Development of Therapeutic Skills

Edited by Mary Jo Trapp Bulbrook

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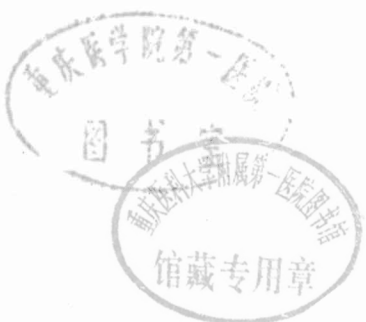

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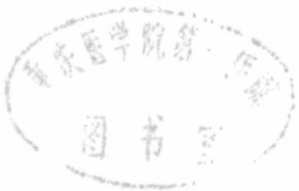

Preface

As an educator and practicing mental health clinician, I am dedicated to facilitating the development of competent psychotherapists working in any area of clinical contact. Within the diversity of our professions lies a common concern with the *process* and *content* of self-development. Yet in eight years of teaching it has become apparent to me that students have as much difficulty bridging the gap between exploring their own development and guiding others to profit from self-examination as they do relating practice to theory. This book illustrates how some real people learned to use consciously discovered personal strengths in psychotherapy with others.

The literature on psychotherapy is extensive and varied. In addition, many different professions offer therapy based on a variety of theories, thus creating confusion as to how one develops skill in providing psychotherapy in different settings. I believe that no one professional group has *the* correct approach. Rather, every therapist in training—whether nurse, physician, social worker, psychologist, counselor, minister, or educator—must examine and select from the entire range of viewpoints on the theory and techniques of psychotherapy.

But one does not become a skilled psychotherapist merely by analyzing theories or accumulating clinical hours. On the contrary, an existential growth process must take place through conscious self-examination in relation to the effectiveness of the therapeutic encounter. Even in those therapies that minimize dynamic use of the self, an existential integration is still required for the therapist. *You cannot eliminate process from learning content in psychotherapy.* Those who do not achieve the integration remain merely technicians, unable to utilize their own personal resources in creative problem-solving.

This book is intended for beginning professionals interested in development of self as the therapeutic catalyst. Consequently, the book can be used profitably by nurses, physicians, counselors, social workers, psychologists, and ministers as they

attempt to apply their professional expertise to help persons deal with the problems of life through the therapeutic process.

I would like to acknowledge the invaluable help of Barbara Thurmond, Stephanie Holm, and Rose Ann Janner, students, and Patricia Cain, Billie Jean Robinson, Linda Matthews, and Louise Lastelich, graduate students, all of the Texas Woman's University College of Nursing. I would especially like to extend my thanks to Mary Nell Robertson for her participation in this effort. Mary Nell is a former client and was kind enough to share her experiences as a consumer of mental health care with us. This book is really about and for people such as Mary Nell.

M.J.T.B.

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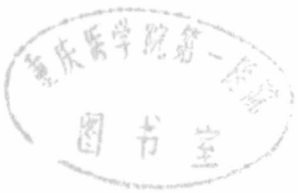

Contents

1 *Becoming a Psychosocial Nurse*

MARY JO TRAPP BULBROOK

BECOMING A THERAPIST

Early childhood memories are difficult to recall and emerge very slowly. I remember being five years old, standing in the large lot behind our white frame house – I was happy, singing to myself, and very observant of nature, the sky, and trees. I experienced oneness with nature, but not alienation from people. My sister, three and a half years older, was with her friends while I was off by myself: part of the world, yet in control of my own life space.

Mom was at home busy with the routine of housekeeping. Dad was at the gas station in front of our home, maintaining his traditional role as breadwinner, minding the station from 7 A.M. to 6 P.M., six days a week, and 8 to 10 A.M. on Sunday.

Spotty, my "Heinz 57" puppy, who was an important life companion for 10 years, was ever at my side, offering licks and tail wags to soothe a little girl's hurts and pains. From him and my other pets, and from being an astute observer of nature, I developed a keen ability to relate genuinely and spontaneously to strangers, friends, and family.

I remember fun times of playing "dress-up," one of my sister Carolyn's and my favorite pastimes. Dad would take his girls from room to room pretending we were out on the town. Fun times were simple. Money for "extras" was scarce. Many sacrifices were made to provide proper food, shelter, education, and health care. And love was there. We didn't directly ask for love, but expressions of love were given freely.

Dad is a great philosopher and has many favorite sayings. Both he and Mom recognized the responsibility of parenting, but they oftentimes felt unprepared for the tremendous task of caring for two children. However, as they will state today, "We did the best job we could, given what we are and what we had." This philosophy, which I adopted, permeates my life, and I in turn pass it on to my own children and my students.

When I was about seven years old, I had to decide whether or not to cross the busy street and buy some candy at the neighborhood store. I saw the cars zoom by and heard Dad's command, "Don't cross the street or you will get a spanking." I weighed the alternatives and decided a spanking lasted for only a few minutes and I did really want some candy. I decided to accept the consequences of my behavior and cross the street. The cars screeched to a stop and Dad came to deliver the consequences. This event typified a pattern in my young life that still holds true. I hear authority, evaluate for myself the implications of my behavior, make my own decisions, and accept the consequences.

Some of the values that I absorbed from these early experiences with my parents and that influenced my early life were: (1) work hard; (2) take care of yourself and others; (3) follow the teachings of your religion; (4) do what the Church and parents tell you to do; (5) obtain a good education; (6) acquire pleasing social values; (7) be critical; (8) appreciate that families are important; and (9) be good and honest.

Religion was one of the most important early influences in my life. But at that time in my life I did not question the values taught by the Church. I learned about sin and guilt and was taught to listen to and respect others. I still incorporate the Christian value to do good for others, and follow the teachings of the Catholic Church.

Grammar school and high school were really dormant periods for me. There was more self-imposed aloneness, good achievement in school, constant boredom in the summer, and a longing to be and do something. Expressions of creativity were limited to dress and hair. Singing, clowning, and drama filled the void of monotonous sameness. Reading and concentration were difficult, but the source of the problem was not identified until college, and then quite accidentally. I discovered a genetic problem that had left me neurologically imbalanced, which was at times reflected in my problems with reading and concentration. However, years of study and self-discipline have compensated for the difficulty.

The above problem hindered significantly my accomplishments and success in school. At times I would be an "A" student, but then would come up with "Cs." Only when my creativity was rewarded would I achieve an "A." The right side of my brain, which controls creativity, had not been affected. To this day I do not know why. The fact that my creativity was pleasantly rewarded led me as a therapist, teacher, and mother to

encourage the development of creativity in others. I believe creativity is a unique and wonderful gift.

At this particular point in my life, life happened to me. I was made unhappy or happy by what was done to me. Many times I did not feel "OK" and was very sensitive to criticism and lack of approval. I began to observe the discrepancies between what significant others said and did, and what they expected of me. An intolerance of inconsistency and ambiguity developed. Negativism predominated and loneliness was deeply felt. I gained relief by turning to nature, music, and animals.

My dating schedule was normal. At times I became very disenchanted with the frivolous "Let's have fun today and to hell with tomorrow" attitude. But at times I did evaluate relationships according to the superficial guidelines in vogue. Frequently I checked with my friends as to how they interpreted religious teaching on boy/girl relationships. The terms and descriptions used to provide guidance seemed vague, and there appeared to be much talking around the problem. The groundwork was laid for my later attention to what was practiced as opposed to what was said. Frustration arose from all these "double" messages. Student nurses in the all-girl private college I attended had busy work and study schedules. I remember those days primarily as ones of preparation for a career. Again life happened to me — not I to life.

Significant change came toward the end of my junior year when I began psychiatric nursing. I was not prepared for what happened to me — my life's foundation began to shake. I experienced extreme confusion over who I was, what nursing was, and where I fitted into the picture. I even contemplated leaving the whole field of nursing. I wanted to fulfill my obligations as recipient of a National Institute of Mental Health grant but felt that nursing must not be for me. I sought advice from my family, friends, teachers, the director of the nursing program, and the president of the college. All gave me conflicting advice, resulting in intense confusion and physical stress.

I decided to ignore the pain and maintain my course of study in psychiatric nursing until I had a better sense of direction. I immediately experienced extreme relief when the psychiatric rotation was over, and the next day I had my answer — pediatric nursing. The children captured my head and heart, and I felt I had found my area of interest.

Upon graduation with a bachelor's degree in nursing in 1966, I worked at Cincinnati Children's Hospital. I had decided I had enough nursing education but still wanted to go to school, which

I enjoyed immensely. I decided to combine my two interests and began studying Montessori education with a teacher who was a student of Maria Montessori. I now had additional knowledge of preadolescent growth and development based on a keen awareness and observation of the emerging personality of the child.

The year from September, 1966 to September, 1967 was busy. I completed my master's degree in Montessori education, worked fulltime at Children's Hospital, got married, and moved to Texas at age 23. Until that time I had spent most of my life in Ohio with my parents. When I kissed my parents good-bye and jumped into the car, I became overwhelmed with the impact of my decision. The bird had finally jumped out of the nest. I felt I was in the air alone, my nest gone.

The following year constituted a period of reeducation. I sorted out the parental and school-taught values and began to find out who I was. Luckily, I married a man who encouraged my personal development at this time, which included continuing education, working on a doctorate, working full-time, and developing close, intimate friendships. My old pattern of aloneness was being undermined. I worked as an instructor in nursing, teaching fundamentals, pediatrics, and obstetrics. New fields of nursing and knowledge intrigued me.

In 1968, through the encouragement of a friend, I went back to school. I had become bored with work and wanted something more. Then I met Dr. D. He expanded my thinking to theory development and a whole new world of process relationships/energy exchanges. I now knew I had to free my intellect: Ideas were the lost piece in the puzzle necessary to put Mary Jo together.

For three years I cautiously tested a renewed interest in psychiatric nursing, despite memories of extreme pain in nursing school. Luckily, I had a colleague who shared my interest and I informally learned psychiatric nursing from her. We discussed in detail concepts in psychiatric theory and practice, and I tested my ideas for clarity.

I did not realize until later, after experiences with both undergraduate and graduate psychiatric nursing students, that anyone studying psychiatric content must automatically investigate their knowledge of their own life. In other words, *one must first determine one's own psychological growth and development before determining it in others.*

Having now gained enough confidence in myself, I started graduate nursing, with clinical psychiatric/mental health nursing

as my doctoral theme. Again, getting through the content was painful. It didn't immobilize me this time, however, and I could learn and achieve. I embarked on a painful three-year struggle to learn those strengths and weaknesses that enhanced or hindered me as a person, therapist, and teacher.

It was during this period that I became aware that I had an unusual talent with people. Patients and staff responded very favorably to me, although at times the staff seemed uncomfortable. A psychologist once told me that I was so direct and open that I sometimes frightened them.

My first parenting experience in 1971 coincided with this formal academic interest. Although it was a great experience, it took me two years to fully integrate motherhood into my life. I had performed all the roles of a mother, but it wasn't until in my second year that I knew I had accepted this identification.

This new, independent Mary Jo as a mother was unfamiliar to me and those who knew me. My parents, parents-in-law, and other family and friends criticized and wondered. They frequently forced me to compare my values with theirs: "You should stay at home; be a housewife; take care of kids; your place is in the home; women don't need to use their brain; working should not be so important; your role is second to your husband's."

The process of clarifying my beliefs about myself and living an integrated life was challenging and stressful, but I was overjoyed at my new me and sad that many of those from my past couldn't or wouldn't accept this new person.

The new me now saw a need to clarify my new beliefs. I pursued who I was and what I wanted to be, and accomplished many things. And I now had the courage to never look back.

My first baby was doing great. He was and is a happy, intelligent child. As a result, my parents accepted that I really could handle motherhood/wifehood/personhood and a career all at one time, and the pressure to conform ceased. When my second son arrived, there was no need to restate my position.

I compared my life style with what I read, mainly to see where I fit. Important relationships developed among colleagues in teaching and clinical practice, and with my students.

Then one day Virginia Satir walked into my life and I added a new and important piece to the mosaic that was Mary Jo. I liked everything she said and did as I experienced her therapy with others, as an outsider first, then in training with her. From there I became involved in Gestalt therapy and discovered what was important, to me, as therapy.

PROFESSIONAL FACTORS IN BECOMING A THERAPIST

In my personal work experience I found I had a varying capacity for effectiveness, depending on whom I worked under. This puzzled me. I knew I didn't change that much and couldn't understand why I was more effective at some times than at others. This prompted an investigation into the use of power and authority and the effect of such use on the individual in an institution. Research brought out its effect on work, and highlighted the importance of analyzing communication and power in agencies. The next phase was learning how persons with different philosophies come together, work, and produce results effectively. Realization of this "unity in difference," led me to think about the physician-nurse relationship.

PHYSICIAN-NURSE COLLEAGUESHIP: EARNED AND LEARNED

> Collaborative practices with different disciplines contributing to patient care and treatment are being established in more explicit and formalized ways than previously . . . Changes on the part of the nurse from the past maintenance of a role predominantly dependent upon and subordinate to the physician to the present self-directed and colleague-sharing role have constituted a tremendous step in liberating the nurse to her full capabilities . . . Developing ways to achieve truly collaborative professional practices remains a problem and issue for study and research [1, pp. 10–11].

For me, existentialism provides the guidance to liberate the nurse to her full capabilities.

> Existentialism's first move is to make every man aware of what he is and to make the full responsibility of his existence rest on him . . . [2, p. 20]
>
> Existentialism is concerned principally with freeing man from his isolation and his anonymity, freeing his mind from the confusions that prevent him from seeing his situations and his powers . . . [3, p. 277].

In the spring of 1976 two experiences I had made me become aware that if nurse-educators are to prepare nurses to function as colleagues of physicians and other professionals, attention should be given to the process that enhances the development of colleagueship. My position is as follows: Genuine colleagueship is earned and learned, not imposed by authority. You can be a colleague in name but not necessarily one in behavior or respect.

The first experience occurred during one of my job interviews. The position emphasized the teaming-up of physicians and nurse-educators to prepare residents and registered nurses for

community mental health psychiatry. For this emerging field the university focused on core curricula common to doctors and nurses. The program was built on the assumptions that to function as a true team, colleagues must respect the contribution of each professional involved, and that this is achieved through successful communication. In addition, if we expect people to practice as colleagues they must first learn to study as colleagues and have appropriate role models.

The psychiatrist-director, one of the nurse-educators participating in the program, and I met to discuss the job offer. I shared with the psychiatrist my personal beliefs about psychiatry, psychiatric mental health nursing, research, and education. At no time did I try to say what I thought he wanted to hear. I had made up my mind that if we were to be a successful team from the beginning, there would have to be clear and direct communication between us before I accepted the job. I listened to his position on the same topics and had clarified for me what I misunderstood or what had not been clear. I left the interview with the comfortable feeling that we both had a clear understanding and accurate knowledge of each other's philosophy.

I was taken aback, but pleasantly so, when the nurse who witnessed the interaction exclaimed, "He really liked you and treated you like a colleague!" The nurse and I started to analyze the interaction to see what had actually taken place. Did my having a doctorate set the pace? It may have, but I believe that what occurred had more to do with earned respect. We explored each other's belief system about what works in psychiatry, and did not attack one another. We were equals trying to understand each other. The degree opened the door and produced a willingness to listen, but the "paper credentials" are soon forgotten if substance doesn't follow.

If we as nurses want to be treated as colleagues, we must know what we are talking about and not depend only on credentials. For some whose knowledge base was obtained elsewhere, all the credential offers the individual is confidence in her own worth as a contributor to the health team. As professionals we must look to humanness in establishing a baseline for earned respect.

The next experience came two days later. For the past eight months I had worked in what was a new setting for me: the Veterans' Administration Hospital, with undergraduate nursing students. I was very frustrated in the beginning at not being an equal on the health team and not able to use my clinical specialization in psychiatry. The students and I were the "visitors," the "guests" in the clinical agency. (To digress briefly: I'm not sure

that educators in a clinical setting don't set themselves up to be outsiders and not colleagues. A colleague on a health team must have knowledge and successfully communicate it to others. Perhaps what they are unconsciously saying to the agency is "Well, here I am, with all this wonderful expertise. Now you must accept me and fit me into the system the way I want to be fitted into the system." This attitude should be searched for and examined if found.)

For two months I tried to set up a group therapy session based on my treatment beliefs in order to provide a role model for the students. The students were seeing only the medical model group experiences, and I wanted them to experience *reality-oriented Christian Gestalt existential therapy* (*ROCGET,* pronounced "rocket"). Despite all my efforts, I was not successful. Finally I said to myself, "Dammit, you are doing something wrong. Regroup, and use your head to figure out how to accomplish your goal!" I decided that perhaps I hadn't earned the respect from my medical colleagues that would allow them to give me the opportunity to utilize my skills. I stopped playing the game "Gee, look what I can do. Why don't you let me do it?" I decided to see if what I did was what they needed and could accept. The question became: How do two philosophical positions meet to accomplish the task of therapy? Perhaps my lack of success originally stemmed from not utilizing my knowledge as a ROCGET therapist from the beginning. When your knowledge and behavior are not integrated you have not maximized your contribution.

In the group the psychiatrist behaved like a humanist even though in group therapy he lectured on Freudian concepts of mother-child relationships, the Oedipus complex, castration worries, and so on. Over a period of several months the psychiatrist and I informally created a strong relationship based on a mutual caring, for both patients and students. Our informal dialogues centered around each other's beliefs about people, treatment, the medical model versus existential models, and education. We began to really understand and listen to each other.

Once this communication pattern was established, we moved into the next phase of the relationship. The two of us participated in group therapy for four months with the nursing students and patients. The psychiatrist took the lead for the group, using the medical Freudian model. The students began to question him after they participated in the group, trying to understand and make sense of the lecture material he was giving during group sessions.

At this point it occurred to the psychiatrist that if my students didn't understand his lecture with its psychoanalytic content, what good was it doing the patients? One day he came to me and asked what could be done to improve group interaction. I felt that the time had now come for me to demonstrate my belief system. Our relationship was firm, and it would not be threatening to him to take professional advice from a nurse. I very candidly said, "The patients who are getting well in your group do so because of your humanness – what you are, not what you say. If you would stop lecturing them and let this quality come through, I believe you would see what I mean."

He responded favorably to this directness. Next I had to help him free himself from his "doctorness" and allow the humanness to emerge and take the lead. I accomplished this by being a role model for him. I began to conduct the group on the basis of my ROCGET therapy. My humanness joined his humanness and things began to happen. All at once the patients who met for half-hours began staying one-and-a-half hours and had to be told to leave. Many patients were talking, and the group moved exceptionally fast. Although the psychiatrist participated, I could tell that essentially he was watching my techniques.

Several weeks later I gave him a copy of *Why Am I Afraid to Tell You Who I Am* by John Powell. The next group session after he had read it, he immediately began to conduct the group as a humanist, using the style described in the book. It was as if it had all suddenly clicked for him.

The students couldn't get over how he had changed. Soon our particular treatment style – person-to-person therapy (PTP therapy) – emerged. We had reached genuine colleagueship. I was more skilled with psychotic patients and could also introduce femaleness to the interaction. We were truly a PTP therapy team – male and female – for the patients to relate to. At times we would disagree with each other. Sometimes I would team up with the patients to give them strength to negotiate with the psychiatrist.

As time went on we grew and refined our PTP therapy model. And there was a beauty in our professional relationship from which I experienced tremendous personal satisfaction. The therapy model was born from our contact, a unique way to advance science. Now a scientific base for the PTP therapy model must be developed.

I was also interested in investigating further the colleagueship we had achieved. Two independent and strong-willed individuals, each espousing a very different therapy model, met, achieved