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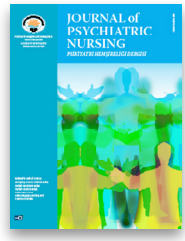

Experimental Study

The effect of psychodrama group therapy on coping and the quality of life of palliative care nurses

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Abstract

Objectives: Healthcare professionals play a crucial role in palliative care. Palliative care professionals experience physical, psychological, and emotional distress. Thus, the aim of this study was to determine the effect of psychodrama group therapy on palliative care nurses' coping and quality of life.

Methods: This study adopted a single-group, repetitive-measurement (pretest, posttest, and follow-up) experimental design. The study population consisted of 15 nurses in the palliative care clinic of a training and research hospital on the European side of Istanbul. Twelve nurses participated in the first session; however, one nurse did not take the posttest and follow-up test. Therefore, the sample consisted of 11 nurses. Data were collected using a Personal Information Form, the Ways of Coping Inventory (WCI), and the Professional Quality of Life Scale (PQLS).

Results: There was a significant difference between the pretest, posttest, and follow-up test WCI "helpless" (p=.001) and "submissive"(p=.000) subscale scores as well as between the pretest, posttest, and follow-up test PQLS "compassion fatigue" (p=.003) subscale scores.

Conclusion: Psychodrama group therapy helps palliative care nurses to use more effective coping strategies and experience less compassion fatigue.

Keywords: Life quality; nursing palliative care; psychodrama coping.

What is presently known on this subject?

- Personal coping strategies and social support help palliative care nurses deal with stressors.

What does this article add to the existing knowledge?

- Psychodrama group therapy helps palliative care nurses to use more effective coping strategies and experience less compassion fatigue.

What are the implications for practice?

- Psychodrama techniques should be used to help nurses cope with stressors, feel less burnout, and improve their quality of life.

Palliative care addresses symptoms, pain, psychosocial problems, spirituality, and quality of life. It is defined as a type of care involving patients and caregivers to adopt a holistic approach in managing the symptoms of serious diseases.[1] The World Health Organization defines palliative care as an approach that improves the quality of life of patients and their families facing problems associated with life-threatening illnesses through the prevention and relief of suffering through early identification and assessment and treatment of pain and other problems, which can be physical, psychosocial, and spiritual.[2]

Healthcare professionals play a crucial role in palliative care. Some patients face challenges at the end of life, which brings communication problems. Palliative care professionals experience physical, mental, and emotional distress while caring for such patients.[3] Nurses, an essential part of the healthcare team, are responsible for maintaining high-quality care and supporting patients and their family members.[4] The philosophy of palliative care nursing is to combine medical science with compassion.

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Nurses should have excellent clinical knowledge and skills and the expertise to manage interpersonal problems and help patients and their family members to make decisions.[5] Palliative care nurses often witness death and experience stressors related to death. Some healthcare professionals can cause patients and their families to feel helpless because they do not acknowledge the emotions evoked by conversations about end of life (EoL) issues.[6] Nurses experience work-related stressors that affect their professional quality of life. Those stressors are caused by emotional reactions, fear of death, empathic approach, resistance to treatment, communication problems, and demands.[7,8] Stress and burnout take a toll on palliative care nurses. Therefore, we should determine nurses' burnout levels and identify the factors that can reduce or prevent it.[9] Earlier research has shown that coping strategies and social support help nurses experience less stress.[10]

Emphasizing the importance of action in life, Moreno wanted to develop a treatment method, in which people can express their feelings and thoughts while in action. That treatment method is called psychodrama, which is defined as the transformation of one's mental world into action.[11] Psychodrama makes people more spontaneous and allows them to take creative actions and thus experience catharsis.[11] According to Moreno, spontaneity is responding to situations. In other words, spontaneity produces stimuli according to situations or gives feedback according to external stimuli.[11] Psychodrama allows people to scrutinize their internal conflicts by enacting them on stage.[12] Psychodrama is a multidimensional method that promotes internal changes, provides insight, fosters self-awareness, enhances personal development, and stimulates cognitive, affective, and behavioral integration. In psychodrama, participants look at themselves on the outside and see the same things from different angles or from the perspective of others, which helps them re-evaluate situations. Research shows that psychodrama helps palliative care professionals identify their care-related problems and develop communication skills.[13,14] Thus, the aim of this study was to investigate whether psychodrama group therapy could help palliative care nurses adopt effective coping strategies and achieve a better quality of life.

The research hypotheses are as follows:

H1: Psychodrama group therapy helps palliative care nurses adopt effective coping strategies.

H2: Psychodrama group therapy helps palliative care nurses achieve a better quality of life.

Materials and Method

Research Model

This study adopted a quasi-experimental, pretest, posttest, and follow-up test design in order to determine the effect of psychodrama group therapy on palliative care nurses' coping strategies and quality of life. First, participants filled out the Ways of Coping Inventory (WCI) and the Professional Quality of Life Scale (PQLS) as a pretest. Second, participants attended a six-session psychodrama group therapy (intervention) for six weeks. Third, participants filled out the WCI and PQLS as a posttest. Lastly, participants filled out the WCI and PQLS (follow-up test) three months after the intervention.

Study Group

Participation in this study was voluntary. The study population consisted of 15 nurses in the palliative care clinic of a training and research hospital on the European side of Istanbul. The nurses were informed about the research purpose and procedure; consequently, 12 nurses agreed to participate in the study and attended the first session. One nurse did not take the posttest and follow-up test. Therefore, the sample population consisted of 11 nurses. Table 1 shows the participants' demographic characteristics.

Data Collection Tools

The data were collected using a Personal Information Form, the PQLS, and the WCI.

Table 1. Sociodemographic characteristics

Sociodemographic characteristics	Mean±SD	
Age (years)	27.18±2.85 (min:22, max:32)	
	f	%
Gender		
Woman	7	63.6
Man	4	36.4
Marital status		
Single	8	72.7
Married	3	27.3
General work experience (years)		
1-3	7	63.6
4-6	2	18.2
≥7	2	18.2
Palliative care work experience (years)		
<1	3	27.3
1-3	8	72.7
Challenges of palliative care		
None	3	27.3
Communicating with patients	1	9.1
Communicating with patients' family members	6	54.5
Enshrouding a dead patient	1	9.1
	Mean±SD	
The positive effect of psychodrama	7.27±2.45 (min:1, max:10)	

SD: Standard deviation.

The Personal Information Form was based on a literature review conducted by the researcher. The form consisted of 12 items regarding demographic characteristics and palliative service experiences.

The PQLS was adapted to Turkish by Yeşil et al.[15] (2010). The scale consists of 30 items and three subscales (compassion satisfaction, compassion fatigue, and burnout). The items are rated on a five-point Likert-type scale ("0=never" to "5=very often").[15] The scale had a Cronbach's alpha (α) of 0.745 in the present study.

The WCI was developed by Folkman and Lazarus (1985)[16] and adapted for Turkish university students by Şahin and Durak (1995) (Türküm, 2016). It consists of 30 items scored on a four-point Likert-type scale (0=Not Used; 1=Used Somewhat; 2=Used Quite A Bit; and 3=Used a Great Deal). The scale consists of five subscales: (1) self-confident, (2) optimistic, (3) seeking of social support, (4) helpless, and (5) submissive coping styles.[17] The inventory had a Cronbach's alpha of 0.821 in the present study.

Data Collection

The data were collected between March and April 2020 from voluntary nurses working in the palliative care clinic of a training and research hospital on the European side of Istanbul. All participants filled out the WCI and PQLS (pretest) before the intervention (a six-session psychodrama group therapy). Then, they attended the intervention. They filled out the WCI and PQLS right after the intervention (posttest) and three months after the intervention (follow-up test).

Intervention

The date and time for the intervention were set out at all participants' convenience. The sessions were held on Wednesdays for six weeks for 2.5 h in the training room of the palliative care unit. All participants were briefed about the research purpose and procedure. They were also informed that participation was voluntary. The intervention consisted of techniques facilitating adaptation, such as role switching, mirroring, empathy development, matching, augmented reality, etc. The sessions were designed according to the research purpose and the participants' needs. They were conducted by the first author, a psychodramatist, and a consultation-liaison psychiatric nurse who has led many sessions of teamwork and workshops. All sessions were conducted with a co-therapist. Group supervision was carried out after each session.

Sessions

Week 1 (Session 1): Participants played group games to get to know each other and familiarize themselves with psychodrama. They were informed about the process and psychodrama. Group rules were set. Participants filled out the data collection tools (pretest).

Week 2 (Session 2): Participants played games to promote group cohesion. They also played a game about nursing in the palliative service in a psychodramatic setting. The session was terminated after participants shared their feeling and thoughts.

Week 3 (Session 3): Each participant was asked to think about a problem they experienced in the palliative unit and act it on stage. The session was terminated after all participants shared their thoughts and feelings and gave feedback.

Week 4 (Session 4): Participants talked about the problems they faced while caring for EoL patients and communicating with their family members. They all played warm-up games about that theme, shared their thoughts and feelings, and gave feedback.

Week 5 (Session 5): Participants decided to play psychodrama games about "communication with patients' family members" and shared their thoughts and feelings and gave feedback.

Week 6 (Session 6): Participants analyzed the whole process and said goodbye. They talked about how the intervention raised their awareness of "being a palliative care nurse" and helped them speak the same language to share their experiences and find creative and spontaneous solutions to palliative care-related problems.

Statistical Analysis

The Shapiro–Wilk test was used for normality testing because the sample was smaller than 50.[18] The results showed that the data were nonnormally distributed ($p<0.05$). The Friedman test was used to compare the mean pretest, posttest, and follow-up test scores. The co-therapist collected the data collection tools.

Ethical Considerations

The study was approved by the Clinical Research Ethics Committee of Gaziosmanpaşa Taksim Training and Research Hospital (Date: 04.03.2020 & No: 46). Written and verbal permission was obtained from the hospital. All nurses were briefed about the research purpose and procedure. They were also informed that participation was voluntary and that they could withdraw from the study at any time. Informed consent was obtained from those who agreed to participate in the study.

Limitations

The study had three limitations. First, it was conducted only in one center. Second, the results are sample-specific. Third, the intervention consisted only of six sessions because all participants were too busy and had difficulty finding substitutes to attend the intervention.

Results

Results Regarding Hypothesis 1

Table 2 shows the Friedman analysis of variance results regarding all participants' pretest, posttest, and follow-up test

Table 2. Friedman analysis of variance results regarding the pretest, posttest, and follow-up WCI scores

WCI scores	Measure	Mean±SD	Mean Rank	Scale's Min. Max.	χ^2	SD	p
Self-confident	Pretest	16.45±3.38	2.09	21.00	0.927	2	0.629
	Posttest	16.81±2.99	1.77				
	Follow-up	17.18±4.09	2.14				
Optimistic	Pretest	9.27±3.25	1.77	15.00	0.974	2	0.614
	Posttest	9.72±3.00	2.14				
	Follow-up	9.54±3.32	2.09				
Seeking of social support	Pretest	7.00±3.43	2.05	12.00	0.059	2	0.971
	Posttest	6.36±1.96	1.09				
	Follow-up	6.72±2.41	2.00				
Helpless	Pretest	10.00±3.54	2.86	24.00	13.650	2	0.001
	Posttest	6.36±1.96	1.64				
	Follow-up	6.54±4.32	1.50				
Submissive	Pretest	5.18±1.94	2.45	18.00	16.222	2	0.000
	Posttest	4.90±2.02	2.32				
	Follow-up	3.54±2.01	1.23				

WCI: Ways of Coping Inventory; SD: Standard deviation- Friedman Test.

Table 3. Wilcoxon Signed -Ranks Test results regarding the pretest, posttest, and follow-up WCI "helpless" and "submissive" subscale scores

	Measure		N	Mean Rank	Sum of Ranks	Z	P
Helpless	Pretest -Posttest	Negative Ranks	0	0.00	0.00	-2.814	0.005*
		Positive Ranks	10	5.50	55.00		
		Ties	1				
Submissive	Pretest - Follow-up	Negative Ranks	0	0.00	0.00	-2.716	0.007
		Positive Ranks	9	5.00	45.00		
		Ties	2				
	Posttest - Follow-up	Negative Ranks	0	0.00	0.00	-2.588	0.010
		Positive Ranks	8	4.50	36.00		
		Ties	3				

*Bonferroni correction for the p value was determined as p=0.017. Z: Wilcoxon Signed Rank Test. WCI: Ways of Coping Inventory.

WCI scores. There was a statistically significant difference between the pretest, posttest, and follow-up test WCI "helpless" (p=.001) and "submissive" (p=.000) subscale scores. The Wilcoxon signed-rank test with Bonferroni correction was used to determine the source of the significant difference (Table 3).

There was a statistically significant difference between the pretest and posttest WCI "helpless" subscale scores (p=.005) There was a statistically significant difference between the pretest and follow-up WCI "submissive" subscale scores. There was a statistically significant difference between the posttest and follow-up WCI "submissive" subscale scores (p<0.017). Participants had a higher mean pretest WCI "helpless" subscale score than the posttest scores, a higher mean pretest WCI "submissive" subscale score than the follow-up test score, and a higher mean posttest WCI "submissive" subscale score than the follow-up test score. These results showed that the intervention helped participants use helpless and submissive coping strategies less often.

Results Regarding Hypothesis 2

There was a statistically significant difference between the pretest, posttest, and follow-up test PQLS "compassion fatigue" subscale scores (Table 4). The Wilcoxon signed-rank test with Bonferroni correction was used to determine the source of the significant difference (Table 5).

The Wilcoxon signed-rank test results showed a significant difference between the pretest and posttest PQLS "compassion fatigue" subscale scores (p<0.017). Participants had a significantly higher mean pretest PQLS "compassion fatigue" subscale score than the posttest score. These results showed that the intervention helped participants experience less compassion fatigue.

Table 4. Friedman analysis of the variance results regarding the pretest, posttest, and follow-up PQLS scores

PQLS scores	Measure	Min.	Max.	Mean±SD	Mean Rank	χ^2	SD	p
Compassion satisfaction	Pretest	18.00	48.00	35.63±9.00	1.73	1.366	2	0.505
	Posttest	20.00	47.00	36.09±7.28	2.09			
	Follow-up	16.00	48.00	37.27±9.45	2.18			
Burnout	Pretest	8.00	24.00	16.00±5.51	2.18	0.800	2	0.670
	Posttest	5.00	35.00	15.27±8.58	2.00			
	Follow-up	5.00	27.00	14.90±5.59	1.82			
Compassion fatigue	Pretest	7.00	26.00	15.18±5.03	2.50	11.692	2	0.003
	Posttest	4.00	20.00	8.27±6.00	1.45			
	Follow-up	2.00	30.00	11.72±9.33	2.05			

SD: Standard deviation- Friedman Test. PQLS: Professional Quality of Life Scale.

Table 5. Wilcoxon Signed-Ranks Test Results regarding pretest, posttest, and follow-up PQLS "Compassion Fatigue" subscale scores

	Measure	N	Mean Rank	Sum of Ranks	Z	P
Pretest -Posttest	Negative Ranks	0	0.00	0.00	-2.812	0.005*
	Positive Ranks	10	5.50	55.00		
	Ties	1				

*Bonferroni correction for the p-value was determined as p=0.017. Z: Wilcoxon Signed-Rank Test.

Participants' Views on the Intervention

Sessions 1 and 2: Participants stated that before the sessions, they could not spend time together because they were too busy and thus noted that the intervention helped them come together and use body language to express their thoughts and emotions. They added that they would like to attend such sessions again.

Session 3: Participants acted as nurses or patients and their family members. Acting as patients made them experience fear of death, anxiety, fatigue, and sadness. Acting as patients' family members made them feel worried, fearful, fatigued, and nervous. Acting as nurses made them realize that they had communication problems and experienced stress and burnout because they were too busy to meet the psychosocial needs of the patients and their family members. They also noted that the game they played during this session helped them brainstorm and made them feel good because it allowed them to find common ground.

Session 4: Participants stated that they had communication problems as they avoided answering the questions posed by patients and their family members because they did not want to say something wrong to them. They noted that they gave superficial answers to patients and family members and left the room after referring them to doctors. They added that this session allowed them to talk more easily.

Session 5: Participants were asked to relate a situation where they had difficulty talking to patients' family members. One participant volunteered to perform it on stage. Matching was conducted to encourage participants to find solutions to the problem. Participants stated that this session helped them create a common language to talk to patients and their family members. They noted that the session allowed them to come up with different solutions that they would not be able to find by themselves. They also added that the session encouraged them to develop empathy toward patients and their family members.

Session 6: Participants stated that they experienced the same problems and felt the same feelings but did not talk to one another about them. They noted that the intervention had turned "me" into "us." They added that they would benefit from one another's experiences and support one another from now on. They stated that they would like to attend this intervention on a regular basis. They said that the intervention let them "breathe a fresh air."

Discussion

Palliative care nurses have difficulty providing care and meeting patients' family members' needs and expectations.[7] Being a palliative care professional requires a wide range of skills, given the that they witness death and, consequently, need to understand the beliefs and attitudes associated with death. Otherwise, those healthcare professionals experience burnout, emotional exhaustion, compassion fatigue, depersonalization, and a low sense of self.[19] Therefore, we need to provide healthcare professionals with effective interventions to reduce their work stress and improve their quality of life. Palliative care nurses work under stressful conditions, and this

study subjected palliative care nurses to psychodrama group therapy, with the aim of reducing the impact of workplace stressors and improve their professional quality of life.

The first hypothesis suggested that psychodrama group therapy would help palliative care nurses adopt effective coping strategies. Oflaz et al.[20] found that psychodrama helped nurses know themselves, understand others, express their emotions and thoughts, and empathize with their patients. Baile et al.[13] reported that psychodrama allowed palliative care nurses to resolve their problems with patients and their family members. Our participants, who had talked about their care-related problems in Session 3, realized that they could find alternative solutions to those problems in Sessions 4 and 5. Our participants had a mean pretest WCI score, which was similar to what has been reported by earlier studies.[21] The WCI subscale scores showed that our participants used "self-confident," "optimistic," and "seeking of social support" coping strategies more often than "submissive" and "helpless" coping strategies. Our results indicate that palliative care nurses use effective coping strategies to deal with stress and care-related problems.

Our participants had significantly higher mean posttest and follow-up test WCI "self-confident" and "optimistic" subscale scores than the pretest score. They had lower mean posttest and follow-up test WCI "seeking of social support" subscale scores than the pretest score. However, the difference was statistically insignificant. Our participants had significantly lower mean posttest and follow-up test WCI "submissive" and "helpless" scores than the pretest score. Participants noted that they used individual coping strategies to deal with their problems instead of sharing them with their colleagues. Thus, we can state that psychodrama group therapy positively affects coping strategies for three reasons. First, it encourages nurses to become more spontaneous and creative and share their problems with their colleagues. Second, it helps them develop strategies that focus on problems and emotions in the face of stressors. Third, it allows them to express their emotions and thoughts through acting. According to Yalom,[22] group therapy has numerous benefits. First, it allows people to meet their psychological, sociological, and physiological needs. Second, it helps them learn faster. Third, it motivates them to change their behaviors and attitudes for the better. Fourth, it encourages them to learn more about how to react in certain situations. Fifth, it provides them with the opportunity to develop coping skills. Sixth, it improves their well-being. The analysis at the end of Session 6 showed the healing power of the intervention as our participants stated that it helped them develop the skills necessary to cope with problems. This result confirms Hypothesis I.

The second hypothesis suggested that psychodrama group therapy would improve the quality of life of palliative care nurses. Palliative care nurses always witness pain and death, causing physical and emotional distress.[23] Baqeas and Rayan[24] determined that palliative care nurses had high levels of work-related stress and low quality of life. Most of our participants also stated that they faced difficulties when providing palliative care (72.7%). Cross[1] maintains that we should support palliative care nurses in reducing their burnout and compassion fatigue levels and increasing their job satisfaction. Italia et al.[25] found that psychodrama helped EoL care nurses experience less burnout. Our participants had higher mean posttest and follow-up test PQLS "compassion satisfaction" subscale scores than the pretest scores. They also had a lower mean posttest and follow-up test PQLS "burnout" subscale scores than the pretest score. However, the differences were statistically insignificant, probably for two reasons. First, we looked into the short-term effect of psychodrama group therapy on participants' professional quality of life. Second, professional burnout is a multifaceted condition.

Although palliative care is a special field, both professionally and personally, it also brings a series of personal risks and difficulties (burnout, compassion fatigue, etc.).[26] Compassion fatigue is caused by empathy and secondary trauma. In other words, compassion fatigue is caused by burnout and the stress of witnessing and/or hearing about the traumatic experiences of others. Healthcare professionals with compassion fatigue experience helplessness, inadequacy, sadness, and anger.[27,28] Some of our participants also had difficulty getting into the role of a patient or a patient's family member during the sessions. Cho and Cho[29] determined that palliative care nurses with more resilience and less stress were 42.9% less likely to experience compassion fatigue. Our results are consistent with the literature. In the last session, our participants stated that psychodrama group therapy helped them recognize their feelings, cope with challenging thoughts, and adopt positive behaviors. Psychodrama group therapy reduced our participants' compassion fatigue, confirming Hypothesis II.

Conclusion

Psychodrama group therapy helps palliative care nurses experience less compassion fatigue and replace ineffective coping strategies with effective ones. Therefore, authorities should use psychodrama techniques to help nurses cope with stress and improve their quality of life by reducing their burnout levels. Liaison psychiatry nurses should also use psychodrama techniques to support palliative care nurses. Researchers should recruit larger samples and adopt a pretest-posttest-experimental control group designs. Future studies should be more longitudinal and involve more psychodrama group therapy sessions.

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