Psychodrama

Using Psychodrama in Palliative Care Education to improve participant`s communication skills
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1. Palliative Care 20 day courses: A new educative design

On Feb. 15th 2015 the first batch of 18 participants of a 20-day all-academic course (160 teaching hours) in Palliative Care received their certificates at KMC Hospital Mangalore. It was a joint venture of MediAcion, Hamburg, Germany and Manipal University.

The certificate was issued according to the suggestions of EAPC (European Association of Palliative Care). The course's content comprised the UG curriculum of Palliative Medicine suggested by Indian Experts of Palliative Care designed for PG use and some additional subjects in end-of-life care like HIV, Dementia, Physiotherapy, Music-Therapy, Geriatric Care and topics related to nursing. The faculty came from Germany and India. As most of the participants were already teachers at different universities and colleges, they had been participants and faculty at the same time: Professors in Anesthesia, Internal Medicine, Geriatrics, Nursing and Physiotherapy, assisted by teachers in music-therapy, counselling/psychotherapy, palliative-care-coordination, social work. Apart from training in Palliative Care participants got "train the trainer" input and feed-back on their own teaching. Between 4 modules of 5 days each, there had been work exposure time of 4 weeks to 4 months to implement the new training, skills and attitude in day-to-day work. Modifications, successes and failures were discussed in the training group itself. Of 18 participants 14 will be future teachers/trainers of palliative care in their respective colleges/universities starting 2015.

The course's new educative concept was already envisaged and demonstrated at IAPCON 2014 at Bhubaneswar. It was well received at Mangalore. These courses will be available for all who want sound knowledge in Palliative Care (and its teaching), but do not want to leave their own work at Hospitals or private practice for more than 5 days at a stretch. Apart from knowledge, as it can be learned in E-learning as well, skills and attitudes are taught. These skills and attitudes will not be learned by copying a senior role model (as in bedside-teaching), but by developing them within one's own needs and capacities and in one's own way. Therefore 50 % of the course is reflection on one´s own work with own case studies and training of one´s own communication skills in role plays.

2. Three Case Studies on Communication Skills Development

In Germany 20 day courses are obligatory for most who want to work in palliative care services. During the last 5 days doctors bring in own cases and/or doubts/problems, which they face during end-of-life-care. They mostly face problems in communication with relatives, differences with other staff, and in breaking bad news to patients. Some have problems of grief and work-life-balance. On the last day of a course one doctor admitted, he experiences "fear" of meeting incurable cancer patients during home care. He didn't know, how to make contact, what to say, how to manage the whole situation himself. He was hesitantly explaining the matter, believing this problem might be just his own, and suspected no other participating doctor might feel like him. When the group was experienced in psychodramatic role play, he was willing to find out a solution for himself using this methodology, I asked the doctor to stand.

Facilitator (F): Please get up and choose somebody for your fear.
Protagonist/doctor (P): (gets up choosing the tallest person in the group): He can be my fear. He is tall. (In the group the Protagonist is the shortest in body size. The tall person gets up and stands beside the protagonist)
F: Do you feel this fear when you meet the patient?
P: Yes, when I am on my way and reach his house, it's difficult for me to meet the patient.
F: Please choose a patient, give him a chair and a place in the room. Choose a place for yourself and one for your fear.

P: (stands and faces the sitting patient, placing the fear between them.)
F: Now you can´t see the patient at all, and he can´t see you either.
P: That is true. But that's how I feel. I can only see my fear.
F: What do you want?
P: I want fear to go away.
F: Can you make a role change with the fear?
(After the role change, F asks the person who is acting as "fear" to stand in the place, where P stood. And he asks P to stand in the place, where "fear" was standing. Now F asks the person acting as fear to repeat the words: "I want fear to go away".)
F: (speaks to the doctor, who is now standing in for fear): You are the fear now. How do you feel, when the doctor says: "I want fear to go away!"
P: I am a strong fear. I will not go away. I will be here always.
F: Please make a role change to the former position and listen to what fear is telling you (Now all go back to their original places, and "fear" repeats the words: I am a strong fear. I will not go away. I will be here always.)
F: (to P :) How do you feel?
P: Fear will always be with me….
F: I have a suggestion: Can you ask fear to stand at your side? (Fear moves accordingly, standing at the doctor´s side, and both face the patient).
P: Now fear is on my side. Now I can see the patient. But the patient sees me and my fear. It is very embarrassing.
F: Can you try and see how the patient really feels? Can you perform a role change with him?
P: (Does so accordingly. He sits on the place, where the patient was sitting, and patient stands where the doctor stood, fear on his side). "OH!" (P being the patient gets tears in his eyes): This is very good. I like what I see. I see a doctor visiting me. And he comes to visit me, his fear on his side. I have a lot of fears too. I never had a doctor visit like this. I like this doctor. He and his fear are most welcome. I do not have to pretend, it's all right. That is fine with me. The doctor can come and meet me with all his fears (a little later the play ended).

All participants in the group admitted that they have fears, anxieties or self-doubts, when approaching incurable patients.

Second Case Study: Similar work was done with an Indian MD at Mangalore during the first week. He discovered it was not his capability that connects him to patients in end-of-life–care, but more his vulnerable side, his insecurity, which reveal empathy and love as a core value hidden behind all the unpleasant feelings. First he placed his insecurity behind himself touching his neck and his capability in front of himself, so the patient can see it. He discovered the patient can see only a part of him, and he can´t see the patient. After a time of role change, he placed his insecurity to his left, his capability to his right. First he felt a little "naked", but then discovered he felt more human, and contact with the patient was stronger, not so artificial.

Third Case study: Other doctors tried out role play and/or act storming (see more on that methods below) to break bad news directly to the patients. First, they explained this should not be done according to Indian standards and culture. Later they tried. After finding a way to do it, they explained: "We know now how to do it, we can do…". They even tried in their daily work. One doctor had a son telling him, he should not speak to his sick father nor his mother. He explained to the son the mother might know already and reluctantly the son agreed, that speaking to the mother is needed. When the doctor spoke to the patient/father, it was clear, he had been fully unaware of the status of his sickness or at least unwilling to accept it. He only thought of being cured soon. When the doctor suggested returning home for Deepavali he refused, wanting treatment to be completed. The doctor just said: "Might not be Deepavali every year again….". The patient silently understood, went

home and died two days later. And the family had time to say good bye to each other. A week later the son had an accident and went into coma for some weeks. A cruel fate. But if the doctor had not spoken to the mother and patient, it would have been still worse. The whole group thought over the way, the doctor spoke to the mother and the patient as a way of communication during the last days of the end-of-life-care and considered speaking to family members and patients even earlier.

3. Psychodrama methods for palliative care teaching

Psychodrama is one of the five humanistic psychotherapy approaches developed by J. L. Moreno (1889-1974) in early 20th century. Next to psychotherapy it is commonly used in HRD, OD and even in education. Apart from limited use in the late 1990s´ Psychodrama has not received much exposure in India. Since 2012 Western trainers along with Indian colleagues have been teaching groups on certificate level, see for example: www.vedadrama.com.

Psychodrama's foremost method is the protagonist role play. Such training of Medical Doctors in Palliative Care can be on all subjects with special communication needs and problems like a) breaking bad news, b) overcoming collusion, c) bereavement counselling, and even – see case above - d) the needs of caretakers themselves.

There are many approaches and methods which can be used for palliative care training:

a. Normal role play: Performing the situation again, finding out what happened
b. Role reversal: putting oneself in the place of the other to get a different perspective
c. Protagonist play: Interact on an interpersonal level as protagonist with all other persons involved (with support from other training group members). But the protagonist will play each and every role and get different perspectives (see b) even trying out other situations ("surplus reality").
d. Inner Psychodrama: The protagonist gets a view of all his inner attitudes, skills, needs and shortcomings, to find new solutions and other related methods
e. Act Storming: The protagonist takes on the patient's role (or relative) while other group members try to find new solutions to the case, which the protagonist might not yet have tried. This gives a triple effect: 1.) the protagonist experiences a longer role reversal, 2.) the group tries out more possibilities – which can be fun – and the protagonist can decide, what will be helpful 3.) If all solutions are not new to the protagonist, he at least can feel, he has done his level best.
f. Vignette: Have a short overview on a case or problem in someone personified by the protagonist with help of group members, but without role play (for those more reflective and shy to act).
g. Constellation Work: Consider the whole constellation and let others act freely and improvise.
h. Group play: Let the group create and act out a script on the problem, which can be worked on.

4. Conclusions

- A second group of palliative care medicine cum train-the-trainers course will start August 2015 and is open for admission now. A similar course of palliative care nursing will start at Mangalore also August 2015. More details at: www.palliaction.com.
- Psychodrama Practitioners certificate courses take place at Bangalore and Chennai in 2015/2016, see: www.vedadrama.com.
- It is suggested to try psychodramatic role play as education methodology in similar courses as an adjunct to existing approaches. More experience has to be gathered regarding that.
- Scientific studies of results are underway at the Universities of Mallorca/Spain, Aachen/Germany, Edinburgh/GB, and Manipal/India.
- Letter of Intent has been signed in 2012/13 with JIPMER; Pondicherry and MMC, Chennai; preparatory talks with AIIMS, New Delhi and KIDWAI, Bangalore have also taken place.
- Indian Central Government Secretary Health and Family Welfare supports this way of teaching and inviting foreign trainers. The German Federal Ministry Health of Government supports too.
- All support and/or funding are most welcome. Please contact ceo@palliaction.com .

Pictures

Picture 1: Role play

Picture 2: Protagonist Play

Picture 3. Trainers Training at Chennai

Dr. Jochen Becker Ebel (speak: Dr Yogan Beker Ebel) is owner and CEO of MediAcion (speak Medi-ac-thion) a private German palliative care training institute. With his 30 freelancer trainers he annually trains up to 100 medical doctors and 250 nurses in Palliative care since 2002 in the governmentally prescribed 20-day courses all over Northern Germany.

Since 1985 he is a regular visitor to India / Tamil Nadu. He lived for over 6 years at Tiruvannamalai in the end of CFO and RDO of the Sri Ramana Maharshi Research and Development Trust. Since 2012 he engages in the field of Palliative Care in India. A pilot 20-day course at Mangalore 2014/2015 end just now. He sees his future in training palliative care trainers and psychodrama trainers at Mangalore, Bangalore, Chennai and Tiruvannamalai, see: www.vedadrama.com and www.palliaction.com.

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