel, K. E. "Psychiatric Therapy." *In* J. McV. Hunt, ed. *Personality and the Behavior Disorders.* New York, The Ronald Press Company, Vol. 2, p. 1107.

18. Brower, Daniel. "Bibliotherapy in Progress." *In* Daniel Brower and Lawrence E. Abt, eds. *Progress in Clinical Psychology.* New York, Grune and Stratton, 1956, Vol. 2, pp. 212-213.

19. Bryan, Alice I. "Can There Be a Science of Bibliotherapy?" *Library Journal,* 64:773-776, Oct. 15, 1939.

20. Bryan, Alice I. "Toward a Science of Bibliotherapy." *In* George Lawton, ed. *New Goals for Old Age.* New York, Columbia University Press, 1943.

21. Gottschalk, Louis A. "Bibliotherapy as an Adjuvant in Psychotherapy," *American Journal of Psychiatry,* 104:632-637, April 1948.

22. Hinsie, Leland E., and Campbell, Robert Jean, eds. *Psychiatric Dictionary.* New York, Oxford University Press, 1960, p. 95.

23. Lazarsfeld, Sofie. "Use of Fiction in Psychotherapy (A Contribution to Bibliotherapy)," *American Journal of Psychotherapy,* 3:26-33, Jan. 1949.

24. Levine, Maurice. *Psychotherapy in Medical Practice.* New York, The Macmillan Company, 1946, pp. 107-108.

25. Shrodes, Caroline. "Bibliotherapy: An Application of Psychoanalytic Theory," *American Imago,* 17:311-319, 1960.

26. Schneck, Jerome M. "Bibliotherapy for Neuropsychiatric Patients," *Bulletin of the Menninger Clinic,* 10:18-25, Jan. 1946.

27. Karpman, Ben. "Objective Psychotherapy, Principles, Methods, and Results," *Journal of Clinical Psychology* (Monograph Supplement, No. 6), July 1948.

28. Powell, J. W., *et al.* "Group Reading and Group Therapy," *Psychiatry,* 15:33-51, Feb. 1952.

29. Wilson, J. Watson. "The Treatment of an Attitudinal Pathosis by Bibliotherapy: A Case Study," *Journal of Clinical Psychology,* 7:345-351, Oct. 1951.

30. McCormick, Elsie. "They Can Be Talked Back to Sanity," *Today's Health,* 40:44, March 1962.

31. Robinson, Alice M. *Remotivation Technique.* Manual Available from APA —Smith, Kline, and French Laboratories, Remotivation Project, Box 7929, Philadelphia, Pa.

32. McCormick, *op. cit.,* p. 45.

33. Tews, Ruth M. "Case Histories of Patients' Reading," *Library Journal,* 69:484-487, June 1, 1944.

34. Tews, Ruth M. "The Patients' Library." *In* Thomas E. Keys. *Applied Medical Library Practice.* Springfield, Ill., Charles C Thomas, 1958, pp. 57-134.