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Using Sociodrama and Psychodrama To Teach Communication in End-of-Life Care

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Abstract

End-of-life discussions can be stressful and can elicit strong emotions in the provider as well as the patient and family. In palliative care, understanding and effectively addressing emotions is a key skill that can enhance professional competency and patient/family satisfaction with care. We illustrate how in coursework for a Master's degree in palliative medicine we used dramatic "action methods" derived from sociodrama and psychodrama in the portrayal of two challenging cases to train providers in the emotional aspects of caring for patients with advanced cancer. We describe the specific techniques of constructing and enacting case scenarios using warm-ups, role-creation, doubling and role-reversal. In particular, we illustrate how these techniques and others were used to reveal and address the "hidden" emotions, attitudes, and values that were central to the communication dilemma. Finally, we present an evaluation completed by the 26 participants who attended the course.

Introduction

The things we have to learn before we do them, we learn by doing them.

– Aristotle

Palliative care practitioners often face serious communication challenges.[1] Patients and families can respond to the stress of setbacks in care and unfavorable medical information with strong emotions such as uncontrollable crying, anger, blame, or denial.[2–3] Patients may pose difficult questions such as, "How long do I have to live" or "What will the end be like?"[4] Family members may urge the clinician not to reveal the "bad news" to the patient or may refuse to consider taking a patient off life support when the patient is hopelessly ill.[5] Studies reveal that although effective communication is associated with important outcomes of care,[6–9] the absence of meaningful practitioner training in this area can leave providers inadequately prepared.[10–14] We describe the methods of sociodrama and psychodrama and how they were used in coursework for a Master's degree in palliative medicine to explore the challenges of difficult conversations that occur in end-of-life care.

What Are Sociodrama and Psychodrama?

Sociodrama and psychodrama are group activities developed by the psychiatrist Jacob Moreno who used enactments of real-life situations to reveal the attitudes, beliefs, feelings, and values that underlie social interactions, thus deepening our understanding of them.[15–16] Sociodrama is an *educational* modality whereby group members explore the challenges of professional roles, such as giving bad news, by dramatically portraying them.[17] Psychodrama is a *therapeutic* intervention for helping an individual sort out emotions such as grief around patient loss.[18] Sociodrama and psychodrama have been used to enhance nurses' competencies in patient management,[19] assist trial lawyers to hone their jury selection and presentation skills,[20] and help medical students improve their patient interviewing.[21]

How Sciodrama and Psychodrama Work

Sociodramas and psychodramas, led by an experienced facilitator, have four stages. In each stage, techniques known as *"action methods"* (Table 1) accomplish specific goals. In the beginning stage, warm-up exercises introduce group members to one another, enhancing their working relationship and

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Table 1. Psychodrama and Sociodrama "Action" Methods

Warm up exercises: a form of "getting to know you" – Enhances the working relationship among group members through sharing of information; they are also intended to increase the spontaneity of group members and begin to move them into action.

Role-taking – Participants enact characters from a case that they have selected. Case selection is "learner centered" and reflects the priorities of the participants. The characters are invented by the group from their own experiences with similar cases. This enables participants to take on roles in the scenario.

Doubling – Doubling encourages participants to speak for characters in the enactment to facilitate their immersion in their role and reveal unspoken or hidden emotions, thoughts, and attitudes; in doubling participants stand behind a character and speak for them revealing attitudes, values, and feelings that they imagine the character might have based upon the challenge facing him or her. Participants can also double themselves as characters.

Role-reversal – A technique whereby the facilitator asks the protagonist to assume the role of important characters in the scenario to help "set the scene." Role-reversal is also used to allow the protagonist or main character to experience, in the role of others, the impact of his or her own actions and communication. Thus, a protagonist who tells a patient that there is no hope would reverse roles with that patient and become that patient in order to experience what that statement "feels like."

Processing – Whereby teaching points are formally taught or emerge from the group observation and discussion around take-home points.

Role-training – A form of role-play whereby participants practice skills that can help them in becoming more expert in their professional role.

generating scenarios to be enacted. During the second stage, a scene is enacted by the group participants. *Role-taking and role-reversal* enable participants to assume the persona of characters in the scenario. *Doubling* facilitates immersion in a character's persona and reveals unspoken or "hidden" emotions, thoughts, and attitudes. The third stage involves skills practice or *role-training.* The fourth stage is *processing,* whereby group discussion and didactic presentations enable participants to identify "take-home points."

Setting and Learners

Learners were 26 Italian palliative care clinicians and staff (physicians, nurses, psychologists, physical therapists, and support staff) who were participating in coursework for a Master's degree in palliative medicine offered by the Academy of Sciences of Palliative Medicine at the University of Bologna, Italy, directed by Professor Guido Biasco. During a workshop, lasting 7 hours over 2 days, several case scenarios generated by the group were enacted to reveal important hidden dynamics that represented significant barriers to effective communication at end of life.

Choosing the scenario

After warm-up exercises (Table 2) participants worked in groups of four and discussed scenarios that they would want to consider in a dramatic portrayal. These scenarios (Table 3) were listed on a flip chart and group members ranked them by importance for them.

Table 2. Warm-Up Exercises

Locograms: participants stand on a place in the room that represents what is true for them. For example, participants were asked to imagine the room representing a map of Italy. Everyone went and stood on the imaginary area that represented the town where they were born. They then moved to the place where they received their professional training. In spectrograms, learners form a line with polarities. For example, they are asked to find their place on the line that represents the amount of experience they have in palliative care with one polarity representing not much and the other a lot. Each person then says how much experience he or she has.

Working in dyads: Learners break into dyads and recount a situation where they successfully used one or more communication skills to tackle a difficult situation in palliative care, such as consoling a family member who was upset or giving bad news compassionately. Several of these were shared with the group.

Working in groups of four: Two dyads worked together to discuss one or more situations of challenging communications in palliative care with which they have they struggled. Each group of four then shares these situations out loud with the larger group and these are written on a flip chart. The situations generated by this group can be found in Table 3.

Setting the scene

The problem of "how to deal with a family member who impedes information disclosure to the patient" was the first scenerio selected for portrayal. The facilitator (WB) guided the group in the creation of the scenario. In response to the facilitator's question, *"Who is in this enactment?"* the group created five characters: Paola, a 55-year-old woman terminally ill with advanced colon cancer; her husband Giuseppe, 48 years old; her sister Agnes, 40 years old; and Paola's doctor. In the group's creation of the scenario, Agnes was a family

Table 3. Case Scenarios Generated by the Group

- The patient who is poorly informed of the seriousness of his or her disease
- Refusal of the family to allow the doctor to communicate the seriousness of the disease
- Patient denial
- Requests for assistance in dying
- How to communicate hope in the presence of serious illness
- How to give bad news
- Communicating with persons from different cultures
- Communicating with a person with cognitive impairment
- How to respond to persons who have not been given the truth about their illness
- How to prepare the family for an illness with a poor prognosis
- How to support the palliative care team in its work in dealing with patients at the end of life
- How to know when a patient is a suicide risk

member who adamantly opposed any information being given to Paola about the seriousness of her illness. Giuseppe did not agree with this, but he wanted to avoid an argument that would upset Paola. Four group members volunteered to play these roles. To immerse the volunteers into their characters, the facilitator guided them in doubling themselves (i.e., they stood behind their chair and the facilitator asked them to talk about their inner thoughts and feelings). Agnes said, *"I just won't let the doctor tell her anything."* Guiseppe said, *"This isn't right, but I don't want to upset Paola."* Several group members also came forward to double Agnes, affirming her determination with statements such as, *"My sister is ill and I have to take the responsibility now"*; others doubled Guiseppe: *"She really has the right to know, but what can I do?"* and Paola: *"No one will tell me what's wrong with me!"* The doubling thus set the stage for the enactment.

By asking, *"Where does this scene take place?"* the facilitator guided the group in setting the scene at Paola's home where her doctor was making a visit. Present were the patient, her husband, and her sister. As the enactment began the physician was met at the door by Agnes who, before letting him into the house, said in a caustic way, *"Please don't talk to my sister about the seriousness of her condition,"* but Paola repeatedly asked him: *"Doctor can you tell me what is wrong with me? I'm just feeling so badly and I am thinking that it is something really serious."*

The facilitator then stopped the action and consulted the group as to how the doctor might resolve the dilemma. The group adopted a suggestion that a family meeting be held among the doctor, Agnes, and Giuseppe. As this evolved Guiseppe said,*"Look, my wife already knows there is something seriously ill and she deserves to be told."* Agnes continued to be adamantly against disclosure. The facilitator investigated Agnes' attitude further by having Agnes again double herself. He asked her, *"What are you most worried about if your sister is told?"* Agnes revealed that in the past her mother had been told that she was terminally ill, and then she became very depressed and committed suicide. Agnes said she still felt very guilty and was terrified that the same thing would happen to her sister should she come to know the poor prognosis of her cancer.

The facilitator acknowledged how terrible this must have been for her and allowed the participant to emote about it in the role of Agnes. The facilitator consulted the husband and the doctor, who felt that in this situation even although Agnes was upset, it seemed that Paola clearly wanted to know the information and seemed ready. Agnes reluctantly agreed to go along with the idea stating, *"You can tell my sister, but I'm not going to be responsible for what happens. I just don't want to be there."*

The scenario moved to informing Paola about her condition. With some coaching the group member in the role of the physician explained the medical situation to Paola in very simple terms. She was surprisingly calm, stating that she knew that things were not good, and then she asked, *"How much time do I have left?"* The doctor told her that she probably had months instead of years, and although startled she remained calmed. The scene ended in a touching embrace between husband and wife during which Giuseppe said, *"I will be at your side."*

In the debriefing (processing) that followed the group raised the following take-home points:

- It is not uncommon for these scenarios to happen in certain cultures and it is easy to be taken aback by such requests.
- It is useful to ask both what the patient wants and to explore the family's fears and concerns.
- Patients often know how ill they are and want to talk about it.
- Negotiation is an important part of disclosing adverse medical information.

The Case of Maria

Dramatic action techniques can also be used as psychodrama to help professionals address personal challenges in patient care. In this scenario a nurse enacted her dilemma in communicating with a cancer patient, which left her questioning her own competence. Thus we move from a sociodramatic scenario in the case of Paola, a hypothetical situation created by the group, to a real situation described by a group member in which as the "protagonist" she played herself.

Irene (not her real name) described her experience with Maria, a 78-year-old woman with stage IV lung cancer, currently in hospice. Maria had previously experienced a stroke, which left her with expressive aphasia. Irene, the nurse for Maria, felt sad for her because her husband Francesco would visit for only short periods of time before leaving. This obviously upset Maria who became very agitated after Francesco left. Irene was new to hospice work and felt helpless in assisting Maria. She wondered if she was cut out for the job.

To delve deeper into this dilemma, the facilitator asked Irene to select group members to play the role of Maria and Francesco. He then had Irene reverse roles with Maria and describe herself to the group. Speaking as Maria, Irene expressed frustration and anger that she could not talk to Francesco or to her nurse, and how it pained her that Francesco would leave very shortly after he came. Group members doubled Irene as Maria by standing behind her and saying how they felt as if they were Maria: *"I feel sad and abandoned"*; *"I am very angry"*; and *"After 45 years of marriage, this is what has happened to us?"* The facilitator then reversed Irene into the role of Francesco. As Francesco she also expressed frustration and sadness at being cut out of the role of caregiver and provider, a role that he had had for their entire marriage. Group members again doubled and expressed the anger and despair of Francesco at seeing his wife at the end of her life and unable to communicate.

The facilitator guided Irene in stepping back into her actual nursing role, in which she expressed anxiety and helplessness at not being able to improve the situation. The facilitator then asked, *"Irene, what do you need to enable you to go forward in your job?"* Irene replied, *"Someone to help me, perhaps."* The facilitator then asked whether an experienced member of the hospice team, such as a psychologist, could address her anxieties and provide some ideas to help Maria. Irene then picked someone from the group to be a psychologist. The facilitator then had Irene stand behind her chair and talk more about her inner feelings of distress. After some thought, Irene disclosed that Maria reminded her of "Mama Rosa," her own grandmother who had practically raised her and with whom she was very close. She related how Mama Rosa was physically fragile and how when she saw Maria, she also saw Mama Rosa, which frightened her. The group member in the role of

psychologist comforted her by saying that working with patients with advanced disease is difficult when they remind us of someone whom we love, and we relate to them with the same anxiety that we might relate to someone very close to us such as Mama Rosa, if she were ill. The facilitator added that sometimes working with people at the end of their lives requires psychological work to create awareness of such factors. Irene understood this. The facilitator then reversed Irene into the role of Mama Rosa and asked, *"Mama Rosa, if you were ill what would be the most important thing you would want from Irene?"* Irene as Mama Rosa replied, *"I would wish that Irene could be with me."* This statement provided an important insight for Irene because at that moment she understood also what Maria needed from her husband…his presence. At this point, the facilitator reversed Irene back into her own role as nurse and set up a conversation with Francesco accompanied by the psychologist. With some coaching Irene stated, *"Francesco, I know that it is very difficult for you and frustrating to be with your wife when she cannot communicate. However, I have seen in Maria's eyes and in the expression on her face, her sadness and even alarm when you leave."* Francesco was surprised, but also said somewhat tearfully how he understood, since they rarely had been separated. The facilitator asked the group for suggestions for Francesco. Someone proposed that Francesco might bring Maria news of the family or even read her the local newspapers, because it was clear that, although she could not speak, she understood much. The group agreed. It was at this time that the drama ended.

After the drama the entire group participated in a discussion in which the following points emerged:

- How difficult hospice work can be and how helpless we can feel at times in our job.
- How personal issues can deeply affect us when we work so close to patients.
- How it is important to understand the feelings that underlay complex interactions.
- How talking to someone can help us find solutions.

Evaluation

Approximately 6 weeks after the workshop, participants completed a brief questionnaire rating on a 5-point scale from "very much so" to "not at all" the relevance of the workshop, it's content, organization, use of time, and effectiveness. Participants averaged 8.7 years experience in their profession and ranged from being a new graduate to working for more than 30 years in their area. More than half had worked for 5 years or more. More than 90% agreed that the workshop had been well organized, had used time effectively, and was useful to them in their profession. More than 85% found the workshop enhanced their competence in their field (note that four participants who were not involved clinically with patients gave lower ratings in this area). Thus 75% reported that they had used skills learned in the workshops in the 6 weeks since it had been conducted. Twenty participants made specific comments about what they found useful about the workshop. Ten comments endorsed the realism of the cases and the practical application of the material and thirteen the utility of the role-play and possibility for many group members to participate. Other comments involved the clarity with which the material had been presented and the highly interactive format.

Negative comments (nine) were: there had not been enough time (four); the case endings seemed too contrived (two); the role-play made them feel too much on stage (one); and the cases had not been relevant to their professional activity (two).

Ten participants expressed interest in additional workshops. These included "more of the same" (three); longer workshops (two); communication with co-workers; talking with families about end-of-life issues; how to counsel patients; cultural issues in incurable illness; and how to prevent burnout (all one).

Discussion

Sociodrama and psychodrama are methods for "putting words into action" and exploring the subtext of human emotions that lies beneath difficult communications and interactions.[22] Revealing hidden attitudes, emotions, and values allows participants to respond to human problems and dilemmas. In the case of Paola, discovering that Agnes had felt responsible for the death of her own mother helped everyone understand how, although this story was "made up," past events and unspoken fears can lead family members to protest information being disclosed to the patient. In the case of Irene, a true story, it became clear that she struggled to help Maria because she also unconsciously identified Maria with Mama Rosa, and this triggered her own fear of Mama Rosa becoming ill and her not knowing how to help her. As an inexperienced palliative care nurse, Irene was not practical in doing the sort of reflection that would help her understand her own anxiety. However, once Irene had made the connection between Maria and Mama Rosa, the facilitator was able to explore with Irene, in role-reversal with Mama Rosa, what Mama Rosa might need from Irene in that situation, thus, leading to Irene approaching Francesco. Irene's learning that her own identification with patients could cause disturbances in communication was something that the group could relate to because this is not an uncommon phenomenon when one works with seriously ill patients.

Fears, anxieties, and doubts are often present in "high stakes" interviews in palliative care and can be present in professional caregivers as well as in the patient/family members. Revealing these hidden emotions can both diminish their influence and reveal solutions to communication problems. In our evaluation 75% reported using one or more skills they had learned in the course in subsequent interactions with patients and families.

Compared with case discussions, standardized patient interviews, lectures, and reflective exercises, sociodrama and psychodrama are similar to other dramatic methods of teaching such as role play and theater. Their enhanced simulation deepens "empathy for the other,"[13,23–28] a key aspect of uncovering the unspoken thoughts and feelings that can make end-of-life communication challenging. They differ from role-play and theater methods, however, in that the empathic opportunities for group members are increased both by their "ownership" of the scenario, their doubling or taking on the role of characters in the drama,[29] and through practice sessions.

In other workshops that we have conducted, we have added formal discussion of skills and "skills practice," giving participants the opportunity to try out with each other skills that facilitate communication such as the empathic statement,

"Francesco, I know that this is very difficult for you," which Irene used.

Although scene-setting, doubling, and role-reversal were developed for sociodrama and psychodrama, they can be used in any case-based teaching sessions in which "stepping into the shoes" of others can help learners make an empathic connection and experience what different communications "feel like." By reporting our results we hope others will experiment with these techniques.

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