Enhancing the empathic connection: Using action methods to understand conflicts in end-of-life care

Silvia Tanzi, Guido Biasco, Walter F. Baile

Abstract
Empathy is a core feature of patient-centered care. It enables practitioners to better understand patient and family concerns that are key to satisfaction with care, prevention of anxiety and depression, and patient empowerment. Current methods of teaching communication skills do not specifically focus on enhancing the ability to "stand in the patient's shoes" as a way of connecting with the patient and/or family experience and understanding feelings that may be a source of conflict with providers. In this paper, we present a model for deepening empathic understanding based upon action methods (role-reversal and doubling) derived from psychodrama and sociodrama. We describe these techniques and illustrate how they can be used to identify hidden emotions and attitudes and reveal that which the patient and family member may be thinking or feeling but be afraid to say. Finally, we present data showing that these methods were valuable to participants in enhancing their professional experience and skills.

Introduction
In providing end-of-life care to patients with advanced disease, conversations around treatment failure, transition to palliative care, resuscitation and discontinuation of life support can evoke strong emotions in both the patient and family, as well as in the physician.\(^1\)\(^2\) Regarding the latter point, it can be daunting for the clinician to be present and know how to respond when patients and families are shocked by bad news, are in disbelief when told that their loved one may not recover from an illness or are intensely saddened when it is explained that there is no more effective treatment for a progressive disease.\(^3\)\(^4\) It may be even more of a challenge for the practitioner when patients and families respond to negative information with denial or anger or blaming of the medical team.\(^5\)

In educating doctors and nurses to deal with emotions, we have used a theoretical model called “The Emotional Jug”\(^6\) (see table and fig. 1) to explain how patients and families sometimes disguise their distress behind other emotions, either consciously or unconsciously. Thus, fear of dying can become denial of the severity of the disease or result in blaming the treatment team. Moreover, helplessness in the face of futility can be transformed into passivity and anxiety, and uncertainty about the future can become overcontrolling behavior.

Teaching the complex skills required to explore and respond to the patient’s and family’s emotions, whether they are obvious or hidden, can be a challenge. Looking to the literature, formal teaching of such communication skills for health care

Corresponding author
Walter F. Baile, M.D.
Professor of Behavioral Science and Psychiatry
Distinguished Teaching Professor
Director, Program for Interpersonal Communication and Relationship Enhancement (Il*CARE)
Department of Faculty & Academic Development
The University of Texas M. D. Anderson Cancer Center
PO Box 301402, Unit 1426
Houston Texas 77230-1402
Phone: 713-745-4116
E-mail: wbaile@mdanderson.org

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practitioners began in the ’70s and ’80s, when survival from serious diseases increased and ethical norms dictated that the patient be given truthful information and encouraged to participate in decision making. Despite this, evidence-based teaching methods have not yet completely caught on, both in Anglo and non-Anglo countries.7-10

In teaching communication skills, case presentations have been effectively used to illustrate key issues and challenges in patient care. This method is often accompanied by role-plays,11 in which learners are given the opportunity to try out different strategies, such as how to give bad news. Learners thus may interview a standardized patient or role-play among themselves to permit strategies for communication to be tried out in a safe way, where they can be coached to improve their skills. This type of experiential learning is considered the cornerstone of teaching communication and interpersonal skills.12-15

In this paper, we describe the use of advanced role-play techniques called “action methods” and how they are incorporated into dramatic enactments. Action methods are derived from the teachings of Jacob Moreno (1889-1974), a psychiatrist who used them to create scenarios in which challenging social situations were enacted so that participants could “see” rather than “hear about” problematic interactions.16

They are aptly named action methods because they are used in the setting of enactments that dramatically recreate problematic interactions often involving conflict in order to reveal the underlying complex social dynamics. These methods differ from standard role-play in that they are focused on having participants step into the shoes of the patient, thus creating empathy for him or her.

As previously mentioned action methods do not usually stand upon their own but are instead usually part of an enactment called psychodramas (an individual’s story) or sociodramas (a story created by the group), which strive to replicate the communication dilemma. They are meant to reveal the communication complexities with the goal of not only developing a deeper understanding of them but to enable participants to formulate and explore possible communication solutions. Action methods are designed not only to help recreate a scenario but to immerse the group participants in the life of the enactment and to stimulate an empathic connection to the feelings of the different characters participating in the drama and how they influence the action, potentially leading to insight into the communication

<table>
<thead>
<tr>
<th>Emotion</th>
<th>Thought/Feeling</th>
<th>What a person does/says/exhibits</th>
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<tbody>
<tr>
<td>Fear/Anxiety</td>
<td>My father’s going to die. I can’t handle this.</td>
<td>DEMANDING BEHAVIOR: “Don’t tell him his cancer has come back”</td>
</tr>
<tr>
<td>Helplessness</td>
<td>I just don’t want to make the wrong decision.</td>
<td>SEEKING REASSURANCE: “What would you do doctor?”</td>
</tr>
<tr>
<td>Loss of Control</td>
<td>I can’t stand not knowing what is going to happen.</td>
<td>ANGER: “The CT was done this morning. You mean you haven’t seen it?”</td>
</tr>
<tr>
<td>Confusion</td>
<td>They’re telling me I’m better but I don’t feel good.</td>
<td>DISTRUST: “I don’t think they’re telling me the truth”</td>
</tr>
<tr>
<td>Guilt/Shame</td>
<td>If I had been there for her maybe this would not have happened.</td>
<td>BLAMING OTHERS: “Why aren’t you doing more for him?”</td>
</tr>
<tr>
<td>Denial</td>
<td>It just can’t be true. I’m so scared.</td>
<td>UNREALISTIC EXPECTATIONS: “I just know there’s going to be a miracle”</td>
</tr>
<tr>
<td>Panic</td>
<td>I can’t handle this hospital confinement.</td>
<td>IMPULSIVENESS: “I’m going to leave the hospital”</td>
</tr>
<tr>
<td>Discouragement/ Hopelessness</td>
<td>I don’t think I’m going to make it.</td>
<td>VICTIMIZATION “Nothing good ever happens to me”</td>
</tr>
</tbody>
</table>

Table 1. Examples of how painful emotions may be displaced by those that are easier to express
dilemma. This can consequently lead to a deeper understanding of hidden emotions, such as fear and helplessness, which lie behind troubling behaviors such as anger and blame and that are sources of conflict among the patient, family and the medical team.

In this paper, we describe several action methods and illustrate how they were used in a workshop with learners who were participating in a communication skills workshop as part of a program awarding a master’s degree in palliative care. We explain how, through enacting a case of a difficult conversation, a debriefing of the learners and incorporation of didactic elements into the program, a simple case presentation can be transformed into a powerful vehicle for professional development in communication skills.

### Methods

The dramatic enactment we will discuss was conducted as a part of a two-day communication skills training workshop for 19 palliative care professionals attending the Master’s Program in Palliative Care at the University of Bologna, Italy. The learners who participated were nurses, palliative care physicians, oncologists, psychologists, physical therapists and a philosophy student. (See table 3.)

The enactment followed sequential steps. (See appendices in the online version of Journal of Patient Experience at www.patient-experience.org for the entire story and accurate description of the psychodrama.)

- Warmups (described in references 17 and 18) and in Table 2
- Presentation of the story (See below.)
- Setting the scene (appendix 1)
- Preparation for learners and scenario-setting using some action techniques with the group mediated by the facilitator (role reversal, role immersion, doubling, asides, role training) (appendix 1)
- Enactment: Each character assumes the role that they learned. (appendix 2)
- Debriefing with arising benefits from the enactment (appendix 3)

About two months after the workshop, a questionnaire was submitted by email to all participants. The survey asked participants to evaluate the workshop along five dimensions: organization, usefulness of skills taught, effectiveness of the program, acquisition of skills and acquisition of knowledge.

### Selecting a case for enactment

The first step of the workshop was to solicit a challenging case from the participants. Lidia, a hospice nurse, volunteered to present the two-part case of Angela, and Lidia’s conflict with Angela’s son and Lidia’s own supervisor. The facilitator (WB), trained in the use of action methods, guided Lidia in telling the following story to the group: Lidia was assigned to make a home visit to Angela, an 82-year-old woman who had recently been discharged from the hospital, where she had been admitted with abdominal pain. Angela was diagnosed with advanced pancreatic cancer. Angela’s disease was inoperable, and after diagnosis, she was discharged home on opioid analgesics and scheduled for a followup visit by the home hospice nurse, Lidia. However, keeping with the wishes of her son, Antonio, an engineer who lived at home with his mother, Angela was not told of her recent diagnosis, nor about the severity of her disease.

Table 2. “Action” Methods

<table>
<thead>
<tr>
<th>Warm up exercises, a form of “getting to know you.” These enhance the spontaneity necessary for participants to enter into role-play and promote the working relationship among group members through sharing of information</th>
</tr>
</thead>
<tbody>
<tr>
<td>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 the role of characters in the scenario</td>
</tr>
<tr>
<td>Doubling. Doubling encourages participants to speak for group members taking on roles to facilitate their immersion in their role and reveal unspoken or hidden emotions, thoughts and attitudes. In doubling, participants stand behind a role-player and speak for him or her, revealing attitudes, values and feelings that they imagine their character might have, based upon the challenge facing that person. Participants can also double themselves as characters.</td>
</tr>
<tr>
<td>Role-reversal. A technique whereby the facilitator asks the main character to assume the role of other characters in their scenario to help set the scene. Role-reversal is also used to allow the main character to experience, in the role of others, the impact of that person’s own actions and communication. Thus, a main character 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.</td>
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<tr>
<td>Processing. This discussion that follows the enactment gives participants the opportunity to say how the enactment affected them personally or what it was like for them to be in the role of someone in the enactment.</td>
</tr>
<tr>
<td>Role-training. A form of role-play in which participants practice the skills that can help them become more expert in their professional roles.</td>
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</table>

For an opportunity to see these action techniques and how they are implemented, the reader is directed to http://www.mdanderson.org/education-and-research/resources-for-professionals/professional-educational-resources/i-care/teaching-and-learning-communication-skills/action-methods.html.
After the home visit, however, Lidia was abruptly taken off of Angela’s case with no explanation. Several days later, the medical director of the hospice called to tell her that the hospice coordinator had transferred her from the case because Angela’s son, Antonio, complained that, in talking to his mother, he noticed that Lidia acted very serious and a little sad, and he did not want this type of communication with his mother. The actual enactment is described in the appendices.

Appendix 1 describes how the role-play encounter was set up by using warm-ups.

Appendix 2 describes how the enactment played out in a sociodramatic fashion, with participants taking on the part of the characters.

Appendix 3 describes the debriefing of the scenario, whereby those involved in the enactment talk about how it felt to them being in the role of others and what insights they obtained. Group members also relate as to how the drama affected them personally.

Comments on the enactment
One of the important goals of psychodrama and sociodrama is to explore conflicts. In the story, Lidia had two emotionally laden conflicts: that with Antonio, and that with her coordinator. The goal of the planned enactment was to use action methods to recreate first the scenario of Lidia so that her interaction with Angela and Antonio could be examined and explored by the group and the social dynamics more deeply appreciated and understood. Then Lidia would have also the opportunity to enact a conversation with her supervisor over the actions that she had taken to remove Lidia from the case.

Results (see tables 3-4)
The median average of work experience of participants was nine years and ranged from the newly graduated to the most experienced learner, who had been employed for more than 30 years in the area. More than half of the group had been in their position for five years or longer. Ninety-four percent of participants rated said that the workshop was well organized (rating of 4-5) and that time was used effectively. Eighty-two percent said it was useful or very useful) to them in their professional lives. Eighty percent of participants rated the format as very effective and as providing them with important communication skills. To the question of, “Which aspects of the workshop did you like most?” half (nine) of the participants mentioned the applicability of the techniques taught and the realism of the scenarios. Six mentioned the methodology used, such as role-play or doubling, and three students underlined the skill of the facilitator in being clear, straightforward and spontaneous.

From the post-workshop questionnaire, it can be seen that all learners reported that they had implemented at least one skill learned from the workshop. The most frequent of these was the use of empathic statements.

Seventy percent of the learners expressed the desire to attend additional workshops, and several suggested they be focused on communication with family or children. Three proposed additional training by watching videos of difficult cases with discussion, or participating in other workshops with co-workers at their place of employment.
The participants uniformly rated the course highly and reported an increase in their technical communication skills, favorable changes in their attitudes toward communicating bad news and higher self-reported confidence in their ability to effectively communicate with patients and family members.

Discussion
The simulation of cases is a technique of proven effectiveness for teaching communication and interpersonal skills in medicine. Role-play and dramatic techniques have been used in the medical field to improve basic communication, teach complex communication techniques, increase empathy and improve self-confidence. They have also been used in palliative care and end-of-life care.

In many countries, there is a lack of communication skills programs and information regarding how to effectively address difficult communications in patient care. This is especially true in Southern European countries, where a patient-centered model of care may still be unfamiliar. Workshops such as those described, which include formal teaching, role-play and small/large group exercise have been effective in this setting in teaching communication techniques. However, action methods have not routinely been incorporated into this teaching.

Advanced role-play enactments such as sociodrama and psychodrama that incorporate action methods put words into action and explore the substrate of human emotions behind the difficult communications and interactions. Revealing the hidden attitudes, emotions and values allows participants to respond to human problems and dilemmas.

In comparison with other methods of teaching, such as the discussion of cases and interviews with trained actors, sociodrama and psychodrama are similar to other dramatic teaching methods such as improvisation and theater. Unlike role-play and theatre, these techniques enhance the opportunity to increase empathy, and by putting directly in action scenarios they have established, the students can double and assume the role of characters on stage.

Doubling is a technique (see table 1) for revealing unspoken thoughts and feelings, thus broadening our understanding of the dynamics of the encounter and stimulating the group to reflect and observe on how the unspoken thoughts and feelings of the character might be motivating the character to act and speak in a certain way.

The doubling technique illustrated in the scenario described (see appendix 1 for details) serves to bring the group into the enactment by creating empathy for the characters by asking them for a moment to step into the shoes of Angela. The empathy immerses them in the drama in a deeper way. It is also a gateway to addressing patient emotions that were previously hidden and allows the facilitator to brainstorm with the group to formulate empathic responses to these emotions. Thus, during the workshop, the facilitator stopped the action occasionally to teach specific skills, such as how to make empathic statements to address patient emotions and their own emotions. This intervention can introduce a pedagogical element into a sociodramatic or psychodramatic enactment and expand its goals.

Conclusion
This paper illustrates how action methods used psychodramatically can reveal the personal and interpersonal dynamics often seen in complex patient and family encounters. These insights are particularly important because, in Southern European countries such as Italy, openness in discussing bad news is less common and the paternalistic approach of protecting the patient is very strong. Some available data suggest that the climate is changing toward providing essential medical information to patients and families, but unpleasant communication such as disclosure of diagnosis and prognosis is often concealed.

Finally, the conclusions drawn from the evaluation of this project must be interpreted cautiously because of the small sample size of palliative care professionals. However, it does provide suggestive evidence that communication techniques such as those mentioned above could be learned using dramatic enactments such as the one described. This could be done perhaps at the same time, and also without increasing costs of standardized patients, by incorporating action methods into communication skills teachings using conventional role-play.

Appendix 1: Setting the scene
Lidia’s Conflict
Interviewed by the facilitator so that the group could understand her conflicts, Lidia presented the story of Angela and her son, Antonio, to the group. Specifically, she related that in making a home visit to Angela, which was scheduled by her hospice organization, she was met at the door by Antonio, who greeted her and related briefly the history of his mother, telling Lidia that his mother did not know her diagnosis and was not to be told. Lidia was bewildered by this request. After an introduction to his mother, Lidia sat and spoke to Angela for some minutes, conducting a review of symptoms. Lidia related to the group that she was concerned about Angela because she was having significant abdominal pain. During the meeting, Angela asked Lidia what was wrong with her. As Lidia
Setting up the dramatic portrayal: the facilitator’s interventions

In order to explore Lidia’s dilemma, the facilitator used an action method called role-reversal to set up this dramatic portrayal. It consisted of several steps. In the first step, Lidia was asked to select someone from the group to help her in the portrayal by taking on the role of Angela. When a person was selected to be Angela, we will call her Maria, the facilitator (WB) helped Lidia prepare this person for the role of Angela by reversing roles with Maria and becoming Angela. This is necessary because only Lidia has a personal knowledge of Angela, and Maria, who will assume this role, must learn (and also the group must learn) the social particulars about Angela and what she is thinking and feeling. This is called role-immersion. Lidia was thus interviewed by the facilitator in the role of Angela. The facilitator asked social questions, such as how old she was, about her family and details of her medical illness. This revealed for the group that Angela was in distress from abdominal pain and troubled by the lack of knowledge about what was wrong with her. During the interview, when Angela talked about how bad she felt, the facilitator introduced the concept of doubling. The purpose of doubling is to explore Angela’s feelings and attitudes that are unspoken but that could contain important information about her current emotional state, wishes and thoughts. Doubling consists of two parts: in the first part of self-doubling, the character (in this case Angela) is asked to stand behind her own chair or take a step back from her standing position. The facilitator then asks, “Angela, can you tell us what you are thinking and feeling that you might not be saying?” Angela exclaimed that she was hurting, the medicine is not doing much good and she is worried. She also said that she was puzzled why her son sent the nurse away. This doubling provides the group with additional information that is important in understanding the dynamics of Angela’s illness and the reactions to it.

In the second half of doubling, members of the group were asked to come up and stand behind Angela to add their own empathic understanding of what Angela might be feeling. The facilitator started by asking, “Who can imagine what Angela might be feeling?” Group members who raised their hand then proceeded to stand behind Angela and speak as if they were Angela. In this situation, phrases that were expressed included, “I’m so confused.” “I’m afraid of what is wrong with me.” “I’m angry that they sent me home from the hospital still hurting.” In these situations, the facilitator might also double Angela, for example saying, “I’m not sure why Antonio is acting so strange. He wouldn’t let that nurse finish her visit with me.” The selection of additional characters in the drama was guided by Lidia, who was then asked to choose someone to take the part of the son, Antonio. She reversed into (assumes) the role of Antonio and was interviewed by the facilitator.

Facilitator: “Antonio, tell us about yourself and about your mother.”

Antonio: “I have lived with my mother all of my life, and I can’t stand to see her in this state. She is the only one who understands me. The thought of losing her is devastating.”

Group members doubled for Antonio, and picking up on his last statement, further expanded on what he might be feeling “I just can’t think of losing my mother.” “I am really anxious about what is going to happen to her.” “I don’t know what will happen if she finds out she has cancer.” “What will I do without her?” Thus, the feelings of fear, anxiety, helplessness and anticipated loss emerged from the doubling, which helped deepen the group’s understanding of the very troubling situation that Antonio found himself in and helps the group member playing Antonio immerse himself into his role.

Appendix 2: The dramatic portrayal

Enacting the drama

Having set the important characters in the scenario, the facilitator moved the group into an enactment, and each character assumed the role that he or she learned from observing the role reversal. However, this is only the beginning of the use of role reversal, as we will see how the facilitator used it to help Lidia put together all the underlying components of the different personae that we have seen up to now — Angela’s desperation and confusion, Antonio’s fear and sense of helplessness, and Lidia’s puzzlement about what happened in that scenario.

Facilitator: “OK, Lidia, can you precede with the encounter?” At this point, Lidia describes the scene that she will enter, the kind of home that Antonio and Angela live in and other details that might lend realism to her visit and immerse the entire group in the scene.

Lidia meets Antonio at the door, he ushers her in and tells her that his mother does not know her diagnosis, so she should not bring this up with her. Lidia says nothing but enters Angela’s room.

Lidia: “Good morning, Angela. I’m Lidia, a nurse from the hospital. How are you feeling today?”

Angela: “I’m very tired and my stomach hurts. I am not sure what’s wrong.”

Lidia begins to explore the nature of Angela’s pain when Antonio interrupts. “We need to keep taking these pills, mother, so you feel better. You really look tired, and I think we need to let you rest now.”

Exploring the conflict

The enactment proceeded to the point where Antonio stopped the interview and asked Lidia to leave. At this point, the facilitator stopped the action and asked Lidia if she wants to try to discover what was happening to Antonio that he bullied her out the door. With agreement, the scenario was replayed. This time, however, the facilitator, with dramatic license,
allowed Lidia to have a conversation with Antonio, helped by the group, which made suggestions for tactics for her to use such as praising him for his care of his mother, empathizing with his distress and saying, “I’m sorry for your plight” to attempt to align with him. Lidia tried some of these approaches with Antonio, but they seemed to not get very far. The facilitator then suggested that she might explore more deeply what Antonio meant earlier when he said that he would feel “devastated” and that his mother was the only one who understands him. However, in order to allow Lidia to speak as Antonio, each time she asked him a question, she reversed roles with Antonio’s role in order to answer her own question because, on some level, only Lidia knew Antonio and, better than anyone else, could guess what Antonio might be thinking and feeling.

Thus, when Lidia was responding as Antonio to her own question as what the he meant when he said he would feel “devastated” if his mother died and that she was the only one who understood him, Antonio revealed that he was gay and had kept this secret from a lot of people, but this mother knew and always accepted him. This was unlike his deceased father, who was very critical and disapproving of his lifestyle. Although Antonio now had a partner, it was also a new relationship and he could not handle all of the stress of this and his mother’s illness. After revealing this in the role of Antonio, Lidia was reversed back into her own role. She was asked if she knew this information before and she said she had known it coming into the case presentation but had not considered an important determinant of Antonio’s behavior. This conversation led to a discussion of Antonio’s distress. The group at that point recognized the intensity of the bond between Antonio and his mother and speculated that Antonio’s complaint that Lidia was too serious and somber with his mother represented his underlying fear that his mother would come to understand from her conversation the seriousness of her own illness, which frightened him.

Pursuing a second conflict

In order for Lidia however to get complete closure on her situation it was also necessary for her to have a conversation with her coordinator, who had pulled her off Angela’s case, as her own feelings of anger and confusion about this issue had also been part of the dynamics of the presentation. She was invited to choose someone from the audience to play the role of the coordinator and subsequently told the group about her coordination through role reversal. Doubling of the coordinator by the group suggested that the coordinator might have been ill at ease in discussing the issue of Antonio with Lidia and that perhaps her motives for taking her off of the case had nothing to do with Lidia’s competence, given what had been previously revealed by the dramatic enactment. There followed a discussion of how, despite Lidia’s lingering anger after a year, Lidia could still have had a discussion with her coordinator about the seriousness of her own illness, which frightened him.

Appendix 3: Debriefing of the scenario

Processing the drama

In a debriefing, Lidia was able to relate that she had, at some point, been told that Antonio was gay but had not related that to his distress. In fact, without the benefit of the actual Antonio, we do not know exactly why he was protecting his mother from the information. However, for Lidia, it was important for her to realize that Antonio’s asking her to leave did not likely have to do with her being an incompetent nurse but instead likely had to do with Antonio’s relationship with his mother. This was very relieving and therapeutic for her because, after a year, she liberated herself from the confusion she had been carrying regarding why Antonio might have sent her away and asked for someone else. As part of the debriefing, other actors in the scenario spoke about how it affected them to be in their role. Other members of the group shared how the drama affected them personally.

References


