

Psychodrama Theory and Group Work in Reflective Practice Groups for GPs

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Introduction

On obtaining certification as a psychodramatist I recall Max Clayton saying “Now the real learning begins” — and it certainly did! I got a job as a medical educator and have gradually transformed from being a GP on the treadmill of 15-minute consultations into a medical educator and group leader. When I wrote my AANZPA thesis “Psychodrama for Doctors” (Begg, 2005) I proposed psychodrama as a path to help doctors develop self-awareness and interpersonal relationship skills that would help medicine progress towards a new holistic medical paradigm. I imagined ways of using action methods in medical settings. I then experimented with various aspects of psychodramatic production as opportunity arose in my work for the NZ College of GPs’ education program — concretisation, action sociograms, role play etc. However, group work and psychodrama theory have proved the most useful aspects of my psychodrama training for my current work. This article is about my *Reflective Practice Group* for first year General Practitioners (GPs) which I have been leading for 13 years. I will introduce you to these groups and share some ways I see psychodrama theory and group leadership skills contributing this work. Hopefully, this will be of interest and relevant to your work, especially if you run groups in settings where psychodrama is not explicitly practiced.

Context

It is morning tea break on a Friday. I walk into the seminar room to the buzz of animated conversation between GP registrars. These are fully qualified doctors in their first year of training to become specialist general medical practitioners (GPs, or family doctors). I love seeing this diverse group of 30 or so people engaging with each other. They are mostly between 27 and 35 years old and fresh from hospital work. There are always some who are older and have experience in different specialties, or other life experience

before doing medicine. Quite a few have trained overseas. Occasionally we have fully trained cardiologists or surgeons and the like who are changing career for various reasons. For some, English is their second language. This makes for an interesting mix.

After morning tea my Reflective Practice Group gathers in our group room. I have one and a half hours with 7 registrars each week. The explicit purpose of these groups is to reflect on non-biomedical aspects of practice. This includes difficulties in the doctor-patient relationship, challenges in the practice teams, coming to grips with general practice work and developing the identity of a GP. Transforming from hospital doctors with sicker patients in fully equipped hospitals to GPs working with independent people in the community is quite a process. Patients walk in and walk out, come with their own expectations and ideas and look after themselves between visits. They do not always follow advice. Uncertainty is rife as diseases are often seen early when diagnoses are not yet clear. Learning to work in the time limited appointments of general practice is another of the many challenges faced.

Getting going

At the beginning of the year these GP registrar group members are in survival mode as they settle into their placement practices and get to know their host GPs, partners, nurses, receptionists and others. They need to ask questions such as “How do I do this?”, “Can you come and have a look at this rash?”, “What do I charge for this?”, “Where is the liquid nitrogen kept?” “What form do I use for this?” and “How do I record a new diagnosis on this computer system?”. It would be common to have to check something out every second consultation during the first few weeks. When we meet in Reflective Practice Groups (RPGs), they are generally very keen to talk about practical details and to know how their peers do things in their practices. This is an important way of getting to know each other and *putting themselves on the map* of the group. As a group leader I value these exchanges as a way for them to display themselves to their peers.

GP registrars are capable high achievers often with great expectations of themselves so it can be stressful to be floundering in their practices while trying to get their feet on the ground. Being seen as competent is important to their identity as doctors. A commonly faced conflict in RPGs is that of needing help with a problem while fearing being judged as incompetent or inadequate in some way if the problem is presented. To address this focal conflict (Champe & Rubel, 2012) I often begin groups by asking questions that help them display their competence such as:

What have you enjoyed about your work in the week since we have met?

How has your hospital experience been useful to you and your practice in the last week?

Tell us about a satisfying experience with a patient.

What interested you recently that could be relevant to your peers?

This enables functional roles to be expressed — an important principle of psychodrama. It tends to get the ball rolling and often, paradoxically, naturally leads to someone offering to present a patient encounter that did not go so well. Warming up to other group members through stories that highlight capability can diminish their fears.

Group process

There is a strong tendency for the group to want to focus on problems of diagnosis and management with advice and information being sought from the group. This is generally the norm for medical groups they have been in previously. Despite the explicit focus for RPGs being non-biomedical aspects of their works, getting this to happen has been a major challenge I have faced in these groups. It requires swimming against a tide that pulls towards medical problem solving. Group works skills (Yalom & Leszcz, 2005) learnt through psychodrama training have been a great help with this task. Skills such as:

- relating to group process and resisting seduction by the content
- drawing attention to group members appreciating each other
- noticing non-verbal responses and encouraging words to be added to these.
- naming themes of group discussion
- drawing attention to the mood of the group and group members
- identifying focal conflicts when recognised

These all tend to help the focus move towards their deeper concerns, such as: fear of complaints or making a mistake; emotions such as sadness, despair, anger and disgust generated by their work; challenges in boundary setting with people seeking drugs, medical certificates, benefits etc; and a myriad of other things. There is usually plenty going on in group members' lives that can affect their work — new relationships, buying houses, having babies, wondering if they have made the right career choice, sickness in family members etc. And work can affect their lives with its various stresses and time demands. Accepting these as relevant subjects enriches the life of the group.

Today group discussion leads to a case presentation that initially seems to be about a worrying medical problem.

Case presentation

This is a compilation of cases with identifying details changed

Sam diffidently offers to presents a case. "It's not long..." he says. A couple of group members encourage him, and he tells us about Fred, a 72 man who came in for a driver's medical. His notes show that he has high blood pressure and has been prescribed 3 drugs to manage this. At this appointment his blood pressure is dangerously high (260/150). A simplified version of the crux of their interaction follows:

- Sam: Are you taking your medication?
Fred: Yes, I am.
Sam: In that case I need to send you into hospital as your blood pressure is dangerously high.
Fred: Oh, I just ran out a few days ago...
Sam: Only a few days? I still think you need to be admitted as you are at serious risk of a stroke.
Fred: Oh, well actually, I haven't been taking them for a while. I don't like taking them.

Sam's description was richer in detail than this and covered other aspects of the consultation, but mainly stuck to medical facts. He made himself out to be blunt and challenging and there was a sense that Fred was a difficult non-compliant patient. I also heard a sense of satisfaction in getting the patient to admit to not taking his pills and got the feeling that Sam enjoyed his interaction with Fred.

The group engaged with Sam's story and expressed concern at the risks of such a high blood pressure. They bombarded Sam with questions such as "What was he on?" "Did he get side effects?" "How long ago did he stop taking them?", and "Did he stop all of them?". Questions about medical facts and management are common following a case presentation in medical groups. This is consistent with the role of problem solver that is strongly ingrained from medical training. While useful in diagnosing and managing medical conditions, in this context a barrage of questions runs the risk of shaming the presenter through revealing areas not considered and requiring justification of actions. The presenter, who may already feel over exposed is held in the spotlight. It can be a challenge for a group leader to cut across such a strong norm, but important if we want to create a friendly conducive environment for future presentations. One way I do this is by intervening to appreciate questioners' lively interest and desire to get involved, then request they hold back for a while so we can make something of what has already been said.

I asked Sam what the patient was like as I had little sense of the patient as a person, apart from being a challenge. Sam described an unkempt man

with straggly grey hair and really bad psoriasis — “skin flaking off everywhere. He is overweight and doesn’t come in much.” He sounded like a homeless man to me and so I asked about his social circumstances — “lives with his wife in a state house”. Then I suggested Sam stay quiet for a bit as “you have given us a lot to go on” and asked the rest of the group to wonder out loud what might be going on for this man and what might you feel if he was your patient. Balint* groups have taught me this way of producing the presenter’s *drama* within this educational group setting. Often I get the ball rolling with some modelling.

Group leader: He sounds a bit like a homeless man. I was surprised he is married
Fariq: I bet he’s not treating his psoriasis either
Mary: He shouldn’t be driving with his BP that high
Fariq: It’s so hard when people don’t look after themselves. I get very frustrated.
Ben: Yes, me too. It’s depressing and hard work.
Jayne: Maybe he’s depressed
Ben: Maybe he has dementia
Sarah: Maybe his wife has dementia. He seems uncared for.

Speculations like these encourage spontaneity and creativity in group members who can have fun coming up with ideas. It helps them role reverse with the patient — and the presenter often feels well doubled by this process. If questions are aimed at the presenter I try to intervene and reflect them back to the group, getting them to guess at answers and encourage the presenter to sit back and consider these ideas. This keeps him from being the focus of the group. He is also away from the pressure of the consulting room and this gives opportunity to sit back and reflect. This enables him to see the bigger picture and develop empathy for the patient — and himself.

Advice giver is another role well-developed by medical training that has potential to undermine presenters. A strong desire to ask questions or give advice in relation to presentations can be driven by a need to defuse emotions such as anxiety, anger and sadness generated by stories presented. Registrars face, and share stories ranging from complex medical problems to stories of child abuse, sexual assault, patient complaints, delivering new cancer diagnoses and confronting drug seekers. Reactive advice giving based on immediate emotional responses generally does not take

* Balint groups have a specific focus on the relationship between doctor and patient. They evolved from the work of Michael and Enid Balint in the UK post second world war. Present day groups commonly include psychotherapists and other professionals who work in close relationships with patients/clients. More information can be found at <https://www.balintaustralianewzealand.org/>

into account all that has occurred between presenting doctors and their patients. Intervening to help the advice giver recognise and identify feelings that generated their response can potentially serve to both increase consciousness of the advice giver and protect the presenter from the advice.

Another intervention I use is to I ask for speculations on the relationship between the patient and the presenter if it does not emerge naturally. Returning to this group's work with Sam and his patient Fred, Sarah shares her thought that maybe Sam was being a bit of a bully by scaring him into admitting not taking his meds. Ben thought it sounded like friendly concerned banter and Mary agrees as she heard enjoyment in Sam's story, as well as frustration and real worry that Fred was in danger. More ideas flow:

- Sarah: He hasn't been in for a while.. maybe he doesn't like doctors
Ben: Maybe he's sick of being told to take his pills
Jayne: Maybe he feels guilty for not taking his pills, so he lies
Mary: It sounded like Sam enjoyed jousting with Fred. And maybe Fred wants to talk about his trouble with side effects. Maybe no one else has taken the time with him.
Fariq: Yes, I think he will know Sam is worried about him and doesn't want him to have a stroke. Maybe he didn't really know the risk he was taking.

After a while I ask Sam to join us in wondering about what was really going on in the consultation. He shares that he really was worried. And that he did feel a bit like a bully too. From this sharing it is apparent Sam has become more conscious and reflective about his own functioning from listening to the group speculations. This method can produce mirroring in a way that is easy to take on. Sam also shares his concern about Fred's social situation and interest in pursuing this when he next comes in. And he plans to have a discussion with his usual GP. These ideas emerge from Sam without the need for advice. We learn Fred has agreed to restart one of his pills and to come back for follow-up. I acknowledge the relationship Sam must have built with Fred for him to be returning. The group murmur and nod agreement. To finish this case presentation, I thank Sam and ask group members what is relevant to their own work from this discussion. This parallels sharing after a drama in a psychodrama session. It helps group members concretise any learning in words and connects Sam to his colleagues through enabling him to see the relevance of his presentation to group members.

Case discussions such as these generally build connections between group members, increase trust and strengthen their identities as GPs. They

provide a counter to the relative isolation of 1-1 consultations. Establishing strong professional relationships with Colleagues who know you and can provide support when needed reduces the risk of burnout — an all too common experience in our profession. The final section of this article addresses another potential cause of burnout, and discusses how these groups can address this.

The Imposter Phenomenon

Progressive	Coping	Fragmenting
Ordinary fallible human	Striving perfectionist	Fearful fraud
Honest error sharer	Fallibility concealer	Mistake denier
Clear limit setter based on accurate self-knowledge	Superwoman/man	Judgemental self-flagellator
Conscientious worker	Anxious over worker	Slave driver
Worker within known capabilities	God impersonator	Scared pretender
Recogniser of own success	Belittler of own achievements	Rejector of own abilities and achievements
Internaliser of positive feedback	Deflector of positive feedback	Negator of positive feedback

This is the common experience that doctors have in feeling like they are playing the role of doctor rather than actually being one. The *Imposter Phenomenon* (Clancy & Imes, 1985), was first named in relation to experiences of professional women by Clancy in 1985, but it is not limited to women, medicine, or high achievers. I have heard the “Imposter Syndrome” referred to not infrequently in medical circles. Sufferers of this feel fake and fear being found out as a fraud — not a “real” doctor. Shame can be experienced for not feeling like the genuine article. I have experienced this, and you may recognise it in yourself at times. The importance of being right and the perfectionistic demands of

practicing medicine contribute to *imposterism*. We are all fallible human beings, including doctors, and yet a close to perfect doctor is what everyone wants — especially when sick and vulnerable. I have listed some roles associated with this syndrome in the table on the previous page.

Roles analysis of the Imposter Phenomenon

Imposter Syndrome arises when functioning from the fragmenting and coping roles listed above. Strengthening the progressive roles is the antidote to feeling like an imposter. When these are developed the fragmenting and coping roles tend to drop away. These progressive roles are associated with being known and accepted for who you are without pretence or over achievement. Experiential psychodrama and psychodrama training groups enabled me to share my vulnerable self and I discovered, contrary to my fears, this tended to strengthen my connections with others.

I gained a sense of myself as acceptable that was not dependant on performance, but rather was based on group members really getting to know me. Reflective practice groups have the potential to provide similar experiences for GP registrars. They provide opportunity for strong connections to develop between group members in which they are valued despite sharing very fallible human experiences from their work. Imposter syndrome is countered when group members develop enough trust to share things that are potentially shameful in a group of peers where they are known and valued. Hopefully, this has given you a taste of some of the ways group work and psychodrama theory underpin my work with running Reflective Practice Groups. They are full of complexity and challenges, not always running smoothly, but generally they are enlivening, satisfying to run and give great scope for reflection. The real learning continues! I feel truly fortunate that psychodrama has led me to this work and provided a foundation of theory and experience to guide me.

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