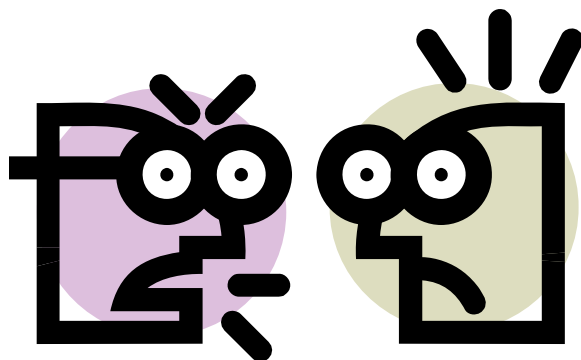


Participatory Role Plays and Dialogues

(A Preventative Tool to Reduce Conflict
Between Patients and Staff)



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DIALOGUES AND ROLE PLAYS

A HOW- TO

Dialogues and role plays can be an effective tool for creating communication between persons receiving services and staff members and administration. They are a way for people to be empowered to express themselves and for problem areas to be looked at and solved in a safe and supportive setting.

Dialogues are created so that all participants are treated equally. The usual power imbalances that are present in most group settings such as community meetings or treatment groups are eliminated so that people can listen to each other and understand each others' perspectives and viewpoints. Adding the dimension of role plays to the dialogue allows for creativity in problem solving. Common scenarios that frequently cause conflict on patient units are acted out with participants interchanging roles and afterwards coming up with shared solutions that people can agree on. Sometimes inflexible policies and procedures or ordinary everyday events are triggers that cause conflicts that could be handled differently.

In a recent dialogue, for example, some of the patients on a particular unit complained because they were required to get up on Sunday mornings when they wanted to sleep late. Staff struggled to get them up; the kitchen staff complained that breakfasts went uneaten. Acting out the role play helped everyone to understand the different frustrations. After the role play they came up with a solution: the kitchen staff would make bag breakfasts for those who wanted to sleep late; everyone, including nursing was happy because they could relax and did not have to struggle with this issue.

The outcomes from role playing little problems and solving them can create a climate for bigger problems to be solved. Communication is the key.

What does a dialogue look like?

Dialogues are usually conducted in groups of 20-25 participants and are held for approximately one hour; 15 minutes of the hour are needed for set-up, encouraging people to attend, freeing staff, including a few minutes of awkwardness as some people hesitate to join. (It is perfectly okay for patient observers seated outside of the group, but not okay for staff to participate from beyond the group (unless work requires them to be)—in this way someone who is too withdrawn to join the group benefits from listening and may even join when they are comfortable.

It is important that there be two co-facilitators, one of them from management or administration is often helpful in order for the dialogues to be taken seriously. It is also helpful if the co-facilitator enjoys group communication and acting. They will help set the tone for the role plays and their participation is a great incentive.

All people on a unit are invited to attend, even those who may have difficult behavior problems, while naturally excluding persons who are being attended or who are in seclusion. Preparation should have taken place so that staff and service recipients understand the purpose of the dialogues. While all patients should be encouraged to attend, participation is voluntary.

Seating is important. Whereas in most groups seating is arranged with staff separated from patients mixed seating is essential for the success of the dialogue. A circle is formed: everyone should be able to see each other and be in comfortable seats whenever possible.

The facilitator takes time to talk about the purpose of the group. If the lead facilitator is a consumer/survivor, it will be helpful for s/he to talk about themselves and their experiences as an ex-patient. This helps to inspire the patients to feel that they will be valued. They are often interested as well, to find out that someone has shared similar experiences and has survived to be in a leadership position.

Opening Exercise:

Introductions are to be fun! First, people introduce themselves to the person next to them by stating their name and where they are from. While they do this they are to shake hands, paying attention to the type of handshake they offer; warm, hearty, with feeling. They are also instructed to have eye contact with the other individual. The way this is introduced must have an element of fun or it falls flat or feels like therapy. This is not therapy. It is introduced as what makes us all feel good. For example, when we walk down the street and someone says hello in a genuine friendly way, it makes you feel good. When people do not look at you and say hello with a grumble it does not make us feel good. Another aspect that is pointed out is the element of touching. When someone gives a good firm handshake, caring is communicated through touch.

Following the handshake and basic introduction,

After people do the exercise in a positive way, they are asked to do the same exercise in a non-caring way. People are instructed to avoid eye contact, give a negative greeting, a limp handshake. This often is amusing to people and often produces embarrassing giggles.

In addition to saying who they are they are to share their favorite hobby. What do they most like to do?

Invariably this gets people talking and frequently at the end of the exercise people are still talking to each other.

Often, also, there is a type of sharing that has not occurred before. Staff has shared things that no one in the group knows about, staff or patients. One staff member talked about making dollhouses in their spare time. Another shared that they liked to go rock

climbing. Patients often share interests that reveal hidden talents. Conversations along these lines could stimulate a continuing dialogue just at this level. And there may be an interest in having dialogues of this type or on special topics at various times.

Starting Role Plays:

Start by asking people in the group if anyone has acted in a school play or enjoys acting. There are usually a few people who have performed in plays or bands, etc. Sometimes you will know ahead of time that certain individuals have acting experience. If you find this out you may want to meet with them separately prior to the dialogue to inspire and encourage them to participate. In one instance two individuals came to other units to help with dialogues and role plays because of their skill level.

It is helpful to do a survey prior to the dialogue to find out what staff and patients see as conflict areas on each unit. The results can be compiled ahead of time and shared with people who participate in the dialogue.

If information has not been gathered find out from individuals in the group what causes conflict on their unit. Sometimes situations are brought up that are common to many individuals; other times it may be one person's situation.

Sometimes the facilitator has to choose a situation to act out, if a theme is not volunteered. One common theme is the TV. Some people want to watch one program; another group wants to watch something different. Sometimes the telephone time limits can be a source of conflict. There are many common themes that appear in many hospital settings. In each dialogue someone usually has a suggestion for a scenario that can be played out.

Once it is decided that a particular conflict is to be acted on, recruiting players is the next step. If someone has made a suggestion, you ask them to be one of the players. Who do they want to be, the patient or staff? After they choose who they will play they may then choose someone in the group to play against them. Often they will choose a friend or buddy to play against them. "If you do it, I'll do it." Or they may choose a favorite staff member. It is important to start with something fairly simple so that people feel safe to get up and play a role. After some encouragement there are usually the right number of players for the situation; usually two. While you want to see some role reversals, it is more important for people to play the role they wish to play.

The first time the scenario is played the conflict is acted the wrong way. The wrong things are said by patient and staff. Exaggerations are okay. Only if someone becomes inappropriate with language do you intervene, and then it is usually the group that will provide the necessary response.

After the wrong way is played, the right way is played at which time a solution to the problem may emerge or a solution may be brainstormed later. You do not give people

suggestions of what to say. They create their script spontaneously and on the spot. If they ask, you might help them.

The facilitators have to be alert at all times. There may be times when role plays will not work on a particular unit. Sometimes there are patients that have developmental disabilities or communication problems. The goal on a unit like this would be to do very easy communication exercises. The facilitator might go around the room and do an introduction with each patient. Often, even in a group like this a group discussion begins or you turn to singing or other creative exercises.

There may also be a situation where staff do not feel safe to do the role plays or if they see one going awry, they may wish to end the role plays. When this happened at one hospital we eliminated the role plays and conducted dialogues that were equally effective. Instead of role plays there was discussion about certain problems and solution building.

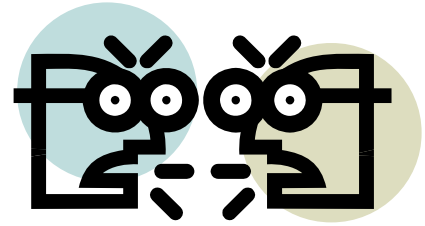
Ending the Dialogue

The ending of a dialogue is important. Usually the arts are used. Find out if someone is a poet or a singer. Almost everyone has a person who wants to perform. Group singing is a nice way to end as well. If someone plays a guitar, ask them to play, staff or patient. You might someone from recreation to bring in some music that can be played. You can anticipate and plan for an ending or have it be spontaneous. You may want to make a list of creative games that could be played and vary them each time.

A dialogue should always end on a positive note.

Following is a group of common scenarios that have been role played. The right way and the wrong way are presented.

Scenario #1



Patient in group gets up in the middle of the group and does not say anything, he just leaves.

Group Leaders: Where are you going?
Patient: I don't want to be in this group. It is boring, plus I have a headache.
Group Leaders: Well, there are rules and everyone has to participate in group.
Patient: I don't care about your rules! Bug Off!!

The situation escalates from here. The tech in the group follows the patient, encounters him outside the room:

Tech: Hey Man, you've got to go back.
Patient: I'm not going back, make me.

The situation continues to escalate. There is a physical encounter. A tech calls for help. Security comes. A "code red" is called. The group gets extremely restless. The group leaders have trouble maintaining control of the group.

Replay – Helpful Tips: (1)



1. Group leader does not want to get into an argument with the patient. May note person wanting to leave and state that someone will go and talk with him about it.
2. Tech should know something about the individual. If the person is new, the tech may want to follow the lead of the patient and soft pedal on the issue.
3. Find out why the patient wants to leave. Person may have difficulty sitting for long periods. Maybe they need to be able to leave early because of this. Person may be too sleepy due to medications. Person may be upset about something that may or may not have anything to do with the group. Find Out.
4. Offer some possible alternatives:
 1. Take a short walk.
 2. Sit down and watch tv to return later
 3. Perhaps this person has been to group many times and finds it boring.
Is that reasonable?
5. Find out later if all patients are bored with the subject. Maybe the information is not presented in a way people want to hear it. What would the people attending suggest to improve the content.
6. Never allow a power struggle to develop that leads to an escalation requiring physical intervention. If this happens, it is as much a failure of the staff and how the situation was handled as it is the patient's escalation.

Scenario #2



Patient refuses to get out of bed

Nurse: Time to get up. Shines flashlight in pts face

Patient: I don't want to get up

Nurse: You have to get up. You have to be up before the day shift comes in.

Patient: No. Leave me alone.

Nurse: You have to get up to get your meds and have breakfast

Patient: You can't make me

Nurse: Well then, I will have to call security.

Helpful Tips to play this differently: (2)



1. Nurse asks person why they don't want to get up. Is there a reason?
2. Is this an isolated incident or a pattern for this individual?
3. Is the patient receiving sleeping medication? Does the dosage need to be changed or the medication changed?
4. Suggest alternatives such as:
 - Suppose I give you another half hour to sleep and come back later?
 - Have a special time for late sleepers to get up on weekends and provide a bag breakfast made by the kitchen so that cooks are not inconvenienced.
 - Try other fun techniques: Music played in the morning that is stimulating
 - Set time to talk about it later.
5. Discuss the issue as general topic, not targeted at individual in morning meeting and see if the other patients have suggestions.
6. Never threaten a person with security.
7. Realize there are some situations you do not win.
8. Find ways to create other incentives.

Scenario #3

Medication Refusal

Patient: I don't want to take this medication

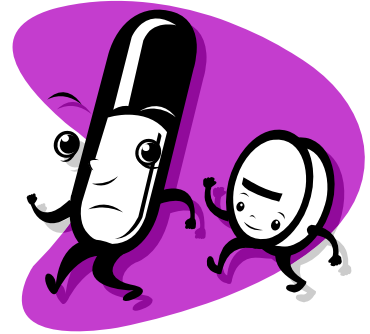
Nurse: You have to take it. The Doctor ordered it.

Patient: Well, I'm not taking it. There are too many side effects.

Nurse: Well, you will have to talk to your doctor about that. For now, you have to take it. You do not have a choice. Either that or I will have to give you a shot.

Patient: Puts it in mouth and spits it out.

Nurse: Gets angry. Screams at patient. Situation escalates. Security is called. Person is placed in seclusion and restraint.

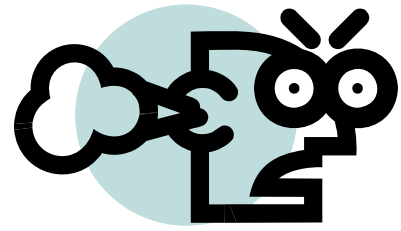


Helpful Tips to play this differently: (3)

1. Nurse should ask why the person does not want to take the medication.
2. Knowledge of state and federal laws for refusal is important. Even involuntary patients in most states have the right to refuse.
3. Frequently there are legitimate reasons why people do not want to take them.
4. Nurse can avoid the argument and tell patient that she will mark in record that the person refuses, with the reasons why and will inform the doctor when he comes in.
5. Find out if patient may be willing to take some of the medications or if he/she refuses all of them.
6. Nurse and patient should be informed about the medication patient is taking. Patient has the right to know all side effects; hospital has obligation to provide information in writing.
7. Education groups should be held to discuss medications. Allow for dialogue, discussion, and questions.
8. Important to know that no one person reacts the same to medications as another; so there should not be pat answers given to downplay patient's concern.
9. May want to look at how education is presented. Call the medication group; "Meds: do you want to know?" Forget calling it the Psycho-education group.
10. Never threaten. However, if the situation was an emergency to begin with, there is provision for one-time medication orders.

Other strategies that have worked? Please list your thoughts:

Scenario #4:



Abrupt High Level Escalation

Scene: Probably common area such as day room or living room. Many people are in the room, including a few staff. Other staff members sit at the nurses station nearby. The room has been quiet up until this time and it is not apparent why the person has escalated. The person in crisis is angry. His build is large and he is threatening to hurt both self and others. The cause for the eruption may not be evident and the escalation is already in progress.

Patient: I want out of here or I'm going to hurt someone. Let me out. You hear? I said OUT—Move Screams that he is being hurt. Wants out!! Starts banging on wall.

Male nurse approaches the situation and moves in quickly: Puts his hand on the patient's arm.. Hey calm down. Stop that screaming.

Another staff member comes up quickly also: He gets on the other side of the patient. He talks also and tells the patient to be quiet.

A third staff member also comes; All three are male. They close in on the person while the patient begins to thrash around.

All three staff plus the patient are talking. Two of the males have taken hold of his arms.and begin to take him down.

Other patients in the room are watching. The nurses at the desk are slow to react but when they do come over they tell the patients to leave the area and say things like: Hey, get of the room—NOW. There is nothing to get upset about;

One of the patients does not want to leave but wants to get involved. The nurse who is ushering other patients out does not notice.

Observing patient says; I know him. I want to go over there and help.

Nurse, no you can't. Get out of the room.

One person who was sitting quietly, a small female is crying as she does not like hearing the language and is afraid that she is being hurt as she is a trauma survivor.

The individual who is escalated refuses to calm down.

The patient by this time is on the floor and a nurse is getting an injection.

The patient flails and continues to scream and is taken to the seclusion room and placed in 4 pt. Restraints. All staff have been trained but during the act of restraining him someone compromises his breathing while laying hands on his chest. IN 15 minutes the patient is quiet, asleep and in 4 pt restraint.

Tips and Re-play recommendations: (4)



1. It is not obvious what caused the person to escalate but know that there is probably a reason.
2. Instead of quick action, go slow. The same staff should circle the patient but allow for space and say almost nothing.
3. Is there a staff person who knows the patient and has a rapport? Is there any cultural factors. Language is different in cultures so calming may be different according to these factors.
4. Being quiet allows the person to calm down on his own.
5. When it is appropriate one staff should be the designated communicator and state something calmly, like, Hey, man. We're not going to hurt you. We don't want you to hurt us either.
6. Later, is there something we can do? What do you want?
7. Later: Do you know what made you angry? Can you tell us.
8. Important to state what you are doing. "We are here only to keep us all safe. We are not going to put our hands on you. It's okay.
9. In the background the staff members should reassure the other patients while taking them away from the situation. "I am taking you away so that you are safe. It is a scary situation but we know how to handle it.
10. The female crying may need someone one on one with her. She may need to be in a comfort room or similar type space.
11. After the individual is de-escalated, medication can be offered. Person with rapport stays with the individual until the person feels safe.
12. Tone of voice is important. Though the situation is not calm, the voice of staff should remain as calm as possible.
13. It is amazing what Quiet can do.



Patient has privileges taken away because he loaned someone 50 cents for a coke

Patient: “Why did I lose my privileges? I was just trying to help someone who doesn’t have money.”

Nurse: “You know the rules. You cannot give loans of money or food to other patients.”

Patient: “But, why not? We should be able to do something kind for people who don’t have money.”

Nurse: “We cannot break the rules. If we break them for you we have to break it for others.”

Patient: “This is not fair.” (Person becomes angry and starts to beat fist against the wall)

He continues to escalate as the nurse comes up to patient saying, “Calm down or you will have to go into the quiet room.”

Other patients watch and listen. Another staff person comes up to support the nurse and to intervene.

Replay Tips:



1. Note that the patient did not deny he knew the rule. He just felt it unfair in this situation.
2. Nurse could listen more to the circumstances of the purpose of giving the money instead of cutting the person off. S/he might hear from the other person to find out how the person felt about the situation.
3. Nurse could give an explanation of why the rule; for example, “We do have a rule about this because there have been so many instances where people are being threatened to pay money back double or being exploited in a variety of ways; give other examples.”
4. If it is certain that the patient was trying to be helpful person should be supported for trying to help another, but not supporting breaking the rule.
5. Nurse may offer to take this up in community meeting to see if this could be an exception; let others in the community help decide. This should happen quickly so person does not lose a pass or privilege.
6. Patient may still not like this but should have a better feeling about the situation. H/she will express willingness to discuss this at community meeting.
7. Patient could be given the opportunity to file a grievance or follow the complaint system.

Two people fight over the TV. One person has been watching a game that is not over but his/her time is up. The other person is anxious to watch a program that has already started and it is, in fact, his/her time.



Person #1: “Hey, it’s my turn to watch the TV. Your time is up.”

Person #2: The game is almost over. It is really exciting and I’ve got to watch the rest of it.”

Person #1: I don’t care. It is my turn.”

Person #2: “I’m not moving. Go get the nurse.”

Person #1: “Hey, I said it’s my turn and that’s it. I don’t want to get the nurse.”

“MOVE.” (push and shove)

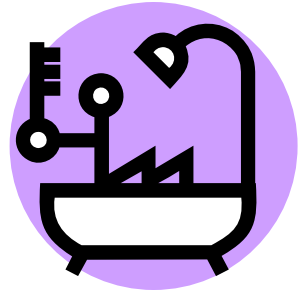
Staff notice the fight and come in, breaks it up and turns off the TV. “Now, no one gets to watch it.”

Replay and tips:



1. Make sure there are two TVs on the floor. It will always be a problem with people wanting to watch different programs. Also people who are in the minority who may like to watch the Discovery Channel or other less popular shows may never get to watch them.
2. Find out if there are others watching the game in addition to the person being asked to change the channel

Person Refuses to Bathe



(This has been an ongoing problem and the individual begins to have an odor, hair is dirty, and clothes are unkempt)

Patient: “NO, I don’t want to take a shower.”

Nurse: “ But you have to. Every person is required to bathe every day.”

Patient: Is silent or makes motions to indicate that he/she is unwilling. Or states an emphatic “NO”

Nurse: Well, we will have to take you to the shower then. I will get the tech to help me get you there. (this means that there will be forcible intervention with hands-on taking person to shower.

Patient: continued refusal

Nurse: “Hey, I need help getting this guy to the shower.”

Re-play and tips:

1. Find out if there are any cultural or religious beliefs that practice infrequent bathing. If there is a cultural element present it might be a good idea to find a staff member who practices a similar belief.
2. Make some accommodations for this individual. It may not be necessary for everyone to have a daily shower. Allow person some choice.
3. Find out if there is a particular staff member that relates well to this individual.
4. Question whether individual would prefer bath or shower.
5. Do not escalate the situation by forcing a shower.
6. Peer specialist may be helpful in reaching this individual.
7. May consider whether person has fear or phobia related to water.

Other common problems that lead to conflict:

1. ***Night staff has difficulty getting patients up.*** Also they express frustration because consumers miss breakfast.

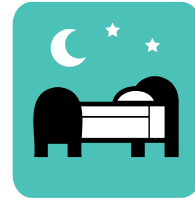
Suggestions:

Allow sleeping late on weekends.

Provide snack breakfast in bag for people who sleep late.

Keep fresh fruit or granola bars on the unit

Acknowledge that there might be legitimate situations where people don't sleep well at night—they may be adjusting to a medication change or they may have had other reasons why they didn't sleep well.



2. ***Shaving*** (this is a common big issue)

Staff tells person that it is not the right time or one staff member bends rules but another does not.

Suggestions:

Allow some flexibility whenever possible to allow people to shave. Make sure people know what the rules are by having the rules posted.

Staff needs to explain that some people need supervision to shave, therefore there has been times created for this.

