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Poetry therapy: An investigation of a multidimensional clinical model☆

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ABSTRACT

The tripartite practice model for poetry therapy developed by Mazza (2003) is composed of receptive/prescriptive, expressive/creative, and symbolic/ceremonial modes (RES). The structure of this model was investigated by means of an online survey of therapists across disciplines. Analysis of the data collected supported the components of the RES as a suitable framework for describing the range of language arts-based methods used therapeutically, and for classification of therapists in relation to this application.

Poetry and other literary genres have been used both formally and informally in healing capacities in the United States since the early 19th century (Mazza, 1999). Although poetry therapy was formally recognized in 1969, to date there has been little systematic investigation of its differential use and treatment effectiveness (Heimes, 2011; Mazza, 2003; McCulliss, 2011a). In keeping with ethical and clinical standards it is imperative to investigate the extent, specific methods, strengths, and limitations of the differential use of poetry therapy. Heimes (2011), in an extensive review of poetry therapy research, found that most studies appeared in the fields of psychiatry, psychotherapy, and psychology; however, it was also noted that poetry therapy was present in a wide range of contexts (e.g., cancer treatment, addictions, and geriatrics).

The use of poetry and a variety of poetic methods (e.g., metaphors, journal writing, letter writing, and ceremonies) in health and mental health disciplines has been widely reported in the professional literature (Chavis, 2011; Mazza, 2008; McCulliss, 2011a). The gap in the literature, however, is a systematic investigation of the use of poetry therapy methods with respect to professional discipline, theoretical orientation, client characteristics, problem/disorder, treatment modality (i.e., individual, couple, family, and group treatment), and stage of treatment.

Based on the best available evidence, Mazza (1999, 2003) developed a three-component, multidimensional poetry therapy practice model. The first component, receptive/prescriptive (R/P), involves the introduction of already existing poetry (or other forms of literature) in a therapeutic context. The purpose could include validating a feeling, promoting self-disclosure, and advancing group discussion. Of course, the timing and selection of poetic material must always be considered (Chavis, 2011; Hitchcock & Bowden-Schaible, 2007; Rolfs & Super, 1988). The second component, expressive/creative (E/C), encourages client expression through a number of writing methods (e.g., poetry, letters, journals, and stories). Various individual and group exercises can be used for clinical/health purposes. They might act as a safety valve to express feelings, provide a sense of order and control, or promote group process variables such as cohesion. There is existing research by James Pennebaker et al. on the positive effects of expressive writing on physical and emotional health (Lepore & Smyth, 2002; Pennebaker, 1993). L'Abate and Sweeney (2011), and the contributors to their edited text, offer an extensive review of the research basis for the therapeutic aspects of writing as it relates to mental health. The third, the symbolic/ceremonial (S/C) component, uses metaphors, rituals, symbols, storytelling, and performance (for example, dance or movement) as a means to deal with life transitions; for example, a ritual to deal with death and loss (Mazza, 2003). Mazza's integrative model of poetry therapy, consisting of these three components (receptive/prescriptive, expressive/creative, and symbolic/ceremonial) will henceforth in this article be referred to as the RES model. The model offers a structure for the study and understanding of this realm of clinical practice.

Purpose of the study

The conceptual base of the RES model of poetry therapy encompasses not only poetry therapy in the traditional sense, but also other related disciplines and methods that utilize language arts in some form or another (Chavis, 2011; Gladding, 2010; Mazza, 2009). Thus bibliotherapy, journal therapy, narrative therapy, expressive arts therapy generally, and even music, dance, art, and drama

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therapies fall within the boundary of the RES multidimensional model. Because of this diversification within the broad field of poetry therapy, it would be reasonable to expect that these different disciplines might exhibit a focus on one component of the practice model such that empirical support for the distinction between one discipline and another can be derived from an exploration of practitioner usage of the components. For the purpose of further refinement of the RES model, the current study examines data collected via an online survey of clinical practitioners.

To date, little exists in terms of empirical support for the use of poetry therapy in clinical practice, yet its use in its various forms is relatively widespread, as evidenced by the existence of organizations providing forums for practitioner association, dissemination of ideas and evidentiary support, and the training and licensing of practitioners. In the current climate of eclecticism and the integration of approaches, it would also be reasonable to expect general practitioners to incorporate one or more versions of poetry therapy or its related disciplines into their practice. Collecting practice data is, however, a complex undertaking, and a subsidiary purpose of the current study was to test the feasibility or practicality of protocols suggested for web-based surveys, for which response rates in excess of 50% have been reported, with higher percentages found when e-mail requests were combined with traditional mail (Couper, Traugott, & Lamais, 2001; Dillman, 2000; Dillman, Smyth, & Christian, 2009; Groves et al., 2004).

Specific aims

Therefore, this current study will begin the process of accumulating socially significant interdisciplinary research that seeks to bridge the divide between "art" and "science" in the interests of health and healing.

Mazza's (1999, 2003) multidimensional poetry therapy practice model was developed on the best available evidence that supported each dimension. Much of this evidence was from anecdotal reports, case studies, and qualitative research. The strongest empirical support was drawn from related studies on the health benefits of expressive writing (e.g., Pennebaker, 1993; Pennebaker and Chung, 2007; Tegner, Fox, Phillip, & Thorne, 2009) and bibliotherapy (Hebert and Furner, 1997; Hynes & Hynes-Berry, 2012; McCulliss, 2011b; Olsen, 2007; Rossiter & Brown, 1988). The current study seeks to clarify terminology that has remained a problem in examining the research and practice base of poetry therapy. For example, bibliotherapy with a primary emphasis on the receptive/prescriptive component, has in some instances been considered synonymous with poetry therapy. It was hypothesized that there would be identifiable differences in the components of the tripartite model utilized by different categories of therapists employing some form of language arts in a therapeutic context. This and future studies will also explore the use of the model by practicing therapists.

Method

In an ideal research world, equal access to all practicing licensed clinical social workers would be assured. The reality in this regard, as this study discovered, is far from desirable. With the limited budget available, one of two concurrent preliminary tasks was to compile a database of practitioners to whom invitations to participate in an online survey could be e-mailed.

Procedure for acquiring e-mail addresses

No single source exists which records and makes available contact information for all practicing licensed clinical social workers and related practitioners in the United States or the other countries included in this study. Furthermore, the sources of such information that do exist are not equally accessible to researchers. Some organizations will allow various levels of access to their member contact lists, but often at a price which ruled out their use for the present study. The consequence was that the size of the total population of practitioners was unknown, which in combination with an inability to achieve equal access to them all, made probability sampling impossible. The study was, therefore, always going to rely on some kind of convenience sample, based on however many practitioners the team could acquire e-mail addresses for. The steps taken to compile a mailing list were as follows:

1. A Google search was initiated using, separately, the search terms "poetry therapy," "bibliotherapy," "expressive arts," and "expressive writing."
2. For each search, links were followed to the websites of organizations and individual practitioners or practices that fell under the umbrella of therapy using one or more of the three different approaches to the use of the written or spoken word (the RES practice model). Only included were organizations and practices in the following English-speaking countries: USA; UK (England, Scotland, Wales, and Northern Ireland); Republic of Ireland; Canada; Australia; New Zealand; and South Africa.
3. Links to relevant sites were bookmarked, and contact information recorded and listed (mailing address, uniform resource locator (URL), phone number, and e-mail address).
4. Links given on each website were followed, repeating steps 2, 3, and 4.
5. When the process ceased to yield a significant number of new relevant websites, the search was terminated.
6. Each organization or practice listed was contacted to establish the number of professional members or practitioners.
7. Member lists were requested for the purpose of e-mailing invitations to take part in the online survey about poetry and related therapies.

The organizations thus identified fell into five broad categories of usefulness to the study:

a. Non-responders.
b. Those for whom membership in the organization allowed the member to access the e-mail addresses of the members for purposes that included research, or whose member contact information was freely available on the organization website.
c. Those for whom contact with members was available for purchase. The organization would distribute the invitation to participate in the survey to whatever quantity of the membership we paid for. This avenue could have provided rapid and extensive access to large populations of practitioners, but the cost would have run to tens of thousands of dollars and hence was prohibitive in this exploratory study.
d. Those who expressed an inability to assist us in the way we requested, due to stringent data protection laws or anti-SPAM rules. Some of these groups, however, offered to help by distributing the invitation to participate via electronic newsletters, listserves, or online groups, or by e-mailing their membership on our behalf.
e. Those for whom e-mail contact information was not available under any circumstances.

In addition to the steps taken above, a further Internet search was conducted in an attempt to locate directories of licensed clinical social workers or therapists within the United States, for which e-mail addresses were included in the contact information. Keywords used for this search were 'therapist' and 'directory'. The final potential database arrived at by all methods consisted of