

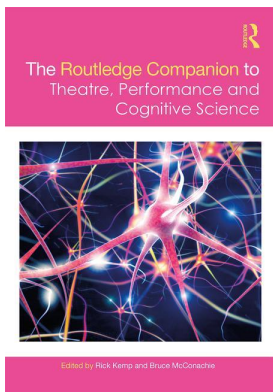
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THE PERFORMANCE OF CARING

Theatre, empathetic communication and healthcare

Rick Kemp and Rachel DeSoto-Jackson

Introduction

Empathy has been the subject of much interest in recent years, both in public discourse and in the fields of neuroscientific research. A popular understanding of empathy focuses on the idea of feeling another's emotion. In neuroscience, the term and the concept is much debated, with a recognition that it is complex and multi-modal in having cognitive, emotional, behavioural and cultural components. This chapter uses a case study to examine the application of theatrical expertise to training in empathetic communication for students in healthcare professions. We use the term 'expertise' advisedly and emphasise that we conceive of theatrical expertise as embodied, situated and enactive, with a tendency to inclusivity since it is always collaborative in its application. The case study is contextualised by information on concepts of empathy in the cognitive sciences, which suggest potential explanations for the self-reported benefits of the training by its participants. Despite the contested nature of the concept of empathy in the cognitive sciences, numerous behavioural studies over the last three decades suggest that empathy (with its varied definitions) is desirable in the interactions between patients and healthcare professionals (e.g. Bas-Sarmiento et al. 2017; Charon 2001; Herbek and Yammarino 1990; Petrucci et al. 2016; Roter et al. 1997; Suchman et al. 1997; Vanderford et al. 2001;). Patients' perception of a lack of empathy by health professionals has been shown to negatively influence outcomes in treatment of a variety of conditions, ranging from the common cold (Rakel et al. 2009) to cancer (Back et al. 2003). Furthermore, technological advances in healthcare have also prompted a trend towards using information technology to drive patient-provider relationships (Weiner and Biondich 2006). This technology can further reduce the interpersonal interaction in encounters between patients and healthcare professionals, and thus the means through which empathy is both communicated and experienced. Significantly, it has been shown that primary-care physicians who spend less time with patients are more likely to experience malpractice claims (Levinson et al. 1997). While there have been numerous studies on the importance of empathy in healthcare, less attention has been focused on developing effective models of teaching empathy and, more specifically, empathetic communication in healthcare education.

Theatrical expertise offers one approach to developing a method of teaching empathetic communication within healthcare. Actors and directors are experts in the execution,

recognition and analysis of features like posture, gesture, eye movements, facial expressions, spatial proxemics and the tone and cadence of voice in interpersonal communication. These abilities in themselves are features of communication; we are considering them within a conceptual context of enactivism, which leads us to suggest that the conscious awareness and guided practice of these behavioural activities can stimulate both enhanced awareness of emotion in others and a responsive affective state in oneself. This proposal is made using a recognition of communicative empathy as a two-stage process, involving both the recognition and the reflection of affective state (Coll et al. 2017). This conceptual framework of empathy is integrated with practical theatrical expertise within an undergraduate course offered by our Department of Theater and Dance at Indiana University of Pennsylvania (IUP). Titled 'The Performance of Caring,' the course was originally intended for nursing students, but has since been expanded to include majors in multiple disciplines.

Cognitive science and empathy

We focus on a cognitive definition of empathy that is frequently used in clinical studies, rather than seeking to provide a comprehensive review of neuroscientific understandings of empathy. This focused definition facilitates the operationalisation of a behavioural training. As the authors of one neuroscientific study of empathy state, 'Empathy involves experiencing emotion vicariously, and understanding the reasons for those emotions. It may be served partly by a motor simulation function, and therefore share a neural basis with imitation (as opposed to mimicry), as both involve sensorimotor representations of intentions based on perceptions of others' actions' (Braadbart et al. 2014, 367). This description correlates with the concept of 'embodied simulation' developed by neuroscientist Vittorio Gallese to describe the neural mechanisms underlying social cognition: 'The results of neurocognitive research suggest that in the brain of primates, mirror neurons, and more generally the premotor system, play a major role in several aspects of social cognition, from action and intention understanding to language processing' (Gallese 2007, 659). Gallese has demonstrated in several studies that 'embodied simulation can underpin basic forms of social cognition like the capacity of empathizing with others' emotions and sensations' [Gallese 2003a, 2003b, 2005a, 2005b] (ibid.). While Gallese focuses on what is known as 'bottom up' processing (the information received from sensory input), recent research reviewed by Andy Clark in *Surfing Uncertainty: Prediction, Action and the Embodied Mind* (2016) suggests that cognition is the result of an interaction between sensory input and information coming 'top down' from memory, beliefs and hypotheses. These are more abstract mental concepts that, to the degree in which they influence action, result in what is called 'top down' processing. The 'bottom' and 'top' in the metaphor reflect a hypothesis that the brain's activity is hierarchical, with more abstract mental concepts at a 'higher' level than sensory input. It is important to remember that this description is a metaphor, since the dominant conceptualisation of the brain's mechanisms in embodied cognition is that of networks of patterns of neural activity that are constantly varying the ways in which neurons connect through synapses. Clark's 'predictive processing' model suggests that as sensory input is received, it is compared with 'predictions' arising from mental models formed by past experience. An example of a 'match' between the sensory input and a 'prediction' could be correlating the visual information gained from looking at a tree with the mental concept of 'tree.' If the sensory information does not match the concept (for example, if one determines that the branches and trunks of the tree are made of metal), then this 'unpredicted input' is compared with higher level, more abstract concepts until a match is found (a metal sculpture of a tree). Of course, this

process is happening at extraordinary speed and at a level of cognition of which we are not consciously aware. The predictive processing model of cognition has relevance for the concept of empathy because top-down predictions interact with bottom-up perception. Thus, pre-formed beliefs can affect one's understanding of another person's affective state. One neuroscientific study on empathy has demonstrated that one is less likely to feel empathy for a person who is perceived to be in some way 'different' than oneself, with one of the most significant factors in perception of difference being race (Xu et al. 2009). This bias happens below the level of conscious awareness, so the challenges of empathy training include developing activities that can not only bring unconscious biases to the level of awareness, but also have an effect on these biases. A pathway towards accomplishing these goals involves linking guided behavioural activities with neuronal 'embodied simulation,' which is what we explore in this chapter.

We have chosen to use Gallese's term 'embodied simulation' to describe behavioural interaction in healthcare education. In the training of healthcare professionals, 'simulation' describes clinical practices in education involving realistic scenarios in an environment that poses no risk to patient safety. The formats of simulations range from clinical assessment of high fidelity manikins (the term used in healthcare to denote realistic mannequins) that have biometric features such as a heart rate and respiratory sounds, to procedural task-training through human interactions with 'Simulated Patients' (SPs) portrayed by trained actors. The Association for Standardized Patient Educators (ASPE) defines an SP as 'a person trained to portray a patient scenario...for the instruction, assessment, or practice of communication and/or examining skills of a health care provider' (ASPE 2017, n.p.). Our use of the term 'embodied simulation' describes the process of learning through behavioural interaction. We use this term for two reasons. Firstly, it distinguishes this approach from types of training that rely solely on the use of manikins and/or video. As theatre practitioners, we believe that embodied learning is necessary for significant behavioural change to occur. This opinion is supported by studies demonstrating the success of 'learning-by-doing' approaches in this field (e.g. Gracia-Pérez and Marta Gil-Lacruz 2017). Secondly, it consciously echoes Gallese's term for the neuronal behaviour involved in social cognition. The two are linked because observable behaviour stimulates neurological embodied simulation – our term is intended to describe the learning processes that stimulate the neurological process. This approach is compatible with a core principle of coordination dynamics, which is that the coordination of neurons in the brain and the coordinated actions of people and animals share a common mathematical or dynamical structure. As indicated in Chapter 3, this principle suggests that, as cognitive psychologists Keith Sawyer and Stacy DeZutter state, 'When cognitive processes are distributed across groups, they become visible, and scientists can observe them by analyzing the verbal and gestural interactions among the participants' (2009, 81).

The field of embodied cognition also strongly proposes that a sense of self is 'situated' in that it arises intersubjectively among humans and also from interaction with the environment. By linking embodied simulation in its observable, behavioural sense with neurological embodied simulation, we propose that the actions involved in embodied training can be used to guide the neurological processes that occur below the level of awareness. In a previous publication, one of us (Kemp) proposed that the actor's persona in rehearsal and performance can be thought of as a 'situational self' (2012). Within the theatrical approach to empathetic communication training that we examine, the same concept is used to encourage healthcare professionals to recognise that their behaviour and communication is affected by, tied to and affects the interpersonal context (situation) within which they are operating.

Simulated patients (SPs)

The importance of embodied simulation in healthcare education is supported by a study that indicates 'empathy can be improved and successfully taught at medical school especially if it is embedded in the students' actual experiences with patients' (Mercer and Reynolds 2002). This study further defines clinical empathy as 'an ability to: (a) understand the patient's situation, perspective, and feelings (and their attached meanings); (b) to communicate that understanding and check its accuracy; and (c) to act on that understanding with the patient in a helpful (therapeutic) way' (Mercer and Reynolds 2002, n.p.). While the use of manikins in simulation can be useful for invasive training procedures such as performing a tracheotomy, what is absent are the tiny movements of non-verbal communication that occur in response to others' behaviour and with which patients express affect. The use of SPs in healthcare simulation has grown since their initial use in 1963 when neurologist Howard Barrows began utilising non-medical students to portray illness and give feedback to medical students. With the success of this model of interactive learning, he termed these individuals 'Simulated Patients,' which he defined as 'a person who has been carefully coached to simulate an actual patient so accurately that the simulation cannot be detected by a skilled clinician' (ASPE 2017 n.p.). Barrows recognised that the impact of using an SP in medical education lies in their ability to perform realistic reactions, 'not just the history, but the body language, the physical findings, and the emotional and personality characteristics as well' (ibid.).

With the emergence of SP use in healthcare education, the terms 'Simulated' and 'Standardized' have often been used interchangeably. As methods of SP training have progressed, the two terms have become distinct from one another (Lewis et al. 2017). 'Simulated Patients' are trained to portray the roles of patients and family members within realistic medical scenarios. SPs act and react to the healthcare professional based on the interaction rather than a prescribed scripted response (Allegheny Health Network 2017; Lewis et al. 2017). While there are learning objectives to be met and contextual information conveyed, SP encounters allow healthcare students to learn in an environment in which responses mimic real interactions. The SP is trained to facilitate a realistic encounter that presents not only the history and physical findings, but also uses body language with emotional and personality characteristics. 'Standardized Patients' are used to portray specific medical conditions when consistent and standard responses are necessary. They are used extensively in testing healthcare students' clinical skills, usually as a part of an Objective Structured Clinical Examination, a form of performance-based testing used to measure candidates' clinical competence (OSCE 2015). Standardized Patients are more likely to provide reliable reactions to questions asked by healthcare professionals. The Standardized Patient will respond to questions and situations in a consistent manner, regardless of how the healthcare professional interacts with the Standardized Patient (Allegheny Health Network 2017). Within an educational model, the SP is preferable, as a range of reactions can be experienced without adhering to a scripted response. This allows for variations in communication based on the verbal and non-verbal stimuli from the healthcare professional. For example, if the healthcare professional neglects to greet the patient and give their name when entering the room, this may prompt the SP to respond in a way that indicates a lack of trust for the healthcare professional, which in turn affects aspects of the interaction such as full and honest responses during health history intake. Observations of these (and other) reactive behaviours would later be shared by the SP during a debrief with the healthcare professional at the conclusion of the simulation. Studies demonstrating the effectiveness of debriefing as a learning tool and the development of models of debriefing strategies have been prolific in recent years (e.g. Cantrell 2008; Decker et al. 2013; Sawyer et al. 2016).

The increase of simulation use in healthcare education has created a growing need for SPs to perform not only the roles of patients, but also of their family members. Reflecting this, the term ‘Simulated Patient’ has been updated to ‘Simulated Participant’ to acknowledge the various roles an SP may perform as well as ‘all human role players in any simulation context’ (Lewis et al. 2017, 2). In this chapter, the term ‘Simulated Patient’ refers specifically to the trained actors in a simulation and is not synonymous with healthcare student participants. The identification of best practices and the generation of research in the area of SP training have grown since the inception of the ASPE in 2001. A study published in the journal *BMC Medical Education* cites the importance of ‘the authenticity of role play and quality of feedback provided by SPs’ and recognises that ‘the available literature on SP training mostly addresses instructor-led training where the SPs are given direction on their roles’ (Perera et al. 2009, 1). Historically, SPs often come from diverse backgrounds, and many are without theatrical training as actors. Likewise, SP educators and trainers often emerge from healthcare and related fields rather than theatre programmes. As the use of SPs in healthcare education expands, the inclusion of theatrical experts offers an approach to SP training that is grounded in a rich tradition of actor training. While there are many schools of actor training methodology within the field, an Applied Theatre approach presents specific methodology transferable to SP training through which more effective simulations might be achieved.

The field of Applied Theatre has gained momentum in recent decades as a form of theatrical work that occurs in non-traditional spaces such as prisons, health and therapy settings, community centres and museums (e.g. Landy and Montgomery 2012; Prendergast and Saxton 2010; Prentki and Preston 2008; Rohd 1998; Taylor 2003). While the methodologies within Applied Theatre are wide ranging, they are connected by an overarching goal of using participatory theatrical practice to create communities, embrace human interconnections and generate social change through the use of ensemble practice. One such methodology is Theatre of the Oppressed, which is a system of interactive theatre focused on rehearsing actions for change developed by Brazilian director and activist Augusto Boal (1985). Theatre of the Oppressed, like many Applied Theatre methods, is grounded in ensemble practice. An Applied Theatre, ensemble-led approach to healthcare simulation results in the creation of original scenarios that reflect greater depth of patient identity, history and life circumstances in the development of an SP role. For example, an individual actor creating a character history of a patient with diabetes is limited to their own perception of this disease. In an ensemble-led approach, the actors create a character history as a group by offering various perspectives, encounters and experiences that might shape a patient’s history. This in turn offers a simulation experience that better portrays the diversity of patients, thereby more effectively training healthcare professionals to meet patient needs. An Applied Theatre approach also offers the ability to address ineffective communication and collaboration among healthcare professionals. This phenomenon has been identified as a barrier to patient safety and quality of care (Institute of Medicine 2003). As medical disciplines have become increasingly specialised, specialists have had to focus on developing skills in their specific area of expertise resulting in an unintended outcome of compromising patient care due to failures of interprofessional collaboration (Palaganas, Epps, and Raemer 2014). (The unhyphenated form of ‘interprofessional’ is standard in medical fields). The emergence of interprofessional healthcare simulation has evolved in response to these collaboration failures in patient care. Currently, interprofessional simulations are utilised in a variety of professions and settings including emergency medicine, obstetrics, operating rooms, rapid response teams, psychiatry, pharmacology,

radiology, occupational therapy and allied health professions (Titzer, Swenty, and Hoehen 2012; Zhang, Thompson, and Miller, 2011). However, to improve patient safety, the Institute of Medicine (IOM) recommends that healthcare professional educational programmes ‘design and implement early and continuous interprofessional collaboration through joint classroom and clinical training opportunities’ (Institute of Medicine 2010, 6). Interprofessional simulations allow healthcare students to gain a deeper understanding of the various healthcare professional roles that serve to provide quality patient care in a safe, controlled environment.

Case study: the performance of caring

‘There is a change in myself that I have realized from the beginning of the semester until now. There is growth in my communication, body language, empathy, and mindfulness skills. My goal is take this information I have learned and practiced from this class and continue to use them [sic] throughout my career and life in general. These skills will help me to be a better nurse that [sic] is attentive, understanding, empathetic, and kind’ (DeSoto-Jackson 2016, n.p.). This reflection, written by a student in The Performance of Caring course, highlights the perceived value of training in empathetic communication. Effective empathetic communication goes beyond existing ‘SBAR’ protocols for interprofessional engagement. SBAR is an acronym for Situation, Background, Assessment, Recommendation, a technique that is used to facilitate prompt communication in healthcare settings (Thomas, Bertram, and Johnson 2009). While empathy in clinical settings is viewed as a desirable behaviour in healthcare professionals, dedicated practice to embodying the behavioural characteristics of empathy in practice is seldom part of the pedagogy. In response to this need, the Performance of Caring course, originating in 2013, was developed at IUP to offer training for healthcare education students in empathetic communication skills.

The Department of Theater and Dance began its collaboration with the College of Health and Human Services to provide SP for clinical simulations in the Department of Nursing. With the success of this early collaboration, the Performance of Caring was created to serve nursing students in developing empathetic communication skills. Since then, the department has successfully implemented and broadened a number of Applied Theatre interdisciplinary collaborations designed to enhance the education and training of current and future healthcare professionals, both on campus and in the region. These efforts take a variety of forms, yet all incorporate methods from the field of Applied Theatre for embodying core principles that are learnt and practiced in order to improve healthcare communication. While this approach originates in theatre training, it is remarkably consonant with a set of recommendations for teaching communication skills to oncologists:

- (1) lecture-style methods alone are ineffective;
- (2) adult learning principles should be used;
- (3) teaching must include skills practice;
- (4) teaching must attend to learner attitudes and emotions;
- (5) the learning environment should integrate knowledge, skills, and attitudes; and
- (6) reinforcement is critical for the learning process.

(Back et al. 2003)

The Performance of Caring course, currently taught by DeSoto-Jackson, offers students theatrical practice-based exercises and skill-building that teach the ‘language’ of empathy and non-verbal communication so as to positively affect patient/healthcare professional interaction. The course has since been expanded to include a focus on inter-professional communication prompted by the changing healthcare landscape. In its current formation, the course includes students from the following majors and fields of study: Nursing, Nutrition, Dietetics, Sports Medicine, Criminology, Hospitality Management, Psychology and Early Childhood Development. Students enrolled in the Performance of Caring often report at the beginning of the semester that they struggle with knowing how to talk to patients and how to demonstrate caring, empathetic communication (DeSoto-Jackson 2016). Applied Theatre offers many tools for practical approaches to preparing students with enhanced skills in interpersonal, empathetic communication using methods common to the training of performing artists. Using exercises and training techniques derived from Augusto Boal’s Theatre of the Oppressed – a method within the field of Applied Theatre – students engage in collaborative learning models with specific attention to the ways in which culture and structures of power affect communication (Boal 2002).

The course is organised within three overarching units: Basic Communication, Building Empathetic Relationships, and Overcoming Challenges. Students are assessed through diagnostic, mid-term and final simulations that apply communication strategies learnt in each unit. Students’ grades are largely determined using a self-assessment and peer feedback model which has been shown to be effective in simulation practice (Perera et al. 2009). SPs, rather than Standardized Patients, are utilised within this course to allow for a variety of interactions rather than standardised responses. Attention is given to performing diverse simulation scenarios within each skill-building unit including cultural communication, de-escalation, confrontation and communicating major life changes. As expressed by a student in the course, ‘This class has helped me to become more confident when communicating my needs. I really feel one area I excel in is empathy. I always felt I was able to connect with people when in conversation, but sometimes feel uncomfortable doing so in a professional environment. This class has taught me the importance of listening and opening up when appropriate. There is something very special that happens when two people connect’ (DeSoto-Jackson 2016, n.p.).

In contrast to other theatre-based forms of SP training, the Performance of Caring course incorporates many of Boal’s Theatre of the Oppressed techniques. These include Forum Theatre, in which ‘spectactors’ move from observing enacted situations to proposing actions for change by participating in the enactment, and Image Theatre, in which students use static embodied poses to create images of social interaction. This process enhances participants’ perceptions of the ways in which posture and spatial arrangement communicate meaning (Boal 2002). Using these techniques, participants develop a depth of understanding of the circumstances facing patients in diverse populations and learn best practices for improving their communication with these patients. These methods enhance the understanding and embodiment of verbal and non-verbal cues which are essential to empathetic communication. Ensemble-based characterisation exercises serve to further enhance the understanding of the variety of circumstances impacting patients within diverse groups. An example of this is an ensemble-created scenario in which a patient identifies as transgender and

multi-racial. Through this scenario, students learn the complexities of gender identity and how misidentification can hinder the building of trust with a patient. Student nurses also learn to manage their own anxiety when encountering unfamiliar situations and patients with whom they don't initially identify with. Within the scenario, students apply physicalised practices learned in the unit such as eye contact, lower vocal resonances and relaxed body postures, which are conducive to building trust with a patient. This in turn may elicit more forthcoming responses during patient intake, resulting in more effective patient care. Students also learn how to adapt their mannerisms to a variety of situations in which they work with patients. Often students in the course exhibit reluctance to change or adjust their body posture or spatial proximity during an interaction, which results in an apparently 'frozen' state. Using improvisational theatrical practices, students learn how to 'prepare to be unprepared,' which allows them the flexibility to adjust to their circumstances and react confidently during encounters which are unexpected. This method of Applied Theatre training offers students concrete skills in de-escalation, assertiveness and confrontation in addition to empathetic communication. As one student reports, 'I am now prepared to meet difficult situations in the workplace through the interactive scenarios we have learned in class. My confidence has also increased exponentially through this class as well as learning to be mindful of my body language' (DeSoto-Jackson 2017a, n.p.).

The course units and specific exercises are structured around DeSoto-Jackson's original model of an empathetic communication process termed the L.O.V.E.TM approach: **Listen**, **Observe**, **Value**, **Empathize**. This model expands to include specific skills for each step in the L.O.V.E. approach to empathetic communication: **Listen** actively, **Observe** verbal/non-verbal cues, **Value** other perspectives and **Empathize** through verbal/non-verbal response. What follows are specific exercises within each area that target skill-building.

Listen: 'Minute Conversations' is an early exercise adapted from Peggy McIntosh's approach to unpacking privilege and is used to teach students active listening, which many students report struggling with in our technology-saturated society (McIntosh 2003). Students begin moving around the room, greeting each other as they pass by. When they hear 'stop' from the facilitator, students form pairs with another student close to them. Within these pairs, students are asked a targeted question of personal significance such as 'describe a time when you felt powerless.' While the question itself is valuable, the focus in this exercise is on students' listening to their partner's story. The listening students are instructed to not respond verbally and to minimise non-verbal reactions to their partner's story. The students are given one minute to tell their story before they alternate with their partners, who then get to share their own stories based on the original question. This exercise is repeated three times with three different questions and with different partners in each rotation, so students practice actively listening with a variety of other people. During the debrief of this exercise, students often express surprise at how difficult it was for them to remain silent and focus on listening. They recognise how often they prematurely prepare responses in their mind rather than focusing on what the people in front of them are saying when they are speaking, or how often they interrupt other people when they are speaking. Following this exercise, students also begin to understand how important embodied

communication is to feeling that they have been heard. This forms the basis of recognising verbal and non-verbal cues in others as well as themselves.

Observe: ‘Habits Interview’ is an exercise that builds an awareness of individual and others’ verbal and non-verbal cues. This exercise begins by teaching students the basic components of verbal and non-verbal communication from actor training such as posture, gestures, facial expressions, tone, volume, diction, dialect, repetition, tempo. Space is also identified as a contributor to effective communication, and students explore the myriad ways spatial proximity can be employed in communication, such as sitting face-to-face or standing at a distance. Within pairs, one student begins the exercise by creating a spatial arrangement of the environment to conduct an interview. While this student is creating this space, his or her partner receives the interview questions which include instructions for conducting the interview. These have an unexpected instruction; rather than recording the verbal content of their partner’s answers to the listed questions, they are asked instead to record the vocal and non-verbal cues that their partners demonstrate. At the end of the exercise, there is always astonishment when partners reveal that they have been recording these cues rather than their responses. This leads to a detailed debrief in which the partners and the instructor reveal the observed vocal and non-verbal cues. The exercise is then repeated for the other partner; while they are now aware of the observation, students have found it to be just as informative. Two skills are targeted in this exercise: observation of self and observation of others. Both are key to demonstrating empathetic communication through observation of patient behaviours and self-control of the health professionals’ own behaviour.

Value: ‘Culture Box’ is an assignment that initially appears to be an ice-breaker activity. However, what is discovered through the activity is a deeper understanding of the experiences of others and how those experiences shape individual perspectives. This exercise is adapted from the Intergroup Dialogue approach to communicating across diverse groups (Dessel 2008). A key premise of Intergroup Dialogue is the distinction between discussion, debate and dialogue, with dialogue being preferable, since it is a communication mode that seeks to understand another person’s perspective without judgement and without trying to further a position (discussion) or win an argument (debate) (Maxwell et al. 2011). The method’s approach is intended to teach communicators how to value other perspectives; this does not imply that one must adopt or agree with the other person’s perspective. In the Culture Box activity, students are asked to create a ‘box’ that contains three physical objects that represent their cultural identity. This is paired with learning the many aspects of cultural identity recognised through social categories such as race, gender, religion or belief system. The box can take any form that best represents a students’ unique identity. For one student, this meant putting their items inside of a pizza box to represent their college lifestyle. During the activity, students share the stories behind their objects, and respond to questions from their peers. In the debrief following this activity, students unanimously express increased feelings of connection to their peers and appreciation for the various identities represented. This leads to a more in-depth analysis of the ways in which personal connections can be made with those from seemingly different identities (by asking questions, finding commonality, relating to an emotional response) which leads to valuing diverse perspectives. This is an important skill for empathetic communication in healthcare, given the diversity of patients who seek medical care.

Empathize: ‘Forum Theatre’ and ‘Image Theatre’ are techniques that are used throughout the course as methods of rehearsing the practical, embodied skills of empathetic communication, which apply the definition of empathy as a two-stage process involving both recognition and the reflection of affective state (Coll et al. 2017). In traditionally structured simulations, students engage in the action of the scenario, and then receive feedback on their performance during the debrief. However, this single-stage process limits the students’ ability to practice embodied skills that create behavioural changes over time. Within theatrical performance, it is widely recognised that rehearsal is a critical means of learning embodied action. In traditional theatre models, rehearsals are often orchestrated by a director who ensures a unifying process from which a performance is presented to a spectating audience. Forum Theatre uses a different process that favours an ensemble model of collective creation and employs an interactive performance format that seeks direct audience engagement through interaction. By utilising a Forum Theatre method, diverse voices and perspectives can be introduced. This offers an expanded view of the simulation scenario. Using this method within the course, students begin by creating scenarios within small groups based on their lived experiences. These are later expanded to generate additional scenarios of interactions they expect to encounter in their professional careers. Students then use ‘Image Theatre’ to create an embodied tableau of the scenario. In this method, students produce still images using their bodies to represent the scene. By freezing the scene, other students are able to offer specific feedback on observed non-verbal cues represented in the image. After analysis of the non-verbal cues, students perform their scenarios with a SP (the SP is portrayed by other students during class sessions and by trained actors during the assessment simulations). During these embodied simulations, students call out ‘stop’ to halt the action and make direct interventions in that moment. This is a method specific to Forum Theatre and offers students the opportunity to make immediate changes to their verbal and non-verbal communication. The use of this rehearsal method has resulted in students’ increased ability to make adjustments in the moment and emphasises the recognition and reflection stages of empathy through the L.O.V.E.TM approach to empathetic communication.

Conclusion

The Performance of Caring course has yielded overwhelmingly positive responses from students with each iteration. One student writes, ‘This is one of the most challenging yet rewarding classes I have ever taken and worth all of the money I spent on tuition’ (DeSoto-Jackson 2017b, n.p.). Upon completion of the course, students have self-reported increased confidence, reduced performance anxiety in simulations, the development of practice-based empathetic communication skills and a heightened awareness of verbal and non-verbal behaviours. The importance of this course for healthcare professionals is encapsulated in one senior nursing student’s response; ‘I wish I had taken this course earlier since the skills I have learned in this class have made me better at communicating with patients. This should be a required course for all nursing majors’ (DeSoto-Jackson 2016, n.p.).

These innovative methods, applied within the framework of cognitive science, are intended to increase empathetic communication skills for healthcare professionals, which will lead to greater patient safety and quality of care. As we continue to explore the use of Applied

Theatre approaches, we anticipate that the course will continue to evolve. Our next step is to generate empirical evidence of the efficacy of DeSoto-Jackson's L.O.V.E.TM model. We are also developing a condensed model of this training that can be used to train healthcare professionals who are currently in the field. The potential benefits of this approach are supported by psychologists Thirioux, Birault and Jaafari, who address the issue of burnout in physicians: 'Burnout is a multidimensional work-related syndrome that is characterized by emotional exhaustion, depersonalization – or cynicism – and diminution of personal accomplishment' (2016, n.p.). They point out that while burnout and empathy are closely linked, the nature of the relationship between the two remains poorly understood, in part because of a lack of distinction between empathy and sympathy. They propose that 'clarifying the link between burnout, empathy and sympathy would enable developing specific training in medical students and continuous professional formation in senior physicians and would potentially contribute to the prevention of burnout in medical care' (ibid.). We hope that the approach we have outlined in this chapter can contribute to the development of this type of training for healthcare professionals and prompt further research in embodied empathetic communication.

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