Special Article

Applying Sociodramatic Methods in Teaching Transition to Palliative Care

Walter F. Baile, MD, and Rebecca Walters, MS, LMHC, LCAT, TEP
Departments of Behavioral Science and Faculty Development (W.F.B.), The University of Texas M. D. Anderson Cancer Center, Houston, Texas; and Hudson Valley Psychodrama Institute (R.W.), New Paltz, New York, USA

Abstract
We introduce the technique of sociodrama, describe its key components, and illustrate how this simulation method was applied in a workshop format to address the challenge of discussing transition to palliative care. We describe how warm-up exercises prepared 15 learners who provide direct clinical care to patients with cancer for a dramatic portrayal of this dilemma. We then show how small-group brainstorming led to the creation of a challenging scenario wherein highly optimistic family members of a 20-year-old young man with terminal acute lymphocytic leukemia responded to information about the lack of further anticancer treatment with anger and blame toward the staff. We illustrate how the facilitators, using sociodramatic techniques of doubling and role reversal, helped learners to understand and articulate the hidden feelings of fear and loss behind the family's emotional reactions. By modeling effective communication skills, the facilitators demonstrated how key communication skills, such as empathic responses to anger and blame and using "wish" statements could transform the conversation from one of conflict to one of problem solving with the family. We also describe how we set up practice dyads to give the learners an opportunity to try out new skills with each other. An evaluation of the workshop and similar workshops we conducted is presented. J Pain Symptom Manage 2012;■:■−■. © *2012 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words
Sociodrama, communication, palliative care

Tell me and I'll forget; show me and I may remember; involve me and I'll understand.
—Chinese Proverb

Introduction

Evidence supports the crucial importance of effective communication between patients and health care providers.[1–8] However, significant gaps remain in communication among patients with cancer and their professional caregivers.[9–11] This also is true in palliative care.[12–14] For example, Baile et al.[13] recently showed that, although the level of depression was directly related to the severity of patients' illness-related concerns, palliative care physicians treating patients with advanced cancer

Address correspondence to: Walter F. Baile, MD, Departments of Behavioral Science and Faculty Development, Unit 1426, The University of Texas M. D. Anderson Cancer Center, P.O. Box 301402, Houston, TX 77230-1402, USA. E-mail: wbaile@mdanderson.org

Accepted for publication: March 9, 2012.

0885-3924/$ - see front matter
http://dx.doi.org/10.1016/j.jpainsymman.2012.03.002

performed poorly in identifying areas that patients were seriously worried about, such as relationships with family members. Moreover, as we move into the future, teaching effective communication to medical professionals treating patients with advanced disease will become increasingly important.[15–18] This was recently underscored during a workshop sponsored by the National Academy of Sciences Institute of Medicine, in which the skills necessary to discuss end-of-life choices were described as a linchpin for delivering quality and cost-effective cancer care.[19]

Evidence-based training in communication skills for medical professionals began in the 1980s. It is often based on Lipkin et al.'s "learner-centered" approach,[20] which emphasizes small-group work in a retreat setting, skill practice using standardized patients (individuals who are trained to take the role of patients), and a curriculum focused on teaching key communication skills, such as delivering bad news. Verification of the model's effectiveness in teaching oncologists key skills, such as giving bad news, has been demonstrated both in clinical trials with experienced oncologists[21] and oncology nurses[22] and in longitudinal studies with oncology fellows in communicating around end-of-life issues.[23] Despite these positive outcomes, a workshop format for teaching communication skills to oncology professionals has not been widely used.[24–26] Workshops, especially residential ones, can be costly and time intensive and often reach only a small number of persons at a time. The expense of hiring standardized patients, bringing in trained facilitators, and/or securing an off-site location for training may strain the budget of many programs. Moreover, most training programs described in the literature have been directed toward nurses or physicians, yet many other oncology professionals, such as social workers, physician assistants (PAs), mid-level providers, patient advocates, and patient access staff, who also play important team roles in oncology patient care, need communication skills training. These and other practical considerations have led to the development of additional methods for teaching communication skills in medicine, such as interactive theater,[27] multimedia instruction,[28–31] bedside and clinic teaching,[32,33] videotaping of encounters followed by feedback,[34] and role-play in small groups.[35] Innovative training methods, such as the use of virtual reality also are being explored.[36,37] Here, we describe how we applied sociodrama, a method of dramatic enactment, in teaching the skills and principles needed to master a difficult communication challenge at the end of a patient's life. We present the results of a brief evaluation of the workshop and discuss how sociodramatic techniques might be applied more widely.

Sociodrama

Sociodrama is derived from psychodrama, which was developed by Dr. Jacob L. Moreno, a psychiatrist who used group enactments of life situations aimed at helping clients deepen their understanding of and resolve interpersonal conflicts or mental problems, such as addictions, post-traumatic stress disorder, and the effects of traumatic experiences.[38] Sociodramas are similar to psychodramas but do not explore intrapersonal issues, such as the effects of a traumatic childhood but address common challenges that arise when individuals interact, such as resolving conflicts and disagreements and challenges in parenting. Sociodramatic portrayals can be used to teach communication skills to medical professionals. Sociodramas differ from more conventional approaches to communication skills teaching in medicine, such as case discussions, in that they use the added dimensions of space, movement, and imagination.[39] That is, the objective of sociodrama is to *portray* social situations rather than merely describe them. In sociodramas, participants take on the role of another. This allows them to develop an empathic understanding of that person's point of view or feelings. Thus, for example, a doctor assuming the role of a nurse might better understand how that nurse could become frustrated and angry when the medical teams caring for a terminally ill patient in the intensive care unit (ICU) are communicating different goals of care to the patient's family.

One application of sociodrama, "role training," focuses on preparing individuals for professional roles and responsibilities. For example, sociodrama has been used in business management and education[40] and the legal setting[41,42] to enhance leadership and presentation skills of executives, teachers, and trial lawyers.

However, few published reports discuss how sociodrama might be used to train health care providers to exercise the interpersonal skills needed in their professional roles, especially in end-of-life conversations with patients, where many pitfalls exist around communication.[13] In the example described previously, role training might involve providing an opportunity for the various members of the ICU staff to try out communication strategies that could be effective in resolving the communication dilemma. In this study, we illustrate how sociodrama deepened the understanding of the communication challenges faced by oncology clinicians in the transition of a patient to palliative care.

Essentials of a Sociodramatic Workshop

In this section, we describe the elements of sociodrama and then present the details of its application in a workshop entitled "Difficult Conversations: Dealing with Strong Emotions in Patients and Family Members" attended by a group of cancer center faculty and staff.

Time Allotted

Workshops can last from several hours to several days depending on the time available to participants. In general, it takes at least two hours to conduct a workshop comprising warming the group up, enacting one scenario, presenting a brief didactic, and giving learners the chance to practice skills. With more time, additional scenarios can be portrayed.

Confidentiality

Participants are asked to keep the details of workshops confidential and refrain from discussing participants' performance outside the workshop. This confidentiality agreement is meant to encourage full participation and ensure that all the participants may safely and spontaneously express their feelings and be comfortable in portraying characters in the drama.

Facilitation

The role of the facilitators is to direct warm-ups, help the group select and set up the scenario to be enacted, assist them in developing the characters, and guide the sociodramatic portrayal. They also may teach skills, using a brief lecture format. They lead practice exercises and the debriefing. Workshops are usually facilitated by trained sociodramatists who are board certified or other professionals experienced in conducting workshops using both sociodrama and small-group methods.

Conceptual Framework

Sociodramatic workshops are generally divided into four phases: warm-ups to build a connection among the participants and select the main theme of the workshop, the enactment, the practice session, and the debriefing and evaluation.

Warm-Ups

Warm-up exercises, a sort of "getting to know you," aim to promote group cohesion by reducing the anxiety often associated with role-play. They also facilitate the ability of group members to be spontaneous in the role of different characters in scenarios and in doubling other characters (see below). Warm-ups promote group work, as they allow for the introduction of the facilitator to the group and a casual transition into the type of activity that the group will be doing, which often involves disclosure of feelings. Groups who do not have warm-ups are often characterized by passivity and a lack of enthusiasm. Examples of warm-ups can be found in Table 1.

Selection of Scenarios to be Portrayed

In the final warm-up, participants in groups of four discuss a challenging communication they encountered that reflected the theme of the workshop. This "learner-centered" approach results in the emergence of a "menu" of potential scenarios that could be enacted. As each small group presents the situations (usually one or two per group), they are clarified, synthesized, and listed on a flip chart. Subsequently, each group member votes on his or her choice for an enactment in the order of priority of importance for them. The scenario with the highest number of votes is enacted first.

Creation of Characters

After a scenario is chosen by the group, group members volunteer or are asked by the

Table 1
Warm-Ups Used in This Workshop

1. **Introductions.** Attendees were asked to give their names, tell the group the department in which they worked and their role in the department, and reveal one thing about themselves that most people would not know. For example, one participant reported that she had climbed Mount Kilimanjaro. Another reported that her hobby was making necklaces using exotic breads. A third described a passion for the clarinet. A fourth described his hobby of baking unusual breads.
2. **Spectrograms**. Group members were asked to form lines which divulged information about group members. They first lined up according to their number of years of service to the institution. They then lined up according to the distance they had to drive from home to work. Finally, they lined up according to the number of hours they had in communication skills training.
3. **Polarities**. Group members were asked to go to one of two sides of the room or the middle of the room according to where they stood on certain preferences, for example, being a "night owl" or a "morning person." Several group members were asked to give details about their choices.
4. **Locogram.** Participants were asked to imagine the room as a map of the world and to go to their birthplace and then to the place where they received their professional training. All the participants shared information about their choices about these locations.
5. **Sharing successful stories**. Participants were asked to partner with another group member and discuss a successful end-of-life conversation they had had and the strategies they used that helped them be effective.

facilitator to play characters in that scenario. Participants may decline but usually do not. As each person agrees to take a role, he or she moves into the center of the room, which becomes a sort of stage, where space is made for the enactment. Volunteers are introduced to their roles by the facilitator when she asks the group to assign characteristics to each character, such as age, gender, occupation or profession, and demeanor and the particulars of a character's illness. Thus, group members may take a gender role different from their own. To further set the scene, the facilitator asks "Where does this scenario take place?" Then, using chairs and other props in the room, the group members create an imaginary setting, for example, a hospital room, clinic, or office, for the scenario. Subsequently, immersion into the roles is deepened for each character when the facilitator asks each participant playing a role to stand behind his or her chair and imagine what his or her character might be thinking at that moment. This is called "doubling" and is meant to deepen the role of the character by revealing their imagined thoughts and feelings at that moment as it relates to the scenario. The rest of the group also contributes to this character creation by doubling each character—that is, after the character sits back down, other group members step behind that character and make their own statement about what he or she might be thinking. Depending on the nature of the scenario selected, one or more "main characters" may emerge whose task it is to "take on" the particular communication challenge framed by the scenario.

Rolling the Scene

After the characters are set and the goals of the conversation are clarified, the facilitator encourages the main character to begin the dialogue, pointing out that they may stop it any time they get stuck by calling a "time-out."

Debriefing Learners

When learners get stuck or when there is a teaching point to be made, the action is stopped either by the facilitator or by the learner in the role of the main character. A group discussion ensues regarding how to move the dialogue forward. This is assisted by another doubling of characters in the enactment so that their inner and hidden thoughts and feelings at that moment are revealed. Often a didactic presentation of a key communication strategy, such as when and how to make an empathic response to feelings revealed by the doubling, assists in helping the learner move the conversation forward. At times, other learners may try a response or the facilitator may demonstrate one. The original learner can then make his or her attempt. Also, the participants who portrayed each character are asked to comment on how they felt in the role of their characters in this reenactment. This reinforces the empathic understanding of how it feels to be in the shoes of another person.

Practice Session

The purpose of the practice session is to reinforce communication skills that the participants could potentially transfer to their

everyday practice. To make this an authentic experience, participants are asked to sit with their original partners from the warm-ups and imagine a real-life scenario that could require the same skills they saw in the enactment. This might include an emotional experience that would require empathy on the part of another. They were instructed not to pick a scenario that was too disturbing for them. Each pair then related their experience to each other and their partner replied, using, for example, the skills listed in Table 2.

Workshop for Oncology Professionals

We applied the techniques described in a workshop for clinicians at our hospital entitled "Difficult Conversations: Dealing with Strong Emotions in Patients and Family Members." Of 28 clinicians who registered for the workshop, 14 attended. This rate is rather typical of the rate we find in workshops geared for clinicians. The professional positions of the attendees were three physicians, one nurse practitioner, one nurse manager, two clinical department managers, one PA, two social workers, three registered nurses, and one intern. Their time in practice at the institution ranged from five weeks to 30+ years (mean 13.9 years).

Time Allotted

Three hours were set aside for the enactment(s) in this workshop.

Choosing a Scenario

At the end of warm-ups (Table 1), participants took 10 to 15 minutes to discuss a time when one or more of them struggled to deal with emotional patients and family members. The following scenarios, in order of importance, emerged from the groups of oncology professionals in our workshop:

1. Patients and/or relatives who feel "entitled" and are demanding and angry
2. Discussing the end of life with the family when a patient is "fading"
3. Being compassionate without "losing it" by becoming overly emotional
4. Relatives who question the care you are giving
5. The relative who obsessively checks every detail of the patient's chart
6. The emergence of emotions in the transition to palliative care.

In this sociodrama, several themes generated by the group overlapped and the scenarios were combined. Therefore, although seven participants voted for Scenario 1 and five participants voted for Scenario 5, the group agreed that

Table 2
Skills for Difficult Conversations

1. **How to prepare for a difficult conversation**. Difficult conversations are just that—difficult—because we don't know what to expect, may be unsure of our skills, or may not know how the other person's responses will affect us. In this case, Dr. Johnson might have prepared for the conversation by discussing it with her nurse who not only had a close rapport with Brian but also agreed to accompany him to the family visit.
2. **Asking before telling.**[43] Find out how much the patient and his or her family know about the illness before you start. In this way, the health professional knows how much denial or how large an educational gap he or she must deal with.
3. **Responding to emotions before providing explanations.**[44] Emotions inhibit one's ability to think rationally. This is particularly true when bad news is being delivered. Responding to patients' or relatives' emotions with empathetic and validating statements, such as "I know this is quite a shock to you" can decrease the emotional intensity in the room and promote the feeling by the patient and family that the health professional truly understands their feelings.
4. **Inviting further explanation by using "Tell me more."**[45] Often, an underlying emotion is not readily apparent and lurks behind a question, such as "You mean you're just going to give up on us?" Asking another person to expand on what he or she means (e.g., "Tell more about what you mean by 'give up'.") allows the other to talk more about his or her concerns and puts the health professional in a better position to respond.
5. **Avoiding "amygdala hijacking."**[46] This is a concept borrowed from the literature on emotional intelligence and exhorts a clinician to not let his or her own emotions prevent him or her from effectively communicating. It uses a "six-second rule," which encourages practitioners involved in emotionally charged conversations to avoid responding with their "limbic lobe" or emotional brain (usually with "fix it" responses aimed at undoing bad news) and instead to wait until an urge to offer an ill-advised solution, false reassurance, or be defensive subsides so that they can respond more thoughtfully.
6. **Making wish statements.**[47] "I wish I had more treatment options for Brian but I don't think further treatment will help him and may actually make his condition worse" is a powerful way of aligning with the family, demonstrating that you have the best interest of the patient at heart while at the same time defining the sad reality of the lack of further treatment options.
7. **Brainstorming.** This method consists of collaborating with the family to resolve an issue. In the scenario constructed by our participants, it consisted of involving the family in the decision about who would tell Brian about his condition and who would be in the room.

Scenario 1 would be combined with Scenarios 4 and 6 and the scenario to be enacted would illustrate a transition to palliative care in which demanding, angry relatives question the care plan.

After the theme was selected, the PA in the group proposed a scenario in which a family becomes angry about the attempt to transition their son to palliative care (often group members suggest scenarios that reflect situations with which they have had firsthand experience). She suggested a character, who the group named Brian (not the patient's real name), who was 20 years old, and she agreed to play that role. In response to the facilitator's question "What other persons could you imagine might be in this scene?," the group was led by the facilitator in selecting the other characters in the drama: Brian's mother, father, and sister; then Brian's nurse; and the physician who had to deliver the bad news.

Creating Characters

The following are brief descriptions of the characters in the scenario created by the participants in our workshop:

Brian is a 20-year-old young man with acute lymphocytic leukemia that has been refractory to treatment. Brian has been in treatment for about two years. He is "in denial" about his illness and does not want to talk about it. The treatment team has exhausted all potentially curative options and has called a family meeting to discuss transitioning Brian from anticancer therapy to purely palliative care. In doubling himself, Brian says, "I just want to go back to my room."

Brian's father (played by an ICU nurse), a mechanic, does not usually talk much but gets angered easily. In doubling himself, he states that he feels strongly that Brian will get better because he looks so good. Another group member stepped behind the chair of the person playing Brian's father and as his double said, "I'm sure the next chemo will work."

Brian's mother, a stay-at-home mom (played by an internist), knows that Brian is very sick, but she believes that Brian is at the best hospital. In doubling herself, she states "I know we'll get a miracle."

Brian's 13-year-old sister (played by an ICU nurse) is frightened and does not understand what is happening with Brian. Doubling reveals that she feels guilty because she once told him, "I wish you were dead," after being teased by him.

Dr. Johnson (played by a physician-pathologist) is a new attending physician and does not have much experience in giving bad news. She does not know Brian very well, as she has only recently arrived on service. In doubling herself, she says that she feels anxious about discussing the situation with Brian and his family.

Dr. Johnson's nurse (played by a lymphoma physician) is very experienced and knows Brian better than any other member of the staff and has been taking care of him for several months throughout his illness. As her double, she says that she is concerned about the meeting and worried about how the new doctor will handle the conversation.

Rolling the Scene

The following section illustrates the scenario as Dr. Johnson, accompanied by her clinic nurse, arrives to speak to Brian and his family.

> *Dr. Johnson:* Good morning. I want to talk to you about Brian's treatment. As you know he is very sick. Unfortunately, at this point, we have run out of cancer treatment options for him.
>
> *Brian's father:* How can that be possible? He looks so good and has been feeling better. We are at the best cancer center in the world. How dare you come in acting like God?
>
> *Brian's mother:* What are you telling us, that we should just give up? This is my son!
>
> *Brian (with a defiant and negative attitude):* I'm feeling just fine.

After another minute of dialogue, in which Dr. Johnson tries to explain the facts of Brian's illness but is met with more or less the same emotional response from the family, she turned to a facilitator and asked for a "time-out," stating "I don't know where to go with this now. I'm stuck," at which point the enactment stopped. Dr. Johnson expresses how the anger of the parents "really threw me off." The facilitator then led the group in a discussion of how they might respond to the family's

strong emotions. After asking "Who can imagine what this father really felt inside?," she invited those who raised their hands to stand behind the father's chair and describe what they imagined he might really be experiencing emotionally. The facilitator did the same with the mother, the sister, and Dr. Johnson. Through this method of doubling, the group members identified unspoken feelings and attitudes that lay behind the anger and blame, and that was an important part of the "subtext" of the drama.

The following are examples of doubling statements made by group members:

Brian's father: I feel so helpless.

Brian's mother: Oh my God, I'm going to lose my son.

Brian: I'm really scared about what's going to happen.

Brian's sister: I don't want to be here. I hope I didn't make him sick. Sometimes I got so angry when he teased me that I wished that he would die.

Dr. Johnson: I feel really badly for Brian and for making everyone angry.

On the basis of these unspoken feelings, the group members suggested skills that Dr. Johnson could use in addressing the family's anxieties and fears, such as trying to stay calm and being empathic. A facilitator then briefly reviewed other communication skills for discussing this topic with Brian and his family (Table 2).[43–47] Handouts outlining the skills were distributed to the group for reference during the discussion and in the subsequent practice. One facilitator then reenacted the scenario, assuming the role of Dr. Johnson and demonstrated the skills suggested by the group and in the handout.

In the replay of the scenario, the facilitator stepped into the role of Dr. Johnson and before talking to the family, first consulted with her nurse, who suggests that he/she have a conversation with the family first without the patient to deal with their "unrealistic expectations."

Facilitator in the role of Dr. Johnson (to the nurse privately): We need to meet with Brian and his family. It's going to be tough. You know this family really well. Do you have any suggestions?

Nurse: Yes. This is tough. They are really in denial. I wonder if would be better to meet first with the family without Brian.

Dr. Johnson (now meeting with the family): Before we start, can you tell me what you understand about where we are with Brian's treatment?

Brian's mother: Well, we need to discuss how to go ahead with the next treatment.

Dr. Johnson: I can see that you were expecting us to continue treating Brian with chemotherapy.

Brian's mother: Yes, that's what we discussed.

Dr. Johnson: I know that this will come as a shock to you, but Brian's leukemia at this point has not responded to treatment and at this point, further chemo would do him more harm than good.

Brian's mother (angrily): What? But he is doing so well. You said you could treat him. Isn't this the best cancer center in the world?

Dr. Johnson: I know that it's hard to imagine that we're at this point. It's indeed very sad for me too.

Brian's father: Is this because of money?

Dr. Johnson: Tell me what you mean.

Brian's father: Well, I know we only have Medicaid. Is it because this doesn't pay much?

Dr. Johnson: I can assure you that's not the issue. I know that Brian looks good and am glad he is not feeling too badly, but at this point Brian's disease has gotten much worse and I don't think he could tolerate more treatment without suffering.

Brian's father: Isn't there anything else you can do?

Dr. Johnson: I really wish there were other options.

Brian's father: How should we tell Brian?

Dr. Johnson: What were you thinking?

Brian's father: I think that you should tell him, Doctor.

Brian's mother: We should be there, too.

Dr. Johnson: This is going to be very tough for all of us. I would also like to have our nurse there because she knows Brian so well.

The facilitator then "debriefed" each character to assess how they felt about the conversation at that point. Some responses were as follows:

Mother: I felt that even though the news was bad, the doctor was on my side.

Father: I felt less angry and very sad.

Sister: I was really scared.

Group members then took some time to name and discuss the skills they saw, and the workshop proceeded to the practice session.

In traditional "role training," the facilitators would have reconstructed the scenario and given the participant portraying Dr. Johnson the opportunity to try out new skills in a reenactment. Although this opportunity is very desirable, it would not have given all the participants an opportunity to practice skills. Thus, the facilitators designed a practice session for all the participants.

Practice Sessions

For the practice session, each learner had a "skills practice sheet" that listed and gave examples of the skills to be practiced (Table 2). They were asked to select an event in their lives that created strong emotion but were told not to make it too "traumatic." For example, one participant talked about the time when their longtime pet dog went missing for days. The second participant in that pair listened and practiced the skills outlined on the handout. Then the second participant talked about their frustration with their teenager, and the other participant listened and practiced the skills. The participants used the previously distributed skills summary sheet that included a list of the specific skills they were expected to practice and a brief description and examples of each; they could refer to this sheet while they took turns practicing the skills with each other, and the facilitators were available for coaching. At the end of the practice session, the group gave feedback on the practice experience to the facilitators and completed evaluation forms.

Evaluation

At the end of the workshop, each group member was given the opportunity to state one or more skills he or she had learned from the workshop. Interestingly, in addition to stating several skills that they felt they learned, several participants noted how valuable the skills could be not only in their professional interactions but also in their relationships with family members and friends.

At the end of the workshop, all 14 participants completed a brief evaluation in which they assessed the workshop along several dimensions. Sample responses are presented in Table 3. Most participants found the workshop relevant and valuable for their practices and wished there were more time for the enactment, a finding we consistently have experienced in conducting workshops of two or three hours. Finally, participants were given a more comprehensive handout describing, in additional detail, an approach to end-of-life discussions, including the skills that they had practiced.

Discussion

The simulation of actual or constructed patient cases is now recommended as the most effective way for teaching interpersonal and communication skills in medicine.[48,49] Sociodrama is one of several methods that promote experiential learning through combining the case study method with role-play and theater techniques. Role-play and theater techniques have been used in the medical field to teach communication in the area of patient safety,[50] to enhance basic communication skills,[51] in empathy training,[52] in promoting self-awareness,[53] and in training nurses and psychiatrists to improve their patient assessments.[54,55] They also have been used to a limited extent in teaching palliative medicine and end-of-life care.[56–58] Sociodrama is unique among simulation methods used in teaching communication skills in medicine in that it uses specific techniques of warm-ups, role reversal, and doubling to assist health care professionals to "get in the shoes" of patients, their patients' relatives, and also their colleagues during enactments of communication challenges.[59] In this regard, sociodramatic techniques have been found to be more effective than lecturing and reflective

Table 3
Results of the Evaluation of the Current Workshop

Variable	Strongly Agree (%)	Agree (%)
Program was well organized	71	29
Program scheduled time efficiently	71	29
Program was effective	93	7
Techniques presented were valuable to my job	86	14
Program provided valuable knowledge	93	7
Program provided needed skills	93	7

Evaluation Comments

What did you like most about the program? (13/14 participants)
- The opportunity to practice the skills learned
- You gave me the tools to respond to intense situations
- Identification of skills
- The relevance to my practice
- The small size of the group—the actual practice
- The role-playing really drove home the points we learned about difficult conversations
- Interactive and practical
- The teaching technique (e.g., active, engaging, and hands on)
- That all members were encouraged to participate and share their honest feelings
- Scenarios, role-playing, speakers, and discussion
- The interaction of the group
- Interactive and encouraged participation
- Expressing how each role felt

What did you least like about this program (10/14)
- Nothing!
- Need to be creative
- Sometimes there seemed like a lot of talking at once/ competing speakers
- 0
- Not knowing anyone, I felt a lot intimidated
- A little unorganized at times
- N/A
- N/A
- N/A
- Needed a second break

N/A = no critique available.

listening in improving empathic ability.[60] When combined with formal teaching and an opportunity to practice skills, this "didactic sociodrama" extends beyond the usual technique of sociodramatic portrayal.

In the sociodrama described in this study, a physician assumed the role of a nurse, another physician assumed the role of the patient's mother, a PA assumed the role of the patient, and nurses assumed the roles of the patient's sister and father. Thus, each participant in the role of the patient, family member, or professional colleague had an opportunity to experience the attitudes, feelings, and emotions inherent in the demands of that role.

Doubling is another method for creating empathy and revealing the "hidden" feelings that exist in highly emotional encounters. Early in the drama, group members doubled each character to say what they imagined they were thinking. Later in the drama, they doubled to comment on the feelings behind the family members' shock, anger, and blame. Thus, when Brian's mother responded to the bad news by angrily saying, "How could this be? This is the best cancer center in the world!," a group member stood behind her and restated this reaction by saying, "Oh my God, my son is going to die." When Brian's sister said, "Does this mean he's going to die?," doubling portrayed not only the shock and fear but also the guilt she felt by previously wishing Brian dead. Thus, doubling gave voice to the fear, grief, and helplessness that underlay the denial, blame, and hostility that emerged when they heard the bad news. Uncovering and allowing the expression of the hidden feelings—''speaking the unspeakable"—is a goal of sociodrama and a powerful tool for helping one "face one's demons," such as the fear of losing a child to cancer.[61,62] Thus, unspoken emotions often represent the "elephant in the room," a sort of emotional subtext too unbearable to face directly. This is crucially important also because there is an accumulation of evidence that patients' evaluations of the quality of their medical care are influenced by how their providers handle the emotional component during visits.[63]According to Kim et al.,[64] there are five core attributes of cases that make them valuable for instructional purposes. They must be relevant, realistic, engaging, challenging, and instructional. In our sociodrama, the group elected to portray a very difficult challenge: a young man and his family who were in denial about his illness and became angry when they were told that no further treatment options were available. The authenticity of this challenge is supported by studies that have shown that encounters with patients and relatives who are in denial are among the most challenging encounters for cancer clinicians.[65,66] In addition, reactions of anger and blame, which exemplify this family's response, are exceedingly challenging for many clinicians to address and can create discomfort or defensiveness for

those who are communicating the bad news or can cause the clinician to alter the message so it seems less ominous.[67–69] These might lead the practitioner to offer additional treatments that may not be in the best interest of the patient. The fact that most of the group could identify with this communication challenge created realism and an inquisitiveness that facilitated their portrayal of characters in the sociodrama. We attempted to incorporate other principles of adult learning into the workshop,[70] staying learner centered in creating the scenarios, providing a didactic scaffolding for the learners, modeling behaviors, and giving them an opportunity to practice. Thus, after the scenario was enacted, the facilitators discussed and demonstrated communication skills found to often work in situations in which strong negative emotions are elicited.

In the practice session, participants were instructed to share a personal situation that was emotionally laden while their partners listened, used empathetic and exploratory statements (e.g., "Tell me more"), and made "wish" statements. In this way, they could experience how different it feels when someone uses these skills when responding to a real emotion on their part as opposed to the "rational response" used by many clinicians when dealing with patient and family emotions. We have found that this approach encourages participants to practice the skills, and the feedback has indicated that at least 60% of participants have attempted to implement these skills within three months of a workshop similar to the one described in this study.

Warm-ups, although often the least favorite activity of group members, who often see it as time taken from the actual enactment, allow for group building and the establishment of safety. We have found that establishing a connection among participants, although it does take time away from the actual drama, lowers the anxiety level and encourages participants to be more willing, spontaneous, and creative in their participation. Moreover, the enactment part of the workshop develops from the warm-up discussions. Because the participants create the characters, they have a sense of ownership and an interest in how the scenario plays out.

Cegala and Eisenberg[71] note that communication skills training should explore ways of maximizing instructional effectiveness and facilitating dissemination without increasing cost. Sociodrama appears to be particularly suited for addressing end-of-life communication issues, in which significant interpersonal and communication challenges prevail. We have conducted sociodramas for a variety of audiences who were dealing not only with patient issues but also with communication issues among their groups. From complex situations, such as negotiating the goals of care among ICU teams to helping patient access specialists dealing with prospective patients, common themes of "finding the right words," responding to emotions of others, and "dealing with one's own emotions" often emerged.

Sociodrama is cost-effective because it does not involve the hiring of actors or standardized patients and requires no props or special equipment. However, practical issues can present significant barriers to this kind of work. In the workshop described, only half of the attendees who originally signed up actually arrived. This may represent conflicts in scheduling that arose or lack of time. Moreover, for clinicians, investing three hours of time to learn communication skills may require a high level of motivation. Facilitators versed in using action techniques are rare. Although many training programs for learning sociodramatic techniques exist throughout the country, many of them focus on more intrapsychic work (psychodrama) instead of role training for professional communication skills. However, medical teachers who regularly use role-play to instruct their students can easily learn the techniques of creating roles and doubling. We have presented a workshop on this topic at a recent meeting of the American Association of Communication in Healthcare,[72] and workshops on this topic are regularly held at the annual meeting of the American Society of Group Psychotherapy and Psychodrama. Another barrier to using these techniques includes finding enough time to work with groups that have not worked together. We have found that a minimum of two (and ideally, three) hours is needed for the warm-up and role training to be meaningful, although we have facilitated brief role-training sessions in as little as 30 minutes for ICU staff members and currently conduct monthly one hour sessions for first-year medical oncology fellows.

Table 4
A Sample of Topics Enacted in 50 Workshops Conducted for M. D. Anderson Faculty and Staff and Follow-Up Evaluation

RNs: The struggle to communicate with an overwhelmed physician who is not telling the truth to a family member regarding her husband's prognosis because of his own discomfort
Gynecology residents/fellows/students: Addressing the underlying grief of a desperate mother from another country who cannot accept the lack of further curative treatment for her young daughter with terminal lymphoma
ICU nurses: Working one's way "out of the middle" by learning to be heard when a very ill patient's attending and the ICU staff disagree about the goals of care
Cancer center faculty: How to give effective feedback that might be construed as negative when you are supervising trainees
Patient access specialists: Dealing with angry patients or family members who could not be given an appointment for an evaluation in the cancer center because of administrative issues, such as incomplete documentation or lack of insurance coverage
Chaplains: Saying goodbye to a revered leader who was retiring
Mixed group of physicians, nurses, and other clinical team members: Dealing with an argumentative family member who arrives from out of town questioning the teams about the treatment of their relative

RN = registered nurse; ICU = intensive care unit.

We have conducted over 40 workshops for cancer center staff at the University of Texas M. D. Anderson Cancer Center using sociodramatic techniques. Sociodrama is not limited to solving the problems of the here and now but also can help staff work through past problems, such as patient loss, and future issues involving changes in leadership, both of which were topics of workshops we have conducted (Table 4).

Using exit questionnaires similar to the one described for the workshop described previously, we have found that participants consistently found that the workshops were well organized, met their needs, and were effective. There were several limitations to sociodramatic workshops that also emerged from the exit questionnaires. In many of our workshops, we had time to portray only one or, at most, two scenarios; thus, some attendees were disappointed that there was not enough time; therefore, we extended the length of the workshops from two hours to three hours. Second, a small minority of responders to the evaluation questionnaire stated that they did not like role-play and one participant stated that she was shy. Last, it is difficult to know if our workshops produced lasting skill acquisition. To probe this further, we invited 289 participants in previous "Managing Difficult Communications" workshops to complete an additional online evaluation. Of those, 141 participants responded, indicating a response rate of 48.8%. Results of this survey can be found in Table 5.

Table 5
Online Evaluation of 50 Workshops Conducted for M. D. Anderson Faculty and Staff

Respondents ($N = 141$)

Domain Responses	Percentage Affirming
I learned skills and practical techniques	80
I have implemented one or more skills	73.1
I have found the following useful or very useful	
Warm-up exercises	80.5
Role-playing challenges	80.0
Didactic skills discussion	82.7
Discussion of take-home points	85.7
Opportunities for interaction with others	89.0
I would recommend the workshop to others	80.5
I would attend similar workshops	80

Representative comments included the following: "We were able to bring up real issues and find solutions within ourselves"; "I feel that this course was a learning experience and one that I can use in everyday practice"; "I liked the role-play, but I did not like the fact that only one case was explored"; and "I think that you should offer this course once a month with different (case) challenges."

A remaining challenge is how to more objectively assess skill acquisition and implementation. We are currently pursuing additional resources to allow us to compare sociodrama with more traditional communication skills training techniques, such as videotaping and small-group learning.

Disclosure and Acknowledgments

There are no financial items to disclose, and the authors declare no conflicts of interest.

References

1. Caplan AL. Cancer and bioethics: caring and consensus. Cancer 2008;113(Suppl 7):1801–1806.

2. Poole MS, Real K. Groups and teams in health care. Communication and effectiveness. In: Thompson TL, Dorsey AM, Miller KL, Parrott R,

eds. Handbook of health communication. Mahwah, NJ: Lawrence Erlbaum Associates, 2003:369–402.

3. Siminoff LA. The ethics of communication in cancer and palliative care. In: Kissane DA, Bultz BD, Butow PM, Finlay IG, eds. Handbook of communication in oncology and palliative care. New York: Oxford University Press, 2010:51–61.

4. Zachariae R, Pedersen CG, Jensen AS, et al. Association of perceived physician communication style with patient satisfaction, distress, cancer-related self-efficacy, and perceived control over the disease. Br J Cancer 2003;88:658–665.

5. Brown JB, Stewart M, Ryan BL. Outcomes of patient provider interaction. In: Thompson TL, Dorsey A, Miller KI, Parrott R, eds. Handbook of health communication. Mahwah, NJ: Lawrence Erlbaum Associates, 2003:141–161.

6. Catt S, Fallowfield L, Jenkins V, Langridge C, Cox A. The informational roles and psychological health of 10 oncology multidisciplinary teams in the UK. Br J Cancer 2005;93:1092–1097.

7. Tamblyn R, Abrahamowicz M, Dauphinee D, et al. Physician scores on a national clinical skills examination as predictors of complaints to medical regulatory authorities. JAMA 2007;298:993–1001.

8. Hohenhaus S, Powell S, Hohenhaus JT. Enhancing patient safety during hand-offs: standardized communication and teamwork using the 'SBAR' method. Am J Nurs 2006;106:72A–72B.

9. Kahn SB, Houts PS, Harding SP. Quality of life and patients with cancer: a comparative study of patient versus physician perceptions and its implications for cancer education. J Cancer Educ 1992;7: 241–249.

10. Hack TF, Degner LF, Parker PA, SCRN Communication Team. The communication goals and needs of cancer patients: a review. Psychooncology 2005;14:831–845. [discussion 46–47].

11. Hancock K, Clayton JM, Parker SM, et al. Truth-telling in discussing prognosis in advanced life-limiting illnesses: a systematic review. Palliat Med 2007;21:507–517.

12. Pollak KI, Arnold RM, Jeffreys AS, et al. Oncologist communication about emotion during visits with patients with advanced cancer. J Clin Oncol 2007;25:5748–5752.

13. Baile WF, Palmer JL, Bruera E, Parker PA. Assessment of palliative care cancer patients' most important concerns. Support Care Cancer 2011;19: 475–481.

14. Hancock K, Clayton JM, Parker SM, et al. Discrepant perceptions about end-of-life communication: a systematic review. J Pain Symptom Manage 2007;34:190–200.

15. Smith TJ, Hillner BE. Concrete options and ideas for increasing value in oncology care: the view from one trench. Oncologist 2010;(15 Suppl 1): 65–72.

16. Hewitt M, Simone JV, eds. Ensuring quality cancer care. National Cancer Policy Board, Institute of Medicine and Commission on Life Sciences, National Research Council. Washington, DC: The National Academy Press, 1999.

17. Institute of Medicine. Crossing the quality chasm: A new health system for the 21st century. Washington, DC: National Academy Press, 2001.

18. McCahill L, Ferrell B, Virani R. Improving cancer care at the end of life. Lancet Oncol 2001;2: 103–108.

19. Institute of Medicine, National Academies of Sciences. Assessing and improving value in cancer care: Workshop summary. 2009. Available from http://www.nap.edu/catalog/12644.html 2009 Pg 106. Accessed September 26, 2011.

20. Lipkin M, Caplan C, Clark W. Teaching medical interviewing. The Lipkin model. In: Lipkin M, Putnam S, Lazare A, eds. The medical interview. Clinical care, education and research. New York: Springer Verlag, 1995.

21. Fallowfield L, Jenkins V, Farewell V, Solis-Trapala I. Enduring impact of communication skills training: results of a 12-month follow-up. Br J Cancer 2003;89:1445–1449.

22. Fukui S, Ogawa K, Ohtsuka M, Fukui N. A randomized study assessing the efficacy of communication skill training on patients' psychologic distress and coping: nurses' communication with patients just after being diagnosed with cancer. Cancer 2008;113:1462–1470.

23. Back AL, Arnold RM, Baile WF, et al. Efficacy of communication skills training for giving bad news and discussing transitions to palliative care. Arch Intern Med 2007;167:453–460.

24. Hoffman M, Ferri J, Sison C, et al. Teaching communication skills: an AACE survey of oncology training programs. J Cancer Educ 2004;19:220–224.

25. Hebert HD, Butera JN, Castillo J, Mega AE. Are we training our fellows adequately in delivering bad news to patients? A survey of hematology/oncology program directors. J Palliat Med 2009; 12:1119–1124.

26. Kersun L, Gyi L, Morrison WE. Training in difficult conversations: a national survey of pediatric hematology-oncology and pediatric critical care physicians. J Palliat Med 2009;12:525–530.

27. Blattner A. Interactive and improvisational drama. New York: iUniverse Inc., 2007.

28. Department of Faculty Development, M.D. Anderson Cancer Center. I*CARE. Interpersonal communication and relationship enhancement. Available from http://www.mdanderson.org/education-and-research/resources-for-professionals/professional-educational-resources/i-care/index.html. Accessed August 3, 2012.

29. Spagnoletti CL, Bui T, Fischer G, et al. Implementation and evaluation of a web-based

communication skills learning tool for training internal medicine interns in patient-doctor communication. J Comm Healthc 2009;2:159–172.

30. Back AL, Arnold RM, Baile WF, Tulsky J. Oncotalk Teach Video Series. 2011. Available from http://depts.washington.edu/oncotalk/videos/. Accessed September 26, 2011.

31. Tulsky J, Arnold R, Alexander SC, et al. Enhancing communication between oncologists and patients with a computer-based training program. A randomized trial. Ann Intern Med 2011;155:593–601.

32. Cox K. Teaching around the patient. Med J Aust 1993;158:493–495.

33. Back AL, Arnold RM, Tulsky JA, Baile WF, Edwards K. "Could I add something?": teaching communication by intervening in real time during a clinical encounter. Acad Med 2010;85:1048–1051.

34. Pinsky LE, Wipf JE. A picture is worth a thousand words: practical use of videotape in teaching. J Gen Intern Med 2000;15:805–810.

35. Nestel D, Tierney T. Role-play for medical students learning about communication: guidelines for maximizing benefits. BMC Med Educ 2007;7:3.

36. Lok B, Ferdig RE, Raij A, et al. Applying virtual reality in medical communication education. Virtual Reality 2006;10:185–195.

37. Deladisma AM, Cohen M, Stevens A, et al. Do medical students respond empathetically to a virtual patient? Am J Surg 2007;193:756–760.

38. Blatner A, Blatner A. Foundations of psychodrama: History, theory and practice, 3rd ed. New York: Springer Publishing Company, 1988.

39. Crawford RJ. Follow up of alcohol and other drug dependents treated with psychodrama. [letter]. N Z Med J 1989;102:199.

40. Blattner HA. Acting-in: Practical applications of psychodramatic methods. New York: Springer, 1972: 98–119.

41. Cole DK. Psychodrama and the training of trial lawyers: finding the story. North Ill Law Rev 2001;21: 1–4.

42. Nolte J. The psychodrama papers. Hartford, CT: Encounter Publications, 2008.

43. Baile WF, Buckman R, Lenzi R, et al. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. Oncologist 2000;5: 302–311.

44. Baile WF, Costantini A. Communicating with cancer patients and their families. In: Wise TN, Biondi M, Costantini A, eds. Clinical Manual of Psycho Oncology. Washington, DC: American Psychiatric Press, 2012. In Press.

45. Back AL, Arnold RM, Baile WF, Tulsky JA, Fryer-Edwards K. Approaching difficult communication tasks in oncology. CA Cancer J Clin 2005;55: 164–177.

46. Goleman D. Emotional intelligence, 10th ed. New York: Bantam Dell, 2005.

47. Quill TE, Arnold RM, Platt F. I wish things were different: expressing wishes in response to loss, futility and unrealistic hopes. Ann Intern Med 2001;135: 551–555.

48. Kahn K. Simulation in medical education. Med Teach 2011;33:1–3.

49. Philibert I. Simulation and rehearsal. Practice makes perfect. ACGME Bulletin 2005;1–3.

50. Kirkegaard M, Fish J. Doc-U-Drama: using drama to teach patient safety. Fam Med 2004;36: 628–630.

51. Kruger C, Blitz-Lindeque JJ, Pickworth GE, Munro AJ, Lotriet M. Communication skills for medical/dental school at the University of Pretoria: lessons learnt from a two year study using a forum theatre method. SA Fam Pract 2005;47: 60–65.

52. Dow AW, Leong D, Anderson A, Wenzel RP. Using theater to teach clinical empathy: a pilot study. J Gen Intern Med 2007;22:1114–1118.

53. Oflaz F, Meriç M, Yuksel Ç, Ozcan CT. Psychodrama: an innovative way of improving self-awareness of nurses. J Psychiatr Ment Health Nurs 2011;18:569–575.

54. Ballon BC, Silver I, Fidler D. Headspace theatre: an innovative method for experiential learning of psychiatric symptomatology using modified role-playing and improvisational theater techniques. Acad Psychiatry 2007;31:380–387.

55. Will R, Forsythe J. Family theatre: an interdisciplinary strategy for teaching family assessment. Nurse Educ Today 1993;13:232–236.

56. Torke AM, Quest TE, Kinlaw K, Eley JW, Branch WT. A workshop to teach medical students communication skills and clinical knowledge about end of life care. J Gen Intern Med 2004;19(5 pt 2): 540–544.

57. Jones C. Sociodrama: a teaching method for expanding the understanding of clinical issues. Palliat Med 2001;4:386–390.

58. Charlton RC. Using role-plays to teach palliative medicine. Med Teach 1993;15:187–193.

59. Sternberg P, Garcia A. Sociodrama. Who's in your shoes?, 2nd ed. Westport, CT: Praeger, 2000: 8–13.

60. Kipper DA, Ben-Ely Z. The effectiveness of the psychodramatic double method, the reflection method and lecturing in the training of empathy. J Clin Psychol 1979;35:370–375.

61. Travado L, Grassi L, Gil F, Ventura C, Martins C. Physician-patient communication among Southern European cancer physicians: the influence of psychosocial orientation and burnout. Psychooncology 2005;14:661–670.

62. Platt FW, Gordon GW. Field guide to the difficult patient interview. Baltimore: Lippincott, 1999: 91–99.

63. Venetis MK, Robinson JD, LaPlant Turkiewicz K, Allen M. An evidence base for patient-centered care: a meta analysis of studies of observed communication between cancer specialists and their patients. Patient Educ Couns 2009;77:379–383.

64. Kim A, Phillipa WR, Pinaky L, et al. A conceptual framework for developing teaching cases: a review and synthesis of the literature across disciplines. Med Educ 2006;40:867–876.

65. Meier DE, Back AL, Morrison RS. The inner life of the physician and care of the seriously ill patient. JAMA 2001;286:3007–3014.

66. Wallace JA, Hlubocky FJ, Daugherty CK. Emotional responses of oncologists when disclosing prognostic information to patients with terminal disease: results of qualitative data from a mailed survey to ASCO members (abstract). J Clin Oncol 2006; 24(Suppl):8520.

67. Griffth JL, Griffith ME. Speaking the unspeakable: use of the reflective position in therapies for somatic symptoms. Fam Syst Med 1992;10:41–8551.

68. Beale EA, Baile WF, Aaron J. Silence is not golden: communicating with children dying from cancer. J Clin Oncol 2005;23:3629–3631.

69. Trice ED, Prigerson HG. Communication in end stage cancer: review of the literature and future research. J Health Commun 2009;14:95–108.

70. Kaufman D. ABC of learning and teaching in medicine. BMJ 2003;326:213–216.

71. Cegala DJ, Eisenberg D. Enhancing cancer patients' participation in medical consultations. In: Kissane D, Bultz B, Butow B, Finlay IG, eds. Handbook of communication in oncology and palliative care. New York: Oxford University Press, 2010.

72. Baile WF, Walters R, Epner D. Transforming a difficult patient: a sociodramatic approach to challenging conversations. Presented at the Annual Meeting of European Association for Communication in Healthcare (EACH), Verona, Italy, September 7, 2010.