

Training Oncology Professionals in Key Communication Skills: Adapting Psychodrama and Sociodrama for Experiential Learning

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The authors describe how sociodramatic methods were applied to teaching communication skills to professionals in a comprehensive cancer center. The article briefly reviews the importance of communication skills in oncology and the challenges in teaching key skills such as empathy and addressing emotions. It indicates how action methods can be applied to enact case scenarios generated by groups attending communication-skills workshops. It describes the advantages of action methods over other techniques for teaching communication skills in the medical setting. It suggests how these methods might be more widely disseminated among teachers of medical communication skills.

KEYWORDS: Psychodrama; Sociodrama; Communication Oncology.

INTRODUCTION

Professionals who work with cancer patients and their families are often required to conduct many “high-stakes” interviews with patients and families. These include discussing the cancer diagnosis, describing harsh treatments to patients

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and families, communicating the failure of anticancer therapies and treatments and/or the presence of irreversible side effects, and talking about ventilator assistance and other end-of-life issues (Baile and Costantini, 2013; Back, Arnold, Baile, Tulsky, and Fryer-Edwards, 2005; Baile et al., 2000). In particular, they must not only provide information clearly and geared to the patient's preferences and education level, but they must recognize and address strong emotions which emanate from such conversations, such as frustration, disappointment, demoralization, panic, or even blame and anger. They must attempt to resolve conflicts among members of the treatment team, such as when there is disagreement about whether the goals of care for a particular patient are palliative or curative (Baile, Palmer, Bruera, and Parker, 2011; Hack, Degner, and Parker, 2005; Hancock et al., 2007; Pollak et al., 2007).

The importance of clear and effective communication is obvious not only in approaching these situations but also in promoting positive teamwork, talking to patients about clinical trials, and conducting family meetings to discuss the possible outcomes of treatments. These conversations occur on almost a daily basis. In fact, it has been estimated that the average cancer clinician will give bad news over 30,000 times during his or her career (Fallowfield, 1993).

Communication when it is the basis for support, encouragement, and empathy provides a "secure base" or anchor, where patients know that they can expect honesty, compassion, and a hopeful attitude (Gerretsen and Myers, 2008). In fact, as Seetharamu and colleagues (Seetharamu, Iqbal, and Weiner, 2007) point out, trust and hope are fundamental positive psychological experiences for patients and families, who are often confused, frightened, worried about the future, and dealing with major changes in their lifestyle and often ultimately death and dying.

Despite the presumed imperative for cancer professionals to offer clear, empathic, and ethical communication, oncologists, oncology nurses, physician's assistants, social workers, and patient advocates receive little or no effective training in communication skills (Hoffman et al., 2004). By this we mean that they are often not exposed to the principles of effective communication (Hebert, Butera, Castillo, and Mega, 2009), such as using the steps of SPIKES (Baile et al., 2000; see Table 1), a widely accepted process describing the communication steps for giving bad news. Nor do they often have an opportunity to practice essential skills such as the ability to make empathic responses when the patient becomes overtly emotional or to expose the "hidden" concerns of patients when they ask questions such as "Doctor, will this cancer kill me?" (Kersun, Gyi, and Morrison, 2009).

COMMUNICATION SKILLS TRAINING

In attempting to learn communication skills in oncology, professionals may read papers on communication, but this is usually limited to a description of a method or provision of data on what is effective communication. Such information in papers is not easily translated into skills. Medical professionals and students may be exposed to clinicians whom they can emulate as good communicators, but without coaching they will not know if they themselves are able to correctly perform the skills they saw. They may discuss cases, but this also does not teach

Table 1. SPIKES for breaking bad news.

SPIKES is an acronym for the following skills used in giving adverse medical information to patients and families.

S = Set Up the Encounter

- a) Prior to the meeting, try and prepare yourself psychologically. Even though you are the bearer of the bad news, you can also be an important part of the patient's support system.
- b) Have a plan as to how you will give the news and also for subsequent treatment.
- c) Find a quiet place to have the encounter. Turn off your pager. Make sure the most important people for the patient are in the room.

P = Perception

In order to know where to start the conversation, find out what the patient already knows or has been told: "Tell me what you understand about ..."

I = Invitation

Make sure the patient is ready for the conversation: "Is it OK for me to go over the results of ...?"

K = Knowledge

- a) Give information in small chunks.
- b) Check for understanding.
- c) Avoid jargon.

E = Emotions

- a) Address all emotions with empathic responses.
- b) Use exploratory questions to better understand the underlying feelings.

S = Strategy and Summary

- a) Articulate a plan.
 - b) Check for understanding and allow questions.
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actual skills. They may be supervised at a patient's bedside, but that does not allow for practice in a safe format, because they are being observed by a supervisor and because the discussions are often extraordinarily challenging, often requiring extensive practice and coaching (Baile, 2009).

Training programs in communication in oncology have been found to be most effective when they incorporate both the opportunity to learn what to do in communication (such as the steps for giving bad news; see Table 1) and how to do

it (the skills required in implementation; Baile, 2011) and the opportunity to practice with coaching. Learners also learn best when they are involved in their own learning, set their own goals, understand the skill they need to acquire, and have an opportunity to practice (Kaufman, 2003). Because many academic centers where oncology professionals are taught do not have formal courses on communication skills (Hoffman et al., 2004), oncology professionals are often left floundering when confronted with strong emotions in a patient, for example crying in response to the news that a cancer has come back or anger at a treatment's being ineffective. In fact, professionals often respond in ineffective ways such as becoming defensive, changing the topic, or offering false reassurance that things will get better (Venetis, Robinson, Turkiewicz, and Allen, 2009).

Most educators agree that actual practice is highly important in helping develop effective communication skills (Kaufman, 2003; Kurtz, Silverman, and Draper, 2005). One of the most common methods to allow for practice is the use of standardized patients. These are usually actors who have been trained to take on the role of patients through the use of scripted characters and extensive preparation. In one model called Oncotalk (Back, Arnold, Tulskey, Baile, and Fryer-Edwards, 2003), actors are used in a retreat setting, where intense focus on acquiring communication skills over a three-day period has shown that novice learners under appropriate guidance and coaching can acquire key skills which will prepare them for the stressful conversations that will face them over the subsequent years that they are in practice (Back et al., 2007).

Some of the downsides of such a format of using standardized patients in a workshop or retreat setting are that it is costly, as both actors and clinician-coaches have to be paid for their time, and that it is labor intensive to prepare scripts for actors. Moreover, the training only reaches a small group of people, as groups are kept small—four to six learners for each facilitator—so that everyone can have a turn while a more experienced clinician acts as coach. With standardized patients, a learner is able to practice on a limited number of issues without necessarily being taught universal strategies of good communication, strategies that can be generalized to many other situations.

USING ACTION METHODS TO TEACH COMMUNICATION SKILLS

For the past two years, we have conducted workshops using action methods at the University of Texas MD Anderson Cancer Center to teach effective communication skills such as those previously mentioned (Baile and Walters, 2013; Baile et al., 2012). MD Anderson is a Comprehensive Cancer Center as designated by the National Cancer Institute. It employs 18,000 people, including over 1,000 faculty who are part of the University of Texas system, and has 350 inpatient beds dedicated exclusively to oncology. We have worked with a variety of disciplines (see Table 2) to teach effective communication in situations relevant not only to the practice of oncology (such as giving bad news) but across other dimensions relevant to an academic cancer center, such as giving feedback to learners, modeling principles of mentoring and supervision, and teaching the skills of coaching communication skills.

Table 2. Issues raised in workshops using action methods.

Topic	Audience
Amygdala Hijacking (Controlling your own emotions and addressing those of others)	MD Anderson Faculty
Communication Skills in Difficult Encounters (Developing awareness of your emotional triggers and how not to fall victim to them)	MD Anderson Nurses
Difficult Conversations in Mentoring and Supervision (Giving Feedback in Supervision, Mentoring, and with Colleagues)	MD Anderson Women Faculty
Giving Bad News (What we say and how we say it)	MD Anderson Department Administrators/Clinical Administrative Directors

Our workshops were organized around different issues of crucial communication (see Table 2) using a format of three-hour sessions focused on topics generated by the learners. Sessions are attended by anywhere from 6 to 30 participants and are held in conference rooms easily accessible by those taking time away from patient-care responsibilities.

The methodology we use in these workshops is to select a theme for a workshop, such as “Dealing with patient emotions,” and then conduct a sociodramatic portrayal of common scenarios which reflect this theme and which are elicited from members of the group. Since most group members do not know each other, and groups are a mixture of doctors, nurses, and other professionals as listed in Table 2, we use extensive warm-ups to prepare the group to enter into action. Warm-ups include polarities, spectrograms, and locograms (Blatner, 2000). They often focus on issues relevant to the group, such as how much training in communication skills the group members have had (spectrogram) or where they received their medical or professional training (map of the world). The group is further warmed up through asking members to pair off in dyads and to discuss a difficult conversation reflecting the theme of the workshop (e.g., dealing with difficult emotions) that was successful for them. They then work in small groups of four to discuss further and more specific examples of communication which were challenging for them and which they struggled with. These scenarios are then

written on a flip chart and the group votes as to which challenge will be enacted that day (see Table 3 for a list of scenarios suggested for one workshop). Learners then volunteer or are selected by other group members to take on the role of characters in a drama.

Action methods are used both to set the scene and to move the drama along. Of the action methods we have used, one of the most important is role reversal. Getting someone into the shoes of another person is the central skill (Blatner, 2000; Sternberg and Garcia, 2000).

We use basic psychodramatic interviewing in role reversal to help the learners immerse themselves in the role of the other (Blatner, 1996; Sternberg and Garcia, 2000). We call it empathic interviewing.

A series of simple questions allows participants to warm up to and then become fully immersed in the role of their character (usually a patient or family member, but it may be a staff or hospital worker) for a short time. This helps them figure out how the patient should best be approached.

The questions which assist a participant warm up the learner to the role might include "Who are you?," "How old are you?," "What are you wearing today?," "How are you sitting or standing?," "What can you tell me about your family, your work?"—all questions designed to help learners immerse themselves in the role of the other. Then we ask, "What is it you expect to hear today? If you get bad news and it isn't good, what can this medical professional do to make it easier to hear?"

Another psychodramatic technique that can be very useful in helping participants immerse themselves in the role of the other is the double. "The double is played by one or more group members. The double is a mind/feeling reader. He or she is a person whose role it is to tune into the enactor's unexpressed thoughts and feelings and express them. The double helps the actor to realize and acknowledge what he is thinking or feeling. The double positions himself behind and slightly to the side of the person for whom he doubles" (Sternberg and Garcia, 2000, p. 61). We may ask characters to double themselves so that they can dig further down into the depth of their feelings in order to expand and deepen their character.

Common responses of a doctor in the role of a patient would be things like "I don't want to be lied to," "I don't want a lot of excuses or for them to go over everything they had tried," "I don't want them to try to make me stop crying or stop being angry," and "I think if they could just sit and be quiet with me while I try to wrap my mind around what they just said."

We also invite group doubling of both the medical professional and the patient before the scene begins and at any point during the scene. This often further immerses the character in his or her role and lends an enhanced authenticity to the scenario, which takes on a life of its own when the participants begin to interact as their characters. For example, a doctor is getting ready to tell a patient that there are no additional anticancer treatments available. Group members are invited, "Raise your hand if you can imagine what this doctor might be feeling as she gets ready for this conversation." Everyone whose hand is raised is asked to come and stand behind the doctor and, one at a time, make a doubling

Table 3. Issues raised in workshops using action methods.

Clinical issues (raised by physicians, physician assistants, nurses, social workers, and patient advocates who attended workshops)
How do I give unexpected bad news to patients and families?
How do I deal with a family in denial about their child's terminal illness?
What do I do when the family member does not want me to give information to the patient?
How do I deal with the situation when there is serious disagreement around goals of care for a patient who is terminally ill?
Management and supervision (raised by nurse managers, supervisors, and medical staff in a mentoring situation)
How do I talk to a colleague who is avoiding a difficult conversation about prognosis with a patient?
How do I mentor a trainee who responds to feedback with denial and anger?
How do I deal with my own emotions when supervising others?
How do I give effective feedback?
Training in psychodrama techniques
How can I use role reversal in my work with patients and families?
How can I use the “empty chair”?

statement. The doctor is then asked after each doubling statement to repeat it if it is accurate and to change it if it is not. In this situation, doubles often state, “I’m scared that the patient might cry,” “ I feel really helpless,” or other expressions of underlying feelings. Group members are also invited to double the patient’s role at various times when the director deems it necessary to get the patient’s underlying feelings out in the open.

When communication skills are taught via action methods such as role reversal and doubling, participants gain practical and usable techniques for developing the sort of empathy skills that they can transfer into any other situation (Blatner, 2000). We can also stop action to identify what is working well or not by having the communicator reverse roles and check it out. We also stop the action to teach basic principles of communication, such as how to give bad news (Baile et al., 2000), to provide a “cognitive roadmap” as a framework within which the

more process-oriented communication techniques such as making empathic responses can be tried.

The empathic interviewing and role reversal can be done sociodramatically or psychodramatically, depending upon the need of the group or individual. In a short workshop offered in the workplace, we tend to stick to sociodramatic explorations. In an all-day training or an ongoing series, we naturally move into psychodramatic explorations of the issues brought up. In a psychodramatic scene, a real doctor would play him- or herself and would choose someone from the group to play his or her real patient. The doctor would act out a real scenario that either has occurred or they expect to happen. In a sociodramatic scene, all of the characters are made up and everyone from the group can have input into the situation. We invite the group to make up the roles of the physician and patient. We ask them to tell us the doctor's age, gender, and years of experience. We ask them to tell us the name, age, and familial and professional status of the patient. In addition, we ask them to make up the nature of the cancer that the patient is dealing with, as well as any additional relevant medical information. The group then makes up the situation and what the doctor needs to tell the patient.

By encouraging the group members to double the roles portrayed, the sociodrama allows the entire group to participate in the experience of developing empathy for the characters and insight into what might be effective communication to address the subtext of emotions that are often revealed under the surface of an angry or tearful patient—that is, the anxiety, fear, disappointment, and sadness which are often unspoken but emerge as blame, denial, or defensiveness. For example, in a recent sociodrama conducted around a theme of difficult, angry family members in denial about their young son's terminal illness, group members were able to double the terrible sense of anticipated loss that lurked under the surface of the mother's blame of the staff for the lack of treatment success.

In our sociodramas we can also move into classical role training (Dayton, 2005) by inviting many different group members to step into the chair of the patient and into the shoes of the medical professional trying to communicate effectively. This provides an opportunity for many group members to experience the roles of both the patient and the communicator, to both practice helpful words and experience the impact of these words. In addition, we provide handouts and a brief overview of the skills seen in the drama and of others we have taught that group members will eventually find helpful in acquiring the skills relevant to the theme of the workshop.

We finish by giving each group member the opportunity to practice in dyads, solidifying the learning through experiential exercises such as making empathic statements in response to a partner's story. This exercise can be based on a sociodramatic scenario or it can be practiced psychodramatically and be more personal. The specific communication skills that participants practice are how to make exploratory ("Tell me more about what you are thinking"), empathic ("I can see you weren't expecting such bad news"), and validating ("Most people would feel that way also") statements.

Other verbal techniques for aligning with the patient and family include praising the patient for effort and emphasizing the important role of the family in

supporting the patient. We finish by giving each group member the opportunity to practice in dyads, solidifying the learning through experiential exercises such as making empathic statements in response to a partner's story. This exercise can be based on a sociodramatic scenario or it can be practiced psychodramatically and be more personal. The specific communication skills that participants practice are how to make exploratory ("Tell me more about what you are thinking"), empathic ("I can see you weren't expecting such bad news"), and validating ("Most people would feel that way also") statements. Other verbal techniques for aligning with the patient and family include praising the patient for effort and emphasizing the important role of the family in supporting the patient.

Traditional role play is also used to teach communication skills, but without the use of role reversal it is quite difficult for many people to develop empathy for what the patient is going through (Clayton, 1992; Nolte, 2008). Without effective and empathic role reversal, it is hard to know what to say to a patient, because you are not standing in their shoes. Receiving feedback from peers or a standardized patient does not come close to finding out from within the role what works and what does not. What might work for one patient will not work for another. In addition, traditional role play does not necessarily teach the skill of role reversal, a skill that can allow for generalization of the learning to many different situations; it is not just learning how to speak to this particular patient but learning the skill of how to get into someone else's shoes to be more effective in communicating. Learning how to step into the shoes of each patient teaches the skills for learning how to best respond to each individual patient, not just the one being dealt with in that moment.

Moreno—who was a medical professional himself—did not have extensive opportunities to use his methods in the training of those caring for patients (Moreno, 1946–1969). That is not to say that action techniques are as relevant in this setting as in dealing with social groups and patients. We have used these methods in teaching almost a thousand cancer professionals over the past seven years. Evaluations have shown a wide acceptance of action methods (Baile and Walters, 2013; Baile et al., 2012). One challenge in working with professionals in the cancer setting has been their reluctance to work on a deep level of emotion, both patients' and their own, and especially in a group setting. We find that carefully designing a series of warm-up exercises that are simple and geared to the professional setting helps reduce anxiety and increases willingness to participate. Here the adage "From outside in" or "From periphery to center" (Blatner, 1996) helped us formulate beginning warm-ups, such as using a spectrogram for the group to get to know how long colleagues have been at our institution, to more inside warm-ups, such as a locogram asking group members to stand on a spot which represents their biggest communication challenge in giving bad news. Another challenge for facilitators is that of acquiring an understanding of the medical, psychological, and organizational issues facing those involved in the care of patients with cancer and their families. While many of us have had personal journeys with cancer or family members who have unfortunately had this illness, being part of the workforce has been important in allowing us to select appropriate

themes for the workshops based on the specific needs and concerns of cancer-care providers.

FUTURE DIRECTIONS

Where do we go from here? In 2010 we presented a ninety-minute workshop on the use of what we termed empathic interviewing at the European Association for Communication in Healthcare conference held in Verona, Italy (Baile, Walters, & Epner, 2010). What 45 communication-skill trainers learned was how to use basic role reversal through interviewing in role to help their students learn how to be more effective communicators. We have also begun to offer train-the-trainer workshops at MD Anderson, teaching supervisors and skill trainers how to use the techniques of role reversal and doubling with their own skill groups and supervisees. We have used action techniques in teaching communication skills at other institutions in the United States, such as the Cleveland Clinic, and internationally in Germany, Italy, and Portugal. Although statistical-based research is sketchy at best at this point, participant evaluations have been very positive (Baile and Walters, 2012). We hope to present more of our teaching methods in publications, at national and international conferences on communication in health care, and at national psychodrama meetings to gain feedback from peers that will help us to further refine our methods.

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