Bibliotherapy: An Approach to Treating Mental Illness in the Classroom

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A Senior Thesis submitted in partial fulfillment
of the requirements for graduation
in the Honors Program
Liberty University
Fall 2014

Acceptance of Senior Honors Thesis

This Senior Honors Thesis is accepted in partial
Fulfillment of the requirements for graduation from the
Honors Program of Liberty University.

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Abstract

The prevalence of adolescent mental illness has increased at an alarming rate over the past two decades.  Due to a lack of accessible mental health care and the stigmatization of mental illness, parents of children with these disorders are often reluctant to seek help. These children often resort to negative self-coping methods among which include substance abuse, violence, and suicide.  These negative self-coping methods have a harmful, lasting impact on the individual as well as the surrounding community.

Bibliotherapy, which harnesses the meditative power of books, can teach helpful coping skills to students with mental illness.  When effectively utilized in the classroom, teachers can provide therapeutic strategies for students with mental illness.  This leads to a healthier classroom environment for the student, their facilitators, and their peers.

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**Introduction**

The tragic event that took place on April 20, 1999, left 15 people dead and the community of Littleton, Colorado in shock (Larkin, 2007).  Dylan Klebold, one of the perpetrators of the Columbine High School shooting, kept a journal of his thoughts prior to that infamous day.  The following is an excerpt, as annotated and transcribed by psychologist Dr. Peter Langman (2014):

> People are so unaware…. well, Ignorance is bliss I guess…. that would explain my depression. […] I don't fit in I've been thinking of suicide gives no hope, that I'll be in my place wherever I go after this life … that I'll finally not be at war with myself, the world, the universe – my mind, body, everywhere, everything at PEACE in me – my soul. & the routine is still monotonous, go to school, be scared & nervous, hoping that people can accept me. (p. 1-2)

As revealed in his writing, Klebold was not in a sound state of mind prior to the tragedy. Professionals go as far to indicate that Klebold may have suffered from schizotypal personality disorder (Langman, 2009).  Had his disturbing behaviors been recognized as such by teachers or school administrators, perhaps intervention and support in the classroom could have helped Klebold, thus thwarting his turn to violence.

Since Columbine, numerous incidents involving equally as troubled students and similar outcomes have taken place across the country (Schildkraut & Hernandez, 2014). Society cannot remain complacent on this issue any longer.  Measures must be taken to

ensure that students displaying disturbed thoughts and behaviors are not left with the opportunity to hurt themselves or others.

If not provided with adequate resources and support in all areas, including social and psychological development, children with mental illness and their families are left to navigate life seemingly on their own.  When children with mental illness attend school without support or treatment, their behavior can ultimately affect their peers and teachers in the classroom.  As a result of their actions, these children are usually treated differently by their fellow students and educators, often leaving them to feel ostracized and alone (Friend, 2011).  Instead of reaching out for help, children and adolescents with mental illness often turn to negative self-medicating and self-coping methods.  This results in high rates of substance abuse, crime, homelessness, and suicide (Markowitz, 1998).  Action must be taken in effort to help these students so that they better understand themselves and the world around them.  Bibliotherapy in the inclusive classroom environment is a potential answer.

## Defining Mental Illness

Approximately 20% of youth ages 13 to 18 experience some sort of severe mental disorder each year (Duckworth, 2013).  Mental illness can be a life-altering and incapacitating disease that affects not only the individual, but their family and community as well.  According to Mental Health America, "mental illnesses are serious medical conditions, just like cancer or diabetes, that can have a dramatic impact on a person's life, family and community and on society as a whole – and they can be tremendously debilitating" (Aguilar-Gaxiola, 2013, p. 1).

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders*, as cited by Stein, Phillips, Bolton, Fulford, Sadler, and Kendler (2010), proposes the following definition of mental and psychiatric disorders:

A behavior or psychological syndrome or pattern that occurs in an individual, the consequences of which are clinically significant distress (e.g., a painful symptom) or disability (i.e., impairment in one or more important areas of functioning); must not be merely an expectable response to common stressors and losses (for example, the loss of a loved one) or a culturally sanctioned response to a particular event (for example, trance states in religious rituals); that reflects an underlying psychobiological dysfunction; that is not solely a result of social deviance or conflicts with society; that has diagnostic validity using one or more sets of diagnostic validators (e.g., prognostic significance, psychobiological disruption, response to treatment); that has clinical utility (for example, contributes to better conceptualization of diagnoses, or to better assessment and treatment). (p. 9)

It is important to understand that no definition perfectly encompasses all of the possible aspects of mental illness (Stein, Phillips, Bolton, Fulford, Sadler, & Kendler, 2010). Professionals believe that the onset of mental illness is an unfortunate and complicated mix of biological and psychological factors (Friend, 2011). Neither nature nor nurture is more responsible for the development of emotional and behavior disorders; both factors play a dynamic role. Biological factors may include inherited genes and brain injuries (Kopp & Beauchaine, 2007). Psychological factors may include chronic stress, stressful

life events, childhood maltreatment, and additional family factors (Wagner, Kutash,

Duchnowski, Epstein, & Sumi, 2005).  Due to the interwoven forces of nature and

nurture, it is often difficult to pinpoint the exact cause of the disease.

As with any disability, a student who is eligible for accommodation through the

public school system must exhibit certain characteristics and behaviors, indicating the

exceptionality and a need to address it.  These characteristics are explained in the

Individuals with Disabilities Education Act or IDEA (2004).  According to IDEA (Code

of Federal Regulations, Title 34, and Section 300.7(c) (4) (i), emotional and behavior

disorder is defined as the following:

> …a condition exhibiting one or more of the following characteristics over a long
>
> period of time and to a marked degree that adversely affects a child: an inability
>
> to learn that cannot be explained by intellectual sensory, or health factors; an
>
> inability to build or maintain satisfactory interpersonal relationships with peers
>
> and teachers; inappropriate types of behavior or feelings under normal
>
> circumstances; a general pervasive mood of unhappiness or depression; a
>
> tendency to develop physical symptoms or fears associated with personal or
>
> school factors. (Individuals with Disabilities Education Act, 20 U.S.C. § 1400,
>
> 2004)

Specific mental illnesses categorized under this definition include, but are not limited to,

depression, dissociative disorder, bipolar disorder, anxiety disorders, borderline

personality disorder, panic disorder, obsessive compulsive disorder, posttraumatic stress

disorder, schizoaffective disorder, and schizophrenia (Friend, 2011).

**Signs and Symptoms**

According to the American Psychiatric Association (2014), several continuous symptoms must be observed over a long period of time in order to a student to be considered as living with a mental illness.  One or two symptoms is not enough to raise serious concern.  These symptoms can include, but are not limited to:

Recent social withdrawal and loss of interest in others; an unusual drop in functioning, especially at school or work, such as quitting sports, failing in school, or difficulty  performing familiar tasks; problems with concentration, memory, or logical thought and speech that are hard to explain; heightened sensitivity to sights, sounds, smells or touch; avoidance of over-stimulating situations; loss of initiative or desire to participate in any activity; apathy; a vague feeling of being disconnected from oneself or one's surroundings; a sense of unreality; unusual or exaggerated beliefs about personal powers to understand meanings or influence events; illogical or  "magical" thinking typical of childhood in an adult; fear or suspiciousness of others or a strong nervous feeling; uncharacteristic, peculiar behavior; dramatic sleep and appetite changes or deterioration in personal hygiene; rapid or dramatic shifts in feelings or "mood swings." (American Psychiatric Association, 2014, p. 1)

Troublesome behaviors (e.g. despair and hopelessness, lack of interest in family, friends, or activities once considered enjoyable, and even violent tendencies) that do not subside or progress into a new stage are all signs of a possible mental illness (Jordan, 2013).

Students suffering from these diseases can be difficult for educators to work with in the classroom. Children with mental illness can be disruptive, impulsive, inattentive, resistant to change, aggressive, and manipulative. These students often lack concentration, have low self-esteem, display self-injurious behavior, and struggle working in groups (Bambara, Fogt, & Kern, 2002; Burrello & Wright, 1993; Culpepper, Kamps, Wendland, 2006). In addition, they are often withdrawn; they may be excessively teased, verbally or physically abused, neglected or avoided by their peers (Friend, 2011). These behaviors can make the classroom environment unhealthy, chaotic, and ineffective. By providing supports for the child with mental illness, their behavior and performance could progress, thus improving the overall classroom environment.

**Prevalence**

Society usually typecasts children displaying these behaviors (e.g. impulsive, inattentive, and aggressive) as intentionally bad or attention seeking (Byrne, 2000). Rather than punishing these students, steps should be taken to determine if there is not an underlying cause for the abnormal behavior. An individual labeled by this stereotype could possibly be living with a mental illness. The Centers for Disease Control and Prevention states that approximately 8.3 million children, ages 4-17, have mental health concerns (Simpson, Cohen, Pastor, & Reuben, 2008). More importantly, research suggests that prevalence of childhood mental illness is increasing (Perou, Bitsko, Blumberg, Pastor, Ghandour, Gfroerer, & Huang, 2013). It is estimated that approximately 13-20% of school age children and adolescents in the United States live with some sort of mental illness (Perou et al., 2013). Among them, nearly four

million children and adolescents live with a serious mental disorder that causes significant functional impairment in several areas of their life. It is estimated that at least 21% of children and adolescents age 9-17 have a form of mental disorder that causes at least minimal impairment (United States Public Health Service, 1999). These statistics indicate that there is an increased probability of a teacher having student one or more of these students in the classroom. This alone should be alarming enough to capture society's attention.

## The Reality of Childhood Mental Illness

Children are being mainstreamed untreated into the classroom because of the gaping hole in accessible mental health care. When students are mainstreamed into the classroom without support, they are treated differently by their peers and virtually ostracized because of their behavior. Parents, teachers, and professionals are often at a loss as to how to help their children. As the child suffers, the rates of school shootings, suicide, substance abuse, and dropping out continue to rise.

### Understanding the Mental Healthcare System

Recognition, diagnosis, and the treatment of children with mental illness dates back to the late 1800s (Friend, 2011). In 1924, the American Orthopsychiatric Association was founded to study information on childhood illness. It was not until the mid-1950s that behaviorists proposed that emotional and behavioral problems were learned and could be changed by teaching more appropriate behaviors. During the 1960s there was an increase in medical focus for treating children with emotional and behavioral problems (Friend, 2011).

In the past, institutions were the main form of treatment for individuals with mental illness. Things shifted in the 1960s when the movement to deinstitutionalize people with disabilities and mental illness began taking off (Koyanagi, 2007). Patients were moved from larger government-run institutions, to smaller local mental health homes or mainstreamed back into the public (Public Broadcasting System, 2012). The number of hospital beds for patients with mental illness has decreased significantly. The number of state institution beds per 100,000 people went down from 339 in 1955, to 22 in the year 2000 (Lamb & Weinberger, 2005). While initiated with good intentions, this shift took place before an effective alternative for institutionalization was established. Deinstitutionalization has left mental health patients and their families to seek help from nursing and residential homes rather than from psychiatric hospitals. These nursing and residential homes are often understaffed, underequipped, and insufficient to meet the needs of individuals with mental illness (Novella, 2010). Furthermore, deinstitutionalization has left families of children and adolescents living with mental illness with virtually no support. Parents and families often lack the financial resources and knowledge of mental illness to provide adequate care for their child (Novella, 2010).

It is not difficult to see how inadequate mental healthcare is in the United States. America has shifted from hospitals that were often understaffed, underfunded, and in violation of human rights to an inadequate system that is very difficult to navigate or access (Lamb & Weinberger, 2005). More often than not, it does not matter if mental health services are provided because patients are too frightened and ashamed to seek services due to the stigma attached to mental illness (Rusch, Angermeyer, & Corrigan, 2005). In any given year, only 20% of children with mental disorders are identified and

receive mental health services (United States Department of Health and Human Services, 2000). In 2012, it was estimated that half of adolescents with mental illness and psychiatric disorders received no treatment (Duckworth, 2013). In addition to these problems, the over 11 million families who are affected by mental illness have no health coverage (Duckworth, 2013). According to the National Alliance on Mental Illness (2013), "uninsured persons are more than twice as likely to delay or skip medical care, leading to serious health issues, problems on the job, and use of emergency services or hospitalization" (p. 1). Health plan applications are often rejected for families with pre-existing conditions such as serious mental illness. The reality of the mental healthcare system is that even people with health insurance face unequal or no benefits for mental health or substance use care (Duckworth, 2013).

As mental health care falls behind, the prevalence of mental illness only continues to rise. The percentage of children who have been diagnosed with a serious mental illness has increased over the past twenty years. The Agency for Healthcare Research and Quality (as cited by Perou, Bitsko, Blumberg, Pastor, Ghandour, Gfroerer, & Huang, 2013) reported that "in 2010, mood disorders were among the most common principal diagnoses for all hospital stays among children in the United States, and the rate of hospital stays among children for mood disorders increased 80% during 1997–2010, from 10 to 17 stays per 10,000 population" (p. 2). Approximately 8% of adolescents aged 12–17 years reportedly had more than 14 mentally unhealthy days in the past month (Perou et al., 2013). Children are being diagnosed more and they are provided with less services. School systems are often left to deal with the fact they may be the only resource

available for children and their families.  It is necessary that teachers and administration

learn how to adequately provide for these students.

**Understanding the Stigmatization of Childhood Mental Illness**

Society often believes the misconception that individuals living with mental

illness are simply acting out (Byrne, 2000).  Children who display characteristics of

mental illness are labeled as attention hungry and are believed to be able to snap out of it.

What is difficult for society to realize is that these individuals cannot simply snap out of

it (Byrne, 2000).  People underestimate the severity of mental illness and the difficulty of

living with it.  According to Mary Hewitt (2003):

> Unfortunately, since students with emotional disabilities have an
>
> "invisible" handicap and look normal, there are some real myths
>
> surrounding the etiology of their disability and level of control they
>
> possess over their handicap.  Many people believe that they could control
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> their "problem" through the use of shear will power.  Since students with
>
> emotional disabilities frequently do not appear physically different, it is
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> difficult for many to view them as requiring the same level of specialized
>
> care as those students with visible handicapping conditions. (p. 34)

If a student has a physical ailment or impairment (e.g. cancer, diabetes, Down-syndrome,

a broken leg, etc.) it is often expected that care is provided and, more importantly,

empathy is shown.  Unfortunately, this is very rarely the case when it comes to mental

illness.  A continued misunderstanding and lack of treatment for children living with

mental illness only prolongs their negative behavior, impacting the classroom.

As disturbing behavior and violence exhibited by those with suffering with mental illness continues, so too does misunderstanding, ultimately perpetuating stigma. According to the American Psychological Association (2014), stigma is defined as "the negative reaction of people to an individual or group because of some assumed inferiority or source of difference that is degraded" (p. 1). Ignorance of mental illness breeds judgment, fear, and hate of the disorder.

As a result of widespread ignorance and misunderstanding, mental illness is often either vilified or romanticized by media and the general public. According to European Psychiatry, "Media analyses of film and print have identified three common misconceptions about people with mental illness: they are homicidal maniacs who should be feared; they are rebellious, free spirits; or they have childlike perceptions of the world that should be marveled" (Rusch et al., 2005, p. 530). These attitudes skew the reality of mental illness, further distorting society's understanding of individuals suffering from these disorders.

Stigma can be especially harmful to the development of mentally ill students. Fear and judgment often begin in the primary grades. As the student progresses, the stigma follows. This affects the student socially and emotionally. A student with mental illness is frequently avoided by neuro-typical peers, who often shun and bully them. As they grow, that stigma follows children with mental illness throughout their life, suffocating them socially and emotionally. Society has the tendency to disapprove of those with mental illness more often than those with other disabilities, simply because the mental illness is not a physical disability and thus cannot be seen (Hewitt, 2003).

If stigma is the belief then discrimination is the action that is the result of those beliefs. As a result of neuro-typically developing individuals' misunderstanding and lack of empathy, discrimination surfaces. According to Rusch, Angermeyer, and Corrigan (2005), discrimination is born from the following attitude:

> First, public stigma results in everyday-life discriminations encountered by persons with mental illness in interpersonal interactions as well as in stereotyping and negative images of mental illness in the media. Second, structural discrimination includes private and public institutions that intentionally or unintentionally restrict opportunities of persons with mental illness. (p. 532)

Mental illness is a dangerous cycle of the individual's disturbing behavior and society's misunderstanding and reaction to it. Prejudice experienced by individuals with mental illness yields anger and can lead to hostile behavior (Rusch et al., 2005). Abnormal behavior and violence breed a lack of understanding from the outside world. This furthers the stigma and the individual is left feeling shamed, fearful, and suspicious of seeking services. As with any exceptionality, once society begins to see an individual as their illness or as a problem, stereotypes, prejudice, and discrimination surface. According to Rusch, Angermeyer, and Corrigan (2005), "it is important to note that labeling often implies a separation of 'us' from 'them'. This separation easily leads to the belief that 'they' are fundamentally different from 'us' and that 'they' even are the thing they are labelled" (p. 530). In attempt to escape judgment and bullying from their peers, students suffering with mental illness sometimes turn to negative self-coping methods.

This can often lead to them dropping out of school or resorting to substance abuse, crime, and suicide (Markowitz, 1998). The New Hampshire-Dartmouth Psychiatric Research Center reports that "substance use disorder is the most common and clinically significant co-morbidity among clients with severe mental illnesses, associated with poor treatment response, homelessness and other adverse outcomes" (Brunette, 2004, p. 471).

As a result of being ostracized by their peers and feeling alone or helpless, many students living with a mental disorder give up on school completely. According to the United States Department of Education, it is estimated that nearly 50% of students 14 and older living with some form of mental illness drop of school. This is by far the highest dropout rate of any exceptionality group (Duckworth, 2013).

The most sobering statistic regarding childhood and adolescent mental illness is the rate of suicide. According to the National Institute of Mental Health, "suicide is the third leading cause of death for individuals age 15 to 24 years" (Duckworth, 2013, p. 1). It is estimated that over 90% of individuals who commit suicide lived with and suffered from some form of mental illness (Duckworth, 2013). The Center For Disease Control released information indicating that "the overall suicide rate for persons aged 10–19 years was 4.5 suicides per 100,000 persons in 2010" (Perou et all, 2013, p. 2). According to these numbers, there is no doubt that measures need to be taken to help the mentally ill.

**The Role of the Educator**

As the number of children and adolescents living with mental illness increases, so too does the number of these students in the classroom. It is crucial to provide educators with the tools and skills necessary to help these children.

From social and emotional development, to cognitive and academic ability, students with mental illness are some of the most difficult students to successfully teach and impact in the classroom.  As a result of the lack of understanding and support in the classroom, "outcomes for students who have emotional disturbance (ED) were the poorest compared to the other disability groups.  Results from studies revealed average academic achievement for these students were below the 25th percentile; they had the highest dropout rate compared to all disability groups" (Duchnowski & Kutash, 2011, p. 323).

The result of these students being mainstreamed into the classroom is that teachers are left to handle and assess the situation virtually on their own.  Doing so allows for a more effective, less chaotic classroom environment for all learners and educators.  Teachers are untrained on how to deal with students who have minor and severe mental illness.  In order to effectively assess the situation in their classroom, educators have to find alternative ways to teach so that the student develops adequately both academically and emotionally.  Teachers must be efficiently trained to administer simple therapeutic exercises throughout their accommodated instruction.  One of the alternative ways of teaching is the use of bibliotherapy.  Training educators in these strategies could provide effective treatment and therapeutic exercises for students with mental illness, as well as reverberate a healthier environment throughout the classroom.

**Defining Bibliotherapy**

Psychotherapy, otherwise known as "talk therapy," is an efficient tool utilized by professionals to treat mental illness (The National Institute of Mental Health, 2013, p. 1).

Well-known types of psychotherapy include Cognitive Behavioral Therapy (CBT),

Dialectic Behavior Therapy (DBT), Interpersonal Therapy (IPT), and Family-focused

Therapy (FFT).  Other, lesser known and utilized types of therapy may include

psychodynamic therapy, expressive or creative arts therapy, animal-assisted therapy, and

play therapy (The National Institute of Mental Health, 2013).

Falling under the umbrella of expressive therapy is bibliotherapy.  Bibliotherapy

is the treatment of psychological or emotional problems through the use of selected

reading materials (Russell, 2012).  This therapeutic approach works by presenting

individuals with material that teaches them that they are not alone and that their

emotional responses are perfectly normal (Russell, 2012).  This self-help approach to

mental illness and therapy originated in the early nineteenth century when Benjamin

Rush became one of the first Americans to recommend the use of bibliography:

"Reading was considered one of the best therapeutic measures in treating mental patients,

and by the middle of the nineteenth century every major mental hospital had a patients'

library; many were quite extensive" (Weimerskirch, 1965, p. 510).  When utilized

correctly and efficiently, books have psychological effects that can be beneficial to a

child's wellbeing, especially for those who live with mental illness.

When practiced, bibliotherapy has a psychological effect on the human brain.

According to Joan Reitz (2014), bibliotherapy occurs in three phases.  Bibliotherapy

nurtures a sense of wellbeing and allows individuals to feel good through the means of

reading.  As students read about and relate to characters they discover certain parts of

themselves and their own character that they did now know existed.  In the first phase,

the reader identifies him or herself with a particular character in the book. This causes

the second phase: a psychological catharsis, or release. It is during the second phase that

the reader experiences "rational insight concerning the relevance of the situation

suggested in the text to the reader's own experience" (American Library Association,

2014, p. 1). Bibliotherapy allows an individual with an emotional or behavioral disorder

to feel a connection with a character who experiences something similar to them. The

connection allows the reader to learn from the character, his or her behavior, and his or

her responses to certain situations, thus providing comfort to the student.

## Administering Bibliotherapy

### Inclusive Environment

In order to implement effective bibliotherapy in the classroom, a positive and

inclusive atmosphere must be established (Maich & Kean, 2004). One of the most

important characteristics that lead to the development of an inviting and appropriate

classroom environment include student-teacher and student-peer relationships built on

trust, respect comfort, and knowledge of one another (Maich & Kean, 2004). These

characteristics for the appropriate academic environment can be found in an inclusion

classroom setting. An inclusion classroom environment is one that provides students

who have special needs with reasonable accommodations and modifications so that they

can learn and thrive in the general education classroom alongside their neuro-typically

developing peers (Friend, 2011). In accordance with IDEA (2004), children with

exceptionalities who are fully capable of academically succeeding in the general

education classroom with reasonable accommodations and modifications are to be placed in the general education classroom under an inclusionary setting.

Inclusion is an academic and social atmosphere that leads to a sense of belonging within the classroom community.  According to Hewitt (2010), the inclusion classroom teaches awareness and nurtures understanding of differences, disabilities, and disorders. In addition, it teaches students with mental illness that they are worthy of a standard education and deserve the same quantity and quality of time and attention that typically developing students receive from teachers.  Inclusion is a positive and inviting alternative to self-contained classrooms.  Rather than separating students with special needs from their neuro-typically developing peers, the two demographics learn in the same environment.  According to Duchnowski and Kutash (2010), students with mental illness who were taught in an inclusion classroom were more likely to seek and receive mental health services.

Bibliotherapy has the potential to play a fundamental role in the treatment of mental illness but it must be implemented in the correct classroom environment. Mental illness can be very difficult to understand and to work with.  Students with mental illness can be extremely difficult in the classroom setting when they are not receiving proper and sufficient treatment.  Inclusion provides a healthy, positive environment for bibliotherapy to take place effectively.  As long as bibliotherapy is implemented correctly and effectively in an inclusion classroom setting, the next generation of students with mental illness have the opportunity to develop and progress in a welcoming and encouraging environment.

**Process**

Bibliotherapy can be administered at virtually any time of the school day and used with individuals, small groups, or the whole class. The treatment's versatility makes it easy to integrate into the inclusion classroom curriculum (Maich & Kean, 2004). School professionals report that "bibliotherapy sessions can take place as children arrive at school, during special activities, at silent reading time, as a part of library time, during lunch, or just before it is time to leave for the day" (Sullivan & Strang, 2003, p. 76). While it can be incorporated in many different ways and times throughout the school day, it is crucial to administer bibliotherapy when students are in a calm environment and in a reflective attitude.

The educator should choose material that contains ideas or themes similar to the student's personal situation. The educator must fully understand both the selected material and the student and how the two relate to one another. While administering treatment, the educator must maintain active dialogue with the student to assess their understanding and interpretation of the material. In addition to discussion, teachers should "allow the children to engage in expressive activities, such as drawing, role-playing, or writing, so that each child has the opportunity to share his or her feelings" (Sullivan & Strang, 2003, p. 77). During the past few years, there have been more books and movies released on these topics.

**Examples**

The list of book titles targeting childhood mental illness is extensive. There are numerous bibliographies and collections of literature that provide lists of titles that could

be appropriately used in the classroom for bibliotherapy purposes (Maich & Kean, 2004). For example, *The Language of Goldfish* by Zibby Oneal (1990) tells the story of a young teenage girl's mental breakdown. *Edward the "Crazy Man"* by Marie Day (2002) is about changing the perceptions of homelessness and schizophrenia. *Sad Days, Glad Days: A Story about Depression* by DeWitt Hamilton (1995) tells about depression. *Kissing Doorknobs* by Terry Spencer Hesser (1998) dives into the life of Tara, a girl who has Obsessive Compulsive Disorder. *The Glasshouse* by Paul F. Collins (2010) is the story of Clara, a girl with paranoia who eventually learns to accept and survive in her imperfect world. *Go Away, Mr. Worrythoughts!* by Nicky Johnston (2008) tells of Bayden, a boy living with anxiety. All of these books incorporate a character who is struggling with mental illness. These titles, and so many more, are excellent bibliotherapy resources that can be utilized to help children cope with their own mental illnesses in the classroom.

**Effectiveness**

Bibliotherapy has the potential to intervene in a variety of areas. The benefits of bibliotherapy can include:

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| 1. An awareness that others have faced similar problems. |
| 2. The knowledge that alternative solutions to problems exist. |
| 3. The development of a freedom to talk about problems. |
| 4. The growth of problem solving skills. |
| 5. The further development of a positive self-concept. |
| 6. Relief of emotional or mental stress. |

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|---|
| 7.   The development of honesty in self-image. |
| 8.   The growth of interests beyond just the self. |
| 9.   The fostering of a better understanding of human behavior. |

(Maich & Kean, 2004, p. 9)

These benefits can be seen in a number of case studies.  For example, a case study of a second grade boy who received bibliotherapy treatment from school professionals indicated a noticeable difference in behavior and a dramatic shift in the student's ability to function in the classroom.  Before treatment, the student viewed himself in a negative way, as a problematic and weak child who felt isolate and along.  Prior to receiving bibliotherapy, the child also indicated that he searched for escape from these beliefs.  The student's teachers assessed his situation through story-telling and books that presented experiences very similar to that of the student.  Bibliotherapy adequately equipped the child to face and deal with his negative perceptions and anxiety.  Due to the emotional release, the student was then able to focus more attentively and thoroughly in the classroom, leading to academic improvement.  Along with enhanced academic and cognitive function, the student showed an improved ability to deal with conflict and relationships (Carlson, 1999).  While the generalizability of case studies are limited, this example and others indicate that bibliotherapy has potential benefits when administered efficiently in the correct classroom environment.

Meta-analyses provide further evidence of the potential benefits that bibliotherapy can have for students with mental illness. When reviewing meta-analysis reports, it is

crucial to note that effect sizes are the measure of the effectiveness of what is being tested and indicates the correlation between two variables (Gregory, 2004). In addition, it is important to understand that effect sizes that are around 0.20 are considered small, whereas effect sizes that are around 0.80 are considered large. In a meta-analysis of cognitive bibliotherapy for individuals with depression, it was reported that in one of the studies "a mean effect size of .82 for six diverse students that compared cognitive bibliotherapy clients with wait list control clients" (Gregory, 2004, p. 275). Furthermore, the overall weighted effect size for the 29 studies examined during the entire meta-analysis was 0.99. The meta-analysis concluded that "studies of cognitive bibliotherapy yield outcomes that compare favorably with studies of psychotherapy lends credibility to bibliotherapy" (Gregory, 2004, p. 278). According to this meta-analysis, bibliotherapy is credited with having a positive effect on the individuals who were studied.

Admittedly, relatively speaking, there is not much research that has been done to study the effects of bibliotherapy when administered in the classroom to students with mental illness. As a result of this lack of hard evidence and proof, many may wonder if bibliotherapy is as practical as it seems. According to the government of Newfoundland and Labrador, as cited by Maich and Kean (2004), "Children are able to see reflections of themselves, their times, their country, their concerns [in literature]…whatever the nature of the story, well-written realistic fiction will always help readers gain a deeper understanding of themselves and others" (p. 5). Maich and Kean (2004) go as far to argue that if a student connects with a story or a specific character, then bibliotherapy should be considered successful. Furthermore, if positive mental or emotional health

change is seen, then bibliotherapy was worth the time invested into the therapeutic approach.

**Outreach**

Educators can further the effects of bibliotherapy as a treatment for mental illness by encouraging students to share what they have learned through bibliotherapy in their home and in the community. This can foster a relationship between these two areas of the students' life. Additionally, teachers can reach out to parents and community group leaders and encourage them to apply bibliotherapy in their respective environments. "Parental contribution to the intervention process can be accomplished by sending home copies of the reading selections, journals, and any activity assignments the children complete" (Sullivan & Strange, 2003, p. 77). This can help families and communities further the positive effects of bibliotherapy not only as a treatment for mental illness but to reduce the stigma associated with the disease.

Additionally, local community support groups for adolescents with mental illness could integrate bibliotherapy into meetings. Local support groups could use a book club format as a coping skill and bibliotherapy. As group members read the novel or book on their own, they experience the therapy and catharsis of bibliotherapy on a personal level. Then, when they meet together as a group to share their experiences reading the novel, they then connect on an interpersonal level and benefit from bibliotherapy in a whole different light. Local support book clubs could become yet another resource in the community for individuals affected by mental illness.

**The Bigger Picture**

Though it has been over 15 years, some are still left to wonder if any action could have been taken to prevent the tragic events at Columbine High School. Though nothing can be claimed with absolute certainty, if intervention was made at home and at school, perhaps Dylan Klebold would not have found it necessary to express himself through violence. What is more important is to reflect on this event, the cause of it, and what can be done to ensure that tragedies like it do not become more commonplace than they already have.

From insufficient mental health care to stigmatization, children and adolescents suffering from mental illness do not receive the treatment and support they need. As a result, children with mental illness end up in the general education classroom with very little health services or accommodations. The student, their peers, and their facilitators are put in a difficult situation. When left untreated, these students' mental illness leads to, at best, a chaotic classroom and, at worst, school violence.

Educators hold a moral and social responsibility of providing the tools and resources each student needs in order to develop cognitively and emotionally. Students with mental illness are of no exception. In order to adequately provide for their students who suffer from mental illness, teachers must take alternative approaches to instruction in the inclusion classroom. A healthy balance of training, patience, and persistence can be a positive influence and outlet for these students. In his novel, *The Abolition of Man*, C.S. Lewis (1947) eloquently states, "the task of the modern educator is not to cut down jungles, but to irrigate deserts" (p. 27). A responsibility to cultivate the lives and minds

of students with mental illness has fallen on the shoulders of educators.  It is time that

educators stand up and do something constructive with that responsibility.

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