

On Death and Beyond

Psychodramatic approaches in the professional counselling / supervision of Hospice workers and in the field of Palliative Care

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1. Introduction

Context

I have been working as a supervisor and counsellor in hospice and palliative care in Germany for several years now. In the last few years sociometric and psychodramatic methods have played an increasing role in my work. My main field of competence and most of my clients come from palliative and hospice work as well as bereavement counselling.

I give training in this topic for counsellors/“supervisors” and psycho-dramatists and doctors, nurses, theologians and other staff in palliative medicine / palliative care.

The nationwide number of palliative care stations, inter-disciplinary palliative care teams and their need for counselling/supervision has almost doubled between 1999 and 2007. Ambulant hospice Home-Care often involves the services of volunteer workers. Their work is now becoming more professional, as they are offered supervision and support – paid by the German Health Insurance - due to legal regulations since 2003.

Support for volunteer workers is itself undergoing transition. Specific offers for supervision are now being made by external supervisors to volunteer workers in hospices, replacing the support previously given by well-trained therapists from within the institutes. Since the end of 2008, hundreds of ambulant palliative care teams have been founded to give complete coverage in the field of ambulant palliative care. Team-Supervision is a decisive quality factor in these new teams.

A Survey

At the end of 2004 the board of the German Society for Supervision (Deutsche Gesellschaft für Supervision e.V.) followed a group of supervisors' recommendation to set up a project group to investigate the availability and quality of supervision in the field of hospice work and palliative care. In cooperation with the German Hospice Association (Bundesarbeitsgemeinschaft Hospiz, now DHPV), and the German Society for Palliative Medicine (DGP), a questionnaire was sent out to ca. 1600 institutions. More than half of the Hospices, one third of the Hospitals with Palliative Care Units and one fifth of the volunteer groups responded. The results among those who responded showed that supervision was offered in almost all of them.

It is usually a compulsory element for both volunteer and paid staff. It is given free of charge and within official working hours for their paid staff. It proves beneficial in helping people to solve problems and provides support for their employees. They also found that supervision promotes personal development, motivation and professional competence. The supervisors come mainly from external sources. Almost all of them are qualified supervisors, although seldom specifically trained for hospice work.

However, often other criteria are more important when assigning a contract: experience in palliative care and hospice work is considered more important (61%) than belonging to an association which specializes in supervision and guarantees good quality (16%).

Topics presented:

The following are some typical examples presented to me in the context of the dying, death and bereavement processes, of what might concern people when working with sickness, death and “beyond”:

- *“My father had a great influence on my life and decisions about my career... He died two years ago... Now I need to make new decisions and I am unsure.... ”*
- *“The 90 year-old that I have looked after for several years died yesterday. I only want to talk about it and see if there is anything to discuss in the supervision...”*
- *“As a hospice counsellor I had looked after the deceased so intensively.... and now the family has not even invited me to the funeral. And I was not there when he died. Somehow, something is still unfinished“*
- *“I have registered here for the course on palliative care for theologians so that I can learn how to counsel the dying and the bereaved but now I am in the situation that my own father died four days ago... I don't think I can stand being in the group if we talk about grief. How can I do my work if I'm grieving myself? ”*
- *“I have experienced so much suffering in the past year. Three friends and relatives have died, but also my partner died suddenly. I wanted to marry her but it didn't come to that. I blame myself and I feel so sad. I have so many questions...”*

Life circumstances, the people concerned, and emotional situations differ. What these issues all have in common is that there is another person who has died. This means that the protagonist is unable to reconcile any of these issues with the deceased. There is no one there to confront and therefore improving communication skills or clarifying the actual situation can have little influence in resolving their psychosocial concerns because a real encounter is no longer possible.

Other clients of mine are constantly dealing with death and all its consequences:

- *“The dying woman demanded so much from us. We couldn't do anything to please her. How can I cope with this kind of situation in the future, if I have to care for such a difficult person again?”*
- *“I work in a hospice. Several people have just died. I can't sleep at night and I have nightmares. I imagine my husband lying next to me with a slashed stomach and blood everywhere. I am afraid when I wake up... afraid something bad could happen to my family if I am constantly working with death and the dying.”*

Psychodramatic approach

After my supervision training at the Institute for Social Practice in Hamburg (1999-2002), I suggested to my clients that they could replay the scene with the deceased even though they were no longer alive. I even encouraged them to create new scenes between the protagonist and the deceased: expressing unspoken parting words; talking and using gestures as if the deceased were still present, overcoming the boundaries of death.

One of the hospice workers, who had been caring for a cantankerous old man, spoke up. She told us, just to bring us up to date, that he had now died. I asked her how she felt. She said: *“I'm o.k., but I don't feel any emotions”*.

I invited her to act out a scene. Soon it became clear to all of us just how much she had suffered at the hands of the rich and condescending man who had passed away. She had been constantly put down and treated as a doormat, and now an enormous amount of hidden anger was arising in her. We did not have much time left in the session; however just being able to talk about it and express her anger was enough to bring her some relief. She had not been able to say farewell so the process was incomplete for her. This could only be partly resolved during the role-play but we were able to help her with

further counselling in later sittings. She had the opportunity to express her unspoken thoughts to the deceased, but her conscience still rebelled: "*De mortibus nihil nisi bene*" ("*Do not say anything but good about the dead*"). This is a common hurdle which I have often come across in supervision.

I would like to share with the readers of this paper my reflections on these and other common hurdles; my successful and not so successful experience when counselling these kind of problems; as well as suggesting further professional criteria for improving this work. From a psychodramatic point of view: which basic rules should apply to this specialized topic, and when do we actually encourage protagonists to bring deceased antagonists on to the stage?

The deceased as Supporter in the role-play

Among those who read this article I got a lot of support. The most surprising one reached me in 2007, by mail, from Zerka T. Moreno. In 2009 she wrote to me again and pointed: "*I have a problem with the word "antagonist". In English, especially, it has a negative meaning. What if the absent other is God or a newborn child or another beloved person? Moreno would not agree with that definition. Besides, the other may not be antagonistic at all, but meaningful to the protagonist in some way. Psychodrama is not a public fight, but an active exploration of relationships*".

So it came to my mind the idea of speaking of "*syntagonist*" instead of "*antagonist*". This is a new word, which can rarely be found in the dictionary so far. However, in the XVIth century in Spain, foreigners became syn-tagonists: people who played a major dramatic role in support of the protagonist, selflessly, against the antagonist. Check on www.darkfiber.com/blackirish . The interconnection in this context will be "Sympathy" (see: Synagonism) and "support", but should not be "synthesis".

In German medical use, the **syntagonist** is a muscle on the same bone but on the other side of the "antagonist", which makes that part of the body move in one or the other direction. Therefore the idea seems to be apt to use syntagonist and antagonist as a couple, depending on what position each of them has with the protagonist.

2. Theory

Field competence for supervisors: Outline of a seminar

Supervisors (meaning external counsellors who support paid and voluntary staff in their work) working in the relatively new field of hospice and palliative care are currently discovering their need for more personal competence, more self-awareness and personal development as well as improved specialized field competence.

I have been offering so-called field competence courses for small groups of 8 to 12 participants and have therefore had a unique opportunity to counsel colleagues who are actually working in this specific field.

The counsellors and supervisors who attended my field competence seminars in Hamburg and Vienna from 2006 to 2008 were able to take new work skills home with them.

The course focused mainly on the following five themes which reflect what we saw as being the main training needs:

- First weekend: Palliative medicine and palliative care, ethics and medicine, pain management, symptoms of the terminally ill in the final stages.

- Second weekend: Special needs in the supervision of (hospice) volunteer workers; supervision in the context of multi-professionalism and cooperation in hospice work.
- Third weekend (first day): The special role of spirituality and religion, bringing meaning and transcendence to the death and dying process; and:
- Third weekend (second day) Psychosocial themes, dealing with illness, forms of bereavement, 'burn out'.
- Fourth weekend: Specialised structures applying to hospice funding organisations and their effect on supervision; contracts with volunteer workers requiring supervision; 'Money' as a taboo issue in volunteer work; developmental stages in (hospice) organisations; making contracts, task definition, availability of financial aid for supervision.

In addition to receiving specific knowledge the participants also wanted to review their work and their approach to it. From our overall experience, including this and other courses, plus knowledge gained from work practice and related literature, the above mentioned DGSv. project group developed a recommended curriculum with the aim of qualifying participants accordingly.

In this context I see the following three problem areas which supervisors should consider:

- Supervision can be used by those who request it as a means of avoiding conflict, consciously or unconsciously, by insisting that supervisors confine themselves to specific case work thereby avoiding other points of view (self-observation, group-reflection). In my opinion supervision should always include the group, society or institution and should offer the supervised enough room for open reflection.
- The supervisor should be clear about his own wishes, concerns and emotional involvement when he works with the dying or wishes to do so in the future. Supervision should definitely not be used to work on our own issues, or be used as a filler to compensate for an otherwise empty life, or to preach our own life experiences or to deal with unresolved personal grief.
- Supervision should be a continually evolving process, especially within the field of volunteer work in hospices. Supervised will usually expect a good group experience at each meeting – they will want openness within the group. When supervision is structured to work on case studies only, the group will often miss the chance to warm-up to each other and there will be a lack of group dynamics.

Psychodrama as a supervision method for volunteer workers

In his article 'Supervision for volunteer workers - psychodramatic supervision for hospice employees' G. Rosenberg reflects in detail on his supervision practice and using case examples he demonstrates how supervision based on psychodrama is especially suited to the volunteer sector. He reaches the conclusion that: "supervision based on psychodrama is particularly suited in more ways than one to working with volunteer workers". "Supervisors are often confronted with scepticism and disapproval when working with volunteer workers. It is therefore of particular importance that the supervisory process is structured to meet the special requirements of volunteer workers."

Psychodrama (and Socio-drama) is oriented towards the integration of action and experience, which often reflects the basic needs of many volunteer workers and fits well with typical group dynamics in the volunteer sector.

I wholeheartedly agree with this. Rosenberg begins with special rituals to structure the meeting and then follows with sociometry as a warm-up method: “volunteer workers like to work with symbols and metaphors as opposed to professional jargon and terminology. It can be particularly productive in the exploration phase to ask them to name personal as well as latent or manifested group themes with the use of metaphors. Such metaphoric pictures are a good basis for future work, and at the same time they give us an insight into the group as a whole”.

Use of Sociodrama in Supervision of Volunteer Workers

Rosenberg has devoted considerable attention to the use and implementation of sociodrama: “Under supervision volunteer workers should learn to recognise their emotional reactions as being an echo, a mirror of the dynamics taking place in their respective cases”.

Replaying actual work situations often brings relief and enables psychological hygiene. Psychodrama provides an extensive repertoire of techniques for achieving this. However it should be noted that in the beginning stages of supervision with volunteer workers who have no previous supervision experience it is not advisable to go straight into individual work with case studies because it is – against all expectations - unlikely to succeed. This is because they are used to working in groups and are reluctant to expose themselves, which they would have to do if they presented their individual cases. Using a protagonist approach too early in the supervision process can bring out fear and scepticism in the participants. When a protagonist presents his case there is a group tendency to make the problem seem smaller by turning it into a general problem for the whole group. The supervisor can counteract this by introducing well structured sharing of experience in the early stages of the session. The chances are that individual case work will be more productive once initial inhibitions about self-observation and individuation lessen. A certain level of maturity is needed in the group before productive individual work can begin.

Socio-drama is an ideal tool in the early stages of supervision when case study is not yet possible but where the concrete issue is already tangible.

Sociodrama...

- Facilitates theme oriented and case oriented work by making social (not individual) roles visible: participants explore a theme which mirrors a common interest and real experiences ‘playfully’;
- Avoids individual protagonist work; instead it is possible to involve many of the participants in the group; roles can be casted several times without loss of depth;
- Leads into scenic role play and works with (social) roles: The group learns to accept role reversing as a central method, instrumental to psychodrama in supervision;
- Opens the group up for a change of perspective in which roles and new positions, which might otherwise remain unseen, become explicit and can be voiced;
- Enables volunteer workers to leave the (trusted) relationship level and move towards discovering their own position and recognising their own social role and enables them to reflect on this in the context of their work.

I find the use of sociodrama in this context very exciting. Five years ago I always began my work as a supervisor with protagonist oriented methods, even with new volunteer hospice workers. This was due to my relative inexperience in psychodramatic methods and probably because I concentrated on the tools which I already had in hand.

No doubt there were cases of quiet resistance which did not receive enough attention: “*I haven’t got a topic today*”. However, normally, I could structure the group situation by using protagonist role-play: warm up, finding a topic, choice of protagonist using sociometry, protagonist role-play including sharing and feedback, possibly a second shorter run through, and a closing ritual.

Several participants felt themselves restricted in their impulse to help others because they were not able to give them advice. It was only later that I came to see this in a positive light: this basic ability to refrain from giving advice is an indispensable quality in hospice care personnel.

Protagonist work - Advanced training in bereavement counselling with volunteer workers

The desire for further training in the hospice sector is high among volunteer workers. This is because of the desire for more self-development, improved counselling skills, learning of new methods, and the need for more self-assurance in challenging situations. Even experienced terminal care counsellors feel particularly insecure and helpless in family conflict situations. It is not the person dying but more often the relatives involved who become the topics of discussion in supervision; this is particularly the case in the context of anticipatory grief.

Two years ago, when we advertised our training for experienced hospice carers, eleven women and one man from eight different hospice groups registered because they wanted to deepen their knowledge and ability as volunteer bereavement counsellors. The training was aimed at teaching how to advise and counsel the bereaved in hospices, setting up of self-help groups for the bereaved and bereavement cafés, and the enhancement of personal competence in caring for the terminally ill and the anticipatory grief of their relatives.

The first two weekends were dedicated to self-awareness and reflection on how they have worked up until now. In the case of well trained hospice carers with several years of experience behind them I could usually risk diving straight into the subject matter. The protagonist role-play method was already known by all the members of the group. The participants hardly knew each other which actually was advantageous for the course: group norms and roles could be freshly assigned. Hospice work and related issues, plus prior experience in an almost identical training, served as a common bond for everyone in the group. If I had not known about the individuals’ previous formative experience I would have taken more care at the beginning of the course, given the emotionally sensitive topic which we were dealing with – as “*grief withdraws readily*” from closer examination and does not want to be ‘worked on’ but rather wants to be experienced.

At the beginning of the second weekend I noticed certain reservations among the participants: – I heard statements such as: “*everything has gone; I can’t think of anything; nothing specific*” ; and also “*I need more time; I can’t open up*” and “*it is not important*”; and there was fear of bothering the group with unimportant or personal problems; I also noticed an increase in physical expressions such as: headaches; knee problems; colds; serious illnesses; hard of hearing; “*it affects me too much*”.

Two new topics were named: difficulty in counselling new arrivals in the hospice; grief following the death of a neighbour. The statements made in the opening round were

surprising for several reasons: it was unusual to hear so many complaints about physical problems during supervision or further education, almost all volunteer workers had something to contribute from their own experience and finally the participants- as they themselves said – had looked forward to the second weekend and were well informed on course topics and methods. I took time with the participants to review the opening round in detail, mentioning unconscious avoidance, somatic symptoms, and brought this into context with our topics.

Together we noticed: when talking to someone who is grieving about grief and other feelings which go with it, it can often seem as if no feelings are there. A warm-up phase is needed to create the necessary basic feeling of security. Only then, can people slowly open up to this theme. The group had reacted and was now showing me that I had jumped in too quickly.

Talking about it and reflecting on it made it easier for all of us, including myself. Suddenly all the topics, wishes, desires and expectations for the course were present and the group was once more open to working with a protagonist. They decided to work with the help of sociometry.

“Warming up” in a Bereavement Counsellor Seminar

The following morning (second weekend of the bereavement seminar), we had an opening round to discuss how the participants were doing and what their state of mind was. Some participants talked about their dreams. Following this I began with a warm-up session, which is familiar to those working in hospices. In these sessions feelings of grief can arise quickly so a careful approach is needed.

Here are the instructions for the warm-up:

- The participants sit in a circle and have several pieces of paper and a pen. There is a bowl in the middle. First of all everyone works by themselves.
- Exercise: write down the names of five significant people in your life, one on each piece of paper (c.a. five minutes)
- Examine your feelings for these people (another five minutes)
- Place two pieces of paper (voluntary) in the middle or in the bowl.
- Imagine these people are no longer in your life and never will be again. What happens? How do you feel? Feel into the loss of relationship. (Three minutes)
- Ask your neighbour to take away another piece of paper and put it, face-down, in the middle.
- Imagine this person is also lost to you for ever. See which piece of paper/name is missing. Feel the loss. (Several minutes in silence).
- Then: exchange your experience in groups of 2 or 3.

The warm-up was evaluated with intensity. One participant cried, although she said that she was alright. The participants were emotional but stable. The issue of “grief” was clearly present.

End of warm-up: *“Give-up all the pieces of paper! This game is over.”* I emphasize, it is “only a game” and is only meant as a warm-up. None of your friends or relatives has actually been hurt as a result of this game. It was however possible to get in touch with your own grief this way.

We conclude the warm-up with a ritual: I put a cloth over the bowl with the pieces of paper in it, collect the pieces up into the cloth and pull everything with one movement away. Then I put the empty bowl to one side.

Self-development experience for supervisors: courage to grieve

Before I devote myself to concrete protagonist centred supervision and counselling, I would like to pay attention to the counsellors and supervisors themselves. The dying process, death and grief are challenging situations for us all: everyone must die at some stage. Partings due to death are often key experiences in our lives. Personal competence culminates often in the conscious confrontation with one's own strokes of fate, partings, one's own grief and the acceptance of our own mortality.

In autumn 2006, I offered a seminar lead by Eva Leveton to 15 participants of the above mentioned Field Competence course, as well as to other counsellors and supervisors. This two day workshop, entitled: "Courage to Grieve", was completely dedicated to personal development and self-experience. Confrontation with one's own grief helps when dealing with grief in a professional context.

More often than not one's own inexperience with grief is the reason for wanting to work professionally in the field of bereavement counselling, dealing with illness, hospice work and giving supervision in health organizations.

The participants were invited to work with the following issues:

- Own unfelt grief and the possibility of reliving situations where parting had been difficult;
- Blocked feelings in respect to illness, the dying process, death and grief;
- Own way of dealing with feelings that are suppressed such as anger, auto-aggression and a feeling of emptiness after experiencing loss.

In the framework of this seminar, we could work with our resolved, unresolved and disliked grief in two extensive protagonist role-plays and several group sessions.

It is very healing to be able to integrate grief and pain from loss – often beyond our own generation, including those strokes of fate experienced by our grandparents.

Eva Leveton was an ideal counsellor for us. She encouraged us to try to be brave enough as to live with our grief and to use psychodrama for our own practice when counselling the bereaved. We learned that it is possible to use protagonist centred role-plays when counselling people with these existentially important concerns.

Role Reversal: playing the deceased

Eva Leveton prompted us to imagine there was a deceased person in the middle of our circle, and to imagine that we were this person or would play their role. We took time to feel into this role and then talked in detail about what made it difficult for us -and probably our clients- to get in touch with death in this role-play or even playing the role of the deceased. Here are the results of these individual thoughts:

- *I don't want to destroy the (nice) picture (a participant who had recently lost her mother);*
- *I'm afraid of my own death;*
- *I'm afraid of being paralyzed by the intensity of the feelings;*
- *I get breathless, I am afraid of suffocating under the scrutiny of the people standing around;*
- *I don't want to be an ugly corpse – I want to be beautiful;*
- *It is still too soon after a death that I recently experienced – it still upsets me.*

We discovered how we would like to be treated ourselves, when we play the role of the deceased and thus how we should treat our protagonists:

- The group leader should ask: "*Is everything alright?*" and every now and then, ask again if I want to continue.
- The group leader should be experienced.

- The group leader should help me in my role as deceased by holding a good role interview.
- Be careful! Physical touching the deceased or even physically immersing into the role of the deceased can bring up the fear of contamination.
- Playing the role of an unpleasant, “evil” or morally reprehensible deceased should not be contemplated as this could lead to unpleasant experiences being relived and which, although it apparently no longer exists, remains with me after the role-play.

From my own experience I know it is not advisable in every case to role reverse, even if it normally turns out to be helpful. Up to now I have not proposed it should be done when one’s own children are the deceased. And I have not done it in the cases where the protagonist did not want to take part. I remember there was a scene which was unpleasant for all concerned, where I asked a professional working in this field, to play the role of a recently deceased person within a team supervision session, and he spontaneously refused.

Many fears were voiced: “*We should leave the dead in peace*”, one team member said. “*I don’t want to play this person; she should not come alive again in the role-play. I couldn’t get rid of the unpleasant memory of her so easily and don’t want it to be reinforced*”. Luckily this person was spiritually very stable.

The role-play should always be based on the protagonists’ own willingness to participate and his explicit consent, not the leader’s desire to help.

Surplus Reality: Acting out one’s own death

To be able to act out one’s own death brings considerable relief; it takes away the overpowering aspect of this “taboo” theme (death) even though a little apprehension still remains. Dealing with themes around death, the dying, the deceased and bereavement can create a sense of closeness among participants, as we experienced in Eva Leveton’s group.

Healing energy for life can be released by confrontation with death, the big taboo topic. To experience our own death in advance (e.g.: in meditating on death) is another possibility for practicing. Our own death is experienced with the help of a (led) fantasy journey. This can be very effective in resolving fearful situations. It is however necessary to have good counselling when taking part in such an exercise.

When depressive clients (who have suicidal thoughts) feel secure enough in their therapeutic surroundings it is possible for them to act out their own death wish and thus experience relieve.

For further information see Case study A (in 3.Practise).

Setting the stage: Finding the right position for the deceased

The clear differentiation between the action on the stage and real life actions is self-evident in psychodrama sessions. This helps orientation during the role-play and also for the time afterwards. This formal setting of boundaries is especially important when crossing time and death borders. When the choice of a deceased as a "syntagonist" (instead of "antagonist"- see 1. Introduction, last paragraph) has been made for a role-play, and has been put on stage, is when the question usually arises: where is the deceased now? Where is the right “space” for the deceased?

In one of my first sessions, I counselled a person who sought my advice about wanting to change his occupation, but who found this decision very difficult to make.

He was the only son of an extremely influential father. On his father’s advice he had become a teacher -like him- but was very unhappy in this job. I suggested the possibility

of contacting his deceased father using psychodrama. At first he was somewhat surprised but then agreed to do it.

The question was: where is your father now? He imagined his father to be in "heaven". He succeeded in reversing roles: In the father role he could look upon his son's life in a relaxed and happy manner. This role reverse enabled him to see things from a different perspective which then became amicable, trusting and approving: "*Do what is important for you*", was the liberating sentence that he said to himself, in his father's role. The time had come to break away from his fathers' influence and give his life a new direction. He could integrate the fatherly feeling he experienced playing his fathers' role into his own life. In most counselling sessions this is known as integration of introjections and has a very positive effect for that person in his everyday life.

The question of the "whereabouts of the deceased" was also asked during a supervision session with hospice counsellors.

A middle-aged volunteer worker was counselling a 95 year-old who was ill. Her question was: where was her son who had been presumed dead? The hospice counsellor was unsure herself and brought this into the supervision:

The old (slightly dement) lady waited daily for her son who was more likely than not dead, to return from the Second World War. As the person who was officially in charge of looking after her had insisted that the lady should not open the door to strangers, she does not open the door when she thinks she hears her son returning. She tells the hospice counsellor about this problem with such vehemence that the counsellor herself wondered: could it be that the son is really still alive and has come back? She brought this improbable but somehow -for her- possible quandary into the supervision: that the lost son could return and presented the old lady's problem to me, as if it was her own problem.

In a role-play with a "simple change of role" (= terminology from Prof. Dr. Schwinger from a seminar at the ISP in Hamburg, in contrast to this there is also a "second level change of role" as will be seen below) did not produce any new aspects, as, although it was possible to feel the old lady's distress, it was not possible to connect with the son. The protagonist put the son at the side of the stage behind a column, in a "non-position", where he could hear and speak but not be seen.

Contact was only possible in a role change at the second level. According to Prof. Schwinger a "second level role change" occurs when the protagonist does not return to his role but, on occasions which are rare but are indicated under certain circumstances, slips into yet another syntagonist role (second level). Thus a discussion takes place between the first level syntagonist and the second level syntagonist, who now and then "helps" the protagonist understand his own intuition and to get in contact with it. E.g. A protagonist may change into the role of her own father and then from the father role to another syntagonist role at the second level e.g. that of her grandfather, or as in the case we have here now. Working at the second level is often speculative but nevertheless helpful as "surplus reality".

At first the hospice counsellor played the role of the old lady and from this role moved to that of the son, who is perhaps still alive or may be deceased. (=second level syntagonist). Thus it came because of the need of conversation between the old lady and the son, both played by the protagonist who had suddenly become emotional and creative. The son had certainly kept his place in the heart of the old lady, who had been grieving for years. The hospice counsellor's question was answered when she asked the old lady whether she had heard her son's voice as that of a seventeen year old or a seventy year old. It became clear to her when she answered: "*I hear him with exactly the same voice as he had then*", that the old lady heard her son from inside her still as a

seventeen year old and not from outside as a living person. For the old and slightly dement lady her son was still alive. The hospice counsellor now knew how she could carefully counsel the old and dement lady with her unfinished grief.

It is helpful in all protagonist role plays dealing with death and grief, to let them choose a safe place beforehand where they can go in the event of sudden outbreaks of strong emotions such as fear, panic, anger, shame or guilt. The group leader should choose a safe place for dealing with emotions early on in the process and not wait for the first signs of panic. The protagonist can then retreat to this secure place when feelings overcome him during a role-play. It is also possible to use a double to play the scene for the protagonist, who can then observe the scene from an outside position. If the group leader / counsellor can give the protagonist support and assurance while dealing with their emotions, then it is quite possible, within the context of the role-play, to cross the boundary between life and death, without fear or false shame.

Determining Level of Reality: Finding the right time

In addition to determining the 'Whereabouts' of the deceased it is also important during a role play to clarify the 'time' factor. There are three typical times:

- The present-time -as for the above-mentioned father "who is in heaven"- when the time is "now";
- the past Time -in most cases the actual time of dying or the last bedside conversation-; or
- even a former time of conversation/meeting within the biography.

Protagonists often decide to go back to their own youth or childhood to relive situations that occurred then, in which e.g. the deceased father was particularly fatherly. There can be moments of deep intimacy in these role plays; *A protestant pastor, whose father recently deceased, first went back to an early childhood memory in her role play. It was unclear to her in this first situation if her father had preferred her or her sister. It took place during a child's game at the kitchen table. She could experience that on the one hand he was fatherly but on the other hand she was feeling neglected. Then, we switched time: As an adult looking back at her childhood she wanted to relive this experience and find her adult position to it. At the end of the role play in 'present-time' she spoke with her deceased father about everything, telling him what was good and what was bad for her. She could now symbolically release him from this world. She opened the window and let him 'fly away', together with thanking him for the fatherly attention which he had given her and the forgiveness for all the love and attention which he had withheld.*

However protagonists usually want to replay the final bedside scene and the final or unspoken words with the person who is terminally ill, in order to be able to say farewell in a more reconciliatory manner. Thus the place and time are clearly defined: The partner of the deceased, the relatives as well as the hospice counsellor have often been unable to be at the bedside at the actual moment of death. They often miss the exact moment of parting and being able to say words of thanks or words of forgiveness for one another. This can easily be reconciled during psychodrama.

A group of people including those interested in hospice work and others suffering from bereavement met up during a congress on the theme: Unspoken farewells – experiencing suppressed grief. The group chose a man whose thwarted wish to marry due to the untimely death of his partner was weighing heavily upon him. He had the feeling of not having given everything he could and not having kept his promise. This protagonist experienced great relief and consolation just by playing the death scene in the role-play. He felt that their joint intention to get married was a shared inner reality at

the point of death and therefore no longer needed an outward manifestation. He had perhaps told himself this before but wanted it to be verified. He experienced it strongly in the role play and in the feelings that arose afterwards. This is the experience he had longed for.

The group let their tears flow freely together with him, he felt secure and reassured. The syntagonist, who was quiet and sensitive during his improvisation, helped the inexperienced man in this role-play. Thus there was no need for a direct role reversing, which would perhaps have been too emotionally challenging for him. All in all plenty of time is needed for such a session, especially when the core issue is grief.

Example for “setting stages and times”

One protagonist, during a self-experience seminar on grief for hospice counsellors, took over an hour to set up her daughter’s death scene: In this case three ‘time zone factors’ were set up parallel to one another: The time of death, the time for grieving, and the present time: The dying scene was set up using figures and various other materials: the daughter, the biological father / ex-husband, and the ex-husband’s dog who brought about the death. The second scene was the time of grieving with the rest of the family, who were all feeling sad, behind a barbed-wire fence, including herself, her second child and her present husband, the step father of the deceased daughter. The third part of the picture was an undefined place in a green field with flowers and a ball in the middle. The protagonist did not say a word while setting up the three scenes however her intense concentration engulfed the whole group. They followed the proceedings quietly and intently. By means of slow and gentle interrogation and an equally gentle role reversing, the tragic death of her daughter was re-lived by all.

It would have been a good option to encourage her to role reverse at this point, however, I had the feeling it wouldn’t have worked. It would have meant too much emotional strain. I couldn’t verify whether this decision was correct at that moment, it is just how things went and I followed my intuition. Later it became clear that I wasn’t completely wrong, as the protagonist had already worked a lot on this issue and it was not important for her on that day to examine the relationship with the deceased daughter.

The protagonist’s main interest was to change the long-lasting and -even after five years still inhibiting- grieving process which she had inflicted upon herself, the other child and her husband. None of the grieving family members came out from behind the barbed wire and no friend was able to go inside. It was not the first time that the protagonist had worked on her grief and she was herself a trained therapist. She wanted to, and could, feel the past and the present again to see *“where do I stand now with my grief, where can I open up small and large holes in my fence so that my husband and my surviving daughter can breathe again and get some space?”*

Reversing roles with her husband and child she was really happy about every little opening that showed itself. Finally the protagonist cleared nearly all the fence elements away and was able to feel freer herself and suddenly turned her attention to the ball in the middle of the green field, threw it up high in the air and said happily: *“now you too can fly away!”*

She changed her daughter’s position from ‘resting in a pleasant place’ to ‘moving lightly’.

She – and also the group who were going along with everything – felt relieved and free. Whether the daughter actually was in a pleasant place – as most of the spiritually and religiously experienced hospice counsellors assumed – or whether the protagonist’s inner feelings were lighter, flourishing and being lived out cannot be objectively clarified.

Enabling an interview with the deceased

Hospice counsellors often suffer from not being included by the relatives at after death ceremonies, etc. The reason behind this is often that the relatives associate the hospice counsellors with bringing death, being angels of death. Under these circumstances it is not so easy to feel grateful to the counsellors. In almost all cases it was possible to replay the last encounter with the deceased in such a way that unspoken words of gratitude and respect on both sides can be expressed posthumously.

These words were not actually spoken but were felt and are there internally although they were not articulated. If they would have been spoken then it would have been something like: "Yes, that's exactly it, and if only it could have been said at the time". If some of the counsellors are still unsure of the last words of gratitude, then I ask them to watch the scene from the side of the stage (using an auxiliary ego to represent the hospice counsellor and another for the deceased) and to see for themselves: Is it right like that? Could this actually have taken place in reality?

When the protagonist is playing the role of the terminally-ill or recently deceased patient, where it is questionable whether they can still express themselves audibly, it is often a good idea to come to an agreement between the session leader and the protagonist. Usually the protagonist is helped by the idea of speaking his thoughts out loudly. The idea behind this is that seriously ill or deceased patients can also think aloud -and can therefore be heard in a role-play- without diverting too much from the real situation.

Accepting role reverse: Death is not an untouchable taboo

Often it is not the relationship between the deceased and the protagonist that needs developing or healing. Rather the deceased and death itself represent elements in the life of the protagonist which could be clarified. For example nightmares are frequent phenomena experienced by workers in hospices and on palliative wards. Nightmares are seldom worked on during supervision, as they are thought to be private.

A hospice worker reported having nightmares about her husband seeing him stabbed to death and smeared with blood. This nightmare made her feel guilty about having a job that involved dealing with death and the deceased. I offered her the possibility of using a magic shop: She could give up her nightmare for ever in a magic shop, if she was prepared to pay a deposit: something that she had plenty of and that is of value to her. She immediately thought of her strong sense of responsibility which she could give up a little of. Nobody was surprised that she primarily felt over responsible towards her husband. As this was the case, I asked her, in the role of the shop owner, to give up 50% of her responsibility that she felt towards her husband. She only wanted to deposit 20% because she was afraid that he could not cope without the other 80%. I, in my role as owner of the magic shop, was happy with 20% at the beginning and promised to permanently lock away her nightmares that same night. In the pause that followed, the connection between her exaggerated feeling of responsibility and her nightmares became clear to her and so she painfully offered to give up more of her excess of responsibility, so that her husband could live his own life and she could take more responsibility for hers. The nightmares really did not return in this and in other cases too.

Protagonist Role-play as a Grieving Ritual?

In protagonist role-playings, even the deceased can become active participants. And the deceased can now be remembered by the protagonists in a more positive light i.e. the parting scene can be relived and / or completed. The protagonist's concerns can be

resolved even after death. Psychodrama can be used as a form of rite for the living as it has as clear structures as the ones found in rituals.

Three important aspects of a ritual: the main characteristic of a ritual is letting go of everyday processes; secondly, the climax (=spiritual moment) and finally the integrating newly found knowledge into everyday life. Transposing this to psycho-drama role playing, this could mean:

- Beginning the ritual by letting go of everyday processes = Protagonist and psycho-drama director walk together onto the 'stage', after having been given permission for this action by the group participants using sociometry to choose the protagonist.
- Ritual action = the role-play itself, reliving the past and experiencing a new level of reality (here: surplus reality)
- The climax of the ritual 'celebration' including the 'spiritual moment' = the cathartic process (according to Moreno) or at least a certain clarification (cf. the Catharsis debate at the last meeting of the DFP in June 2007).
- Integration into daily life = coming back into the group for sharing and feedback.

In this context I have experienced how healing psycho-drama in protagonist role-plays can be: taboos on the issue of death and dying can be resolved and it is possible to approach the topics more realistically. Death is no longer an issue to be avoided at all costs and relevant unresolved 'sticky' issues can be clarified. (In this context catharsis is understood as a cleaning or clearing process). There is permission to talk about death within the context of protagonist role-play rituals. And over and above this: In the face of the silence, inactivity and finality of death, unable to do anything more, it is beneficial to be able to talk about one's feelings with the deceased, with death itself or with one's own inner concerns in a role-playing which is a safe, structured ritual.

3. Practise

Case study A:

The "I" narrator, or in some places the double of the protagonist speaking in the "I" form (Ella Mae Shearon describes this case shortened, cited by Paffrath, 2007).

Maria lives alone; she has no-one around her, not even a pet. At the age of 47 she is going through a bad period in which she is facing the existential decision whether to live or not.

This is the most important question for her. She feels that she has enough energy to make important decisions about her life; to choose herself if she wants to live or die Subconsciously the death process has become predominant and she is actually about to move more in the direction of death than life. I ask her in the "I" form: *"How shall I kill myself? How do I imagine that I will do it?"*

Maria describes how she wants to jump from a cliff on the coast of Normandy. I ask more questions: *"where would I leave from? How do I get there? In a car? What do I have with me?"*

A surplus reality psychodrama exercise brings the feelings up: "to get rid of it, act it out!" We get her suicidal feelings moving. The psychodrama develops.

The next scene shows Maria getting into her car with packed food rations (cake) and driving towards the French coast to jump off the cliff. I comply with the fantasy or the subconscious thoughts of the protagonist according to the surplus reality model. These

are then acted out in the form of a psychodramatic scene. This is a play with an open end. It follows the protagonist's thoughts and enables the dangerous, self-destructive fantasies to be acted out in a natural, non-threatening, almost real manner. The story gains more and more subjective reality and the scene continues on as she drives towards the coast of France. Her situation changes immediately the minute after she arrived at the border control. Maria approaches the border guard. An impressive scene. Tension rises. Maria begins a dialog with the guard. Using the technique of reversing roles in individual psychodrama style, Maria now impersonates the role of the guard and says to herself (sitting in the car): "*No. Maria you cannot cross this border. Nothing is right!*" The border control exists in her own fantasy and in this role stops her from crossing the border.

This dialog between Maria and the border guard symbolizes her inner fight, on the one hand in the direction of suicide, on the other hand in the direction of saving herself and deciding to live. The figures on the stage mirror her inner psychological dilemma, being drawn towards death as opposed to life. The dialog in the scene arises as a result of the border guard stopping her.

As she cannot cross the border anymore, she sets up another scene, back in her own role again. Now she goes to a restaurant in the country where the locals meet up for a good meal and wine. She parks her car and goes to the restaurant, where she carefully sets up the scene with roles that represent important inner helper parts of herself, which she acts out.

Slowly a new positive feeling for life emerges after role reversing with many of them. Two men are sitting opposite her, eating and drinking and full of the joys of life and a yearning for sexuality. By means of a role play with just one of the men first, she asks herself "*What are you doing here? What right do you have to be here?*", etc. Back in her own role, she answers these questions. In a role-play with the second man she feels accepted, and attractive. Impulses to live begin to stir again and hope starts to arise. She begins to look different: she becomes livelier, hopeful, provocative... In following sessions Maria continues to open up: dressing in a more feminine and attractive way, she laughs more, has new aims in life.

Case study B:

Protagonist role-play in the context of caring for the terminally ill and bereavement counselling

The protagonist describes her concern: "*I had promised a terminally ill patient that she could have a nice room in the hospice. However the room she was given is small, narrow and dark. This patient is very unhappy. I have the feeling that I am morally involved and have not kept my promise. I don't want to feel guilty and I want to learn to be more careful with my promises. I would like to know what I can do.*"

The protagonist sets up the stage. The room is narrow, dark and small, no light as promised. The patient is lying on the bed (represented by a chair). A sister in law makes a short visit but leaves again on the grounds that she has to look after pets and go to a confirmation. The roles are not allocated yet, only the room is set up. There is the previous room in which the promise was given; a ward in a general hospital and yet another room on a palliative ward. This is where the first contact took place. And a fourth room: the patient's 'girlfriend's' flat (they were both around 70 years old), where the terminally ill patient had lived before moving into the palliative ward. The girlfriend had asked the patient not to return there after hospital treatment but to move out.

The protagonist wants to clarify this matter with the patient who is now lying in a dark room in the hospice. The volunteer worker comes to visit. The patient is played by another participant. This syntagonist is a friend of the protagonist. She knows the patient well and has told us that she has similar issues herself. This choice could on the one hand be a source of trouble when working on the protagonists' inner concerns as her friend could potentially bring her own issues into the process if she is not stopped by the course leader. However the choice seemed to me to be helpful for the structural treatment of the topic because the friend, who knows the person whose role she should play, can improvise later and make the process more vivid.

The patient – acted by the protagonist in the role play – is annoyed. Nothing is as it had been promised. She is also annoyed by the course that her illness is taking. The protagonist promises strawberries (instead of a light room?) as compensation. We watched the scene: haggling took place between the hospice volunteer worker and the patient, who seemingly has the right to be annoyed, the volunteer worker feels helpless. Should she arrange a change of hospice in order to get a nicer room? A second role-play does not bring anything new to the situation. The person who is really guilty – the protagonist says – is the 'girlfriend'.

The protagonist plays the role of 'girlfriend' who does not come to visit any more and is therefore seen sitting in a chair in her house, (the fourth place set up). The protagonist reverses roles and plays the 'girlfriend': *"The patient cared for my parents. That was a difficult time. My mother died four months ago. My friend and I had planned to spend the rest of our lives together. Now a difficult period of caring for her has come about. It doesn't fit into our concept. I prefer to visit a health farm with my sister. I want my peace. I am a little sad about not being able to fulfil our nice future plans."* Everybody notices the deep disapproval and moralistic criticism which the protagonist shows towards her friend: *"this so-called 'friend' is responsible for the patient becoming "homeless" and therefore a place had to be found quickly for her, she had to accept the next best place in a not so nice hospice. The personnel are friendly but it is not possible to live well here and to find peace"*.

In another role-play reversing roles with the patient we learn that: *"Nice colours are missing, personal pictures on the wall too; books... worst of all good health is missing, but also contact with her friend"*. It is true that although the patient was cross with her friend, she could however understand her. She had had so much sorrow. Perhaps everything is too much for her.

As leader of the group, I suggest that the protagonist might like to try out a meeting with her "friend" within this role-play, just to see if anything changes. This attempt to meet develops slowly: first there was contact via a postcard, then a date made by telephone, then a first meeting full of reproach, which led to a break in contact. Finally the protagonist actually tried to listen to her "girl-friend", and during the role-play there was a gentle hint of feelings being shown. Now however the protagonist wanted to clarify whether the patient really approved of the meeting with her ex-"girl-friend" or whether this would lead to a conflict of loyalties.

The hospice volunteer worker/protagonist tells the patient that she has a proposal: she wants to meet her "girl-friend". She asked the patients' opinion on this. The patient (in free improvisation) is at first indignant. In the acted interview (played by the protagonist, as well as the syntagonist who also knows the patient well) she admits: *"I don't mean to harm her anyway. I am just annoyed and feel lonely. If she suffers a little it's o.k. However, if the hospice counsellor can help her in her difficult situation, as she has me (the patient), then why not. Perhaps my "girl-fiend" will even visit me sometimes. Then I wouldn't feel so lonely"*.

Now the protagonist really tried to make contact with the girlfriend and to talk to her. She is however still only interested in helping the patient. During the improvisation it became clear: The girlfriend also needed someone to talk to. Perhaps she is still mourning. The role-play ended there.

During the feedback the opinion that was expressed was: the girl-friends' actions, that seemed at first glance to be reprehensible, were perhaps on second thoughts to be understood. Could it be a reaction to her own loss and lingering grief? The syntagonist interpreted it as such in her feedback, that she felt the interaction had been intense and that the visit to the health farm was not what it was about, but rather that she had said those words as a defensive reaction, because she was still suffering from the effects of her mothers' death and didn't want to have to deal so much with death in her life.

The group and I slowly came to the assumption that it is not easy to talk about grief openly and it cannot be "worked" on. Trying to reach people who are grieving and enabling them to talk about it is a very delicate process. And it is often difficult to stay with their reaction – if it really was grief that the terminally ill patients' "girl-friend" was going through, and not just the need for health-farm care which is an understandable wish for a woman of her age.

All the participants (volunteer workers, patient, "girl-friend") found grief -if it was grief- difficult to bear and live with. This is why nobody paid attention to the "girl-friend" and why she was morally judged ("why does she want to go to a health farm when her friend is dying?").

However, hospice work is based on an aware decision to include all people involved with the terminally ill person in the counselling process - partners, family and other contacts. In addition we learned that the bereaved need a concrete offer of a counselling session – which can be either accepted or rejected.

During the processing of this case, the group of trainees had been able to experience and internalize the core elements of bereavement counselling and was now more able to understand and recognize the issues compared with what would normally be taught in pedagogically well-structured lectures.

Case study C:

Coaching a bereavement counsellor A protagonist oriented session.

The 60 year-old, unmarried protagonist tells us about her problem: *"I'm still sad about my neighbour's (40 year old) death. He was the father of two small children and an active member in the joint family residence project. (ca. 30 tenants – young and old – families and singles, all living together). I had a lot of contact with him, even though I was not a relative. I would like to be able to handle my grief and the situation better"*.

I suggested that she gives other participants in the course (training course for volunteer bereavement counsellors) the chance to talk to her and get some "practice" at the same time.

She agreed to do this. We look around the circle to see who would like to "practice": four people signal a clear refusal, two hesitated, and three showed they were willing to participate. The protagonist chose her first counsellor from those who had hesitated. This person was now pleased to have been chosen and was happy to take part.

The counsellor used a method which was already familiar to her: empathic questioning (using almost entirely open questions) and "feeling into" the situation. The protagonist described the situation: the residential project; what the loss of the young man meant for the project and what his loss meant for his family. Slowly the protagonist admits: *"yes, I am really grieving, more than I admit and show to myself and to others."* The task

ended after 15 minutes with the protagonist deciding: *“I want to do something, something to take care of myself so that I can better deal with my grief.”*

The discussion came to a good conclusion and at the same time a decision was made for a new beginning. The protagonist is in a stable state. There is enough time and there were enough people offering to lead a practice session. Therefore I suggested that the protagonist might like to take a second counsellor to help clarify her decision. She agrees. The aim is to find out what exactly she needs to do to help her with her grief.

The second counsellor goes, rather fiercely, straight into the problem but with a different aim: the grieving protagonist should talk with the bereaved widow so that they might help each other with their grief. Despite intervention from the session leader, the counsellor cannot give up her idea. She carries this idea, which is important to her – rather too vehemently – into the new role-play and for whatever reason was unable to make contact with the protagonist. (We learn from this later).

During this discussion we also learned that: the protagonist had taken photos of the young neighbour at a birthday party, knowing that he was terminally ill, so that she could keep a picture of him for herself. She also took a second photo: when the terminally-ill young man had to go into hospital, the patient’s wife had hung photos of him in all the corridors of the residence, pointing out that her husband was now in a hospice. When he died she secretly took one of these photos and kept it for herself before the widow took them down again.

I proposed a third round of counselling and focused on the “secrecy” with which she took the photo and on the permission she should have obtained to take a photo officially. The result was: the protagonist would perhaps talk to the widow and ask for an “official” permission to take that photo.

At the same time she would reveal her own (secret) affection for the young man, which has found expression in her long-lasting grief and feeling of loss (which had not yet been felt and openly talked about). She could also give the widow an opportunity to talk about her grief (which as a widow was of a different kind).

The protagonist, who was a pensioner, often blushed during the talk which would seem to confirm the hypothesis that there may have been a desire for a deeper (erotic?) relationship.

These desires seemed to be the reason why she could not talk openly to his widow.

We evaluated the person leading the session: the protagonist felt that on the whole the counselling had done her good, however, she was not quite sure of what the second counsellor wanted from her and this had made her feel insecure. The second counsellor explained that she had an idea where she wanted to lead the protagonist. We worked on two points from the talk with the “second counsellor”: her very high pitched, slow and empathic voice did not fit with her clear and direct style in leading the session, it was not congruent. And: if as a leader you don’t manage to let go of a fixed idea and you want to do something, then you can say this directly and let the protagonist decide whether it is relevant for her or not. In this way the issue can be clarified. In the evaluation of the first counsellor the group noted that: everything was good. To ask open questions was good. And: it came to a clear conclusion and thus both the counsellor and the protagonist were satisfied with the session. I thanked the protagonist for enabling us to “practice” using her grief as an example and the counsellors for having the courage to work in front of the group. In particular I thanked the second counsellor because we were able to learn a lot about our own capabilities and difficulties which may arise in counselling.

The following weekend the protagonist reported that in the meantime she had made good contact with the widow and had spoken to her about the similarities and differing

aspects of their grief. Apparently she had not spoken about the photo, i.e. the longing for “intimacy, connection and erotic” are not yet allowed. The protagonist, as helpful and caring as she is, now wants to take care of the widow’s “grieving children” (a matter which I do not confront or comment on in any way).

Case study D:

Volunteer worker gains confidence and loses her excessive “guru-like” expectations during counselling.

After a warm-up session Ada was chosen. I have known her for some years; she was in my first training group (2001 – 2002) and was a participant in my first supervisions. She owns an esoteric book shop and has a lot of experience in counselling the terminally ill. Her long grey hair and wise appearance had won her jobs with a model-agency for senior models – as well as deep trust with the terminally ill.

However, she herself felt insecure, which gave her a certain charm.

Her topic is: She often feels that her counselling is not structured enough and she experiences chaos. One hospice case was particularly upsetting to her: there was a lack of healthy boundaries in the relationship. She suffered from her own high expectations on herself and at the same time an inferiority complex.

My suggestion to her was to work on these inner issues within a constellation setting and thus be able to observe and experience herself from the outside as a counsellor. The syntagonist was then chosen and the stage set up. A place in the middle was reserved for the syntagonist, a seriously ill person. Next to her there are two people representing Ada’s main counselling skills and qualities: one person is the empathetic scatter brain with a note pad on which she writes everything down so that she doesn’t forget anything and the second person represents the back-stroking perfect hospice counsellor robot.

I notice that both inner parts are consciously or unconsciously tense in some way. She is worried about “structure” however the inner part of her which represents structure is just a “robot”. Yet this is the part which is actually stroking the patient’s back and ‘showing’ that she cares. The counterpart is the part which Ada wants to limit and control: disorder, spontaneity, chaos. The problem is that this chaos seems somehow more caring and lively. The chaos part is not actually chaotic when she is doing her job, it is writing everything down and very busy making notes. Ada says that is what you are supposed to do. This is the confusion in which she finds herself.

I tried reversing the roles, but Ada can’t get into it, buries herself even more in chaos. I can’t get her to feel into the role, so I can’t interview her. I therefore suggest that she choose a double (also “Alter ego”, not an auxiliary ego that doubles but another auxiliary ego that comes into the scene for Ada, when she watches from outside -called ‘double’ in the following description-) and we both watch everything from the outside. The auxiliary ego stands opposite the person being counselled, Ada now repositions her two counselling skills/qualities. At first they stood next to the person being counselled (probably my mistake because I had mixed the internal and external levels, but that is just the way it happened). Ada takes them away and puts them next to her double. There they become true inner aspects and no longer the external ones. She thinks that everything is now OK until she notices the ambivalence: The empathetic / chaotic part writes everything down and wants to organise herself; the cold/perfect part does the stroking and seems warm. Ada realizes the ambivalence that she feels when the chaotic part on the one hand writes everything down but on the other hand does not keep to any structure. Ada now goes back to her position. Both internal parts stand next to her, the chaotic part taps on her left shoulder, the ‘perfect counselling robot’, now renamed

'compulsive perfectionism', is shuffling around at her right shoulder. She notices a third force pressing on her head and calls it: the many ideas / thoughts of a sceptic. She now has her ideal picture of how counselling (and her doing the counselling) should be: the 'hospice guru', sitting between her and the person being counselled. New roles are now allocated, the 'sceptic' and the 'hospice guru'! Finally we perceive something changing and know that we have made progress.

Ada, slowly but surely, deals with all her inner issues in the role-playing. First, the 'Perfectionist' part with all its fears, then the sceptical and then the chaotic part. She does this carefully and with high regard for each of the parts, saying to all parts that she had needed them and will need them. Only then, she can finally remove the guru. She gets the incentive to do this during the role-play. While playing the seriously ill person, she says: "*When the guru is between us I can't see you Ada; and I want to be counselled by you as you are now with all your chaotic parts.*"

The role play ended there. Ada left the scene quite relieved. During the detailed sharing and feedback round which followed the role play, Ada was given assurance that she may and can and should counsel in this way: just as she is now. She was a little reluctant to accept this at first, so her parting words -with just a touch of irony- were that she was unfortunately not a "Guru" but actually in her own way she was.

Case study E:

Death, guilt and a new life

I would like to describe a protagonist role-play in this context: It took place during a self-awareness seminar where 60 volunteer workers from hospices, telephone help-line counsellors, hospital counsellors and workers from charity organizations met up. I counselled a small group of participants: one male and eight females with their traumatic experiences in their jobs as voluntary workers. The male participant had had a depressing experience during his job as telephone help-line counsellor: a young female caller phoned in to say she was about to lose her baby. He told us that he had also lost his first child early on in life. The next morning the group chooses him almost unanimously to be the protagonist and we dedicated ourselves to him and his case for almost the whole day.

The protagonist is a tall good-looking 50 year-old man. He tells us that he lost his first child early on. His son was born soon after. However the marriage broke up due to differing ways of dealing with bereavement. The protagonist said: "*there were certainly other reasons for the break-up of the marriage, but in the role-play it became clear to me that my feelings of "(un)conscious guilt" for my responsibility as father and towards my family, but especially towards my son, had prevented an earlier end to the marriage*".

His career went well for some time. He took part in communication training workshops and was also involved in giving training. However psychosomatic complaints forced him to give up his job. He was unable to work during the day and sleep at night due to fear and panic attacks.

Protagonist: "*I suffered from severe depression, which was combined with fear, although I did not experience panic attacks during this emotional (or rather unemotional) phase*".

He was eventually pensioned off early. In the meantime he feels better, and has formed a second, happier, relationship. His son has turned out well which he tells us with some pride. He has a good social life again and makes friends easily. However he still suffers from disturbed sleep.

His concern: He is a good telephone counsellor. He answers most of the enquiries patiently, with empathy, clearly and with humour, even those from disturbed callers. Just one conversation some time ago left him speechless: A young woman rang up and “shouted” into the phone that she was bleeding and about to lose her baby. Fear and panic arose in him and he felt paralyzed.

The protagonist commented one year later on this: *“The caller did not shout into the phone. Had she done that, then my focus might have gone from the dying child to her emotional state. Then I could have ignored the rising feeling of paralysis due to suddenly being confronted again with the death of a baby. In this case it would have been better for the caller if she had shouted, as it was she who helped me to confront my themes more than I could help her. I would prefer to talk about emotional paralysis and a feeling of helplessness, rather than fear and panic because I perceive them as more external issues”*.

This comment made particularly clear to me how the experience had been interpreted differently from what had actually happened (by both the group leader and the protagonist). The group leader had experienced and remembered the scene (and the manner in which the protagonist had presented it), to be more outwardly oriented, more explosive and crisis ridden. However the protagonist remained in the actual feeling of being paralyzed and helpless and feeling empathy and understanding for his client.

I have deliberately described this discrepancy in detail but left other issues unmentioned. This discrepancy can be used to show how Psychodrama works: even when the group leader and the protagonist have differing perceptions of the situation -coloured perhaps by their own feelings, experiences and interpretations- the protagonist can stay with his real feelings during the role play and during reflection afterwards. Strangely enough he hardly experiences any disorientation during the role-play; he stays self-controlled, keeping a clear head in the situation. The role-play continues as it actually happened without him having any further feelings of disorientation.

Despite his paralyzing fear during the role play the protagonist wanted to take a more detailed look at the situation to see if he could find a solution. He wanted to experience how psychodrama works and had therefore specifically joined this group. The panic experienced previously started up again while replaying the situation. There was no opportunity to change anything or to re-find his voice. From the observer position he began to think that the memory of his daughter’s death could be the reason for the paralysis. We set up a second parallel scene. As he didn’t want to bring his own deceased daughter on to the stage I asked him if there was anything else which could symbolise his daughter to put on the stage instead. The symbol he chose was a special gravestone. He wanted to speak with his son (maybe also with his ex-wife) at this gravestone. Protagonist: *“this gravestone actually stands in the cemetery in my town, which has been put there for prematurely deceased children who have not yet been buried. I actively participated in the organization of the setting up of this stone and gave a donation”*.

The deceased daughter soon seemed less important. Indeed he then wanted to know from his son whether he had felt neglected in his life as he had had the responsibility of enabling the dead sister to live on through him; if due to their grieving he had not had all the parents care and attention that a son would normally expect, and if so, how he could now do justice, or make up to him in his role as a father.

In exchanging roles with the son it became clear that all these questions were only relevant for the father and that the son did not feel happy standing at the gravestone or being faced with these questions. The protagonist learned from this scene that there was

neither energy nor a solution to be found there, and that there was no correlation to the real situation.

We went back to the original scene, where we re-examined the inner issues which had led to the paralysis. The stress of having to do everything right, the hopelessly excessive demands, had constrained him and put pressure on him. A punishing feeling of guilt sat heavily on his shoulders. Syntagonists took over the constricting straight jacket parts for him. An auxiliary ego took his part in the scene to give him space to watch everything from the outside. Then he began to realise that the heavy syntagonist on his shoulders was like his father. He needed to free himself from him. He tried to. However, in the scene, he could not liberate himself from his father. His wretched situation had a purpose: the more he endured the pressure from his father, the more he could protect his son from his father's (and, his now emerging, grandfather's) extreme behaviour. The power of the 'bad father' destiny could only be broken if he, as father, carried all the burden of previous fathers to protect his son from possible pressure. We now needed the son on stage again in order to verify this point. Already in the previous scene we had learned that he could not relate to his father's guilt. And he did not have the feeling of having missed out on anything in his childhood, especially when taking into account his sister's death and his parent's grief.

Protagonist: *"The previous scene relieves me from feeling responsible and guilty with my son about my daughter's death."*

Now the son, played by the protagonist, could clearly say to his father: *"I am now grown up. I feel good. You were a good father to me and I am successful. You can be proud of me and I know you are proud of me. You don't have to carry the burden of your father's brutality anymore and turn away from me. I am responsible for my own life."*

The inner voices also changed their tone and became helpers. In that way the protagonist could let go of his father (who in the meanwhile had died), and declare that he was no longer prepared to live with the pressure which he had felt from his father. In his own words: *"my father is now deceased, but my inner father image has changed in such a way that I am able to have freer contact with my son and not feel guilty or responsible. This also enables me to have a different attitude towards the caller (in the role play)."*

Fatherly feelings arose in the protagonist. The enormous fear of doing something wrong and the non-fatherly feelings disappeared. Therefore it was also possible to have good contact with his son and with the caller from the original scene. Everybody was enthusiastic about the immense creativity which the protagonist used to counsel the caller (and the astonishing empathy shown by the improvising syntagonist). There must have been a reason for the young woman to ring the anonymous and discreet help-line counsellor rather than an emergency doctor. The counsellor could relieve her fears with understanding and in a definitely fatherly manner. Protagonist: *"to my mind I reacted more as a partner rather than as a father, on equal terms with the caller and taking the caller seriously in her moment of distress, instead of transposing my own guilty feelings on to her and her dying child. This is what had been resolved by the protagonist role play."*

Thus it had paralysed him and disturbed his relationship with the caller: *"It was the analogy of the dying child, which brought back feelings of guilt and responsibility towards my son. And this debilitating helplessness brought about by the huge pressure and at the same time insecurity of being a father. It is purely my own childhood experiences with regard to my own father which brought about my inner conviction that*

I had to keep the burden of (ancestral) fathers from my son. In the protagonist role-play I associated the pressure and helplessness to my inner father. ”

At that point he realised that the pressure from the syntagonist on his shoulders was just like his own fathers'. It was also the pressure of being a father and the insecurity about his own fatherly instincts which paralysed him. As soon as this pressure was relieved his natural fatherly instincts towards his son returned and also his contact in relationship with the young caller who could have been his daughter. He could now counsel her well.

The seminar participants also felt how their own lived and un-lived grief came alive again during the role-play. They were intensely involved in the transformation process from total paralysis to a new found aliveness. The relief experienced by letting go of pressure was also felt by the others. Some could now tearfully tell us that they had also lost a child and that they still suffered daily. Four participants had lost a child, one several times late on in pregnancy, another during birth and two during infancy.

4. Epilogue: “Are you a sad person?”

The day that I had finished a rough draft of this paper, 14th July 2007, I was sitting at the hairdressers.

I started talking to the hairdresser while she was washing my hair. She had seen that I had typed something into my computer while I was waiting. She asked: “are you writing a book?”

I said, “I have written a book but at the moment I am writing something shorter.”

She said, “How interesting!” While the water was running over my head and she was shampooing my hair, I added: “I don't write crime stories. I write about bereavement!” Completely astounded, she asked – with a little pity in her voice, “Are you a sad person?” I negated this and explained my job to her. As so often happens, she spontaneously imparted her last sad experience to me: her friend's father died at the age of 42. She had felt totally helpless when talking to her friend. I replied: “then you did the best you could: you felt helpless and didn't run away – and didn't try to divert your friend's attention away from her grief by talking too much. You stayed with her and her grief and felt your own helplessness and perhaps even your friend's helplessness with empathy”. She found these thoughts interesting and helpful. For someone who writes books about it and hasn't got a better trick up their sleeve, this is an acceptable and perhaps somewhat uncomfortable method of how to counsel others who are grieving.

During the second rinse, while still lying in a Freudian manner on the chair, I also tell her about myself, as is usual at the hairdresser. After the death of my father I could not help my mother with her grieving. Everything you know about bereavement seldom helps when your own family is involved.

The hairdresser reacts critically to this piece of information. How can I help others when I can't help myself?!

I explain that I have an issue with my mother and she with me, my father with me and me with him and of course my mother with my father.

My mother was very sad when my father died, understandably. I however was happy with the way my father had rounded up his fulfilled life and how he had passed peacefully away. If my mother had been a stranger I would have been able to counsel her. However the various family ties played a role here. My expectations of her and hers on me and the different ways in which we were grieving made it impossible to be there for each other. I am not a counsellor but a son to my mother and to the deceased. I'm not sure if the second rinse helped to clarify matters but somehow or other it became

clear to me that it is really good to have external professional and voluntary bereavement counsellors for those who are dealing with bereavement. And in passing, between two rinses at the hairdressers, grief became an acceptable issue to talk about in public.

How would I have answered the question, “Are you a sad person?” I laughed and said: “No!”

I am really not, at least no more than others. And the lightness and playfulness of psychodrama helps me to deal well, even lightly, with this heavy ‘issue’.

I wish to thank all, who supported me: The protagonists, the colleagues, my teachers of ISP and ISI, especially Paul G. Grapentin. Special thanks to Eva Leveton, San Francisco, who guided me and Jorge Paz, Barcelona, who gave the text the English shape and all the readers of the text, who gave some support/comments - please do not hesitate, to send me some more.....

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