# 11

# Acts of care: applied drama, 'sympathetic presence' and person-centred nursing

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The practices and principles of nursing have long been associated with kindness, respect and compassion (Nursing and Midwifery Council, 2015). Nursing pedagogy promotes these attributes as necessary for humanistic, 'person-centred', therapeutic practice. Professors Brendan McCormack and Tanya McCance, in the Person-Centred Nursing Framework (PCNF, see Figure 11.1), identify the importance of 'respecting the patient's rights as a person, building mutual trust and understanding and developing therapeutic relationships' (2017: 1). Such values resonate with a relational ethics of care, as described by Virginia Held (2006), Joan Tronto (2013) and Nel Noddings (2013). However, nurses sometimes struggle to maintain these principles in the face of increasingly 'mechanistic' paradigms of care (de Zulueta, 2013: 123), inadequate staffing levels and ever-changing challenges to patient safety (Louch *et al.*, 2016).

In the wake of critical reports on the UK National Health Service (NHS), there has been increasing concern about the quality of the 'patient experience'. A nationwide report into complaints against the NHS, which received more than 2,500 submissions, described 'many accounts of patients not being treated with dignity or respect' (National Archives, 2013: 16). The Belfast-based Patient Client Council Complaints Support Service, in their 2016–17 annual report, identified communication problems and staff attitude as the basis for 28.5 per cent of total complaints (PCC, 2017). The same report shows that the most effective methods for resolving complaints, all of which depend on interpersonal communication, account for 82.5 per cent of all resolutions. This evidence suggests that improved communication skills could resolve many of the issues faced within the NHS – and health

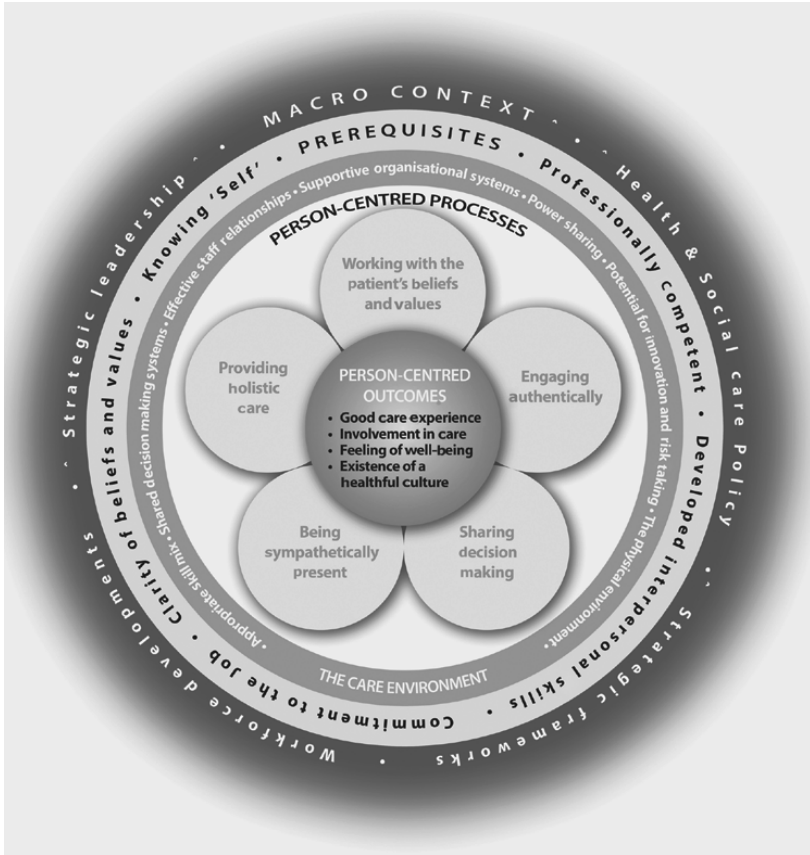


**Figure 11.1** Person-centred nursing framework

care globally – yet these so-called soft skills are often neglected within medical and nursing training in favour of a focus on technical or hard skills (Monden *et al*., 2016).

This chapter discusses an interdisciplinary teaching project at Ulster University (UU) that has attempted to address some of these issues through a combination of applied drama, actor training and simulation training. Through this pioneering collaboration, Drama lecturer Dr Matt Jennings has worked with nursing lecturers Pat Deeny and Mary Findon-Henry to improve the communication and interpersonal skills of UU adult nursing and mental health nursing students since 2013. The project initially intended simply to improve the nursing students' performance in the role-play assessments used to evaluate their clinical skills in the final year of their studies. However, as the project developed, it emerged that specific techniques derived from drama training provided nurses with a systematic approach to improving the performance of care in general.

Such a systematic approach to communication training appears to be an urgent necessity. Health care simulation is a global phenomenon, rich in potential as a pedagogical methodology (Aggarwal *et al*., 2010), yet the research literature has repeatedly identified a need for more systematic approaches to training and evaluation in communication skills (Hallenbeck, 2012; Levett-Jones and Lapkin, 2014). A 2016 'review of reviews' covering dozens of international studies in the field of health care simulation, identified a widespread need for 'stronger simulation designs, standardization of the process from prebrief to debrief, and faculty training', particularly to address poor interpersonal communication (Doolen *et al*., 2016: 301). Research in the field 'clearly indicates a need for specific training to address such deficiencies in communication […] such training should start from undergraduate level and continue into postgraduate professional development, involving as many professions as realistically possible' (Siassakos *et al*., 2011: 148).

Findings from this project suggest that drama training for health professionals could help to address such deficiencies. Drama training can provide a framework for reflecting and improving on interpersonal interactions – in simulation, in clinical practice and in everyday life – and a set of techniques with which to practise related skills. Our experience suggests that drama training for health professionals has great potential to improve current approaches to health care simulation and the performance of care within the wider health sector. This collaborative combination of applied drama with clinical skills training supports both cognitive and emotional approaches to improving communication and care relationships.

The chapter begins by outlining the place of this project within the broader field of arts and health, exploring the gaps and intersections between applied drama and health care simulation. It will then discuss some key principles of contemporary nursing pedagogy, such as the PCNF and 'sympathetic presence' (McCormack and McCance, 2010: 3). After this, it will examine key practices and moments that have emerged during the delivery of the project, as part of a qualitative investigation of its outcomes and impact.

## *Arts and health*

In terms of interdisciplinary practice, arts and health (or 'arts in health') has become a rapidly expanding area of research and practice (White, 2009; Baxter and Low, 2017; Fancourt, 2017). According to Mike White (2009), creative arts interventions in health care settings help to build relationships, maintain resilience, create more comfortable and user-friendly clinical environments, and support holistic approaches to care. Arts activities are a means of 'nurturing and sustaining meaningful human relationships' in support of individual and social health and well-being (White, 2009: 3).

The UK government All-Party Parliamentary Group (APPG) report *Creative Health* (2017) presents substantial evidence that participation in the arts can be beneficial for mental and physical health, recovery and well-being. Veronica Baxter and Katherine Low (2017) argue for a deeper understanding of the impact that social factors (such as economic disadvantage, environmental pollution, geographic and psychological isolation) can have on health outcomes. From their perspective, arts interventions should aim to address social inequalities, political structures and other contextual factors, as well as supporting well-being through participation.

Emma Brodzinski (2010) examines a wide range of performance-based practices within the field of arts in health, including theatre in health education and health care simulation. Brodzinski discusses role play for training and evaluation, which has become a core element of health care training globally. One common approach is to use actors to play patients (known as 'standardised patients' or 'patient actors'), an internationally established practice since the 1960s (Barrows, 1993). For instance, Loth *et al.* (2015) describe a long history of specialised training for patient actors in Australia since 1975. The use of such patient actors allows health care students to simulate the practitioner–patient relationship in a consequence-free environment. This approach has become crucial to the assessment of students and practitioners of medicine and nursing. For instance, all UK-based health professionals must demonstrate their clinical skills through evaluation processes like the Objective Structured Clinical Examination (OSCE), which includes elements of simulation and role play.

There has been little crossover to date between the specific practice of health care simulation and the broader social practices of applied drama. Applied drama interventions that do engage with health care training often seek to support the development of creativity and empathy in general terms, in line with the idea that the medical humanities can help to humanise medicine (White, 2009; Baxter and Low, 2017; Fancourt, 2017). Yet few arts interventions have attempted to use applied drama techniques to address specific clinical problems in the performance of health care.

Some approaches have sought to narrow the gap between these potentially complementary performative techniques. The APPG report *Creative Health* (2017) cites the Performing Medicine project, developed by Clod Ensemble in London, as a rare example of an approach that involves close collaboration between artists and health practitioners to improve skills in clinical practice. Performing Medicine employs visual artists, dance and theatre practitioners to work with medical professionals, exploring clinical experiences, in order to develop new ways to resolve communication issues. These interdisciplinary teams use the circle of care model to improve 'nonverbal communication, self-care, spatial awareness, and appreciation of the person with an emphasis on understanding the perspectives and contexts of others' (Willson and Jaye, 2017: 643). Similarly, Reeves and Neilson (2018) discuss a project that used forum theatre to present interactive versions of simulated scenarios in palliative care, to improve nursing

students' communication skills. In Sweden, the drama caring and reflection in nursing education model (DRACAR) has used drama workshops alongside traditional nursing teaching to address gaps between nursing theory and praxis. Students bring their own experiences of delivering or receiving health care into workshop sessions, where they use 'drama techniques such as improvisation, role-play, forum-theatre, and nursing-play' to rehearse alternative actions and behaviours (Ekebergh *et al.*, 2004: 625). Such arts and drama interventions could potentially begin to bridge the gap between arts in health practices and conventional health care simulation.

## *Health care simulation*

The term 'health care simulation' is an umbrella term for all forms of simulation used in the preparation and training of health care students and professionals. There is abundant evidence that simulation training can improve clinical skills. For instance, Victor *et al.* (2017) have found that simulation training for nurses led to improvements in knowledge levels, critical thinking and clinical judgement. Health care simulation increasingly incorporates theatrical production elements, such as costumes, props, make-up and automated mannequins (Lateef, 2010; McAllister *et al.*, 2013; Reid-Searl *et al.*, 2014). Lateef notes a plethora of 'new techniques and equipment' improving practitioners' confidence and skills while avoiding patient risks (2010: 348–9). Mannequins for medical simulation are increasingly sophisticated, automated and technically specific; some are designed for needle insertion and airway management or feature rubber orifices for catheter insertion. However, a reliance on robotic mannequins can reinforce mechanistic paradigms of treatment, as against more holistic approaches (Brodzinski, 2010; de Zulueta, 2013; Reid-Searl *et al.*, 2014). Despite the technological innovations, the area of greatest need is still training in communication and interpersonal skills, both with patients and within health care teams (Siassakos *et al.*, 2011; Hallenbeck, 2012; Levett-Jones and Lapkin, 2014).

Brodzinski has also observed that there are limitations to the effectiveness of health care simulation in terms of credibility and commitment, arguing that role play can seem 'hyper-real', leaving students 'painfully aware of the false nature of the scenarios' (2010: 123–4). One consequence of this is that 'students may realise the setting is artificial and fail to fully engage, attend or remember' (McAllister *et al.*, 2013: 1453). In addition, Fidment (2012) highlights the intense levels of stress and anxiety experienced by students subjected to the OSCE examination process. While these studies focus on deficiencies in terms of realism and performance anxiety, other studies (see Bach and Grant, 2017; Gault *et al.*, 2017) urge a greater focus on kindness, respect and compassion within simulation training. For this to occur, health care simulation needs to promote a shift away from the primacy of technical skills and recognise the importance of interpersonal and communication

skills, treating 'the person as a whole, concerned with the interrelationship of body, mind and spirit' (McEvoy and Duffy, 2008: 414).

## *PCP, sympathetic presence and empathy*

One prime example of a more holistic approach to nursing is person-centred practice (PCP). The PCP approach hinges on the primary concept of 'personhood', whereby an individual is treated as someone with his or her own characteristics, values, beliefs, attitudes, unique life story and future goals. PCP models, such as the PCNF, provide guidance for inciting and sustaining cultural changes in health care environments. The framework addresses 'person-centredness' throughout the whole system of care, considering such *macro* elements as 'care environment' and 'health and social care policy', as well as *micro*-level factors, such as 'shared decision making' and 'providing holistic care' (McCormack and McCance, 2010: 3)

The framework also addresses empathy and its place within nursing practice, suggesting the alternative term 'sympathetic presence'. The PCNF defines sympathetic presence as 'an engagement that recognises the uniqueness and value of the individual, by appropriately responding to cues that maximise coping resources through the recognition of important agendas in their life' (McCormack and McCance, 2017: 102). When sympathetically present the nurse is 'in the moment' (McCormack and McCance, 2010: 104), paying attention to how other people feel, without trying to assume or share their emotional or physical state. As McCormack and McCance describe it, sympathetic presence involves a recognition that a conventional understanding of 'empathy' (i.e. to 'walk in another person's shoes') is neither desirable nor possible, as one person cannot 'fully comprehend another individual's particular experience' (2010: 102).

Meanwhile, attempts to improve the capacity for empathy among health care students have encountered significant challenges. For example, a study conducted by Nunes *et al.* (2011) showed that self-reported empathy scores for undergraduate medical and nursing students, based on questionnaire responses, significantly declined during the period of their training. There is also evidence that some attempts to improve empathy within health care education have been counterproductive. A study conducted by Ward *et al.* (2012) discovered that students exposed to situations designed to improve empathy, including interactions with real patients, had lower empathy scores after the interventions. A study by Heggestad and colleagues discovered that undergraduate nursing students appeared to suppress their personal responses to challenging clinical situations, through strategies of 'emotional immunisation' (2016: 11). Student responses became increasingly limited to the realm of 'cognitive empathy', 'the capacity to understand and imagine the lived experiences of other persons', as against 'affective empathy', which is 'both a bodily and spontaneous emotional experience' (Heggestad *et al.*, 2016: 2). These students, perhaps understandably, were better prepared to

consider another person's situation through rational and practical understanding, rather than allowing themselves an emotional reaction to the suffering of another.

Nursing students and practitioners who resist or reject affective empathy might be trying to manage the demands of the emotional labour of care (Smith, 1992). Such emotional labour is seen as a crucial aspect of the nursing profession; yet it rarely features as an explicit element of traditional nursing education. The decline in empathy scores, as nurses try to immunise themselves against their patients' pain, may be a tactic to avoid emotional burnout. Heggestad *et al.* (2016) observe that although 'affective empathy' may be desirable, students can often experience 'empathic overarousal', a term attributed to Hoffman (2000: 13), whereby 'affectivity becomes so overwhelming that it becomes uncontrollable for the person and clouds his or her judgments' (Heggestad *et al.*, 2016: 10). The question for this chapter is whether practical training in sympathetic presence can develop skills in both cognitive and affective empathy, encouraging nursing students to engage with the patient experience while supporting their own capacity to cope.

Alternatively, as the project has developed, we have considered whether it might be appropriate to abandon the conventional idea of empathy completely, as some drama practitioners have done. Political and applied theatre artists, since the early twentieth century, have rejected the perception that drama should generate empathy through identification with a hero, as originally suggested by Aristotle. Both Bertolt Brecht and Augusto Boal asserted that the traditional Aristotelian focus on the fate of the tragic individual – whereby audiences should identify with the suffering of the protagonist and cathartically 'feel their pain' – is coercive, limiting the capacity for independent critical thinking, social agency and collective action (Brecht, 1978; Boal, 1998; Nicholson, 2005).

Boal, trying to avoid such fixed narrative functions, developed theatrical techniques that allow spectators to intervene in the onstage action and take an active role in changing the story (1998: 33–5, 102–4). He titled this approach to socially conscious, interactive theatre making 'theatre of the oppressed' inspired by Paolo Freire's 'pedagogy of the oppressed' (Freire, 2000). Forum theatre, a core element of the theatre of the oppressed approach, is a format in which audience members can engage with performances devised to represent their own challenging experiences. We will discuss this technique in more detail later in the chapter. Both Brecht and Boal called for dramatic forms that encourage critical discourse and pragmatic community action, for theatre that supports actual social change.

One way that applied drama can transform health care training is to encourage a shift in the conception of care from fixed *adjectival* forms (such as 'I am a caring person' or the 'care system') towards more fluid and relational *verb* forms (such as 'I care for you' or 'we care for each other'). This shift supports a mutual and pragmatic recognition of vulnerability, interdependence and contingency, reflecting the debate between the paradigm

of an ethics of care and more traditional virtue ethics. For example, Held (2006) characterises virtue ethics as emphasising the inherent attributes of the individual – the virtuous traits that an individual possesses – rather than the fundamental interdependence of human beings, encountered in the relational act of care.

Applied drama can help to understand the performance of care as a set of relational tasks, based on transitive verbs (e.g. 'to reassure', 'to comfort', 'to observe', 'to listen'). The performance techniques of Constantin Stanislavski (discussed in more detail later in this chapter) analyse the subtext of any given situation – the meaning of what is actually happening between people – as a set of such transitive actions and reactions. Basic actor training can improve the performance of such actions. In the process, actors can learn to attend more closely to the responses of other people. This 'attentiveness' is a key element of Tronto's model of care ethics, which posits it as a primary necessity in the delivery of care (2013: 34). The cultivation of conscious attentiveness can help carers to recognise and clarify their intentions (both conscious and subconscious) and the consequences of their actions within the caring relationship.

Framing sympathetic presence as a relational practice of attention and intention in the performance of care, means that it can be taught and learnt as a specific set of transferable skills, using time-honoured techniques drawn from actor training. While sympathetic presence is only one factor in the PCNF, it is the process whereby carers 'establish a therapeutic relationship', crucially described as 'the fabric that weaves together other person-centred processes' (McCormack and McCance, 2010: 103). Yet there is little detail in the research and teaching literature to explain how the process of sympathetic presence might actually be applied in practice. Acting techniques can improve communication in health care simulation and clinical practice, by providing a framework for understanding sympathetic presence in pragmatic terms, as a set of skills based in attentive interaction.

In keeping with the dialogical, contextual and relational conception of care, we have engaged in a continuous process of pedagogical collaboration and shared reflection with students and staff, from both nursing and drama, adapting to the needs and perspectives expressed by the participants and co-researchers as the project has developed. In this way, we have tried to model the processes of person-centredness in our teaching and research, as well as practice. The next section of the chapter highlights some of the key developments in this methodology as it has emerged over the last five years.

## *Developing practice in action: processes and moments*

### Early stages: role play and forum theatre 2013–15

This interdisciplinary project has seen many changes, adaptations and breakthroughs. It began with a workshop in June 2013, introducing UU

nursing lecturers and tutorial assistants to applied drama, as a methodology to enhance their creativity in teaching. Dr Matt Jennings (first author of this chapter) facilitated the drama workshop. Senior nursing lecturer Pat Deeny (co-author of this chapter) saw the potential of drama training as an element of nursing pedagogy and suggested that it might help nursing students to perform their final year role-play assessments. While nursing students had been playing doctors, patients and family members, as well as nursing staff, in their simulation scenarios, many had been struggling with performance anxiety, particularly in front of a camera, and some found it hard to take the simulation seriously. Jennings and Deeny believed that drama might help the students with these issues and planned a workshop to explore the possibilities.

Initially, from September 2013, applied drama was introduced within the curriculum of a compulsory third-year nursing module, 'The Safe and Effective Nurse'. The module requires groups of nursing students to present a role-play scenario, based on real-world encounters, in order to demonstrate their technical and communication skills after a six-week period of clinical placement. Groups of eight nursing students are allocated one of three fictional scenarios, each of which includes three phases in the treatment of an individual patient, and are encouraged to prepare and rehearse their presentation before the assessment. The simulations are filmed on a fixed camera; afterwards, the students watch the footage and reflect on their performances in an essay assignment. In early iterations of the module, students had consistently expressed concern about the presence of the camera and a lack of belief in the verisimilitude of the scenarios and were often self-conscious about watching themselves on screen.

In September 2013, 240 final-year nursing students attended drama workshops facilitated by Matt Jennings, in groups of 60 students per one-hour session. The aim of the workshop was to ease their performance anxiety and support their ability to commit to a convincing realism in their role-play scenarios. Each workshop began with basic relaxation and breathing exercises drawn from yoga and martial arts, centring the participants in their bodies, followed by warm-up drama activities drawn from Boal's *Games for Actors and Non-Actors* (2002). The students then explored exercises associated with the 'method of physical action', as developed by Constantin Stanislavski (Carnicke, 2010: 16). While Boal is probably the most influential practitioner in the field (Babbage, 2004), Stanislavski's approaches to acting and actor training are less commonly associated with applied drama. The nursing students engaged in basic exercises in developing their ability to perform 'actions' and 'objectives', according to Stanislavski's understanding of sub-text (Benedetti, 1998). As mentioned above, an 'action' is a transitive verb, something that someone attempts to 'do' to someone else, while the 'objective' is the intended goal of those actions, often understood as the need or desire of a specific character within a set of given circumstances (Benedetti, 1998: 6). Through dramatic improvisation, nursing students explored playing actions on each other (such as 'I reassure you', 'I

challenge you' and 'I observe you'), with clear objectives (such as 'I want you to trust me' or 'I want to get an accurate diagnosis'), within such given circumstances as a busy emergency ward or a patient's home.

Student responses following this introductory session were encouraging, although the lecturers felt that a more substantial intervention would be necessary in order to provide more context and explanation of its relevance to clinical practice. In the following academic year (2014–15), UG drama students taking an optional 'Theatre and Community' module joined the workshops and collaborated with nursing students as co-creators in a devised performance.

After an initial set of drama workshops with the full cohort of 220 nursing students, a small group of drama students devised a short forum theatre play, based on the experiences of a subgroup of nursing students during their clinical placements. In forum theatre, audiences watch a performance based on real-world problems encountered by members of their own community or collaboratively developed with other groups facing similar challenges. After the first presentation of the play, the actors perform selected scenes again; during this replay version, audience members can stop the action at any point and replace an actor in the scene, to try to change the outcome. In this way, forum theatre audiences transform themselves from passive spectators to active 'spect-actors' (Boal, 1998), enhancing their capacity for creative agency, through imagining and practising possible solutions to real-world problems.

From September to December of 2014, five drama students developed a forum theatre play drawn from weekly communication with twenty-five volunteers from nursing. The play presented the character of Jane as its protagonist, a nursing student on clinical placement who has experienced bullying, inappropriate behaviour and inadequate instruction from senior colleagues. In one scene of the forum theatre play, Jane encountered a character from one of the simulation scenarios presented in the 'Safe and Effective Nurse' module, John-Jo McKitray. According to the brief for the simulation scenario, John-Jo is an eighty-one-year-old farmer from North Antrim in the early stages of dementia. In the early phases of the scenario, John-Jo (played by one of the nursing students) has had a fall and fractured his hip, setting off a traumatic process of pain, confusion and distress over the following phases.

During one of the later phases of the scenario, a confused and vulnerable John-Jo demands to see his wife. John-Jo's wife has been dead for twenty years and the nursing students treating him are aware of this. In the simulation assessments, this moment often stumped the nursing students; later, watching the filmed footage of themselves, many realised that they had performed unhelpful actions or not paid enough attention to the patient in the moment. Some had lied to John-Jo, telling him that his wife was on her way or simply ignored his distress while concentrating on their clinical tasks. At this point, they began to understand the importance of sympathetic presence. This insensitivity was compounded by the surprise twist in the

scenario – a moment of dramatic interaction not included in the brief – in which John-Jo's son or daughter (also played by a nursing student) suddenly arrives and becomes outraged that they have misled her father by telling him that his wife is still alive. After watching the footage, many students realised that their own discomfort had affected their performance of care, particularly when they tried to avoid the interpersonal challenges of the situation. Yet despite these realisations, many nursing students struggled to identify specific methods to overcome the challenge. The drama students decided to include the John-Jo scenario in the forum play, to see whether nursing students might be able to share constructive ideas for alternative courses of action.

The drama group performed the forum play for the third-year nursing students at the end of the semester, after the completion of their role-play assessments. In the final scene, Jane struggled to handle John-Jo's demand to see his wife and his escalating distress. The hospital staff were either unable or unwilling to help. The joker, or master of ceremonies (Luke Merritt, who contributed to the development of this chapter) encouraged nursing students from the audience to take over the role of Jane and demonstrate how they might handle these challenging 'given circumstances'. A few brave 'spect-actors' experimented with various strategies to change the outcome, while the drama student playing John-Jo (Harrison McCallum, who also contributed to this chapter) improvised and reacted to their actions.

One nursing student played a particularly effective set of actions, achieving their objective of soothing John-Jo while maintaining his trust. Instead of lying to him or rejecting the request to see his wife, the nursing student first spent some time engaging with John-Jo on a non-verbal level, attending to him 'in the moment' as he repeatedly asked for Margaret. During a pause in John-Jo's refrain, the nursing student responded: 'So, I hear that you're a farmer up in Antrim? How's that going these days?' The actor playing John-Jo stopped for a moment to consider his answer. At this point, the audience of nursing students erupted in laughter, and then applause. During the subsequent conversation about farming, the nurse guided John-Jo back to his bed, providing an instructive example to a hapless doctor character in the process, leading to further laughter. This laughter seemed to come from the moment of recognition, seeing a nursing student playing identifiable actions to achieve clear objectives; it also reflected the potential for aesthetic delight in live performance, when neither actor nor audience know what is going to happen next.

The value of this moment was not just in the creation of a comic scene. The nursing students witnessed one of their peers successfully demonstrate person-centred care in action, through sympathetic presence, within a familiar yet challenging clinical situation. In doing so, the 'spect-actor' showed that nursing students could demonstrate exemplary communication skills despite their relatively low status in the hospital hierarchy. In addition, the momentary pause provided a flash of non-verbal communication to the whole audience; it represented an eruption of uncontrolled and unpredictable

agency, of 'liveness' in the performance of care, releasing the collective anxiety about technical competence. This performance of relational action showed that a carer could practice person-centred care while achieving clinical tasks in a challenging environment – crucially, in an unrehearsed, non-coded and spontaneously creative way. This was the point when Jennings and Deeny realised that applied drama had the potential to provide a set of techniques for teaching sympathetic presence as a specific practice, rather than a general concept or an inherent attribute of the professional carer. Prior to this, UU nursing staff and students had struggled to define sympathetic presence beyond the abstract PCNF definitions discussed above. Part of the purpose of this chapter is to suggest a fuller definition of sympathetic presence that bridges the gap between theory and practice.

## Developing practice: 'presence', 'attention' and 'intention' 2016–18

The role-play assessments in 2013–14 and 2014–15, as well as the forum theatre presentation in 2014, confirmed that applied drama could both ease students' anxiety and provide a toolkit to support their understanding of the performance of person-centred care. We continued to develop the principles of the toolkit over the next two years, adapting our approach in response to feedback from students in their module evaluations, as well as tutorial assistants involved in the assessing of the simulations. Some nursing students had requested an earlier introduction to applied drama, in order to give them time to understand the principles and techniques before the pressure of final-year assessments. In 2016–17, the intervention was adapted to include an introductory drama workshop in the final semester of the second year of the nursing programme, to prepare students before their simulation assessments in the following semester. The same cohort received two further drama sessions during the first semester of their third (and final) year, prior to the role-play assessments. Matt Jennings delivered these workshops with the support of third-year drama students studying a module in 'Performance and Health'. The extra workshops also introduced basic techniques of puppetry and object theatre, using these skills to animate medical mannequins. We do not have space within this chapter to discuss the experiment with applied puppetry, although this will be the subject of a future publication.

In 2017–18, the two third-year workshops lasted an hour and a half, as against the previous sessions of forty-five minutes. Participant numbers for each workshop were also decreased (from sixty nursing students to thirty-five), to allow more time and attention for small groups and individual students. There was an extra follow-up session during the final week before their simulation assessments, where drama staff and students provided brief, but detailed, feedback to small groups of nursing students rehearsing their scenarios. The role of the drama team was to remind nursing students to play actions and objectives, paying attention to their interpersonal relations with patients, family members and each other. At this point, many

nursing students had become primarily concerned with performing technical skills correctly, with a lesser focus on communication.

Next we will discuss four individual exercises from the training programme in detail. In particular, it will examine moments that have emerged during the delivery of the workshops that have stimulated significant critical reflection on the function of the methodology. These four moments challenged our thinking in ways that were productive and profound, yet occasionally problematic. These moments highlight the potentially fruitful intersections and collisions between nursing practice, care ethics, sympathetic presence and drama training. The first three moments are described from the point of view of co-author Karl Tizzard-Kleister, who has been researching this project for an interdisciplinary doctoral thesis since 2017 and are extracts from a first-hand report of Karl's observations while participating in the workshops led by Matt Jennings in June and September 2017, as well as his experience of facilitating an introductory workshop himself in June 2018. They describe the experiences of workshop participants as they encounter the three key concepts of 'presence', 'attention' and 'intention'.

## Presence

> After a brief introduction welcoming the nursing students to the session, the workshop begins with breathing exercises designed for relaxation and centring. The groups quickly find a collective awareness in exercises drawn from Aikido martial arts, which focus on synchronising breath and movement; the entire group simultaneously enact the same movements and breathing patterns. For every group who perform this exercise, an awkward and profound silence follows the final collective out-breath. This moment is held for as long as possible. This moment and atmosphere, the facilitator explains, represents 'presence'. The group are encouraged to offer what they think 'presence' might mean, beginning the dialogical learning that recurs throughout the workshop. Participants have the opportunity to explore their ideas, to embody them and reflect on them. Students tentatively offer thoughts on what 'presence' might be. Some say it is 'not having your mind elsewhere', others use the nursing terminology of 'sympathetic presence'. Most groups come to define presence as 'being here and now', which is shown to be related to the concept of 'stage presence', and indeed illustrates bodily what sympathetic presence might feel like. (Tizzard-Kleister, unpublished notes, 2017)

## Attention

> The concept of 'attention' is introduced through an 'image theatre' exercise (Boal, 1998) whereby two people stand still in freeze frame representing a handshake. This then changes into an image of one person turning their back on the other. These images provide a stimulus to discuss their understanding of space, physicality and relationality. It further deepens the engagement with dialogical pedagogy, as participants realise that each person's interpretation of the image is distinct and yet valid. After this,

the group spilt into pairs and engage in activities, such as mirroring and Colombian hypnosis (Boal, 2002), which involve a leader and a follower. The students explore the sensitivity required to allow the follower to follow, as well as the consequences of certain actions as they explore and exchange leader/follower roles. The students express an embodied experience of control, resistance and power. Some participants find relinquishing control difficult, others say that being in control felt uncomfortable. Group discussions focus on how they may be required to take control of difficult situations or relinquish control to others in certain clinical circumstances. This consideration of the ability to take and relinquish control may allow them to recognise when patients might want to take control of their own care or when they might need another person, such as a nurse, to share this control with them. (Tizzard-Kleister, unpublished notes, 2017)

## Intention

The next step in the workshop focuses on the importance of conscious and unconscious 'intentions' in interactions between subjects. In non-verbal activities and short improvisations, participants practice playing actions with objectives. One scenario involves two nurses ignoring a silent patient, who is begging for help, but is motionless and can only communicate with their eyes, while the nurses discuss what each other is wearing. Many of the students note that it is startlingly easy to ignore a silent person, although their 'presence' never entirely goes away. The interactions build in complexity, as the students explore a variety of tactics to achieve their 'intentions'. 'Given circumstances' are then added to these interactions, creating situations for the small groups to recreate, such as 'explaining complex treatment in a busy ward' or 'giving bad news to an anxious relative'.

The participants often remark surprise when they discover that what they say does not always convey what they mean in these situations. Those playing the patient characters are equally surprised at what they can learn from their peers' performance of care. For instance, the use of a patient's first name, though indeed a personal touch, can alienate the patient if it is overused or begins to sound formulaic. Similarly, physical contact may or may not be appropriate in different circumstances and with different people. This is interesting, because most of the students believe that sympathetic presence depends on maintaining eye contact, performing therapeutic touch or addressing the patient by their first name. Only when a student tries to play counter-intuitive or taboo actions, such as to ignore or intimidate a patient, do they realise how common – and damaging – these behaviours might be. In this way, the students are better able to understand the need to be sympathetically present, attentive and responsive in the moment. (Tizzard-Kleister, unpublished notes, 2017)

## 'I could be hurt by you'

The following section draws on the reflections of all the authors, in relation to a particularly powerful and affective exercise – known as 'I could be hurt by you' – that distils the essence of the approach and provides an intensely

interpersonal encounter of shared vulnerability. It provokes an embodied and emotional understanding of what it means to depend on others for safety and well-being – an uncomfortable subjective position, yet deeply relevant to performing care in clinical practice.

The delivery of some drama exercises has remained the same since the beginning of the project (such as 'mirrors' and 'hypnosis'); others have been regularly revised and adapted at various stages, including 'I could be hurt by you'. This activity has been used in almost every workshop since the beginning of the applied drama intervention. The intention of the exercise is to create a moment of affect, a short performative act embracing an aesthetic of mutuality and care (Thompson, 2015). Matt Jennings first encountered it while training as an actor at the University of Western Sydney in the early 1990s and has adapted it for use in a wide range of community contexts ever since.

The activity involves pairs of partners, holding hands and looking into each other's eyes for the duration of the exercise. The facilitator asks the partners to think about each other's eyes in various ways – to imagine that they are looking into the eyes of a baby or the eyes of a very old person. They are also asked to love them, then to hate them and then to let their imagination run wild. Finally, they are asked to speak a simple line of dialogue to each other: 'I could be hurt by you'. They can deliver the line any way they wish, while continuing to hold hands and maintain eye contact. They must say it at least once, but they can repeat it as many times as they like. After some time, when all of the participants have uttered this phrase at least once, they then acknowledge the end of the task with a hug, a handshake or whatever exchange feels mutually comfortable for each person.

Some participants in the initial sessions in 2014 and 2015 reported feeling uncomfortable after the exercise. These participants were generally unable to articulate specific reasons for feeling this way, but some said that they felt intensely emotional after the exercise. For some, it was a profoundly moving experience; for others, it was awkward and confronting. Some said that it was both meaningful and uncomfortable at the same time. By 2017, it was clear that the project team needed to be sensitive to the range of potential responses to the exercise and to ensure that participants did not leave feeling hurt or troubled by the task. The value of the exercise as an aesthetic experience of care is difficult to define, but impossible to overlook. We wanted to ensure that the exercise aligned with what we intended to communicate – the interdependence and shared vulnerability of the caring relationship, and the emotional connection required to build such relationships.

Before the 2017–18 nursing workshops, the project team considered the feedback from previous years and extensively discussed the ethics and affective impact of this particular exercise, agreeing that we should adapt it in some way and provide 'trigger warnings' about the emotional risks. In addition, participants were told that if the actions 'to love' and 'to hate' seemed too confronting, then they could try to play the actions 'accept' or 'reject' instead. During the introductory workshop in June 2017, Matt

Jennings also added an extra element of instruction, in a moment of improvised facilitation. Instead of ending on the statement 'I could be hurt by you', he asked the participants to follow this with 'and you could look after me'.

The addition of the statement 'and you could look after me', after 'I could be hurt by you', acknowledges that while we might have the power to hurt each other, we also have the capacity to do the opposite. The sensation, as well as admission, of vulnerability is an integral part of the exercise. Students are encouraged to recognise and embrace the *necessity* of emotional interdependence with their partner. Students anecdotally and observationally responded favourably to the adaptations.

This simple task is still challenging for participants. They are asked to 'stay with the trouble', to borrow the evocative title of Donna Haraway's 2016 book. 'Staying with the trouble' means that we cannot solve problems independently of the messy and entangled contexts in which they occur. 'I could be hurt by you' asks participants to admit their own vulnerability and recognise the vulnerability of another in an affective relational exchange, in an aesthetic performance of an ethic of care.

Nursing is not traditionally associated with taking conscious risks; safety and contingency are the priorities in an intensely high-stakes profession (Dingwall *et al.*, 2017). However, practitioners are required to be open in their communication with those they care and are often required to advocate on their behalf. As the theorists of person-centred practice explain (McCormack and McCance, 2010, 2017), this is not possible until a nurse first 'knows themselves' and is comfortable with their own vulnerabilities. Feminist thinkers (see for example, Butler *et al.*, 2016), argue for a re-evaluation of vulnerability, away from ideas of victimhood and passivity. Political philosopher Martha Fineman (2008) suggests that far from being a state of lower status and victimhood, vulnerability is in fact a key ontological feature of being human.

Nicholson defines applied drama as providing a creative space where 'people feel safe enough to take risks and to allow themselves and others to experience vulnerability' (2005: 129). If nursing education struggles to provide such a 'safe space' for students to challenge the perception of vulnerability as a sign of 'victimhood', perhaps applied drama can provide the techniques and spaces to explore the emotional risk of 'person-centred' nursing practice. Through drama, nursing students can embrace their own vulnerability in safety.

## *Conclusion*

This chapter makes the argument for collaboration between nursing and drama pedagogies, in order to deepen students' understanding of the relationships that they build with those in their care and provide methods to enhance their communication skills, both emotionally and cognitively. The scope for the application of drama training to health care simulation,

within a person-centred curriculum, is clear and has great potential for further development.

This approach asks nursing students to develop skills in sympathetic presence through health care simulation, in order to enhance their ability to engage in caring relationships that are compassionate as well as technically competent. This collaborative approach to health care simulation and applied drama practice promotes an understanding of care as a fluid and formative relationship, not just a clinical task. Drama pedagogies can provide novel and effective methods to improve the performance of person-centred nursing. Training in these skills can also support the professional and personal resilience of the health practitioner. Drama training can provide opportunities to learn to look after oneself, as well as the people one cares for, by helping us to come to terms with the limits of our capacities, to acknowledge our shared vulnerability and to 'rehearse the transformation' of the caring relationship.