

## Chapter 17

# Co-Creation Practice: Education, Nursing and Psychodrama

*Abstract: Illustrating the educational and psychoeducational application of Creation theory, an online program for clinical training and supervision for psychiatric nurses is being developed at a major American medical center.<sup>1</sup>*

Action is not just change, experience, or experiment. Action is foremost practice.<sup>2</sup> It is thus cogent to conclude this study of creation with a program created by one of the founding members of our research group<sup>3</sup> that incorporates basic principles for promoting creativity derived from our empirical and mathematical study of creative processes. This is an online program designed to educate nurses as primary care psychiatric practitioners,<sup>4</sup> and to increase their number in medically underserved

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<sup>1</sup> Project Aha! Online Clinical Supervision for Psychiatric Mental Health Nurse Practitioners. Rush University Medical Center. This project is supported in part by funds from the Division of Nursing (DN), Bureau of Health Professions (BHPr), Health Resources and Services Administration (HRSA), Department of Health and Human Services (DHHS) under grant number 1D09HP02987-01-00 Advanced Education Nursing Grants for \$478,739. The information about the grant is supplied by the author and should not be construed as the official position or policy of, nor should be endorsements be inferred by the Division of Nursing, BHPr, DHHS or the U.S. Government.

<sup>2</sup> Control experiments often are controlled by those who performed, and there are serious questions regarding the objectivity, reliability and validity of many drug evaluations; for instance, anti-arrhythmic agents were eventually demonstrated to increase mortality. Clinical experience, often dismissed as “anecdotal” often is more reliable than controlled experiment because it reflects the actual conditions in which agents are used and are not directly affected by commercial interests.

<sup>3</sup> The Peter and Maria McCormick Forum for Clinical Philosophy, Rush University.

<sup>4</sup> This program prepares “Psychiatric Mental Health Nurse Practitioners”. These professionals are well suited to fill roles as direct care providers, case managers and program developers in the mental health care system (Repta, 1999 Behavioral managed care administrator’s view: Traditional clinical nurse specialists employment in the private health care sector. In National Advisory Council on Nurse Education and Practice [Eds.]. *Federal support for the preparation of the clinical nurse*

rural and urban areas.<sup>5</sup> A critical aspect of developing innovative community-based services is educating mental health professionals who belong to the community, and also are capable of utilizing the resources from governmental and corporate institutions which, being institutions, are inherently unable to have feelings for the community. In this program, the students will perform their clinical practicum and residency

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*specialist workforce through title VIII*. pp. 44-45). Washington, DC. :HRSA.). At this time, the number of psychiatrists working in mental health facilities continues to decline in the USA (Manderscheid et al., 2000. Highlights of organized mental health services in 1998 and major national and state trends. In R.W. Manderscheid & M. J. Henderson [Eds.], *Mental Health*, United States [2000] Chapter 14. Retrieved November 15, 2001, from <http://www.mentalhealth.org/publication/allpubs/SMA01-3537chapter14.asp>). Experts agree that at this time, meeting treatment needs in the USA demands new roles for mental health professionals to provide services that are cost effective and accessible (New Freedom Commission on Mental Health, 2003. *Achieving the promise: Transforming Mental Health Care in America*. Final Report. CHHS Pub. No. SMA-03-3832. Rockville, Maryland.). The aim is to extend patient care, not to reduce costs to foster profits by establishing a two-tiered system of medical care, physicians for the rich and paramedical professionals for the poor. In China, "barefoot doctors" with scant medical training played a major role in improving medical care for the poor in rural areas after the Japanese and civil wars, but the standards are now improving.

<sup>5</sup> A large number of Americans suffer from mental illness. Estimates are that 20% of the adult US population (circa 50 million people), are affected by a mental disorder in a given year (Reiger et al., 1993. One-month prevalence of mental disorders in the United States and sociodemographic characteristics: The Epidemiological Catchment's Area program. *Acta Psychiatrica Scandinavica*, 88, 335-47.). The prevalence rate climbs to 30% with the inclusion of those known to have an addictive disorder (Kessler et al., 1996. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. *American Journal of Orthopsychiatry*, 66, 21-23.). Only 15% of persons with severe mental illness receive care from a mental health professionals, 40% of persons do not receive treatment at all (Kessler et al, 2001. The prevalence and correlates of untreated serious mental illness. *Health Systems Research*, 36, 987-1007.), and 70% of persons with a mental disorder do not seek services (Howard et al, 1996. Patterns of mental health service utilization. *Archives of General Psychiatry*, 53, 696-707.). Meeting the population's mental health needs is impeded by poverty, lack of public health programs, the transformation of health care into a profit-making industry, and geographic maldistribution of providers. Low socioeconomic status is associated with increased risk for mental illness and with under utilization of mental health services (DHHS, 2001. *Mental Health : Culture, race and ethnicity. A supplement to mental health: A report of the Surgeon General* Retrieved November 15, 2000 from <http://www.mentalhealth.org/cre/default.asp>). Poverty creates risk factors for mental health, increases stress and reduces access to professional care (Costello, Compton, Keeler and Angold, 2003. Relationships between poverty and psychopathology: A natural experiment. *Journal of the American Medical Association*, 2023-2029). According to the latest census, the 9.6 percent of the people in non-metro areas and 9.2 percent in metro areas live below the poverty line (Economic Research Service, USDA, 2003. *Briefing room: rural income, poverty and welfare*. Retrieved from <http://www.ers.usda.gov/Briefing/IncomePovertyWelfare/ruralpoverty/>). In Chicago, 1.7 million people live below the poverty line (City of Chicago Department of Public Health, 1999. *Community Area Health Inventory, Volume I*. Retrieved on November 1, 2001 from <http://www.ci.chi.il.us/Health/Publicationnns/Community/AreaHealthInventoryvolume2/CommAreaVol2.html>). There is a critical need to improve the geographic availability of mental health services (Surgeon General's report, 2001).

in their own communities, and the faculty of Rush University of Chicago will provide clinical supervision to students and their preceptors. This led to the choice of online teaching to reach students who live in rural communities.<sup>6</sup> Supervision and preceptor mentorship are vital aspects psychiatric clinical education, but are difficult to provide from a distance. An innovative feature is the design of tools for delivering the clinical supervision component online. Also, the online program targets a group of students for whom on-campus participation is not readily available. Online learning is the only manner to reach a significant student population. Our goal is education, not simply training, and this distinction must be stressed in our times, when universities are transmogrified into career avenues, because patient care requires no less than true professionals.

### 17.1 Online Education, Content and Form

Content and form are inseparable (Aristotle) and co-create each other but they do not co-determine each other. The medium is not the message.<sup>7</sup> Online learning does not determine what and how we learn and teach. It simply expands the ways in which we can do it, opening horizons and allowing for greater individuality. As any other method, there are advantages and disadvantages.<sup>8</sup> Among the latter, social and personal

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<sup>6</sup> Carlson-Sabelli, L. (2002). Welcome to Online Clinical Reasoning. University of Illinois at Chicago Nursing Institute Central States Workshop for Nurse Educators, Chicago, IL.

<sup>7</sup> Marshal McLuhan, coined the phrase "the medium is the message" as a critique of the effects of technology and advertisement on popular culture and human beings relations. Einstein denounced our times as one in which the perfection of means obscures a poverty of goals. Leonardo's masterpieces were created with exceedingly primitive brushes. The Spanish poet Antonio Machado sung: "Dejar quisiera mi verso como deja el capitán su espada, famosa por la mano viril que la blandiera, no por el docto oficio del forjador preciada." (I wish to leave my verse as the captain leaves his sword, famous for the virile hand that brandished it, not for the learned skill of the blacksmith. who crafted it.) Let this also apply to equations and computer programs.

<sup>8</sup> Online learning is already opening horizons and changing how we teach traditional courses. As any other method, there are advantages and disadvantages. It is also the only manner to reach a significant student population. Unique characteristics of online education include efficient information access, convenient methods for updating course information, making corrections to instructions, linking resources, the creation of an automatic paper trail of all discussions, increased social distance, and reduction of cues to appearance, race, social status, and physical disabilities, allowing for anonymity. It results in a greater sense of equal participation, and decreases inhibitions. Online learning can thus facilitates the construction of new knowledge by supports social negotiation

isolation are significant. One of the features of the program being developed is to turn this around by creating a virtual community. Thus the apparent weakness of online teaching becomes its strength.

Electronic distance learning methodologies already in use<sup>9</sup> are employed to deliver the educational content. The main difference with standard courses is the greater flexibility afforded to the student<sup>10</sup> and to the faculty, and the enormous number of resources that are not available in standard lectures.

Clinical reasoning is modeled using the narrative perspective.<sup>11</sup> Creative interactive activities to engage students in reflecting on their own process are accomplished through composing and analyzing clinical scenarios, dialogues and stories built around therapy interactions. Role playing scenarios provide the student with an imaginary role, allowing the student to try out new behaviors in a “mistakes allowed” atmosphere as well as seeing how others might handle the situation.

The teaching methods utilize up-to-date programs, and do not depart from well-known principles already applied in online teaching of nursing: to encourage active learning, cooperation among students, and student-faculty contact, to provide prompt feedback, to emphasize time on task, to communicate high expectations, and to respect diverse talent and ways of learning. Creation Theory serves these goals with a number

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of ideas, providing multiple perspectives, facilitating access to vast information, and supporting collaboration and networking in ways that surpass the campus environment.

<sup>9</sup> We use WebCT, Campus Edition Courseware for delivering all of the core and specialty courses for academic credit through Rush University. Project Aha! is created as a website that can be accessed by students and preceptors through WebCT, and by graduates and guests, through the Internet.

<sup>10</sup> The Aha! Center web site will be a place-oriented site, where students have the feel of “traveling” among rooms in which they do various interactive activities using image map hyperlinks. Discussions to promote reflection will be held in asynchronous chat environment. Faculty and preceptors will have online offices. Real time chat will be available for individual meetings, and clinical supervision. There will be a Resource Center, a Student Lounge and a Presentation area for viewing each other’s work. Visitors will be able to tour the “premises” and read materials about the program, “visit” potential clinical sites and learn about the learning activities, documents, completed assignments, evaluation data and other relevant information, will be housed and retrieved from the WebCT electronic databases.

<sup>11</sup> Mattingly and Fleming. (1994). *Clinical reasoning: Forms of inquiry in a therapeutic practice*. Philadelphia, F. A. Davis; Schon. (1983). *The reflective practitioner: How professionals think in action*. New York: Basic.

of new methods and strategies. Five tools are being developed through collaboration among faculty, students, and computer experts.<sup>12</sup>

Learning in action involves bringing together clinical practice with theoretical analysis and reflection. Co-creation and bipolar feedback is effected through psychodramatic role reversal as well as through interactions among students, between individual students and their preceptors and advisors, and between them and the faculty. A critical appraisal of the supremacy of the psychological involves considering how the patient's perspective and the student's own perspective affect patient care. Education is personalized: the entire educational process is student-centered –here the flexibility of online programs is evident. Yet there also are group activities, teaching the reality of work situations.

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<sup>12</sup> The Moment Maps are dramatic portrayals that include selected dialogue of a psychotherapy session (e.g. to highlight a moment of difficulty or of learning). Doing and viewing moment maps alerts students to deep-seated beliefs, and to the potential impact of the student therapists' values on patients. Constructing moment maps from their own therapy with patients allows students to demonstrate how they connect knowledge with action. Automated Clinical Development Scale is a tool that enables students and preceptors to quickly enter clinical evaluation data in a checklist form, and receive a graphic and narrative report of strengths and learning needs. These automated ratings provide a springboard for discussion of clinical performance between student and preceptor. The ratings are based on the "diamond of opposites" method (Chapter 4.3). Tutorial Quiz: Students are asked to create a tutorial quiz depicting essential learning that takes place during clinical time. This tool provides a method for students to demonstrate reasoning skills and to engage in peer teaching, which promotes leaning. An Electronic Portfolio Data Base provides each student with a method for tracking the progress of the "characters" patients they work with through their clinical experience. Sharing Clinical Stories: Faculty, students and preceptors exchange clinical stories in an asynchronous discussion forum. Story telling as a method of sharing learning experiences has been used with great success in education. As one story stimulates another, students become vicariously involved with the experiences of their classmates. Faculty monitors these stories, and intervenes to focus or broaden meaningful topics and themes. Telling one's experience leads the student to bring it to the conscious verbal level that is intrinsically higher than the action level. It forces them to role reverse with the audience that needs to understand the story, and automatically makes one see oneself from the outside, to connect the different parts of the story, to see how one leads to the other, so they can see the power of their action. Electronic Authoring Software to create Role Based Clinical Reasoning Scenarios: This tool will provide faculty and preceptors an authoring method to create "on the spot" customized clinical activities that capture the learning moment (i.e., the faculty member or clinical preceptor will use a standard format to design and present a creative learning activity that meets a specific need of a particular student at a particular time). We envision these activities as methods for students to imagine themselves solving problems related to various clinical competencies. These activities place a student in the center of an imaginative scenario as the responsible care giver. The structure of the activity provides links to web resources and tools helpful in deciding what to do and how to do it. A student enters a scenario, does something, and comes up with a "product" that can be displayed online, demonstrating interventions and their rationale. Each scenario is devised to help the student demonstrate aspects of nationally recognized clinical competencies. The activities are later evaluated, refined and kept to be used for other students.

Students collaborate and teach each other. The aim is **competency, not competition**.

As an example of how we apply theoretical concepts, learning and evaluation are not separate tasks but an integral unit. Evaluation is a tool for psychoeducation. The student must become competent to perform a vital social task, nursing care. In this system, the student's evaluation is not a matter of competition between students –a psychopathogenic system that teaches competition rather than responsibility and curiosity. At the beginning of their clinical year, students complete a self-assessment of their perceived level of expertise in each area of clinical competency, and then rate themselves on their performance over time. At the same time, preceptors assess their own level of skill on each of the preceptor competencies and also rate their own performance over time. After seeing the data from the other, the student and preceptor discuss how well the ongoing activities are useful for the student in meeting competency standards. What opportunities have the students had, missed, or have not been available? The mutual feedback between student, preceptor, and faculty puts into practice the concept of creative biotic feedback –mutual, bipolar and hierarchical. In any certifying program the student must satisfy the teacher's criteria. Here there is an additional objective, congruence. The student needs to learn to see herself or himself as others see them. This is a component of learning how to take care of a patient, as well as of working with others. More generally, it is a component of empathy that will well serve them in their personal life. We each have strengths and weaknesses, which are perceived by others and by ourselves in different ways. Matching student perception with their preceptor's perceptions serves as useful feedback for both to grow. It teaches us what to expect from others, given the way we are perceived by them. It teaches us who we are. This is Socratic dialectics: Know thyself. It also illustrates Heraclitus' justice of opposites. This matching of opposites –self and other -- is not an equilibrium point, but may be expected to promote empathic, ethical, and effective behavior. This example, intuitively clear, illuminates the idea, discussed in Chapter 8, that the symmetry of opposites produces bios, not equilibrium. The "justice of opposites" is extended by the grading of the teacher by the students, and further enlarged by the input of faculty, and the interchange

among students. Students contribute to each other's work. This is the beginning of a virtual community that may serve for psychotherapeutic supervision and, in a way, collective psychotherapy (see later). Because we change and our environment changes, the matching of our subjective impressions of our own selves and the objective view of others is a life-long creative process. A psychotherapeutic aim is for students (and faculty) to learn that a sine qua non condition to be good is that others regard it as good for them. It serves the student as a student, but it also has positive effects in their professional and personal life and, indirectly, in the life of society.<sup>13</sup>

## 17.2 Primary Psychiatric Care

We shall be brief. General principles are discussed in Chapter 16; more specific issues are outside the scope of this book. The application of process principles and of nonlinear dynamic methods to nursing practice has been described in published articles.<sup>14</sup> Primary Psychiatric Care requires focusing on the fundamentals. The concept of action leads directly to the notion of agency and spontaneity as mental health, and to the self-concept of persons in their patient role. Patients must learn to tolerate being patients and relinquishing control, and yet also avoid becoming passive patients. A person must be an agent as much as (s)he can. To promote both patience and agency requires well-timed and sensitive bipolar feedback. Both the caregiver and the patient must be aware of the fact that we all are in part agents and in part patients, at least we are patients when infant and when sick. Indeed illness can make us vulnerable and passive like children. But it is also important not to infantilize the patient. Everyone who is sick is also healthy in many ways, and everyone who is healthy still has health issues. A person

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<sup>13</sup> It is easy to convince ourselves that what we want to do is good for others, and if they do not recognize it, it is because they are paranoid or stupid. False innocence is a major sin of powerful.

<sup>14</sup> Sabelli, H., Carlson-Sabelli, L. and Messer, J. (1994). The Process Method of Comprehensive Patient Evaluation Based on the Emerging Science of Complex Dynamical Systems. *Theoretical and Applied Chaos and Nursing*. 1: 33-41; Carlson-Sabelli L., Sabelli, H. C., Patel, M., Messer, J., Zbilut, J., Sugerman, A., Walthall K., Tom, C. and Zdanovics, O. (1995). Electropsycho-cardiography. Illustrating the Application of Process Methods and Chaos Theory to the Comprehensive Evaluation of Coronary Patients. *Complexity and Chaos in Nursing* 2: 16-24.

should not lose status because (s)he is sick. Here enters the ability of the caregiver to role reverse with the patient, and to evaluate his/her performance from the perspective of the other, as discussed before. It is necessary to perceive the patient as (s)he is now, which varies moment to moment, and also to view living as a process in which the patient has a past and hopefully a future. Prevention and therapeutic intervention, in addition to their own intrinsic function, also become vehicles to convey the psychotherapeutic notion of creative determination of the future by the present.

Treating the patient as a person requires attending to the individual, to the family, and to their culture. Psychiatric care is particularly culturally sensitive. Our program includes specific measures to recruit, retain, and graduate students from underrepresented minority groups and/or students from disadvantaged or low-income backgrounds, as well as learning experiences to promote an understanding of cultural diversity. For instance, we are creating role-based scenarios that include patients of a variety of cultural backgrounds. We are also developing an ongoing online forum for students and educators to share culturally sensitive experiences about psychiatric and mental health issues.

The concept of biological priority and psychological supremacy can be readily translated as **health, work, family, and soul**.<sup>15</sup> Placing health first means focusing on psychobiology. Students must learn to recognize biopsychiatric illnesses such as bipolar disorder, and also to distinguish them from presumably entities that may or may not be real illnesses but that are given names for insurance purposes. Health issues go beyond psychiatry. Primary psychiatric care involves primary medical care and “triaging”,<sup>16</sup> meaning referral to appropriate medical sources, because the psychiatric professional often becomes a trusted long term care giver.

“Nursing” suggests mothering. Indeed patients may need mothering. Among structured exercises for health care education, one is to role reverse with a patient and with a child. Another is to experience mother

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<sup>15</sup> Consider a young schizophrenic man: First, take your medication. Next, get a job. Third, relate to your family, develop friends, may be a girlfriend. Then, attend to your spirit. (On the contrary, it would be unhealthy to attend to voices with religious instructions before taking antipsychotic medication.)

<sup>16</sup> It is of course tempting to point out the occurrence of threeness in triage.

archetypes.<sup>17</sup> A “parental” vision of health care articulates with a “parental” conception of co-creating opposites.

### 17.3 Co-Creating Community

Structure is a springboard for creativity. We are creating a **virtual community** that includes the university faculty, the students and their preceptors at their local communities.<sup>18</sup> (We intend our graduates to become our future preceptors.) Clinical supervision is an essential aspect of education and practice for mental health professionals. It has traditionally been accomplished in personal one-on-one or small group formats, and in many cases is very expensive. Mutual supervision among professionals can thus serve a major role in maintaining and enhancing professional standards. One of the central goals of our program is to create a virtual supervision community of Mental Health Practitioners using sociometric and sociodynamic principles. The plan becomes a sociodynamic experiment in forming a networked community of professionals.

The sociometric structure of the virtual supervision community is built around the notion of double dyads and triads – three attractors produce chaos, four produce bios. The structure is engineered on the principle of 1,2,3, 4 and many. The process is student centered. As a student is accepted into the program she/he is assigned a faculty advisor. So we have a natural dyad – advisor and student. We have another natural dyad, the faculty supervisor – advisor pair. As the student enters the clinical portion of their education and is assigned a preceptor in the last year of the program, a triad emerges. This system is based on the notion that pairing, triads and tetrads all are creative entities different from each other, each with advantages and disadvantages (e.g. the well-

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<sup>17</sup> We include the Goddess as Mother Nature and Mary as the Mother of Jesus. This provides an enormous range for exploring how we conceive caring, particularly when the student observes how others interpret these archetypal figures.

<sup>18</sup> Carlson-Sabelli, L. (2002, March 16). Aha! Strategies that encourage student involvement in their own learning in a virtual clinical supervision community. *American Association for Higher Learning National Conference*. Chicago, IL.

known phenomenon of “triangulation”<sup>19</sup>). Building a virtual clinical supervision community is a sociometric experiment that will be documented, in an effort to evaluate creative and destructive dynamic in dyads, triads and tetrads. Some organizations and groupings can be more effective than others in promoting the aims of the virtual supervision community. Here we have a social experiment to be tracked as a study of class relations (faculty, students and preceptors). We make a psychotherapeutic expectation of the outcome, a co-creative system, but we also expect conflicts. How we handle them is also part of the psychoeducational process that conveys (or does not) the concepts of personalization and co-creation, and incorporates (or fails to do so) the scientific methods of sociometry as augmented by nonlinear dynamic techniques.

#### 17.4 Sociometry and Psychodrama as a Clinical Philosophy

In the educational program, and particularly in the development of the virtual community, we incorporate sociometric principles and psychodramatic action techniques<sup>20</sup> that originate with Jacob and Zerka Moreno,<sup>21</sup> and further elaborated by Ann Hale.<sup>22</sup> For instance, we use psychodramatic techniques online (soliloquy, doubling, role reversal, surplus reality). We also incorporate sociodramatic techniques in our Co-creative children puppet theatre<sup>23</sup> and other forms of Co-creative

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<sup>19</sup> Virtually all significant relationships, beginning with the nuclear family, include three or more parties. Triangulation describes pathological processes arising in personal triads. For instance, a couple's unable to handle differences and disagreements may triangulation an adolescent, either pushing the child out as a scapegoat or pulling him/her in as a coalition partner or mediator.

<sup>20</sup> Carlson-Sabelli, L. (2001). The use of psychodrama in nursing. In Joyce J. Fitzpatrick (Ed). *The Psychiatric Mental Health Nursing Research Digest*. New York: Springer.

<sup>21</sup> Moreno, J. L. (1978). *Who Shall Survive?* Beacon, NY: Beacon House; Raaz, N., Carlson-Sabelli, L., and Sabelli, H. C. (1992). Fragmented stories--putting together the pieces: A psychodramatic model. In Kluff, E. (Ed). *Expressive and functional therapies in the treatment of Multiple personality*. Charles Thomas, Springfield, IL; Carlson-Sabelli, L., Sabelli, H. C., and Hale, A. (1994). Sociometry and Sociodynamics. In *Psychodrama since Moreno: Innovations in theory and practice*. Karp, Watson and Holmes, Editors.

<sup>22</sup> Hale, A. (1987). New Developments in sociometry. *Journal of Group Psychotherapy, Psychodrama and Sociometry*, 3, 119-1123.

<sup>23</sup> Carlson-Sabelli, L. (1998). Children's puppet theatre for traumatized Children: A process theory approach. *International Journal of Action Methods: Psychodrama, Skill Training, and Role Playing*, 51: 91-112.